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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	Larry Levitt, "Managed Competition and Global Budgets: Fitting Fiscal Discipline to Market Forces" (15 pages)	12/1992	P6/b(6)
002. list	Requests to attend the health care conference (1 page)	ca. 02/09/1993	P5

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Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Materials, 1993 - 1994)
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FOLDER TITLE:
HRC Briefing Pennsylvania Health Care Conference, February 11, 1993 (Binder) [2]

Kara Ellis
2006-0810-F
ke220

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]
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Requests to attend the health care conference
that have been turned down as of 1:00 pm Tuesday 2/9/93

Samuel Depasquali, M.D.
480 Pierce Street
Kingston, PA 18704
717/288-3558 (w)

Jean Golumb
DES State Chair
RR2, Box 2251
Nescopeck, PA 18635
717/759-8365
(heard about the conference on the news)

Charles E. Davidson, Esq.
Vice President of Strategic Planning
General Counsel
Managed Care of America, Inc.
820 Parish Street
Pittsburgh, PA 15220

Lynn Cooper Breckenmaker
Capital Area Health Care Coalition
P.O. Box 360
Camp Hill, PA 17001
717/761-7380; fax 717/763-4779
(called and requested an invite; La-Verna not familiar with this group)

Polly Spare
Voices of Retarded
210 Hillendale Drive
Doylestown, PA 18901
215-348-4059 Fax 215-348-4029

Donald Snow
Plumbers and Pipefitters Local Union 520
7193 Joanstown Road
Harrisburg, PA 17112

Charles Davidson
412-922-2803

Rocco and Bob Artenzio
Continental Medical Systems

Frannie Battista
PMS

Jenny Williamson

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Structure of the New System: Health Reform Briefing 1 (2 pages)	03/17/1993	P5
002. briefing paper	Malpractice and Tort Reform: Health Reform Briefing 2 (1 page)	03/18/1993	P5
003. briefing paper	Underserved Populations: Health Reform Briefing 3 (2 pages)	03/19/1993	P5
004. briefing paper	Benefits: Health Reform Briefing 4 (2 pages)	03/20/1993	P5
005. briefing paper	Long Term Care: Health Reform Briefing 5 (2 pages)	03/23/1993	P5

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FOLDER TITLE:
Health Care Reform Briefings [1]

Kara Ellis
2006-0810-F
ke1020

RESTRICTION CODES

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Structure of the New System

Health Reform Briefing 1 -- March 17, 1993

This briefing for the President, Vice President and First Lady reviewed the structure and the responsibilities of the purchasing cooperative in the new system. Key elements of the new system including responsibilities for states and the structure of both the purchasing cooperative and accountable health plans were discussed, but further specification of structure and standards for operation are needed for drafting. Specific issues raised in the discussion included:

- **Participation in the Purchasing Cooperative;** Should we require all employees to be in the HIPC or permit employees in firms outside the HIPC to elect to receive their coverage through the HIPC? Should firms of 500 or 1000 be required in the HIPC? HRC favored allowing anyone to join regardless of firm size and requiring firms of 1000 in the HIPC.

- **Community Rating:** Discussion of the need to age-adjust the community rate and distributional effects of moving toward community rate. It provides some assistance to firms with large numbers of retirees. Open discussion without resolution.

- **Parameters for Ideal versus Minimum Plan:** The President asked for two models of health care reform -- one that sets out the ideal system we would construct if we were building the system from scratch and the other that sets out the minimum we need to do to make this effort worth doing. President wanted to know what is the least we could do to make a difference.

- **Public Health:** Discussion with President, Vice-President, and HRC about the importance of improving the public health infrastructure and being sure that system promotes investments in health even if payoff is in the future. President wanted to see a public health component to the plan and raised issue of using base closings to provide additional sites for health care services. HRC raised issue of how we pay for public health vision and need to address this in budget for public health. President said we needed to address three federal issues -- federal delivery system (DOD, IHS, VA), federally funded local centers (CHCs), and federal subsidies (medical schools, NHSC).

- **Global Budget:** Nature of the budget and accountability at state level was explained. Agreement that state would be responsible for keeping spending within budget, but would be given a band within which to operate and mechanisms

including retroactive adjustments and taxation of plans to accomplish budget control.

- **Physician Choice:** President noted that first concern of American people is losing health insurance and second is losing choice of physicians. Doctors should be allowed to participate in multiple plans to ensure choice of physician.

- **Role of States:** States would administer the system, set up the HIPCs, monitor performance, and be at risk for the budget. The President sees the national credibility coming from the benefits from the plan and not the administration. He wants states to have the ability to fix the program if something goes wrong in the system or for a population. There needs to be a federal default if a state does not implement the program, but the President wants to use withholding federal funds as lever to get all states to participate.

- **State Opt-out:** If a state meets the fundamental principles of universal coverage for the standard benefit package and budget control, it could design and implement its own program. More guidance is needed on how the opt-out would work and what standards would be met for a state to qualify to run own program.

- **Accountable Health Plans:** With regard to the boards of AHPs, HRC viewed diversity as very important. The board of the plans should include plan providers, both physicians and nurses, as well as consumers.

- **Low-income Protections:** President asked how we would keep plans from shafting consumers, especially the poor. Discussion focused on HIPC responsibility for monitoring quality, need for upfront resource development in poor areas, and prohibition against redlining (raised here as a HIPC issue).

- **Inter-HIPC Bank:** How to hold and process the funds being collected by the HIPCs was raised. President requested a two to three hour discussion of this be scheduled.

- **Model Legislation:** We need to develop model legislation for states with regard to implementation of the new system as well as changes in state practice and managed care plan requirements.

- **Long-term Care:** President would like to see more home care available and long-term care coverage phased in, even if over 30 years. A fundamental policy decision needs to be made on state versus federal responsibility. Addressing the long-term care issues for the non-elderly population is a different issue.

Malpractice and Tort Reform

Health Reform Briefing 2 -- March 18, 1993

The briefing for the President, Vice President, and First Lady addressed enterprise liability under the new system as well as tort reform. The discussion provided specific proposals for drafting (see March 20 memo revision), including:

- **Enterprise Liability:** Federal rules should require accountable health plans to assume sole legal liability for the care they finance. Direct providers of care should not be subject to suit except in cases of gross negligence or willful, wanton, or malicious conduct.

- **Data Bank:** Plans must provide the name of the physician to the national practitioner data bank when a payment is made on a claim of negligent care by a physician. The discussion raised concern about limited use of the data bank by states in licensure decisions and the need for plans to check the bank to prevent negligent physicians from moving to other states.

- **Alternative to Litigation:** It was agreed that each plan should be required to have an alternative to litigation and make that alternative available to all plan enrollees. This mechanism would be the gate that must be passed before access to the courts. The mechanism could be chosen from a menu of options (arbitration, mediation, early offer of settlements) described by the federal government. (Note: The President said he wanted to require plans to offer the alternative mechanism, but not specify alternative in federal law. He would let states require it as a way to achieve savings. President did not want federal government to cut off access to the courts at the state level.) Use of an ombudsman process was also discussed; President was concerned about level of bureaucracy.

- **General Tort Reform:** We would require the states, as a condition of receiving federal funds through the HIPC, to prescribe limits on non-economic damages. The state could set the cap at whatever level it desired, but would have to put a cap in place. HRC requested information on the 20 states that currently have caps and the level of those caps.

- **Practice Guidelines:** The use of practice guidelines in establishing standards of care was discussed. It was agreed that this area should be encouraged and fits with the quality assurance systems to be developed to monitor care in the new system, but is not at a stage of development where use of practice guidelines could be required in the malpractice initiative.

Underserved Populations

Health Reform Briefing 3 -- March 19, 1993

This briefing for the President, Vice President, and Mrs. Gore addressed both the especially vulnerable populations that require special assistance in the reform structure and the need to develop capacity in underserved areas. The discussion focused more on identifying special needs and identifying mechanisms for addressing these needs in the new system than on a specific proposal. The major issues raised included:

- **AIDS:** The need to go beyond risk adjustment and provide a reinsurance mechanism for some populations with chronic high cost diseases, such as AIDs, was raised. The President asked whether fully funding Ryan White act programs would address the problem; discussion focused on need to go beyond Ryan White and use reinsurance to spread risk. President concerned that a few communities bear the brunt of caring for this population, stressed need to socialize costs of such care more broadly than for HIPCs or states.

- **Public Health:** President stressed importance of turning public health issues into leadership issues, such as taking on smoking policy as a national campaign. Personal preventive health services should be covered in the benefit package; public health responsibilities should be devoted to community-wide initiatives. Importance of maintaining core public health functions with stable funding stream discussed. President supportive of consolidated core funding stream and of using some sort of premium set-aside rather than annual appropriation.

- **Community Providers/ Safety Net Providers:** President wanted to be sure the legislation does not stop public health clinics from doing the things that they do well such as immunizations. Protections for existing providers who have been there in rural areas and underserved areas need to be built into the plan to prevent new entities from driving out traditional providers. President discussed broadening use of NHSC doctors and described this as a marvelous opportunity for using national service program to expand care in underserved areas, including work as translators and other support staff. President noted how impressive the bi-lingual and multi-lingual clinics are and the importance of having these providers in the system.

- **State Options:** President asked if our plan would permit a state to just allow everyone to be insured through the state employee system. President wants our framework to permit states to offer this. (Note: legislation needs to

specify what standards states must meet to offer own option, eg. benefit package).

- **State Responsibilities:** In the discussion of accountable health plans and vulnerable populations, the President raised concerns about protecting vulnerable populations from underservice and inadequate plans. The President said there must "absolutely not" be underserved-only HIPCs, plans. The President wanted states to be the arbitrator of disputes regarding plans and to provide assistance to help set up plans. The need to provide both capital and technical assistance to develop management skills and capitation experience in underserved areas was discussed. If necessary, state should be able to operate own health plan to correct problem plan or provide services where no plan has entered market (need to provide authority in legislation).

- **Rural Underserved:** President concerned that heavy federal regulation of hospital closures in rural areas has prevented hospitals from being converted to other service-delivery uses, while the federal government has let states treat the poor very unfairly and unevenly with virtually no controls. Must overcome federal barriers to converting rural hospitals to multiple uses.

- **Funding:** The HIPC could skim some dollars off the top to use for development of services in underserved areas and rural areas. President thought it very important that purchasing cooperative or state take some dollars off the top for services that will not be addressed in the market. President stressed need to not do anything to undermine the public health delivery system, but wanted to make sure the federal government did not stand in the way of innovative collaboration at the local level (eg. multiple use for rural hospital sites).

- **Responsibility and Accountability for Care of Poor:** Discussion of federal versus state responsibility for poor evolved from discussion of desire for state flexibility. President discussed the need to socialize the cost of the poor and other vulnerable populations and the dominant actor in that being the federal government because of the tremendous disparity in capacity at the state level. The President did not want the poor to be shafted, but also did not want the federal government to over-regulate the process. Socializing the cost of the poor should fall to the federal government, but states still need to be held accountable.

- **Undocumented People:** President views these as tough questions that require a whole separate conversation on immigration policy. Need to save for another day.

Benefits

Health Reform Briefing 4 -- March 20.1993

This briefing for the President, Vice President and Mrs. Gore described the benefit packages in the market today, the cost implications in terms of overall health spending of alternative levels of comprehensiveness in the benefit package, and the major choices in designing the benefit package. The cost of the benefit package can be controlled by limiting the benefits covered or by varying the cost-sharing within a comprehensive package.

The fundamental decision is whether to move all people up to a common benefit package and equivalent coverage or to retain a two-tier system. The proposed plan would provide a comprehensive set of benefits with cost-sharing based on the type of plan selected (HMO, PPO, or fee-for-service). The level at which that plan is set in terms of costs has not yet been determined. Issues discussed included:

- **Out-of-Pocket Limits:** Discussed need to look at average out-of-pocket costs today including the administrative costs and then compare to maximum exposure under the plan. An annual limit of $1000 per individual would provide most people with improved coverage.

- **Medicare:** Medicare has substantial cost sharing requirements and ranks below the 10th percentile range on an actuarial basis. President was concerned that if plan goes to the 50th percentile for the non-elderly, we would have to improve Medicare or the elderly would feel shafted. President was particularly concerned about the 7 million elderly who rely solely on Medicare for coverage (without Medigap or Medicaid). President said we have to do prescription drugs for the elderly because it is the right thing to do. He feels the elderly will support a phase in of full coverage and long term care if we do drugs now. Economics are clear for slow phase-in of long-term care.

- **90th Percentile Plan:** Discussion focused on how to achieve most comprehensive coverage for most Americans; 90th percentile plan would improve coverage, but cost an additional $38 billion (assuming no cost controls). President wanted to know what to take off on other side and how Medicaid was being brought up in terms of payments to doctors. Will look at the numbers and distributional matrix next week.

- **Preferences on Benefits:** President feels this package must conform to preferences of American people for own doctor and security. Need to find out how Americans view security and what benefits make the most difference to

them. People hate: can't select their own doctor; having to wait for care. People like: tangible financial benefit; security. Workers' compensation is very important for small businesses.

- **Abortion:** President asked what most private plans do regarding abortion. Most plans are silent and don't exclude or include it specifically. There will be a specific discussion of this issue later.

- **Specific Benefits:** In reviewing potential excluded benefits, the President asked to look at covering medically necessary orthodontia for children and the Vice President raised issues related to technology and alternative treatments, such as biofeedback. President asked for cost of covering full EPSDT package for children and OT/PT and presentation later on substance abuse and mental health. President did not want benefit package defined by provider type. Should override state law to allow plans to add services by providers other than physicians; otherwise every state legislature will turn into a battleground.

- **Technology:** Discussed need to adjust benefit package to reflect new technology. Vice President wanted National Board to do the assessments.

- **Americans with Disabilities Act:** Secretary Shalala raised need to review the benefits for conformance with the ADA.

- **Free Choice of Provider:** President again stated the importance of assuring Americans that they will have the right to choose their own provider.

Long Term Care

Health Reform Briefing 5 -- March 23, 1993

This briefing for the President, Vice-President and Mrs. Gore described options for long-term care reform ranging from incremental reforms to social insurance for long-term care. The implications of the different options were discussed without identifying a recommended option. Four options were presented:

- o incremental changes in public programs along with limited steps to improve private insurance
- o restructuring Medicaid long-term care (including the block grant option) and aggressively promoting private insurance
- o social insurance for long-term care
- o pre-funded universal private insurance

Specific issues raised in the discussion included:

- o **Goals of reform:** The President stressed the importance of not discouraging families from caring for the disabled and the need to develop supportive systems for families, but not replace family care. We should also recognize that no state in America will force people out of nursing homes.
- o **Open-ended versus capped spending:** President wanted options developed that put a ceiling on spending to provide cost control, but provide flexibility to states to manage within the budgeted amount. Under the incremental approach, states could be given the ability to reclassify patients in nursing homes to move them to community settings without encountering problems with the Boren Amendment. Alternatively, President liked giving states a global budget for long-term care and freeing them from the Boren Amendment.
- o **Private Long-term Care Insurance:** Discussion focused on difficulty of establishing and regulating private market for long-term care insurance. Having government offer insurance on a one-time only basis was discussed, but concerns were raised about whether single time choice could be maintained to avoid adverse selection.
- o **Social Insurance:** President was not in the room for discussion of social insurance; returned as price tag of $60 billion was being discussed. No discussion with President.

- **Prefunding Private Insurance:** This pay-as-you go approach is primarily targeted at funding long-term car for the baby-boom generation and does not help the current elderly population. President was very skeptical of the approach. He was concerned that this option did not allow people to use their prefunded savings since they could neither cash the account out or borrow against it. President did not feel an option for 20 years from now was where we should be; "when we are old, we will be a powerful enough constituency to ensure we have services." President did not think it was practical to ask people to prefund care and be locked in to big contributions without a guaranteed return.

- **Disabled Non-elderly Population:** President wanted to see options that addressed the needs of the non-elderly disabled as distinct from the elderly. President said we might want two policies -- one for frail elderly and one for non-elderly disabled. Need to develop community-assisted living for the disabled and have contributions on sliding scale to allow the disabled to work.

- **Alternatives:** President wanted to be sure what we propose provides people with alternatives and assures that the care provided is adequate. Monitoring and maintaining quality is important, especially with a frail and highly disabled population.

- **Sliding Scale for Contributions:** Need contributions on a sliding scale to make plan affordable for middle class, but can sliding scale be administered? Needs more work.

- **Public Opinion:** President wanted more information on what the elderly want and what steps would be viewed as the best first steps toward reform. Need more research on what elderly and disabled groups want; bring in advocates and find out.

- **Elderly:** President asked if we do the right thing on drugs, will the elderly go along with the bill?

- **Next Steps:** President asked for two options on long-term care -- the least we should do and the most with the cost of each approach.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Veterans Administration/DOD/Indian Health Service: Health Reform Briefing 6 (2 pages)	03/24/1993	P5
002. briefing paper	Mental Health: Health Reform Briefing 7 (2 pages)	03/25/1993	P5
003. briefing paper	Ethics, Workforce, and Quality: Health Care Reform Briefing 8 (2 pages)	03/26/1993	P5
004. briefing paper	Short-term Cost Controls: Health Reform Briefing 9 (1 page)	03/31/1993	P5

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Veterans Administration/ DOD/ Indian Health Service

Health Reform Briefing 6 -- March 24,1993

This briefing addressed the role of the Veterans Administration, the Department of Defense, and Indian health Service health care programs in the health care reform initiative. The discussion focused on the extent to which these systems should be integrated into the new system.

The VA option would have the VA become an accountable health plan for veterans who elect it, but not their families. The DOD option would have military facilities become accountable health plans for active duty dependents and retirees, but retain direct care for active duty personnel. The Indian Health Service would create two options that allow Indian Health Facilities to either become accountable health plans or be providers under accountable health plans; Indians would not be under state plans.

Veterans Administration

- **VA as an Accountable Health Plan:** If veterans elect to have the VA as their accountable health plan, President was concerned that their families should also be allowed at some point to select the VA as their care plan. President asked Secretary Brown what the attitude of constituency would be to opening up facilities. Brown expressed capacity concerns, but noted strength of VA is that it is already a managed care setting.

- **Expanding Capacity:** President wanted to see the infrastructure developed to offer this plan to whole families so they do not split care among plans. Recognition that current system has been underfunded and needs additional capital to increase capacity.

- **Regulatory Hassles:** Discussion reviewed the multiple layers of regulations and purchasing system problems in the VA with emphasis on what could be freed up under the new system.

- **Ability to Compete:** President pushed VA on their assertion that they could compete effectively in the new system. President worried about what happens when a facility is unable to compete, but sees VA as a way to revitalize care in rural areas.

- **Incentives to Save Money:** Under current system, any savings a facility incurs are used to offset the revenues received. President wanted to find a way to let people who save money keep some of it and not give everything back to government.

Department of Defense

- **Direct care:** President noted that any changes in DOD health system would not include active duty personnel -- only dependents and retirees. He noted that Secretary Aspin felt it crucial that there be no perception of reduced benefits and the President says he agrees.

- **Military Health System as Accountable Health Plan:** If military direct care facilities became accountable health plans, President wanted to know if dependents and retirees would enroll. Discussion focused on difficulty for military to compete because of cumbersome administrative structures. If cost-sharing were equalized between direct care and other plans, it was alleged that many DOD patients would probably leave the system.

- **Base Closings:** Since many retirees continue to live near bases to get their medical care as well as prescription drugs, President asked whether it was feasible to keep medical facilities open at some of the bases slated to be closed to address these needs. He asked that this option be developed further; important as part of base closings.

- **Direct care versus Private Plans:** In response to discussion that it may be cheaper to pay premiums for private insurance than use military facilities for direct care, President said he was reluctant to close public delivery systems -- believes they can be efficient. Given responsibility for active duty personnel, need to maintain capacity in military facilities.

Indian Health Service

- **Options:** Indians want to have both a provider option and an accountable health plan option for Indian Health Services and are willing to open their clinics to others in rural areas. President endorsed expansion in rural areas and agreed Indians would not come under state governance in the reform plan.

- **Holistic Medicine:** Indians want to be able to offer their care in traditional manner and will not give up their holistic approach in a standard benefit package.

- **Funding Levels:** Limits in coverage among Indians due to funding limitations; noted this was an obligation honored in the breach. President anxious to expand funding and improve the delivery system for the 50 percent of Indians living on or near reservations, but also wanted to see how we could improve coverage of other half of population living in urban areas. President asked for options to give them some relief.

Mental Health

Health Reform Briefing 7 -- March 25, 1993

This briefing opened with a presentation by Mrs. Gore reviewing the need to improve coverage of mental health services. The briefing focused on inclusion of comprehensive mental health benefits in the standard benefit package and the implications of shifting to coverage on a capitation basis. Two options were presented -- a comprehensive option based on capitation through accountable health plans and a less comprehensive fee-for-service option.

The current underfunding of mental health and drug abuse services in the private sector plans results in higher costs for public sector programs. In health care reform, the additional cost for mental health coverage with preventive services in the health plans would be offset by savings in advanced care and catastrophic spending under public programs. This results in a potential "wash" cost-wise for these expansions.

The major points raised during the discussion were:

- **State Mental Health Responsibilities:** The President asked how inclusion of mental health services in the capitation rate would affect state mental hospitals and Community Mental Health Centers and whether there would have to be parallel state mental health systems. Under reform, it is assumed states will continue mental hospitals for long stays and forensic cases, but move other services including CMHCs into the accountable health plan networks. Need for resource development for CMHCs was discussed and should be considered in underserved areas initiatives.

- **Substance Abuse:** With a huge backlog of drug abuse cases, President asked how the problem could be addressed without substantially increasing the costs. the reliance on out-patient, not inpatient, care in the proposal was cited as a way to hold down costs. President asked if VA facilities could be used for treatment.

- **Drug Therapy:** Drug therapy is now a major component of treatment and the full cost of prescription drugs is included in these cost projections. (15 percent of premium cost is for drugs)

- **Capitation versus fee-for-service:** The President sees a capitation system as no worse than the current system because what we have today is so awful. President noted that comprehensive but capitated benefits in the proposal were only $15 per person year more than the incremental reform option.

- **Need for Outreach:** The President asked what could be done about the homeless people he sees when jogging. How do they get brought into treatment? President talked about need to address housing assistance and HUD programs as well as get mental health services to them.

- **Prevention versus Treatment:** The "crown jewel" of this plan would be to spread the cost of earlier, better treatment to replace later, more costly crisis intervention.

- **Out-of-pocket Purchases:** If services under the system are limited, President noted that individuals would always be able to buy more services if they wanted -- "no country in the world where you can't buy more"

Ethics, Workforce, and Quality

Health Care Reform Briefing 8 -- March 26, 1993

This briefing covered three areas -- ethics, workforce issues, and quality of care monitoring under the new system. The Ethics group discussed values underlying the health reform plan and set out broad principles that leave individuals, not institutions or boards, with authority over life and death issues. (Note: The ethics group did not have written briefing materials.) The quality and workforce groups discussed how these issues should be addressed in the reform plan.

Ethics

- **Care of the Terminally Ill:** President said this is a decision that must be left to families, but we need to help get better information to the families. He asked if living wills helped reduce costs; response was no.

- **Ethics Panels:** The Vice-President expressed concern that any panel on ethics would be diverted to the abortion/right to life issues and that abortion will become the lightning rod in each plan.

- **Informed Consent:** The importance of informed consent, but the difficulty in establishing true informed consent was discussed. The Vice-President views current practice as protecting doctors more than patients. President concerned that informed consent mainly for highly educated consumers.

Quality

- **Report Card:** Under the reform initiative, plans would be evaluated using a report card system. President asked if report card would be more aggressive than current quality monitoring. Secretary Shalala concerned that more intensive monitoring needed to be sure those who are dissatisfied are not from specific subgroups, such as the poor or minorities. She is uncomfortable with how well quality can be monitored, especially in capitated plans with an incentive to under-treat. President asked who would set the report card; to be set by National Board, but plan or HIPC could add additional information.

- **Total Quality Management:** The TQM approach needs to be built from the bottom up and not imposed from the top down. Vice-President noted that TQM assumed to come from report card, but need to be sure it results from availability of report and that we also identify other aspects of quality.

Workforce

- **Supply in Rural Areas:** President expressed concern about burn-out in rural areas and noted that of all the things we've tried, none work well in the long run. The best option is to expand the National Health Service Corps -- "just balloon the NHSC in the next budget." President also wanted to see more ways to support professionals in rural areas through conversion of rural hospitals to primary care centers.

- **Medical Education:** President and Vice-President both strongly endorsed service pay-back as a goal in financing medical education. Vice-President wanted to know what portion of private education is subsidized by public dollars and whether we could tie-in a public service obligation to the portion of the educational costs paid by taxpayers. Discussion of a percentage set aside for medical education.

- **Non-Physicians:** President wants to address state certification and medical practice acts to promote broader use of non-physicians in care delivery.

Short-term Cost Controls

Health Reform Briefing 9 -- March 31, 1993

This briefing addressed the options for containing costs in the interim before the new system is fully in place. Building on the earlier presentation to the National Economic Council, the presentation described five options: a freeze controlling provider prices, health insurance premium regulation, temporary revenue surtaxes on providers whose revenue growth exceeds a target, all-payor rate-setting, and increased use of managed care in the public and private sector. The discussion focused on the following issues:

- **Current Experience with Costs:** President asked about recent reports showing costs coming down and asked about the credibility of proposing controls if costs were in fact growing more slowly. Price of service is slowing, but volume and intensity still growing at problematic rates making short-term cost controls potentially important part of legislation.

- **Experience with All-payer Rate-setting:** No consensus in group on impact of rate-setting; evidence of its effectiveness in Maryland and New York discussed; concerns about implications for cost-shifting raised.

- **Premium Regulation:** President viewed this strategy as attractive only if it lead us directly where we want to be going; this approach seemed more complex than the merits it might bring.

- **Possible combination approach:** President thought that a combination of managed care and rate controls might provide the most short-term impact, but asked for more ideas on what made sense as short-term approaches. These were the only two strategies he saw as working, but he raised concern about how they would we implemented at the state level.

- **Speeding-up the New System:** Some savings could be achieved by bringing the new system on line faster in some states, but President concerned that these would be private not public savings; need to address cost-control in the federal budget.

- **Need for Savings:** President stressed that this bill needs scorable savings in the near-term to be passed.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	A. Priority Democratic Targets [partial] (1 page)	01/06/1994	P5
002. list	B. Priority Democratic Targets [partial] (1 page)	01/06/1994	P5
003. list	C. Priority Democratic Targets [partial] (1 page)	01/06/1994	P5
004. list	A. Republic Priority Targets [partial] (1 page)	01/06/1994	P5
005. list	B. Republican Targets [partial] (1 page)	01/06/1994	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Materials, 1993 - 1994)
OA/Box Number: 12503

FOLDER TITLE:
How To Get Clinton Healthcare Plan Through The Congress, January 6, 1994

Kara Ellis
2006-0810-F
ke1022

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]
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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]

A. Priority Democratic Targets (Most Important to Target Immediately)

This includes 1) big undecideds on Ways & Means, Energy & Commerce and Education & Labor, 2) those who, on tough floor votes, have difficulty supporting the President or 3) very tough districts.

Key Health Committees:

Andrews (NJ)
Andrews (TX)
Baesler (KY)
Boucher (VA)
Brewster (OK)
K. English (AZ)
Hall (TX)
Hoagland (NE)
Jacobs (IN)
Lambert (AR)
Lehman (CA)
Margolies-Mezvinski (PA)
Pallone (NJ)
L.F. Payne (VA)
Roemer (IN)
Rowland (GA)
Schenk (CA)
Tauzin (LA)

TOTAL = 18

Others:

Browder (AL)
Chapman (TX)
Condit (CA)
Coppersmith (AZ)
Danner (MO)
Deal (GA)
English (OK)
Geren (TX)
Hayes (LA)
Inslee (WA)
Klein (NJ)
Lipinski (IL)
Mann (OH)
Orton (UT)
Parker (MS)
C. Peterson (MN)
Pickett (VA)
Sisiski (VA)
Spratt (SC)
Stenholm (TX)
Swett (NH)
Tauzin (LA)
Taylor (MS)
Valentine (NC)

TOTAL = 24

B. Priority Democratic Targets (should get priority attention and flattery).

These are Democrats who 1) have not co-sponsored the Gephardt or McDermott plan, and 2) demand a lot of attention before they are supportive, or 3) have tough districts.

Applegate (OH)
Bacchus (FL)
Barca (WI)
Barcia (MI)
Barlow (KY)
Byrne (VA)
Cantwell (WA)
Costello (IL)
Cramer (AL)
Darden (GA)
Fingerhut (OH)
Glickman (KS)
Hamilton (IN)
Harman (CA)
Holden (PA)
Johnson (GA)
Johnson (SD)
Lancaster (NC)
LaRocco (ID)
Mazzoli (KY)
Ortiz (TX)
Penny (MN)
Peterson (MN)
Poshard (IL)
Sarpalius (TX)
Sisisky (VA)
Skelton (MO)
Spratt (SC)
Tejeda (TX)
Torricelli (NJ)
Valentine (NC)
Volkmer (MO)
Whitten (MS)
Wilson (TX)

TOTAL = 34

C. Priority Democratic Targets

These are Democrats who are not cosponsors of the Gephardt or McDermott bills but, in the end, have a pattern of being supportive. They are at the moment probably "keeping their powder dry."

Bevill (AL)
Bryant (TX)
Coleman (TX)
DeFazio (OR)
de la Garza (TX)
Derrick (SC)
Frost (TX)
Glickman (KS)
Green (TX)
Hall (OH)
Hefner (NC)
Jefferson (LA)
Kaptur (OH)
Kildee (MI)
Kleczka (WI)
Klink (PA)
Kopetski (OR)
Lowey (NY)
Meehan (MA)
Menendez (NJ)
Mfume (MD)
Mineta (CA)
Mollohan (WV)
Natcher (KY)
Neal (MA)
Pickle (TX)
Pomeroy (ND)
Price (NC)
Reed (RI)
Rose (NC)
Sangmeister (IL)
Schroeder (CO)
Sharp (IN)
Stupak (MI)
Visclosky (IN)
Wyden (OR)
Wynn (MD)

TOTAL = 37

A. Republican Priority Targets.

These are Republicans who are sometimes independent and who might have districts (union) supportive of the Clinton plan. Members of the moderate Tuesday and Wednesday Groups should be given some attention also (see previous tab).

Morella
Boehlert
Houghton
Leach
Huffington
Greenwood
Machtley
Ridge
Ravenael
Diaz-Balart
Ros-Lehtinen
Gilman
Torkildson
Blute
Weldon
Quinn
Franks (CT)
Young
Bilirakis
Gunderson
Gallo
Goodling
Hobsen
Regula
McDade
Snowe
Zimmer
Gilchrest
Franks (NJ)
Lazio
Schiff
Walsh

Total = 32

B. Republican Targets.

These are occasionally independent but don't hold your breath. Some have voted for issues such as unemployment compensation.

Baker
Bentley
Blute
Camp
Canady
Castle
Clinger
Emerson
Gillmor
Hoekstra
Kim
Kasich
Levy
Meyers
Rogers
Saxton
Santorum
Shuster
Solomon

Total = 19

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	Passing Health Reform: Policy and Congressional Summary (16 pages)	ca. 1993	P5
002. list	Health Care Timetable (1 page)	ca. 1993	P5
003. paper	Health Care Reform: Communications Summary (28 pages)	ca. 1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Materials, 1993 - 1994)
OA/Box Number: 12503

FOLDER TITLE:
Passing Health Reform [1]

Kara Ellis
2006-0810-F
ke1023

RESTRICTION CODES

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P1 National Security Classified Information [(a)(1) of the PRA]
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PASSING HEALTH REFORM

POLICY AND CONGRESSIONAL SUMMARY

PASSING HEALTH REFORM

THE HEALTH SECURITY ACT WOULD SUCCEED IF ENACTED AS WRITTEN. IT WAS ALSO CONSTRUCTED AS A NEGOTIATING DOCUMENT. IT HAS DOZENS OF MOVEABLE PARTS WHICH CAN BE CHANGED AND STILL BRING SUCCESSFUL HEALTH CARE REFORM. IT ALSO HAS VARIOUS LAYERS WHICH CAN BE REMOVED WHILE STILL PRESERVING ITS ESSENCE.

NO MATTER WHAT WE PRODUCED, CONGRESS WOULD WANT TO MAKE MAJOR MODIFICATIONS. WE HAD TO CREATE A DOCUMENT WHICH COULD ALLOW FOR THIS.

OUR POLITICAL STRATEGY

THE WINNING CONGRESSIONAL MAJORITY FOR HEALTH CARE REFORM DEPENDS ON HOLDING ALMOST ALL LIBERAL AND MODERATE DEMOCRATS, WINNING A SIGNIFICANT NUMBER OF CONSERVATIVE DEMOCRATS AND ATTRACTING 8-10 MODERATE REPUBLICANS IN THE SENATE (ASSUMING WE NEED 60 VOTES) AND 15-20 IN THE HOUSE.

THE CLINTON PROPOSAL (WHILE SLIGHTLY LEFT OF CENTER FOR THE CONGRESS AS A WHOLE), IS ALREADY RIGHT OF CENTER FOR THE COALITION WHICH WILL EVENTUALLY COME TOGETHER TO VOTE FOR HEALTH REFORM. IN FACT, WE HAVE MOVED THE CONGRESSIONAL DEMOCRATS TO THE RIGHT ALREADY THIS YEAR. PRIOR TO THE CLINTON PRESIDENCY, DEMOCRATS IN CONGRESS WERE DIVIDED BETWEEN SINGLE-PAYER ADVOCATES AND ADVOCATES OF "PAY OR PLAY" WHICH WOULD HAVE CREATED A HUGE FEDERAL PROGRAM FOR HEALTH CARE COVERING MOST AMERICANS. ONLY A HANDFUL OF DEMOCRATS SUPPORTED MANAGED COMPETITION.

WHY WE STARTED LEFT OF CENTER

IN THE SPRING, THERE WERE TWO POSSIBLE WAYS TO FORM OUR DOCUMENT POLITICALLY;

- IN THE CENTER WITH MODERATE REPUBLICAN AND CONSERVATIVE DEMOCRAT SUPPORT WITH THE INTENT TO NEGOTIATE WITH LIBERAL SINGLE-PAYER AND "PAY OR PLAY" GROUPS TO OUR LEFT; OR

- LEFT OF CENTER WITH LIBERAL AND MODERATE DEMOCRAT SUPPORT AND NEGOTIATE TO THE CENTER.

THE DIE WAS CAST IN MAY WHEN COOPER AND OTHERS ALLIED WITH HIM MADE CLEAR THAT THEY WOULD NOT SUPPORT UNIVERSAL COVERAGE IN THIS BILL, PREFERRING TO COME BACK AND PASS IT IN A FEW YEARS, AND WHEN THE CHAFEE GROUP DECIDED TO PRODUCE THEIR OWN BILL WITH AS BROAD REPUBLICAN SUPPORT AS POSSIBLE AND NEGOTIATE WITH US AFTER VARIOUS BILLS WERE INTRODUCED.

THIS LEFT US NO CHOICE BUT TO GO CENTER LEFT TO ENSURE A FIRM BASE OF SUPPORT FOR OUR BILL UPON INTRODUCTION.

HEALTH CARE REFORM:
THE BOTTOM LINE

HEALTH REFORM WILL BE SUCCESSFUL IF WE ACHIEVE THE FOLLOWING GOALS:

- UNIVERSAL COVERAGE BY THE END OF THE DECADE
- COMPREHENSIVE BENEFITS
- COMMUNITY RATING
- COST CONTROL
- ADEQUATE FINANCING FOR THE PROGRAM

THE NEW SYSTEM WHICH WE CREATE MUST FIT TOGETHER. IMPLEMENTATION WILL BEGIN DURING THE PRESIDENT'S FIRST TERM. THE BILL WHICH PASSES CONGRESS MUST WORK NOT JUST POLITICALLY BUT ALSO SUBSTANTIVELY.

THIS MEANS RESOLVING SUCCESSFULLY 14 MAIN ISSUES AND HUNDREDS OF "SIDESHOW" ISSUES, EACH OF WHICH HAS ITS OWN CONTROVERSIES.

MAIN EVENT ISSUES

A. UNIVERSAL COVERAGE

1. EMPLOYER/INDIVIDUAL MANDATE
2. LEVEL OF DISCOUNTS
3. SUBSIDIES FOR UNDERSERVED AREAS

B. COMPREHENSIVE BENEFITS

4. SCOPE OF BENEFIT PACKAGE
5. MEDICARE PRESCRIPTION DRUG BENEFIT
6. LONG-TERM CARE
7. PUBLIC HEALTH INITIATIVES

C. COMMUNITY RATING

8. INSURANCE REFORMS
9. SIZE AND STRUCTURE OF ALLIANCES

D. COST CONTROL AND FINANCING

10. RULES FOR ACCOUNTABLE HEALTH PLAN COMPETITION
11. INCENTIVES FOR CONSUMERS TO BE COST CONSCIOUS
12. PREMIUM CAPS
13. MEDICARE AND MEDICAID SAVINGS
14. NEW REVENUES

A SAMPLING OF SIDESHOWS

1. SUBSIDIES TO ACADEMIC HEALTH CENTERS AND TEACHING HOSPITALS
2. RESIDENCY SLOTS FOR PRIMARY VS. SPECIALTY CARE PHYSICIANS
3. RELATIVE PAYMENT RATES FOR PRIMARY VS. SPECIALTY PHYSICIANS
4. OVERRIDE OF SCOPE OF PRACTICE LAWS
5. ANTI-TRUST REFORMS
6. ESSENTIAL PROVIDER PROVISIONS
7. CLIA SIMPLIFICATION
8. UNIVERSAL REIMBURSEMENT SYSTEM
9. MEDICARE AND MEDICAID SIMPLIFICATION
10. NATURE OF QUALITY REPORT CARD AND INFORMATION COLLECTION
11. SPECIAL TREATMENT OF SUB POPULATIONS - AIDS PATIENTS, RARE DISEASE PATIENTS, ALZHEIMERS PATIENTS, TWO DOZEN OTHERS
12. WOMEN'S HEALTH RESEARCH FUNDING
13. INCENTIVES FOR COMMUNITY-BASED HEALTH PLANS
14. RISK ADJUSTMENT FORMULAS
15. TREATMENT OF CHIROPRACTORS, PODIATRISTS, ETC.
16. INCENTIVES FOR PRACTICE IN UNDERSERVED AREAS
17. INCENTIVES FOR STUDENTS TO ENTER PRIMARY CARE
18. MEDICAID WRAPAROUND SERVICES
19. NURSING HOME REGULATION
20. TREATMENT OF STATE AND FEDERAL WORKERS
21. STATUS OF INDUSTRY RUN MULTI-EMPLOYER HEATH PLANS
22. ESTABLISHMENT OF FEE SCHEDULES
23. DEFINITION OF A FAMILY
24. TREATMENT OF SUBSTANCE ABUSE
25. DIRECT REIMBURSEMENT FOR NURSES

A SAMPLING OF SIDESHOWS (CONTINUED)

26. NATURE OF MALPRACTICE REFORM
27. MANAGED CARE VS. FEE-FOR-SERVICE
28. PROTECTIONS FOR RURAL AND URBAN UNDERSERVED POPULATIONS
29. SIZE AND NATURE OF "SIN" TAXES
30. FEDERAL CONTROL VS. STATE FLEXIBILITY
31. ABORTION
32. TREATMENT OF UNDOCUMENTED PERSONS
33. PRIVACY ISSUES
34. MEDICAID INTEGRATION
35. MEDICARE INTEGRATION
36. SIZE AND NATURE OF TAX CAP
37. TREATMENT OF UNDER 65 RETIREES
38. PREMIUM AND SUBSIDY STRUCTURE
39. STATE MAINTENANCE OF EFFORT REQUIREMENTS
40. ERISA AMENDMENTS AND WAIVERS
41. RESPONSIBILITY FOR FINANCIAL RISK
42. INDEPENDENT CONTRACTOR RULES

HUNDREDS OF OTHERS

THE END GAME

WE MUST WIN SUFFICIENT CONSERVATIVE DEMOCRATIC AND MODERATE REPUBLICAN SUPPORT BY COMPROMISING FEATURES OF OUR BILL, BUT WE MUST BE CAREFUL NOT TO ALIENATE TOO MANY LIBERAL DEMOCRATS BY GOING TOO FAR.

DEPENDING UPON OUR POLITICAL SKILLS, THERE ARE A RANGE OF END GAMES WHICH CAN RESULT. THE PATH TO NEGOTIATING THESE DEALS WILL GO MEMBER BY MEMBER AND WILL OFTEN INVOLVE MODIFYING PROPOSALS ON THE HUNDREDS OF "SIDESHOW" ISSUES WHICH WILL BE IMPORTANT TO VARIOUS MEMBERS AND THEIR CONSTITUENT GROUPS.

VIRTUALLY EVERY MEMBER WE CONVERT WILL INVOLVE POLICY CHANGES WHICH THE MEMBER CAN CLAIM TO HAVE WON. THERE ARE SO MANY ISSUES EMBEDDED IN THE BILL WHICH ARE SO IMPORTANT TO THE OVER 1,500 HEALTH CARE INTEREST GROUPS AND THEIR CONSTITUENCIES THAT WE CAN MAKE HUNDREDS OF THESE MODIFICATIONS WITHOUT HURTING THE INTEGRITY OF THE BILL IN ORDER TO GAIN VOTES.

END GAME - SCENARIO I

IF WE CAN SUSTAIN THE PUBLIC DEBATE, AND NEGOTIATE WELL, UNDER THE MOST OPTIMISTIC SCENARIO, WE WILL WIND UP WITH THE FOLLOWING TYPE OF COMPROMISE:

- UNIVERSAL COVERAGE PASSED IN THIS BILL ON OUR TIMETABLE WITH AN EMPLOYER/INDIVIDUAL MANDATE AND LARGER SUBSIDIES OR A SLOWER PHASE-IN FOR SMALLER COMPANIES.

- PREMIUM CAPS WHICH ARE SOMEWHAT LESS RIGID THAN THE ONES WE PROPOSE.

- HEALTH ALLIANCES FOR COMPANIES OF 500-1,000 OR UNDER (WHERE THE ONE PERCENT ASSESSMENT GAINED FROM ADDITIONAL CORPORATE ALLIANCES WOULD PAY FOR THE EXTRA SMALL FIRM SUBSIDIES).

- SMALLER MEDICARE AND MEDICAID SAVINGS.

- A SLOWER PHASE-IN OF LONG-TERM CARE AND THE PRESCRIPTION DRUG BENEFIT TO COMPENSATE FOR THE LOWER MEDICARE AND MEDICAID SAVINGS AND A TIE-IN BETWEEN THE SAVINGS AND THE SPENDING ON THESE PROGRAMS.

- A FEW HUNDRED MINOR MODIFICATIONS.

END GAME - SCENARIO II

IF WE ARE ONLY MARGINALLY SUCCESSFUL IN THE PUBLIC DEBATE AND SECURE A LESSER BILL WHICH STILL FULFILLS THE PRESIDENT'S PRINCIPLES, IT MIGHT LOOK LIKE THE FOLLOWING:

- UNIVERSAL COVERAGE ON A SLOWER TIMETABLE -- BY 2000, WITH AN EMPLOYER AND INDIVIDUAL MANDATE WITH THE EMPLOYER SHARE REDUCED (WORST CASE, AS LOW AS 50 PERCENT), POSSIBLY LIMITED TO THE LOW COST INSTEAD OF THE AVERAGE COST PLAN, POSSIBLY WITH A SLOWER PHASING-IN OF THE FULL BENEFITS OR WITH ENHANCED SMALL COMPANY DISCOUNTS.

- LESS STRINGENT PREMIUM CAPS WHICH TRIGGER IF COMPETITION DOES NOT PRODUCE A CERTAIN LEVEL OF SAVINGS BY A CERTAIN TIME.

- A SLIMMED DOWN LONG-TERM CARE PACKAGE WHICH PHASES IN MUCH SLOWER AND A MORE SLOWLY PHASED-IN PRESCRIPTION DRUG BENEFIT, AND A TIE-IN BETWEEN THE SAVINGS AND THE SPENDING ON THESE PROGRAMS.

- LOWER MEDICARE AND MEDICAID CUTS.

- A SMALLER TOBACCO TAX.

END GAME - SCENARIO II (CONTINUED)

- SMALL ALLIANCES -- 100 OR UNDER, POSSIBLY VOLUNTARY, WITH STATES ALLOWED TO GO HIGHER AND A NATIONAL RISK POOL TO REINSURE CASES ABOVE $25 OR $50 THOUSAND PER YEAR.

- REDUCTION OF THE ONE PERCENT CORPORATE ASSESSMENT.

- A FEW HUNDRED MINOR MODIFICATIONS.

TIMING AND NEGOTIATING STRATEGY

THERE ARE THOUSANDS OF NEGOTIATIONS WHICH HAVE TO TAKE PLACE INVOLVING HUNDREDS OF ISSUES BETWEEN LATE JANUARY AND EARLY JUNE. MANY CAN BE DONE ON A STAFF TO STAFF LEVEL.

A WHOLE NEW SET OF DIFFICULT NEGOTIATIONS WILL TAKE PLACE AFTER JUNE WHICH WILL BE MORE CONCENTRATED.

MANAGING THIS PROCESS SO THAT IT KEEPS MOVING FAST ENOUGH TO SUCCEED ON OUR TIMETABLE WILL REQUIRE A HIGHLY ORGANIZED EFFORT ON OUR END.

- WE MUST SPEAK WITH ONE VOICE. A SMALL GROUP IN THE WHITE HOUSE MUST COORDINATE.

- IN COOPERATION WITH LEADERSHIP AND KEY COMMITTEE STAFF, WE WILL PREPARE BY THE END OF JANUARY A WEEK-BY-WEEK SCHEDULE TO TRY TO CLEAR AWAY THE "SIDESHOW" ISSUES SO THEY DON'T BOG US DOWN -- IDENTIFYING ONES WHICH WILL BE USED TO SECURE VOTES LATER IN THE PROCESS.

THE TIMING OF COMPROMISES, WHO THEY ARE MADE WITH AND WHAT WE GET FOR THEM IS PROBABLY OUR FUNDAMENTAL SET OF STRATEGIC DECISIONS.

WE MUST SIGNAL A WILLINGNESS TO BE FLEXIBLE IN GENERAL (THOUGH NOT ON BASIC PRINCIPLES), BUT WE MUST HOLD OUR POSITIONS AS LONG AS POSSIBLE. PREMATURE SIGNALS OF SPECIFIC COMPROMISE COULD DOOM US.

LEGISLATIVE END GAME

THOUGH CAREFUL WORK MUST BE DONE TO CULTIVATE MANY MEMBERS WHO WILL ULTIMATELY BE WITH US, THERE ARE A RELATIVELY SMALL NUMBER WHO WILL BE THE "SWING VOTES." THERE ARE FEW SURPRISES ON THE LIST.

OUR EFFORTS WILL ULTIMATELY FOCUS ON THEM.

THE SENATE

THOUGH OTHERS WILL TAKE CONSIDERABLE WORK, THE FOLLOWING LIST OF POSSIBLE BUT DIFFICULT VOTES WILL BE KEY IN THE SENATE.

DEMOCRATS		REPUBLICANS	
BREAUX	ROBB	CHAFEE	GORTON
NUNN	DORGAN	DURENBERGER	BOND
JOHNSTON	KERREY	COHEN	SPECTER
BOREN	HOLLINGS	PACKWOOD	D'AMATO
BRYAN	EXON	HATFIELD	DOLE
SHELBY	DECONCINI	DANFORTH	BENNET
	HEFLIN	KASSEBAUM	DOMENICI
			BURNS
			HATCH

WE NEED 16 OF THESE 29 SENATORS TO GAIN 60 VOTES (16 OF 20, IF THE LAST COLUMN OF LESS LIKELY REPUBLICANS IS EXCLUDED.)

THE HOUSE

IF THE VOTES ARE STRUCTURED PROPERLY, WE SHOULD ULTIMATELY HAVE THE SUPPORT ON THE HOUSE FLOOR TO PASS A GOOD BILL. THERE ARE CERTAIN KEY COMMITTEE VOTES WHICH WILL BE PARTICULARLY IMPORTANT.

ENERGY & COMMERCE	
DEMOCRATS	**REPUBLICANS**
SHARP	BILARAKIS
TAUZIN	McMILLAN
RICHARDSON	UPTON
SLATTERY	PAXON
BOUCHER	KLUG
COOPER	GREENWOOD
ROWLAND	
LEHMAN	
PALLONE	
SCHENK	
MARGOLIES-MEZVINSKY	
LAMBERT	

ASSUMING WE GET ALL THE OTHER DEMOCRATS, WE NEED 8 OF THESE 18.

WAYS & MEANS	
DEMOCRATS	**REPUBLICANS**
PICKLE	THOMAS
RANGEL	GRANDY
FORD	HOUGHTON
STARK	
COYNE	
ANDREWS	
McDERMOTT	
KLEZCKA	
PAYNE	
HOGLAND	
NEAL	
BREWSTER	

ASSUMING WE GET ALL THE OTHER DEMOCRATS, WE NEED 8 OF THESE 15.

HEALTH CARE TIMETABLE

December / January

Activities: [December 1 to January 25]

- Health Principals meet with priority list members
- Committee Staff /Administration policy resource
- Field Hearings
- President conveves meeting / dinner with Chairs and Leadership
- State of the Union

February / March

Activities: [February 1 to March 28 - (7 weeks)]
Recess: February 14 to Februaury 22

- Subcommittee hearings
- Priority Member negotiations with committee chairs
- Subcommittee and / or full committee mark-up (House committees)

April / May

Activities: [April 11 to May 30 - (7 weeks)]

- Senate Finance and Labor mark-ups
- Leadership reconciliation of different bills
- House Rules Committee mark-up

June

Activities: [June 7 to July 1 - (3 weeks)]

- House floor consideration
- Senate floor consideration

July / August / September

Activities: [July 11 - September 30 - (11 weeks)]
Recess: July 2 - July 11
August 15 - September 6

- House and Senate Conference

October

Activities: [October 3 - Adjournment]

- Final passage

THE COMMUNICATION BATTLE

IF THE CONSERVATIVE DEMOCRATS AND MODERATE REPUBLICANS WE NEED ARE DRIVEN TO SUPPORTING A BILL WITH NO UNIVERSAL COVERAGE AND CONTROLLING COSTS THROUGH REDUCTION IN BENEFITS, WE WILL HAVE FAILED TO MEET OUR "LIVE IN THE SAND" OBJECTIVE.

THIS WILL HAPPEN ONLY IF THE OPPOSITION SUCCEEDS IN SCARING PEOPLE ABOUT OUR PLAN. THE POTENTIAL EXISTS FOR THEM TO SUCCEED IF THEY CONVINCE THE MAJORITY OF AMERICANS WITH GOOD COVERAGE THAT:

- QUALITY OF CARE WILL DETERIORATE
- RATIONING OF CARE WILL OCCUR
- THEIR COSTS WILL RISE TO FINANCE THE UNINSURED AND THE CREATION OF A BIG GOVERNMENT BUREAUCRACY
- CHOICE OF DOCTOR WILL BE LIMITED

THE OPPOSITION'S ABILITY TO SCARE PEOPLE WILL SUCCEED IF PEOPLE BELIEVE THAT:

- TOO MUCH CHANGE IS COMING TOO FAST
- OUR SOLUTION IS A BIG BUREAUCRATIC ONE WHERE POLITICS WILL RUN HEALTH CARE.

SOLVING OUR COMMUNICATIONS PROBLEM

THE DEBATE WILL BE CONDUCTED ON TWO LEVELS:

- THE PUBLIC DEBATE
- THE ELITE DEBATE

THE PUBLIC DEBATE

AMERICANS TRUST THE PRESIDENT MORE THAN THE REPUBLICANS IN CONGRESS (62%-21%) ON HEALTH CARE (USA TODAY POLL 12/16).

WE SHOULD ENGAGE THE CONSERVATIVE REPUBLICANS ON PRINCIPLES, PITTING OUR PHILOSOPHY AND PRINCIPLES AGAINST THEIRS. WE SHOULD NOT ATTACK REPUBLICAN MEMBERS, WITH THE EXCEPTION OF THE FAR RIGHT MEMBERS, LIKE SENATOR GRAMM, BUT WE SHOULD ATTACK THEIR PRINCIPLES AND SUPPORTERS.

WE HAVE BEEN THE ONLY TARGET. WE MUST HAVE AN OPPONENT TO PROVIDE CONTRAST ON THE ISSUES. COOPER, CHAFEE AND THE SINGLE-PAYER SHOULD NOT BE THE PUBLIC OPPONENTS. WE NEED THEM AT THE END. WE MUST AND CAN DISCREDIT THE CONSERVATIVE REPUBLICAN PHILOSOPHY WHICH SAYS THERE IS NO PROBLEM AND PROPOSES NO SOLUTION.

- THEY ARE OUT TO DESTROY HEALTH REFORM AND WILL NEVER BE WITH US.

- DESTROYING THEM MAKES IT EASIER FOR MODERATE REPUBLICANS AND CONSERVATIVE DEMOCRATS TO SUPPORT A MODIFIED VERSION OF OUR PLAN.

- THEY ARE VULNERABLE ON OUR CORE ISSUES OF SECURITY AND AFFORDABILITY.

THE PUBLIC DEBATE (CONTINUED)

- THEY CAN BE PORTRAYED AS DEFENDERS OF WHAT PEOPLE DON'T LIKE IN THE CURRENT SYSTEM.

- THEY ARE AND CAN BE PORTRAYED AS EXTREMISTS. THEY HAVE LITTLE ORGANIZED INTEREST GROUP SUPPORT.

JUST AS THE REPUBLICAN CONVENTION ENERGIZED DEMOCRATS, INDEPENDENTS AND MODERATE REPUBLICANS FOR THE PRESIDENT, ENGAGING REPUBLICAN CONSERVATIVES WILL ENERGIZE OUR BASE.

THE CONSERVATIVE REPUBLICANS ARE INVITING US TO DO THIS

- CALLING OUR PLAN SOCIALIZED MEDICINE

- ARGUING THAT THE HEALTH CARE STATUS QUO IS GOOD

- PROPOSING EXTREME SOLUTIONS WHICH TAKE AWAY SECURITY AND DISCIPLINE THE CONSUMER

- THEY HAVE INDICATED AN UNWILLINGNESS TO WORK TOGETHER TO SOVLE THE PROBLEM UNDER ANY CIRCUMSTANCES.

WE SHOULD DEVELOP A COORDINATED CAMPAIGN TO PROMOTE OUR PRINCIPLES VS. THEIRS TO BEGIN IN EARLY JANUARY.

THE ELITE DEBATE
OUR PROBLEM

WE HAVE ALLOWED THE ELITE DEBATE TO GET AWAY FROM US. WE MUST SEIZE THE INITIATIVE SOON.

CONVENTIONAL WASHINGTON PUNDITRY HOLDS THAT OUR BILL IS "OLD DEMOCRAT," LIBERAL BIG GOVERNMENT, BUREAUCRATIC, ETC. AND THAT "CLINTON LITE" IN THE FORM OF A BLENDED COOPER/CHAFEE WITH UNIVERSAL COVERAGE IS THE ULTIMATE SOLUTION.

THIS PERCEPTION HAS BEEN FED BY SUCCESSFUL DLC AND COOPER/BREAUX PRESS CONTACTS BACKED UP BY SOME IN OUR ADMINISTRATION WHOSE COCKTAIL PARTY CONVERSATION HAS GIVEN CREDENCE TO THIS END GAME VIEW.

FURTHER, THE BUSINESS, MEDICAL SPECIALIST AND HOSPITAL BOARD ELITES WHO ARE FRIENDS OF NEWSPAPER EDITORS AND REPORTERS AND LEGISLATORS ARE COMMUNICATING CONCERNS ABOUT OUR PLAN WHICH FURTHER FEED THE PROBLEM.

FEARS OF BEING FORCED INTO A D.C. HEALTH ALLIANCE, WITH ALL OF THOSE "POOR PEOPLE" HAS NOT HELPED WASHINGTON JOURNALIST ATTITUDES, EITHER.

SUPPORTERS HAVE BEEN FOCUSED ON "NIT PICKING" US RATHER THAN ADVOCATING FOR US.

THE ELITE DEBATE
REGAINING THE INITIATIVE

THE COMPLEXITY/BUREAUCRACY ARGUMENT IS AT THIS POINT BEST ADDRESSED BY ACKNOWLEDGING THAT HEALTH CARE IS A COMPLEX ISSUE AND FOCUSING THE MEDIA ON THE FACT THAT COOPER/BREAUX AND CHAFEE ARE ALSO COMPLEX AND BUREAUCRATIC.

THE "OLD DEMOCRAT" LINE IS BEST ADDRESSED BY FOCUSING ON OUR RELIANCE ON COMPETITIVE FORCES AND A PRIVATE SECTOR SOLUTION RATHER THAN TRADITIONAL DEMOCRATIC GOVERNMENT BASED "SINGLE-PAYER" OR "PAY OR PLAY" PROPOSALS.

WE SHOULD EMPHASIZE THAT THE NBC/WALL STREET JOURNAL POLL SHOWS MOST AMERICANS PREFER A CLINTON TYPE SOLUTION TO A COOPER ONE.

WE SHOULD ALSO EMPHASIZE THAT EVEN A COOPER/CHAFEE MERGER COULD NOT PRODUCE ANYWHERE NEAR THE VOTES NEEDED FOR PASSAGE.

THE KEY TO ALL OF THIS SUCCEEDING IS:

- A CONSISTENT ADMINISTRATION MESSAGE DELIVERED BY ALL MESSENGERS

- A BETTER MOBILIZATION OF OUR "GROUP SUPPORTERS" TO AMPLIFY OUR MESSAGE

OUR THEMES

OUR THEMES OUGHT TO REMAIN CONSISTENT.

1. WE PROVIDE HEALTH CARE SECURITY -- COMPREHENSIVE BENEFITS THAT CAN NEVER BE TAKEN AWAY. NO LIFETIME LIMITS. NO PREEXISTING CONDITION EXCLUSIONS. NO AGE DISCRIMINATION.

2. WE WILL MAKE HEALTH CARE AFFORDABLE BY LIMITING THE RATE OF GROWTH OF INSURANCE PREMIUMS.

3. WE ENHANCE CHOICE.

4. WE MAINTAIN HEALTH CARE AS A PRIVATE SYSTEM. THE GOVERNMENT GUARANTEES SECURITY, AFFORDABILITY AND PROTECTS CONSUMERS, THEN GETS OUT OF THE WAY.

5. YES, THE PLAN IS COMPLEX, BUT THAT IS BECAUSE HEALTH CARE IS COMPLEX. OTHER SERIOUS PLANS ARE EQUALLY COMPLEX.

6. THE PLAN SIMPLIFIES THE SYSTEM FOR CONSUMERS AND PROVIDERS THROUGH, FOR EXAMPLE, A SINGLE CLAIM FORM AND ONE COMPREHENSIVE BENEFIT PACKAGE.

7. THE PLAN PROMOTES RESPONSIBILITY AND EQUITY BY SHARING THE BURDEN OF HEALTH CARE COSTS FAIRLY AMONG ALL PEOPLE AND BUSINESSES.

OUR THEMES (CONTINUED)

8. THE PLAN PROVIDES A MEDICARE PRESCRIPTION DRUG BENEFIT AND HOME AND COMMUNITY-BASED CARE.

9. THE PLAN EMPHASIZES PRIMARY AND PREVENTIVE CARE.

PUBLIC COMMUNICATIONS ISSUE

WE ARE HOLDING OUR OWN ON SOME ISSUES:

- THE NEED FOR COMPREHENSIVE REFORM NEXT YEAR.
- UNIVERSAL COVERAGE (HEALTH SECURITY) WITH COMPREHENSIVE BENEFITS.
- THE NEED FOR AN EMPLOYER MANDATE
- THE JOB EFFECTS OF HEALTH REFORM.

MAJOR ATTACKS ON OUR BILL

THERE ARE A NUMBER OF AREAS OF ATTACK ON WHICH WE MUST DO A BETTER JOB:

- COMPLEXITY AND BUREAUCRACY: THE BILL IS TOO COMPLEX AND TOO BUREAUCRATIC

- NUMBERS: THE NUMBERS ARE SHAKY

- BUSINESS: THE BILL IS BAD FOR BUSINESS

- COST CONTAINMENT AND RATIONING OF CARE: PREMIUM CAPS WILL LEAD TO RATIONING OR A DETERIORATION OF QUALITY

- LIMITS ON CHOICE: THE PLAN WILL FORCE PEOPLE INTO MANAGED CARE LIMITING CHOICE OF DOCTOR

COMPLEXITY AND BUREAUCRACY

THE POLITICS OF HEALTH REFORM
THE COMPLEXITY PARADOX

THE COMPLEXITY OF OUR BILL UNDERMINES OUR CHANCES FOR SUCCESS, BUT WITHOUT COMPLEXITY SUCCESS IS IMPOSSIBLE.

THIS PARADOX IS ROOTED IN A SERIES OF NECESSARY POLICY DECISIONS WHICH CREATE COMPLEXITY.

- BUILDING ON THE EMPLOYER/EMPLOYEE SYSTEM INSTEAD OF GOING TO A SINGLE PAYER, TAX-BASED SYSTEM. TO DO OTHERWISE WOULD REQUIRE RAISING $300-400 BILLION IN TAXES. HOWEVER, THE EMPLOYER/EMPLOYEE SYSTEM MEANS THE FOLLOWING COMPLEXITIES:

  - A SYSTEM OF COVERAGE AND SUBSIDIES FOR THE UNEMPLOYED

  - COLLECTION MECHANISMS FOR DIFFERENT TYPES OF EMPLOYERS/EMPLOYEES

  - ENFORCEMENT OF MANDATES ON EMPLOYERS AND INDIVIDUALS

- PREMIUM-BASED FINANCING INSTEAD OF A PAYROLL TAX. A PAYROLL TAX, THOUGH SIMPLER, MEANS SIGNIFICANT INCOME REDISTRIBUTION AND ON BUDGET FINANCING FOR THE WHOLE

HEALTH CARE SYSTEM. A PREMIUM SYSTEM CREATES THE FOLLOWING COMPLEXITIES:

- SUBSIDY PROGRAMS FOR SMALL AND LOW-WAGE FIRMS AND LOW INCOME INDIVIDUALS

- EXTRAORDINARY MEASURES TO REGULATE THE INSURANCE MARKET TO ENFORCE COMMUNITY RATING

- RULES FOR DEALING WITH DUAL ELIGIBILITY

- INITIATIVES TO DEAL WITH PROBLEMS ASSOCIATED WITH FAMILY DEFINITIONS AND PREMIUM CLASSES

- COMPETITION BACKED UP BY PREMIUM CAPS TO CONTROL COSTS RATHER THAN EITHER COMPETITION OR CAPS ON THEIR OWN. UNIVERSAL COVERAGE WITH NO CONTROL ON THE GROWTH IN COSTS WOULD BE A FINANCIAL DISASTER. COMPETITION BACKED UP BY PREMIUM CAPS ENSURES COST CONTROL. IT MEANS THE FOLLOWING COMPLEXITIES:

  - ACCOUNTABLE HEALTH PLANS

  - INSURANCE REFORM REGULATIONS

- MECHANISMS TO SET PREMIUM CAP BASELINES

- EFFECTIVE COMMUNITY RATING TO END DISCRIMINATION AGAINST PEOPLE WITH PRE-EXISTING CONDITIONS, PEOPLE WORKING FOR SMALL COMPANIES, SELF-EMPLOYED PEOPLE OR PEOPLE WHO LIVE IN UNDERSERVED AREAS. THIS MEANS THE FOLLOWING COMPLEXITIES:

  - HEALTH ALLIANCES

  - RISK ADJUSTMENT

  - AID TO UNDERSERVED AREAS

  - MEDICAID BLENDING IN ALLIANCES

- TRYING NOT TO MAKE PEOPLE WORSE OFF THAN THEY ARE TODAY. THIS MEANS THE FOLLOWING COMPLEXITIES:

  - SUPPLEMENTAL INSURANCE WITH NO TAXATION

  - CORPORATE AND TAFT-HARTLEY ALLIANCES

BUREAUCRACY AND COMPLEXITY

BUREAUCRACY

OUR BILL AND OTHER SERIOUS BILLS ARE ALL TOO BUREAUCRATIC AND INVOLVE TOO MUCH GOVERNMENT.

SINGLE PAYER, COOPER, CHAFEE AND OUR BILL ARE OVERLY BUREAUCRATIC IN SOME WAYS THAT ARE SIMILAR AND SOME THAT ARE DIFFERENT.

SINGLE PAYER

THE SINGLE-PAYER BILL CREATES GOVERNMENT CONTROL OVER PRICES, FUNNELS ALL MONEY THROUGH THE GOVERNMENT AND INVOLVES GOVERNMENT CONTROL OF MEDICAL EDUCATION FUNDING, DOCTOR SUPPLY, ETC.

COOPER

THE COOPER BILL INVOLVES MORE FEDERAL CONTROL THAN ANY OTHER BILL. ITS FEDERAL BOARDS HAVE WIDE RANGING POWERS, SOME OF WHICH ARE NEW, SOME OF WHICH USURP STATE POWER AND SOME TAKE OVER DOL OR HHS RESPONSIBILITIES. IRS BUREAUCRACY INCREASES DRAMATICALLY TO ADMINISTER THE TAX CAP. A VAST MEANS TESTING APPARATUS WILL HAVE TO BE CREATED TO ADMINISTER ITS SUBSIDIES.

COMPLEXITY AND BUREAUCRACY

BUREAUCRACY (CONTINUED)

CHAFEE

THE CHAFEE BILL ALSO HAS A POWERFUL NATIONAL BOARD, COMPLEX NEW AUTHORITY FOR THE IRS, A DOZEN NEW HHS RESPONSIBILITIES AND A HUGE NEW MEANS TESTING APPARATUS. IN ITS 850 PAGES ARE ALSO SIGNIFICANT NEW REGULATIONS TO CREATE MED-SAVE ACCOUNTS, FEDERAL INSURANCE REGULATIONS, NEW LONG-TERM CARE REGULATIONS, ETC.

THE CLINTON BILL

ALAS, OUR BILL ALSO HAS FAR TOO MUCH BUREAUCRACY, MUCH OF IT ADDED TO SATISFY DEPARTMENTAL CONCERNS, ACTUARY REQUIREMENTS AND CONGRESSIONAL ALLIES. A SAMPLING FOLLOWS:

- A BOARD TO REVIEW BREAKTHROUGH DRUG PRICES AND NEW AUTHORITY TO THE HHS SECRETARY ON PRESCRIPTION DRUG PRICING FOR MEDICARE -- AT THE REQUEST OF SENATOR PRYOR

- NEW ERISA REGULATIONS AND RESERVES AT THE REQUEST OF DOL

- NEW REPORTING REQUIREMENTS FROM HEALTH PLANS AND PROVIDERS AT THE REQUEST OF HHS AND OMB

- PENALTIES FOR ALL MANNER OF VIOLATIONS OF DIFFERENT SECTIONS OF OUR BILL AT THE REQUEST OF HHS AND JUSTICE

COMPLEXITY AND BUREAUCRACY

BUREAUCRACY (CONTINUED)

- NEW TAX LAW DEFINITIONS AT THE REQUEST OF TREASURY.

CRITICS OF OUR PLAN, WHO SCREAM "BUREAUCRACY" ARE SOMETIMES REFERRING TO PROVISIONS WE SHOULD DEFEND:

- THE EMPLOYER/INDIVIDUAL MANDATE
- PREMIUM CAPS AS A BACKUP TO COMPETITION FOR COST CONTROL
- ALLIANCES

HOWEVER, WE SHOULD GIVE GROUND, AT THE RIGHT TIME, ON THE HOST OF BUREAUCRATIC STRUCTURES AND REGULATIONS WHICH ARE NOT REALLY ESSENTIAL FOR FUNDAMENTAL REFORM.

NUMBERS

THE NUMBERS PROBLEM
THE BACKGROUND

FOR ALMOST 30 YEARS, HEALTH CARE COSTS HAVE ADVANCED STEADILY, DEFYING ALL ATTEMPTS BY GOVERNMENT TO SLOW THEM DOWN.

THE PROBLEM OF RISING COSTS WAS ONLY EXACERBATED WITH THE ENACTMENT OF MEDICARE AND MEDICAID. THESE PROGRAMS ADDED SIGNIFICANT NEW DEMAND TO THE HEALTH CARE SYSTEM WITH NO CONTROL ON THE PRICES CHARGED. THE RESULT WAS A BONANZA TO HEALTH CARE PROVIDERS, AND THE BEGINNING OF OUR MODERN HEALTH CARE COST PROBLEMS.

EARLY ATTEMPTS TO CONTROL WAGES AND PRICES DURING THE NIXON YEARS RESULTED IN DRAMATIC INCREASES IN UTILIZATION OF SERVICES AND AN EXPLOSION IN PRICES ONCE CONTROLS WERE RELEASED.

VOLUNTARY CONTROLS DURING THE CARTER YEARS SUCCEEDED FOR A SHORT PERIOD AND THEN ALSO FAILED TO BRING THE GROWTH OF COSTS UNDER CONTROL.

LIMITATIONS ON HOSPITAL PRICES UNDER MEDICARE AND MEDICAID IN THE 1980s DID SUCCEED IN HOLDING DOWN THE GROWTH OF INPATIENT HOSPITAL COSTS, BUT RESULTED IN AN EXPLOSION IN OUTPATIENT COSTS AND IN A COST SHIFTING TO PRIVATE SECTOR PREMIUMS, THUS FAILING TO CONTROL THE GROWTH IN HEALTH CARE COSTS OVERALL.

THE NUMBERS PROBLEM
THE BACKGROUND (CONTINUED)

MORE RECENTLY, SOME LARGE COMPANIES HAVE EXPERIENCED DECLINES IN THE RATE OF GROWTH IN THEIR HEALTH EXPENDITURES THROUGH MANAGED CARE, BUT SOME WORKERS CLAIM THIS HAS COME AT THE EXPENSE OF BENEFIT LEVELS AND QUALITY OF CARE. SOME EXPERTS BELIEVE THERE HAS BEEN SOME COST SHIFT TO SMALLER FIRMS, WHOSE PREMIUM INCREASES HAVE ACCELERATED.

MEDICAID GROWTH SKYROCKETED THE PAST FEW YEARS AS SOME STATES "GAMED" THE SYSTEM AND AS BENEFITS WERE ENHANCED - MEDICAID AND MEDICARE ARE PROJECTED TO GROW AT RAPID RATES FOR THE REST OF THE DECADE.

NONE OF THIS WAS CORRECTLY PREDICTED BY THE GOVERNMENT WHEN IT PROPOSED THESE VARIOUS PROGRAMS. THIS HAS LED PEOPLE TO DISTRUST HEALTH CARE NUMBERS.

NUMBERS

THE NUMBERS PROBLEM
THE CYNICISM

WITH THIS PAST 30 YEARS OF HISTORY, IT IS EASY TO UNDERSTAND A CONVENTIONAL WISDOM WHICH SAYS:

1. HEALTH CARE COSTS CANNOT BE CONTAINED.

2. NEW ENTITLED BENEFITS WILL, THEREFORE, LEAD TO INCREASED HEALTH CARE COSTS.

3. HEALTH CARE COST PREDICTIONS ARE ALWAYS UNDERSTATED.

THESE BELIEFS, DEEPLY FELT AFTER YEARS OF EXPERIENCE, HAVE LED TO HEALTH CARE GRIDLOCK.

MANY READ THIS RECENT HISTORY AND CONCLUDE THAT NEW ENTITLEMENTS FOR UNIVERSAL COVERAGE AND "HEALTH SECURITY" ARE NICE, BUT THEY CANNOT BE GUARANTEED UNTIL COST SAVINGS ARE DEMONSTRATED. TO DO SO WOULD BE FEEDING FUEL TO THE FIRE OF HEALTH CARE INFLATION.

NUMBERS

OUR SEPTEMBER EXPERIENCE

BECAUSE OF THIS SKEPTICISM, WE SPENT A TREMENDOUS AMOUNT OF TIME ON AN UNPRECEDENTED EFFORT TO PUT TOGETHER OUR NUMBERS.

HOWEVER, DURING SEPTEMBER, THE WAY IN WHICH OUR NUMBERS LEAKED OUT TO THE PRESS BEFORE THEY WERE READY, FUELED PEOPLE'S WORST FEARS.

- THE ROUGH DRAFT THAT LEAKED ON SEPTEMBER 7 WAS NEVER INTENDED FOR THE PUBLIC. ITS NUMBERS PRESENTATION WAS CONFUSING AND LED TO SERIOUS MISUNDERSTANDINGS.

- WE HAD NOT YET BRIEFED OUTSIDE ECONOMISTS, SO THEY WERE INITIALLY CRITICAL. IT TOOK TIME TO MOBILIZE OP-EDS FROM SUPPORTERS AND TO MAKE THE EXPERT COMMUNITY UNDERSTAND AND ACCEPT THE NUMBERS.

- CAREER PERSONNEL AT TREASURY AND OMB HAD NOT YET REVIEWED THE NUMBERS. THE PRESS WAS INUNDATED WITH THEIR DISCLAIMERS AND DOUBTS, ON BACKGROUND, SERIOUSLY STRAINING OUR CREDIBILITY. WHEN THEY FINALLY DID THEIR REVIEWS, OUR NUMBERS CHANGED VERY LITTLE, BUT THEIR WORK WAS NOT COMPLETED UNTIL MID-OCTOBER.

SENATOR MOYNIHAN'S "FANTASY" COMMENTS, BASED ON A MISUNDER-STANDING OF OUR NUMBERS, ALMOST BURIED US.

NUMBERS

THE ONGOING PROBLEM

WE HAVE MADE GREAT STRIDES IN DEFENDING OUR NUMBERS AND HAVE TURNED THE TIDE SOMEWHAT.

- OUR SAVINGS ESTIMATES ARE NOW MORE WIDELY SUPPORTED

- OUR FEDERAL DOLLAR ESTIMATES HAVE BEEN VALIDATED INDEPENDENTLY

HOWEVER, THERE WILL CONTINUE TO BE AN UNDERCURRENT OF SUSPICION AND DISCOMFORT SIMPLY BECAUSE IT IS GOVERNMENT AND IT IS HEALTH CARE.

BUSINESS

THE HEALTH CARE BILL IS BAD FOR BUSINESS

THE HEALTH CARE BILL WILL BE OF SIGNIFICANT BENEFIT TO THE VAST MAJORITY OF AMERICAN BUSINESSES WHO NOW PROVIDE HEALTH CARE COVERAGE.

WE HAVE THUS FAR FAILED TO CONVINCE THE BUSINESS COMMUNITY ABOUT THIS.

COMPANIES THAT HAVE "RUN THE NUMBERS" USUALLY FIND SIGNIFICANT BENEFITS, BUT THEY ARE STILL UNEASY FOR THE REASONS DETAILED IN THE FOLLOWING SLIDES.

WE ALWAYS HAVE UNDERSTOOD THAT THE SMALL BUSINESS COMMUNITY WOULD AT BEST BE DIVIDED. WE HAVE DONE A REASONABLY GOOD JOB "HOLDING OUR OWN" IN THIS FIGHT. OUR DISCOUNT STRUCTURE IS HELPING.

OUR BIGGEST SETBACK IN ANY AREA HAS BEEN WITH THE LARGE BUSINESS COMMUNITY WHERE WE EXPECTED BETTER SUPPORT.

WE PLAN TO WORK AT BUILDING A BUSINESS COALITION IN SUPPORT OF HEALTH REFORM, GETTING THIS IN PLACE BY THE END OF JANUARY.

VIEWS OF THE CLINTON HEALTH CARE PLAN:

LARGE BUSINESSES WITH COMPREHENSIVE BENEFITS

PERCEIVED PROBLEMS	PERCEIVED POSITIVES
• WORRY IN GENERAL ABOUT BIG SOCIAL PROGRAMS; LONG-TERM CARE, PRESCRIPTION DRUGS AND COMPREHENSIVE MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS SEEM TOO RISKY • ARE NOW CUTTING COSTS BY CUTTING EMPLOYEE BENEFITS; WE WILL LIMIT THEIR FLEXIBILITY • NOW HAVE NEGOTIATING CLOUT DUE TO SIZE, ARE AFRAID OF LOSING THAT CLOUT WHEN THEY BECOME SMALL PURCHASERS VIS-A-VIS LARGE REGIONAL HEALTH ALLIANCES • ONE PERCENT CORPORATE ASSESSMENT WILL ADD TO THEIR CURRENT COSTS • ERISA MODIFICATIONS WILL LIMIT THEIR FLEXIBILITY AND POSSIBLY COST MORE MONEY – CANNOT MOVE OUT OF REGIONAL ALLIANCES ONCE THEY MOVE IN – POTENTIAL FOR RESERVE FUND ASSESSMENT – STATE SINGLE PAYER OPTION WHICH PREEMPTS ERISA – NEW REPORTING REQUIREMENTS ARE SKEPTICAL ABOUT OUR NUMBERS AND WHETHER THE 7.9 PERCENT CAP WILL REALLY HOLD ARE SUSPICIOUS THAT WE DON'T REALLY WANT CORPORATE ALLIANCES TO SUCCEED	• EARLY RETIREE BENEFIT IS BIG POSITIVE FOR SOME -- BUT THEY WONDER WHETHER IT WILL PASS CONGRESS • COST CONTROL; MANAGED COMPETITION FRAMEWORK; MANY PRIVATELY LIKE PREMIUM CAPS • LIKE THE 7.9 PERCENT CAP, THE END TO COST SHIFTING FROM THE UNINSURED AND THE EMPLOYER MANDATE, BUT QUESTION WHETHER THE 7.9 PERCENT WILL HOLD • THE SHARING AMONG EMPLOYERS OF THE FAMILY CONTRIBUTIONS

VIEWS OF THE CLINTON HEALTH CARE PLAN:

LARGE BUSINESSES WITHOUT COMPREHENSIVE BENEFITS

PERCEIVED PROBLEMS	PERCEIVED POSITIVES
• REQUIRED CONTRIBUTION FOR PART-TIME WORKERS WHO NOW GO UNINSURED • REQUIREMENT THAT ALL EMPLOYERS SHARE IN FAMILY PREMIUM PAYMENTS • PROPORTIONAL PREMIUM RATHER THAN PAYROLL TAX FOR PART-TIME EMPLOYEES WHICH CAUSES ADMINISTRATIVE BURDEN • STATE-BY-STATE PHASE-IN • SINGLE-PAYER ERISA PREEMPTION • BENEFITS PACKAGE RICHER THAN ONES THEY OFFER • EARLY RETIREE AND SMALL BUSINESS SUBSIDIES WHICH BENEFIT THEIR COMPETITION AND SUPPLIERS BUT NOT THEM	• 7.9 PERCENT CAP, IF THEY BELIEVE IT • COST CONTROL

VIEWS OF THE CLINTON HEALTH PLAN

SMALL BUSINESS

THERE IS A GENERAL DISTRUST OF GOVERNMENT AND DEMOCRATS AMONG SMALL BUSINESSES. BEYOND THIS, SMALL BUSINESS REACTION DEPENDS PRIMARILY ON WHETHER THEY SAVE OR SPEND UNDER THE PLAN.

SIZE OF FIRM	COMPREHENSIVENESS OF CURRENT BENEFITS	
	LOW BENEFITS	HIGH BENEFITS
75–500	BIG SPENDERS	SMALL SAVERS
5–75	SMALL SPENDERS	BIG SAVERS
1–5	SAVE ON FAMILY PREMIUM WHICH WILL GENERALLY COVER WORKER CONTRIBUTIONS	BIG SAVERS

COST CONTAINMENT AND RATIONING

THERE MUST BE A GUARANTEE THAT COSTS WILL BE CONTROLLED. A CONTINUATION OF THE PRESENT RATE OF GROWTH IN HEALTH CARE SPENDING AS A PERCENTAGE OF GDP IS UNACCEPTABLE.

UNDER THE NEW SYSTEM, COMPETITION CAN AND WILL CONTROL COSTS. FOR THE FIRST TIME ECONOMIC INCENTIVES WILL BE IN PLACE THAT WILL LEAD TO A LOWER RATE OF GROWTH IN HEALTH CARE SPENDING.

THE PREMIUM CAPS ARE A BACKSTOP. ONLY IN THE EVENT THAT COMPETITION FAILS WILL THEY APPLY. THEY ARE NOT LIKELY TO BE USED.

PREMIUM CAPS DO NOT LEAD TO RATIONING AND LOW QUALITY.

- BENEFITS ARE SPECIFICALLY DESCRIBED IN LEGISLATION AND CANNOT BE DENIED TO PEOPLE.

- THE BILL ENSURES THAT HEALTH PLANS COMPETE ON QUALITY SO THAT QUALITY WILL NOT BE COMPROMISED.

- PREMIUM CAPS ARE A TRIED, EFFECTIVE METHOD OF CONTROLLING HEALTH CARE COSTS, AND GIVE HEALTH PLANS GREATER BARGAINING LEVERAGE WITH THEIR PROVIDERS.

- CHARGES OF RATIONING AND LONG WAITING LINES ARE USUALLY INVOKED IN COMPARISON WITH CANADA. THE CANADIAN SYSTEM CONTROLS SPENDING BY SETTING PRICES FOR DOCTORS

AND GIVING HOSPITALS ANNUAL OPERATING BUDGETS. OPERATING WITHIN A FIXED BUDGET, A HOSPITAL COULD TRY TO LIMIT THE NUMBER OF COSTLY PROCEDURES IT PERFORMS, LEADING TO WAITING LINES. WE SPECIFICALLY REJECTED THAT TYPE OF DIRECT PRICE CONTROL.

- THE MOST DILIGENT PROTECTORS OF AVAILABILITY AND QUALITY OF HEALTH CARE SERVICES -- DOCTORS -- FAVOR THIS METHOD OF CONTROLLING COSTS. IN THE AMA'S OWN SURVEY, 55% OF PHYSICIANS SAID THEY SUPPORT CAPS ON INSURANCE PREMIUMS.

- UNLIKE TODAY, OUR PLAN GIVES EVERY HEALTH CARE CONSUMER AN OUTLET FOR RESOLVING PROBLEMS IF THEY FEEL THEY'VE BEEN DENIED NEEDED SERVICES OR RECEIVED POOR QUALITY CARE.

LIMITS ON CHOICE

CRITICS CHARGE THAT OUR BILL LIMITS PEOPLES' CHOICE OF DOCTORS. CHOICE IS BEING TAKEN AWAY FROM PEOPLE TODAY. PRESSURED BY RISING COSTS, EMPLOYERS ARE OFFERING EMPLOYEES ONLY MANAGED CARE PLANS THAT MANY EMPLOYEES FIND UNSATISFACTORY.

THE CLINTON PLAN INCREASES CHOICE:

- EVERYONE IS GUARANTEED A CHOICE OF PLANS, EVEN EMPLOYEES OF LARGE FIRMS, WHO TODAY, ARE DENIED CHOICE AND OFTEN ARE FORCED INTO MANAGED CARE PLANS

- EVERYONE MAY CHOOSE A FEE-FOR-SERVICE PLAN, WHERE THEY CAN CHOOSE TO SEE ANY DOCTOR THEY WANT

- EVEN THOSE WHO CHOOSE THE LOW-COST SHARING OPTION (HMO MODEL) MAY CHOOSE A POINT-OF-SERVICE OPTION ALONG WITH IT, WHICH ALLOWS THEM TO SEE ANY DOCTOR THEY WANT (WITH A HIGH COINSURANCE PAYMENT)

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	General Targeting Strategy (8 pages)	ca. 1993	P5
002. list	Appendix 5: Priority Targets (1 page)	12/14/1993	P5
003. paper	Congressional Timetable (2 pages)	ca. 1993	P5
004. list	Appendix 1: [Health Security Act Cosponsors] (2 pages)	ca. 1993	P5
005. list	Appendix 2: Committee Referrals of the Health Security Act (1 page)	ca. 1993	P5
006. list	Appendix 3: [Committees of Primary Jurisdiction] (4 pages)	ca. 1993	P5
007. profile	Appendix 4: Profiles of Key Swing Committee Members (15 pages)	ca. 1993	P5
008. list	Priority Targets (3 pages)	12/14/1993	P5
009. note	First Lady's handwritten notes on congressional strategy (4 pages)	10/19/1993	P5
010. memo	Mike Lux to Hillary Rodham Clinton, Maggie Williams, and Ira Magaziner, re: Action Plan (5 pages)	11/19/1993	P5
011. list	Current Status of Group Analysis (5 pages)	ca. 1993	P5

COLLECTION:
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Passing Health Reform [2]

Kara Ellis
2006-0810-F
kel024

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]
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General Targeting Strategy

The Congressional targeting strategy focuses primarily on three groups of Members: Cosponsors, Members of Committees of Jurisdiction, and Members who are influential with other members. (The final category of Members is made up primarily of moderates with the exception of some minority caucus Members.) For each of these groups we have a variety of strategies to build the coalition we need to pass the Health Security Act next year.

We are working to solidify the backing among those who have cosponsored the bill, by making sure they are comfortable with the policy and by events geared to increasing support among their constituents. This strategy is aimed at continuing to build our list of supporters as the year progresses. (See Appendix 1 for a current lists of House and Senate cosponsors.)

Much of the early action next year will take place in the five primary Committees of jurisdiction in the House and Senate. Our targeting emphasizes the key members needed to form the majority necessary to vote the bill out these committees. Since our efforts with the Committees are critical to the success of our legislative strategy, the majority of this memo is dedicated to an assessment of these Committees. (See Appendix 2 for a list of all the Committees to which the bill has been referred, Appendix 3 for membership lists of the five committees which have been given primary jurisdiction over the legislation and Appendix 4 for profiles of the key swing votes on these Committees.)

Finally, our targeting list identifies Democratic Members who do not serve on the Committees but are viewed as important because of their ability to influence other members. These Members may control blocs of votes in caucuses or delegations or serve as bellwethers for other members with similar philosophies. On the Republican side, these members are our most likely moderate Republican votes. As such, they are keys to forging the majority we need when the bill reaches the House and Senate floors. (See Appendix 5 for our priority targeting list.)

1. Cosponsor Strategy

We currently have 31 cosponsors in the Senate and 101 in the House, but it would be a mistake to consider all of these as solid yes votes at this time. While a number of these are committed to reform and supportive of our plan, others signed on out of a sense of loyalty to the Administration, the Leadership or the Party. Others came on under pressure from their Chairmen or the Leadership. Our approach is designed to reinforce their decision to cosponsor the bill by aiding their understanding of the details of the legislation, increasing their comfort in talking about the plan in public settings, providing assistance in building support in their districts and enlisting them to recruit additional cosponsors.

Over this recess period we have under way a number of activities to reach out to our cosponsors. In addition to the "thank you" breakfast held last week, we have contacted each of the cosponsors and offered them the opportunity to have an administration principal either attend a town meeting in their district or to brief a group of their influential health providers in Washington. We are starting to receive responses to this offer and are working to arrange the logistics. In addition, we are working with the Democratic Policy Committee in the Senate and their House Leadership on a series of regional health care summits planned by our key cosponsors in these areas and featuring the First Lady during January and February.

2. Committee Strategy

As the center of the action on shaping the legislation shifts from the White House to the Congress, we must ensure that the Congress takes ownership both of the issue and the substantive details. Over the next several months, this investment will be critical since we will need to rely on the key Chairmen and the leaders to defend reform against well-run campaigns against it. Our efforts also will involve an ongoing dialogue with those moderate and swing Members whose votes will be pivotal on the Committees.

But high profile negotiations with particular Members over the most controversial issues will represent only a small fraction of the decisions to be made by Congress. Most of the action will take place behind the scenes, by House and Senate Committee staff who will shape ninety percent of the final details. As a result, relationships with the Committees cannot be top heavy; they ultimately must be strong, both professionally and personally, at the staff level as well.

While much attention tends to be focused on the Chairmen and the Staff Directors, the technical staff will make many key decisions, and shape the debate of the remaining controversial decisions which are bumped up to the political decisionmakers. To develop the most effective relationships with the technical committee staff, our legislative and policy staff must invest a great deal of effort as soon as possible with the objective of becoming an indispensable resource to them. Otherwise, they will resort to historic relationships with the departments, the think tanks and other outside experts, who may wish to influence the process not to our liking. We need to create a framework which integrates our experts in this process on a daily basis.

With that stated what follows is an assessment of where we stand with the Committees and our targeting strategy for critical and swing Committee Members.

Overall Assessment by Committee -- House

Looking at the three lead House Committees, it seems clear that strictly in terms of getting the votes to report a bill out of Committee, Education and Labor will be the easiest Committee and Energy and Commerce will be the hardest, with Ways and Means in between. In the case of each Committee, assuming that we win no Republican votes, we can afford to lose only four Democrats. This overall view should give you a sense of how the votes must shape up.

Energy and Commerce

While we can only afford to lose four Democrats, our list of possible problems is considerably longer: Hall, Slattery, Cooper, Rowland, Boucher and Tauzin. The possible Republican gains are long shots, with Greenwood being the best bet and Hastert, Klug and Upton on the target list as well. We should be able to limit our loss of Democrats to four or less, but it is clear that this group will have considerable leverage over the shape of the final package. At introduction we have 8 out of 27 Committee Democrats as co-sponsors, with 23 votes needed to report the bill out of Committee.

If it becomes clear that Energy and Commerce cannot report out as comprehensive a package as the other Committees, it may become necessary for the Committees to diverge and then to bring a compromise package together for floor consideration.

The Committee historically has had strong subcommittees, and the Health subcommittee in particular has generally taken the lead on minor and major health legislation. The full committee typically plays a strong role in reviewing subcommittee action, particularly in controversial areas, but most of the details tend to be worked out in subcommittee.

The Chairman has referred the bill to the Subcommittees for a very short time period, only until March 4th of next year. This is to keep the bill on schedule but it also reflects his nervousness about getting the votes to needed in the Subcommittee. We will need to target the Health Subcommittee and its Members for special attention early in the process because it will be the first place there is a vote on the bill. Since we can only afford to lose two Democratic votes in the Subcommittee (and Roy Rowland and Ralph Hall are unlikely to support the bill), we will have to work especially hard on such moderates Slattery, Brown and Pallone. Even with their support, that will leave Congressman Cooper as the final vote for passage. That is why we even need to establish a dialogue with Rowland and Hall in case their votes prove necessary.

Ways and Means

It is likely that at some point Rostenkowsi will shift the action from subcommittee to full committee, which will diminish Stark's role to some extent. Unlike the Energy and Commerce Committee, Ways and Means has a tradition of major issues being worked out in full committee. Tax reform, for example, was handled almost entirely at the full committee level. Also unlike Energy and Commerce, the subcommittee staff works for the full committee chairman.

While it will be necessary to deal with Stark's concerns, he will try to pull the bill as close as he is able to towards a single payer approach. At the same time, the center of the Committee will pull us in the other direction. On the subcommittee Sandy Levin and Ben Cardin will be key to maintaining a balanced approach. In the end, the full committee is likely to refine and alter the approach if the subcommittee fails to reach a consensus on a politically viable approach. When it gets to the full committee, such Members as Matsui and Kennelly are important since they are influential both with the Chairman and on the floor.

The Democrats most at risk are Payne, Brewster and Andrews. Andrews has told us that he wants to support a bill with universal coverage. The most likely Republicans to vote for a bill are Houghton and Grandy, with Johnson in the next tier. At introduction we have 11 out of 24 Democratic members of the Committee as co-sponsors, with 20 votes needed for passage.

Education and Labor

The Democratic majority on the Committee is very strong. The most at risk democratic votes are Members like Rob Andrews (D-NJ) and Gene Green (D-TX), and these votes should be possible as well. The Republican prospects are not very strong, with Steve Gunderson being the most likely. At introduction we have 16 out of 27 Democratic Committee members (including delegates and Resident Commisioner who can vote in Committee) as co-sponsors, with 22 needed for passage.

Overall Assessment by Committee -- Senate

The infighting between the Finance Committee and the Labor and Human Resources Committee over primary jurisdiction illustrates how difficult it will be for these two primary Committees to work out an amicable division of labor. It is now clear that the two Committees of primary jurisdiction will report out their own versions and visions of health reform legislation. The Labor Committee will have a much easier time of getting the votes needed to deliver their bill to the floor and, no doubt, it will look much more like the bill we have introduced than the one the Finance Committee will report out. The Finance Committee will do whatever is necessary to poll out a bill with bipartisan support.

While it will take them more time and possibly be more contentious, the Finance Committee has the institutional leverage to report a bill that will attract a significant number of votes on the Senate floor. In the end, however, the real power brokers will be Majority Leader Mitchell and Minority Leader Dole. They will be the players who will have the ultimate power to decide what goes to the Senate floor for the initial vote. (Obviously, the leadership will not be able to exert much control over the Senate free-flow amendment process.)

Senate Finance Committee

Because of the philosophical/political make-up of the Finance Committee, it will be much more difficult to obtain the 11 votes necessary to report out a bill. However, a bill reported out of the Committee, particularly if it has received the support of some of the moderate Republicans on the Committee, is more likely to receive bipartisan support than a bill out of the Labor and Human Resources Committee. More specifically, it could be argued that such a bill would be less likely to be targeted with an extended (and possibly detrimental) debate and/or fall victim to a filibuster on the Senate floor.

As of this writing, it appears there are 8-9 relatively certain Democratic votes on the Committee. At introduction, we had 8 of 20 members of the Committee as cosponsors. The two that we must be most concerned about are the two we are always concerned about: Senators Boren and Breaux. The Republicans worth paying particular attention are: Senators Packwood, Dole, Danforth, Chafee, and Durenberger. Two of these Members -- Dole and Chafee -- are particularly critical because they control blocks of Republican votes which can provide cover to those Republicans who want to support reform. Two other Republicans who should not be written off are Senators Roth and Hatch.

Of major importance will be our relationship, and the relationship of the Committee Members, with Chairman Moynihan. His primary interest will be to illustrate his ability to report our a bipartisan bill which can gain the support of the state of New York and Governor Cuomo.

Senator Packwood's departure, should he decide to retire, would be a blow to gaining support from moderate Republicans. His likely successor as Ranking Republican would be Senator Roth, with Senator Danforth next in succession. If Senator Packwood does leave, whether Senator Dole chooses a moderate or conservative to fill the seat on the committee may be a signal of his intentions with regard to health reform. (Note: Senators Gramm and Lott, two of the most conservative Members of the Senate. were the runners up the last time there was Republican opening on the Finance Committee.)

Finally, to strengthen personal relationships, as well as to determine the Members' priorities, Senator Rockefeller has initiated a series of Committee Members only meetings. He has hosted at least three meetings and, from all reports, they have gone fairly well. This is a constructive development since the Members will be less likely to be adversarial during the upcoming debate if they have formed stronger personal ties.

Senate Labor and Human Resources Committee

Of all the five primary Committees of jurisdiction in the Congress, this Committee is the most able and willing to work with us and be responsive to our priorities. It also is the Committee that can most easily and quickly deliver a majority of its Members to report out a bill.

While the Committee should have little problem reporting out the bill on a straight party line vote, there are several moderate Republicans Members including Ranking Republican Senator Kassebaum, our sole Republican cosponsor Senator Jeffords and Senator Durenberger. Of some interest, two Republicans serve concurrently on this Committee and the Finance Committee -- Senators

Durenberger and Hatch. It is likely, however, that they will side with the Finance Committee on issues of substance and jurisdiction.

Committees with Narrow Jurisdiction

We will need to work which each of the Committees with narrower jurisdiction as the process unfolds, but in all likelihood, they will act on a more delayed schedule, waiting to see what superstructure their sections will fit into. The referral in the House calls for committees with limited referral to complete action within two weeks after the three lead committees report out a bill. In the Senate, Committees are likely to report out their own bills concurrently, or soon after, the bills start being reported out of Labor and Finance.

Although we frequently think of the Judiciary, Governmental Affairs, and VA Committees, we cannot forget that there are many other Committees who will demand a role. We are currently, conducteing weekly interagency legislative meetings to coordinate our approach with these other committees.

Committee Activities

Over the last few weeks, Ira Magaziner, Roger Altman and representatives of the White House Legislative Affairs staff have met with key moderate Democrats to open a dialogue on health reform. They also are in the process of meeting with the committee and subcommittee staffs to establish a positive working relationship for the coming weeks. Administration principals (Cabinet Secretaries or Senior White House Officials) and Legislative Affairs staff have been assigned to each of the targeted Members to serve as main contacts on health reform and to monitor their status.

3. Influential Members Strategy:

On the House side, we have identified a number of Democratic Members who do not serve on the primary Committees of jurisdiction but we view as important for our prospects in the House. These include caucus chairs such as Jose Serrano (Congressional Hispanic Caucus) and Dave McCurdy (Mainstream Forum and DLC) and members who are keys to important state delegations such as John Murtha of Pennsylvania. It also includes members such as Dan Glickman who will be influential with other moderate Democratic Members.

The most influential Members of the Senate serve on the Fiance and Labor Committees. However, among our priorities are several moderate to conservative Members who do not serve on these committees and will be amongst the most difficult votes for us to hold including Senators Exon, Heflin, Kerrey and Lieberman. The non-committee Republicans include moderates who are strong prospects -- Senators Cohen and Hatfield. It also lists Senators Bond and Bennett who are taking an active and influential role in Dole's Republican Health Care Task Force. and are worth an outreach effort.

We have also assigned administration principals and legislative affairs staff to each of these Members and have offered them the opportunities for events here or in their district. Ira Magaziner and Roger Altman have been meeting with these members one-on-one over the last few weeks. Their assigned administration principals are also to schedule face-to face meetings with them by the end of January.

Appendix 5

PRIORITY TARGETS (12/14/93)

HOUSE COMMITTEE MEMBERS:

WAYS AND MEANS:

Pickle (TX)
Rangel (NY)*
Ford (TN)
Stark (CA)*
Coyne (PA)*
Andrews (TX)
McDermott (WA)
Klezcka (WI)
Payne (VA)
Hogland (NE)
Neal (MA)
Brewster (OK)

Thomas (CA)
Grandy (IA)
Houghton (NY)

ENERGY AND COMMERCE:

Sharp (IN)
Tauzin (LA)
Richardson (NM)*
Slattery (KS)
Boucher (VA)
Cooper (TN)
Rowland (GA)
Lehman (CA)
Pallone (NJ)
Schenk (CA)
Margolies-Mezvinsky (PA)
Lambert (AR)

Bilarakis (FL)
McMillan (NC)
Upton (MI)
Paxon (NY)
Klug (WI)
Greenwood (PA)

EDUCATION AND LABOR:

Miller (CA)
Andrews (NJ)
Roemer (IN)
Green (TX)
Klink (PA)
English (AZ)*
Strickland (OH)*
Baesler (KY)

Goodling (PA)
Petri (WI)
Roukema (NJ)
Gunderson (WI)
Molinari (NY)
Miller (FL)

* = Health Security Act Cosponsor

CONGRESSIONAL TIMETABLE

As discussed earlier, the timetable for Congressional action will be ambitious and create a great challenge for the Leadership and the Congress as a whole. Appendix 6 provides an outline of a feasible schedule of Congressional legislative actions. Since the most important element of these actions will take place at the Committee and Leadership level, this section focuses primarily on this aspect of the process.

Since jurisdiction is divided among several committees in both the House and the Senate, it will be necessary for different, and perhaps conflicting approaches to be stitched together before legislation is brought to the full House and Senate for a vote in the spring. This process will require several weeks after the bill is reported from the committees. The process will require leadership both from the Administration and from Congressional leaders, but the Committees must also be permitted enough room to work out issues independently, and to win a majority in each committee. The Administration must avoid attempting to micro-manage at each Committee, while at the same time providing the technical support and prodding without which the process is likely to bog down.

In the Senate, Majority Leader Mitchell has the authority and responsibility to schedule the timing and substance of what is brought to the floor before the full Senate. In so doing, he (working closely with the Administration, Chairman Moynihan and Chairman Kennedy, as well as -- hopefully -- Republican Leader Dole) must decide what provisions will go into a Leadership amendment to the bill (S. 1757) pending on the Senate calendar.

As of this writing, it is unclear whether the Finance Committee and the Labor and Human Resources Committee will be able to work out an amicable agreement on a division of jurisdictional responsibilities. Regardless, the advantage we have going in is that the Majority Leader has very good working relationships with the two Committees and will not hesitate to push the Chairmen and the Committees, to the degree necessary, to report out their versions of the legislation in a timely manner.

Should there be an unacceptable delay in reporting out the bill, the Majority Leader can always call up the bill directly off the Senate calendar, amend the bill himself and call it up for Senate consideration. (Obviously, this would not be the most preferable action because it would bypass the Committee process and signal a significant lack of consensus.) Under any scenario, when Senator Mitchell makes a unanimous consent motion to bring the bill up for floor consideration, it is extremely likely that some Member will object. As a result, a 60 vote cloture motion will be necessary for the Senate to take up the bill.

In the House, the process will be managed by the leadership through the Rules Committee, which will determine what version goes to the floor, as well as the content and order of amendments that will be permitted on the floor. In the event that any one Committee is unable to report out a full version of the health care plan, the version going to the floor could reflect the high water mark rather than the least common denominator, with the burden then on the opposition to muster a majority to amend the package.

It would be ideal for the Committees to track each other closely, but if they are unwilling or unable to coordinate, the Rules Committee can still fashion a single new bill representing a negotiated agreement, if the leadership is willing to use the powers of the Rules Committee. Since the leadership has firm control over the Rules Committee, provided we maintain a majority in the full House, a bill could not be held hostage even if a problem develops in one or another committee. In the event that a Committee is unable to muster a majority to report the bill to the floor, the Rules Committee could report out a rule that would discharge the Committee from further consideration and clear the bill for floor consideration nonetheless.

Since a rule only requires a majority of votes, not unanimous consent or a supermajority, even substantial opposition would not present an insurmountable obstacle to floor consideration.

The process of reassembling a bill at the Rules Committee will involve many of the most significant decisions and the Administration will want to play a substantial role in the negotiations. To preserve our ability to help shape the final product sent to the House floor, it would be preferable to avoid making unnecessary commitments during earlier committee consideration. It is inevitable that many issues will be revisited when the bills are stitched together again by the leadership at the Rules Committee. At the same time, the Administration will need to provide constant prodding to keep the process moving along, and on many occasions, we will need to help committees develop alternatives to keep the process moving along.

Once the bills pass both Houses, the conference will represent another test for the Congress and the Administration. It is our expectation that the conference will last through the summer and through most of September. And, as is typical with the Congress, only the prospect of the end of the session and the pressure from Members desiring to adjourn to attend to reelection efforts will produce the conference agreement.

Our success in influencing the conference process will depend on the degree to which we were able to establish productive working relationships with the Committee Chairmen and the Leadership earlier in the legislative process. To the degree this occurs, the Chairmen will call on us to referee conflicting opinions and positions. It will also open the door for us to put pressure on the conferees to conclude the agreement prior to Congress going out of session.

Appendix 1
Health Security Act - House Cosponsors

1. Gephardt, Richard (D - MO)
2. Bonior, David (D - MI)
3. Hoyer, Steny (D - MD)
4. Fazio, Vic (D-CA)
5. Kennelly, Barbara (D - CT)
6. Lewis, John (D - GA)
7. Richardson, Bill (D - NH)
8. Dingell, John (D - MI)
9. Rostenkowski, Dan (D - IL)
10. Ford, Bill (D - MI)
11. Waxman, Henry (D - CA)
12. Collins, Cardiss (D - IL)
13. Stark, Pete (D - CA)
14. Williams, Pat (D - MT)
15. Clay, Bill (D - MO)
16. Brooks, Jack (D - TX)
17. Moakley, Joe (D - MA)
18. Abercrombie, Neil (D - HI)
19. Ackerman, Gary (D - NY)
20. Andrews, Thomas (D - ME)
21. Barett, Thomas (D - WI)
22. Berman, Howard (D - CA)
23. Bilbray, James (D - NV)
24. Blackwell, Lucien (D - PA)
25. Borski,Robert (D - PA)
26. Brown, George (D - CA)
27. Brown, Corrine (D - FL)
28. Cardin, Benjamin (D - MD)
29. Clyburn, James (D - SC)
30. Coyne, William (D - PA)
31. de Lugo, Ron (D - VI)
32. DeLauro, Rosa (D - CT)
33. Deutsch, Peter (D - FL)
34. Dicks, Norman (D - WA)
35. Dixon, Julian (D - CA)
36. Durbin, Richard (D - IL)
37. Edwards, Don (D - CA)
38. Engel, Eliot (D - NY)
39. English, Karan (D - AZ)
40. Eshoo, Anna (D - CA)
41. Faleomavaega, Eni (D - AS)
42. Filner, Bob (D - CA)
43. Flake, Floyd (D - NY)
44. Foglietta, Thomas (D - PA)
45. Frank, Barney (D - MA)
46. Gejdenson, Sam (D - CT)
47. Gibbons, Sam (D - FL)
48. Hastings, Alcee (D - FL)
49. Hilliard, Earl (D - AL)
50. Hinchey, Maurice (D - NY)
51. Johnson, Eddie B. (D - TX)
52. Johnston, Harry (D - FL)
53. Kanjorski, Paul (D - PA)
54. Kreidler, Mike (D - WA)
55. LaFalce, John (D - NY)
56. Lantos, Tom (D - CA)
57. Levin, Sander (D - MI)
58. Long, Jill (D - IN)
59. Martinez, Matthew (D - CA)
60. Matsui, Robert (D - CA)
61. McKinney, Cynthia (D - GA)
62. Meek, Carrie (D - FL)
63. Minge, David (D - MN)
64. Mink, Patsy (D - HI)
65. Murphy, Austin (D - PA)
66. Murtha, John (D - PA)
67. Norton, Eleanor (D - DC)
68. Oberstar, James (D - MN)
69. Obey, David (D - WI)
70. Owens, Major R. (D - NY)
71. Pastor, Ed (D - AZ)
72. Payne, Donald (D - NJ)
73. Rahall, Nick (D - WV)
74. Rangel, Charles (D - NY)
75. Reynolds, Mel (D - IL)
76. Romero-Barcelo, Carlos (D - PR)
77. Rush, Bob (D - IL)
78. Sabo, Martin (D - MN)
79. Sawyer, Thomas (D - OH)
80. Scott, Robert (D - VA)
81. Serrano, Jose (D - NY)
82. Shepherd, Karen (D - UT)
83. Skaggs, David (D - CO)
84. Slaughter, Louise (D - NY)
85. Smith, Neal (D - IA)
86. Stokes, Louis (D - OH)
87. Strickland, Ted (D - OH)
88. Studds, Gerry (D - MA)
89. Swift, Al (D - WA)
90. Synar, Mike (D - OK)
91. Thornton, Ray (D - AR)
92. Thurman, Karen (D - FL)
93. Traficant, James (D - OH)
94. Underwood, Robert (D - GU)
95. Unsoeld, Jolene (D - WA)
96. Vento, Bruce (D - MN)
97. Watt, Melvin (D - NC)
98. Wheat, Alan (D - MO)
99. Wise, Robert (D - WV)
100. Yates, Sidney (D - IL)
101. Swett, Dick (D - NH)

Health Security Act - Senate Cosponsors

Daniel Akaka (HI)
Max Baucus (MT)
Barbara Boxer (CA)
Dale Bumpers (AR)
Ben Nighthorse Campbell (CO)
Kent Conrad (ND)
Tom Daschle (SD)
Christopher Dodd (CT)
Diane Feinstein (CA)
John Glenn (OH)
Bob Graham (FL)
Tom Harkin (IA)
Daneiel Inouye (HI)
Jim Jeffords (VT)
Edward Kennedy (MA)
Patrick Leahy (VT)
Carl Levin (MI)
Harlan Mathews (TN)
Howard Metzenbaum (OH)
Barbara Mikulski (MD)
Carol Moseley-Braun (IL)
Daniel Patrick Moynihan (NY)
Patty Murray (WA)
Claiborne Pell (RI)
David Pryor (AR)
Harry Reid (NV)
Donald Riegle (MI)
Jay Rockefeller (WV)
Paul Simon (IL)
Harris Wofford (PA)

Total: 31

Appendix 2

COMMITTEE REFERRALS OF THE HEALTH SECURITY ACT

House:

Energy and Commerce
Ways and Means
Education and Labor
Armed Services
Veterans' Affairs
Post Office and Civil Service
Natural Resources
Judiciary
Rules
Government Operations

Senate:*

Finance
Labor and Human Resources
Armed Services
Veterans' Affairs
Government Affairs
Indian Affairs
Judiciary

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* [Because of the jurisdictional dispute all of the health reform bills introduced in the Senate have been referred directly to the Calendar rather than to the Committees. However all these committees can be expected to report out intiatives within their jurisdiction.]

Appendix 3

HOUSE COMMITTEES OF PRIMARY JURISDICITION

Energy and Commerce Committee

Democrats (27):

John Dingell, MI (Chair)*
Henry Waxman, CA*
Philp Sharp, IN
Edward Markey, MA
Al Swift, WA*
Cardiss Collins, IL*
Mike Synar, OK*
W.J. Tauzin, LA
Ron Wyden, OR
Ralph Hall, TX
Bill Richardson, NM*
Jim Slattery, KS
John Bryant, TX
Rick Boucher, VA
Jim Cooper, TN
J. Roy Rowland, GA
Thomas Manton, NY
Edolphus Towns, NY
Gerry Studds, MA*
Richard Lehman, CA
Frank Pallone Jr., NJ
Craig Washington, TX
Lynn Schenk, CA
Sherrod Brown, OH
Mike Kriedler, WA*
Marjorie Margolies-Mezvinsky, PA
Blanche Lambert, AR

Republicans (14):

Carlos Moorhead, CA
Thomas Bliley, VA
Jack Fields, TX
Michael Oxley, OH
Michael Bilarakis. FL
Dan Schaefer, CO
Joe Barton, TX
J. Alex McMillan, NC
Dennis Hastert, OH
Fred Upton, MI
Cliff Stearns, FL
Bill Paxon, NY
Paul Gillmor, OH
Scott Klug, WI
Gary Franks, CT
James Greenwood, PA
Mike Crapo, ID

* = Health Security Act cosponsor

Ways and Means Committee

Democrats (24):

Dan Rostenkowski, IL (Chair)*
Sam Gibbons, FL*
J.J. Pickle, TX
Charles Rangel, NY*
Fortney "Pete" Stark, CA*
Andrew Jacobs, IN
Harold Ford, TN
Robert Matsui, CA*
Barbara Kennelly, CT*
William Coyne, PA*
Michael Andrews, TX
Sander Levin, MI*
Benjamin Cardin, MD*
Jim McDermott, WA
Gerald Kelczka, WI
John Lewis, GA*
Lewis Payne Jr., VA
Richard Neal, MA
Peter Hoagland, NE
Michel McNulty, NY
Mike Kopetski, OR
William Jefferson, LA
Bill Brewster, OK
Mel Reynolds, IL*

Republicans (14):

Bill Archer, TX
Philip Crane, IL
William Thomas, CA
E. Clay Shaw, FL
Don Sundquist, TN
Nancy Johnson, CT
Jim Bunning, KY
Fred Grandy, IA
Amo Houghton, NY
Wally Herger, CA
Jim McCrery, LA
Mel Hancock, MO
Rick Santorum, PA
David Camp, MI

* = Health Security Act cosponsor

Education and Labor Committee

Democrats (27):

William Ford, MI (Chair)*
William Clay, MO*
George Miller, CA
Austin Murphy, PA*
Dale Kildee, MI
Pat Williams, MT*
Matthew Martinez, CA*
Major Owens, NY*
Thomas Sawyer, OH*
Jolene Unsoeld, WA*
Patsy Mink, HI*
Robert Andrews, NJ
John Reed, RI
Timothy Roemer, IN
Eliot Engel, NY*
Xavier Becerra, CA
Robert Scott, VA*
Gene Green, TX
Lynn Woolsey, CA
Carlos Romero-Barcelo, PR*
Ron Klink, PA
Karan English, AZ*
Ted Strickland, OH*
Ron deLugo, VI*
Eni Faleomavaega, AS*
Scotty Baesler, KY

Republicans (15):

William Goodling, PA
Thomas Petri, WI
Marge Roukema, NJ
Steve Gunderson, WI
Richard Armey, TX
Harris Fawell, IL
Cass Ballenger, NC
Susan Molinari, NY
Bill Barrett, NE
John Boehner, OH
Duke Cunningham, CA
Peter Hoekstra, MI
Buck McKeon, CA
Dan Miller, FL
(vacancy)

* = Health Security Act cosponsor

SENATE COMMITTEES OF PRIMARY JURISDICTION

Finance Committee

Democrats (11):

Daniel Patrick Moynihan, NY (Chair)*
Max Baucus, MT*
David Boren, OK
Bill Bradley, NJ
George Mitchell, ME*
David Pryor, AR*
Jay Rockefeller, WV*
Thomas Daschle, SD*
John Breaux, LA
Kent Conrad, ND*

Republicans (9):

Bob Packwood, OR
Robert Dole, KS
William Roth, DE
John Danforth, MO
John Chafee, RI
Dave Durenberger, MN
Charles Grassley, IA
Orrin Hatch, UT
Malcolm Wallop, WY

Labor and Human Resources Committee

Democrats (10):

Edward Kennedy, MA (Chair)*
Claiborne Pell, RI*
Howard Metzenbaum, OH*
Christopher Dodd, CT*
Paul Simon, IL*
Tom Harkin, IA*
Barbara Mikulski, MD*
Jeff Bingaman, NM
Paul Wellstone, MN
Harris Wofford, PA*

Republicans (7):

Nancy Kassebaum, KS
James Jeffords, VT*
Dan Coats, IN
Judd Gregg, NH
Strom Thurmond, SC
Orrin Hatch, UT
Dave Durenberger, MN

* = Health Security Act cosponsor

Appendix 4

PROFILES OF KEY SWING COMMITTEE MEMBERS

HOUSE COMMITTEES

Energy and Commerce Committee

DEMOCRATS:

CONGRESSMAN RICK BOUCHER (D-VA): Congressman Boucher is a lawyer and former McGovern advance man with one of the most liberal voting records in the Virginia delegation. He is unyielding in his opposition to the tobacco excise tax. On the Energy and Commerce Committee, Boucher played an important role as a member of the "group of nine" in the 100th Congress - a caucus of moderate-to-conservative Democrats who tried to end a Clean Air stalemate between pro-industry and environmental factions. Boucher also serves on the Judiciary Committee and is a member of the Rural Health Care Coalition and the Mainstream Forum.

On health care matters, Boucher will be concerned about black lung disease as well as tobacco. He has voted pro-choice.

CONGRESSMAN JIM COOPER (D-TN): Congressman Cooper is using the press he is gaining on health care as a spring board to his run for the Senate. In last week's profile. TIME magazine described Cooper's reaction to attacks on his plan by the White House: "he's relishing every minute of it." Cooper considers the employer mandate the most controversial element of the plan - "a clumsy and expensive way of achieving universal coverage." He contends that by knocking down the barriers that block poor and sick people from obtaining health insurance, his plan would come close to universal coverage leaving as "few" as six million uninsured. His pursuit of his own plan and stated search for common ground is consistent with his history as a Member who has been instrumental in forging compromises on the Energy and Commerce Committee.

Recent Developments: December 2 USA Today: Regarding Ira's speech to the Chamber of Commerce and offer of compromise, "It's a continuation of their past policy of wanting to discuss options with everyone. You'll see continued discussion among the White House, Chafee, and Cooper."

In the December 3 Wall Street Journal article about Cooper he said: "All our bills are first cousins ... This really is a battle between the Old Democrat and the New Democrat – whether you believe the philosophy of entitlement or the philosophy of empowerment ... I do like to fight for what I believe in. I'm not ashamed to eat crow."

In a December 14 New York Times squib about universal coverage, Cooper complains: "There are 20 other dividing lines they could have chosen."

CONGRESSMAN RALPH HALL (D-TX): Congressman Hall's voting record reflects the rural area he represents. Fiscally conservative, he often votes with the Republicans, as he has done this year in voting against the Administration on all three economic policy votes. He sits on the Health Subcommittee and has been targeted by the health insurance industry.

Hall is a member of the Rural Health Care Coalition and is opposed to employer mandates and cost controls on providers. He is also anti-choice. Hall is sympathetic to physician concerns and supports improvements in organ transplantation. He is close to Chairman Dingell. While it is highly unlikely that Hall will vote for the final package, he might be persuaded to vote for it in committee to get it to the floor.

CONGRESSMAN JIM SLATTERY (D-KS): Congressman Slattery is a moderate to conservative Democrat who has been willing to buck the leadership in order to reduce the budget deficit. As a candidate for governor in 1994 and member of both Energy and Commerce and the Veterans' Committee, Slattery's interest in health care combines both his present federal and hoped for future state role. He is also a member of the Rural Health Care Coalition and the Mainstream Forum. In the 100th Congress, he was part of the committee's "group of nine" on the Clean Air Act. Slattery often works together with Representative Glickman and Long and moderate conservatives look to him for leadership.

Health care is one issue on which Slattery has indicated a willingness to spend more federal dollars. He has sponsored or cosponsored bills to expand Medicaid coverage to poor children, to improve rural access to health care, and to improve the availability and affordability of health insurance for small businesses. In the current health care reform debate, Congressman Slattery is concerned about states and state flexibility, especially with respect to cost containment. He believes the mandate for small business is excessive. He is also very concerned about a payroll tax. Slattery has suggested limiting the deduction for tobacco advertising. While he wants to support the Administration on health care reform, he is strongly anti-choice and might oppose the final package if reproductive rights are included.

Slattery told the AP following the President's speech: "I want to give the President a lot of credit for tackling what I consider the most complex domestic problem we have faced in 50 years." He was specifically interested in funding. He told the Kansas Eagle: "It's going to need more changes ,... to make it fit Kansas."

Recent Developments: The Washington Times reported on October 16 that Reps. Slattery and Cooper were working on a plan that would allow women to purchase supplemental insurance for abortion services at a minimal price.

Slattery told Newsday on October 31: "It's vital the government be candid with the American public about how far the Clinton plan can go ... we are not going to solve this problem ... because we're all going to die."

CONGRESSMAN ROY ROWLAND (D-GA): Congressman Rowland is a key player on health care reform not only because he is a physician and respected southern Democrat, but because he will be a point person for veterans, rural areas, and small business. Chairman Dingell and Rep. Waxman rely on Rowland's credibility and as a go-between for committee moderates and liberals. Rowland is also close to Rep. John Lewis.

Rowland is concerned about financing the plan and is opposed to mandates. After the President's speech he told The Atlanta Constitution, "(The President) talked about a lot of things that I agree with. But I'm uneasy about creating another large federal program when we don't have a way to pay for it and it could be worse than what we have now." He is a strong supporter of preventive health care for children and high-risk mothers. In past legislation, he has authored "anti-hassle" bill to reduce Medicare red tape.

Recent Developments: Rowland told the AP on November 18 that Congress should not take the package apart. "I believe this issue should be tackled in whole." The next day, after introduction of his Community Health Improvement Act, he signalled a possibly different approach when he told the Atlanta Constitution: "I think part of the health care system needs fixing and part of it is working pretty good."

CONGRESSMAN W.J. "BILLY" TAUZIN (D-LA): Congressman Tauzin is a Cooper-Grandy cosponsor. He is known as a coalition builder on the Energy and Commerce Committee, most notably forging a compromise that facilitated the passage of the Clean Air Act. On issues not related to gas and oil, he is often a key swing vote, reluctant to take sides early on and eager to negotiate. He has been targeted by the health insurance industry.

On health care issues, the Congressman is very concerned about the cost of prescription drugs for Medicare and Social Security beneficiaries. He notes that estimates indicate 30-35% of Louisianans are uninsured, and is concerned about rationing. Tauzin is protective of small business employees, and will likely oppose an employer mandate. He favors tort reform but is opposed to coverage of abortion in the plan.

Recent Developments: Speaking about the Cooper-Grandy bill, he told the New Orleans Times-Picayune on October 7: I think it's pretty fundamental that you keep it as close to the private sector as possible. If you go the route of the Clinton Administration, you're talking bigger government and more bureaucracy, which ought to be the last thing on our minds."

REPUBLICANS:

CONGRESSMAN JIM GREENWOOD (R-PA): A former social worker who dealt with children, Freshman Congressman Greenwood campaigned for creating a health care system. He is concerned about rural coverage and small business subsidies and about the employer mandates.

Recent Developments: In a November meeting with Jack Lew, Greenwood questioned the way the premium cap would work in the first three years, believing it looked to him like a total of 15%. He feels there are unrealistically tight constraints in the first three years. He wants to continue to discuss the issue with the administration during the break.

CONGRESSMAN J. DENNIS HASTERT (R-IL): Congressman Hastert was selected by House Minority Leader Michel to be his point person on health care reform. A fellow Illinoisan, Hastert's appointment was a surprise, considering that he is only in his fourth term in the House and his second term on the Energy and Commerce Committee. Congressman Hastert is generally not known to be a mover and shaker in the House or in health care reform. However, he does seem to reflect the "Michel style" of House Republican. While Hastert is a staunch conservative, he is willing to offer proposals and be a part of the process. On health care, however, he seems to be taking a fairly hardline approach.

Congressman Hastert has sponsored his own "Health Care Choice and Access Improvement Act" (HR 150), which would reform the small group insurance market, increase the tax deductibility for the self-employed, and allow employers to establish tax-free Medi-Save accounts.

Congressman Hastert was pleased with and appreciative of the early briefings by Ira and other members of the working groups to Republican members. He has spoken about the need to hold costs down and to open up access. He has indicated a desire to be helpful.

Recent Developments: Hastert told Reuters on October 4 that the Clinton plan establishes a huge new government agency with more than 50,000 bureaucrats at the federal level alone. "Goverment will define your benefits, decide what new medicines and new technologies you can have, and will attempt to control the prices you pay. Another government-run agency like the IRS is not what Americans want." He said Republicans " cannot sign onto a plan we know is flawed just for the sake of appearing bipartisan. I hope the White House will not choose the path of confrontation."

On October 21 he cosigned the letter to the President regarding SBA involvement in health care reform.

CONGRESSMAN SCOTT KLUG (R-WI): Congressman Klug is a Cooper-Grandy cosponsor and a new member of the Energy and Commerce Committee. He is also part of the Tuesday Group, and previously served on the Select Committee on Children and Education and Labor. In comments to AP after the President's speech Klug had two concerns: small business and the National Health Board. He is a rural health advocate and has called for early intervention programs for at-risk children.

Recent Developments: Rep. Klug cosigned the letter regarding SBA involvement in health care reform.

CONGRESSMAN FRED UPTON (R-MI): Serving his fourth term in the House, Congressman Upton is a protege of former Budget Director Stockman. Upton is a member of the Energy and Commerce Committee and the Wednesday Group. He is known to listen closely to local groups.

Upton is concerned about rural coverage, malpractice, and financing of the administration plan. Upton supports abortion to save the life of the mother and in cases of rape or incest.

Recent Developments: On November 5 Upton told the Washington Post that he was worried that "if the auto companies were forced to lay off people, our money (in Michigan) could easily run out with a quarter (of the year) left, thus stranding families that needed care." He said that possibility, as raised in health insurance ads, seemed all too real to him.

Ways and Means Committee

DEMOCRATS:

CONGRESSMAN MICHAEL ANDREWS (D-TX): Congressman Andrews is considering making a statement in support of universal coverage. He sees himself as providing balance on the Committee as Stark moves closer to single player. He is close to Chairman Rostenkowski, as well as Secretary Bentsen and Rep. Stenholm. Andrews is viewed a bellwether for his delegation, He recently announced his intention to run for the Senate in 1994.

Andrews is a new member of the Health Subcommittee and a supporter of managed competition. He supports a tax cap on benefits and the use of the tobacco tax to fund health care reform. He is nervous about the potential power of the alliances and cost controls and the impact they might have on managed competition. He is also worried about too much government intrusion. Andrews's other concerns include children, immunization, low-income women, and rural areas. Congressman Andrews district is known as the health capitol of the world. He is close to the Texas AMA.

Andrews' vote is a long-shot but women's groups could help as he is indebted to them for their help in his last election.

Recent Developments: At a November meeting with Jack Lew and Ira, he stated he wanted the DLC and the Chafee discussion group to make statements supporting universal coverage. He was puzzled by the attacks on Cooper because he believes we have to work on those in the middle-of-the-road. He wants to help us understand their concerns. Andrews believes tort reform is as important to the Republicans as the alliance strcuture.

CONGRESSMAN BILL BREWSTER (D-OK): Congressman Brewster is a conservative and a member of both the Mainstream Forum and the Conservative Democratic Forum. He is close to Reps. Montgomery, Peterson, and Stenholm.

A licensed pharmacist, he is one of five health professionals in the Congress. Congressman Brewster is concerned about the ongoing funding for health reform. He believes the revenue base must be strong and permanent, and he wonders whether sin taxes will be sufficient. He will be a strong supporter of rural health reform and primary care. In addition, he urges that the President's plan endorse utilization review. Brewster likes global budgets. Although he supports universal coverage and reducing the costs to many small businesses, problem areas for him will be health alliances if they are not always available and if they reduce residents options because of costs.

Recent Developments: After the President's speech, Brewster said: "If this bill is done incorrectly, this country will suffer. It has to be a balanced approach. As the old saying goes, the devil is in the details."

CONGRESSMAN LEWIS PAYNE (D-VA): Congressman Payne represents Southern Virginia where his constituents include several thousand tobacco farmers. He is very conservative and is a member of the Conservative Democratic Forum, the Rural Health Care Coalition, and the Mainstream Forum.

He is a consistent supporter of abortion rights and civil rights but voted against a minimum wage increase and the Family and Medical Leave Act. If he supports the President, he will do so on his own and not due to pressure from the Chairman or the Leadership.

REPUBLICANS:

CONGRESSMAN FRED GRANDY (R-IA): Congressman Grandy, who is challenging his party's governor in 1994, has been considered one of the ablest of the younger generation of House Republicans. He is, of course, pushing his own plan and believes the philosophical debate will be between Democrats emphasizing security and Republicans emphasizing choice. He states his goals as universal access and cost containment. Grandy left the Education and Labor Committee to serve on Ways and Means. He calls himself a "knee-jerk moderate." Although Grandy voted against Family and Medical Leave, he remains a White House target on health care.

Grandy is a member of the Health Subcommittee. He is regularly allied with business and against labor interests. He has expressed concern about the need for increased funding for immunizations. He believes too much money is spent in the last months of life and is concerned about coverage for self-employed individuals. He is an abortion opponent.

Recent Developments: On November 5 Grandy said: "I've got to believe that if Leon Panetta were still chairman of the Budget Committee, he'd call time out at this point. We've passed the point of believing the numbers. It's the assumptions we're contending with now. I don't have any problem with Americans paying more for health care. It's not a question of 40% or 30% or 35%, it's this tendency (by the White House) to over-promise and ultimately under-deliver."

In the November 22 New Republic he said: "The more they beat up on Cooper, the more they help him."

CONGRESSMAN AMO HOUGHTON (R-NY): Congressman Houghton is a new member of the Ways and Means Committee and a Cooper-Grandy co-sponsor. He is one of the few House members to vote against repeal of catastrophic. His core issues are the burden on business, rural coverage, primary care, and what happens to those who cross state lines for medical care.

Recent Developments: Houghton is meeting regularly with Ira to discuss the substance of the bill.

CONGRESSWOMAN NANCY JOHNSON (R-CT) - Congresswoman Nancy Johnson is a moderate Republican who can also be angrily partisan. While she wants to be a player in health care and is a Cooper-Grandy cosponsor, she is a high maintenance member and time spent with her will not guarantee her help. Johnson is attending the bipartisan meetings attempting to map out a "centrist" health plan. The Congressional Quarterly has called her "the most change oriented of the Republicans" because of her having introduced "one of the first major bills to overhaul the insurance system and encourage streamlining of government and of paperwork."

Johnson's husband is an oncologist, and she has said repeatedly that doctors are not the cause of the country's health care ills. She questions the costs and bureaucracy of the Health Security Act. She is particularly worried that the plan could be painful to Connecticut's economy. Health care restructuring there has already led to mergers, cutbacks, and job losses. In 1990 Connecticut ranked eighth in the nation in the percentage of its workers employed in health services.

With her seat on the Health Subcommittee, she has focused on Medicare, health, and child care. Johnson is a strong supporter of outcomes research. She does not see insurance reform as the key to cost control and believes that cost controls in the private sector are more advanced than in the government. She also has expressed worry that alliances would be too big. Johnson has stated that she is very discouraged about abortion coverage and that "the problem is not the Republicans' fault. The Democrats are very divided on the issue."

Recent Developments: Johnson cosigned the letter on the Access Initiative. On October 27 she talked about the employer mandate: "Not only is this a new burden at this time for our economy but it's an open-ended burden which has ramifications for small employers in Connecticut."

Education and Labor Committee

DEMOCRATS:

CONGRESSMAN ROBERT E. ANDREWS (D-NJ): Congressman Andrews believes that for the first time in considering health care reform we can get beyond the special interest groups. While portrayed as adamantly opposed to new taxes, his staff told Secretary Reich in November that Andrews could support the Health Security Act provided that someone explained the final budget numbers to him. Andrews will be influenced by Chairman Ford, organized labor and possibly Governor Florio's defeat.

Andrews's district includes both Prudential and pharmaceutical companies and he is likely to be sensitive to their concerns.
At a May meeting with Chris Jennings, Andrews advocated orienting the message toward those with health insurance. He thinks the cost issue is driving the debate. His main point is that the message be simple. He believes it will be difficult to sell but he wants to be helpful.

CONGRESSMAN GENE GREEN (D-TX): Congressman Green is a freshman and a member of the Mainstream Forum. A lawyer, he represents largely working class neighborhoods of Houston. He serves on both Education and Labor and Merchant Marine and Fisheries.

He has changed his opinion on abortion and is now pro-choice. He is concerned about preventive medicine and pediatrics.

Recent Developments: Green cosigned the letter to the President regarding Medicare and medicaid cuts.

REPUBLICANS:

CONGRESSMAN STEVE GUNDERSON (R-WI): Congressman Gunderson is a Cooper-Grandy co-sponsor who serves on the House Republican Task Force on Health and is a member of the Wednesday Group. After the President's speech. Gunderson questioned some aspects of the plan but said: "there's no doubt in my mind that this is the beginning of a bipartisan process toward enactment of a comprehensive solution." Gunderson also noted that the plan contains provision of a rural health reform bill he introduced in January, such as 100 % deductibility of the cost of health insurance premiums for the self-employed.

On health care issues, Gunderson is worried that managed competition could fail rural areas because of the lack of sufficient medical resources. He questions the bureaucracy in the Health Security Act and the plan's impact on small business. He is also concerned about emergency services with waivers and outpatient clinics.

Recent Developments: Rep. Gunderson cosigned the letter regarding Medicare and Medicaid cuts. About possible cosponsorship, he told the Congressional Quarterly in November: "Even if you are a Democrat who wants to help the administration, why sponsor a bill with an employer mandate when the Senate might strip it out? I told her (the First lady) that the problem with a Republican signing on is that it would mean taking myself out of the legislative negotiations. 'You don't want me to cosponsor it now, you want me at the end.'"

SENATE COMMITTEES

Finance Committee

DEMOCRATS:

SENATOR DAVID BOREN (D-OK) - Senator Boren's initial reactions on health care have been cautious - applauding the effort and worried about financing. Like virtually every member of the Finance Committee, Senator Boren considers himself to be a strong supporter of rural health and small business issues. Boren also supports state flexibility within the context of any health reform proposal. He is worried about the employer mandate. Boren has been a member of the bipartisan group seeking to map out a single "centrist" health plan. The health insurance industry has targeted Senator Boren.

Recent Developments: In an October 1 op ed piece in the New York Times co-authored by Senator Danforth, Boren wrote: "Clinton cannot succeed as a centrist if the Administration continues to follow a 'democrat only' strategy ... Health care may be Mr. Clinton's greatest opportunity for bipartisanship. There is much on which Republicans and Democrats agree, ie: Americans deserve health care security; costs cannot grow at three times the rate of inflation; universal coverage. And we agree on some solutions: insurance market reform; managed competition and purchasing cooperatives."

SENATOR JOHN BREAUX (D-LA) - Senator Breaux was not overly active in health care issues until joining Senator Boren to sponsor the Senate companion bill to the Cooper/Conservative Democratic Forum's managed competition initiative. Being a sponsor of a bill that is now being characterized by many in the media as being in the "center" of the debate is very appealing to his desires of being a major "player" in the health care debate. He wants to be one of the primary dealmakers in this debate and he strongly believes he can deliver a number of votes beyond himself.

While being a cosponsor of the Senate version of the Cooper bill, Senator Breaux is not completely comfortable with every aspect of it. For example, he remains concerned about its ability to adequately respond to rural health needs.

Recent Developments: In a mid-November meeting with Ira, Steve Ricchetti, and Chris Jennings, Breaux offered to help work with moderate-conservative Democrats. He stated (though later in the day retracted) his desire to get the CDF Democrats to sign off on the concept that universal coverage had to be guaranteed in whatever legislation was enacted by the Congress. (All along it has been clear that his major

stumbling block would NOT be this issue or the issue of mandates; rather, his major concern is and will be cost containment and premium caps, as well as size and structure of alliances).

During the meeting, Breaux complained that the White House is "out there savaging the Cooper plan all over the country, and the attack is hurting me too." Breaux has repeatedly called the Health Security Act a "gumbo" and criticized it for its reliance on government regulation to control costs.

On December 4 he told the Washington Post: "The question we must now work on, and we are working on, is how and when do we get there (universal coverage). He stated his belief that a phased-in schedule for universal coverage could be a workable compromise.

REPUBLICANS:

SENATOR JOHN CHAFEE (R-RI) - Senator Chafee has been both temperate in his criticism and firm in his desire to move forward on health care reform in this Congress. Chafee comes to this debate with residual feelings that if not for Presidential and partisan politics in the last Congress, there was enough consensus between his and many Democrats' bills to move forward on health reform. He is working with conservative Democrats to shape a compromise.

Recent Developments: Chafee told the New York Times on November 13 that while he would try to get everyone covered by requiring individuals to buy insurance, that approach has the problem of the specter of the IRS. He said that to enforce the mandate on individuals "you will have to show on your tax return that you have health insurance."

In the November 16 Washington Times he said of the possibility of a national cap on health spending, it is "less of an anathema to me ... maybe if nothing else works that's the way you've got to go."

SENATOR JOHN DANFORTH (R-MO) - It is not yet clear how Senator Danforth's decision to retire will affect his ultimate decision of health care reform. He has, however, been consistent in seeking a bipartisan approach and telling the New York Times: "There are points of disagreement, but it's easy to overemphasize them." He is part of the bipartisan group trying to shape a "centrist" plan. Despite admonitions from his staff and other Republicans, Danforth is an advocate of imposing strong federal/state caps on health spending. He also believes that to do so would require explicit rationing.

The Senator has been vocal in opposing the possibility of new taxes for health care reform. He believes that universal coverage is important, but that it should be phased in. He believes the tax cap should apply to both employees and employers.

Recent Developments: Also to the New York Times on October 31: "It is bureaucratic. There are these massive health alliances."
In the November 5 Washington Post he suggested that the costs of the plan would be shaved by making the benefits less generous.

At Monday's conference Danforth stated: "Entitlements cannot be controlled by health care reform alone."

SENATOR BOB DOLE (R-KS) - The Minority Leader has continued to publicly balance criticism of the plan with a commitment to bipartisanship. While it is hard to dispute his September 24 statement to USA Today that health care would be "a long, long tortuous road," there appears to be building pressure on him to remain cooperative. Dole is very effective with two of our key Republicans - Senators Chafee and Kassebaum. His criticisms have focused specifically on the financing of the plan.

Senator Dole has a strong interest in rural health and is currently Co-Chair of the Senate Rural Health Caucus. Legislatively, he has supported initiatives to protect the viability of small rural hospitals as well as to expand civil rights protection and services for the handicapped. His individual concerns include veterans, mental health coverage, and the self-employed.

Recent Developments: To the AP on December 4: "We have different ideas on how to make it work. We don't like price controls, we don't like mandates on small business people, we don't like these mandatory health alliances ... If I had to guess ... I would say that about in April of next year, there will be a new plan. it will be sort of a consensus plan: some of this plan, some of that plan ... some of the Clinton plan. And if that happens, we'll have braod, bipartisan support." On December 13, his Chief of Staff, Shiela Burke, met with Ira, Steve, Chris, Melanne, and Greg. She was very constructive, more positive than usual, and suggested that we continue our outreach work with the Committees.

A Robert Novak column on December 13 lamenting the GOP passiviity on health care said: "Dole is seen by his colleagues as moving inexorably toward cosponsorship with Senate Majorty Leader George Mitchell on a final compromise."

SENATOR DAVE DURENBERGER (R-MN) – Senator Durenberger has been viewed as a possible ally on both Finance and Labor, especially given his close relationship with Senator Rockefeller. However, Durenberger's cosponsorship of the Cooper-Breaux bill and recent comments to Chris Jennings reflect his moving away from, rather than closer to, the Administration. This is especially noteworthy because his public comments have indicated a willingness to seek consensus.

He has raised questions about the employer mandate and cost containment and is nervous about price controls.

Recent Developments: On the turf battle between the two committees, Durenberger told the Washington Post: "I'm a non-loser. I want to see both of them in there" working together.
He told the Wall Street Journal on November 23: "We're for universal coverage, but not until you can satisfy the American people that it can be paid for."

The Minneapolis Star Tribune reported in mid-November that Durenberger had been stunned when a citizens' jury preferred a single payer plan and rejected both his and Administration representatives. Durenberger's chief-of-staff said: "That experience told us we've got to be able to explain in good, simple, clear language what managed competition is about, because people do not want a complicated system."

SENATOR BOB PACKWOOD (R-OR) – The situation with Senator Packwood is, at the very least, awkward. In addition to the serious ethics charges now being investigated, he has never been comfortable with the Republican leadership. During his re-election campaign, Packwood singled out health care as an issue on which he was closer to then-Governor Clinton than his Democratic opponent. Packwood is a strong pro-choice advocate. He is rare among Republicans, and even some Democrats, in that he supports an employer mandate. Packwood is concerned about the limits that the Administration says it would impose on small business subsidies and for low-income individuals to pay for their health coverage.

Recent Developments: On December 6 Packwood told that New York Times that he blocked part of the bill from going to Labor and acknowledged that whatever emerges next year will not be one committee's product but a "collective bill."

Labor and Human Resources Committee

DEMOCRATS:

SENATOR JEFF BINGAMAN (D-NM) – Senator Bingaman supports the managed competition model's focus on market adjustment of health care costs but has also supported an eventual cap on health care spending. He refused to endorse the plan following the President's speech, saying he wanted to scrutinize it for its effect on New Mexico, particularly rural areas and small business. He would like to see additional individual responsibility build into the system and asked in September: "Why does it not make sense to maintain some kind of additonal cost for individual s who choose to smoke or for employers with workforces that choose to smoke?"

He is a strong advocate of prevention and eliminating waste. He will be concerned about the effects of the package on small businesses. At Jamestown he felt that a payroll contribution of 7 – 8 % was too high. Reportedly, Senator Bingaman was unhappy over our language change from "HIPC" to "Alliance." He feels "cooperatives" are rural friendly. In his view, we should lead with cost containment.

REPUBLICANS:

SENATOR NANCY KASSEBAUM (R-KS) – Senator Kassebaum has pushed her Basicare approach as the only bipartisan proposal but has stressed her willingness to work with the Administration on health care reform. While telling the AP she found the President's plan "bold and thoughtful," Kassebaum also said she had "serious reservations" about it, including creating regulatory bodies which manage nearly everything in the health care system. She was concerned about the cost of the plan and the "potentially damaging" effect on employers, particularly small businesses.

Her elderly mother lives at home, so Kassebaum has a particular interest in long-term care.

Recent Developments: On October 28 she told the Detroit News: "It's like a souffle. Both the costs and the benefits keep rising, and there's a danger it will become so top heavy it falls of its own weight."

PRIORITY TARGETS (12/14/93)

HOUSE COMMITTEE MEMBERS:

WAYS AND MEANS:

Pickle (TX)
Rangel (NY)*
Ford (TN)
Stark (CA)*
Coyne (PA)*
Andrews (TX)
McDermott (WA)
Klezcka (WI)
Payne (VA)
Hogland (NE)
Neal (MA)
Brewster (OK)

Thomas (CA)
Grandy (IA)
Houghton (NY)

ENERGY AND COMMERCE:

Sharp (IN)
Tauzin (LA)
Richardson (NM)*
Slattery (KS)
Boucher (VA)
Cooper (TN)
Rowland (GA)
Lehman (CA)
Pallone (NJ)
Schenk (CA)
Margolies-Mezvinsky (PA)
Lambert (AR)

Bilarakis (FL)
McMillan (NC)
Upton (MI)
Paxon (NY)
Klug (WI)
Greenwood (PA)

EDUCATION AND LABOR:

Miller (CA)
Andrews (NJ)
Roemer (IN)
Green (TX)
Klink (PA)
English (AZ)*
Strickland (OH)*
Baesler (KY)

Goodling (PA)
Petri (WI)
Roukema (NJ)
Gunderson (WI)
Molinari (NY)
Miller (FL)

* = Health Security Act Cosponsor

OTHER IMPORTANT HOUSE MEMBERS:

Chapman (TX)
Condit (CA)
Derrick (SC)
Glickman (KS)
Hamilton (IN)
McCurdy (OK)
Mfume (MD)
Murtha (PA)*
Pelosi (CA)
Pomeroy (ND)
Price (NC)
Rose (NC)
Schroeder (CO)
Schumer (NY)
Serrano (NY)*
Spratt (SC)
Stenholm (TX)
Stokes (OH)*
Valentine (NC)
Volkmer (MO)

Boehlert (NY)
Fish (NY)
Gilman (NY)
Goss (FL)
Horn (CA)
Hobson (OH)
Leach (IA)
Machtley (RI)
Morella (MD)
Shays (CT)
Snowe (ME)

* = Health Security Act Cosponsor

SENATE COMMITTEE MEMBERS:

Finance Committee:

Moynihan* (D-NY)
Boren (D-OK)
Breaux (D-LA)
Packwood (R-OR)
Chafee (R-RI)
Dole (R-KS)
Danforth (R-MO)
Durenberger (R-MN)

Labor and Human Resources Committee:

Kassebaum (R-KS)
Durenberger (R-MN)

OTHER IMPORTANT SENATE MEMBERS:

Exon (D-NE)
Heflin (D-AL)
Hollings (D-SC)
Kerrey (D-NE)
Leiberman (D-CT)
Bond (R-MO)
Bennett (R-UT)
Cohen (R-ME)
Hatfield (R-OR)

* = Health Security Act Cosponsor

10/19

- Dingell - don't compromise internally; WHS tweaking clock + schedule
  1. Bentsen + Panetta re. numbers
  2. public health cutbacks?
  3. big corps + elderly re. ~~elderly~~ retiree
  4. CBO
  5. don't put mandated premiums into tax code
  6. Schedule:
     need hard nosed inside lobby: business, labor
     w/coordinating group
     ↳ need inside person to coordinate
     → Earl Malak (US Steel retiree ran Clean Air group)
     ↳ USX might pay expenses
  7. Rosty + Ford will do it in full committee

10/26 Need focused lobby
Howard Paster
met my friend Polish
ass to see you
succeed

10/20 - Shays has open mind but worried about numbers
"I don't have freedom to sign on right now because of way I'm positioned"
shares Houghton's concerns that unlike space station or supercollider if you're off 10% → billions
Dana White in his office - call to set up w/him + 2-3 others

Goss concerned about absence of information; dealing in dark; benefits are temporary but costs are concerning
"So much has been promised" but how can we get there from here
want to compare the work they've done on numbers
good experience w/ Dra → stick w/ that group there.

- has probs. w/ seniors
- "can we get comfortable w/ this"

☆ - Call Hastert
- Summers said don't pick up rattle

Hastert wants to be bipartisan but has to have give & take

Gunderson Natl Rural Health
Self insured
- gain momentum as we go through process
if Burke Rep signs up on day one! Loses all ability to bring anyone else along
If I became cheerleader of Admin - would not be in any discussion
thinks we will have 60% support

☆ Moderates should meet

Hastert is tool of Rep. leadership which wants to kill Admin plan

15-25 Reps.

- Hobson will work with you anyway I can to pass a bill - don't want to work against you
worked w/ Celeste in Ohio
need "like minded" members so no leaks, etc.

Rachel
Machtley
Grundy

Moynihan 30% / 68% black illegit. rate
since 1970 10% increase/yr .86% rise/yr.
(1950 rate 5%) w/correlation's of .991 rate will
not turn down

Sasser
Cooper speaking out for his plan and against
President ↳ strong willed + opinionated
↳ making great political mistake
↳ ~ 50% contributions from HCA, doctors

☆☆ HCA + Columbia merger → serious implications
DOJ + FTC planned look at this
Anne Bingaman b'fast for Reno → Steve (?) FTC Rep.
↳ 30 days deadline after announcement to take jurisdiction

Wofford yes
☆ Jim Mundy #1 trial lawyer in Pa. (Phila)
Bob Vogel ATLA

☆ John Kerry – Probably not
→ Talmoff – no clarity
need more articulation + military experience
→ CRIME

☆ Glenn
need to see section by section analysis
Diane Lifsey on his staff 224 7985

(NO) Bryan
48 hours ① staff brief ② comparison

10/25
UNS ☆ ✓ Bradley best not to compromise until understand fully

Metzenbaum - individual should have choice of which alliance to join

Lieberman

☆ ① Contact/training of staffs
people? > Bob Graham ② Rapid response for specific questions
Dante briefing > Sarbanes ② DNC/local dem. groups trained to be spokes persons

✓ Conrad - Craig Obey; we did good job on small bus, but concerns: ① Medicare DSH ② overall cost + fraud; ③ What do DSH do to quality incentives

BN Campbell

> Tom Harkin - 1.5% premium 1% compliance

Mikulski 401 342 2484 - Cancer event -
bad experience w/ appropriations

II. **Strategic Assessment/ Action Plan**

November 19, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON, MAGGIE WILLIAMS AND IRA MAGAZINER

FROM: Mike Lux

SUBJECT: Action Plan

In this memo, I want to lay out three organizing frameworks for our strategy from this point forward with interest groups and constituencies:

1. What expectations we have for interest groups, and making sure we hold the groups accountable for those expectations.

2. Building strategies not just around organized interest groups, but around broader constituencies.

3. Building a strategy for going underneath the national leadership directly to their local activists in targeted districts/states.

I. Organizational Expectations

In this section, I will go through what I think is realistic to expect of supportive groups (the major ones) in terms of what they will do and their positioning. I will also talk about how we should relate to the other major players in the debate. A few general points first:

It is clear from our recent experience that throughout most of the process, most organizations are going to continue to focus on the details of the bill instead of the big picture. It is the nature of the lobbyists, and lobbying groups, to want to focus on the details of legislative language. No matter how good a deal they have, they'll always want more.

When it comes to floor action in the House, Senate, and conference report, I do believe we will have a lot of hands on deck lobbying for passage. But as long as the bill's in committee, groups will tend to be more focused on protecting or enhancing their piece of the pie.

It is also clear we should not rely too heavily on allied groups for generating a lot of supportive news in the national media on their own. It's not what they do best, and the national media tends not to cover them unless they are saying something shocking (i.e. negative.) If we come up ideas for them, we can ask them to help, but for the most part we'll have to generate the ideas.

Having said this, however, it is realistic that we demand the following out of our allies:

1. Organizing an active field campaign, one which cooperates with the NHCC to produce concrete results at the Congressional district level, including:

- participation in Congressional town halls;
- phone calls and letters to Congress;
- letters to editor and op-eds;
- participation in radio call-in shows;
- house parties;
- distribution of the brochure, book, and video;
- gathering petition signatures; and
- participation in the on-the-record campaign.

2. Responding to us on rapid response requests coming out of the war room.

3. Responding to us on validation events and other events we put together.

4. Helping us get the bill out of the key committees at the end of mark up.

5. As I indicated earlier, helping us lobby once the bill reaches the floor.

6. Continuing to do positive educational training sessions and mailings to their membership and activists.

In spite of their D.C. lobbyist obsession with details, I believe that most of the time, we can get allied groups to follow our lead on message on all of these activities.

Expectations on Specific Groups. In terms of who I expect to produce what, I would divide groups into the following categories:

1. Our best allies, the ones likely to do all of these things, are:

American Nurses Association
National Leadership Coalition for Health Care Reform
Children's Defense Fund
National Association of Chain Drug Stores
National Association of Retail Druggists
League of Women Voters
National Council of Churches
Families USA
NEA
SEIU
AFSCME
Long Term Care Campaign
AFT

2. Single payer advocates, but close allies (willing to coordinate on message, grassroots efforts, education, etc.):

Citizen Action
National Council of Senior Citizens
National Association of Social Workers
Consumers Union
American Jewish Congress

3. Basically allied, willing to help us in some important ways, but unable (because of a lack of resources or weak field structure), or unwilling (because of timidity, obsession with details, or other problems) to do all of the above:

Catholic Health Association
American College of Physicians
American Academy of Pediatrics
American Academy of Family Physicians
National Medical Association
Disease groups
Veterans organizations
Mental Health Liaison Group
Campaign for Women's Health

There are two extremely important groups who we have courted aggressively and are mostly friendly that need to be singled out because of special circumstances:

AFL-CIO: The problem is not health care -- they are for our bill and will help us. The problem is the residue of anger and bitterness -- both at the leadership and rank-and-file level -- that the NAFTA leaves us. It will take most unions (the exceptions are listed above) a while to cool off and then gear up again over health care reform.

AARP: On the down side, their lack of guts caused them to hold back their endorsement. In addition, their general timidity creates huge strategic problems for us in terms of them taking on Cooper, Breaux, etc. On the up side, they are basically allied on all the key issues, have millions of dollars to spend, and are willing to work with us on message (although their caution won't allow them to go as far as we would like.)

Two final notes on allied groups:

- All allied groups must be held accountable: we should base how hard we work for the things they care about primarily on how hard they work for us.

- Setting up hill staff/WH staff/interest group meetings on certain issues. Part of the administration mantra these past few months has been a pledge to keep working closely with groups on difficult issues after the bill goes to the hill. As a sign of good faith to those who are really helping us, I want to be able to set up meetings on certain tricky detail sections of the bill with interest groups, our staff, and hill staff all involved. I want the groups to feel we are being pro-active and responsive with the hill on some of the key sticking points.

4. The other major players who are most important, and who are positioning themselves somewhere in the middle, are:

BlueCross/ BlueShield
the big 5 insurers
American Hospital Association
American Medical Association
Federation of American Health Systems
Nursing Homes (American Health Care Association and American Association of Homes for the Aging)
Independent Insurance Agents of America

These groups obviously range dramatically in how much of the bill they oppose, how constructive they are being, and their general strategy. They range on the continuum from AHA and the big 5 insurers, who I believe genuinely want reform to happen but have one major problem with our bill, to the Independent Insurance Agents, who are being fairly low key right now and are acting like they want to talk but would just as soon blow the whole thing up.

Much of my time has been, and will be, spent working on these groups to:

- keep their rhetoric basically positive,
- give them enough attention to make them feel it is in their interest to not do anything to make us mad,
- keep them off balance, and
- begin to get an early sense of places deals can be struck.

I will obviously need occasional assistance from people in terms of talking policy to these groups, or in terms of getting key people on the hill to help me in the bad cop game.

II. Developing Constituency Specific Strategies

Through staff assignments here, scheduling of principals, and staff work at the DNC, we need to be thinking through strategies on winning over key constituencies. Stan can help us figure out what are our key swing constituencies, and we can begin to schedule themes of the week to correspond with those groups, as we've been talking about with senior citizens. We can also set up administration /DNC staff working groups to think through specific constituency outreach strategies, which we've already done with business and doctors. Those two teams have already set in motion a variety of efforts.

On the business side, those include:

- setting up meetings of small groups of CEOs with HRC or Ira,

- bringing in groups of small businesspeople in sectors redlined by health insurance companies because of relatively high risk work places, and

- bringing in D.C. reps for sector by sector policy briefings.

On the doctor side, those include:

- setting up the Koop forums,
- doing surrogate training for doctors, and
- working with the doctors from the campaign, the DNC local media teams, and the HPRG to recruit more supportive doctors.

Both of these working groups are continuing their efforts. We may want to set up more such groups if people think it's crucial and we can find the staff resources to do it.

III. Directly Reaching Local Activists in Targeted Districts (instead of always having to rely on national group leadership)

In addition to the meetings we're doing where the members are bringing in the people they respect and want to stroke, I would like us to start bringing in people from the key supportive organizations that can generate pressure on these members. I did this in the budget fight, and it worked very well. It does many different things for us:

- It pleases the national groups that we're bringing some of their local activists to the WH;

- It allows us a way to directly touch and motivate the troops in the key districts without always going through the national groups;

- It generates great local press;

- People go home completely fired up, on message, and generating lots of activity; and

- It is a long-term base builder for the administration as a whole.

These work best as fairly intimate events, maybe 30-40 people, where they hear from:

- a policy expert;
- a message expert; and
- the President, Vice President, HRC or MEG.

I would recommend doing these state opinion leader meetings once or twice a week from January through bill passage.

III. **Current Status of Group Analysis**

I would list the groups in the following six categories:

A. Most supportive

B. Allies that are 90% or more with us; there may be some small issues to work out, but are positive overall

C. Mostly sympathetic, but still arms length because of one issue or another

D. Still advocates of single payer bill, but willing to work with us in a constructive coordinated fashion

E. With us on some big things, but very negative on at least one major feature of the plan

F. Enemies (would rather blow up reform than lose on the issues most important to them)

A. Most Supportive

AFSCME
American Academy of Pediatrics
Alzheimer's Association
American College of Preventive Medicine
American Federation of Teachers
American Medical Women's Association
American Nurses Association
American Postal Workers Union
Catholic Health Association
Children's Defense Fund
Children Health Fund
Families USA
League of Women Voters
Long Term Care Campaign
National Association of Chain Drug Stores
National Association of Retail Druggists
National Council of the Churches of Christ in the U.S.A.
National Council on the Aging
National Education Association
National Health Policy Council
National Hospice Organization
SEIU

B. Allies 90% or more with us

AFL-CIO (and its affiliates)
AIDS Action Council
Alliance for Health Reform
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Physicians Assistants
American Association for Retired Persons
American Association for Children's Residential Centers
American Association of Homes for the Aging
American Association for Marriage and Family Therapy
American Association for Partial Hospitalization
American Association of Pastoral Counselors
American Association of University Women
American College of Physicians
American Council of the Blind
American Counseling Association
American Heart Association
American Legion

American Lung Association
American Physical Therapy Association
American Psychological Association
American Public Health Association
American Thoracic Society
AMVETS
Anxiety Disorders Association of America
The ARC
Association of American Medical Colleges
Association of Schools of Public Health
Bazelon Center for Mental Health
B'nai B'rith International
Campaign for Women's Health
Consortium for Citizens with Disabilities
Disabled American Veterans
Epilepsy Foundation of America
Family Services America, Inc.
The Gay and Lesbian Task Force
The Gerontological Society of America
Joint Center on Political and Economic Studies
Massachusetts Federation of Nursing Homes
Military Order of the Purple Heart
Multiple Sclerosis Society
National Abortion Rights Action League
National Association of Children's Hospitals and Related Institutions
National Association for Home Care
National Association of People With AIDS
National Association for Rural Mental Health
National Association of State Units on Aging
National Black Nurses Association
National Black Women's Health Project
National Consumers League
National Council of Negro Women, Inc.
National Easter Seal Society
National Health Policy Council
National Hispanic Council on Aging
National Jewish Democratic Council
National Leadership Coalition for Health Care Reform
National Mental Health Association
National Minority AIDS Council
National Multiple Sclerosis Society
National Organization on Disability
National Urban League
National Womens Health Network
National Women's Law Center
New Hampshire Health Care Coalition

Presbyterian Church U.S.A.
Paralyzed Veterans of America
Save Our Security
United Auto Workers
United Seniors Health Cooperative
Veterans of Foreign Wars of the United States
Vietnam Veterans of America

C. Mostly Sympathetic

American Association of Preferred Provider Organizations
American Association of Private Practice Psychiatrists
American Cancer Society
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American Diabetes Association
American Psychiatric Association
American Society of Internal Medicine
Blue Cross Blue Shield of Iowa
March of Dimes Birth Defects Foundation
Mental Health Liaison Group (thirty eight organizations)
National Alliance for the Mentally Ill
National Association of Psychiatric Health Systems
National Association of Psychiatric Treatment Centers for Children
National Association of Public Hospitals
National Community Mental Healthcare Council
National Puerto Rican Coalition, Inc.

D. Single Payer

American Jewish Congress
American Speech-Language-Hearing Association
Citizen Action
Consumer Federation of America
Consumers Union
Gray Panthers
Interfaith IMPACT
Interreligious Health Care Access Campaign
National Association of Social Workers
National Council of Senior Citizens
National Farmers Union
National Medical Association

Older Women's League
Union of American Hebrew Congregations

E. Groups that are with us on some big issues, but very negative on at least one feature of the plan.

Alliance for Managed Competition (Big 5 insurers)
American Dental Association
American Group Practice Association
American Health Care Association
American Hospital Association
American Medical Association
American Psychological Association
Blue Cross Blue Shield Association
Federation of American Health Care Systems

F. Enemies

Health Insurance Association of America
Health Leadership Council
Independent Insurance Agents of America
National Federation of Independent Businesses
National Restaurant Association
Pharmaceutical Manufacturers Association

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Ira C. Magaziner to Hillary Rodham Clinton, re: Retrospectives on Health Reform: Update (5 pages)	04/17/1995	P5
002. memo	Ira Magaziner to David Broder and Haynes Johnson, re: Health Reform (16 pages)	04/10/1995	P5
003. transcript	Interview with Ira Magaziner (13 pages)	10/27/1993	P5
004. transcript	Haynes Johnson and David Broder Interview with Ira Magaziner (16 pages)	12/1993	P5, P6/b(6)
005. transcript	Interview with Ira Magaziner (19 pages)	04/09/1994	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Materials, 1993 - 1994)
OA/Box Number: 12503

FOLDER TITLE:
Retrospectives on Health Reform [1]

Kara Ellis
2006-0810-F
ke68

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]

THE WHITE HOUSE

WASHINGTON

April 17, 1995

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: IRA C. MAGAZINER

SUBJ: RETROSPECTIVES ON HEALTH REFORM: UPDATE

Enclosed is a packet of materials which will bring you up to date on retrospectives on health reform.

1. Over the past few weeks, I have spent about 20 hours going over 1993 materials with Elyse Veron, David Broder and Haynes Johnson's assistant. I also had another 2-hour session with Broder and Johnson. I don't yet have the transcripts from these discussions, but I have enclosed final transcripts from my other discussions with them plus a letter which I sent them responding to a few specific questions they asked.

   They are now finishing their drafts of chapters relating to 1993. I will meet them again to discuss 1994 within the next few weeks.

   Although I seethe inside when I think of how disloyal some Administration officials have been to you and the President and how hurtful they have been to me in their private discussions with the press, I decided to stick to the principle of not being critical of other Administration officials and I withheld materials which would cast our colleagues in a bad light. Although it is tempting, I just don't feel it's right to do and it could sew discord in 1996 when the book appears, which would not be helpful to the campaign.

   As you will see from the transcripts, the only exception is when I am asked a question where others are reinventing history and I had to defend decisions you or the President made. I can be more specific about these instances, if you wish, when we talk next.

   Though I don't know how Broder and Johnson will represent events in their book, I believe that they will be more balanced than previous accounts. They appear to understand that:

   - This was an incredibly difficult undertaking in the best of circumstances.

- Delay was fatal.

- The task force was not responsible for the delay; factors beyond our control caused it and we understood and warned everyone about the consequences of the delay.

- Diversions on NAFTA, Haiti, Somalia, etc.; were in part responsible for our inability to communicate effectively in the fall of 1993.

- The power and sophistication of opposing interest groups reached new heights with health reform and this played a major role in our defeat.

However, as of a few weeks ago, they also appeared to believe that:

- We overreached by proposing too big a package against the advice of some senior Administration officials. It was too much for a President with a 43 percent mandate and slight congressional majorities (compared to the Roosevelt and Johnson majorities when Social Security, Medicare/Medicaid and Civil Rights were passed) to pass major deficit reduction and health care in his first two years.

- We did not successfully build an interest group coalition because we did not negotiate well.

I have tried to respond to these two points in my discussions with them over the past weeks and in the enclosed letter I sent them. I may have made some progress.

The main points I have made which they seem to understand are:

1. The President was fulfilling a campaign commitment. Almost all Democrats and moderate Republicans favored comprehensive reform and our approach was a moderate one.

2. Most political advice we received supported a bold, comprehensive package.

3. The policies we proposed had precedents in bills sponsored by moderates and some of the regulatory language was necessary for CBO scoring.

4. All senior officials in the Administration favored the structure we were proposing; employer mandates, premium caps, mandatory alliances, etc; disagreements were only

about scope of benefits, speed of phase-in and tightness of cost containment.

5. We had had extensive discussions with conservative Democrats and moderate Republicans which led us to believe that a watered down version of our bill would ultimately be acceptable.

6. We were willing to be flexible.

7. Nobody to this day has come up with an alternative approach which addresses the goals of health reform and would have worked better politically than our approach.

8. We negotiated in good faith with interest groups. Many made commitments which they backed away from. Delay and our loss of momentum made it impossible to "close the deal" with many interest groups.

9. Despite all the difficulties, mistakes and delays and the battering we took in the fall, we still entered 1994 in better shape than most had predicted.

   - We introduced a comprehensive bill whose financing was validated by Lewin & Company, which was backed by the Congressional Leadership and which was under serious consideration in all relevant committees.

   - All the pundits were saying that while our bill would be changed significantly (which we knew and the President invited from the beginning), a universal coverage health care bill was highly likely to pass.

   - Polls indicated our bill was favored by a 17 point margin overall and by 30 to 50 point margins when matched up against the Cooper, Chafee or single-payer bills.

   - Polls were saying that introducing health reform was the President's greatest achievement of 1993.

2. I am continuing to work with Theda Skopcol, Lawrence Jacobs, Darrel West, James Carville and others who are writing on the subject. Theda is turning her paper into a book. I will get you a draft as soon as I have one. Enclosed is the latest Darrel West article. As you know, James is writing a book. I will give him suggestions for a health care chapter next week.

3. I have enclosed my responses to the Woodward and Drew books. Both authors are

very defensive and we will not likely make progress in getting them to change anything. You asked who in the Administration was responsible for the harmful accounts in their books. The Drew book has been especially harmful. Her accounts are mainly derived from extensive discussions she had with Donna Shalala which were very damaging to you, me and the President. These are the source of her negative comments on pages 189-192, 194, 305-307 and 396. These were backed up by comments from Sara Rosenbaum. Her other main sources were Marina Weiss who is responsible for comments on pages 193, 194 and 308 and David Gergen who played a roll on pages 305-307 and 309. Bob Boorstin and George Stephanopoulous also provided some input (195 and 305-307.) She feels that she is well sourced and won't change her views just based on my letter.

Woodward's accounts come mainly from Gene Sperling, with Marina Weiss and Bob Boorstin playing a role as well. He may change some of his inaccuracies in his paperback edition, but I am not optimistic. Again, he had extensive quotes from meetings with these others to bolster his claims.

Unless we are prepared to show Woodward or Drew documents and respond in kind to other Administration officials who trashed us, there is little we can do to make their accounts more accurate.

I have shared my responses to Woodward and Drew with Broder and Johnson so that they will not accept as uncontested, the gossip, false descriptions and false accusations in those books.

4. I have enclosed a recent Washington Monthly article which you may not have seen on lobbying and health reform.

5. I have enclosed a DLC editorial critical of the Fallows piece. I have tried to figure out why the DLC feels it necessary to continue to hammer us on health care. They are of course frustrated at the lack of success of many DLC candidates and blaming health care for everything lets all other causes be masked. I also think they raise their money in part by convincing corporate contributors that they will save the Democratic party from liberals and they need examples of enemies who they are fighting. At least they are now limiting their attacks to me instead of also going after you.

It is difficult to hear their attacks on our "failed proposal" since their opposition helped contribute to the defeat of health reform. Ironically, it is their attacks and those of Moynihan which allowed Republicans to commit what Paul Starr called the

"perfect crime," killing health reform without getting any blame. For many pundits, the issue became a dispute among Democrats.

Despite my frustration, I have remained completely silent in the face of their attacks and will continue to do so. It will do the President no good to have any debate between the DLC and any of us on health care now. At some point, I will try to improve my relations with them through other issues.

6. I am continuing to meet with different Washington "insiders" to try to amend their perceptions of what occurred. It is a grind, but I believe that it may be doing some good with some of them.

7. I have enclosed an analysis of our bill to answer the questions you raised about the Forbes quote. In my view, which you may remember I expressed repeatedly in the summer and fall of 1993, our bill was too regulatory in many of its specifics, particularly in its enforcement provisions.

   I originally rejected a great deal of this material. At a meeting in your west wing office requested by Sara Rosenbaum, she got authority to put an "enforcement and remedy" section in and to work with HHS and Justice lawyers on an extended set of consumer protection, anti-fraud and enforcement provisions.

   I questioned this again at our meeting in early October 1993 in your OEOB conference room when we went over potential policy changes, but dropped my objections out of exhaustion after Sara and others insisted.

8. I am continuing work on our own recounting of what occurred. As the problems get worse on health care, as Congress confronts Medicare and Medicaid cost growth, and as the optimistic predictions about how the corporate sector is solving the cost problem by itself or how Tennessee-type Medicaid revisions can solve the problem prove to be false hopes, I believe people may have a greater appreciation for what we proposed and what we tried to do.

April 10, 1995

Mr. David Broder
Political Columnist
Washington Post
1150 15th Street, NW
Washington, DC 20071

Haynes Johnson
Professor
George Washington University
National Center for Communications Studies
801 22nd Street, NW
Washington, DC 20052

Dear David and Haynes,

The questions you asked me a few weeks ago were good ones which I don't think I answered fully.

- Why did we attempt such a big, bold, comprehensive approach to health care reform? From articles that David has written about our "over-reaching" on health care and your question comparing the Greenhouse effort with health care reform, it appears that you are trying to understand why we proposed such a large and comprehensive plan.

- Why didn't we try to negotiate deals with interest groups before introducing the bill? You have obviously heard complaints from lobbyists and members of the Congress about our unwillingness to make deals with them and our inability to build an early solid coalition behind the plan.

I will try in this memo to answer your questions in a more orderly fashion than in our conversation. I would like to treat this memo as we are treating the transcripts -- as background material for you.

WHY A COMPREHENSIVE APPROACH

We pursued a comprehensive and bold approach to health reform because (1) the President committed to do so in his campaign, (2) his chief political advisers, Democratic congressional leaders, Democratic governors and supportive interest groups advised that it

was the best course politically and (3) because it made good policy sense. The fact that we failed naturally raises questions about whether this was the right course to follow. But it is unclear whether an incremental approach would have fared any better, if indeed a sound and effective one could have been designed.

The President's Charge

The President is the only person in the Executive Branch of the Federal Government who is elected by the American people. In my view, none of the rest of us, no matter how important we may sometimes think we are, is vested with that type of authority. Our job is to advise him, but ultimately to carry out his vision and decisions. We have a responsibility to be brutally frank in private, give our best advice, even argue with him when we disagree, but we should be loyal to him and his decisions.

To me, this view of my role and the roles of the senior officials of any administration is a given. I have been shocked and disheartened at how many people in the Administration put their own reputations and turf interests above the success of the President who chose them to serve. I admit a severe case of naivete in this matter.

I framed my mission based on a number of conversations I had with the President and First Lady who he designated to be my immediate superior on this assignment. In the language of consulting, my 20-year profession, they were my clients.

The President had an extensive background on health care, understood the issues very well, had a clear sense of promises he made during his campaign that he wanted fulfilled and of the timeframe in which he wanted these promises kept. He also had ideas on the process he wanted to have followed. It was easy for me to follow his lead on health care because I agreed with his vision.

The Policy Framework

After many hours of discussion with hundreds of people over 18 months, the President developed a health plan framework which he believed was right and which the American people seemed to support (for example, see Kaiser poll 3/93). He wanted us to flesh out this framework, test assumptions and suggest changes where the framework didn't make sense. He didn't want us to take off in a new direction without a compelling reason to do so.

This framework included the following as outlined in his Merck speech of September 1992 and in my work plan of January 1993.

- Guaranteeing all Americans health insurance by requiring all employers to pay for coverage and raising government funds (mainly through Medicare and Medicaid savings) to subsidize small and low-wage businesses and the unemployed.

- Maintaining a private health care system.

- Bringing the rate of growth of health care costs down to the rate of growth of personal income through increased competition, backed up by a global budget to cover cases where competition in itself was not sufficient to rein in costs.

- Ending discriminatory insurance practices and ensuring consumer choice of health plans and doctors through community rating, mandatory purchasing alliances, a specified minimum benefits package, a national board to set quality standards for health plans, and guaranteed fee-for-service options.

- Reducing paperwork and bureaucracy in the health care system and cracking down on fraud and abuse.

- Providing a Medicare drug benefit and improving access to long-term care.

At the time, these and the other ideas he espoused were considered "middle of the road" in Democratic and moderate Republican circles. Universal coverage was supported by all Democratic candidates in the 1992 campaign. The employer mandate was considered more moderate than the single-payer financing advocated by traditional liberal groups and by Bob Kerrey and Jerry Brown. Richard Nixon's health plan included an employer mandate; groups like the AMA, HIAA, AHA, Chamber of Commerce, Jackson Hole Group, and candidates like Paul Tsongas all supported one as well.

Managed competition was endorsed by the DLC, moderate Republicans, the Business Roundtable, the Chamber of Commerce and many others as a more moderate alternative than single payer or "pay-or-play," both of which created large federal financing pools and therefore, in the President's view, had too much government.

Containing the growth in health care costs (particularly the growth of Medicare and Medicaid costs) to the rate of growth in personal income, was controversial among many health experts in Washington and not popular with some liberals. But a wide array of experts including C. Everett Koop, Jack Wennberg, Uwe Reinhardt, the Pennsylvania Health Cost Containment Council, and others believed it could be done. Because capping the rate of growth in Medicare and Medicaid was essential to long term deficit reduction, it appealed to conservative Democrats and moderate Republicans. Groups like the AARP who traditionally opposed caps on Medicare and Medicaid found the President's proposal more acceptable because private insurance premium growth would also be capped and the health system would undergo comprehensive reform.

The President felt passionately about the need for comprehensive health reform both as an economic necessity and as a social and moral issue. Rapid growth in health costs was paralyzing family budgets, straining state and federal government budgets and hurting business competitiveness. He met people suffering without adequate insurance or sufficient money to buy prescription drugs everywhere he went in the campaign and wondered why we couldn't provide care for all of our people when every other developed nation in the world did so (while spending a far lower percentage of their economies on health care).

Timing

The President believed strongly in his campaign promise to submit a health plan in the first 100 days of his Administration. Economic growth and deficit reduction in the late 1990s depended on action on health care early. He knew also that health care reform would be a very controversial issue. The longer it took to introduce a bill, the less likely it would be that we could succeed. In early 1993, there was momentum for reform. He wanted to seize this momentum.

My first work plan called for finishing a proposal by the end of May. When I showed it to the President at a lunch a few days after the inauguration, he said that was too late. He wanted a plan by May 3rd -- 100 days.

Process

The President gave a few instructions on the process.

1. First and foremost, he wanted the policy to work. He felt that too much social policy was built on skeletal bills which were not well thought out or were the result of political compromises that simply didn't work. While he recognized that whatever bill we passed would have to go through many mid-course corrections and amendments as implemented, he wanted the framework to be sound.

   He wanted the kind of rigor that I had a reputation for bringing to my private sector clients brought to this project. I had built a very successful consulting practice by retaining blue chip company clients over many years because our recommendations were based on thorough and rigorous analysis and withstood the test of time.

2. He was concerned that we not allow the existing government bureaucracies, by virtue of their knowledge of details, to dominate the policy process. He believed that they were a big part of the problem. As a governor, he had first hand experience with HCFA and found the organization and its many bureaucratic rules frustrating and inflexible. At various points he would say only half in jest, "let's abolish HCFA." He also had heard as had I, that Treasury analysts often controlled policy by presenting numbers and not documenting them. They claimed a confidentiality requirement. The President wanted all assumptions understood and made explicit.

He also believed that a lot of the traditional Washington thinking on health care was stale and that state and private sector innovations were more forward looking.

For all these reasons, he wanted a health care working group which would include people from outside Washington, practitioners as well as theoreticians. He wanted us to challenge the bureaucracies and the conventional Washington thinking on health policy.

3. He did not want the health care special interests to dominate the process. He wanted to allow them to be heard, but not to write the policy, as he perceived was often done on complex technical issues like health care.

4. He wanted the health care effort coordinated from the White House. It involved competing interests of many departments. It was to be a centerpiece of his Administration. He had not made health care knowledge a criteria in selecting an HHS Secretary because he planned to coordinate reform from the White House. He knew his economic team would be preoccupied with the economic package, so he encouraged the formation of a separate policy operation.

From my point of view, the President had set the parameters for what he wanted done, how he wanted it done and when he wanted it done. The President wanted comprehensive reform. My job was to carry out his wishes.

Political Advice

I was confident that I could lead a good policy development effort. I had 20 years of experience in strategy and policy development for private and public sector clients. I knew, however, that I lacked political, legislative and Washington experience. I was also handicapped by not being able to hire my own people. I could bring in consultants and special government employees for a few months, but I could not build a long-term team as a cabinet secretary or the head of the NEC or DPC could do. Virtually all the Administration officials with whom I worked were hired by someone else, loyal to someone else and in some cases wanted to run the effort themselves out of their departments or agencies, or at least to have greater authority. This structure left me very vulnerable politically.

Being new to Washington and to politics, I immediately sought to reach out to the President's political and communications experts for help in shaping the effort. Though the health care political and communications operations did not report to me, I wanted to set policy in the context of their advice.

I visited the senior political officials in the White House the first week after the taskforce was formed. The senior layer of White House advisors (George Stephanopoulos in Communications, Rahm Emanuel and then Joan Baggett in Political Affairs, Howard Paster

in Legislative Affairs, Alexis Herman in Public Liaison and Regina Montoya and then Marcia Hale in Intergovernmental Affairs) all indicated that their primary initial priority had to be the economic package and they designated more junior people to focus on health care.

I met every day with this designated team: Mike Lux in Public Liaison, Bob Boorstin in Communications, John Hart in Intergovernmental Affairs, Chris Jennings (Steve Ricchetti, Paster's deputy in charge of the Senate would occasionally participate) in Legislative Affairs, and Celia Fisher, a DNC employee designated by Political Affairs.

In addition, I consulted the political team which had run the campaign and were now serving as consultants: Mandy Grunwald, Paul Begala, Stan Greenberg and James Carville and talked with them typically every other week.

The consistent unanimous message from all of these political advisors was to create a bold program which was comprehensive and delivered benefits to people in a short time frame.

When questions were raised by some economic advisors about slowing phase in or reducing the scope of the benefits package, all of these political advisors, joined by others including George Stephanopoulos, Gene Sperling, Howard Paster, Donna Shalala and Bob Reich argued for the more comprehensive approach. Similarly, the congressional leadership most interested in health care: Majority Leaders Mitchell and Gephardt and Committee Chairs Rostenkowski, Dingell, Ford, Stark, Waxman, Kennedy, Riegle all advocated a bold comprehensive bill (Senate Finance Chairman Moynihan wouldn't address health care with us during the budget debate.)

During the spring and summer of 1993, the economic program had become unpopular. As reported by the White House office of Public Liaison, our political base had never been enthusiastic about deficit reduction. Though they did not oppose the President, they were not excited. The organized business community -- NAM, NFIB, the Chamber of Commerce, the Business Roundtable -- after years of calling for deficit reduction, was unhappy about the energy taxes and the raise in top level personal income tax rates and were criticizing the program. Polls showed the public was decidedly against the plan, as 95 percent of the people believed their taxes would go up. Not one Republican was supporting the plan. The stimulus package had gone down. Conservative Democrats were balking at every turn. For months, nobody knew whether the package would pass.

The economic team which had designed the package and the legislative and political strategy (in some cases over the objections of the campaign political team) had run into far greater difficulty than they had anticipated and than they had led the President to anticipate. Secretary Bentsen and Director Panetta had found it difficult in many cases to persuade old friends and allies to support the bill. Groups that they thought would be supportive in the business community backed away. Though the bill passed, it was a disillusioning experience and not one which gave the President complete faith in any group of advisors.

The political arguments most often made during this time by the President's political advisors and many key outside supporters were that we had to introduce a comprehensive health bill to excite the Democratic core constituencies. They had been indifferent to the deficit reduction plan and opposed NAFTA. A watered down health bill would be perceived as a betrayal, especially since many already thought we had "sold out" to the insurance companies by not advocating a single payer system.

The disagreements within the Administration in the spring and summer of 1993 were not about the basic structure nor the comprehensive nature of the program. Some called for a smaller package of benefits phased in more slowly with less stringent cost containment, while others felt that a bolder program was the best place to start.

Many of our core interest group supporters -- seniors groups, organized labor, supportive doctors and hospital groups, nurses and social workers, consumer groups, veterans and military dependent groups, disability groups -- wanted the bigger package. A number of swing constituency groups like the AMA, AHA and many health insurers also wanted a comprehensive package.

Business groups were the main supporters of lesser benefits, though even here, both the Chamber of Commerce and NAM, our two leading potential groups for business support, favored a benefits package at the level of Blue Cross government standard, eight percent less in value than ours, (though they were uncomfortable with the size of the drug and long-term care initiatives in the bill.)

If we had watered down the seniors benefits as some on the economic team suggested, would the "Committee to Preserve Medicare and Social Security" have gone into active opposition as they did against the catastrophic bill because of deep Medicare cuts with inadequate senior benefits? If we had cut the basic benefit package as they argued, would labor, already angry about NAFTA, feel that this was a threat to their members' benefits and hold back support or would mental health advocates and disabilities groups protest? If we had done these things, would the NFIB or HIAA or insurance agents have been less critical? We will never know, but most people in the Administration felt that watering down the package at the outset would be too risky politically and that it would inevitably happen in the congressional process.

In light of the "reinvention of history" which is occurring, it is important to reemphasize that no senior official in the Administration spoke up against the basic structure of the bill (except Donna Shalala and early on Alice Rivlin who leaned towards a bolder more government-oriented single payer system and wanted to use Medicare price controls instead of premium caps in the private sector and a VAT or payroll tax for financing). Universal coverage, the employer mandate, premium caps, mandatory alliances, etc., were unanimously supported. The only disagreements were about size of benefits, pace of phase-in and stringency of cost constraint.

The consistent indications we had from moderate Republicans and conservative Democrats were that some compromise which included this structure was going to occur, albeit with lower benefits, a less stringent mandate, triggered premium caps, smaller or voluntary alliances, etc.

In discussions with moderate Republicans and conservative Democrats in Congress during the spring and summer of 1993, it became clear that they would want to water down the mandate and scale back the size of the program from whatever we proposed and get credit for doing it. It was part of the "cover" they felt they needed to support an employer mandate and new entitlements. Leading liberals like Rockefeller, Dingell, Waxman and Kennedy also expected that the ultimate bill would be a scaled down version of what we proposed.

The only voice favoring incremental reforms was the conservative Republicans. But, even this voice was not unanimous. For instance, Don Nickles and other conservative Senator, introduced a comprehensive bill modelled on a Heritage proposal that achieved universal coverage, had an individual mandate and radically altered the health insurance system.

As Bob Rubin can attest, I felt that a smaller package with a slower phase in was prudent and would be where we eventually wound up, but the political advice from inside the Administration, from congressional leaders and from supportive interest groups convinced us that it was safer politically to start bigger and be whittled down in the congressional process.

The President heard the various sides of this discussion at a number of meetings with all his senior economic, domestic and political advisors in May, August and September of 1993 and then made his decisions.

The Policy Rationale

There was also a serious policy rationale for a comprehensive approach. Many states had tried incremental insurance reforms as a way to expand coverage and reduce cost, with very little success. Expanding coverage has to go hand-in-hand with cost containment so as not to drive up health costs. Market-based cost containment requires changes in the rules for health financing which are by nature complex and interrelated (consumer choice, community rating, standard benefits), no matter how designed. The Chafee, Cooper, Jeffords, Nickles, Danforth/Kassebaum/McCurdy, Bingaman, Baucus, McDermott/Wellstone, Stark, Dingel/Waxman, Ford, Rostenkowski, Kennedy and Mitchell bills all called for a comprehensive overhaul of the current system.

The fragmentation and cost shifting within the current health care system means that any change ripples through the whole system. Partial solutions can be easily "gamed" by private sector players with adverse consequences for consumers. It is politically fashionable

to speak of incremental approaches to achieve the goals of health reform more gradually, but nobody has yet put forward a credible proposal of what that would look like. To date, no incremental alternative remotely achieves the goals of health reform. Proposals now on the table do little to expand coverage or contain costs.

Normally, policy proposals can be made more moderate through more gradual phase-ins. While we expected this to happen, more gradual implementation of health reform is expensive. Because health costs are rising at two to three times the rate of inflation, the slower the phase-in of reform, the more expensive are the subsidies needed to finance universal coverage. Thus, health care, unlike most policy areas, presented a contradiction; slower phase-ins while more prudent politically, were potentially less prudent financially.

There was another serious policy consideration which shaped some of the more controversial aspects of our proposal -- CBO scoring. We could not produce a bill which CBO would not certify as containing costs and achieving universal coverage.

CBO had made clear in reports it issued in the spring of 1993 that it did not believe that competition or tax caps would significantly contain costs. Though I believe in the power of competition to reduce costs to a much greater extent than CBO would support, we had to put in place mechanisms which would be scored, or the bill would lose all credibility.

CBO had specified criteria for enforcement of cost containment which its economists would score as effective. We chose the premium caps and mandatory alliances because we thought they would work but also because they met CBO criteria when properly designed and because they had antecedents in bills introduced by moderates -- the Kassebaum/Danforth/ Burns/McCurdy/Glickman bill for premium caps and the Cooper/Andrews/Breaux/Boren bill for mandatory alliances.

These measures were among the most controversial in our bill and contributed significantly to the characterization of our bill as "big government" and bureaucratic. However, as back-up mechanisms for competition and community rating, they were sound policy, had moderate legislative antecedents and satisfied CBO requirements.

Those in Congress who advocated that we start with a more "middle of the road" approach have not been required to define what this would have included. The Chafee and Cooper bills, which were offered as centrist alternatives, avoided public scrutiny. Had this scrutiny occurred, ideas like tax caps, individual mandates, national certification of all health plans, severe Medicare cuts with no additional senior benefits, and complicated subsidy schemes for over 100 million people would have proved difficult to explain and justify.

A Chafee or a Cooper style bill would have engendered active opposition from labor, seniors groups, single payer advocates, businesses with good benefits packages that would now be taxed and a long list of other supporters of the Health Security Act without picking up substantial support from opposing groups who used those bills temporarily to oppose ours

but eventually backed off them.

The Cooper bill was scored as $300 billion short to produce 91 percent coverage even with its unpopular tax on benefits. Scoring on the Chafee bill was likely to be even worse. Imagine if we had proposed a bill with that scoring.

While CBO had criticisms of our bill, they were easy to fix. CBO analysis of the impact of our bill on national health spending was nearly identical to our estimate. They differed with us only on how savings or spending would be shared among businesses, federal government and state and local government. Because our bill produced substantial savings it was easy to make changes to allocate more of those savings to the federal government and achieve deficit reduction and universal coverage. These changes were presented by Senator Mitchell at the Democratic caucus in April of 1994. With the Chafee and Cooper approaches, this would have been almost impossible because there wasn't adequate financing or cost containment.

Was There Any Better Alternative?

The President promised a comprehensive proposal in the campaign. Almost all the political advice we received supported a bold comprehensive initiative. A comprehensive approach made sense on policy grounds. Even Senator Nickles and the Conservative Heritage Foundation, not to mention groups like the Chamber of Commerce, the AHA and the AMA were proposing comprehensive plans that radically altered the financing and delivery of American health care.

In this context, it shouldn't be surprising that we also presented a comprehensive bill. As my January, March, May and August 1993 memos attest, I was worried about the scope and difficulty of what we were attempting, but felt that any meaningful health reform would be politically difficult and that major changes were necessary to achieve the goals most people favored in the fall of 1993.

I am not sure that any approach which seriously addressed the issues, even if more slowly phased or smaller in scope as proposed by some on our economic team, would have encountered less opposition. And, we might have lost support from some of our core supporter groups. Any serious approach would still have had to raise money (through an employer mandate or large tax increases), would have had to have scoreable cost containment (through premium caps, direct price controls, budgets or stringent tax caps), and would have had to have some type of community rating (through health alliances or state or federal laws). Any of these would have led to extensive opposition from powerful, determined interest groups.

As you know, we always assumed our bill would be scaled back. We made clear from the outset that we had "no pride of authorship" and welcomed congressional rewrites as long as the President's principles were met. As you know from our "endgame memos," if

Congress had said, we will achieve the President's goals but we will take ten years instead of five, reduce the benefit levels, constrain costs more gradually, achieve community rating a different way, etc., we would have been very amenable and not at all surprised. We encouraged Chafee, Breaux and others to seek compromises.

Politically, we must at this point say that "we bit off more than we could chew" or some other such phrase. The real test of whether we overreached, however, is whether someone can define what a package could have looked like (even in hindsight) which would have achieved the President's goals (which almost all moderate Republicans and Democrats supported at the time); would have either diffused or pleased enough of our key opponents without alienating our base supporters; would have been judged financially sound by CBO; and still would have had a decent chance of in fact working.

It is easy for people to say "you should have started more to the center" or "you should have been more incremental" or "you should have produced a smaller package." They all have a good ring to them in a town that is comfortable with moderation and in the hindsight of the health reform failure. Our proposal certainly had flaws, but to date, nobody has come forward with a plan that addresses those problems any better and is more politically acceptable than ours.

I don't believe that an analogy with the Greenhouse Compact is really appropriate except in one respect. In the Greenhouse report, we predicted that unless major changes were undertaken in the climate for business and the economic development policies of Rhode Island, the state would continue to lose manufacturing jobs, real income relative to other states and population as young people left due to lack of economic opportunity. The Greenhouse Compact was not adopted and all of these negative consequences have occurred to an even greater extent than we predicted. Would the Compact have changed these trends? I think so, but we will never know. The political process in Rhode Island and the economic policies it produced over the past decade have not solved the problem.

Similarly with health care, our approach has been defeated for now. Will the problems now be solved another way? I hope so, but I'm not optimistic.

Virtually every other industrialized nation on earth achieves universal health coverage, almost all with similar or better benefits and health outcomes, all at 50 to 75 percent our cost relative to the size of their economies.

The interesting question is not why the President, First Lady or I would dare to propose such goals for our country, but rather why the political system of the greatest nation on earth has made such goals seem so bold, radical and unachievable.

WHY WE DIDN'T NEGOTIATE BETTER

To state the obvious, organized interest groups are in business to get the best possible deal for their members. What constitutes the best possible deal depends upon the political climate.

We had two fundamental and unalterable constraints in our dealings with interest groups.

1. Early on, most believed that comprehensive reform was inevitable and that their best strategy was to help us shape it. When the President's honeymoon was short lived and the economic program ran into trouble, and health reform was therefore delayed, many groups retracted initial offers and became more comfortable opposing change.

2. Our introduction of a bill was only the first step in a long congressional process with many entry points (committees) and many steps. It was not inherently good politics for interest groups to sign on unequivocally to our bill without trying to improve their position further in the congressional process. As a result, groups wanted to push us as far in their direction as possible without locking themselves into an endorsement.

During early 1993, we were hopeful of striking deals with a variety of groups for a bill which would be introduced and passed that year.

We anticipated working with congressional leaders from May through August to negotiate with key swing interest groups, particularly health care providers and business groups, and strike deals which would secure their support or at least acquiescence. We also anticipated being able to "lock in" support from our natural allies -- organized labor, senior groups, consumer groups and selected health provider groups.

When the economic program ran into trouble in April and May, the President's popularity plummeted and health care reform was postponed, we lost that opportunity.

After this, in late-June, we had to pursue a different strategy. We divided the groups into three categories: likely supporters; likely opponents; and swing constituencies.

Supporters

We conducted detailed discussions with the likely supporters throughout the summer and early fall to try to lock in as much support as possible when the bill was released. These groups included the AFL/CIO and its various unions, supportive medical groups such as the College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatricians, the National Medical Association, nurses, social workers; seniors groups such as AARP, NCSC, the Committee to Preserve Social Security and Medicare, the

Alzheimers Association; hospital groups such as the Catholic Health Association and the Association of Public Hospitals; and consumer groups such as Citizen Action, the League of Women Voters, Consumers Union, disability groups, disease groups, veterans groups, military dependent groups, mental health advocacy groups, etc.

Most of these discussions were successful, though it took time to gain the agreement we needed. In every case, these groups supported the fundamental elements of our bill. Inevitably, however, they disagreed with some minor elements. Some were single-payer advocates. Many said that they would be supportive but had to see final bill language and secure votes of their boards before they could formally endorse our bill. Many said they would support us but would oppose one or two elements -- the Catholic Health Association opposed our abortion provision and the doctors felt that our malpractice provision should go further.

These discussions were painstaking, time consuming and unavoidable. We secured the support of many of these groups, but often not until late 1993 or even early 1994. Sometimes, their preoccupation with the 10 percent they didn't get in our bill was communicated more forcefully than their overall support.

Opponents

Certain groups had clearly decided to oppose us from the beginning. By late spring, it became clear that the price for support from others would undermine our proposal.

The NFIB made their opposition clear in March. If we had an employer mandate or any substantial taxes, they would oppose us.

The HIAA may have hoped that they could strike a deal with us since they supported universal coverage, the employer mandate and a guaranteed comprehensive benefit package. However, they were unalterably opposed to three provisions of our policy which were fundamental -- consumer choice, community rating and premium caps. Essentially, they wanted insurers to continue to be able to charge different rates to different groups and discriminate against groups that had older or potentially less healthy people; they wanted to market to employers instead of allowing consumers to choose their health plans and they didn't want any limitations on the amounts by which they could raise their premiums.

In our view, consumer choice was essential to the functioning of a good market and was what most Americans wanted. The practice of insurance companies charging more to higher-risk groups not only went counter to the original idea of health insurance but would also raise government spending dramatically because public subsidies would increase for high-risk people. Without premium caps or some similar backup cost containment mechanisms, CBO would not score cost savings in the bill.

In my discussions with HIAA in the summer of 1993, I tried to explore areas of compromise on these issues, for example, triggered premium caps and adjusted community rating (whereby insurers would be protected against bad risks by a national reinsurance pool), but they did not seem interested in real compromises on these issues.

Mike Bromberg's various clients -- the large insurers and for-profit hospital groups -- opposed premium caps and consumer choice, and state flexibility. In February and March they had seemed open to potential compromises on these issues, but by late summer, their positions had hardened. I explored possibilities for triggered premium caps and limits on state flexibility with them in discussions in late summer and early fall, but got nowhere.

By early fall, we expected these groups to join the NFIB opposition.

Swing Groups

The final category were swing groups like the AMA, AHA, Blue Cross/Blue Shield, the PMA, the Chamber of Commerce and NAM. They supported many aspects of our proposals but opposed others. Unlike the opposing groups, they seemed truly committed to comprehensive health reform. Initially in the spring, they seemed interested in making deals with us to be supportive, but as we delayed, they began pulling back. They were not negative in our discussions with them, but they began emphasizing areas of disagreement and stressing that those would have to be resolved before they could be supportive. In discussions over the summer, they did agree to take a constructive position -- to publicly emphasize areas of agreement, to express a commitment to the President's principles and to make clear their desire to work with us to achieve a good bill.

NAM and the Chamber supported employer mandates, seemed inclined to accept triggered premium caps and favored mandatory community rating and consumer choice through mandatory health alliances (albeit smaller ones than we proposed). They were most uncomfortable with state flexibility, the new seniors' entitlements, the size of the benefits package and the size of alliances. We assured them that we would work with them on these issues and they agreed to take a constructive attitude toward our proposals, which they did for a period of time.

The AMA lunged from one position to another -- at times being very supportive -- and at other times being very critical. I had good meetings with them in the spring, but by the late summer, they were backing away. I suspect this reflected the tensions within their own membership. We would agree on various points and then they would have a new set of points at the next meeting. Their willingness to work with us clearly dissipated as time went on.

The AHA and Blue Cross/Blue Shield also had discussions with us about more flexible premium caps and smaller alliances; the AHA was also concerned about the level of

Medicare and Medicaid cuts. But again, they agreed to be generally supportive.

I believe that we discussed in good faith with these groups. We listened carefully to their views and weighed them very seriously. Sometimes we simply disagreed. Other times CBO disagreed.

By the fall, we were not in a position to cut deals with them. In some cases, they had withdrawn from positions they had communicated in the spring and were advocating changes we simply couldn't make without losing core supporters, CBO scoring or fundamental principles to which we were committed.

On top of this, the congressional leadership was strongly urging us not to cut deals. I had agreed to support the Chamber's small business discount schedule which was good policy. We pushed hard for a series of anti-trust changes which were also good policy and supported by the AMA and AHA. In these cases and others, congressional leaders were upset with me. They complained that we were making concessions without gaining any votes and that they should cut the deals, not us.

In many cases, when we moved in the direction of these groups, they had a new series of "concerns" they raised with us. After we worked all summer with the AMA on anti-trust, malpractice and other important issues, they returned in September with a new "bottom line" demand to be guaranteed a seat on the national health board. After discussing concerns about the degree of state flexibility in our plan all summer, NAM came in September with a demand for no state flexibility. This bolstered those in the Administration and in Congress who argued that we should not make concessions but rather should wait for the congressional process. We couldn't bring any closure with these groups because they knew they had another "bite at the apple" in Congress.

The Importance of Momentum

As you know, interest group politics in health care are very difficult. There are many sides to all issues, and there are many issues. Sometimes the real concerns for groups are not the major issue but a series of minor issues which have to be treated very carefully.

For example, all academic health centers support increases in funding for academic medicine. But there are a dozen crucial issues where they will fragment when the design of that funding is considered: Academic centers affiliated with medical schools verses those who are not affiliated; academic centers located in major urban areas with higher payment rates versus those in more rural settings; those who train specialists versus those who focus on primary care physicians; those who do significant amounts of research versus those who don't.

On any given issue, a decision may please one group and anger four others.

I know that it became commonplace for groups to blame us and me in particular for not resolving all of their issues. There was no way for us or anyone else to do so.

The real driving factor in our success with groups had less to do with how we negotiated and more to do with our overall political strength or weakness. Most of the swing groups we faced, have primarily Republican memberships. If the health reform ship, regardless of how battered, was clearly heading to shore, those who represent these interest groups would have argued to their members as they did from November 1992 - May 1993 that compromise with us was necessary.

In the fall of 1993, when strong conservative Republican opposition emerged and we lost momentum from delay and the outcome was less clear, the prudent strategy for most swing groups was to hang back and see how things developed. Finally, in the spring of 1994, when reform was in trouble, then preserving the status quo became the safest course for many of these groups.

I suspect that this overall swing in momentum was more important than any negotiating skills of ours.

THE DIFFICULTY OF OUR TASK

Presidents Kennedy and Johnson tried to get Medicare/Medicaid passed for four years without success. It was only after Johnson won a landslide, had a very Democratic Congress, used all of his legendary political skills and gave up all cost containment (a policy we have paid for since) that we passed coverage for just the elderly and the poor. And that was in an era when public faith in government was high and lobbying was a low budget, unsophisticated cottage industry compared to today.

President Clinton was only elected with 43 percent of the vote, had a narrow Democratic majority in the Congress, faced a well financed, highly sophisticated set of lobbyists and a public skeptical of government. With all of these obstacles, I believe it was a reasonably good achievement to leave 1993 with a thoughtful comprehensive health proposal in Congress, still favored by a solid majority of Americans, backed by major congressional leaders and expected by almost all observers to result in universal health care. Despite mistakes we made and circumstances which were often not favorable, we entered 1994 in relatively decent shape, believing that we could succeed.

I look forward to further conversations on what happened in 1994 which led to failure.

IRA MAGAZINER, it's the day in which the actual legislation goes to the Hill on the health care reform plan. We're sitting in his office, October 27, 1993.

Q: Let me go back to, in a narrative form -- when you first got involved in this process, where did you come into the health care business?

A: Well, I was advising the President from, actually before he announced his candidacy, on issues of competitiveness and American economic policy. I was engaged at the time in a couple-year study in Rhode Island on health care. And in December of '91, when he was already running, we were both at a Renaissance weekend together. He heard me do a panel which involved comments on health care. He came up afterwards and said: "Well, you know, I really agree with a lot of what you're saying here. Can we sit down and talk about health care as well?" And I said: " sure." We talked, and found that a lot of our ideas were very similar.

So during the subsequent months, he often asked me to prepare material on health care for him as well as on other economic issues. And that's where it really started.

I had been advising him for almost a year on other economic issues and skills and education issues which you're familiar with. And then he heard we were doing this two-year project on health care, and he heard me talk a little bit about it, and we started talking about health care. So he asked me also to help him out, and I helped prepare his statement in New Hampshire about health care and other statements for some of the primaries.

When I was putting together "Putting People First" during the campaign, we ranged over a broad number of issues and he still was not completely happy with where he was on health care. And so we talked more about it and eventually evolved a position which he has continued to hold about what should be the general framework on health care.

Q: Talk about that night, where his head was and where yours was at this point.

A: Well, he had spent a number of years studying health care. He had been, I think, head of the National Governors' Taskforce on health care. He knew as a governor about Medicaid and the problems with Medicaid. And I think the fundamental principles that we shared were, number one: that it was a tremendously wasteful system. There were a lot of savings to be had. Two: that it should be kept as a fundamentally private system, not moved to a single-payer government run system. At the time, Bob Kerrey was pushing a very broad-based, single-payer, big-tax system. We agreed that single payer had too much government in it, and you shouldn't have to put so much new money into a system that everybody agreed was as inefficient as this one.

Three: we agreed that better competitive mechanisms were the best way to get efficiency, but that you needed the discipline of a budget as a backup. Finally, we also believed in shared responsibility, that having some requirements for employers and individuals to pay but making it affordable was the right way to go. Those are some of the headlines, but I think there was a common framework developed which goes back to New Hampshire which is still what he talks about today.

B: Where did you bump into the theory of managed competition yourself?

A: I actually didn't bump into it until after I sort of had come to a lot of the same conclusions myself. We did this two-year study where we looked at the health care system in Rhode Island and we did the kind of study I would do in business strategy where we literally followed nurses and doctors and technicians in the health care system around on their shifts, recording what they did with their time, understanding how costs got built up, analyzing inefficiencies in the system. It was a very thorough two-year analysis. And I could see that the incentives were all wrong in the system, and that the way the paperwork had built up and the fragmentation was causing tremendous waste.

I had also a sense that the government role had been the wrong kind of role. When it came in as a regulator to try to prevent abuses, it just added to the problem by the micromanagement it created.

So we had talked about integrated health care networks in our Rhode Island study and allowing those networks to compete with each other. Our study had come out right around December '91. In March of '92, after the then-candidate Clinton had asked me to help work on health care, I came across some of the work that Walter Zelman had been doing with Garamendi in California, and read it. I remember thinking that what they were doing in California fit with what we'd been thinking in Rhode Island.

And so I gave them a call. And Bob Reich and Paul Starr had worked together, and Bob gave me a call and asked if I would talk to Paul and Paul sent me a draft of what he was proposing. It also seemed to fit together with our thinking. I really hadn't had any contact with Clinton's health advisors from Washington because I was mainly associated with the group that was advising Clinton on economic policy and skills and education at the time.

When I worked on the effort to create "Putting People First," the President decided in early-June to include health care. I got in touch with Ron Pollack and some of those who had been advising about health care as well. I began to meet them, and my sense was that we needed an infusion of people from outside of Washington because there was a certain Washington "Democratic think" on health care which did not reflect what was going on elsewhere in the country. It was focused on "pay-or-play" and other big government solutions and was not very serious about cost containment.

Cost containment to them meant price controls, not trying to reorient the system. And so I brought in -- no joy to some of the people there -- a group from outside, people who had experience in industry, people who were working in the states and had experience, in Minnesota and California and Hawaii and other places, and we broadened the group that was advising the campaign on health care.

I don't think I read the pure managed competition material from Jackson Hole until that summer.

We continued to have discussions through the summer in preparation for what was then a speech the President made in New Jersey at one of the pharmaceutical companies, defining more of his health policy. But the general sense of the people running the campaign was we didn't want to get too specific on health care. And so we just left it at the principles level even though we had more detailed analysis done. They felt that the President was already winning with the American people on health care. People thought that he would deal with health care more seriously than Bush. To get into more detail would just invite division.

So the work we had done in more detail was left on the shelf. Then, in late-August, I was asked by Mickey Kantor who was then chair of the campaign, and was also chair of what they called the Pre-Transition Foundation, to head up a quiet effort to produce basic materials that could be used to prepare the first budget if the President were elected. I was told I had two jobs: one was to do the work; and the second one was not to have any newspaper story appear that we were doing it because it would look like hubris.

So I disappeared for two months. Do you know Harrison Wellford? Harrison and I headed that effort for about two months.

B: Can I interrupt you again to go back and pick up on a couple of things? We've been told, and I think something was written at the time, about the section on health care in "Putting People First." Could you give us your recollection? Was it a Sunday that the thing was going to press?

A: *In April, the President called Bob Reich, Derek Shearer and me to go to a meeting in Arkansas. He said I'm not happy with the way my policy and politics are integrated. Could you work on a coherent economic policy statement? So we coordinated the creation of a detailed policy book.

B: What was it he wasn't happy about?

*My letter to Bob Woodward explains this in more detail

A: He felt that the good ideas that we'd had about the economy and how you tie those together with skills and education, technology, welfare reform, infrastructure investments and so on, weren't being communicated. He wanted to try to improve the coordination. And we talked then about putting out a book. And so we prepared -- Bob, Derek Shearer and I -- a lot of background material for that book. Since I had some people at my firm who were interested in working on it, we coordinated putting together that book.

Then we had a couple of meetings with the message people over a couple of months. At this point, health care wasn't going to be part of the book. Then, Memorial day weekend, the decision was made to go ahead with a small book. Bob Reich was going into the hospital, and Derek had something else he had to do, Gene Sperling was just coming on as Bruce Reed's replacement to coordinate economic policy for the campaign, so the President asked me to work with Gene to coordinate the final book.

So I did during the first couple of weeks in June. There was some thought that Ross Perot was going to come out with a policy book. We wanted to get our book out before he did. And if you remember the context then, I remember having dinner, my wife and I, with the President and Hillary on Memorial Day. He was just about to win the California primary and sew up the nomination, but because he was third in the polls and Ross Perot was leading, the ambiance was: oh my God, the Democratic party shot itself in the foot again, they're going to nominate somebody who can't possibly be elected. And the Governor thought we ought to put out this document to demonstrate what we were fighting for.

The decision was then made to include health care about ten days before we were to finish with this. So I pulled out the work that had been done for the New Hampshire statement and took a little bit of the new thinking that we wanted in terms of a competitive marketplace and put it in.

Then the question came up about what to do with the budget deficit estimates that we were going to put in. This was a couple of days before we were ready to finish it. We came to a general conclusion to make health care deficit neutral so that what savings we got in health care could go to pay for what we needed to do for universal coverage. Bruce Reed suggested checking with people that had been part of the health advisory group, the Washington group.

Q: Out of Ann Wexler's shop?

A: That's right. I remember calling Ron Pollack late on Thursday evening and again on Friday, saying we're going to go with a section on health care, and we wanted to use some numbers, and here's what we're thinking of doing. And he said, well I need to get in touch with Judy Feder and Ken Thorpe and so he got Judy on the phone. They

couldn't agree among themselves. Pollack thought you could be more aggressive on cost savings, Feder wasn't sure. So we had this big question. And the President had taken the point of view, which I agreed with, that we would pay for universal coverage as we got savings, and it would be deficit neutral, and that's the way we should proceed.

Some other people from the health care group said, well, you may do that, but we don't want to say that because that could mean universal coverage might not come till '97 or '98 and that might make people feel like it's too far off. You have to guarantee universal coverage by the time you run for reelection.

I had been away from my family for two weeks and I had promised my kids to be home to take them out. So I flew out early Saturday morning, assuming we had resolved the issue and it would just be deficit neutral, and that we would still say that we were going to do universal coverage as we got savings. And I flew home and I was out with my kids at a miniature golf course. And I got this emergency call at the miniature gold place that there was a conference call that had to take place, and there were people on the line. They were saying that they didn't know if we could put "Putting People First" out. It was supposed to come out on Sunday so he could use it in a speech he was making to mayors on Monday.

The decision was finally made just to take the health care numbers out which essentially did assume deficit neutrality, but to say that we would get universal coverage. I advised that you could say that and avoid the issue, but it might not be true that we could really guarantee universal coverage by '96.

So then the President said, well I want to be honest, he said, but what we can do is just assume it's deficit neutral regardless, and then just say we're going to get universal coverage without specifying a date. And I said, well I'm comfortable with that.

So that's the way we left it. Later I learned that earlier on Saturday, Gene really got upset about the confusion on health care. He was new in his job and was angry about the whole incident. But in any event, the book came out and came out on time.

That did set a discussion in motion between the people in Washington and me right afterwards to try to quantify cost savings as we went into the summer. And that's when I first met some of the people that I've been working with, like Judy Feder and Ken Thorpe. But anyway, that's what happened that weekend.

Q: The other thing, before we get to the transition thing that a couple people have mentioned to us was that there was an apparently important meeting over at Wexler's office?

A: That's the one I called with Atul Gawande, yeah.

Q: In preparation for the New Jersey speech?

A: That's right. But basically, the President called me in late-July. He said that we needed to get something formally written up on health care. And I said that I had been in touch now more with the Washington group, and we really need a broader perspective on health care. I told him that I thought that the conventional Washington thinking on health care was out of date. And he agreed because as he'd been going around the country and talking to people -- I think Garamendi was his California campaign chairman at the time -- he had talked to many who felt that that was the case. The traditional "pay-or-play model" which was on the table from the mainstream Democrats, and the single payer model from the liberals didn't speak to what was happening around the country.

So we called the meeting. I don't remember the date, but I believe it was in August. I brought in a broader group of people to join the advisory group that had been meeting. We spent six or seven hours talking through some shifts in policy. And I was trying to make the point that we really had to be more private-sector oriented, and more reliant on competition. I brought Lois Quam from Minnesota and Walter Zelman from California and Paul Starr from Princeton and Jack Lewin from Hawaii and others to talk about their experiences.

I think it was a pretty good meeting.

Q: What were the tension points there?

A: Well, I think at that meeting, the main tension points were clashes of culture about the government role. Also there was tension on how much state flexibility or federal control should be in the system. There was also disagreement about whether to set up a big national government pool or not. I remember Karen Ignani was concerned or upset about leaving insurance companies in charge of the health plans, still gaming the system. Henry Aaron didn't like managed competition and didn't believe competition would contain costs much. So we had some of those tensions.

Q: Was the financing mechanism on the table for discussion and debate at that point?

A: The financing mechanism --

Q: What kind of taxes and how much taxes?

A: Not really. I think the notion of requiring employers and individuals to pay was pretty much where the President had been and everybody understood this. I think there were still some people there, including Karen Ignagni who preferred to see a

single-payer system. But we basically agreed that, throughout the campaign, we would stay where we were in New Hampshire and there would be time to discuss afterwards.

There were a lot of tensions under the surface, but I think the sense was: we know we're not going to get anything done if we don't get Clinton elected. We can talk about some of these differences afterwards. Let's get him elected first.

There were also some personal tensions. None of these people knew who I was, and they were a kind of community that knew each other quite well. And so I think the "who's this guy," was there a little bit. And then I think there was some tension between some of them because these people had been debating each other for years -- the managed competition people and the single-payer people -- so those tensions would occasionally come out from underneath the surface. But I think generally it was a decent meeting. The decision had been taken anyway just to keep the campaign on the general message level.

Q: Well bring us up to the election now. Clinton wins and ---

A: Well for me, there was an important education from the process that I led in September and October. I knew something about the federal budget before that. But for two months, I immersed myself in the federal budget to prepare 10 volumes of material. But something happened around the time of the election. We were supposed to prepare all this material to meet with the President the day or two after the elections. Something happened related to Mickey Kantor's role in the transition, right around election time. And since the work we had done had been done under his auspices as chairman, it became suspect.

There were some tensions there that meant the work got shoved to the side. I'm still not clear I understand it all. In any event, during that period, I had become very acutely aware of what effect health care had on the economy and on the deficit, and what would happen to the economy and the deficit for the rest of the decade if what CBO was projecting about health care were true. There was a real disconnect between having health care costs go up to 19 percent of GDP and having Medicare and Medicaid grow as fast as they were projected to in the late '90s and the early part of the next century, and the possibility of having any real wage increases. Basically, health care cost growth ate up over 120 percent of the increase in workers' wages. So you could not have a real wage increase if this set of figures on health care were true. And the deficit problem could not be solved long term without solving the health care crisis.

So I started writing some memos saying health care has to be addressed by itself as a separate issue. I was given a role in the transition of focusing on the deficit because that's what I'd been doing for two months. I was also asked to be a liaison with the

health group with respect to deficit issues.

The whole transition time was a time best not remembered. People didn't know what was going to happen to them and were jockeying for position and so forth. But nevertheless, it brought it home to me that health care may be the most fundamental economic issue the country faces, besides real wage decline.

Then at the end of November, I came to Little Rock to meet with the President and the First Lady about what I might do in the administration. We talked about a number of different possibilities. One possibility was to take a position like the one I've taken. The way the President put it was that if you're a cabinet secretary, 80 percent of your time is spent managing status quo programs. And when I prefaced our conversation, I said, look, what I'm really interested in is the change agenda you advocated. There are a couple of areas where I've spent a lot of time like skills or competitiveness and technology or defense conversion or health care. And what I'd like to do is help push the change agenda that you ran on in any way I can.

He said, we might try to do a number of these "change" issues in an interdepartmental way. We're going to need somebody to coordinate out of the White House interdepartmental projects that might be big ones that cut across the administration that push the change agenda. And we talked a little bit about my experience as a strategy consultant and on the skills commission, he was aware of it because Hillary was a co-chair on the skills commission. He knew I had gotten unanimous consensus on the skills commission, getting business and labor and educators, Republicans and Democrats on board to something that was fundamentally new.

And so he drew upon that and said, I'd like to bring the kind of rigor that Jack Welch would expect on studies you do for General Electric to government and the kind of consensus building you did on the skills commission. And so we discussed the possibility that I would take on this kind of role.

I'm new to Washington and I didn't know Washington well. I went to a couple of people that I know in Washington and said: would this kind of role work? It sounds interesting. The response was, why don't you commit suicide in Rhode Island and not come to Washington. That basically the idea of sitting in the White House and corrdinating an interdepartmental effort among cabinet secretaries who were going to assert their own turf, is crazy.

So I went back to the President and I said, let's think about this. And so it was kind of left loose for awhile. And we had more discussions about it. But it became clear they wanted me to do something like this. And we just had to figure out what the right place was for it.

Q: In that first meeting after the election, when you're going through the possibilities, where were they coming from, the Clintons -- Hillary and Bill Clinton -- on this? How urgent did they see health care as opposed to X and Y?

A: I was in the kitchen in Little Rock at this meeting. And we were just kicking things around. If you look at "Putting People First," and the change agenda he ran on, the things that I spent the most time working with them on were technology policy, defense conversion and promotion of competitiveness; or the skills and school-to-work transition agenda. Those were probably the two biggest things I had advised on, and those were two key legs of "Putting People First." We also talked about health care. So we talked about all three. For example, I talked with him about defense conversion and technology policy and he said, if you were Secretary of Commerce, could you do that? I said my concern would be that it would depend on the Secretary of Defense and Commerce and other areas working together. If you were just in one position, you might not be able to do it? And he said well maybe you do need to coordinate something like that at the White House.

So it was a very fluid discussion. My sense was that they were trying to move people around on a chess board of places. And I know that I had recommended to him early on, for example, that he look to somebody like John Young as a Commerce secretary and I think there had been some interest in that, but I think he had some financial issues. And then he said well the skills agenda, where do you think is the best place to do that, or how would you do that? And then we talked about health care.

And so it was really a moving discussion. I can't say I came away from that knowing what they would want. What we had from talking in-depth about this was a possible role which I was interested in. So then I went and had discussions and I came back and said, it we do this, it's really got to be in some way where it's clear that I would be representing you on this, because otherwise people advised me that I'd be kind of a eunuch in Washington sitting in as a White House staff person. You can't be dealing with Congress on the basis of things they need from your department if you're not a cabinet secretary. You don't have stature. So you really are dependent. Your stature is derivative which could make it difficult to coordinate things.

And so we kind of reflected on that. We continued to have those discussions and it wasn't until early January that it got resolved, that I would have this position. And I got assurances that anything I would coordinate, either the President himself or the Vice President or the First Lady would be in charge, so that there would be some clout put behind it.

B: It was not clear at that point that the First Lady would actually be in charge?

A: No. I heard that in January. I knew that they were talking of what her role would be.

Q: And not just in health care?

A: Just in general. And she had discussions with me of a personal nature about this tying it all together. And I think the notion that health care would be first was something that they didn't talk about with me until January. I talked to Bob Rubin back in December about this possibility. And we had a couple of discussions about what needed to be done. We talked that if I do health care versus something else, would it be best to carve a separate place in the White House, do it within NEC, etc.?

But those were all just very vague discussion. But it was in January that I learned that the First Lady would chair a taskforce on health care and that it would be the first thing I would start with in this kind of job.

B: What's your own understanding -- I hope at some point to be able to ask her this question directly, but from you know, how did health care come to be the prime domestic priority, and how did it come to be her project?

A: I'm not sure I'm the best person to ask because I wasn't in the inner circle in Little Rock. It was during transition that these kinds of decisions were made. The President had believed for a long time, going back to the spring, that the health care problem was a fundamentally essential problem. I remember he agreed with the memos I sent him on health care and the deficit during the transition.

And so he believed that you couldn't solve the economic problems in the country long term without solving the health care problem. And that was consistent. I remember him pounding the table at the economic summit about health care. And we had met a couple of days before and I'd given him the memo I had done on health care and the deficit.

And so in the State of the Union, he came back to it again. And had we been able to, we would have put health care up with the economic package. But we needed more time to work it out. He used to talk about it as two parts of the economic program.

In terms of Hillary's role, I can't say that I know why she took this on. I do know that she saw it as the major domestic policy issue in the country. And I know that she has an interest in domestic policy overall. And there was a lot of discussion that took place, some of which I was a part of, which I really shouldn't talk about concerning her role and the complexities of her playing a meaningful role.

Q: The politics as well as the issue?

A: The image and politics. Everyone wanted to use the tremendous talent she has. And yet, to have the public accept her policy role was very complex. And so there was a lot of discussion about that. But I can't say I know when the decision was made or how it was made that she would take health care first. I must say it was a tremendously gutsy thing for her to do. I know that many traditional Washington people advised the President -- I was in on some of these meetings -- "Don't take on health care." "If you have to do something to fulfill your campaign pledge, do some insurance reforms, do something to get kids covered in some way, come up with a little bit of money, but don't take the whole thing on."

Q: Spell that out a little because that's fascinating. Because that's Washington looking at an issue that you couldn't ---

A: I remember Harrison Wellford, who's somebody I came to respect enormously for his wisdom and integrity saying something similar. I remember sitting with him in Little Rock during the pre-transition phase and talking about the health care problem. And I said, well, you know, the President said we want to come up with a health care proposal in the first 100 days and try to push that through. I said, I'm advising the President that I think we ought to have two to three priorities for the first year. We've got to do something about the deficit and get a start on that. We've got to do health care, and then try to see if we can't get a start on political reforms.

And he said, well, you know, that's all well and good, but the soonest you could possibly get health care would be four years, maybe eight years. And I kind of looked at him funny, and I said, well, why? And he said, "The money and interest groups that would be arrayed against you and the complexity of the issues will make it impossible." And subsequently, I heard the same thing from virtually every person that had Washington experience that came along. "Health care's too complicated, interest groups are too strong, too powerful." "The divisions of opinion on it are too great." "You'll never be able to bridge the chasm. It will tear the Democratic party apart because you've got single-payer people, and then managed competition people." The common wisdom was "try to do something small so you can say you've done health care. And then get away from it as fast as you can."

So to have the First Lady step up to that and put her own reputation on the line, fully aware of all this, and put herself out in front like that, and the President have the First Lady do it took a lot of guts.

B: Did you encourage her to do it, or did you say you ought to, if you want to do it, fine, but you ought to know what you're getting into? What was your sort of posture?

A: There are some discussions we had of a personal nature that I really shouldn't recount. I think, though, that when it was clear we were both going to be in this boat

together, I did write a note saying, this is what I think we're in for. Because during those couple of months, I'd come to have a better sense of what the conflicts were on health care and the forces involved. So we did have a discussion about it. But we just kind of joked about it and how crazy we both were to try it.

Q: But you laid out the concerns?

A: Oh sure. Oh sure. And she'd heard them directly too from people.

Q: And so had the President?

A: Oh sure.

B: But you had, particularly after the warning that you got about how White House staff people can be, and you had to figure out instantly that if the First Lady was your rabbi, visibly, then you already had some leverage?

A: Well, I had said pretty much that to do this kind of job right, I had to have somebody with clout, whether it was the President himself, or the First Lady behind each step.

Q: Somebody asked Harry Hopkins?

A: So we recognized that it was an enormously complicated policy process that involved interest groups and that it was more or less a personal issue to everybody in the country. It's not like the deficit where people can have a general sense of what should be done. On health care, everybody has an experience with the system. And so we knew we had to do something broad. We knew that the kind of team we'd have to pull together would have to be big because people that are experts in mental health are different from ones that know about benefits or insurance reform. We knew we'd have to move quickly. So we'd have to pull together a complicated structure. We knew we'd be in a fishbowl, we knew that the government wouldn't be organized yet, so we wouldn't have people to draw upon from the different departments in the first days.

I remember talking to my wife before I came into this, and her saying: you're getting yourself into something that you can't possibly succeed at. And we kind of talked and joked about basic Business 101 where they say: "don't take responsibility for something you can't control." We talked about how that's what this was all about. And so I went in with my eyes open about it. But on the other hand, I've been out around the country for almost 10 years talking about change in economic policy and health care. If the President of the United States gives me an opportunity to do this, how can I say no?

I'm going to have to run.

B: Can we come back and do another thing like this?

[END OF INTERVIEW]

Interview with IRA MAGAZINER at the White House, Saturday, April 9, 1994

Q: ... you're coming back from Congressional recess, and then there's going to be a huge push. Let's start with that.

A: When was the last time I talked to you?

Q: It was after the State of the Union message. (The January)

... and you were feeling more up and down at that point.

A: We talked last September ...

Q: Two last fall and one very shortly after the September 22 speech, and then another one toward the ... I can't remember now whether it was just before or just after Congress went out in November.

(Some cross talking, mostly about when they last talked.)

Q: How do you feel about this project that you're involved in?

A: Right now, I'm feeling very good about it. I think the Congress and major committees are engaged in health care. And the leadership and the chairs of those committees are committed to the President getting universal coverage. The initial markups that we can see coming are well within the framework of the end games that we had always anticipated. And so we feel pretty good about it. We're basically spending a tremendous amount of time working with committee staff and leadership staff, different members, just kind of briefing, responding to questions of theirs. And we're being able to use a lot of the options that we had looked at back during the taskforce process so where members say, "well, we're not going to be able to get the mandatory alliances through the way you've done them, what are you really trying to get at, is there another way and can we do something that uses voluntary alliances." We're pulling out some of the options we looked at on different ways you can do it.

So we're deeply engaged in those discussions. We're feeling pretty good. I think we're also, now that the President and the First Lady are out on the road in a concerted way, I think we're sort of stabilizing the public debate, which is crucial. So I think we're in good shape.

Q: Are you letting each of the committees kind of do its own thing at this point? Or are you trying to get them to focus ...

A: I'm not sure we could be in control anyway, but from our point of view, the fact that they each have to do different things to develop a consensus, is okay. As long as we get pieces of what's important -- all the pieces that are important somewhere -- through some committee. Basically, we've got the three major committees in the House. Their bills will be melded in Rules Committee and go to the floor, and in the Senate we have two committees, and then we'll go to Mitchell's office and to the floor, and then to conference. As long as we have the major pieces in each house that need to be there, somewhere, we're happy. As long as the framework is within the scope of the President's bill.

So far, for example, what we see in the House which is moving a little bit faster as usual, is the Stark markup. Even though it has a different structure to it, it's fine. It meets the President's goals and keeps the process moving, it has a serious mandate in it and so on and so forth.

The Dingell markup that he's trying to get a consensus on in his committee is a good markup and meets all the goals. It uses some options that we had worked with that were slightly less favored by us, but are quite good. So we're pretty happy with that.

Labor in the House is moving. I think they're probably going to report a single-payer bill as well as some version of our bill. And that's fine.

And similarly in the Senate. I mean, the leadership is engaged. The Kennedy committee is moving and we expect to get something there pretty quickly.

The Finance Committee is more engaged now. They're a bit behind the others, but they're really engaged in a lot of serious hearings. So I think all that's going pretty well.

Q: As you remember, we're looking at the system. We're using health care as a test of whether the political system can come to grips with a particular issue, and what the lessons are of that experience. And you have gone through quite a lot of back-and-forth yourself in the process. What's it taught you so far?

A: You mean in the whole thing?

Q: Yeah, just going through this.

A: Well, there are a lot of different aspects of it. I mean, I think, for somebody who's spent their life in the private sector, coming to the government and being here in Washington and sort of being out on point on something as complicated and controversial as this, there's no question you meet unexpected things every day. I could give you a thousand answers to that question. I always knew it wouldn't be easy; I think I understood from the beginning how difficult it would be. People I

talked to who had been in Washington a long time -- I think I said this to you before -- said I was probably crazy to take this kind of position, that it was going to be controversial and there's no way to avoid that.

I think probably the biggest surprise has been -- and I think even if you know this theoretically, until you live it, you don't really know -- having everything you do be so subject to the day-to-day news cycles. And I think that's something that surprised me.

Q: But in an earlier stage, you expressed your dismay and distress at the leaks that seemed to be designed to sink this before it ever got run out of there. That doesn't seem to be happening anymore. There seems to be much more of an Administration position that's there day-to-day. What's happened to bring about that change?

A: I think once the policy was finalized, then people understood that what they might be doing to try to affect the nature of the policy was no longer possible, it was not going to have an affect as the Administration's policy was out there. And number two, some people were read the "riot act" about their behavior. So I think that's made a difference. And I think also that the Administration is older now. I mean, in the beginning, we were trying to do all this while different people in the Administration were getting their own sea legs and trying to establish themselves and establish their own turf. And I think now that's more stable than it was. That makes a difference.

I think also the fact that this is now on the front burner while it was not for the first months, I think it makes it somewhat freer. You know, we have sort of a front-line team at the White House now involved in coordinating, whereas in the first months we were sort of off to the side here, doing this while the White House was mainly focused, as it should have been, on budget reconciliation and on NAFTA and then on the Brady bill and so on. And now this is front and center, so I think it's a more integrated operation.

And I think also having, since January, Harold, Pat, George and me operating as a team, kind of engaged everyday, takes a tremendous amount of pressure off of me and makes it much more possible to coordinate this with the whole White House strategy.

Q: One of the things we obviously have to do is to deal with the Whitewater impact. I'm not talking about the rightness or wrongness, the rumors or the scandal or whatever it may be, but the impact internally and how it has affected you as you've gone through it, and what's it like to go through that. Put us in your shoes here.

A: Well, it hasn't really affected me. I think the major affect it's had on health care is just that it takes people's time away that they might otherwise have spent on health care. I don't think it's had a public affect, but the extent to which certain people are

subpoenaed to appear someplace and have to get certain papers in order means that they're not doing health care.

So that's a major impact. But otherwise, I don't think so. I mean, it doesn't alter the President's and the First Lady's stand on health care. When they go out around the country, I don't think it's had a public impact.

Q: David asked you about the leaks, ... another thing, how do you feel about the press?

A: I made a mistake early in going along with the communications decision to not be engaged with the press. And I think I mentioned to you, for example, with Dana Priest, I didn't meet her until April. Because the sense was I shouldn't talk to the press.

I think all of that was a big mistake. There has been some hostility from the press towards the health care effort, and I think we brought it on ourselves by not being more open to the press on a regular basis.

There are one or two members of the press who I think have been unfair to the whole issue and to me personally quite frankly. But I think that's not the rule. The New Republic and Robert Pear certainly fall into that category but I think by and large, the press is doing its job, and I think we should have been much more forthcoming on a regular basis early on. If we had been, I think some of the problems we've had with the press wouldn't be there.

Q: What conceptually was the reason for that?

A: I don't know. I'm not the right one to ask on this. I was new to Washington. Communications is not my forte. Now, I can give a good speech, I can do a decent job on television and so on, but I'm not a communications strategist per se. And so I deferred. But you'd have to ask others about why they felt that. The only thing that was communicated to me was the sense that, you've got a ton of work to do, if you and the others are spending all the time talking to the press, you won't get your work done.

I think there might have been also a sense that this guy is new to Washington, we don't know how he'll do with the press. There may have been a sense of that, too, I don't know. But you'd have to ask others.

Q: I just finished up a piece for The Post, talking to people who were involved in the fight over catastrophic insurance, about what the lessons were. One of the academics ...

A: Don't get them scared about that again.

Q: No, they're talking about it. That's why I'm asking. One of the academics who's looked at this thing, a fellow from the University of Pennsylvania, draws five lessons. In the fifth and final, he said the most important is: Control of information flow is the single most important ingredient in whether something is going to be sustainable or not.

A: Is he saying after it passes, or before?

Q: His point about catastrophic is, it was not explained clearly in the beginning and once it was passed, nobody except the opponents, people who were trying to sink it, was out there saying: Just look what they've done to you. And when I talked to them on the phone, he said: I think that lesson has not been well-applied so far because, as I look at it -- this guy's an academic talking up in Philadelphia -- said, from where I sit, it looks to me as if the opponents are sort of controlling the debate.

Was that factor of the flow of control of information, the public opinion side of the thing, a central factor as you in your strategic thinking about this project? And if so, then what do you think has happened?

A: I think control is too strong a word. I don't think you can control information flow in a democracy like ours, and that's a good thing, the fact that people can't control information flow. I remember writing a memo to the First Lady in early-May, saying we would need to frame more carefully how we're going to try to get the message out about what we're trying to do. And advocating a more concerted effort to do that. I think we knew from early on that we would have to do that.

Q: When this is done, we would love to have a copy.

A: I'd be happy to show you some memos. And I said in that memo and in retrospect it was very true, we need to bring somebody in. My forte is not communications. We need to bring somebody in who has that kind of background, and I suggested a couple of names, including Harold Ickes, as one person to do that. And of course, that's come to pass. I know it should have happened six months earlier. So I think we were aware of that.

And then the discussions in June, July I guess it was July -- how do you do NAFTA and Reinventing Government and health care all at the same time? I wrote another memo saying if we don't have an active communication effort, with the President and the First Lady out there, for the first four to six weeks after health care is introduced, we're going to get in trouble. If we don't get the message out early about what this is, and define it in the terms we want, we will lose -- because the health insurance industry was already on the air.

And so we had an agreement that the post-September 22nd period would have four to

six weeks of presidential time, every week.We geared up for that. We had a good message. The speech went very well. Then we went to Tampa, had a very successful town hall meeting. Then we had the week of the First Lady's testimony -- very successful. And we were supposed to have four more weeks of presidential time. He went out to California to start that, and then Somalia hit the morning we got on the plane. So it was like two minutes of health care, the whole couple of days in California.

The President had to rush back and we didn't have any more health events. Then Haiti hit. Then NAFTA heated up, he had to do NAFTA first because that had a deadline.

So we literally had one and a half days of presidential time on health care between September 27 and January. And the First Lady was out, but basically that's when the health insurance industry's ads intensified and when the plan was being attacked very aggressively by different groups. And we just did not have the ability to define our proposal.

And the other problem we had which came around that time too was that it was difficult to have enough surrogates trained because health care is complex and it's not like the deficit where you can give a set speech to the Secretary of X and send him out. There really was a lot of prep time needed. And so when officials went out on health care, people had very personal questions, so you had to know what you were talking about. Forums didn't work because most Administration officials were not conversant enough in the issue.

So that caused some problems. And then the other thing was, we were inundated here. We were short-staffed. And we were inundated with just getting the bill done and redone. And so we lost the momentum for a number of months. And I think now we're starting to recover. I think this past couple of weeks out in the field has been very good, and we're already beginning to see some results.

Q: Let me go back. Can you flesh out -- that's a critical period. Were you on the plane to ---

A: Yeah.

Q: So you knew that there was a diversion of Somalia, Haiti and so forth. What was happening to sort of make the case say to the First Lady and the President: We can't lose the momentum here. We've got to also, you know ----

A: I was in on meetings where those things were being talked about. But if you remember, I mean, Somalia, Haiti and you had some Bosnia stuff going on -- it had an urgency to it. You really couldn't sit there and argue very forcefully not to focus

on them, and I didn't. I mean, I've always viewed my role not as an advocate for health care but as an advocate for the President. Sitting in the meetings and hearing the arguments for what he had to do on those issues, I couldn't argue against spending time on them. Those things demanded immediate attention.

And once he got through those, it must have taken about three or four weeks -- and then we were behind the eight ball on NAFTA, we were losing it, and he had to turn up the heat on that. And that had a fixed date to it. So I did not advocate for him spending more time on health care because I didn't think it would have been the right thing to do. And they were saying that health care's not going to be voted on till next spring or summer. You can't do that.

Q: Was it the First Lady -- where was she at this process?

A: She was out making speeches during that period of time. And that helped keep things alive to some extent. I couldn't be out on the road hardly at all then because, this office was like Grand Central Station with 15 to 20 interest groups or congressmen a day coming in to advocate something in the final bill. And we were drafting the bill at that point, and a whole lot of decisions that seem small compared to whether you get universal coverage or not, but which are crucial to individual members of Congress or interest groups, were being decided. The First Lady was involved with some of those decisions as well.

Q: In retrospect, was it a good decision on the part of the President and First Lady to try to nail down all of those provisions and details in the bill before it went up?

A: Yeah, this is the $64,000 question. But I think on balance we had to. And I advocated the other way for a long time. I mean, I basically had advocated all spring and summer for going to a kind of skeleton bill ... having a detailed policy book to back it up, so that if somebody said, well, how's that going to work, you could tell them ... but not putting it in the bill.

Q: Well that's fascinating because everybody assumes that you're the one who wanted to work it all out.

A: No. I wanted it worked out in the policy book, so that we wouldn't get caught by somebody. Remember, the policy book has been out since early-September. We had a lot of backup material so that if somebody said: well, exactly how are those things going to work? Or, how's the money going to flow, or whatever -- we could have answers. We would have answers, but I didn't want to put them in the bill.

And I was ultimately convinced the other way, but only after a fair amount of persuasion. And interestingly enough, it was some people on the Hill who called and said, you'd better describe this thing in detail, or else it's going to be the stealth bill.

If you're going to advocate such major change in the system, you should define it. The benefits package was always going to be defined. That was never a question. That was a decision. But, for example, in the bill there are about 90 pages defining how the subsidies work. And every other bill in the past has had two paragraphs saying, we'll subsidize low-income people somehow. They felt that the kinds of questions we were getting from the initial rounds of hearings were so specific that if we were really going to have the kind of national debate we wanted and be able to lay something on the table, we ought to come out with detail.

And so we finally agreed to do that.

Q: For this history book, whether you'd want to be the source of not is up to you, but who were the people on the Hill who were arguing that you need to cross the t's and dot the i's?

A: Well, I had a call from Gephardt, for example. And he related to us problems with past legislation where things were done in skeleton fashion and then the regulators sat down and wrote 10,000 pages of regulations, afterwards you wound up with something different than what you thought you were going to get.

And Rostenkowski and some of Kennedy's people had the same advice.

Q: How was the decision make? Was there some point when ...

A: We made a decision in August to draft a long and a short version, so that we'd have the long version if we needed it. The short version could be drawn from the long version. Sometime in September, I think around mid-to the end of September -- we decided to go with the longer version. And I can't remember a specific meeting when that happened.

Q: Was it before Clinton's speech?

A: It was right around the time of it.

Q: This was a presidential decision?

A: I think it was a decision more made among the First Lady, myself and others, sitting around the room. A number of people involved in the drafting and some of the congressional liaison people. It was presented to the President and he saw the pitfalls of it, and he also saw the reasons for doing it.

Q: And from your April 9th -- or whatever the date is today -- perspective, do you think your first instinct was correct? Or you ---

A: No, I think on balance, what we did was right even though we've taken a lot of heat for it, because I think that we're going to wind up with a better policy that's got more of a chance of working the way it's intended. And I think, despite all the criticism, we'll have a better debate because of it. I think it basically causes the Congress to have to think it through.

I think what CBO said is accurate about this. The CBO report said if you really describe how any of the other plans are going to work, they'd be at least as complicated as the Clinton plan. And I think it's better to have that all on the table. I remembered going to visit my family in Rhode Island for a day in August, reading all this legalistic language, and I called Hillary and said: you know, you read this darn thing, and it sounds like the worst bureaucratic nightmare in the world. And she said: well, a lot of that's just the legal language. When you draft any bill, it sounds like that. And I remember thinking, but that's part of what's wrong with these laws. And Paul Starr and Mandy Grunwald had the same reaction, that it's going to seem like this is too regulatory.

And then I broke it apart, and saw that 150 pages of it was long-term care. The longest piece, interestingly enough, is one that has involved the least controversy. We picked up a suggestion that had been in the Bentsen bill about better regulation of private long-term care insurance. It is the least intrusive, least governmental part of the bill, yet its the longest section in the bill. And I remember having discussions about that with somebody, saying, well, in a sense, when you try to leave something private as opposed to having the government take it over, you then have to put some regulatory framework around it. If you spell that out, it sounds regulatory. And it's either going to be in the bill, or it's going to be done afterwards.

So what I became convinced of, and I think it's right, even though we have suffered in the way the bill was attacked, is that it's better to spell things out. The biggest danger of this reform effort is not that you don't pass the bill, but it's that you pass the bill and it doesn't work. It runs haywire. And you really mess up things. And I think there's no doubt in my mind that we've made mistakes in the bill. I mean, it is too complicated not to make some mistakes.

Having it all out there like this is helping us find the mistakes, because people are really able to look at the details, critique them and a lot of the changes that are going to be made in the congressional process are going to make it a much better bill, and we're going to be better off for it.

If we'd just put a skeleton thing in, we never would have found all that out. And I'd be scared to death to just pass that skeleton bill, have some things be fundamentally wrong with it, have a bunch of bureaucrats that run the departments sit down and actually write out how it's going to work a year or two from now, and have the President blamed if it doesn't work.

So when I take that longer term view, even though I would say in the past six months we have been hurt by the fact that we spelled everything out, politically, I think in the longer term, it probably was the right thing to do.

Q: What do you think will happen on this next October, November?

A: I think before the election, whether it's August, September, October, we'll have a bill. I think there is a much, much better than even chance. In fact, it's quite likely. I think it will have a much higher percentage of our approach in it than people might expect when it finally comes out. I think -- in September, and then again in December, the President signed off on a series of acceptable end games. And I've described to you that the bill was designed as a negotiating document and designed to have pieces stripped away from it and so on. And so far, what we're seeing, is well within the bounds of those end games.

So I'm still quite optimistic. And it'll be a different bill, for example, there will be something that does the functions of the alliances ... they certainly won't be called alliances. Pete Stark's calling them clearinghouses now and that's fine. And things will be done differently, but I think we're going to get it.

Q: I'm going to go back to the earlier discussion about the sort of the public debate just for one moment, and get you to focus what I think is implicit in what you were saying, which is that in our system of politics and government, as it operates today, unless the President personally is delivering a message, that message doesn't really get through. Is that what you're observation would be about this?

A: That's interesting. I think, it is a good question and I don't know the answer. But I think the President being out there delivering a message is a heck of a lot better than anybody else doing it. Whether you couldn't do it without the President, I don't know. But on something this hard and this complicated and this controversial, it's very hard to do without the President. The First Lady, when she is in a media market can break through. But she will be less likely to be on the national news than the President. And I think it's particularly true, I don't know whether it would have been true of some other presidents, but this President and this First Lady are such good communicators, and they command the attention of a crowd that I think they can make a difference. Cabinet secretaries or senior White House officials, forget it. We have no clout. We can, in individual situations, sit down with a group of people in somebody's district and make a difference, but the effect on the public is minimal.

Q: One of the institutions that tried to engage in this, but seemingly without much success, is the Democratic party.

A: Well, I think they had some degree of success in what they've been doing at the grassroots level and so on. But there's nothing like having the President out there.

And I think the fact that he'll be doing a lot more of that these next months will be helpful.

Q: I don't have a clear picture of Hillary Clinton's thinking about how this thing should proceed. You said you talked to her about the legalistic, too legalistic, on the phone or whatever, and she responded like a lawyer, if I understood you.

A: I think she had the same concerns. But there are some specific things that I was just sort of pointing to and I read her some passages and so on. And she was just saying, but that's the way legal language sounds. No, I think her thinking was very similar to mine. I mean, we both went back and forth on this.

Well, she's instinctively a tremendous communicator. And when she gets out there, she does a tremendous job. And we always saw two separate tracks. Not woo many people were going to read the bill. And we needed a different track for communication. But just with respect to what the legislation itself should look like, I think we both went back and forth over it. I mean, basically, when you put out a long bill, two things happen: One is the very fact that it's length will make it seem bureaucratic, and what you're doing seem regulatory; and number two, that it will give opponents a chance to kind of pick out a passage here or there and build it up, whatever the passage turns out to be.

On the other hand, the arguments on the other side for example were also valid. We talk about giving everybody a health security card. Unless you can point to a fairly detailed set of confidentiality protections for people and anti-fraud provisions and so on and so forth, people are going to get nervous about it. Or if nurses and doctors are very concerned about scope of practice issues or whatever. To try to do that in one paragraph or two is very hard. To reassure them that you're really going to meet the concerns they have. So there are arguments on both sides.

I think what we did was right.

Q: I want to move to a slightly different area. One of the other dimensions of this thing that we're trying to track is the role and the activities of some of the interest groups. Obviously, something like this, you can't do across the board. But I'd like to get your reflection on one that I've been sort of tracking, which is the Health Insurance Association. At Rostenkowski's urging, I gather you met at some point early this year with Gradison. And he sends you a memo at your request saying, here is a way that we think you could see objectives -- you have many which he claims to support -- without putting a lot of our members out of business. But a decision is made, apparently, that you're not going to sort of pursue that negotiation or discussion. And as I understand it, you have not -- or the White House has not -- been participating in the meetings that he and other interest group people have been having with committee staff. Can you walk us through that?

A: Yes. I think, first of all, just to set the record straight, Bill Gradison is a good guy. I mean, our kids are in the same school. I met with him twice, once in the spring, once in the summer.

Q: Of last year?

A: Of last year. So the notion that somehow we weren't meeting is not true. We met twice and given the 1,100 interest groups we have to deal with, that was a reasonable number of meetings. We didn't ultimately agree with him, but we talked.

During the period from May till November, I was probably the most unpopular guy in Washington. Because every day, there'd be a bunch of people coming in here, saying, put something in the bill. And ultimately, in most cases, it was me saying, no. And congressman X would call and say: "you've got to do this and this and this." And we'd sit and talk about it, and we'd say, no, we just don't think that's good policy. And then it was well, Magaziner is a political jerk because he didn't do this.

So every day I was doing that with interest groups and Congress. Calls were made based on what we felt was the best policy and what we thought would be the best place to start, politically. And it was clear to us that we had to get out of that business, and that basically, Congress has to take ownership of the bill. As I said, I think probably, even if we'd come down from the mountain with the tablets on health care, Congress was going to rewrite them anyway. It was important they take ownership. And therefore, they should be the ones cutting the deals, not us to build a political consensus. And obviously, they're going to be letting us know what they're doing and that's happening. But they should be out there leading that, not us. Because otherwise, we undermine them and their ability to do it.

So we had the situation starting in November where I was Mr. Inflexible because basically, people were coming in and in some cases, quite frankly, coming in with good suggestions. If we controlled the process, I would have said, yeah, we made a mistake on that one; or yeah, you're right about that. But it would have been a mistake for us to do that. I mean, let members of Congress do that and get votes for changes they make, not us.

So we were in this hiatus which we're finally out of now. But it was the worst possible time, December, January, February -- because we had all these groups -- business groups and others -- pressuring us to make changes. And we had to just say, it's on the Hill now. Yet the Hill wasn't acting yet so there was a hiatus. And so we just took a tremendous beating during that time. But I think it was the right decision, and we have very, very capable committee chairs, like Rostenkowski and Dingell who are co-sponsors of the bill. They are committed to getting this done. They've committed to the President to meet his goals. And the more freedom they have to do

what they've got to do, the more likely we are to succeed.

Q: Let me ask you about one other thing, and Haynes knows this better than I do because he's done more of the interviewing. AARP, I mean, here's somebody that you gave a big, a couple of big somethings to and yet they clearly are hanging back.

HAYNES: Tell us about your view of dealing with AARP in this process. We've heard from the other side.

A: You've heard from the AARP?

Q: Yes. I've been tracking (it?), the reluctance in the meetings and trying to get, at one point, Hillary turned from the President_____ we want an endorsement, and if there's not going to be an endorsement, we're not going to deal with you. There's a lot of back and forth --

A: I want you to explain to me why they've acted the way they have.

Q: Well it's pretty Byzantine, I must say -- the variety, the board, the range of the people and so forth. But from your side, what is it ...

A: Well, I mean, with the Health Insurance Association, and Bill Gradison's a very skilled man, very nice man, and very knowledgeable about the process. Ultimately, some of what they want to see in the bill, we just don't think is good public policy. And a lot of what they have suggested to us, at the times that I met with them, still left insurance companies able to cherry-pick, and it was not really community rating, it was swiss cheese, so we just didn't agree. And we agreed on universal coverage and so on, but we just didn't agree on a bunch of other things.

And so it's not surprising that they were going to oppose us. But the AARP is different. We think this bill is extremely good for seniors. And the prescription drug benefit and the beginning of long-term care, and the early retiree benefit -- half their members are age 55-65 -- are things that we think are very good for seniors and we think that, we took their counsel on every issue. It was our goal to take the counsel of many senior groups, to produce something which they should be supportive of.

Now, to be fair, they have been supportive in some ways. If you read their newsletters, you look at what they're saying to their members, look at their pronouncements, with one or two exceptions early on, they've been very positive.

We go hung up in this trap of endorse or not. And it's been a source of great frustration. I'll never forget though this is a problem we've had with this particular writer, but there was a New York Times headline when we were doing a very positive event with AARP, and the officers of AARP, (it was in New Jersey) were

just effusive about how good the bill was, but then they had a board meeting a day or two later and they still decided not to endorse the bill, and the headline is that they'd refused to endorse. And I had groups in the following week, I remember, they were saying, why does the AARP oppose your bill?

So, it's been a source of frustration, and I understand they have their own internal problems to work out, but I hope that they'll become more positively aggressive soon because I think, you know, as the Stark markup indicates this is no guarantee. Even the prescription drug piece is watered down in the Stark markup.

Q: The impression I had is you did want them to endorse.

A: Oh sure.

Q: And Hillary wanted very collectively.

A: Well we wanted them to endorse ... one other factor we had in the fall in terms of public communications which was frustrating, and I think it's changing now, is that groups who are generally supportive of us felt the bill went 90 percent of the way towards what they would like. They were spending their time trying to push us on the other 10 percent instead of out their advocating for the bill. And that was very difficult.

That's changing now. I feel part of what's making me more optimistic now is a lot of these groups now are out there, understanding that it's getting around to show time, and they'd better start supporting. So I think that's turning around too. But the fall was tough.

Q: Can you give us an example of that, where you see the change in the attitude taking place?

A: Well, I was in a session the other night that the Vice President had at his house with a couple hundred representatives of the mental health groups, for example. And they would have liked us to give more on mental health benefits. They acknowledged that what we've done advances mental health benefits tremendously, but it doesn't do everything that they had hoped we could do. And so there was a lot of grumbling about, why aren't they going all the way? Why do we still have limits on some benefits?

Now I think they're understanding that they could lose mental health benefits, and if they want to protect even watered down benefits from what we proposed, they'd better get out there and start fighting for what we've got. That was certainly the sense of that session at the Vice President's house. And I think we're going to see a lot more advocacy. That's just one example of it now.

Q: How much power do these groups have in our system?

A: You asked me that in October, and I think they have some, but not as much as the big moneyed groups.

Q: But you have to have made some assessment in terms of your dealings with them, and also of what you hear from the Hill.

A: Well, it's getting interesting. I don't know for sure.

Q: Well, let me give it a specific example rather than a generalization. There are people on the Hill who say you cannot pass a health bill in this Congress without the support of the AARP.

A: Well they may be right. I mean, this is my first big political battle in Congress. This is my first look at the inside of the way things work and so I may not be the right person to ask. I think there's certainly a will to try to accommodate different groups on the Hill. But when push comes to shove, what will happen I don't know.

Q: Who's the key person in the Congress in your mind?

A: I don't think there's one key person. That's the problem. It's such a complex piece of legislation going through so many different committees, there are so many difficult votes. I mean, that's the thing you keep coming back to. Most bills have a couple of tough issues. This bill has dozens of them for everybody. And obviously the leadership of the committee chairs is crucial.

Q: How do you keep track of all that, the fact that all the different members of all their districts ---

A: Well, we spent a lot of time learning that. We basically have targeted a number of members, and obviously key committee members are important. But we've understood since last August that the bill had to change. This when we recommended the strategy, which I think was the right one, of not, in the President's speech, saying, here's our bill, take it or leave it; but rather saying, here's our bill, we want to start the debate with a detailed proposal, but here's the principles we really care about, and we're very flexible on the details. I can perhaps show you a memo on this later on.

Now, there were some that argued that that made the President seem too wishy-washy and that he didn't care about his own bill, or whatever. But we think it was absolutely the right thing to do, again because the Congress has to take ownership, the details had to change, they had to find a way to reach consensus.

Nobody could predict in advance what the main pressures were going to be. I mean, you could do it somewhat, but nobody could. And so you had to give the committee chairs and the leadership enough flexibility to do what they had to do. And we'll see. We'll see how that moves. And we still don't know. We know what we have to do so far, but we still don't know how all that's going to work itself out.

But I must say that if I were going to have allies in a battle like this, in Congress, I mean, the Dingells and the Rostenkowskis and the Kennedys on your side is not a bad group of allies. If you want to get something done, they're much better than any of us.

Q: Those memos will be very helpful to us in all of this. We really would ...

Q: The one specific incident which may have turned out in the long run to be significant, or not, I don't know, but I'd love to get your experience of it on the record, is the famous CBO report.

A: Yeah. That's been an interesting dynamic in which you've actually played a role, as you know. But I think the report itself turned out to be pretty good news for us. Probably one of my scariest moments in this whole past year was when I heard about the report. We didn't get the report until about noon of the day it was released. And I got word about 10 in the morning that they were going to be $130 billion off from us on federal spending over 10 years. And I couldn't figure it out from everything I knew, and I went through about two hours of real butterflies in my stomach. And we finally got the thing at noon and I read it over, and it was a complete relief. Where there were discrepancies, they were easy to fix because they had almost identical numbers. There was only $2 or $3 billion difference in a $1.5 trillion system on estimating what the savings would be in national health expenditures year by year. So they were basically projecting the same exact savings in cost for the system as a whole. But where they disagreed with us is they thought state and local governments and businesses got more savings and the federal government spent more than we did, because they thought that businesses would be more successful in gaming the system, for example, or that certain things that state and local governments now spend money on, mental health and others things, would add to the private premium, and therefore federal subsidies, and would reduce state and local governments spending.

So once I saw that, then it was a complete relief because it meant that, there's a dozen little things we could do to get the deficit back to where we wanted by just shifting some things around. We didn't have to find any money, we just had to shift around some spending and tighten up some rules.

Q: But you had no idea until 10:00 o'clock that morning what it was going to be?

A: We had had an idea about this on-budget/off-budget thing, but that's not serious either

because Congress can fix that. If they don't want it on budget, that's a simple thing to fix.

But what we were really worried about, and what panicked me for two hours, was the thought that we were that much off in terms of the total system spending, because that would have meant we would have had to find major new revenues or major cost cuts in some way.

Q: Now there's lots of indications that the Democratic leadership, members of the Democratic leadership, had had a pretty good sit-down with Reischauer earlier that week, but nothing came, no information?

A: My understanding is that that was about the off-budget/on-budget issue. I think both the Republicans and Democrats were pressuring quite a bit, but I think that was about on-budget/off-budget issues, not the actual numbers. And what Reischauer had said all along, and he said it in his testimony, is that the differences in our numbers are going to be relatively small. And that is true, for a $1.5 trillion system. But because of the deficit swelling. For those couple of hours we were really panicked until we saw what it was, and then it was a big sigh of relief.

And basically, I think Mitchell did a great job of questioning Reischauer to make these points.

Q: Yeah. In fact, ... but it was superb.

A: Yeah. And it basically showed ...

Q: Got him a good job.

A: It put the whole thing to rest. I mean the initial day or two of flurry about, whether CBO hurt us, he basically put that to rest because it was very clear that we were very close together.

Q: Did you write those questions for Mitchell?

A: No, though we reviewed them.

A: We're waiting for CBO to evaluate the Cooper and Chafee bills. We wish that would have come by now.

Q: Let me try a different kind of question ... The last conversation I had ** I did was with Clinton, coming back across the country. And ... we're flying across the country,a nd I said: Let me take you back to the campaign. Here we are, there below us is this mystical something called the people. Do you think you misjudged

the people, what they were ready for? In other words, you didn't ask for sacrifice, you'd give them a tax-cut and so forth. Do you think they were ready for more than you were willing to do, or ask of them ...? Turn it around on the health care, when you go back to when this thing is beginning, maybe it's too early to do that, but ---

A: I was out on the road the week before last. I think the vast majority of people, want comprehensive health reform. And that shows up in all the polls. And I think they want the fundamental mechanisms we're putting forward. That shows up in all the polls. The Wall Street Journal, a couple of weeks ago, reflected very much what we see in our polls: if you ask people about universal coverage, employer mandates, premium controls -- various things -- it's all 70 percent plus favorable.

I think what's going on is because this is all so personal, and because people are always nervous about change, I think they want more information. They're nervous. I liken it to an analogy about buying a new house. If you live in a house, if the roof's leaking, you know you've got to get out, it's not comfortable anymore, it's not big enough or whatever, and so then you start looking, and you look at this great new house, and you love it. For the first week or so , you know, this is going to be wonderful. I can't wait. Then all of a sudden, you get a buyer's remorse, the realty firms describe that it happens every time. Then you look at some other houses because it's such a big deal. And so you go through a certain period of time where you're sort of looking around at every other house, and you can't be certain. but one thing that's for certain is that you don't want to come back and keep living in the old house, because if that's what happens, you're going to be angry, you're going to be upset.

I think, you know, that USA Today poll in December reflected this. When they asked people: what is the greatest achievement of Clinton in his first year? Do you remember that? And there was a list of things. And introducing health care was the biggest one. It got more than the Brady bill and the budget. And then they said: what is your greatest disappointment in the first year? And the biggest one was not passing health care. I think if this thing doesn't happen, if you don't get comprehensive reform, people are going to be angry. Because I think their hopes have been raised.

So my view is that we are on target. I think we've not done as good a job as we could have in communicating, we could do a better job at that. But I think when all is said and done, we're going to get it because people want reform.

HAYNES: There's another factor to this, and I want to --- We have been told, here in the White House, that the concern over Whitewater erodes their trust. And if their trust, believability of Mr. Clinton's is eroded, whatever or not, that affects (whether you) sell something.

A: Yeah. I think trust in the President and the First Lady is important. But in all the polls, and this has been very consistent, when people are asked: Who do you trust on health care? Or who do you think cares about people like you and issues like this, and then they put the President up against Congress or the Republicans, it's 60-20, and that's about as good as the President gets. So I think the trust for doing something like this is there.

I don't know anything about it, so it's easy to offer an opinion when you don't know anything about something, but I think this Whitewater thing's going to rebound tremendously against the Republicans because I think when it becomes clearer that there's nothing there, people will get angry at the charges. But I think on health care, when you see the First Lady go out as I have and she gets into crowds that are not the most friendly, physicians and so on, there's a respect for her, a respect for what she's done. I don't think that's eroding.

END OF INTERVIEW

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Kara Ellis
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Haynes Johnson interview with IRA MAGAZINER in the EOB office late Monday afternoon, June 23, 1994.

A: I think there are one or two cases where I may have misspoken on dates, something was late-March and I said early-April or something like that, so I want to look at transcripts and correct them.

Q: One week before the Fourth of July recess. Give us the overview right now.

A: Well, as you know, we had hoped to have all the committees reporting out by July 4th and going to the floor in July. On the House side, Ways and Means should get out by then and Labor should get out by then, might be today actually. Both will be strong universal coverage bills. Energy and Commerce is still uncertain. They're still one vote short. And so we'll have to see where that goes in the next week.

On the Senate side, we have Kennedy's committee out with a good, strong bill. And in Finance there's a lot of discussion going on and we'll know in a matter of days probably, another week, where they'll be. And then both Mitchell and Gephardt are going to the floor in late-July which is on schedule and will try to get to a vote before the August recess.

So in that sense things are on track. Once we have a new vehicle, vehicles that are going to the floor we can go into a more public mode of trying to sell them. We're in the dilemma, I think, in the public debate where there is still very strong support for the elements that we proposed, universal coverage, employer requirements, cost containment and so on. But I think the opposition has scared the public about something called the "Clinton Plan" so that I think that that Wall Street Journal story a while back still continues to be true in our polling. People like what's in the Clinton plan but they don't like the label.

And it's still brought home to me whenever I go out. I think The Post ran an article, Dana Priest with Senator Baucus in Montana which is very typical of what we see. "You'd better not vote for the Clinton bill." "Why?" "Because we don't want the government to take over all the hospitals." Well that's not what we propose doing of course, but there's been a lot of scare.

So I think what we need to do in the re-launch is to come out and say, okay, we've heard the public and we're changing some of these things, we're making it less bureaucratic, less governmental. And what we've got to accomplish is universal coverage, get these costs under control and so on. And I think we will launch a significant public campaign in July, right after G-7, around the vehicles that are going to the floor.

I think there were beginning to be some doubts in the media the past weeks about whether we were still committed to universal coverage, I think the President and First Lady have been very clear this week that we are and that we're going to fight for it. And I think they remain as committed as ever to that. One big question mark, and this has been the question mark for months, is what are the Republicans going to do? We have always believed -- and I think it is correct -- that there are enough moderate Republicans in both Houses who, left to their own devices -- that is to do what they really believe themselves -- could come together with us on a bill that we all could support that would be a universal coverage bill and that would meet the President's principles.

And I think the question mark is whether they'll be left to their own devices to do that or whether the pressure from the Republican right will be so strong that they'll be blocked from coming together with us. I think that is the one big question mark.

Q: I had a conversation with a Democrat in the Senate Finance Committee, he said it was now 60-40 that they wouldn't get a bill out. In the fall. If the White House thinks they're going to get the Republicans now I think they're wrong. Earlier this week, yes. This is similar to conversations I've had with Republicans. What's your conversation internally? You're aware of the tensions that exist up there?

A: Well what the President decided a couple of weeks ago was that we had to find out whether the Republicans were just trying to stall us along until no bill was possible or whether some of them would be serious in their engagements. And so we decided to give it one last try and we hadn't had much work with Republicans. And during the Kennedy process we saw some signs that at least some of them wanted to work with us even if they didn't vote for the bill. And so we said okay, let's give this another big try and so we called in a number of Republican senators as well as some of the more conservative Democrats on the Finance Committee. We put out all the feelers we could and said come to us and tell us what you need and how to do it and so on. You said you were for universal coverage, if you don't like a lot of what we've done, tell us how you want to do it.

And we felt it was worth one last try to do that and we have to see where it leads. We don't know yet for sure. I think that Gingrich has overplayed his hand a little bit in the past week or two in the way he's been blocking the Republicans in the House from working with us and so we don't know whether that might break something loose. So our sense right now is we're going through that one last try to see if we can engage them. If we can't then we'll go forward and we'll fight like hell and we'll start out with a Democratic bill with Jeffords and then try to engage it on the floor and try to see if we can get enough public momentum behind universal coverage to move them then. But there is some growing revulsion, I think, to the filibuster. And I think there is the possibility that the Brady Bill type situation could be created where the House passes a bill -- which we think will happen. And where it's clear

that there's a majority in the Senate which we think we can get just among Democrats, and those moderate Republicans who really want to do something might then come back and say, okay, if you change this, this and this we might be willing to do this, or at least not filibuster it.

And I think we are honest enough to know that that may not happen and that therefore we may wage this battle and lose to a filibuster in which case we'll carry it forward in November. But the public will be very upset if that's what happens to health reform, the House has passed it and the Senate has a potential majority and a group of Republicans just filibustered. Particularly where we have shown the ability and willingness to compromise very significantly, I think that will turn the tables on this thing very rapidly.

So, given all of that, if I had to prioritize where we're coming from, the first priority is let's try to get a bipartisan compromise now or next month, if the moderate Republicans will be allowed to break loose. If that cannot happen then we will try to build our Democratic majorities in both Houses. We will still be inviting Republicans to participate. We'll fight publicly and we'll fight a filibuster and maybe we'll get a very good result and maybe we won't.

Q: There's a phrase that jumps out, "one last try" for instance. This is a big thing.

A: Well when I say the last try I mean you know pre going to the floor.

Q: That took a lot of soul searching. Can you help me understand?

A: Well I first had discussions with Senator Chafee last spring and I think he indicated to you what I also remember which is that we were reaching out to say should we try to fashion something together going way back then. I had these 20 meetings with House Republicans under Hastert because he was the head of their group and I think if you talk to him or members of that group they will tell you they were reasonably productive sessions.

But ultimately they made a decision, and Chafee voiced it to me, saying, no, we think it's best for us to produce our own bill and then we'll discuss afterwards.

We then came back after the bills were introduced, I went to see Chafee in December in Rhode Island in fact. We also made approaches to a number of the House moderate Republicans and said how should we do this, should we start talking? Where are we? And so on. And the view then that they expressed was go through the Senate Finance Committee because a number of us are in that committee, let's play it out through the regular order which is what the Democratic leaders were also saying to us, play it through the regular order. So we did that. And the request was for us to back off and give technical assistance to the committees, give ideas and so

on, which we've been doing, but not to try to over-manage the process -- which I think was the right strategy.

So we followed that strategy and we've been actively involved, as you know, in providing assistance to all the committees, coming up with ideas, running numbers, doing all that kind of stuff. But not trying to drive the process. So there have been a number of occasions where we made approaches to moderate Republicans saying is this the time?

We had a bipartisan dinner at the White House in February or March, invited the Republicans in and so on and so forth. So I think we're seeing where we go now on this. And we'll see what happens in the next week on some of these discussions in the Finance Committee that are going on and then if it doesn't seem as if we can get something that's universal coverage where the Republicans are coming on to it, then we'll go to the floor with something which is democratic and then we'll try again on the floor and see what happens.

There are some people that think that basically the Republican leadership has never been sincere and they basically wanted to just give the President a defeat, they don't want to let him win health care because they feel that would give him too much of a victory. They've never been sincere, they're just stringing us out. There are others who feel that that may be true of the Phil Gramms of the world but that the Chafees and Durenbergers do want something serious and they're trying to work with us.

Q: Isn't it true over here too, a split among those who think let's just fight it out and take it to the country. This is the great issue for Clinton, that it could actually be in some ways a bigger problem. If they don't come up with what you want, take it to the country and we'll win on it. Is that part of the equation?

A: I don't think there's a split at the White House. I think there's a lot of fluid discussion because every day there's a new piece of news and people form different views -- I don't think there's anybody who thinks that we should give up universal coverage and that if we fail to get universal coverage, we've got to fight for it. But on any given day there's a lot of different views on what we should have done and what we should be doing.

Q: We've been dealing with you now and you've gone through this process, enormous investiture of your life. How do you personally feel right now as you've gone through it? The ultimate question is how well did the system function, what does it tell us about the system? It's too early for the final lesson. How do you feel now?

A: Well I feel pretty good about it. I mean you can always look back at things you could have done differently and you know you can't be involved in something as complex and difficult as this without making some mistakes. But as I said before,

I've always viewed this as a process where you put one foot in front of the other every day and know that it's going to be very difficult every day and you just keep plodding ahead. And I compare it to a couple of different things. One is what everybody told me during the first nine months I was here about how difficult it is to get anything serious done in Washington. And the fact that we are going to get a bill to the floor in both Houses, out of committees in each House, to do comprehensive health reform in a pretty bold way, is a first in 60 years of trying to do health reform. It has never happened. Usually reform got bottled up in Ways and Means and a bill never got out.

Four weeks ago the newspapers were writing articles that said, if Rostenkowski is gone -- it's over. I mean every day I came to work and I got calls about what are you going to do without Rostenkowski? This is going to kill health care if Rostenkowski won't be there. And I kept saying well you know you miss somebody like Rostenkowski but I don't think it's fatal, in fact that committee's going to go ahead. And basically Gibbons is going to get a bill out next week. And that nay saying has been happening for a year now so I guess I feel reasonably good about it.

The only worry I have, and it's probably my main worry because it's the thing I'm most responsible for is that if something gets cobbled together towards the end, where the political compromise finds some attractive pieces to fit together but it doesn't work in actuality we could produce something here that might not be good for the country. My worry every day is to make sure that as things are fluid and as we have to change things that we still have a bill that hangs together. And I don't think we're in danger of that yet but I see how quickly things move and it's only going to get quicker. And so that's my concern.

Now you can fix stuff in some of the recesses, you know, those of us who will be working behind the scenes and sort of take the concepts they agreed on and put some language behind it in conference but if the concepts that are put in place don't fit together we could have a problem. So that's my biggest worry. Otherwise I think we're doing okay.

I mean look, if we fight this thing through and we lose it, so be it, you know. But I think our chances of winning are pretty good ultimately.

Q: Describe for me the Sunday session with the cabinet and so forth.

A: On a day-to-day basis there's a small group, Harold, Pat and myself, George sometimes, who are sort of guiding this process and we make decisions to set up meetings like those during the week with Boren and other individuals.

Q: Whose idea was that?

A: To set up those meetings? I think we all participated. I don't think it was any one person. We probably specified the specific individuals but I think Mitchell in some discussions I had with him and I'm sure he had with others said why don't we try to get these people in and see where they are. Try to see if we can make something happen. So we all sort of felt that.

And as we had those discussions, a lot of other people in the White House and in the Administration who were hearing things up on the Hill were calling me and saying what's happening? So we decided that we'd put a meeting together of everybody to see if everybody would be on the same page and to hear the President make it clear to everybody what he wanted to do in health reform. And the hope was to try to get the meeting towards the end of last week but the President needed some rest and we didn't want to inflict it on him so we put it on Sunday night. Korea came up. So we did it Sunday night.

Q: And what was it like there? What was the message?

A: There was some good discussion on where people thought we were, opinions expressed on what we thought the Republicans were doing, would the Republicans be serious, would they engage in the Finance Committee to produce something which, even if it wasn't something we could favor, at least it was universal coverage.

I think the dynamic we had observed during the past three or four weeks was that Breaux or somebody would float something which was movement, with the idea of let's try to engage the Republicans. And so initially he floated small business carve outs as a compromise. Because we all had known, and had experienced conversations with some Republicans who had said maybe they could support an employer mandate if there was a carve out and so he broke the ice and said okay I'll do this.

And then they moved away from that. And then Conrad and some others had come up with this hard trigger idea which at first there had been some reason to believe would attract Republicans, and then they moved away from that. So some people were saying well wait a second, this is just a game, they're just sort of playing with us. So there was discussion about that and what the seriousness of it was.

And some of the Senate Finance Democrats, particularly Boren, but others had always said, look, we'd like to get Republican support on the bill in the Finance Committee. And so we're looking to find where they are. And there was a lot of discussion of that. And then there was discussion whether there was anything we should do to help the process along in Finance. The President made a statement which I won't be able to repeat as well as he made it, he was talking about MFN and China and how people talked about campaign promises and he said that he had a good record of keeping his campaign promises and people who'd studied these things were saying that. But on China he had changed his position from the campaign and he said even though there

may be a political hit on that, he thought policy wise it was the right thing to do and that as he became more educated he felt he had made the right decision from the point of view of the country and so he had changed position.

On health care he said he thinks we're right both politically and policy wise in fulfilling the campaign promise, that basically politically the country wants universal coverage and that shows up time after time in polls, and from a policy point of view it is the right thing to do. You can't fix the system, you can't get cost control unless you do it, and therefore we have to stick with it and we have to be firm about it. And there can be no question that that's what we're for. And somebody raised at the meeting that because we were being so flexible on what we were calling the details, that there was a sense that we might be willing to give up on universal coverage or you know accept the 91 percent solution. And he wanted to make the point very clearly that the 91 percent idea was a fraud and that we could not pretend we had universal coverage if we don't and that we had to go out and be strong about it and if anybody doubted that on the Hill that we needed to send a message that we were very clear about that which of course he's done this week on a number of occasions. So that was pretty much the tenor of the meeting.

Q: What was he like? A fiery Clinton?

A: No, he was resolved. I think he had been very tired during the week because of the combination of North Korea and health care and he had gotten a little bit of rest on the weekend and so he was very measured but very strong.

Q: Did he ask was there going to be uniform support now, we'll march out together?

A: Well, one of the purposes of the meeting was to get everybody on the same page -- not that there had been disagreements -- but rather that there had not been a meeting of everybody in a number of weeks. In the fashion that he usually does invite people to give their opinions on what would work and he didn't say anything for the first 45 minutes to an hour other than asking a couple of questions. Then he said what he thought.

Q: Were there nay sayers? People who thought the process was doomed?

A: Well there were certainly no nay sayers in terms of universal coverage. I think there were varying assessments of where we were and what the chances were of getting Republican support. There were some disagreements about assessments, I guess. There were different assessments on whether if we carried it to the floor and it was Democrats only, whether they would filibuster. There were differences of opinion on whether we could successfully go to the country in July and turn momentum with a new vehicle. There was some discussion about whether we had to do that sooner rather than in July. But it was a very amicable meeting and I think there was

significant comfort in what the President said.

Q: Was there an end game sort of spelled out here?

A: No, because I think everybody felt it was premature. I think there will need to be further discussions about what happens if the Finance Committee can only report out a non-universal coverage bill or what happens if they report out a universal coverage bill that is done in a way that we can't support. Or what happens if they can't report anything out. So there were discussions of that sort. But not an end game.

In terms of the policy end games that we had laid out last September, everything that is being discussed in the other committees, including Dingell's mark, is well within those policy end games. So to this point, we have been very comfortable.

The question of whether Finance could do something within the policy end games depends upon the Republicans. Boren has said pretty unequivocally that he would not go without Republicans. That therefore puts it in the Republican camp to be able to block anything if he sticks with that. Some said, if Boren is convinced we really reached out to the Republicans and they're just playing politics, he might reassess that statement of his. Or he might not. Different people expressed opinions about that. But at least one had to entertain the possibility that if he stuck to that and the Republicans were just playing politics with this, that one could not get something out of the Senate Finance Committee that would be within our policy "end games" and that was the discussion.

Q: Did the President characterize his discussions with these members one on one? I've heard different versions of those from the various people.

A: No, I sat in on all his one on ones. So maybe I wasn't listening too much to that but I think he characterized a little bit what he had heard but I wouldn't think it appropriate for me to do that. But I was in all those meetings and I think what he tried to accomplish, which I think he did accomplish, was to say, universal coverage is my bottom line but I encourage you if you have other ideas on how to get there and how to do this or whatever, I encourage you to pursue those.

Q: What struck you in those meetings?

A: Well I thought he was tremendously effective and very honest. And it was a blend of saying to them, look, we've got to get universal coverage and you know if you don't like the way I propose doing this, I would encourage you to engage in a process with each other, with your fellow members of this committee, and come up with alternatives. And I will not be closed minded about those alternatives as long as they achieve universal coverage. And we may still disagree on some things. But I think that they had to be impressed with his sincerity and the fact that he was, at the same

time, flexible but also committed to certain principles. And in one of the meetings in particular and I think in most of the others as well, he called upon the historic moment that existed here and said a couple of the moderate Republicans who want health reform aren't going to be here next year so even if the Democrats hold their own in the senatorial elections, it may not be so easy next year.

And this is an historic moment and do you really want to let it slip by? And I think that had an impact. And then he was willing to discuss ideas and throw around different ways of doing it and he asked them to be involved.

Q: So you were at the Packwood-Moynihan session.

A: Yes, Packwood, Moynihan and he did ones with Danforth, Durenberger, Chafee, Boren, Bradley. And he had phone conversations with Breaux. He had a phone conversation with Conrad. And had actually met with Durenberger twice. And then of course he talks frequently with Mitchell.

Q: In the Packwood-Moynihan session I've heard several versions. One that struck me most was that Packwood was very straight with the President and very direct about what he could or could not achieve.

A: Well but one of the things you need to understand about all this is that we had a bipartisan meeting just before Memorial Day in Mitchell's office that Mitchell called, and after that meeting I happened to have a conversation, David Gergen and I, with Packwood, and he said some things then about what he could and couldn't do. And they were different than what he said this time. And there's only a couple of weeks apart there. I think what we're reflecting is a change in reality. And we have that in a number of cases, I don't mean to say that he's being disingenuous at all. I think it's just different people are at different places different times. A number of people who signed on to the Chafee bill now say they wouldn't support it. We originally got our premium cap idea, literally lifted it from the Danforth-Kassebaum bill and yet Senator Danforth now is not so sure whether he wants to support it. So people do move. But I'm just saying that, yes, he did do that but you know these things are fluid.

Q: Tell me your observations of Bill and Hillary Clinton now. Have they changed?

A: I think they are both very committed and strong and resilient people obviously. I think there has been some frustration at times at two things: One is Whitewater and all of that nonsense and the degree of personal attacks, the degree of diversion from the real issues. I mean it's one thing to engage in a disagreement with somebody about health care and argue it out and so on and so forth, that's fine. But all this other stuff has no valid public purpose. And also I think secondly the position which we all agree was the right position and the one we knew would be the right position

to take nevertheless can be frustrating at times, which was that we knew our bill had to be rewritten and we also knew that we needed to pull back and let that process go without commenting on what was happening. Now that's not easy.

But I think other than those two frustrations, I think they are feeling liberated now because it's time for us to begin to get back into the process and to be able to go out and fight for it.

Q: Have they verbalized that to you?

A: Oh not quite that way. I mean the First Lady to some extent, yes. And the President too. And the President's text to the business roundtable had only one paragraph on health care and he took off on it, he wanted to engage and let them know that he was going to fight.

I think it's interesting because we got a number of comments back from CEOs who don't like the health care plan who were at that meeting saying that there was a lot of admiration for his feistiness, for his willingness to fight for what he believes in. And so I think that's there. But you know they're both resilient and they believe in this and I think that's governing them.

Q: In terms of strategy at this juncture. Should the President address the country, if so, when and how? Talk about that.

A: Well, sure. The committee process has to run its course and we cannot be in a position of saying we like this committee's bill rather than this one or we don't like that because that undercuts a series of five chairmen all of whom are co-sponsors of our bill and who are committed to universal coverage and so on. So we can't get out actively supporting until we have a new vehicle. And we won't have that vehicle until the House and Senate go on the floor with something. And that's going to be maybe mid-July. So at that point, yes we'll go out and we're talking about the possibility of making a speech to redefine, and we're laying out a very active schedule of appearances during that period, that crucial period. Next month, yes, I think what will happen, it's like an election, I think in the sense that you can go through nine months or a year where you're up, you're down, you're up, you're down in the polls and so on and so forth and then there comes a time when the electorate really focuses in that last month or six weeks. And I think that will happen here.

I think in mid-July we'll be launching the vehicle, the President will say, look, when I laid out my bill in September I said here are my principals and I laid out a detailed bill and I said let's have a national discussion, I'm flexible on the details. We've heard you in the national discussion. We have modified proposals to take cognizance of some of your concerns, A, B, C, D, E and F, now we've got a bill that we think

meets your concerns and gets you what you want -- universal coverage. And now we've got to fight for it. And then we go out for a month or six weeks to focus attention on the fight.

I think also a lot of the groups who have been focused on getting the extra 10 percent they didn't get from us from the Congress instead of fighting for the 90 percent, I think are already beginning now to show some seriousness. I mean we had a little of that in January/February but now I think we see a lot more.

So I think things will really be engaged then and we'll have a four to six week period of very intensive action and discussion. Also the opposition will be out. You'll see tens of millions of dollars in advertising and direct mail against us so it's going to be interesting.

Q: How was the Monday session and what playback did you get from Hillary's remarks?

A: Oh I think the groups were very positive. They wanted to see us be strong. But they also got the very clear message that they've got to get up to the Hill and fight. She was very clear in saying, and it's true that a lot of congressmen and senators are saying well maybe seniors and labor and all these groups support it, but they're not coming into my office every day. Insurance agents are. And so she said that to them. We could lose universal coverage if you guys don't get out there and fight for it. I thought there was a pretty positive reaction.

Q: One of the constant refrains through our conversations is the press. How do you feel about the press?

A: Well I think during the first six months we were here, the White House overall did not deal with the press effectively. I think in the past six or nine months we've been doing a good job in terms of trying to answer press inquiries and being very open with the press and so on. And I think Lorrie McHugh's group has really been working very hard. We've been very open and we've been very accessible.

What continues to puzzle me as somebody who's a partial observer are two things. I don't want to be critical but I have a few questions. Ways and Means which was moving along, stalled for a day, and they had to caucus. Remember that? And then they came back the next day and passed the financing package. On the first day there was a front page Washington Post headline, top right corner, Ways and Means Committee Stalled. Things in Jeopardy, and so on. Next day it cleared, it all passed and the story was buried on A4 I think it was and it was a very small article.

It seems that things that have portended that the process is in trouble seem to get more billing than those that are positive. The day that Kennedy's committee reported out a bill with one Republican supporting it and all the Democrats, most press

accounts focused on the fact that Moynihan was going to lay down a mark and what was in that mark and that the Finance Committee might not support his mark.

There's no question that the media has a tremendous effect on the process itself, it's not just sort of chronicling it, it is impacting day to day. Sometimes it helps and sometimes it hurts but I think it has an effect. I think that's interesting in itself. It can have a tremendous impact from day to day.

There are a lot of reporters who've been covering this who have tried to do a good and a conscientious job. I think that journalism has gotten better in the past six or nine months I guess as the reporters have gotten more steeped in it. There have been a lot of very thorough and astute stories being written. The thing that The Post has, that Marilyn Moon does, the questions and answers, are very accurate and it's very useful. A lot of the health care writers at a number of the papers and some peripheral writers I think have done a pretty good job.

Q: Let me wrap it up.

A: Oh, sorry there was something I was going to say. One thing that would be interesting and I think it's something the journalism profession could think about is the accountability on rumor. There are a lot of cases where things are reported and may even have a long life to them based upon rumor which turn out to be stories that just were not accurate. And nobody can get everything right all the time obviously, but there are some things which seem to have a life like that. And I think it would be interesting to go back and not just judge the success of the journalistic endeavor on whether you get a story first, but retrospectively did you get it accurate.

Q: Okay. Coming up the recess and taking your temperature. What do you really think the end will be? What's the end game?

A: I guess I still think we're going to get a comprehensive bill out. I think it will be within our end game scenarios. I think the House will pass a bill. I think the Senate will have a majority willing to pass such a bill. I think the major question mark in my mind is whether the Republican moderates will join the bill, or whether they'll participate in a filibuster. And I suppose one could put a scenario forward where you have the House bill, Senate majority or a filibuster that holds it up for so long that it kills it. And I think that could happen. But I think more likely is that it won't happen and we will get a vote. I don't know whether we'll get it with 51 or 52 votes and whether the Republicans will filibuster. Or whether the Republican moderates and a couple of conservative Democrats might oppose the bill, but nevertheless vote for cloture because they don't want a filibuster even if they don't vote for the bill.

I don't know. But I think that's still what could happen and it won't be our idea of perfection but it will be a bill that meets the goals we laid out in September, and

that's within our end games.

Q: One last question. Do you think that an opportunity was missed with Dole somewhere along the line? There are people on the Senate who think there was. How do you feel about that?

A: Well I don't know but my gauge of that is no, not with Dole. I don't know Dole and I've had limited contact with him, but the Republican senators I was meeting with -- Chafee, Danforth, Durenberger -- who certainly would have been on the cutting edge of a deal, we kept probing and probing and I think if there was something there we would have found it. I just don't see it.

Q: I was told by two sides that Moynihan and Dole had lots of private conversations and they were running it together. It's time for us to do the bipartisan thing.

A: Well but see the question mark in my mind about that, I mean there's going to be a lot of rewriting history as there always is, but the question mark I've raised about that is whether Dole was ever serious. And I don't think he knew. I think he was making a political judgment and I don't think he knew where the best place to come out was at any given time. And that's why sometimes he was very encouraging. Back last September/October he was saying, "we're going to get a bill, it's going to have universal coverage." The First Lady went to Kansas with him and he said that. But then in January and February he was saying, "there's no crisis."

I think Dole was biding his time, postponing making a decision on which way he was going to go until he accumulated more political evidence. And so I don't think that he would have been ready to move and I think he kept the thing alive with Moynihan because he might well have wanted to be positive at some point -- but then he might not have. And I think he didn't know and so he kept it alive. And I don't think that Chafee and Durenberger and certainly Packwood were prepared to break from Dole until he had made up his mind where he was going. So I don't think there was a deal. And they were all saying to us to do the regular order, everybody was saying that. So that's what we did.

Q: Great. Thank you.

End.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	Regulatory Language in the Health Security Act (1 page)	ca. 1995	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Materials, 1993 - 1994)
OA/Box Number: 12503

FOLDER TITLE:
Retrospectives on Health Reform [3]

Kara Ellis
2006-0810-F
ke1025

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]

REGULATORY LANGUAGE IN THE HEALTH SECURITY ACT

I am not familiar enough with the crime bill to know whether as Malcolm S. Forbes, Jr. contends, the words "penalty," "restrict" and "violate" appears more often in the health bill than in the crime bill.

The health care policy book produced in early-September of 1993 was about 250 pages long. The drafting lawyers turned it into a 1,340 page bill. Both Paul Starr and I questioned how regulatory the initial bill sections sounded, but were told by our legislative drafters that this was necessary to produce a bill that would stand up legally.

The main body of the bill which described the new health system was actually about 650 pages long. This included about 60 pages defining the benefits package, 110 pages describing how cost containment would work and 90 pages on financing, all of which were required for CBO scoring. The other 390 pages described the insurance reforms, employer mandates, alliances, health plans, quality system and federal and state responsibilities.

The Chafee bill, the Mainstream bill, the Dole bill and others were comparable or longer in these areas even though they did not have scoreable cost containment nor a defined benefits package.

Most of the rest of our bill is made up of sections drafted mainly by HHS and by Sara Rosenbaum which cover public health initiatives (about 150 pages), long-term care and the Medicare drug benefit (about 185 pages), Medicare and Medicaid changes (about 170 pages) and remedies, enforcement and anti-fraud and abuse sections (about 100 pages). These parts of the bill contain about 80 percent of the boxes on the famous Specter charts on how bureaucratic our bill is and most of the regulatory language which is often cited in comments like the Forbes one you sent me.

The mandatory alliances and the CBO scoreable premium caps became symbols of our "bureaucratic" bill, but they did not contribute most of the regulatory language.

I was horrified at how many boards, regulations and legal remedies were defined into the package by HHS and by Sara and her drafters and said so. I initially rejected including most of this when we first received drafts from Sara and HHS during July. Sara then requested a meeting which we held with you in early-August when you returned from your trip to Japan, Hawaii and California. She argued that tough enforcement was necessary in the bill to protect various classes of consumers in a variety of ways and that argument prevailed, though I was not comfortable with it. At that meeting, it was also decided to allow HHS to design their programs as they wished as long as they did not deviate fundamentally from the definitions in the June policy book. This was done to buy peace with Donna who was arguing that these sections were solely within the purview of HHS.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Donna E. Shalala to the First Lady, re: Health Care plan (5 pages)	09/15/1993	P5
002. paper	Transition (4 pages)	09/15/1993	P5
003. paper	Tab B: Fraud and Abuse (6 pages)	09/15/1993	P5
004. draft	[Health and Human Services mark-up of Working Group Draft section on the Guaranteed National Benefit Package] (13 pages)	09/13/1993	P5
005. paper	CLIA (7 pages)	09/15/1993	P5
006. paper	Tab D: HHS Technical Comments on 9/07/93 Draft (6 pages)	09/15/1993	P5
007. draft	[Health and Human Services mark-up of Working Group Draft] (21 pages)	09/1993	P5
008a. memo	Leon Panetta and Alice Rivlin to the First Lady, re: Comments on the 9/7/93 Draft of Health Care Reform Plan (1 page)	09/23/1993	P5
008b. memo	Leon Panetta and Alice Rivlin to Ira Magaziner, re: Comments on the 9/7/93 Draft of Health Care Reform Plan (1 page)	09/23/1993	P5
008c. paper	Comments by Chapter - 9/7 Draft Plan (22 pages)	09/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Cicetti, Pam (Health Care Subject Files, A thru C)
OA/Box Number: 13599

FOLDER TITLE:
Health - Agency Reviews [1]

Kara Ellis
2006-0810-F
ke1026

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

SEP 15 1993

MEMORANDUM FOR THE FIRST LADY

As you know, over the course of the past week, we here at HHS, together with members of your staff, have held discussions with numerous members of Congress, and many others both inside and outside of government. We are encouraged by much of what we hear. This is a bold vision and people want to believe in it and want to reform the medical care system.

Still, based on those discussions, we believe a number of key issues deserve closer attention before a final proposal is released. The first set involve the plan's assumptions regarding the financing and tightness of the budget. Over and over, we are hearing that the savings and cost estimates are simply too optimistic. More worrisome is a growing sense that the plan cumulatively is too "big, regulatory, top-down government." Our second set of concerns involve other administrative and policy issues. Our very detailed comments on a range of issues are included in Tabs A-D.

I. KEY FINANCING/BUDGET ISSUES

Medicare Savings

The current level of Medicare savings raise serious policy and political issues for many different constituencies. Our experience of the last few weeks suggests that a storm of protest may be brewing among some constituencies we would expect to be supporters. Members of Congress worry that certain hospitals are likely to be hit harder than others: in particular rural and inner city teaching hospitals who will be squeezed by the private sector and Medicare. Especially in the face of the large cuts already a part of the budget, many regard these new reductions in growth as much too large.

We fear that the perception may be growing that we are financing expanded coverage for the uninsured out of cuts in Medicare and Medicaid. Providers, beneficiaries, and advocacy groups are clearly troubled and many worry that the bill which emerges will not have the levers or the will to control private costs, but the Medicare savings will be imposed nonetheless. One strategy might be to tie Medicare savings to successful private sector savings.

Medicaid Savings

While we think the level of Medicaid savings are more plausible, legitimate concerns have surfaced about the timing and the method of phasing out disproportionate share payments. In particular,

some hospitals will need special help. Part of this is an adjustment problem as hospitals shift their method of financing from one which relies heavily on Medicaid DSH payments to one which relies on health plan payments for the formerly uninsured. But part of the problem includes the continuing need for such hospitals to serve illegal immigrants, and to deal with the substantial and continuing needs of their low income communities. Many of these will be the same hospitals hit by Medicare reductions. Thus, we urge more thought about the level and timing of the phase out of DSH payments and whether other forms of assistance to these facilities may be appropriate.

Public Health

We understand that OMB has proposed a lower investment in public health initiatives. This change suggests a potential reduction of funding for important public health strategies designed to promote the achievement of the goals established for health care reform. Insurance alone cannot guarantee the availability of services in rural and urban areas that now lack service. That guarantee is especially important as we eliminate DSH payments.

The public health initiatives focus on removing non-financial barriers to care and improving disease prevention and health promotion programs. They support a major re-structuring of health professional training which is essential to create a health workforce that meets the needs of alliances, plans, and consumers. Finally, the initiatives support data collection, analysis, and health-related research to inform decision-making by consumers, providers, and policymakers. This information is critical to cost-containment efforts at the state and federal level.

The reduction of funding for public health initiatives seriously impairs our ability to ensure that we not only reform our insurance system for taking care of illness, but also our public health infrastructure which prevents illness in the first place. Reducing funds for public health now will undermine our guarantee that all Americans will have primary, prevention, and emergency services.

Tightness of the Budget

Much of the legitimacy of Medicare and Medicaid savings is tied to the credibility of the budgets imposed on Alliances. We are hearing a chorus of disbelief. We note again that excessively tight budgets create the impression that this will be a government regulated system which will alienate supporters of managed competition while offering opponents a convenient issue to attack.

Ultimately the issues regarding budgets and financing boil down

to two: who is being hurt and are the assumptions credible. A very tight budget for Medicare and Medicaid seems to threaten certain providers who have already been asked to control costs and fees considerably more than those who have eschewed serving the old and the poor.

Estimates that are not credible undermine a cornerstone of our message: security. Many in Congress and most outside experts seem to regard savings of this magnitude as implausible. The newspapers are rapidly making this the health reform story. That makes the plan vulnerable to the attack that Americans cannot count on the security we are promising.

II. OTHER CRITICAL CONCERNS

Protecting Low-Income Families

The common sense proposition that low income families should not be worse off as a result of this plan runs into problems when one looks at the level of subsidies available for low-income persons. Compared to Medicaid, some will be worse off. Discussions with members of Congress suggest that subsidies for low-income persons need to be revised to provide a real choice of plans. Subsidies for the low-income should at least parallel those provided the SSI disabled--that is, a choice of a fee-for-service plan, including subsidies for cost-sharing, even if the plan is above the weighted average premium. The $10 per visit cost sharing in the HMO plan is too high for both AFDC and the SSI-disabled.

Allowing Medicare Beneficiaries to Elect Alliance Coverage

Allowing Medicare beneficiaries unlimited choice among plans in an Alliance likely over time will result in a deterioration of the Medicare risk pool. The proposed arrangement may hurt the Medicare program. Some fear that younger (and healthier) persons will choose to stay in the Alliance, while older persons remain in Medicare. (In addition, we would prefer to use our existing Medicare HMO payment methodology for Alliance plans.)

Shifting VA and DOD costs to the Medicare Trust Fund

Last Spring the Social Security Trustees reported that the Medicare Trust Fund was in serious financial trouble. If the growth in Medicare costs is slowed, the problem will be reduced. Consequently, it is both dangerous and illogical at a time when significant cuts in Medicare are contemplated to also ask the Medicare system to pay costs previously covered by the VA and DOD. This proposal has been defeated repeatedly in the Congress. It was also reviewed and rejected by the President and the Vice President when it was proposed for the Reinventing Government Initiative.

Transition

Many regard the transition as not allowing sufficient time for the states and federal government, including the Board, to put appropriate systems in place. While everyone appreciates the need to bring states into the new system quickly, both to extend coverage and control costs, we fear that doing so too quickly will not permit states sufficient time to certify health plans and develop monitoring procedures nor will the federal government be able to develop a credible regulatory framework. A slower phase-in would also allow new federal subsidies to be phased in.

Fragmented Authority and Confusing Accountability

The current structure creates a confusing array of accountability and authority. The National Health Board sets some policies; States set others. The Board is responsible for enforcing the budget, even though Alliances are creatures of the states. Both HHS and Labor audit Alliances. The Board may direct Cabinet Secretaries to impose penalty taxes and run a health system in a state which fails to do so (even though the federal government cannot assume state powers to regulate insurance, providers, and other aspects of the health care system). Yet, ultimately states are supposed to ensure that the Alliances are effective and accountable. Authority and accountability ought to be in the same place.

The National Health Board

We are also hearing and reading significant concerns that the National Health Board will simply be a new bureaucracy duplicating functions already performed elsewhere but requiring a net increase in government personnel to do so. We believe that the board would need to have a significant staff to carry out all of the functions it is assigned and that the transition will be delayed while the board is established and becomes operational. We urge that its role be reduced and that many operational functions be performed elsewhere.

Early Retiree Benefits

There are clear political advantages to the current policy regarding early retirees. Still, the plan can create perceived inequities worthy of attention. While many of those helped will be middle class, beneficiaries will include those with sizable unearned incomes. Questions of equity arise both for people under 55 and over 64. And we believe induced retirements would further damage the precarious Social Security, Medicare Trust Funds, and private pensions. Moreover, the retirement age will gradually increase for Social Security benefits over the next several decades. Perhaps the subsidies here could be better targeted to low-income early retirees. These issues need substantial high

level review.

All of these remarks are meant to make the President's health plan even better. Rest assured that my colleagues and I will continue to be the strongest voices in support of the plan.

Donna E. Shalala

ATTACHMENTS

Tab A: Significant policy concerns

Tab B: New text on fraud and abuse and a mark-up of benefits text

Tab C: Additional policy concerns

Tab D: Editorial comments and mark-ups

TRANSITION

The plan permits states to start health reform on January 1, 1995. This assumes passage of legislation in December 1993 and accelerated issuance of federal regulations and major procurements. Before a state can come into the system, the Board, the Department, and the states must complete an array of significant tasks, many of which require time for public notice and comment. The success of the new system depends on how carefully and credibly some of these early tasks -- development of criteria for state plan approval, certification of health plans by the states, and development of actuarial and financial systems for monitoring premium and subsidy administration -- are handled. It will not be possible for all this to occur prior to January of 1995. The January 1, 1995 date is unrealistically optimistic and should be pushed back at least by six months.

MEDICARE INDIVIDUAL INTEGRATION

The HHS position continues to be that: (1) individuals should be allowed, upon reaching age 65, to remain in a risk-based plan in which they already are enrolled; (2) Medicare payment would be 95% of the average per capita cost; (3) the premium amount for those over age 65 should be the same as the under 65 population, but age-adjusted or capped at some multiplier of the under 65 population.

(1) HHS believes that adverse selection would occur if the individual opt-in applies to all plans. The available evidence is that Medicare risk contractors are enjoying significant favorable selection. If risk contractors with their mechanisms to control utilization risk select, the incentive to risk select for fee-for-service plans (which have no mechanisms to control utilization) will be even greater. Since plans would have information on the prior use of services for current enrollees, they would be in a perfect position to take steps to encourage only the healthy beneficiaries to opt-in, thus leaving Medicare fee-for-service with the bad risks.

HHS is willing to accept the possibility of adverse selection for a risk-based plan since the alternative is to force a beneficiary to leave a health care delivery system to which they have grown accustomed (if HHS does not have a risk contract with the plan). Beneficiaries previously enrolled in fee-for-service plans, however, do not have a comparable problem when they become entitled to Medicare since they can continue to receive services from the same providers in Medicare.

(2) HHS believes that Medicare should pay risk plans in the

Alliance the same way it pays risk plans that contract with Medicare -- at 95% of the average per capita cost. Even at 95%, we have been overpaying because healthier than average persons have been enrolling in risk plans. If we pay plans in the Alliance at even higher rates, clearly that will place an unfair burden on the Medicare Trust Fund.

(3) We believe that the premium for the over 65 population should be the same as for the under 65 population, but age-adjusted or capped. Otherwise, plans who do not wish to serve Medicare beneficiaries will charge higher than necessary premiums. It would be unfair to subject beneficiaries to a sudden change in premiums at age 65.

BOARD RESPONSIBILITY FOR MONITORING ALLIANCES

The Board is given responsibility for overseeing Alliances and providing technical assistance along with responsibilities for the budget, benefit package, and quality assurance system development. HHS continues to believe that monitoring Alliances is an operational function that will require a large staff and therefore should not be housed with the Board.

MEDICARE SUBSIDY TO VA AND CHAMPUS

For individuals dually eligible for VA/DoD and Medicare, HHS feels strongly that care provided in VA centers should be paid for by the VA and that services provided in military facilities be paid for by DoD. We see no rationale for a transfer of funding responsibilities from DoD or VA to the ailing Medicare Trust Funds.

RETIREES

The new policy on retirees over age 55 and not yet eligible for Medicare benefits contains ambiguities and potentially creates inconsistencies among similarly situated population groups. The proposed policy (on page 235) provides for government subsidies to pay for 80% of the early retiree's premium, while the retiree pays 20% (some or all of the early retiree's 20% share can be paid by the former employer). The estimated cost of this policy is $4 billion.

Retirees are treated better at age 55 than when they become eligible for Medicare at age 65. At that point, Medicare cost-sharing will be greater on average than the 20% or less share

they bear at age 55. This "notch" needs to be reduced.

Are retirees who are over 55 and meet the Social Security requirements for quarters of work to be treated differently from self-employed people over 55 with an equal number of quarters of work? Are self-employed people (who are generally responsible for the employer share of the premium up to 7.9% of self-employed income) also eligible to "retire" at age 55 and receive a full subsidy for the employer's share? If not, why would self-employed and formerly employed individuals be treated differently? Are non-workers and the unemployed also eligible to "retire" at age 55 (i.e., does this provision create a general entitlement to 80% government subsidies at age 55)?

Are early retirees who have large amounts of unearned income required to repay any subsidies they receive, as are non-workers and part-time workers.

Finally, it is unclear why employers with current contractual obligations to retirees are being freed from those obligations. The federal government will provide contributions to <u>its</u> annuitants in the Alliances that will hold them harmless against current benefits and fees. We assume that private companies can support retirees purchase of plans above the weighted average premium in the Alliance. This needs to be clarified.

COST SHARING SUBSIDIES

Low income subsidies for cost-sharing continue to be provided only for a low cost-sharing plan (page 227). HHS believes the poor should not be forced into a low cost sharing plan and that subsidies for cost sharing should be available equally to low-income people at the same income level no matter which plan they choose.

The policy for the SSI disabled on Medicaid on page 200 is much more generous. Provision is made for premium subsides and cost-sharing subsidies to provide access to a fee-for-service plan. HHS believes this policy should be applied to the poor generally.

Finally, the low cost-sharing plan which requires a $10 copayment for each physician visit is too high for the poor.

FEDERAL BUDGET ENFORCEMENT

The federal government is now <u>permanently</u> to enforce the budget at the Alliance level, not just for the first three years. This creates a fundamental tension at the heart of the plan. The

Alliances are creatures of the state, but the state does not enforce the budget. Federal tools are limited to reducing plan bids, but in the extreme, if the prices are forced low enough there will be no plans. The federal government has no access to state police powers, state planning powers, or state insurance regulation laws to influence plan behavior.

HHS believes the plan should continue to make provision for state enforcement of the budget after an initial start-up period. Alternatively, the plan should make the Alliances creatures of the federal government, with encouragement to states who apply and meet standards to take over and run the Alliances and enforce the budget. Either approach removes the fundamental tension.

FRAGMENTED AUTHORITY

One of the problems in the current health care system is fragmented authority. A key test of our ability to deliver on the promise that all will have access to care and that costs will be controlled is the distribution of authority at the national and state levels. The current plan divides authority in awkward ways between actors at the federal level and between the federal and state governments. It is no longer clear who is in charge/who is accountable to the public.

Examples:

Both Labor and HHS audit Alliances--the former for financial management, the latter for subsidies.

The National Board contracts with existing Executive Branch agencies with the peculiar result that an independent board directs Cabinet Secretaries to impose penalty taxes (Treasury) when states do not submit an adequate plan or to run the system (HHS) in default states.

The budget is enforced by the Board directly with the alliances--states no longer assume responsibility after 3 years. States have powers to bring costs under control and yet the National Board is responsible for reviewing budgets for some 200 alliances with no state involvement.

States have no incentives to run the system since the Federal government guarantees health care to all their citizens and we enforce the budget. Heavy tax penalties are the principal tool to assure state action.

FRAUD AND ABUSE

We have prepared a new introduction to the Fraud and Abuse section of the plan. The current section highlights investigative aspects, sanctions, and limits on self referrals and kickbacks. Fraud and abuse activities encompass a much wider array of functions to prevent and detect as well as prosecute malefactors. In fact, most of these components are covered throughout the plan, although some exceptions are noted in our comments below. Our new version of the Fraud and Abuse Section summarizes the broader activities and makes general cross references to appropriate provisions of the health reform plan. It is found below. In addition, we have several other comments on fraud and abuse aspects of the plan which follow our revised introduction.

PROPOSED REVISION TO THE FRAUD AND ABUSE SECTION OF THE HEALTH CARE REFORM PLAN

FRAUD AND ABUSE

The American Health Security Act establishes an all-payer health care fraud and abuse prevention, detection, and enforcement program, and increases funding for and coordinates activities of various branches of government for enforcement against fraud and abuse in the health care system.

BUILT-IN PREVENTION

Prevention of fraud and abuse is built into every level and component of the health care system. Because the benefits package is standardized and risk selection practices are prohibited, Health Plans will compete for consumers solely on the basis of cost and quality. Fraudulent practices which increase costs or reduce Plan quality will make a plan less competitive. Plans will have strong incentives to monitor and correct such abusive practices. Structural changes which will reduce the vulnerabilities of the health care system to fraud and abuse also include the encouragement of at-risk payment systems (i.e., through exemptions to self-referral, anti-kickback, and antitrust prohibitions). Putting providers and plans at some financial risk for the costs of care can eliminate incentives for fraud and other abuses which increase costs.

Management procedures and structures ensure accountability for funds, prevent unauthorized persons or entities from receiving payments, and require truth in marketing and fair marketing practices. State and Federal budget enforcement authority will further discourage churning, upcoding and other types of cost-

increasing abuse. Specific responsibilities are spelled out for plans, alliances, States, the National Board, and other Federal agencies.

Opportunities for fraud and abuse are further minimized by significant reductions in the complexity of payment procedures, including administrative simplifications, standard forms, and uniform codes used for most insurance transactions. Unique identification numbers for providers, plans, employers, and consumers and standards for electronic data interchange make it more difficult to game the system and file false claims.

As operating systems for enrolling consumers and providers, billing for services, paying premiums and benefits, etc., are designed and implemented, fraud and abuse experts will conduct integrity reviews and provide other advice and technical assistance. Audits, inspections, evaluations, and investigations provide vigilance throughout the system.

ENHANCED DETECTION

The same design features that prevent fraud and abuse also help detect it.

Additional measures enhance detection. The Federal, state, alliance and health plan data network described in Tab 15 provides a basis for identifying troubling trends and aberrations and analyzing them for possible fraud or abuse. Other leads come from investigations conducted by Federal agencies and State sponsored units, and from consumer complaints and ombudsman programs. These are reviewed to determine if any are the result of systematic weaknesses which need to be corrected by administrative, regulatory, or legislative action.

STRONGER ENFORCEMENT

The fraud and abuse enforcement program coordinates federal, state an local law enforcement activities aimed at health care fraud and abuse. The Department of Justice and the Department of Health and Human Services jointly direct the program.

[THE REMAINDER OF THE FRAUD AND ABUSE TAB CONTINUES HERE STARTING WITH THE SECTION ON "TRUST FUNDS"]

ADDITIONAL COMMENTS

State Responsibilities for Fraud and Abuse. The plan is silent about State responsibilities for fraud and abuse. While these

might have been presumed, one could also get the impression that the heaviest reliance would be on Federal agencies like HHS and Department of Justice. We clearly need States to be actively engaged in investigating fraud, prosecuting malefactors, identifying troubling trends and patterns, making sure alliances and plans carry out appropriate payment safeguard activities, etc.

Recommendation: Include language in the "State Responsibilities" section to the effect that States will ensure that appropriate measures are taken to prevent, detect, and prosecute fraudulent and abusive practices.

Plan Responsibilities for Payment Safeguards. Again, although it might be presumed, the role of health plans to establish payment safeguard activities is not mentioned. This would include establishing edit screens to avoid inappropriate payments and analyzing expenditures to identify suspicious patterns.

Recommendation: Include language in the "Health Plans" section to the effect that plans will establish payment safeguards to prevent and detect fraudulent and abusive practices.

Income and Eligibility Determinations. The provision stating that "The National privacy policy explicitly through the identification number" makes it difficult to combat fraud in some cases. For example, alliances would not be able to use IRS information, State wage data, SSA data, or data from other programs to verify income and other eligibility information such as immigration status, family size and composition, etc. Even the year-end reconciliation of subsidies would require the alliances to rely on tax information provided by the consumers themselves. We understand the extreme sensitivity regarding privacy, but these provisions run counter to advances made in administration of means-tested programs through such systems as the Income and Eligibility Verification System (IEVS) and Systematic Alien Verification for Entitlement (SAVE).

Recommendation: Allow the identification number to be used to verify income and eligibility.

Inappropriate Employer Incentives. Because special limits on payroll deduction apply to firms with less than 50 employees, firms with slightly more than 50 employees will have incentives to reduce their work force to get the lower contribution rates. Even much larger firms with lower income workers would be motivated to reorganize, artificially breaking themselves up into units of 50 or fewer employees.

Similarly, contributions made on behalf of employees with earnings below $15,000 create disincentives and inequities for employees receiving pay increase slightly over this amount.

Both provisions cited above will also create incentives for fringe benefits to be provided instead of wages.

Recommendation 1: The plan should remove the 50 employee and $15,000 income "notches", replacing them with more graduated factors.

Recommendation 2: Ultimately, refined definitions of earnings and wages will need to be established to prevent gaming these provisions.

Alliance Funds. This version of the plan establishes a separate fund to hold the premiums for each alliance. This proliferation of funds increases the opportunities and odds for fraud and abuse. We recognize that the decision about how the funds should be structured must take into account many important policy considerations other than the desire to reduce fraud. However, if the question should arise again, fewer funds would be better than many from our perspective.

BENEFITS

The attached mark-up of the benefits section is designed to address or ask for clarification of the following issues:

1) To be consistent with the narrative, the table on clinical preventive services has been revised to include the periodic medical exams for adults and screening tests and for high risk populations such as mammograms for women with family histories of breast cancer. Consistent with the language on pg. 21 the table footnote indicates that the screening and vaccines for high risk populations are covered under other parts of the benefit and thus have cost sharing.

2) The term "acute" has been added to the home health care and outpatient rehabilitation benefits. The actuaries indicate that this is the way the benefits were costed.

3) Emergency dental benefits for adults appear to have been inadvertently eliminated from the plan. We restore them.

4) We eliminate routine ear examinations as a separate service since hearing screening is part of the high risk targeted screening provision, and routine otoscope ear exams are included as part of a routine physical.

5) We ask for clarification of the 1998 interim mental health benefit expansions. We are exploring the cost-implications of expanding the outpatient benefit before the inpatient as we believe this is better policy.

6) We recommend eliminating the lifetime maximum limit on orthodontia services. We understand from the actuaries that the restriction that orthodontia is available only as an alternative to reconstructive surgery is a sufficient limitation, and that the elimination of the lifetime maximum does not pose a cost problem.

7) The tables at the end of the chapter are edited for inconsistencies. The mental health specifications are corrected. We note the one day deductible on inpatient mental health services has been inadvertently omitted. Also case management is added to the tables to be consistent with the narrative. We have also added additional clarifying language regarding the case management benefit.

8) Under integration of the public mental health system, we have clarified that states are eligible for "competitive grants," rather than matching grants. We are not aware of any proposal for a matching grant program. The

availability of Federal funds for grants, however, is subject to outcome of decisions on the PHS budget.

9) We have provided language describing family planning and pregnancy related services in order to be consistent with the other benefit provision, which were all described.

Revised Corrected copy by CA 9/13/93

GUARANTEED NATIONAL BENEFIT PACKAGE

The health benefits guaranteed to all Americans provide comprehensive coverage, including mental health services, substance-abuse treatment, some dental services and clinical preventive services.

The guaranteed benefit package contains no lifetime limitations on coverage, with the exception of coverage for orthodontia.

MEDICAL SERVICES COVERED

Each health plan must provide coverage for the following categories of services as medically necessary or appropriate with additional limitations and cost sharing only as specified in the American Health Security Act of 1993 or by the National Health Board. Covered health services are:

- Hospital services
- Emergency services
- Services of physicians and other health professionals
- Clinical preventive services
- Mental health and substance abuse services
- Family planning services
- Pregnancy-related services
- Hospice
- Home health care
- Extended-care services

- Ambulance services
- Outpatient laboratory and diagnostic services
- Outpatient prescription drugs and biologicals
- Outpatient rehabilitation services
- Durable medical equipment, prosthetic and orthotic devices
- Vision and hearing care
- Preventive dental services for children
- Health education classes.

DEFINITION OF SERVICES

Hospital services:

- Inpatient hospital, including bed and board, routine care, therapeutics, laboratory, diagnostic and radiology services and professional services specified by the National Health Board when furnished to inpatients.
- Outpatient hospital services
- 24-hour a day emergency department services
- Definition: A hospital is an institution meeting the requirements of §1861(e) of the Social Security Act.

Services of physician and other health professionals:

- Includes inpatient and outpatient medical and surgical professional services, including consultations, delivered by a health professional in home, office, or other ambulatory care settings, and in institutional settings.

- Definitions

  - A health professional is someone who is licensed or otherwise authorized by the State to deliver health services in the State in which the individual delivers services.

  - Covered services are those that a health professional is legally authorized to perform in that state. No state may, through licensure requirements or other restrictions, limit the practice of any class of health professionals except as justified by the skill or training of such professional.

The benefit package does not require any plan to reimburse any particular provider or any type or category of provider. However, each plan is expected to provide a sufficient mix of providers and specialties and appropriate locations to provide adequate access to professional services.

insert before preventive →

Clinical preventive services:

reorder bullets

① • Well-child care and childhood immunizations. ~~Specified in Table I.~~

④ • Limitation: Must be provided as consistent with the periodicity schedule specified in Table I or as specified by the National Health Board in regulations.

③ • Targeted screening tests and immunizations required for high-risk patients, as defined by the National Health Board, are covered under outpatient laboratory and diagnostic services and outpatient prescription drugs and biologicals.

② • Periodic medical examinations: for children and adults ~~every 3 years for individuals ages 20 to 39, every 2 years for adults ages 40 to 65, and annually for adults ages 65 or more.~~

Family Planning Services
- Voluntary family planning services and Sterilizations (and insertion of contraceptive devices).

Pregnancy Related Services
- Complete obstetrical care for all covered females, including prenatal, delivery and post natal care

WORKING GROUP DRAFT

Replace with new table that includes visits & screening tests for high risk pops & clarifies key language

~~PRIVILEGED AND CONFIDENTIAL~~

TABLE I -- COVERED CLINICAL PREVENTIVE SERVICES

Age	Immunizations	Tests
0–2	4 DTP, 3 OPV, 3–4 HiB, 1 MMR, 3 HBV	1 Hematocrit, 2 Lead*, 7 Clinician visits***
3–5	1 DTP, 1 OPV, 1 MMR	1 Urinalysis, 2 Clinician visits***
6–19	1 Td	Pap/pelvic** every 3 years after menarche, 5 Clinician visits***
20–39	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic** every 3 years***+
40–49	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic** every 3 years***+
50–64	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic and Mammogram** every 2 years
65 +	1 Td every 10 years Pneumococcal – once Annual influenza	Cholesterol every 5 years Mammogram** every 2 years

Preventive coverage includes coverage for women of any age presenting for prenatal care.

* = For children at high risk for lead exposure only.

** = Papanicolaou smears and pelvic exam for females who have reached childbearing age and are at risk of cervical cancer.

*** = Once three annual negative smears have been obtained.

\+ = For females of childbearing age at risk for sexually transmitted disease, an annual Pap smear and screening for chlamydia and gonorrhea.

** = Females only.

*** = Visits for tests and immunizations include blood pressure check, risk assessment and appropriate health guidance.

DTP = Diphtheria, tetanus, pertussis vaccine
OPV = Oral polio vaccine
HiB = Haemophilus influenzae type B vaccine
HBV = Hepatitis B vaccine
MMR = Measles, mumps, rubella vaccine
Td = Tetanus diphtheria toxoid

TABLE I -- COVERED CLINICAL PREVENTIVE SERVICES

Age	Immunizations	Tests	Clinician Visits[+++]
0-2	4 DTP, 3 OPV, 3-4 HiB, 1 MMR, 3 HBV	1 Hematocrit, 2 Lead[*]	7
3-5	1 DTP, 1 OPV, 1 MMR	1 Urinalysis	2
6-19	1 Td	Pap/pelvic[**] every 3 years after menarche	5
20-39	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic[**] every 3 years[***+]	Every 3 years
40-49	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic[**] every 3 years[***+]	Every 2 years
50-64	1 Td every 10 years	Cholesterol every 5 years; Pap/pelvic and Mammogram[++] every 2 years	Every 2 years
65 +	1 Td every 10 years Pneumococcal - once Annual influenza	Cholesterol every 5 years Mammogram[++] every 2 years	Annually

Preventive coverage includes coverage for women of any age presenting for prenatal care.

[*] = For children at high risk for lead exposure only.
[**] = Papanicolaou smears and pelvic exam for females who have reached childbearing age and are at risk of cervical cancer.
[***] = Covered annually until three annual negative smears have been obtained.
[+] = For females of childbearing age at risk for sexually transmitted disease, an annual Pap smear and screening for chlamydia and gonorrhea.
[++] = Females only.
[+++] = All visits include immunizations, laboratory tests and other screening tests, including history, blood pressure measurement, risk assessment, and targetted health advice/counseling.
DTP = Diphtheria, tetanus, pertussis vaccine
OPV = Oral polio vaccine
HiB = Haemophilus influenzae type B vaccine
HBV = Hepatitis B vaccine
MMR = Measles, mumps, rubella vaccine
Td = Tetanus diphtheria toxoid

Targeted tests and Vaccines for High Risk Populations

The following targetted tests or vaccines for high-risk populations (as defined by the Board) are covered elsewhere in the plan under the regular cost sharing provisions of outpatient laboratory and diagnostic services and outpatient prescription drugs and biologicals: Hemoglobin electrophoresis, tuberculin skin test, rubella antibodies, hearing test, hepatitis B vaccine, pneumococcal vaccine, influenza vaccine, mammogram, colonoscopy.

(Continuation of covered services)

Family planning services

Pregnancy-related services

move to pg. 21 before preventive services

Hospice care:

- Covered services (as under Medicare):
  - Nursing care provided by or under the supervision of a registered ~~professional~~ nurse.
  - Medical social services under the direction of a physician.
  - Physicians' services.
  - Counseling services for the purposes of training the individual's family or other caregiver to provide care and for the purpose of helping the individual and those caring for him or her to adjust to the individual's death.
  - Short-term inpatient care, although respite care is provided only on an occasional basis and may not be provided for more than 5 days.
  - Medical supplies and the use of medical appliances for the relief of pain and symptom control related to the individual's terminal illness.
  - Home health aide and homemaker services.
  - Physical or occupational therapy and speech-language pathology.
- Limitations
  - Only for terminally ill individuals
  - Only as an alternative to continued hospitalization.
- Definition:

- An individual is considered terminally ill if the individual has a medical prognosis of a life expectancy of 6 months or less if the terminal illness runs its normal course.

Home health care:

- Same services as under the current Medicare program (including skilled nursing, physical, occupational and speech therapy, prescribed social services) with the addition of prescribed home infusion therapy and outpatient prescription drugs and biologicals.
- Limitations
  - Only as an alternative to institutionalization (i.e., inpatient treatment in a hospital, skilled nursing or rehabilitation center) for acute illness or injury.
  - At the end of each 60 days of treatment, the need for continued therapy is re-evaluated. Additional periods of therapy are covered only if the risk of hospitalization or institutionalization exists.

Extended care services:

- Inpatient services in a skilled nursing or rehabilitation facility.
- Limitations
  - Only after an acute illness or injury as an alternative to continued hospitalization.
  - Maximum of 100 days per calendar year.

Ambulance services:

- Ground transportation by ambulance; air transportation by an aircraft equipped for transporting an injured or sick individual.

- Limitations
  - Ambulance service is covered only in cases in which the use of an ambulance is indicated by the individual's condition.
  - Air transport covered only in cases in which other means of transportation are contra-indicated by the patient's condition.

Outpatient laboratory and diagnostic services:

- Prescribed laboratory and radiology services, including diagnostic services provided to individuals who are not inpatients of a hospital, hospice or extended care facility.

Outpatient prescription drugs and biologicals:

- FDA approved
- Drugs, biological products, and insulin.
- Limitation:
  - Must be prescribed for use in an outpatient setting.
  - No frequency or quantity limitations other than reasonable rules for amount to be dispensed and number of refills. Health plans are permitted to establish formularies, drug utilization review, generic substitution, and mail order programs.

Outpatient rehabilitation services:

- Outpatient occupational therapy, outpatient physical therapy, and outpatient speech-pathology services for the purpose of attaining or restoring speech.

- Limitations

  - Coverage only for therapies used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an acute illness or injury.

  - At the end of each 60 days of treatment, the need for continued therapy is re-evaluated. Additional periods of therapy are covered only if function is improving.

Durable medical equipment, prosthetic and orthotic devices:

- Covered services:

  - Durable medical equipment

  - Prosthetic devices (other than dental) which replace all or part of an internal body organ

  - Leg, arm, back and neck braces

  - Artificial legs, arms and eyes (including replacements if required due to a change in physical condition)

  - Training for use of above items.

- Limitations

  - Items must improve functional abilities or prevent further deterioration in function.

  - Does not include custom devices.

Vision ~~and hearing~~ care:

- Covered services:
  - Routine eye exams, including procedures performed to determine the refractive state of the eyes
  - Diagnosis and treatments for defects in vision
  - ~~Routine ear examinations~~ (note hearing screening part of preventive package, routine otoscope part of physicals)
- Limitations
  - Eyeglasses and contact lenses limited to children under the age of 18.
  - Routine eye examinations limited to one every 2 years for persons 18 years of age or more.

Dental Services

~~Preventive dental services for children~~:

- For children under age eighteen, treatment for prevention of dental disease and injury, including maintenance of dental health. ~~and emergency dental treatment for injury.~~
- Emergency dental treatment for injury for children and adults.

Health education classes:

Participating health plans are permitted to cover health education or training for patients that encourage the reduction of behavioral risk factors and promote healthy activities. Such courses may include smoking cessation, nutritional counseling, stress management, skin cancer prevention, and physical training classes. Cost sharing is determined by the plan.

MENTAL HEALTH AND SUBSTANCE ABUSE

Mental health and substance abuse services form an integral component of a national system of health care. Scientific evidence and societal attitudes have coalesced to support a benefit structure that represents a significant departure from past approaches.

A comprehensive array of services, along with the flexibility to provide such services based on individual medical and psychological necessity through effective management techniques, produces better outcomes and better cost controls than traditional benefits. By the year ~~2001~~ 2000, a comprehensive, integrated benefit structure with appropriate management replaces prescribed limits on individual services.

That change of direction requires a phase-in period to allow health plans time to develop the service system capacity to deliver and manage a more comprehensive mental health and substance abuse benefit. The phase-in allows states, health alliances, and health plans sufficient time to develop appropriate quality assurance programs essential to a managed comprehensive benefit.

It also provides incentives for states to implement a fully comprehensive, integrated system by combining state and local funds now supporting the separate public system with health care reform to reduce duplication and inefficiency, assure cost savings and maximize resources. During the phase-in of the more comprehensive mental health and substance abuse benefit, the federal government supports state demonstrations to prove the efficacy of a comprehensive, integrated system of care with improved benefits.

By the year ~~2001~~ 2000, all states are required to submit to the National Health Board a plan detailing steps it is undertaking to move from the traditional two-tier structure for separate public and private mental health and substance abuse services and develop an integrated, comprehensive managed system of care.

DEFINITION OF BENEFIT

Inpatient and residential treatment:

- Inpatient hospital, psychiatric units of general hospitals, therapeutic family or group homes or other types of residential treatment centers, community residential treatment and recovery centers for substance abuse, residential detoxification services, crisis residential services, and other residential treatment services.

- Limitations

  - By the year ~~2001~~ 2000, management of benefit determines lengths of stay.

    Initially, a maximum of 30 days per episode of inpatient or residential treatment, with 60 days annually for all settings in this category. Health plans upon special appeal may grant an exception waiver of the episode maximum (but only up to the annual limit) for the limited number of individuals for whom hospitalization or continued residential care is medically necessary because the patient continues to make or is at serious risk of making an attempt to harm him- or herself.

    By the year 1998, the annual maximum rises to 90 days.

  - Inpatient hospital substance abuse treatment covers only medical detoxification as required for the management of psychiatric or medical complications associated with withdrawal from alcohol or drugs.

  - Inpatient hospital care for mental and substance abuse disorders is available only when less restrictive nonresidential or residential services are ineffective or inappropriate.

  - Definitions:

    - A hospital is an institution meeting the requirements of §1861(e) or (f) of the Social Security Act.

note the issue of the 1998 package still being considered

- A residential treatment facility is one which meets criteria for licensure or certification established by the state in which it is located.

- **Eligibility**

Individuals are eligible for mental health and substance abuse services as medically necessary or appropriate within the limitations specified.

Individuals are eligible for mental health and substance abuse services other than screening and assessment and crisis services if they have, or have had in the past year, a diagnosable mental or substance abuse disorder, which meets diagnostic criteria specified within DSM-III-R, and that resulted in or poses a significant risk for functional impairment in family, work, school, or community activities.

For mental health and substance abuse this means that

  - **These disorders include any mental disorder listed in DSM-III-R or their ICD-9-CM equivalents, or subsequent revisions, with the exception of DSM-III-R "V" codes (conditions not attributable to a mental disorder) unless they co-occur with another diagnosable disorder.**

  - **Persons who are receiving treatment but without such treatment would meet functional impairment criteria are considered to have a disorder.**

Family members of an eligible participant receiving mental or substance abuse services may receive medically necessary or appropriately related services in conjunction with the patient (so-called collateral treatment).

Professional and outpatient treatment services: crisis services, somatic treatment services,

- Professional services, diagnosis, medical management, substance abuse counseling and relapse prevention, outpatient psychotherapy.

Space

- Limitations

2000 the higher

  - By the year ~~2001~~, limits on outpatient treatment and cost sharing are eliminated, making this benefit comparable to other health services; management of the benefit determines availability of services.
  Initially, a limit of 30 visits per year for outpatient psychotherapy visits ~~(and variation in cost-sharing described later)~~. Medical management, crisis management, evaluation and assessment, and substance abuse counseling are not limited. somatic treatment

The visit limit relative to 1998 is being examined.

there is not currently provision for variable cost-sharing.

CLIA

The CLIA discussion on pages 107-109 contains policies which are politically controversial and may detract from overall support for the health plan. These controversial proposals would entirely exempt an additional 79,000 laboratories from registration fees, modify and reduce laboratory personnel standards, and would require the conduct of targeted but announced inspections.

HHS recommends that these details be removed from the plan while the Secretary negotiates with key Congressional Committees changes to CLIA which both the White House and the Department support.

p.108 Delete 2nd sentence under first dot point ("It is HHS's position that no labs should be exempt from registration and payment of fees").

p.108 First dot point, 5th line, add after tests, "when those tests meet CLIA approved criteria for waived testing."

p.108 3rd dot point, under "Revise personnel standards to provide needed rehab in urban and rural areas," insert the words, "the Secretary shall publish regulations that would allow" after "CLIA," and before "all individuals who are currently engaged..."

p.108 Change will to may in last sentence

p.109 Second bullet, the statement on streamlining inspections implies that only high-volume, high-risk labs would be surveyed. This is incorrect. A better statement would be, "DHHS will target high-volume and high-risk laboratories for inspection first, followed by the inspection of other laboratories that perform fewer, less risky tests. Laboratories about which complaints are received will be inspected immediately, and laboratories with poor performance histories will be targeted for inspections more frequently, and those with sustained good performance will be inspected less frequently."

UNIFORM DRUG REBATE POLICY

As currently drafted, the Medicare drug benefit section sets a separate and different drug rebate policy for Medicare than for other government drug purchase programs. The plan proposes that Medicare obtain a discount on name-brand drugs, only. Because

Medicare is so large a proportion of the market, it may well be appropriate to propose a similar discount should be applied to generics.

HHS recommends that a single government-wide approach be developed for drug rebates and discounting in federal programs. This will both consolidate government buying power and remove the need for a series of separate negotiations with the drug industry over drug pricing.

RESEARCH COORDINATION

Page 143 of the plan calls for the coordination of health services research between the Agency for Health Care Policy and Research in the Public Health Service and the Office of Research and Demonstrations in the Health Care Financing Administration but ignores the role of the Office of the Assistant Secretary for Planning and Evaluation. ASPE also conducts research relevant to the plan -- especially on the impact of plan implementation -- and is responsible within HHS for coordinating research activities of other offices to assure Administration research priorities are met. ASPE's research and coordinating role should be mentioned in this paragraph.

RESPONSIBILITY FOR AUDITING ALLIANCES

On page 64, the plan states that the Department of Labor oversees the financial operations of the Alliances and audits their financial and management systems. On page 237, however, it states that the Department of Health and Human Services verifies and audits financial statements of Alliances related to federal subsidies. The role of each Department vis-a-vis the finances of the Alliances needs to be clarified to avoid duplicative reviews. Our Office of the Inspector General is examining how best to establish Alliance financial procedures which will maximize the integrity of funds.

CONSUMER SATISFACTION SURVEYS

On page 105, the plan states that the National Quality Management Program conducts surveys related to consumer satisfaction, access to health care and health outcomes. On page 116, the plan states that consumer surveys of satisfaction are conducted on a plan-by-plan and state-by-state basis. Responsibility for consumer satisfaction surveys needs to be clarified. HHS believes that the National Quality Management Program needs to be able to

directly survey consumer satisfaction with plans in addition to any satisfaction data states or plans themselves collect. Questions of uniformity, comparability, quality and objectivity of consumer satisfaction data across plans, Alliances and states will arise if these surveys are not conducted by a disinterested federal entity.

WORKFORCE

The plan states (page 128) that funds for supporting residency training will be pooled from two sources: Medicare and all other payers. The formula described for determining the Medicare contribution to the pool is inconsistent with the available amount of money.

- Medicare contributions to the pool in its initial year will be what Medicare would otherwise have paid for direct medical education (DME) of physicians. Assuming the initial year of funding from the pool is FY 1977, the Medicare DME funds will be $1.8 billion, or 30 percent of a $6 billion pool. (A Medicare contribution of 38 percent of the pool would equal $2.3 billion, 0.5 billion more than available).

- As the number of residents supported by the pool is reduced, the Medicare contribution will represent a higher proportion of the total, approaching the Medicare percentage of hospital bed days.

- However, as the trend toward less use of hospital care continues and more training of physicians takes place outside of hospitals, using the Medicare share of hospital bed days to apportion DME responsibility will be less relevant. Therefore, no formula for the Medicare contribution should be locked in at this time.

CHANGED WORDING

Delete the first bullet on page 128.

Replace with "Medicare's initial contribution to the fund will be the amount it otherwise would have spent on Direct Medical Education (estimated at $1.8 billion in FY 1997)."

HEALTH PLAN ENROLLMENT

Health plans can enroll Corporate Alliance members even if they do not enroll Regional Alliance members. The plan should contain

a requirement that if a health plan is admitting new members, it must be open on a first come-first served basis to both Regional and Corporate Alliance members.

MEDICARE COST SAVINGS

Several of the proposals are mischaracterized on pp 198-199. The complete listing should read as follows:

- Reduce the hospital market basket index (HMBI) update by a further 0.5% in FY 1997 and 1% in FY 1998-2000.
- Reduce the indirect medical education (IME) adjustment.
- Reduce payments for hospital inpatient capital.
- Phase down and eliminate the disproportionate share hospital (DSH) adjustment by 1998, to reduce payments for uncompensated care.
- Pay for long-term care hospitals at the SNF rate.
- Expand centers of excellence to additional geographic areas and procedures.
- Phase down home health cost limits to 100% of the median by July 1, 1999.
- In the calculation of the physician expenditure targets, replace the volume and intensity factor as well as the performance standard factor with the real per capita GDP. Eliminate the 5 percent point floor on maximum reductions in updates.
- Establish cumulative expenditure growth targets for physician expenditures, i.e., tied to the FY 1994 baseline.
- Reduce the Medicare fee schedule conversion factor by 3% in 1996, with primary care services exempt.
- Establish prospective payment system for hospital outpatient radiology, surgery, and diagnostic services.
- Contract competitively for Part B laboratory services, except in rural areas.
- Competitively bid other selected Medicare Part B services.
- Extend the Medicare secondary payor (MSP) data match with SSA and IRS.

- o Extend MSP provisions for the disabled.
- o Extend MSP provisions for ESRD patients.
- o Improve HMO payment.
- o Increase Part B premiums for individuals with incomes above $100,000 and for couples with incomes above $125,000.
- o Require copayments for home health visits, equal to 10% of the average home health cost per visit, for all visits except those within 30 days of an inpatient hospital discharge.
- o Reimpose a 20% coinsurance for laboratory services.
- o Phase down the coinsurance paid by beneficiaries in hospital outpatient departments to 20% of the prospective rate for ambulatory surgery, radiology, and diagnostic services.
- o Subject all state and local employees to hospital insurance tax.
- o Set the Part B premium into law and beginning in 1999 set it to reflect the increase in per capita program costs.

QUALITY DATA FOR INITIAL ENROLLMENT PERIOD

In order to provide consumers with comparative information on health plan quality to use during their initial enrollment period, the reform document should require potential applicants for certification as health plans to report information on which to base quality and performance measures for 1994 and 1995. This information would include:

- Enrollment files, in order to provide the federal government with a sampling frame for plan-specific consumer satisfaction surveys, and
- Simple-to-calculate measures (e.g., annual mammography rates; primary care physicians per enrollee).

Chapters 7 and 8 require Alliances to provide their members with an annual Quality Performance Report on health plans. However, the implementation schedule would not allow enough time to generate these measures prior to the initial enrollment period unless the above steps were put in place for the transition.

We believe that it is critical for consumers to have this information during their first enrollment period, because many,

in order to preserve continuity of care, will not wish to change plans during subsequent years. Availability of information is key to reducing consumers' anxiety that they are being forced to make important choices blind.

DUE PROCESS REQUIREMENTS

Mechanisms and procedures for enforcing the provisions of the American Health Security Act, and related due process rights, should be spelled out in the Act. Otherwise, and enforcement actions taken will be tied up in court. We are concerned because these issues do not appear to be addressed in the plan document. Specific examples:

- The National Health Board should be provided with options and enforcement procedures, in addition to those listed in chapter 5, for interventions to provide states with incentive to properly implement the Act and their state plans. These should include positive interventions, such as provision of special technical assistance or additional administrative funds.

- The Act should specify enforcement and appeal mechanisms for plans which states find to be out of compliance with conditions of participation or other requirements. In particular, it should specify the appeal rights available to health plans which the state denies initial certification or decertifies, or against which the alliance takes contract action. We recommend <u>not</u> allowing plans to appeal to the National Health Board, because that would (1) weaken the states' authority, (2) require considerable federal resources, and (3) allow plans to continue performing unacceptably.

GOVERNMENT PROGRAMS

As the plan is now written, veterans -- even those with service connected disabilities -- who do not enroll in a VA health plan, will no longer receive any care from the VA for benefits in the comprehensive benefit package. Veterans will no longer have the same choice of where they will receive their care as they do now (many beneficiaries receive certain services under the VA and other services under Medicare or private health plans). Locking VA/DoD beneficiaries out of benefits to which they are entitled is unfair.

HEALTH SECURITY CARD

It is unclear: (a) who issues the health security card (the government--state or federal--Alliance, or plan); (b) the connection between enrollment in a plan, payment of premium, and receipt of a card; and (c) how illegal aliens will be prevented from receiving a card--since all employers will have to make contributions on behalf of all employees.

We believe that an inter-Departmental group needs to examine these issues so that we can explain to people in simple terms how we will guarantee that they have coverage. The group also needs to explore ways to carry out Alliance administrative functions to minimize overhead.

TAB D

HHS TECHNICAL COMMENTS ON 9/07/93 DRAFT

P.4 Add two bullets at the end of the page:

- No one is accountable for the performance of the health care system -- not hospitals, physicians, other providers or care, or health insurance plans.

- There is poor integration of population-based services and the personal care delivery system, with the result that many serious health problems -- childhood lead poisoning, drug-resistant tuberculosis, immunization of children -- are handled inefficiently or, in some cases, not at all.

P.5 Add a new heading before "CREATING SECURITY"

IMPROVING HEALTH

The American Health Security Act will improve the health of Americans and reduce disparities in health status across different sectors of the population.

- Universal insurance coverage and programs designed to remove nonfinancial barriers to care will ensure that all Americans have access to comprehensive medical services.

- A new and more effective public health system will work in concert with alliances and plans to improve and protect the health of their populations.

p.6 Health costs are to grow no more than GDP here, but elsewhere in the budget section, health costs grow by CPI. HHS prefers GDP as the inflator because it measures overall growth in the economy as opposed to CPI which measures inflation.

P.8 Change the second bullet in "Enhancing Quality" to:

- The American Health Security Act will strengthen the ability of local public health agencies to protect Americans against preventable diseases, to educate them about risks to their health, and to protect their environments against health-threatening exposures.

P.8 Change the "Expanding Access To Care" section to reflect the policy in the plan:

The American Health Security Act will remove nonfinancial barriers to care, ensuring that all Americans have access to the services to which they are entitled, no matter who they are or where they live.

- Health alliances will ensure that all Americans are enrolled in plans providing the full range of services in the comprehensive benefits package.

- The National Health Service Corps will be expanded to reduce the shortage of primary care practitioners in medically underserved areas.

- National grant and loan programs will support the development of practice networks and community-based health plans in rural and urban underserved areas, assuring all Americans an adequate choice of providers and plans.

- Outreach and enabling services assuring access to covered services will be supported through current programs (such as community and migrant health centers) and new grants to States.

- Support for the special needs of school-aged youth in high-risk settings will be supported through comprehensive health education programs and the provision of physical, mental health, and social services in school-based clinics.

- National grant programs will help all public health providers currently funded under Federal programs become fully integrated in the new system.

p.24 Extended care services. Question: Are IMD exclusions overturned?

p.25 Third bullet, must both parties agree for an award to be made in periodic payments, or, is this a decision to be made by the court?

p.28 2nd to last and last paragraphs and p.32-2nd paragraph--no statement of when all states will be integrated. Is that intentional? What happens if a state doesn't submit a plan by 2001? Any penalty? Does the plan have to indicate a "date certain"?

p.77 Essential community providers are to be paid at Medicare rates for community health centers. This should be modified to be consistent with the description of such providers on p. 184, where they include health professionals and institutions operating in underserved

areas. Presumably the latter definition would include hospitals, nursing homes, physicians and others.

p.85 Third bullet, change "expand" to "develop."

Fifth bullet, replace with: "Supplemental services in rural areas."

Public Health System is not an accurate title for the paragraph which follows. Suggest it be retitled, "Supplemental Services."

p.87 Second bullet Current statute provides for a payment equal to 39 percent of the total amount of loan repayments made for the taxable year involved to allow for the tax consequences of loan repayment. This bullet would appear to be a substitute for current law. If that is the case, it should so note and the provision should apply to both urban and rural National Health Service Corps members.

p.105 The second bullet on page 105 should be revised to read: "Develops practice guidelines and technology assessments..."

p.106 The first bullet on page 106 should be revised to read: "Develops methodology standards for practice guidelines and technology assessments..."

p.107 VI. Unrealistic Deadline. Page 107 states that standards for health care institutions will have been pilot-tested and revised by 1/1/96. That deadline does not provide enough time for the pilot test. 1/1/97 would be more realistic.

p.112 V. Information Systems. The last bullet on page 112 should be changed to read, "This information system may be plan or community-based, or shared among several plans."

p.113-114 Development and adoption of computerized patient records systems is, in the long term, extremely important to improving the quality of health care. However, the wording of the second-to-last bullet on page 113, along with the failure to use the term "computerized patient records," under the Point-of-Service Information System section on page 114, could lead to confusion about the Administration's support for development of such systems. We suggest changing the second-to-last bullet on page 113 to read:

Development of full-scale computerized patient record

systems, while an important long-term goal (see next page), is not included in this information systems requirement. This requirement calls for using today's technology to provide information to providers.

p.114-115 The Information Systems section (page 114-115) contains provisions concerning a privacy protection framework that have since been subsumed in a section on privacy protection. In some instances, the two frameworks conflict. The differences should be reconciled.

p.115 VIII. Data network. The network should contain both survey results and quality measures. In both cases, the required data does not meet the standard of bullet 4 on page 115 -- that is, it is not a by-product of routine administration and provision of care. This could be solved by changing bullet 4 to read:

p.117 The National Board should not be entering into contracts to streamline the administration of the Medicare program. HHS should be in charge of this.

p.119 VII. Utilization Review Streamlining. The words "as required under health reform" should be stricken from the end of the fourth paragraph on page 119. The document no longer requires streamlining of utilization review other than under the Medicare program.

Required administrative data is entered once and is a by-product of routine administration and provision of care by health plans and alliances. The network also contains data from consumer surveys and quality measure reporting.

p.119 Add physicians to the list of Part B providers for whom extra billing will be eliminated. The section will read, "Medicare eliminates extra billing for Part B providers such as durable medical equipment providers, orthotic and prosthetic suppliers, ambulances, and physicians."

p.120 Who maintains the national enrollment file? It is to be in place by Jan 1 1996. What happens in states that want to come in during 1995?

p.131 Last two bullets, delete. They are not part of the plan previously forwarded by DHHS and not critical to health care reforms.

p.135 Medicare indirect medical education IME payments are calculated using a formula--they do NOT add up the costs of bad debts charity care, etc. The sentence should be revised to say that as universal coverage is phased in, Medicare subsidies, including IME and disproportionate

share (DSH), can be reduced without undue harm to hospitals that care for the poor.

p.166 First bullet, add the phrase "consistent with State law" after the word "process" in the first sentence.

Second bullet: Assuming the results of the alternative resolution process are admissible in court, the requirement for a certificate of merit is not necessary and would add an additional step to the dispute resolution process.

p.167 The scope of the NPDB should be expanded so that similar information not now available on managed care providers, institutions, and plans would also be available to both the public and to alliances.

p.168 First bullet, replace the text with:

Drawing on the experience of States with the use of practice guidelines, the Department of Health and Human Services will develop a medical liability pilot program based on practice guidelines adopted by the National Quality Management Program. The purpose of this pilot program will be to assess the various ways these guidelines can be used to limit the medical malpractice liability of practitioners who adhere to them.

After the first practice guideline is available, the Department of Health and Human Services reports annually to Congress on the results of the pilot program and makes recommendations for change in malpractice law, as appropriate. The Department disseminates the results of the pilot program in usable formats to the States and provides technical assistance to the States as information becomes available.

p.180 First bullet: Eliminate "and individuals who have little education." This point is never taken up again.

Second paragraph: Delete the words "public health" in the second sentence, since both private sector and public providers are part of the current provider network.

p.182 Fourth bullet, first paragraph: Move the parenthetical phrase so that it follows the heading. Delete the word "continue" at the end of the paragraph.

p.183 First bullet, first paragraph: This paragraph should be reworked as follows:

A new federal authority supports capacity expansion

through grants and loans, with the purpose of increasing the number of providers and health plans in underserved areas, supporting the development of networks of care providers and facilitating the integration of federally funded providers into the new system.

p.185 Third paragraph: Delete the word "automatically." While school-based clinics are eligible for consideration as EPs, they would be subject to the same designation process as other types of EP.

p.186 1st paragraph, last sentence--"Funds will shift from..."

p.186 2nd paragraph under first bullet - should say:

"...Mental health Statistical Improvement Program", not MH Systems Improvement

p.186 Same paragraph--what is the "State Systems Development Program"?

p.210 The provision which allows the postal service to be a Corporate Alliance should be cross-referenced in the FEHBP section.

WORKING GROUP DRAFT

- **Adolescent and School-Aged Youth Initiative** supports the delivery of clinical services through school-based or school-linked sites (consistent with goals of health reform and Goals 2000) and comprehensive health education in high-risk schools.

  Dedicated funds in the capacity expansion program (see above) support school-based clinics targeted at middle schools and high schools. Clinics provide physical and mental health services and counseling in disease prevention and health promotion as well as in individualized risk behavior reduction.

  School-based clinics established under the program are ~~automatically~~ designated as essential community providers.

  Authorized as a formula grant to states ~~funded jointly by the Department of Health and Human Services and the Department of Education,~~ health education focuses on the reduction of risk behaviors among ~~adolescents and adults. The curriculum is~~ linked to *Healthy People 2000* objectives and will target those areas of health risk where research suggests that health education can reduce risk-taking behavior and improve health outcomes.

  Grantees have flexibility in determining ~~what services~~ and what service delivery mechanisms are most appropriate for their community.

MENTAL HEALTH AND SUBSTANCE ABUSE

Mental health and substance abuse services form an integral component of a national system of health care. Scientific evidence and societal attitudes have coalesced to support a benefit structure that represents a significant departure from past approaches.

A comprehensive array of services, along with the flexibility to provide such services based on individual medical and psychological necessity through effective management techniques, produces better outcomes and better cost controls than traditional benefits. By the year 2001, a comprehensive, integrated benefit structure with appropriate management replaces prescribed limits on individual services.

That change of direction requires a phase-in period to allow health plans time to develop the service system capacity to deliver and manage a more comprehensive mental health and substance abuse benefit. The phase-in allows states, health alliances, and health plans sufficient time to develop appropriate quality assurance programs essential to a managed comprehensive benefit.

It also provides incentives for states to implement a fully comprehensive, integrated system by combining state and local funds now supporting the separate public system with health care reform to reduce duplication and inefficiency, assure cost savings and maximize resources. During the phase-in of the more comprehensive mental health and substance abuse benefit, the federal government supports state demonstrations to prove the efficacy of a comprehensive, integrated system of care with improved benefits.

By the year 2001, all states are required to submit to the National Health Board a plan detailing steps it is undertaking to move from the traditional two-tier structure for separate public and private mental health and substance abuse services and develop an integrated, comprehensive managed system of care. which would be ~~replaced~~ implemented during that year,

Bernie Horn
301-443-0001

DEFINITION OF BENEFIT

Inpatient and residential treatment:

- Inpatient hospital, psychiatric units of general hospitals, therapeutic family or group homes or other types of residential treatment centers, community residential treatment and recovery centers for substance abuse, residential detoxification services, crisis residential services, and other residential treatment services.

- Limitations

  - By the year 2001, management of benefit determines lengths of stay.

    Initially, a maximum of 30 days per episode of inpatient or residential treatment, with 60 days annually for all settings in this category. Health plans upon special appeal may grant an exception waiver of the episode maximum (but only up to the annual limit) for the limited number of individuals for whom hospitalization or continued residential care is medically necessary because the patient continues to make or is at serious risk of making an attempt to harm him- or herself.

    By the year 1998, the annual maximum rises to 90 days.

  - Inpatient hospital substance abuse treatment covers only medical detoxification as required for the management of psychiatric or medical complications associated with withdrawal from alcohol or drugs.

  - Inpatient hospital care for mental and substance abuse disorders is available only when less restrictive nonresidential or residential services are ineffective or inappropriate.

- Definitions:

  - A hospital is an institution meeting the requirements of §1861(e) or (f) of the Social Security Act.

- A residential treatment facility is one which meets criteria for licensure or certification established by the state in which it is located.

- Eligibility

Individuals are eligible for mental health and substance abuse services other than screening and assessment and crisis services if they have, or ~~have had in~~ the past year, a diagnosable mental or substance abuse disorder which meets diagnostic criteria specified within DSM-III-R, and that resulted in or poses a significant risk for functional impairment in family, work, school, or community activities.

- These disorders include any mental disorder listed in DSM-III-R or their ICD-9-CM equivalents, or subsequent revisions, with the exception of DSM-III-R "V" codes (conditions not attributable to a mental disorder) unless they co-occur with another diagnosable disorder.

- Persons who are receiving treatment but without such treatment would meet functional impairment criteria are considered to have a disorder.

Family members of an eligible participant receiving mental or substance abuse services may receive medically necessary or appropriately related services in conjunction with the patient (so-called collateral treatment).

Professional and outpatient treatment services:

- Professional services, diagnosis, medical management, substance abuse counseling and relapse prevention, outpatient psychotherapy.
- Limitations

- By the year 2001, limits on outpatient treatment and cost sharing are eliminated, making this benefit comparable to other health services; management of the benefit determines availability of services. Initially, a limit of 30 visits per year for outpatient psychotherapy visits (and variation in cost sharing described later). Medical management, crisis management, evaluation and assessment, and substance abuse counseling are not limited.

- Licensed or certified substance abuse treatment professionals must provide substance abuse and relapse counseling.

- Eligibility criteria specified above for inpatient mental health and substance abuse treatment services apply, except that all persons are eligible for screening and assessment and 24-hour crisis services.

- Definitions for services of physicians and other health professionals apply.

- Coverage for case management with no cost sharing. — Clarify, See language

Intensive non-residential treatment services:

- Partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based services, behavioral aide services.

- Limitations

  - By the year 2001, benefit limits are replaced by management of the comprehensive benefit to determine availability of benefit.

    Initially, a limit of 120 days per year apply.

  - Provided only for the purpose of averting the need for, or as an alternative to, treatment in residential or inpatient settings, or to facilitate the earlier return of individuals receiving inpatient or residential care, or to restore the functioning of individuals with mental or substance abuse disorders, or assist individuals to develop the skills and access the supports needed to achieve their maximum level of functioning within the community.

- Eligibility: As specified for inpatient mental health and substance abuse treatment services.

? Delete ? Nursing

INTEGRATION OF PUBLIC AND PRIVATE MENTAL HEALTH CARE SYSTEMS

Through the end of this decade, the structure of the mental health and substance abuse benefit package requires continuation of the existing public system that provides mental health and substance abuse treatment. It also requires maintenance of the existing block grant program to the states, which supplements spending on mental and addictive disorder programs.

To promote the eventual integration of the public and private systems, states are encouraged to use the flexibility allowed under health reform to fold their expenditures for public mental health and substance abuse programs into funding available to regional health alliances to require integrated care for all health needs, including mental and addictive disorders. States adopting this direction may obtain a waiver from limits in the benefit package and are eligible for federal ~~matching~~ funds through specialinitiative competitive project grants to develop integrated service systems.

EXCLUSIONS

The benefit package does not cover services that are not medically necessary or appropriate, private duty nursing, cosmetic orthodontia and other cosmetic surgery, hearing aids, adult eyeglasses and contact lenses, in vitro fertilization services, sex change surgery and related services, private room accommodations, custodial care, personal comfort services and supplies and investigational treatments, except as described below.

COVERAGE OF INVESTIGATIONAL TREATMENTS

The comprehensive benefit package includes coverage for medically necessary or appropriate medical care provided as part of an investigational treatment during an approved research trial. The intention of this provision is to cover routine medical costs associated with an investigational treatment that would occur even if the investigational treatment were not administered.

- An investigational treatment is a treatment the effectiveness of which has not been determined and which is under clinical investigation as part of an approved research trial.

- An approved research trial is a peer-reviewed and approved research program, as defined by the Secretary of the Department of Health and Human Services, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for that treatment to be medically necessary or appropriate.

  Coverage is automatically available if the research trial is approved by the National Institutes of Health, the FDA, the Department of Veterans Affairs, Department of Defense or a qualified non-governmental research entity as identified in NIH guidelines.

EXPANSION OF OTHER BENEFITS

The initial benefit plan provides comprehensive preventive coverage for all patients and focuses comprehensive dental, mental health and substance abuse coverage on priority concerns including preventive dental services for children and treatment for ~~seriously~~ mentally ill adults, ~~seriously~~ emotionally disturbed children and individuals with substance-abuse disorders.

The National Health Board has discretion to introduce additional benefits earlier if savings from reform and budget resources permit. Additional benefits included in planned expansion include:

Dental Services:

- Preventive dental care extended to adults
- Restorative services
  - Low Cost Sharing -- $20 per visit
  - High Cost Sharing -- 40 percent co-insurance, $50 deductible, and $1500 annual maximum benefit for prevention and restoration

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Mental health and substance abuse initiatives refocus existing formula grants to encourage development of community-based programs by:

- **Restructuring Existing Formula Grants**

  As states implement reform, funding through Community Mental Health and the Substance Abuse Prevention and Treatment Formula Grant is required only for treatment in excess of the comprehensive benefit. Funds shift from support for direct treatment to service system development, supplemental services, and population-based prevention services.

  State Systems Development Program and Mental Health ~~Systems~~ Statistics Improvement Program continue to be funded with the five percent technical assistance set aside from formula grants.

- **Maintenance of Effort**

  States are required to maintain support for mental health and substance abuse treatment activities, although they may obtain a waiver to assist in the development of community-based systems of care to promote the eventual integration of the public and private systems for the treatment of mental and addictive disorders.

- **Special Initiatives**

  Competitive project grants to states support pilot projects related to integrating the private and public mental health and substance abuse systems. Funds support linkage of treatment and prevention for substance abuse with a broad array of health services and systems management for seriously emotionally disturbed children.

- **Research and Demonstration Projects**

  Funds support the development of improved outreach strategies for AIDS and HIV-infected drug abusers, the homeless, individuals involved in the criminal justice system, and populations with co-morbidity, including mechanisms for sharing information about the applicability of promising approaches to prevention within specific populations and service-delivery settings and the effectiveness of prevention and early intervention services in reducing health costs.

  Funds also support development of systems that link substance abuse and mental health treatment with primary care, target rural and remote areas and culturally distinct populations, and facilitate the transfer of knowledge.

- **Training and Staff Development**

  The Department of Health and Human Services expands its curriculum development and health education efforts in clinical prevention within schools of medicine, nursing, and social work as well as its information services for current health professionals and provides primary care professionals with information and training to screen and identify mental health and substance abuse problems and risk factors.

- **Capital Assistance**

  Direct loan and loan-guarantee programs support the development of additional non-acute, residential treatment centers and community-based ambulatory clinics, particularly in medically underserved areas.

AMERICAN INDIANS AND ALASKA NATIVES

Supplemental financing and services provide access to health care for American Indians and Alaskan Natives populations with diverse language and cultural needs, many of whom live in remote and underserved reservation areas. Supplemental services include transportation, outreach and follow-up, community health representatives, public health nurses, non-medical case management, child care during clinic visits, health education, nutrition, home visiting, and supplemental mental health and substance abuse prevention and treatment services.

The Indian Health Service also expands population-based public health and prevention activities. Under new authority, it covers all residents, Indian and non-Indian, living on reservations in addition to populations living near reservations.

Population-based public health and prevention activities include surveillance and monitoring of health status, medical outcomes, threats to public health, public health laboratories, community- based control programs, community health protection and public health information.

HEALTH WORKFORCE

To increase the recruitment, preparation, and retention of American Indians and Alaska Natives into medical, nursing, public health and other health professions, existing programs are expanded.

The Indian Health Scholarship Program and Loan Repayment Program expands to fund all eligible applicants under the current authorities of sections 104 and 108 of P.L. 94-437. Additional financial assistance increases the number of American Indians and Alaska Natives entering training programs under current authorities of sections 103 and 105 of P.L. 94-437.

SANITATION AND ENVIRONMENTAL HEALTH

Additional funding expands construction of water, sewer, and other sanitation and environmental health facilities, as well as provide for training and technical assistance to tribes that wish to operate tribal facilities under P.L. 86-121 and Section 302 of P.L. 94-437.

- Licensed or certified substance abuse treatment ~~professionals~~ providers must provide substance abuse and relapse counseling.

- Eligibility criteria specified above for inpatient mental health and substance abuse treatment services apply, except that all persons are eligible for screening and assessment and 24-hour crisis services.

- Definitions for services of physicians and other health professionals apply.

- Coverage for case management at plan ~~discretion~~ determination for children, adolescents, and adults with serious and complex mental or substance abuse disorders. Combines clinical and coordinating functions. ~~with no cost sharing~~.

Intensive non-residential treatment services:

- Partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based services, behavioral aide services.

- Limitations

  - By the year ~~2001~~ 2000, benefit limits are replaced by management of the comprehensive benefit to determine availability of benefit.

    Initially, a limit of 120 days per year apply.

  - Provided only for the purpose of averting the need for, or as an alternative to, treatment in residential or inpatient settings, or to facilitate the earlier return of individuals receiving inpatient or residential care, or to restore the functioning of individuals with mental or substance abuse disorders, or assist individuals to develop the skills and access the supports needed to achieve their maximum level of functioning within the community.

- Eligibility: As specified for inpatient mental health and substance abuse treatment services.

INTEGRATION OF PUBLIC AND PRIVATE MENTAL HEALTH CARE SYSTEMS

Through the end of this decade, the structure of the mental health and substance abuse benefit package requires continuation of the existing public system that provides mental health and substance abuse treatment. It also requires maintenance of the existing block grant program to the states, which supplements spending on mental and addictive disorder programs.

To promote the eventual integration of the public and private systems, states are encouraged to use the flexibility allowed under health reform to fold their expenditures for public mental health and substance abuse programs into funding available to regional health alliances to require integrated care for all health needs, including mental and addictive disorders. States adopting this direction may obtain a waiver from limits in the benefit package and are eligible for federal ~~matching~~ competitive grant funds to develop integrated service systems.

note ~~pg.~~ pg. 180 book refers to special project grant initiative which is competit not matchir grant

EXCLUSIONS

The benefit package does not cover services that are not medically necessary or appropriate, private duty nursing, cosmetic orthodontia and other cosmetic surgery, hearing aids, adult eyeglasses and contact lenses, in vitro fertilization services, sex change surgery and related services, private room accommodations, custodial care, personal comfort services and supplies and investigational treatments, except as described below.

COVERAGE OF INVESTIGATIONAL TREATMENTS

The comprehensive benefit package includes coverage for medically necessary or appropriate medical care provided as part of an investigational treatment during an approved research trial. The intention of this provision is to cover routine medical costs associated with an investigational treatment that would occur even if the investigational treatment were not administered.

- An investigational treatment is a treatment the effectiveness of which has not been determined and which is under clinical investigation as part of an approved research trial.

- An approved research trial is a peer-reviewed and approved research program, as defined by the Secretary of the Department of Health and Human Services, conducted for the primary purpose of determining whether or not a treatment is safe, efficacious, or having any other characteristic of a treatment which must be demonstrated in order for that treatment to be medically necessary or appropriate.

  Coverage is automatically available if the research trial is approved by the National Institutes of Health, the FDA, the Department of Veterans Affairs, Department of Defense or a qualified non-governmental research entity as identified in NIH guidelines.

Services Targeted To

EXPANSION OF OTHER BENEFITS

The initial benefit plan provides comprehensive preventive coverage for all patients and focuses comprehensive dental, mental health and substance abuse coverage on priority concerns including preventive dental services for children and ~~treatment for~~ seriously mentally ill adults, seriously emotionally disturbed children and individuals with substance-abuse disorders. The plan proposes to phase in additional benefits in the year 2000.

The National Health Board has discretion to introduce additional benefits earlier if savings from reform and budget resources permit. Additional benefits included in planned expansion include:

Dental Services:

- Preventive dental care extended to adults
- Restorative services
  - Low Cost Sharing -- $20 per visit
  - High Cost Sharing -- 40 percent co-insurance, $50 deductible, and $1500 annual maximum benefit for prevention and restoration

~~The~~ Move limits are to be reconsidered

- Orthodontia in cases in which it is necessary to avoid reconstructive surgery
  - Low Cost Sharing -- $20 per visit
  - High Cost Sharing -- 40 percent co-insurance, $50 deductible, ~~and $2,500 lifetime maximum benefit.~~

note limit ~~being~~ reconsidered → reconstructive surgery provision sufficient

Mental Health and Substance Abuse (see previous discussion)

COST SHARING

Consumer out-of-pocket costs for health services in the comprehensive benefit package are limited, to ensure financial protection, and standardized to ensure simplicity in choosing among health plans.

Health plans use standard consumer cost sharing requirements. Health plans may offer consumers one of three cost sharing schedules:

- **Low cost sharing:** $10 co-payments for outpatient services; no co-payments for inpatient services; may offer point of service option with 40 percent coinsurance.
- **Higher cost sharing:** $200 individual/$400 family deductibles; 20 percent coinsurance; $1500/3000 maximum on out-of-pocket spending.
- **Combination:** Plan provides low cost sharing if participants use preferred providers and higher cost sharing (20 percent coinsurance) if they use out-of-network providers.

LOW COST SHARING

	Cost-sharing	Limitations
Overall - Deductible - Coinsurance - Out-of-pocket max Individual Family	 None $10 per visit $1,500 $3,000	
Inpatient Hospital	Full coverage	Private room only when medically necessary
Professional services, outpatient hospital services.	$10 per visit	
Emergency services	$25 per visit	Waived in emergency.
Preventive services, including well-baby, prenatal	Full coverage	Services limited to periodicity in Table 1.
Hospice	Full coverage	As hospital alternative for terminally ill.
Home health care	Full coverage	As inpatient alternative; coverage reassessed at 60 days; added coverage only to prevent institutional care.
Extended care facilities (SNFs, rehab facility)	Full coverage	As hospital alternative; 100 day limit.
Outpatient physical, occupational, speech therapy	$10 per visit	Only to restore function or minimize limitations from illness or injury; reassessment at 60 days; additional coverage only if improving.
DME, outpatient lab, ambulance	Full coverage	

Routine eye and ear exams, eyeglasses	$10 per exam or 1 set glasses	Eyeglasses limited to children only
Dental services -Initial: Prevention	$10 per visit	For <18 only
-Additions in 2001:		Remove age limit on prevention
Restoration	$20 per visit	
Orthodontia	$20 per visit	Only to avoid reconstructive surgery
Prescription drugs	$5/prescription	
Mental health / substance abuse Initial Inpatient services:	Full coverage	30 day/episode; 60 day/year max
Hospital alternatives: ~~Office~~ Outpatient ~~Brief office visits for medical management;~~ except psychotherapy:	Full coverage $10 per visit	120 days maximum no limits
Psychotherapy: Case management	$25 per visit Full Coverage	30 visits maximum no limit ~~plan determination~~
2001 Inpatient services:	Full coverage	
Hospital alternatives:	Full coverage	no limits
Outpatient ~~incl. 1-12 psychotherapy visits:~~ including psychotherapy visits	$10 per visit	

disregard
↓
~~Note Limits on dental being Reconsidered Pathway use included would capping into Cost Sharing as well~~

HIGH COST SHARING

	Cost-sharing	Limitations
Overall - Deductible - Coinsurance - Out-of-pocket max Individual Family	 $200/400 indiv/family 20% $1,500 $3,000	
Inpatient Hospital	20% co-ins	Private room only when medically necessary
Professional services, outpatient hospital services including emergency.	20% co-ins	
Preventive services, including well-baby, prenatal	Co-ins and deductible does not apply	Services limited to periodicity in Table 1.
Hospice	20% co-ins	As hospital alternative for terminally ill.
Home health care	20% co-ins	As inpatient alternative; coverage reassessed at 60 days; added coverage only to prevent institutional care.
Extended care facilities (SNFs, rehab facility)	20% co-ins	As hospital alternative; 100 day limit.
Outpatient physical, occupational, speech therapy	20% co-ins	Only to restore function or minimize limitations from illness or injury; reassessment at 60 days; additional coverage only if improving.
DME, outpatient lab, ambulance	20% co-ins	

Routine eye and ear exams, eyeglasses	20% co-ins	Eyeglasses limited to children only
Dental services -Initial: Prevention	20% co-ins	For <18 only
-Additions in 2001:		Remove age limit on prevention
Restoration	$50 deduc + 40% co-ins	$1500 annual max
Orthodontia	40% co-ins	Only to avoid reconstructive surgery; ~~$2500 lifetime max~~
Prescription drugs	$250/year deduc 20% co-ins oop max applies	

note lifetime limit reconsidered reconstructive surgery requirement sufficient

Mental health / substance abuse		
Initial Inpatient services:	20% co-ins; oop max applies ; 1 day deductible	30 day/episode; 60 day/year max *
Non-residential intensive services:	20% co-ins	120 days maximum
All outpatient except Psychotherapy	20% co-ins	no limits
Psychotherapy: Case Management	50% cost sharing Full Coverage	30 visits maximum no limit
2001 Inpatient services:	20% co-ins; oop max applies	
Non-residential intensive services:	20% co-ins	no limits
Outpatient including psychotherapy visits:	20% co-ins	

* 1 day deductible on inpt. MH should be in on the initial package

COMBINATION COST SHARING

Services (with same limitations as above)	In network	Out of network
Overall - Deductible - Coinsurance - Out-of-pocket max Individual Family	None $10 per visit $1,500 $3,000	$200/400 indiv/family 20% $1,500 $3,000
Inpatient Hospital	Full coverage	20% co-ins
Professional services, outpatient hospital services.	$10 per visit	20% co-ins
Emergency services	$25 per visit	20% co-ins
Preventive services, including well-baby, prenatal	Full coverage	Full coverage
Hospice	Full coverage	20% co-ins
Home health care	Full coverage	20% co-ins
Extended care facilities (SNFs, rehab facility)	Full coverage	20% co-ins
Outpatient physical, occupational, speech therapy	$10 per visit	20% co-ins
DME, outpatient lab, ambulance	Full coverage	20% co-ins
Routine eye and ear exams, eyeglasses	$10 per exam or 1 set glasses	20% co-ins

Dental services -Initial: Prevention -Additions in 2001: Restoration Orthodontia	$10 per visit $20 per visit $20 per visit	20% co-ins $50 deduc + 40% co-ins 40% co-ins
Prescription drugs	$5/prescription	$250/year deduc 20% co-ins oop max applies
Mental health / substance abuse Initial Inpatient services: Hospital alternatives: All outpatient except psychotherapy Psychotherapy Case management 2001: Inpatient services: Non-residential intensive services: Outpatient including psychotherapy	Full coverage Full coverage $10 per visit $25 per visit Full coverage Full coverage Full coverage $10 per visit	20% co-ins; oop max applies; 1 day deductible 20% co-ins 20% co-ins 50% co-ins Full coverage 20% co-ins; oop max applies 20% co-ins 20% co-ins

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

September 23, 1993

THE DIRECTOR

MEMORANDUM FOR THE FIRST LADY

FROM: Leon Panetta and Alice Rivlin

SUBJECT: Comments on the 9/7/93 Draft of Health Care Reform Plan

We have attached OMB's comments on the 9/7/93 draft of the Health Care Reform Plan. As you will recall, we transmitted comments on the 8/6/93 draft in our memorandum dated September 10, 1993. We are working with Ira to resolve the outstanding questions about the plan in order to begin the process of scrubbing the numbers. Please let us know if you have any questions about our comments or this process.

cc: Ira Magaziner

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

September 23, 1993

THE DIRECTOR

MEMORANDUM FOR IRA MAGAZINER

FROM: Leon Panetta and Alice Rivlin

SUBJECT: Comments on the 9/7/93 Draft of Health Care Reform Plan

Thank you for the opportunity to review the revised draft Health Care Reform Plan dated 9/7/93. We look forward to continuing to work with you and your staff over these next few critical weeks as details are finalized.

We are attaching a number of detailed comments and questions, organized by chapter. We have classified comments into 2 types: (1) those that might affect budget estimates, and (2) needed policy clarifications. The greatest number of our comments pertain to three chapters -- "Long-Term Care", "Medicaid", and "Financing Health Coverage".

The 9/7/93 draft contains a number of chapters that remain the same or substantially similar to the 8/6/93 draft. We request that you still review carefully our previous comments on those chapters, which were attached to our memo to you dated September 10, 1993.

A particular continuing concern is the proposed "independent agency" status for the National Health Board. Given the wide-ranging powers of the Board and the President's accountability for the success or failure of its endeavors, we believe the Board should be accountable to the President. To accomplish this, the provision for removal of Board members only for cause should be changed to permit removal at the pleasure of the President. Removal for cause is the key determinant of "independent" status. More generally, the Board should be referred to as an agency in the Executive Branch, not as an independent agency. Further, we continue to believe that an agency with such broad powers should not be exempt from White House regulatory review.

Attachment

Comments by Chapter -- 9/7 Draft Plan

Chapter 3: Coverage

This chapter has not changed substantially since last review; previous OMB comments still apply.

Additional Comments

1) Budget Issues

None.

2) Policy Issues or Clarifications

- Page 13, under "Sources of Health Care Coverage", individuals who are eligible for Medicaid long-term care services should be mentioned. The document does not state whether these individuals will receive their acute care services through the health alliance, as well as continue to have Medicaid pay for their long-term care.

- Page 14, the mention of the health security card here and on page 111 imply that the card will be required for access. All discussions of the card were with the understanding that it can facilitate and expedite access, but could not be a barrier to access. Individuals will lose cards, some will not be competent to necessarily have possession of a card and will not have a guardian for ensuring its availability. The language in both sections should be revised to use the term facilitate.

- The explicit proposal for health insurance for the unemployed who have lost their jobs appears to have been dropped from the 8/6 draft. The health coverage available to unemployed workers in this draft, however, is not clear.

  - Page 15 states that no health plan may cancel an enrollment until the individual enrolls in another plan;

  - Page 74 states that health plans may not terminate, restrict, or limit coverage for the comprehensive benefit package for any reason, including non-payment of premiums. They may not cancel coverage for any individual until that individual is enrolled in another

health plan.

- Page 68 states that if a corporate alliance fails to make premium payments to a health plan, the plan may terminate coverage after reasonable notice. If coverage is terminated, the corporate alliance is responsible for providing coverage to individuals previously insured under the contract.

It appears the intent is to make large employers in corporate alliances pay for the costs of their unemployed workers. Based on the statements above, this coverage could even go beyond six months if the terminated worker remains unemployed.

- Page 15, under "Employer Obligation", COBRA requirements are not mentioned. Whether to eliminate COBRA requirements in favor of another requirement is a policy-level decision, but COBRA should be addressed.

- Employers "may be required" to provide six months coverage of terminated employees or pay 1 percent of payroll to cover unemployed workers:

  - Who makes the decision concerning "requirement" -- the State? the National Health Board? the Alliance? This should be clearly stated. Otherwise, COBRA requirements should continue to apply.

  - Note also that "terminated" employees are a broader group than laid-off workers.

  - Will the 1 percent of payroll only cover the costs of unemployed workers laid off by that employer? If the 1 percent of payroll is not enough, who pays?

  - Must the terminated employee pay his share of the health insurance costs to maintain the corporate contribution?

  - Is there a comparable requirement for smaller employers or those large (over 5000 employee) employers who enter regional alliances to provide health insurance to terminated employees? If not, who covers the health insurance costs of their laid-off employees?

- Page 16, self-employed and unemployed individuals are responsible for paying the family share of the premium as well as the employer share, unless they are eligible for

assistance based on income.

- What happens to unemployed individuals if they cannot pay (or do not choose to pay) for health insurance? Does the individual remain responsible for paying the premium, and how is this enforced?

  For example, an unemployed worker may not qualify for a subsidy based on income from a second earner but still have high recurring liabilities (e.g., a mortgage). Given the average weekly benefit for unemployment insurance of $170, if a health plan costs $4,000 a year, the weekly cost of health insurance amounts to 45 percent of the weekly unemployment benefit.

- Page 16, enforcement of employer responsibility to contribute to employees health coverage should be shifted from the Secretary of Labor to the States. States already run their own unemployment insurance systems, and have been delegated most other enforcement responsibilities under the plan.

- Page 17, for part-time workers, employers will be required to make pro-rated contributions. Students, on the other hand, will be covered by their parents' policies or through the regional alliance of their school. The primary payor for students who work part-time is not identified; it should be the parents' policies, rather than the employers' policies.

- Page 17 (and p. 236), issues related to higher student premiums and dismantling of student health plans continue to be of concern. The expanded comments specify that the student is covered under his or her family's policy. A portion of the premium paid by the employer and the family would be transferred to the regional health alliance where the student attends school. If the student is not a dependent, he or she would enroll directly in the regional health alliance, and presumably would be responsible for the premium, subsidized depending on the level of income.

  These revisions, while providing increased detail relative to the 8/6 draft, fail to address previous comments about how student health services would fit into the new system, and whether they would have to accept all applicants, including non-students, and raise premiums as a result. In addition, questions remain about how much of the premium would be transferred from the family policy to the regional health alliance, and how this would be determined.

Chapter 4: Guaranteed National Benefit Package

This chapter has not changed substantially since last review; previous OMB comments still apply.

Additional Comments

1) Budget Issues

- Home health and extended care benefits for the under-65 population should be brought into line with the Medicare population by requiring a $5 copayment per visit for home health and $10 per day of extended care for low cost-sharing plans. The amounts should retain the same ratios to the copayment amount for physician visits. The high cost-sharing plans, as currently constructed, will require 20% coinsurance on these benefits. Under the plan, Medicare will also require cost-sharing on both benefits after a period of free care.

2) Policy Issues or Clarifications

- Page 22, the table has asterisks that do not line up with definitions below. For example, "***" is placed after "7 clinician visits" for children age 0-2, yet the definition of "***" provided below the table says it stands for "once three annual negative smears have been obtained."

- Page 26, should a physician be required to reevaluate the need for continued outpatient rehabilitation therapy and home health care? While this could be considered too regulatory, it could discourage excessive utilization.

- Page 33, change the "Expansion of Benefits" section to read, "Additional benefits that could be included in possible future expansions include...".

- Page 33, coverage of investigational treatments should be limited to those trials bearing approval from one of the agencies enumerated, or that meet the cited NIH guidelines. Health plans should not be required to cover any other investigational treatments that have not met Federal standards.

- Page 35, remove the requirement that low cost-sharing plans have an out-of-pocket maximum. It is unlikely that the

maximums will be reached. An individual or family that does reach the maximum is likely overutilizing the health care system and a cap on out-of-pocket costs for low cost-sharing plans does nothing to discourage such usage.

Chapter 5: National Health Board

This chapter has not changed substantially since last review; previous OMB comments still apply.

Additional Comments

1) Budget Issues

- Page 47, last paragraph, the discussion of a premium surcharge on all employers does not clearly state that this is the default requirement if states do not establish their own programs.

2) Policy Issues or Clarifications

- Page 43, the NHB breakthrough drug committee seems to create disincentives for drug development in the very area where this should not take place, i.e., when there are significant treatment advances. Congress may already have created enough of a chilling effect with its intensive scrutiny of major breakthrough drugs such as AZT, the new cystic fibrosis drug and the new treatment for multiple sclerosis. The rationale against cost containment is that there will be significant market forces at work under the health care reform system to make such controls unnecessary and overly burdensome. To put in place potential price restrictions in the very areas we want to encourage drug development is counter intuitive. The notion that the committee could judge from other "therapeutically similar" drugs here and in other countries misunderstands breakthrough drugs, and fails to acknowledge price controls in other countries.

Chapter 6: State Responsibilities

This chapter has not changed substantially since last review; previous OMB comments still apply.

Additional Comments

1) Budget Issues

None.

2) Policy Issues or Clarifications

- Page 52, last paragraph, refers to an agency that assumes control if a plan fails. Is this the same as the guaranty fund?

Chapter 7: Regional Health Alliances

Previous OMB comments still apply. This chapter contains a few revisions: i) paragraph added on oversight of health alliances through the Department of Labor; ii) reference to HHS responsibility to establish model fee schedule for all services is eliminated; iii) pages on the operation of alliances have been moved from the chapter on State Responsibilities to this chapter.

Additional Comments

1) Budget Issues

None.

2) Policy Issues or Clarifications

- Department of Labor oversight: A paragraph on "Enforcement" has been added that designates the Department of Labor to oversee the financial operations of the health alliances, including auditing of financial and management systems. Elsewhere, in the chapter on Health Plans, the Department of Labor also is designated with new responsibilities on developing grievance procedures.

  In both cases, the National Health Board should be given primary responsibility, with the authority to designate agency responsibilities as it determines to be appropriate. This provides flexibility, along the lines of the NPR Reinventing Government approach, to designate whomever can best perform the job, rather than following pre-set, legislative or regulatory mandates. If any such function is assigned to the Department of Labor independent of National Health Board action, it should be limited to the corporate alliances.

Chapter 8: Corporate Alliances/ERISA

This chapter has not changed substantially since last review; previous OMB comments still apply.

Chapter 9: Health Plans

Previous OMB comments still apply. Paragraphs have been added on grievance procedures, provider participation in plans, and loans to community-based health plans.

Additional Comments

1) Budget Issues and Clarification

- Page 76, under the section "Health Plan Arrangements with Providers," health plans also should be authorized to competitively bid out for services such as durable medical equipment, pharmaceuticals, and other health care products.

- Pages 80-82, supplemental insurance coverage continues to promise excess and unnecessary utilization. Requiring high cost-sharing plans to offer coverage of cost-sharing liabilities will not help control costs and only encourage the opposite result. The requirement that high cost-sharing health plans offer wrap-around coverage of cost-sharing should be made optional.

  An alternative would be to ban the coverage of cost-sharing altogether and allow supplemental policies to offer only additional benefits.

- Cost of Loans to Community-Based Health Plans: a new section has been added that requires HHS to establish a loan program to assist with the development of community-based health plans. The program "may provide direct loans to health plans or guarantee loans made by private financial institutions."

  The potential for abuse and actual experience with existing Federal loan programs suggests that considerably more analysis and definition is needed regarding the goals and implementation of this program. This description provides no sense of how large the program may be, how much it would cost, what criteria one uses to judge what constitutes a community-based health plan, or what criteria should be used to determine who should receive the loans.

  A preferred alternative is to delete this section altogether. The private market has already anticipated a network-based health care system: providers and insurers are already creating networks in anticipation of health care reform. Government-backed loans will only distort the incentives that exist and result in the creation of health plans that would not otherwise exist.

2) Policy Issues and Clarification

- Grievance Procedure: as noted in comments on the chapter on Regional Health Alliances, the revised plan designates the Department of Labor for new responsibilities -- in this case, for the establishment and monitoring of grievance procedures, including alternative dispute resolution procedures. The Department of Labor may indeed be in the best position to monitor such practices, but either the states or the National Health Board should assume primary responsibility.

  The National Health Board is one option because it could delegate assignments as it deems appropriate. This provides flexibility, along the lines of NPR Reinventing Government approach, to designate whomever can best perform the job, rather than following pre-set, legislative or regulatory mandates. The other alternative would be for states to ensure that regional and corporate health plans establish and monitor grievance procedures. States are responsible for most other survey and certification efforts and jurisdiction on these matters should not be splintered.

- Page 75, employers and employees (in regional alliances) pay a community-rated premium. However, payments to health plans by alliances are adjusted to account for the level of risk associated with individuals enrolled in plans.

  Also on page 75, health plans may purchase reinsurance to cover disproportionate costs beyond those predicted by risk adjustment formulas.

  These two provisions suggest that bad debts due to enrolled individuals not paying their premiums may show up in the community-rated premium. This will socialize the cost across the general population, while the party in default pays no penalty. Because unemployment is cyclical, health insurance premiums could increase to subsidize non-payers. Reinsurance could spread business cycle risks or costs due to structural unemployment across health plans, alliances, and States. Alternatively, the plan could specify a mechanism, through the tax system or a comparable procedure, that States have the option to use to collect overdue assessments.

- Page 76, the requirement that plans pay "essential community providers" should be deleted. If health plans comply with non-discrimination requirements, they should be allowed to determine with what types of providers to contract. Requiring plans to contract with a certain class of providers contradicts the provision that health plans can "limit the number and type of health care providers who

participate in the health plan".

Chapter 12: Integration of Workers' Compensation Insurance

This chapter has not changed substantially since last review; previous OMB comments still apply.

Additional Comments

1) Budget Issues

None.

2) Policy Issues or Clarifications

- Page 90, paragraph about extent of coverage says that benefits will continue to be defined by states, that plans and providers are not allowed to bill patients for balances, but that workers will not be subject to requirements for co-payments and deductibles. Some state workers' comp laws may already allow for co-payments and deductibles. (There are serious efforts to control costs in some states. We do not keep up with the details but suspect they use deductibles and copayments or will need to so in the future.)

  Although workers' comp laws do have broader purposes than "regular" health insurance, there is no reasons to override states' efforts to control costs of workers comp. An alternative would be to suggest adding at the end of the second paragraph, p. 90: "...unless they are allowed under the relevant workers' compensation law."

Chapter 13: Quality Management and Improvement

Previous OMB comments still apply. Additional comments address the revised section containing greater detail on reforming the Clinical Laboratories Improvement Amendments (CLIA).

1) Policy Issues and Clarifications

- Page 107, the resurrection of the explicit CLIA revisions is strongly applauded. The existing regime is a very costly construct with little evidence of improved quality at the cost of approximately $1.5 billion annually. This change should stay in the plan.

- The draft states high-risk laboratories would be warned in advance of on-site inspections. High-volume, high-risk

laboratories would be targeted for on-site inspections, which would be announced in advance. An argument can be made that the pre-announcement is necessary to avoid disruption of patient care. No other health care facilities, however, receive this special consideration, e.g., nursing homes, hospitals, mammography screening clinics, home health agencies, etc. Pre-announcing surveys allows facilities to cover up non-compliance. At a minimum, facilities suspected of non-compliance should be subject to unannounced inspections.

Chapter 15: Information Systems and Administrative Simplification

Previous OMB comments still apply. Additional comments address the revised section on consumer surveys, the deleted reference to PHS budget requirements, and the added new Medicare streamlining proposal to allow doctors to waive coinsurance.

Additional Comments

1) Budget Issues

- Page 118, the data standards process should be started in advance of health care reform legislation. The longer the standards are delayed the longer the continued administrative waste and delayed start-up of improved automation.

- Page 120, the new proposal allowing physicians to waive Medicare coinsurance in cases of "financial hardship or professional courtesy". Currently, health care providers, including physicians, are not permitted to waive coinsurance because of the increased utilization that waivers may cause. The plan proposes to allow physicians to "presumptively" waive coinsurance in cases of financial hardship or professional courtesy, but does not define these terms. These terms are difficult to define in a way that would prevent them from being used inappropriately. The practical effect -- unless new (and undesirable) paperwork is required to allow for enforcement -- would be to allow physicians to waive coinsurance under any circumstance. This is likely to result in increased costs to the Medicare program due to increased utilization. These costs should be estimated and added to the list of Medicare savings and cost proposals.

  Allowing physicians to waive coinsurance also begs the question of why physicians should receive preferential treatment. What about other health care providers, e.g., durable medical equipment suppliers, clinical laboratories,

and home health agencies?

- Pages 119-121, it is unclear whether the costs and savings of other proposals in the Medicare streamlining section have been taken into account in overall cost estimates (see previous comments on this chapter related to streamlining Medicare). An attempt should be made to explicitly estimate these costs.

- Modifications to the chapter on consumer surveys are positive. The chapter no longer designates PHS as responsible for these surveys, and no longer states that PHS will require $200 million to conduct these surveys. This appears to be responsive to previous OMB comments.

2) Policy Issues and Clarifications

- Page 121, the proposal to have the National Health Board explore developing standards for single annual inspections of health care institutions is inconsistent with the proposal to develop minimum standards for health care institutions on page 106, which calls for focused attention on those institutions with problematic records. More frequent inspections may be needed for problematic institutions, while less frequent surveys may be needed for those without problems.

Chapter 18: Academic Health Centers

Previous OMB comments still apply; additional comments are provided. We note that the only significant change is a deletion of an opening "mission statement" that academic health centers perform "broad community functions that must be sustained."

Additional Comments

1) Budget Issues

- The plan counts $6 billion in FY 1994 payments to an academic health center pool. Medicare indirect medical education (IME) payments are currently projected to reach $4.2 billion in FY 1994. Medicare direct medical education payments are projected to equal $1.5 billion. The plan should identify the components of the $6 billion, since it only stakes a claim on the IME funds.

2) Policy Issues or Clarifications

- The plan would add a surcharge to the health plan premium. The plan should specify whether the surcharge shall be paid entirely by the employer, the employee, or whether it will be split between the two parties.

- The plan would require health plans to assure coverage for routine patient care associated with approved clinical trials. Some plans, however, will find it difficult to contract with an academic health center given geographic settings, e.g., rural networks may be hundreds of miles from an academic health center. Secondly, a requirement for plans to contract with an academic health center contradicts the statement on page 76 that allows plans to "limit the number and type of health care providers who participate in the health plan."

  An exceptions process should be structured that will allow plans to opt out of contracting with an academic health center. Plans can purchase reinsurance to protect themselves from the high costs of treatment of rare diseases and specialized procedures.

- Page 139, text states that HHS will determine particular diseases or procedures "for which health plans are required to establish contractual relationships with academic health centers." Such central planning is not necessary (such links will form on demand) and not consistent with the principle of Local Responsibility stated in the chapter on Ethical Foundations of Health Reform (page 12).

Chapter 21: Long Term Care

The chapter has been re-written; OMB comments address this new draft.

1) Budget Issues

- Page 152, it is possible that a portion of the SSI/DI population who are not currently receiving institutional care or home based care would qualify for community based care as under the eligibility standards described. Limited ADLs are used as eligibility criteria for SSI/DI, but this population rarely uses institutional care.

- Page 158, would the monthly living allowance change for recipient of Federal benefits (SSI, VA) change?

- Page 162, this tax deduction would represent a double exclusion for SSI/DI recipients. Work related expenses are deducted from an SSI/DI recipients total income when calculating benefits.

- The calculation of the Federal match rate, as it is affected by current State spending on long-term care, is never specified.

- The interaction between maximum budgeted amounts (established nationally for long-term care spending) and the amount of the Federal match is never addressed.

- Funding for the new low-income program is supposed to be based on spending that would have occurred, if Medicaid were unchanged, for individuals receiving home and community-based care who do not meet the 3-ADL criteria. State Medicaid data almost never distinguishes among disability levels of long-term care recipients. Therefore, this projection will be nearly impossible.

- Requiring States to fund both the non-means-tested and the low-income programs may significantly increase the fiscal burden upon them.

- Tax incentives for individuals with disabilities who work -- employed disabled individuals who require assistance with daily living receive a 50% tax credit. Is this credit refundable? Does the credit only apply to earned income? How does the credit interact with EITC? Was this considered in pricing.

- Medicare beneficiaries pay a premium toward coverage, with individuals having incomes below 100% of poverty exempt from the premium. Should assets be included in the in the computation of the premium exemption threshold?

- Matching rates: Secretary of HHS determines matching rates for allowable costs. How are administrative costs treated under the matching rate computation?

- Tax treatment of premiums for long-term care insurance -- such premiums for qualified plans are excluded from taxable income. Are the premiums excluded for both income and

FICA/FUTA payroll taxation? What is the tax treatment for the self-employed?

2) Policy Issues or Clarifications

- The relationship between current Medicaid home and community-based care and this new program is still unclear. The addition of a low-income program adds another wrinkle. What happens to current Medicaid recipients who meet the 3-ADL criteria? Do reimbursement rates vary between the two programs?

Chapter 25: Health Care Access Initiatives

Previous OMB comments still apply.

Additional Comments

1) Budget Issues

None.

2) Policy Issues or Clarifications

- State Health Care Access initiatives are likely to be influenced strongly by the state's physician community. Low-cost community based care provided by clinics such as Planned Parenthood may not receive access to grants or be permitted to be providers under state access plans.

Chapter 26: Medicare Outpatient Prescription Drug Benefit

Previous OMB comments still apply. The 9/7 draft includes a provision requiring pharmaceutical manufacturers to offer discounts to all purchasers of pharmaceuticals on equal terms. Manufacturers will be able to differentiate drug sale prices if they can identify "mechanisms that can influence physician prescribing behavior." The plan also yields to the National Association of Insurance Commissioners the power to make any desired changes to Medigap coverage of prescription drugs.

Additional Comments

1) Budget Issues

- Full protection against out-of-pocket drug costs through private insurance plans could lead to overutilization, the costs of which would be borne primarily by the Federal

government. Studies have shown that a small co-payment of $3-5 per prescription can effectively reduce unnecessary utilization.

- Page 196, the new sentence on rebates for the dually eligible shifts a substantial amount of funding away from the states to the Feds. The blind, disabled and aged population comprise 70% of all Medicaid expenditures and a comparable portion of a rebate on the $6.8 billion benefit in 1992 -- no small amount! Do the Feds really need the money more than the states?

2) Policy Issues of Clarifications

- What is a "mechanism that can influence physician prescribing behavior?" Will the Secretary be responsible for defining allowable price differentials?

- Page 197, second paragraph under reviews. It is unclear how this electronic claims management system will relate to the national information system. It should at least state clearly that it should be coordinated with the overall information system structure and should not duplicate any of the capabilities or reporting requirements.

Chapter 27: Medicaid Acute Care

This chapter appears unchanged in some sections; previous OMB comments still apply. Changes to the draft health reform plan included in the 9/7 version include: i) the elimination of disproportionate share hospital (DSH) payments; ii) a possible Federal block grant to help fund supplemental (wraparound) benefits for Medicaid cash and non-cash recipients; iii) the premium calculation for Medicaid recipients is detailed; and iv) the National Board is granted the power to create a transfer payment from low-Medicaid plans to high-Medicaid plans within an alliance if the risk-adjustment mechanism is deemed insufficient.

Additional Comments

1) Budget Issues

- Will States have a compelling incentive to alter AFDC or SSI eligibility standards to shift the costs of these recipients into the low-income subsidy pool? Would the maintenance of effort requirements prevent this type of cost-shifting? States could, for example, limit eligibility for State supplemental payments to SSI recipients, effectively

lowering the number of cash recipients eligible for Medicaid. This could affect at about 11% of the SSI cash recipients -- over 650,000 people in 1992. States have even greater discretion in establishing eligibility criteria for AFDC cash payments and could potentially eliminate payments for a majority of current (baseline) recipients.

- page 200, depending on how guaranteed benefits for non-cash recipients would be financed, States may have an incentive to remove individuals from the SSI or AFDC roles, i.e., to move from 50/50 funding for Medicaid to 100% Federal dollars for guaranteed benefits.

- Page 200, the SSI disabled population uses emergency care heavily. During the transition period when Medicaid disabled recipients have access to a non-capitated fee-for service-plan costs could escalate.

- If Federal funding for supplemental services is provided through block grants, will the grant amounts be established to approximate the Federal portion of current State spending on supplemental services?

- What index and base will be used to calculate State Medicaid payments? Payments may be trended forward in two different ways:

  - Multiply spending in the year prior to reform by 95%. Grow the resulting product by the allowable annual rate in the outyears; or

  - "Grow" spending in the year prior to reform by the allowable annual rate. From that amount, subtract 5% of the prior year's spending (in the absence of the growth rate). Repeat this calculation for the outyears.

  The difference between these two methods could compound significantly in the outyears.

- What happens to the other 5% of projected Medicaid spending? Does this 5% accrue as savings to the Medicaid program? Who saves the money, the Federal government or the States? Alternatively, is this money spent elsewhere?

- Will the calculated premium paid by States to Alliances for Medicaid recipients cover the costs associated with Medicaid

recipients in even the lowest-cost plan?

- The description of the negotiations between health plans and alliances for non-cash recipients' premiums is extremely unclear. More information and a straightforward description of the process will be necessary for congressional and public readers.

- Who should have primary responsibility for determining whether transfer payments should be made from plans with few Medicaid recipients to those with many Medicaid recipients? How will this determination be made, and how large will these transfer payments be? Requiring the National Board to make this determination for all plans could be extremely burdensome. Alternatively, health alliances could have primary responsibility, subject to National Board oversight.

- Will the schedule to eliminate DSH payments be coordinated with reductions in other Federal subsidies for hospitals serving large numbers of low-income individuals and with the phase-in of the subsidy for low-income payors?

Maintenance of Effort Issues

- Is it correct to assume that States' Medicaid spending for AFDC and SSI recipients after the implementation of reform would be credited toward their maintenance-of-effort (MOE) requirements? If a State's post-reform Medicaid spending is less than its required MOE contribution in any given year, would it be required to make some sort of lump-sum payment to the Federal Government or to State Alliances? How would these funds be spent, e.g., to offset Federal low-income subsidies costs?

- It appears that the MOE requirement would not allow States to share in public sector savings that would result from non-AFDC and SSI eligibles gaining coverage through their employers. Is the rationale for this approach that these continued costs would be outweighed over time as States' fiscal liability is reduced because of lower health care/Medicaid costs?

- Why does the MOE requirement not include other State and local health expenditures that are made outside of the Medicaid program?

- Must States also maintain spending for acute-care Medicaid services not included in the guaranteed package?

- Will the MOE requirement include States' share of payments financed through provider taxes and intergovernmental transfers?

- Payments to Alliance plans on behalf of Medicaid recipients would be based on each State's per capita Medicaid spending. If the State MOE does not include State spending associated with DSH and provider-tax-related expenditures, will these dollars be netted out of the initial calculation of Medicaid per capita payments to plans? Or will the Federal government make up the difference?

- Establishing a prospective year on which to base State MOE contributions may invite gaming on the part of States. That is, States may downsize their Medicaid programs in the year prior to reform implementation in order to reduce their MOE contribution. On the other hand, once reform is implemented, States may seek to shift more individuals onto Medicaid to reduce the growth in the weighted-average premium and, thus, the growth in the MOE contribution.

- The MOE contribution would be trended forward by a per capita index factor only. Why not also include indexing for Medicaid caseload growth?

2) Policy Issues or Clarifications

- Integration of Medicaid recipients. Alliance offered plans will cover all Medicaid recipients under age 65. This assumes that all elderly individuals will be covered by Medicare. Many elderly individuals (especially those on SSI) are currently on Medicaid. It is unrealistic to expect the current Qualified Medicare Beneficiary (QMB) program to pick up these individuals since the program has not been implemented well.

- Eligibility. No further coverage options are added to current law. Question: Can States drop options?

- Establishment of a single financing pool for plan payments -- would Medicaid recipients start having to pay co-payments which they do not currently have to pay?

- In an alliance with only three plans, it is possible that the premium in the median cost plan could be above the weighted average premium -- especially if enrollment were heaviest in the lowest-premium plan. In this case, recipients would be able to choose only the plan with the lowest premium.

Chapter 29: Transition

Previous OMB Comments still apply.

Additional Comments

1) Budget Issues

None.

2) Policy Issues or Clarifications

- Page 217, to avoid unnecessary disruption why not allow corporations in early opt-in states to maintain there present coverage systems until all corporations have to comply. This would avoid putting companies at a competitive disadvantage. Alternatively, early opt-in states could be offered more flexibility on phasing in the employer mandate to acknowledge the problem.

Chapter 30: Financing Health Coverage

The employer premium subsidy is less specific than in the 8/6 version, and is limited to firms with 50 or fewer employees. Employers still have a cap on premiums for all employers equal to 7.5% of payroll. Individual and family subsidy issues appear to be generally the same as in the previous draft.

Self-employed, non-workers, part-time and seasonal employees discussion is significantly expanded since previous version, which mentioned subjects in passing in the finance section. Retiree coverage discussion is new.

Additional Comments

1) Budget Issues

- Subsidies for Employers: The eligibility criteria for subsidies for employees and employers, and premium caps for employers could be based on total employee compensation, including fringe benefits, instead of payroll. Large

segments of the nation's working population receive employer provided fringe benefits such as health and life insurance, flexible benefit packages, housing, and pensions. Such benefits accounted for 16 percent of total employee compensation in 1989, up from 8 percent in 1960. Most of the growth in employee remuneration over the past 20 years is attributable to the growth in benefit spending. For example, inflation-adjusted benefit spending per full-time employee grew by 63 percent between 1970 and 1989, while average cash wages remained almost flat. The proposed employer subsidy could further encourage firms to pay employees in fringe benefits in order to remain eligible for the government health subsidy, or meet the 7.5% payroll cap.

- Individuals in Regional Alliances: Subsidies are available to individuals and families with incomes up to 150% of poverty. Eligibility could also be based on both income and assets. Numerous income related Federal benefits such as AFDC, Foodstamps and SSI are based on both income and asset tests for eligibility

- Non-workers and part-time workers: Premium payments are reduced for those recipients with family incomes less than 250% of poverty. How does this interact with subsidies that are available to individuals and families with incomes up to 150% of poverty? Does this create work incentives or disincentives? How will this interact with EITC?

  - Overall, specifics and definitions in this area can result in major shifts in premium income and benefit outlays. For example: subsidy interaction with EITC, definition of self-employment income in calculating premium caps.

- Retirees: The effect of this policy goes in the opposite direction of the current law Social Security program, under which the normal retirement age begins to increase from 65 to 67 in year 2000.

  - Retired people over 55 years of age and who meet the social security requirements for quarters of coverage are eligible for subsidies on their employer share of their premium. By encouraging retirements among employer and employees, Social Security and PBGC costs will increase, while Social Security, Medicare and income tax revenues will be reduced.

- Health Premium information on W-2: This will involve some

additional administrative costs for SSA and IRS under the discretionary caps.

2) Policy Issues or Clarifications

- The proposal could encounter serious implementation difficulties if the lowest cost plan is less than 80% of the cost of the weighted average premium. In this instance the worker wanting to choose the lowest cost plan will need a rebate, and the employer will pay less than 80% of the weighted average premium. Such events may occur rarely, but shouldn't there be some mechanism to deal with them?

- Page 224/235, the treatment of part-time workers, especially those who are dependent on their families seems unsatisfactory Are their payments pro-rated according to the number of hours worked? Introducing such a pro-rating scheme may be complicated, but otherwise there is a "big hit" for people working relatively few hours (e.g., 15/week).

- Page 222, the subsidies for low-income families create perverse incentives. It is clear that the government is essentially requiring that poor people enroll in the medium plan rather than in the low cost plan, since for such people the cost will be the same, while presumably the quality is better at the higher priced plan.

  An alternative which could save the government some funds, and give cash to the poor would work as follows: Give the poor the right to the average premium plan, but also give them the right to a rebate of say 50 cents on the dollar, if they elect to pick a plan costing $10 less per month. Some, but not all poor eligible for subsidies will accept this offer, and take the lower cost plan. They will make themselves better off, AND reduce government subsidies. Given the "right" rebate rate, one can ensure that a substantial number of poor people choose to enroll in plans other than the cheapest. Thus one could still avoid the segregation of rich and poor into different plans that is presumably the policy goal that motivated the current draft.

- The administrative costs of the HAs seem ever more imposing. These entities now must worry about bad debt, and end of the year reconciliations for millions of households who are perpetually moving, divorcing and changing employment status, and for employers undergoing bankruptcies. In addition they have to conduct a risk-adjustment exercise,

which may be subject to lawsuits at least during the first years, as AHPs dicker about whether they are fully compensated for their unexpectedly high risk populations. They have to collect from the States for the maintenance of effort funds, although the calculation of these will be problematic, since not all of the MOE funds will go directly to the HAs. Finally, since there will be close to 100 HAs, it is reasonable to expect that some will fail to comply with their Federal mandates. By what process will the proper management of these be maintained if there are accusations of noncompliance, let alone fraud?

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Laura Tyson, Alan Blinder, and Joe Stiglitz to the First Lady and Ira Magaziner, re: Health Care Book (16 pages)	08/30/1993	P5
002a. memo	Alan S. Blinder to the First Lady, re: Possible Changes in the Health Care Plan (5 pages)	03/14/1994	P5
002b. table	Table on the Health Security Act (1 page)	ca. 03/1994	P5
003a. memo	Lloyd Bentsen to the First Lady, re: Health Care Reform Drafting (1 page)	10/06/1993	P5
003b. list	Treasury Department Drafting Issues in Health Care Reform (2 pages)	10/1993	P5
004. memo	Laura Tyson to the First Lady, re: Issues in Health Care Reform (4 pages)	08/05/1993	P5
005a. memo	Leon Panetta and Alice Rivlin to Ira Magaziner, re: Timetable for Budget Estimates (2 pages)	09/24/1993	P5
005b. list	Codes applied to each question (1 page)	09/1993	P5
005c. list	Priority 1 (2 pages)	09/15/1993	P5
005d. list	Medicare Outlay and Beneficiary Assumptions for Pricing of Health Care Reform (4 pages)	09/24/1993	P5
005e. paper	Health Care Reform Pricing Issues - Medicare (4 pages)	09/24/1993	P5
005f. list	Pricing Questions Concerning the Medicare Drug Benefit (1 page)	09/1993	P5

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FOLDER TITLE:
Health - Agency Reviews [2]

Kara Ellis
2006-0810-F
ke71

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005g. paper	Medicare As Secondary Payer Policy (2 pages)	09/22/1993	P5
005h. list	Medicaid Outlay and Caseload Assumptions for Pricing of Health Care Reform (4 pages)	09/24/1993	P5
005i. list	Questions About Pricing of Medicaid Provisions (4 pages)	09/24/1993	P5
005j. list	Long-term care program questions (1 page)	09/1993	P5
005k. list	Long Term Care (pp. 151-165) (1 page)	09/23/1993	P5
005l. list	Financing for the Under 65 Population - Policy Questions or Clarifications (1 page)	09/23/1993	P5
005m. paper	HCR Administration: Overview (1 page)	09/1993	P5
005n. paper	HCR Administration Questions - Pricing Issues: Scope & Parameters (3 pages)	09/1993	P5
005o. list	Questions for Pricing 9/7/93 HCR Package: Public Health (7 pages)	09/1993	P5, P6/b(6)
005p. list	National Health Reform Cost Questions - Veterans Affairs (2 pages)	09/23/1994	P5
005q. memo	Memo from Christine Lidbury re: Federal Employees Health Benefits Program Costing Assumptions (1 page)	09/24/1993	P5, P6/b(6)
005r. list	Questions from J. Fish (1 page)	09/1993	P5

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005s. list	Questions on Pricing for Medicare Payment to DoD and VA (2 pages)	09/20/1993	P5
005t. list	Questions Regarding Institutionalized Populations (1 page)	09/24/1993	P5
005u. schedule	Schedule for OMB Estimates (1 page)	09/1993	P5

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EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON, D.C. 20500

THE CHAIRMAN

August 30, 1993

MEMORANDUM FOR THE FIRST LADY
IRA MAGAZINER

PAM AUG 30 1993

FROM: LAURA TYSON LDT
ALAN BLINDER
JOE STIGLITZ

SUBJECT: Health Care Book

Thank you for the opportunity to review the details of the health care plan. It is an impressive undertaking, reflecting months of careful analysis and data collection. In our view, there are six overarching goals of health care reform, each of which we enthusiastically support:

1. **To provide universal insurance**

2. **To contain costs**, especially through the use of **incentives**

3. **To minimize disruptions** in changing from the current system to the new one.

4. **To keep the new system as non-regulatory as possible.**

5. **To maintain maximal choice at all levels**--states, consumers, firms, providers

6. **To make health care reform deficit neutral in the short run and deficit reducing in the long run.**

The framework described in the health care document goes a long way towards meeting these goals. We share the belief that managed competition is the best way to achieve these goals, and we support the general structure of the reform you propose. Our comments are largely about the specifics of the plan. In particular, we believe that there are some areas where more could be done to achieve goals (2)-(6), and especially (3)-(5).

We summarize our comments in two sections:

-- major issues: we have picked out 5

-- minor issues, many of which are just questions that we'll take up in page order.

Major Issues

I. **Financing of the Health Care Plan**

Several issues in the financing section deserve more discussion.

1. **Generosity of the comprehensive benefits package:** Between late May and now, the plan has become substantially more generous--and correspondingly more expensive. We would raise the question the following way: Is it wise to start a brand new plan--with its many unavoidable uncertainties--by guaranteeing every American a health insurance policy considerably better than FEHBP? We are concerned about such an approach especially in light of the fact that aspects of the financing plan--in particular, the potential savings from budgets on Medicare and Medicaid--are highly uncertain.

   If the benefits package were 10% cheaper, we could probably reduce the annual subsidy cost by $10-$15 billion, which would certainly be welcome. We'd urge consideration of such an alternative (without foreclosing a ramp up to a more generous package later). The plan, for example, has an expansion of some benefits in 2000, which seems like a wise idea. Are the estimates of the additional costs of these benefits in the year 2000 incorporated into the numbers we have seen?

2. **Medicare:** As policy, we really like the idea that you can stay with your old plan after age 65, rather than being forced to switch to traditional Medicare. But, since Medicare is a 5-th percentile plan and the basic package is a 50-th percentile plan, there is a big cost involved. The plan, it appears (page 199), would hand oldsters a big bill on their 65th birthday. ("Beneficiaries pay the difference between Medicare's payment and the plan's premium.") The HHS position is confusing on this point. On page 197, it says that "the cost to the beneficiary can be no greater than under traditional Medicare"--which suggests a big additional bill for the government. But on page 199, it says that "the beneficiary is responsible for paying any difference..." The important question here is: if a beneficiary chooses to stay in the alliance and not join traditional Medicare, who is responsible for the additional cost incurred by that person?

   Also, if a state adopts a single payer system, integrates Medicare, and eliminates or reduces cost-sharing, there is likely to be increased utilization for Medicare, with important budgetary consequences. How are we going to guard against this?

3. **Medicaid:** The Medicaid discussion is confusing. Is this a correct summary: (1) Non-cash recipients are assumed to be out of Medicaid in the reform; (2) Cash recipients will still be on Medicaid, but will be able to choose from Alliance plans like all other individuals; (3) Plans will receive a higher payment for the remaining Medicaid population; (4) Plans will pay providers the same amount for each patient (lower than the current private sector rate but higher than the Medicaid rate). If this is correct, we have several comments:

   -- Is this what has been priced by the actuaries? It seems like there is more potential for spillover from Medicaid costs to private sector costs here than in the old "Medicaid out" policy.

   -- When the plan says that "Plans contract with states, through their alliances or Medicaid agencies, for a capitation rate and maximum capacity for covering the Medicaid ... population", does this imply that there are different Medicaid prices for different plans? This would seem to put federal and state governments at risk. Alternatively, if there is a maximum price, what happens to a plan that does not feel it can serve Medicaid recipients at that price?

4. **Transition.** The "access to coverage" section suggests we are going to set up a new Medicare program for everyone that is not now insured during the transition to the new system. Is this correct?

II. Dealing with Budgetary Uncertainty

Beyond the level of spending, there are additional questions created by the riskiness of the plan. This risk is inherent in any new program, let alone one which affects one-seventh of the economy.

1. **Phase-in of benefits.** A natural way of dealing with risk is to phase in the new system--both the new Medicare benefits and the under-65 benefits. We have spoken about potential phase-ins of the employer mandate in the past, and would like to explore these in more detail. In our thinking, phasing in the benefits achieves most of the savings (all of the savings from global budgets and administration), and the remaining savings (the uncompensated care offset) comes with the new mandate. We have several more specific comments about the phase-in:

   -- We are pursuaded that the major medical phase-in is an

untenable policy.

-- The other natural phase-ins would be (1) by state; or (2) by employer size. We are interested in your views on these issues.

-- Some of the benefits, such as mental health care, dental care, and vision care could be added after the first package. The cost sharing might also fall over time.

In addition, there is the potential to delay some of the benefits expansion for the Medicare population. Perhaps the drug benefit could apply to low-income seniors before it applies to the more general population. Alternatively, the long-term care benefit might be phased-in even slower, with the option to increase the speed if there are sufficient cost reductions.

2. **Explicit budget protection.** As you have stressed, the budgetary consequences of the program depend on many unknowns:

-- The extent of increased retirement from the financing system.

-- The ability of firms to "game the system" by adjusting their sizes or average wage.

-- The ability of the alliances/federal government to collect debts that are owed but not paid.

-- The ability of families to alter income in response to primary earner/secondary earner rules.

-- Natural uncertainties associated with our inability to model incomes precisely.

-- The ability of states to segregate individuals into alliances on the basis of income or expected subsidy receipts.

-- Uncertainty about the premiums that will prevail in the alliance, particularly in the short run, when insurers are dealing with an entirely new system.

We have spoken at various points about automatic measures (such as higher maximum payment rates) that would be triggered if subsidies came in over budget. Are these still on the table?

3. **Residual Risk.** There is a question about who bears the ultimate residual risk in the system. Think of two

scenarios:

-- A plan that is in trouble cuts its premium to attract more consumers. Consumers, since they are guaranteed coverage, enroll in the plan. The Health Alliance, worried about meeting its caps, looks approvingly at the low cost plan, failing to notice that its capital assets are decreasing. The plan borrows, using its capital assets as collateral, to stay afloat, until the day of reckoning occurs, in which case the other plans are left holding the bag. They then find themselves in the impossible position of drastically cutting their premium (since the low cost plan in their area has just disappeared), plus paying a 2% surcharge to make up for the losses of the bankrupt plan.

-- Since consumers know that they cannot be denied a health plan, regardless of their payment, some consumers decide not to pay the premiums on time. Collections fall, and the subsidy costs increase.

Who would bear the utilimate financial responsibility in these types of situations? Does the alliance have the ultimate ability to draw on the Federal Treasury? How can we prevent this from happening?

III. Minimizing the Regulatory Burden

1. **State flexibility:** We thought everyone had agreed to the principle of maximal state flexibility. Yet the current plan seems to have numerous federal interventions. The long list of what the states will be told to do on page 51 is one example, and there are others. Perhaps we should establish a shorter list of four or five requirements, and assume that if these requirements are met, the plan is presumptively approved.

2. **Corporate alliances:** We don't understand the motivation for budgetting and regulation of corporate alliances. A self-insured corporation has the right incentives now: Leaving aside the tax break, it pays the costs it incurs. Many of these self-insured plans do not now offer fee for service. Why force them to? This requirement limits the bargaining power of the corporate alliance when it deals with different plans. More generally, why make enemies by forcing these corporations to change? Also, we thought that in May we had come close to agreeing on 1000 employees as the cutoff. Why did it move to 5000? This both increases subsidy costs and lowers the potential revenue from an out-of-alliance tax.

3. **Rate-setting for fee-for-service:** Fee-for-service plans will be subject to the rigors of managed competition; they will also be capitated and budgeted like other plans. So why do we need fee schedules and the heavy-handed regulation that accompanies them? Also, doesn't having an artificially low fee schedule just work to subsidize fee-for-service plans? We may wind up in the perverse position of subsidizing these plans by imposing a fee schedule and then taxing consumers who join them to meet the budget.

   In addition, what are the rules for doctors practicing in the system? Are the plans allowed to restrict which doctors they cover? Can states compel doctors to treat patients and accept the fee-for-service payment? This may be particularly acute if many doctors enroll in HMOs or PPOs and the fee-for-service fee schedule is very low.
   In addition, are plans allowed to restrict the number of doctors which they enroll?

4. **Medical education:** We understand, and sympathize with, the motivation for steering more medical students into general practice rather than into specialties. But isn't it better to do this by incentives rather than by command and control? The circumscription of free choice here seems extreme.

5. **Choice and Random Selection into Oversubscribed Plans.** Another area where choice is proscribed is the assignment of individuals into plans when plans are oversubscribed. The natural market mechanism for dealing with this contingency is to allow the price of the oversubscribed plan to rise, and thus to induce more individuals to choose alternative plans. We are not allowing this to occur, however, because of the tight budget. We might want to create the ability for this type of price change to occur.

6. **Short-term price controls:** The book includes them. It will not surprise you that the CEA opposes them. But, at the last big meeting with the President and First Lady, we thought we heard a tacit "no" vote on short-term controls. Did we? Just in case the issue is still live, we have several comments about short-term controls (pages 229-234):

   -- we prefer Option 1.

   -- We would be announcing a controls program before we had the necessary survey data to monitor compliance. Also, 6 months sounds like a very short time to get a good survey working in the field. What would BLS or Census say about this?

   -- What does it mean (page 232) that "insurers are expected to pass on savings to consumers..." What if

they don't? How do we know how big the savings are?

-- There are two bullets on drug prices on page 233. Does the second mean drug-by-drug controls?

-- "The Secretary is authorized to deny coverage or reimbursement... for products [of] manufacturers that do not sign agreements" (page 233). That doesn't sound very voluntary.

7. **Powers of the National Health Board.** One important issue about the National Health Board and the alliances is provider representation. While we recognize the concern about Alliances being captured by health care providers, the prohibition against any participation by providers on the Board seems draconian. Providers represent an important set of participants in the health care market. We would prefer to see some representation for them on the National Health Board and Alliance board. As a general policy, having various interested parties work to common solutions seems preferable to creating a confrontational system.

   Also, page 45 says that the National Health Board "enforces the budget." The Board will set the budget, but we don't see how it can enforce it. What does the enforcement involve? Is there a role for HHS or Treasury in here?

8. **Essential community providers.** At various points, there are discussions of alliance responsibilities for essential community providers, rural areas, and other areas needing extra help. Are all of these collected in one place, to examine them collectively? Also, are the plans required to do these, or is it at their option (with financial incentives)?

IV. Issues of Incentives

There are several areas where the incentives to minimize costs might be improved.

1. **Treatment of supplemental insurance.** The text indicates that "The price of any insurance policy covering cost sharing includes the cost of additional benefits plus any expected increase in utilization caused by the insurance". (p. 81) Is the Alliance responsible for levying the additional amount and then giving that to the original plan? If not, the plans may not price this way, in order to select some groups of individuals. Also, this general statement would appear to apply to Medigap policies as well. Is this true?

Also, shouldn't we encourage firms to pay fixed amounts above the required corporate payment, with rebates, so that employees receive the true benefits from choosing less expensive plans.

Finally, we are not sure that the treatment of supplemental insurance addresses one important type of insurance. With a prohibition on balance billing and a mandatory fee schedule, the reimbursement currently received by high-price doctors is likely to fall dramatically. Such doctors may wish to practice outside of the system and patients will want this. Thus, there may well develop a private insurance market to cover these "out of the plan health benefits." There are three alternatives:

-- We could accept this.

-- We could forbid any insurance for procedures covered in the basic plan, which will be hard to do, may be politically unpalatable, and is likely to mean that only the rich will be able to afford expensive doctors.

-- We could take even more draconian steps of forbidding private practice of medicine outside the basic system. This will be harder to do and less politically palatable, however.

Banning balance billing may thus have major distributional consequences. It will guarantee greater equality for those in the basic package, but provides more incentive to opt out of the basic package. It is useful to recognize the winners and losers under this type of proposal.

2. **Tax treatment of benefits.** The book is silent on the tax treatment of benefits. At various points, we have talked about different policies: (1) No exclusion; (2) Exclusion of the employer's required 80 percent; (3) Exclusion of any amount up to an average cost plan; (4) Exclusion of supplemental policies only. Which of these do you support? We believe that a tax cap is a very important policy, not because it raises revenue (thought that is certainly attractive), but because it places <u>responsibility</u> on consumers. It seems inconsistent to worry about high costs and then subsidize the price of more expensive packages by up to 40 percent.

As with the other benefits, there is no reason that the tax cap could not be phased in over time. One alterative is to set the cap at a high level, but fix it in nominal terms. This would have the effect of lowering the real value of the cap. Alternatively, current contracts could be exempt, with the cap applying after they expire.

V. Other Issues

1. **Budget enforcement.** The budget enforcement has the property that if the budget is exceeded, all plans over the maximum amount are brought to the average amount. This has the perverse effect of making the average lower than the maximum amount for an alliance that was having trouble meeting the budget in the first case. In addition, the spread in plan costs, particularly between low-priced HMOs and high-priced fee-for-service plans is likely to be substantial. The evidence from Minnesota, for example, suggests that a budget of this form could force some plans to lower costs by 10 percent in one year. This seems excessive.

   Also, we have three comments about the budget, particularly page 100:

   -- Can we really hope to set budgets for the levels of spending in Year 1? We think this is inadvisable. Let competition discipline the market.

   -- The prose seems to impose the penalty twice--on the plan and on the providers. Do you mean this?

   -- The "alternative" suggestion seems better.

2. **Inter-generational justice.** The health program may in fact be heavily criticized for a failure to achieve intergenerational justice:

   -- Community rating without any age factors has the effect of making young, healthy individuals subsidize older individuals. Over a life cycle, this evens out, but the current old get a net transfer. This will be viewed as exacerbating an existing problem: the current old are getting back in social security and Medicare far more than they contributed.

   -- The provisions for long-term care also serve to exacerbate this intergenerational inequity.

   -- Transferring the burden of retirees from their corporations to the general population also may be viewed as being contrary to intergenerational justice--since, net, it is again the young that will be picking up the tab.

Minor Issues

* At several points, the first being page 6, the book refers to GDP + 1 and such numbers. we gather that has all been replaced by, e.g., CPI + pop + 1 etc. Is that correct?

* On page 8, you refer to a national loan program to support the efforts of local health providers. How is this loan program to work? Have its costs been included in the budgets?

* If our understanding of malpractice reform is correct, it may be too strong to claim that it "eliminates any incentive for unnecessary tests or procedures." (p. 9)

* On page 14, have we provided for an increase in the unemployment insurance taxes to fund the extended coverage of laid off workers? Also, the standards used for extended coverage differ from the standards used for eligibility for UI (which differ from state to state.) Is this likely to lead to confusion? When we extend unemployment coverage to 39 weeks, will insurance coverage be extended in a commensurate way? Have we modelled the unemployment program to apply to all workers, or just those receiving unemployment insurance?

* On page 15, you say that retirees who receive health coverage through their former employers or pension funds continue to receive *those* benefits. Does this mean paid for by their employers or pension funds? If the government picks up those costs, does it pick up the costs of benefits which go beyond the standard benefits package?

* On page 15 and again on page 75, it says that "No health plan may cancel an enrollment until the individual enrolls in another health plan." What happens if the individual has not paid his premium? Does the federal government guarantee the payment? Do we have any estimate of these "deadbeat" costs?

* Page 16 gives the rules for companies joining the regional alliance. Can a large firm that had joined the alliance leave it subsequently if it wants to establish a corporate alliance? What about a firm that grows to over 5000? Do firms over 5000 employees pay 1 percent of payroll for the alliance plans?

* On page 16, we should recognize that in general there will be no plan that sells for the weighted average premium, so that no person will wind up paying 20 percent of the WAP. How about, "Employees pay the balance of the cost of the plan they choose. If they choose a plan costing less than

the WAP, they will pay less than 20 percent of the WAP, and if they choose a more expensive plan, they will pay more."

* Regarding the "emergency care" away from home on page 17. There may be difficulties in establishing standards for this. The problem is related to:

  -- Students living away from home. Will there be transfer payments across alliances? Who gets the payments if the parents buy a family policy?

  -- What about individuals who live part of the year in two different places? Do they have to choose a single place to have all non-emergency care, e.g. if they spend six months in Florida and six months in New York?

* On page 18, part time employees: "percentage of wages earned" What does this mean? Employers do not know workers full wages on all jobs.

* On page 18, IRS rules are designed to avoid people constructing themselves as independent contractors. Are you going beyond existing IRS rules? Employers may not know whether an employee receives more than 80% of their annual incomes from one employer. Are you requiring employees to file their income taxes with their employers? Doing this may be viewed as an invasion of privacy. Have you thought about the problems of distinguishing between net and gross incomes?

* Regarding the independent contractor provision, what happens to independent contractors who take bids from corporations to provide services. Do they get bounced arond from corporate alliance to corporate alliance as their bids change from year to year?

* On page 25, the mental health policy seems very generous. This represents one area where we could cut back and reduce our premiums. Similarly, the drug benefit on page 29 appears to be more generous than current plans. Does it, for instance, cover sleeping pills that are prescribed? This is another area of possible cost saving.

* Page 34 indicated an expansion to unlimited psychotherapy benefits at $25 per visit in the year 2000. Insurers are generally cautious about unlimited benefit plans. Is there actuarial agreement on the costs of this policy?

* On page 35, is it possible for a PPO to use a system other than the FFS cost sharing for out-of-plan use?

* On page 37, is there some indexing of all fees for

inflation?

* On page 42, it is not clear how there can be two prescription drug out-of-pocket payments in the same policy. Does it depend on who the prescribing doctor is?

* On page 45, how will the National Health Board adjust the budgets for alliances to reflect regional variations? Will there be an effort to reduce regional variations over time?

* What does it mean to say (page 46) that one of the Board's members "represents the interests of states"?

* Atop page 48, it says that the Board's regulations will not be reviewed by OIRA. Do we mean this? If so, why?

* On page 49, we have a real problem. First, is it a state or an alliance that fails to comply? We would have thought the latter. The next paragraph says that, if a state fails to comply, all employers in the state lose their health deductions. Aside from the fact (which is not irrelevant) that this penalizes many innocent parties, this provision is likely to evoke fierce opposition for being "anti-business". These provisions raise the specter of fights between states and the federal government.

* The definition of the size of the alliance on page 52 seems too valgue: "[it] must encompass a population large enough to ensure that it exercises adequate market leverage in negotiating with health plans."

* On page 52, how will the states coordinate wtih the IRS to withhold money from people who don't enroll in the alliance?

* We found both the last paragraph on page 54 and the HHS position on the top of page 55 confusing. The last sentence on page 54 seems to destroy the individual's incentive to choose a cheaper plan. Are we reading it right?

* Page 57, top paragraph: This seems a funny way to collect insurance premiums (the insurance is against plan insolvency). A small national assessment on all plans (much less than 2%) would be more like, e.g., bank insurance. We do not want to create another unfunded state mandate. Also, does the insurance tax affect budget compliance?

* Two paragraphs later on page 57, is it a "state" or a "plan" that can provide additional benefits? Also, why stop a state that wants to raise money by taxing corporations?

* On page 57, the single pay option is not clear. It says payments are made directly to providers. "However, pro-

viders, such as HMOs, networks of physicians and hospitals, assume risk by accepting capitated payments to cover the health needs of individuals." Does this mean that under the single payer system, the state will set a fixed capitated fee (as if the "service" is "providing health care for a year.")

* The bottom of page 59 does not state that someone who moves remains under his old plan until he is covered by the new plan--but we assume this is what you mean.

* Two questions on page 60: (1) If an individual makes no selection, why not assign him to the low-cost plan rather than randomly? (2) In a plan that is oversubscribed, we presume that incumbents get preference. But the paragraph does not say so.

* We wondered about the top paragraph on page 61. Does it prevent plans from offering attractive ancillaries to get customers?

* Regarding the provision of information on page 61, presumably we are not requiring the alliance to use all of these methods, but are encouraging them to do so.

* In the multi-year budget (page 61), shouldn't the contract simply require that on average, over the length of the contract, the increases can't be greater than the budget. A high increase in one year, offset by a promise of low increases in subsequent years, should not be disallowed.

* On page 62, the HHS recommendation that alliances can refuse to allow plans to accept corporate alliance members if they are not accepting regional alliance members seems a bit regulatory. Why not allow specialization?

* Do you really mean (page 62) that an alliance must offer a contract to every plan? What if 80 plans apply for, e.g., New York City?

* On page 62, the HHS position has the peculiar property that a new plan which comes in slightly above the target--but far below the highest cost plans in the Alliance--could be rejected; any plan that comes in above the budget target can be thought of as causing the alliance to exceed its budget target. The other measures in the program designed to ensure that target is met would seem to suffice (though they may have undesirable consequences); one does not need, and should not have, an extra instrument of rejecting a health plan.

* On page 63, you say that alliances may use financial in-

centives to encourage health plans to expand into areas that have inadequate health services. Where do they get their revenues?

* We had a hard time understanding the last section on page 64. What is meant here? Doesn't everything have a prospective budget?

* On page 65, can the physicians design their own fee schedule?

* On page 66, you refer to the common control tests. How easy is it to a firm to alter its characteristics to satisfy this test? For instance, does a holding company exercise "common control"?

* Re: page 66: In calculating the number of individuals in a corporation, if some state adopts a single payer system which forces the corporation's employees in that state to participate in the state system, are the number of such employees reduced from the number of employees in the corporate alliance, possibly making the corporation ineligible for being in the corporate alliance? Also, companies fluctuate in employment for cyclical and other reasons. 4800 is only 4% below 5000. We would have thought that a much bigger band was appropriate. If a firm grows to over 5000, is it allowed to form a new corporate alliance?

* On page 69, Taft-Hartley plans are presumably community rated <u>within</u> a plan, not <u>across</u> plans.

* On page 74, does the provision permitting taxes and assessments refer to the corporate alliance tax?

* On the disenrollment for cause (page 79), who is the purchaser that is required to ensuring no gaps in coverage?

* On page 80, wouldn't "insurance against specific diseases" make it too easy to select out (certain) bad risks? Also, why enforce such uniformity (only two policies) on supplementals?

* We don't understand the motives for the third and fourth paragraphs on page 81. The former seems to be a price control, the latter a restriction on self-insured corporations.

* Page 85 speaks to requiring urban plans to serve rural areas. They must open up offices there? Why? Isn't this a costly burden?

* Are 56% (see page 86) of the underserved in rural areas? If not, why send 56% of the money there?

* In the last paragraph on page 86, we didn't understand the phrase "can be recaptured"?

* On page 87, how will administration of budgets be accomplished in the first three years?

* Re: page 97: Aren't workers comp and auto folded in? (see p. 9). Also, if workers' compensation is not included in the budget, isn't there some danger of a ballooning effect whereby more services are provided through the uncontrolled worker compensation and less through the controlled health plan?

* On page 103, we presume that a state is in compliance if its premium is no more than 1 percentage point above the inflation factor, not 1 percent.

* On page 104, it should read "surcharging high-cost plans and/or ppaying rebates to consumers".

* Are corporate alliances under a tighter budget than regional alliances (page 104)? Do they have less ability to exceed the budget in a given year?

* On page 131, shouldn't the surcharge be on the use of the graduate facilities? Why shouldn't HMOs reap the benefits of keeping people out of the hospital?

* On page 139, why should we define procedures that must occur in academic medical centers? Shouldn't a plan just have to prove that it can provide treatment for them?

* Are we covering air and water pollution in our health plan? (See page 149.)

* We stumbled over the following sentence (page 156) about long-term care: "... federal funding is capped based on the estimated cost of serving the eligible population." If the cap is high enough to cover everyone, in what sense is it a cap?

* On page 165, is $15,000 the maximum cost (we hope so) or the maximum tax credit (we hope not)?

* The antitrust section is probably fine, but a few questions on provider collaboration (page 177):

  1. Does a "narrow" safe harbor mean narrow in time?

  2. Don't you mean "market share" not "market power"?

  3. How is a "market" defined? All docs? All cardiologists?

All pediatric cardiologists?

* On page 180, what is the "routine waiver of co-payments", and why is it a bad thing?

* On page 182, in the fourth bullet, are we making it illegal to fail to report violations?

* On page 200, there are no incentives for either the beneficiaries or the doctors to join the HMOs or POS plans. Should we create some?

* On page 201, presumably we mean that the same proportion of beneficiaries meet the deductible, rather than the same number.

* Does page 202 mean that if a drug company refuses to negotiate a price with Medicare, it can't sell to any health alliance? That seems excessive.

* In the section on reimbursement in the drug benefit (page 203), does the assignment discussion imply that balance billing is still allowed under Medicare?

* In the transition section (page 223), what are the "limitations on balance billing"?

* For the low-income subsidies (page 250), would it make sense to just offer a straight percentage discount on all plans below the WAP?

HC - policy F

EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON, D.C. 20500

MEMBER

CLOSE HOLD **CLOSE HOLD**

March 14, 1994

MEMORANDUM FOR THE FIRST LADY

FROM: ALAN S. BLINDER

SUBJECT: Possible Changes in the Health Care Plan

This memo is predicated on the belief that Congress will do a wonderful job of pulling the plan apart, but will then be unable to put it back together again. Hopefully, the Administration will play a central role in the reconstruction. I presume we will want to do this in ways that:

- address most of the major Congressional concerns
- accomplish the President's key objectives
- resemble the original proposal enough so that the new plan will still be called "the Clinton plan."

Toward this end, this memo suggests a list of specific changes in the plan—some major, some minor—designed to improve both its economics and its prospects for passage. The basic philosophy is to accomplish the three objectives listed above while making the plan:

- less regulatory, with less "big government"
- more market-oriented, with better incentives
- less costly.

What follows is a list of 12 suggested changes, numbered for convenience. Only skeletal explanations are given. If you find any of these ideas appealing, much more detail (and some staff work) will be necessary.

THE MANDATE

1. Change to an individual mandate

- An individual mandate would obviate most of the criticisms now being leveled at the employer mandate. It would eliminate:

-- any danger of job loss
-- all incentives for outsourcing
-- the "burden" on small businesses.

- An individual mandate is not a "new" or "radical" idea; it is exactly how we achieve universal coverage in automobile insurance.

- With an individual mandate, subsidies are targeted better: they naturally go to poor individuals, not to "poor" firms. This saves money while eliminating labor market distortions. Rough estimates suggest that total subsidies are slightly **smaller** under an individual mandate.

- It is widely believed that an individual mandate gives firms incentives to drop coverage. This is untrue so long as:

  -- The tax preference for health insurance remains as it is now (but see #5 below).
  -- Subsidies to families are based on the **total** health insurance premium paid, regardless of whether the firm or household pays it. (This provision would improve upon both Cooper and Chaffee.)

- Most firms will continue to provide coverage under an individual mandate for a simple reason: Employees get the tax break only if the company buys their health insurance for them.

- To the extent that people are nonetheless worried that their company might drop coverage, we can allay these fears by some combination of:

  -- an appropriate "maintenance of effort" provision. or cash out 5yr?
  -- requiring that any firm that drops coverage pay its workers the equivalent in cash.

THE ALLIANCE STRUCTURE

2. Make alliances multiple and competing

- Each geographical area would have one public alliance and as many private alliances as the market generated. Health plans could choose among different alliances, and alliances would compete.

- Alliances would do most of the things they are supposed to do under the HSA. They would:

  -- offer consumers understandable choices (e.g., prices for a uniform benefit package)

-- collect and disseminate data on quality
-- enforce community rating
-- perform risk adjustment across plans
-- achieve insurance reform (guaranteed issue and renewability, no preexisting conditions, etc.).

- Apart from running the public alliance, the government would simply make sure that private alliances obeyed the rules, met fiduciary standards, etc. There would, for example, be no prohibition on plans charging more than 120% of the weighted average premium.

  -- To help enforce community rating and avoid adverse selection, the government would also do risk adjustment across alliances.

3. Lower the size limit for self-insured firms and free them from most regulations

- Self-insured firms already have the right incentives to control costs. There is no need to force them into the alliance mold, regulate them heavily, or put them on a budget.

- Subsidies could be made available to low-wage workers in corporate alliances.

- We could still charge the corporate assessment, perhaps more than 1% to make up for the subsidies.

COST CONTROLS

4. Relax the cost containment provisions

- I find this the most vexing issue because:

  -- If premium caps are set too tightly (as I suspect ours are), they don't give market incentives a chance to work and are likely to lead to, first, rationing and then pressures on Congress to change the law. But...
  -- we need scorable savings.

- This leads me to suggest three options:

Option 1 (play or pay): Let each alliance choose between abiding by the premium caps in the HSA or paying a tax on doctors' fees.

Option 2 (looser controls): Loosen the premium caps and make up the lost scorable savings elsewhere.

Option 3 (no controls): Eliminate the premium caps entirely and make up the lost scorable savings (which are greater than in Option 2) elsewhere.

- Under either Option 2 or Option 3, we need an "elsewhere" to find money. Among the possibilities are:

  -- reductions in benefits (like #6-#8 below)
  -- a tax cap (see #5 below)
  -- an excise tax on doctors' fees. Work would need to be done on this, but something like an 8% tax on doctors' bills might produce as much money as our premium caps.

5. Add a tax cap

- We need the tax cap both for the incentives it creates and for the revenue it yields.

- The tax cap should be based on the weighted average premium, not on the plan the household selects. This would maintain the strong incentive for cost-conscious choice that is now in the HSA.

- If possible, it would be better to replace tax deductibility by a tax credit, and cap the credit. But this is another matter, somewhat extraneous to health reform.

THE BENEFIT PACKAGE

6. Reduce the generosity of the benefit package

- Scale back the comprehensive benefit package to, say, the level of FEHBP, or perhaps even lower.

- Further increases in benefits could be scheduled for the future, conditional on getting savings. (Doing this would reduce risks to the budget.)

7. Remove the special benefits for retirees

- This provision has been much criticized as a giveaway.

- With an individual mandate and appropriate subsidies, it has no justification.

8. Phase in the Medicare drug benefit and long-term care more slowly.

REDUCE REGULATIONS

9. Eliminate the price schedule for fee-for-service, and allow balance billing—including balance billing for Medicare.

- The ban on balance billing in the HSA:

  -- invites "off shore" or "underground" medicine;
  -- will endanger Medicare, if fees get set so low that doctors shun Medicare patients.

- Allowing balance billing will increase support for our plan among doctors.

10. Eliminate the "breakthrough drug" provision

- This provision is causing us a great deal of grief for little benefit (because there are so few breakthrough drugs each year).

- The biotech industry is no doubt exaggerating their case, but they have a legitimate one.

- Making this change would defuse opposition from the biotech and pharmaceutical industries.

- We could and should retain the Secretary's authority to refuse to buy a drug for Medicare if she deems it too expensive.

- We could and should insist that drug companies charge American buyers no more than they charge foreign buyers.

11. Reduce or eliminate the centralized control over medical students' choice of specialty

- Other, market-based incentives in the plan should lead to more family doctors and fewer expensive specialists. Incentives are better than command-and-control.

12. Pare the list of other regulations

- There are a host of other regulations in the bill, many of which have little to do with the economics of the plan, but which give it a heavy regulatory feeling.

- Many of these regulations are not central and could easily be trimmed. CEA is not the best place to compile such a list, however.

Send Md. study to Blinder
reg. review of HSA

	HSA	Congressional Criticism	Suggestion
Mandate	on employers	"no employer mandate"	on individuals
Alliances	one per region	"bureaucratic, monopolies"	multiple, competing
Corporate alliances	>5,000	limit is too high	>500?
Insurance market reform			
Community rating:	yes	?	yes
guaranteed issue?	yes	yes	yes
guaranteed renewal?	yes	yes	yes
no pre-existing?	yes	yes	yes
Cost containment			
premium caps?	yes; tight	no	yes?; looser
balance billing?	no	yes	yes
breakthrough drugs?	yes	no	no
tax cap?	no	?	yes
Benefit package	"Fortune 500"	"too generous"	"FEHBP"

1.

→ sell at same prices as sold to foreign plans
↳ lowest price + cover all drugs not just breakthrough
drop 120% over average cost cap but pay w/after tax $s
IRS: is compliance rate for payroll tax/W s.m. biz deficient?
Simpson-Mazzoli requirement that employers show coverage

S- Bentsen

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

SECRETARY OF THE TREASURY

October 6, 1993

MEMORANDUM FOR THE FIRST LADY

FROM: Lloyd Bentsen

SUBJECT: Health Care Reform Drafting

As we all work to finalize the details of the Administration's health care proposal, it becomes important to ensure that the actual legislative language accurately reflects the decisions that are made. Because many of the financing issues were not decided until late in the process, the drafting of those provisions has necessarily been delayed. however, I am becoming increasingly concerned that many of these important issues will not be allocated the drafting time and resources necessary to ensure that they work properly.

To date, the Treasury Department has not been involved in any drafting of the health reform plan and has received only a very rough draft of one relatively minor issue -- the tax treatment of long term care insurance.

We anticipate that considerable drafting attention will be required with respect to a wide variety of tax issues included in the plan. In addition, there are a number of issues that have not been characterized as taxes, but that directly relate to areas in which the Treasury Department and the Internal Revenue Service have considerable expertise. Attached for your information is a listing of these items.

I hope that we can bring our experience to bear by being directly involved in the drafting of the relevant portions of the legislation and in commenting on those issues where Treasury/IRS input might improve the product. In addition, we will need to review the legislative language on certain issues in order to ensure that the policies reflected in the draft statute are consistent with the policies that have been estimated.

I look forward to hearing from you or the relevant members of the drafting team on these issues in the near future.

Attachment

TREASURY DEPARTMENT DRAFTING ISSUES IN HEALTH CARE REFORM

- Tobacco taxes
- Tax cap proposal and rules eliminating the use of so-called cafeteria plans to provide health benefits.
- Tax treatment of benefits paid under new long term care program.
- Taxation of long-term care insurance and accelerated death benefits.
- Disclosure of tax information to alliances and others.
- Information reporting with respect to Medicare as a secondary payer.
- Tax incentives for health care professionals in underserved areas.
- Payroll tax as a sanction to ensure state establishment of regional alliances.
- Changes in ERISA preemption and sanctions (jointly with the Department of Labor).
- Tax credit for the disabled.
- Assessments on employers outside the alliance (so-called corporate assessment).
- Early retiree issues, including the possibility of a one-time assessment on firms benefiting from retiree health changes; the impact on existing tax-favored retiree health prefunding vehicles (401(h) accounts and VEBAs); and the possibility of means testing the government subsidy.
- Availability of tax-exempt financing for Regional Alliances.
- Means-related Medicare Part B premiums.
- Extension Medicare HI to tax to all state & local government employees.
- Impact on so-called COBRA health care continuation rules.
- Tax treatment of entities affected by proposal (regional and corporate alliances; plans and providers).
- Establishment of trust fund for self funded health plans.
- EMPLOYEE HEALTH BENEFITS FUND/Reserve Fund.

- Establishment of National Health Reform revolving fund for investment in the start-up cost VA Health Plans.

ISSUES WHERE TREASURY AND IRS HAVE CONSIDERABLE EXPERTISE

- Premium Collection -- Although the premiums will be collected by the regional alliances, there will be considerable parallels between the collection of these mandated premium payments and the collection of tax revenues. Treasury and IRS input on these issues will help to improve the draft.

- Subsidies -- Although, the subsidies will be provided through the alliances, as noted, as wide variety of questions must still be answered in designing the subsidy scheme, including (i) the appropriate definition of payroll in determining eligibility for employer subsidies; (ii) designing rules to prevent abuse through employer reorganization; outsourcing of low wage workers or misclassification of employees as independent contractors; (iii) the appropriate definition of income for eligibility for the individual/family subsidy; and (iv) verification of eligibility for the individual/family subsidy. The Treasury Department and IRS have been dealing with similar issues for years in connection with the collection of income and payroll taxes and through the administration of the Earned Income Tax Credit.

- Assessments on Plans -- The plan currently includes an assessment on plans in the alliance for a variety of purposes, including the funding of academic health centers. This essentially involves the imposition of a Federal premium tax, although it must be carefully drafted to avoid the appearance of being such a tax. The Treasury Department has done considerable analysis on the method for implementing such a tax.

- Budgets -- The estimates of the effects of the mandate on Federal receipts are sensitive to the assumptions regarding cost containment. In order to minimize revenue loss, the budget caps must be effective.

EXECUTIVE OFFICE OF THE PRESIDENT
COUNCIL OF ECONOMIC ADVISERS
WASHINGTON, D.C. 20500

THE CHAIRMAN

August 5, 1993

MEMORANDUM TO THE FIRST LADY

FROM: LAURA TYSON Laura D. Tyson

SUBJECT: Issues in Health Care Reform

I am delighted that we have begun a series of health care meetings, and I look forward to working with you to finalize our health care reform proposals. I believe that there are three critical issues that we should address in more detail.

I. The Global Budget

Our discussions of the global budget have failed to distinguish between two related but logically distinct questions. First, what will be the <u>likely</u> growth of costs and savings under our proposed system? Second, at what growth of costs should the global budget cap become binding and enforceable? There is no reason why the budget cap should become binding at the <u>likely</u> growth rate of costs. Indeed, there are two good reasons why a higher growth of costs should trigger enforcement of the budget cap:

(a) <u>Since our estimates of savings are necessarily uncertain, setting a higher "trigger" growth rate for enforcement of the global budget involves less risk.</u> In our discussions, the global budget has repeatedly been described as a "backstop" on costs, activated only in the event that the anticipated savings from system reform do not materialize. As the Draft Document "Savings Under Reform" indicates, however, there is considerable uncertainty about what the actual level of savings will be. Because of this unavoidable uncertainty, the most prudent course may be to set the trigger at a level above our best guess of the likely course of costs. Otherwise, we increase the likelihood that the Federal government will find itself operating a highly centralized and regulated system that quickly supersedes the managed competition system we hope to create. And such a system has all the difficulties of short-term cost controls: large administrative costs; difficulty in dealing with managed care plans; increases in volume and intensity over time; and problems with as yet unregulated sectors of health care. It seems wiser to impose these forms of regulation only if they are absolutely necessary.

(b) An unrealistic global budget may quickly force us into untenable positions on Medicare and Medicaid savings. Our current cost scenarios assume that the growth rates of Medicare and Medicaid can be dramatically reduced from about 8 to 11 percent to about 5 percent within three years (in some scenarios, in only one year). The rationale for such an assumption is that slower growth in the private sector will allow us to slow the growth rate of public sector programs. There are two concerns here. First, if we cannot meet the budgeted growth rates of Medicare and Medicaid, confidence in our ability to meet the budget in the private sector will fall. We are placing a great deal of faith on controlling costs in public programs that we have not been able to control effectively for almost 30 years. Second, I believe that it may be much harder to meet the budget in the public sector than in the private sector. The reduction in spending in the private sector will likely come from reductions in the quantity of health care services people demand and receive, as they join managed care and other capitated systems. In the public sector programs, in contrast, there are few incentives to join capitated health care systems. Thus, cuts in public sector spending must come from reductions in the price paid for services, or in the number of services received. If we choose to lower prices, the implication is that there will be large, continuing price reductions in public sector programs. Over time, these types of cuts become less and less sustainable, and the number of services provided to program beneficiaries will ultimately take the hit.

Accordingly, I think we should set the trigger for enforcement of the global budget at a high enough growth of costs to make detailed regulation in the private sector an improbable outcome and to make anticipated savings in public sector programs a probable outcome.

II. Formulation of the Subsidies

I remain troubled by the subsidy system we have designed. Our current system involves over $50 billion of subsidies annually. Even accounting for the fact that some of this cost is offset by Medicaid savings, the subsidy program is still large.

More important, however, is the fact that we are subsidizing such a large share of the population. Median family income in the United States is about $35,000. With a premium of $4,200 and a cap rate of 12 percent, we are still subsidizing families up to $35,000 in the income distribution, or about half of the families in the Alliance. Beyond the enormous political difficulties associated with passing a system in which such a high share of families receive subsidies, there is the concern that we are putting the Federal government at substantial risk. If one-third of families are subsidized, every one dollar increase in total premiums increases Federal spending by thirty-three cents. This type of budget exposure leaves the Federal government vulnerable to fluctuations in premium costs and growth rates.

There is no easy answer here. If we decide the subsidy schedule should only extend to an income level where one-third of HIPC families would be subsidized (roughly $25,000) the required cap rate would be 17 percent. This seems untenable, from both a political and an economic standpoint. What amounts to a new 17 percent payroll tax rate would have substantial job consequences, particularly for low-wage workers who are already at a disadvantage in the labor market. Alternatively, if we retain the current cap rate but just terminate the subsidy at some level of income, those with incomes just above the cap will have less income after paying for health insurance than individuals just below the cap. This type of "notch" in effective tax rates is both inequitable and creates adverse labor market incentives.

It seems to me that we have five alternatives:

(a) Recognize the drawbacks in the current system but remain with this formulation.

(b) Consider a system that subsidizes firms but not individuals. By using a variation on "play-or-pay" financing -- requiring firms to pay 80 percent of the cost but capping the firm's contribution as a share of total payroll -- we may be able to limit the subsidy amount. The drawback is that high wage firms would face extraordinarily high costs in hiring low wage workers, which would show up as lower employment.

(c) Reduce the generosity of the benefit package. While this will lower the share of families receiving subsidies, it will not completely solve the problem. Even under the premiums in the Bush Plan (about $3,750 for a family policy), for example, people up to $31,250 would be receiving a subsidy with a premium cap of 12 percent.

(d) Consider alternative financing mechanisms beyond the employer mandate. There are two alternatives to the employer mandate. First, financing could be based on a new source of revenue, such as a value added tax. Second, we could require individuals to purchase insurance (an individual mandate) and subsidize low-income people through the income tax system. These alternatives may be politically difficult, however, because they involve a substantial change from the current system.

(e) Re-examine the phase-in of the program to lower transition subsidies. One of the goals of the slower phase-in plan presented last May (the major medical phase-in) was to limit subsidies to individuals who are not currently insured. This lowered subsidy costs during the transition period. It might be worth pursuing such plans further. For example, the mandate could be implemented in stages, with large firms mandated before smaller ones. Such options are clearly feasible only as a phase-in policy, not as a long-term policy. Since uncertainties about costs and savings are

most pronounced in the first few years of the new system, however, phased-in approaches are worth considering. Even if we have an extensive subsidy system in the long run, we may want to minimize subsidy costs in the short run.

As I indicated, I do not know of an easy answer to the subsidy/financing problem. I believe that we should discuss it in some detail and examine some of the tradeoffs.

III. Implementing Incentives for Cost Minimizing Plan Choice

The strength of our plan is its ability to lower health care costs through market-based mechanisms. There are three policies that have been discussed that will aid in this objective. I am not certain where our decisions currently stand, but I think each of these policies deserve further discussion. The policies are:

(a) Revising the tax treatment of employer provided health insurance. Many individuals currently pay only about 60 percent of the costs of more expensive health insurance, with the remaining 40 percent subsidized by the government. In addition, people insure even small deductibles and coinsurance payments because insurance premiums are tax favored relative to out-of-pocket spending. This first dollar insurance, however, increases health care utilization as well as administrative expense. Reforming the tax treatment of employer provided benefits -- either by taxing them to the individual or limiting their deductibility to firms (as in the Cooper bill) -- will help to limit the growth of health care costs.

(b) Allowing individuals to claim all of the savings from choosing lower priced plans. In the current market, many employers pay 80 percent of the cost of whichever plan is chosen by the employee. Individuals thus face only 20 percent of the additional costs they bear from choosing more expensive services, leading to greater health care utilization. If individuals were able to enjoy any health care savings they generated by choosing lower cost plans, health care spending would decline. This has been the experience of companies like Alcoa and Xerox, as the task force savings document indicates.

(c) Subsidizing individuals only up to the lowest cost plan. When there is a range of plan costs, we need to choose a rule about how much to subsidize: the lowest-cost plan; the average-cost plan; the highest-cost plan; or some other formula. By choosing the lowest cost plan we can encourage subsidy recipients to choose less expensive health care providers.

cc: Ira Magaziner

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

September 24, 1993

THE DIRECTOR

MEMORANDUM FOR: Ira Magaziner

FROM: Leon Panetta and Alice Rivlin

SUBJECT: Timetable for Budget Estimates

As you have often emphasized, it is important for the credibility of the health reform proposal that all Federal cost and savings estimates be thoroughly scrubbed. In order to provide thorough the estimates, our OMB budget examiners will need clarification of some of the policies in the health reform plan. Decisions are also needed on certain economic and technical assumptions to be used in preparing estimates of the Federal budget effects of the reform.

This memorandum lists the points that need clarification. We understand the pressures for a very rapid turnaround. We will be able to produce cost estimates 2 weeks after we get a complete set of programmatic specifications to price out.

Policy Clarifications: There are a number of policy questions that must be clarified before OMB can estimate the plan's total costs to the Federal budget. A list of these questions is attached at Tab A. (These should look familiar: Many of our questions were forwarded to you as an attachment to our memorandum on the 8/6/93 draft of the health reform plan, and we have compiled an additional list of new questions pertaining to the 9/7/93 draft, which was forwarded earlier this week.)

Economic and Technical Assumptions: Up until now, the economic assumptions used for estimating the costs and savings from the health reform proposal have been the January 1993 "CBO" assumptions, the same assumptions used for the President's February and April budget submissions to the Congress. They include the assumption that inflation will average 2.7 percent per year in 1996-2000. In August, the Administration revised its economic assumptions for the Mid-Session Review. The new assumptions are no longer based on the CBO economic forecast. Inflation averages 3.5 percent per year in 1996-2000 in the new projections.[1] We recommend basing the budget estimates for health reform on the new Administration economic assumptions so that we will be able to compare it with other Clinton Administration proposals and forecasts and to produce an internally consistent estimate of the impact of the proposal on

[1] CBO has also revised its economic forecast. The current CBO economic forecast calls for an inflation rate of 3.0 percent rather than 2.7 percent.

the deficit. You should also be aware that the health reform proposal, as a pending Administration legislative proposal, will have to be re-estimated for the President's FY95 budget submission, using revised economic and technical assumptions. The practice has been that these budget estimates are made by the affected agencies on a budget-account basis using the Administration's own economic assumptions. These are likely to differ somewhat from current forecasts, but the disparities are likely to be minimized by adopting the current Administration forecast now.

"Scorekeeping" Issues: As we have discussed, there are certain Budget Enforcement Act (BEA) "scorekeeping" issues that will need to be resolved before legislation is proposed to implement the health reform proposal. We will need about two days after the OMB/Treasury estimates are final to assess these scorekeeping issues. Please note that for presentation to Capitol Hill, OMB and Treasury estimates will have to be divided into the following categories: discretionary, PAYGO (receipts and mandatory), and indirect impacts. Depending upon how the current policy divides into these categories, we may want to suggest changes in the language used to describe the policy in the detailed specifications you are drafting. Moreover, it might be productive for us at OMB to surface any scorekeeping issues with CBO in advance of finalizing the policy specifications.

In addition, it appears that there will be BEA issues relating to the proposed increases in discretionary spending in the health reform plan, which appear to be far too large to fit within the existing discretionary caps. We have discussed this issue with respect to the proposed increased spending for various programs of the Public Health Service; if these increases are maintained, the BEA will have to be amended, because it sets an absolute limit on discretionary spending that would be breached by this additional spending. While this might conceivably justify a proposal in the health reform bill to amend the BEA to raise the discretionary caps (which might be justified with the argument that the new discretionary spending is more than offset by PAYGO savings that will be achieved by the Medicare savings proposals), this depends on how much of the increase in receipts and the decrease in mandatory spending will be scoreable under the BEA. (It appears that some of the receipts that are currently being scored may reflect indirect impacts that cannot be scored under BEA). As you can see, these issues involve complicated technical questions, as well as questions regarding our approach to the Congress that must be carefully considered as part of the overall legislative strategy for the reform effort.

Attached at Tab B is a proposed schedule for completion of our work. Please let me know if you have any questions.

cc: The First Lady

Attachments

The following code applies to each question or set of questions:

Priority 1: Cross-cutting questions that more than one group needs answered before pricing can begin.

Priority 2: Questions that must be answered before pricing of a specific component.

Priority 3: Questions whose answers may not affect the pricing but which may highlight the need to sharpen the focus of legislative specs.

PRIORITY 1

15 Sep 93

1. From/To health coverage status over time (FY94 - 2000) - where are people now, where will these go each year — detailed pricing and modelling assumptions and data.

   - state and local coverage - mandated? subsidized?
   - uninsured
   - movement from one of two spouses employer's paying premiums to two working spouses having employers pay contributions - When? Alliance by alliance, time period
   - are welfare recipients induced off the AFDC, General Assistance, or Food Stamp rolls
   - coverage of temporary employees — particularly federal temporaries

2. What is the premium plus surcharge, guaranty assessments and other amounts — Are the weighted average premiums *ex ante* or *ex post*?

   - Timing of development of health alliance premium by major state and concentrations of federal beneficiaries

   - Breakout the surcharges for Nationally desired activities, their timing, State Guaranty funds

   - Growth of premiums, and surcharges, etc. over time and changes in benefits — 2000 etc.

3. Amount of payment by FEHB on behalf of over 65 non-Medicare annuitants and the increase in premium cost

4. Interaction of Medicare and Medicaid drug benefits — what are the rules?

5. Maintenance of Effort for Medicaid — detailed description and HHS pricing over time.

6. Assumptions on VA Health Plan participation and direct appropriations — same with Indian Health, DoD/Champus

7. National Health Board function and staffing

8. Health cost containment, its effect on the CPI — and federal revenues/outlays

9. Income and firm subsidy designs E. G. What is income, etc. and the costs of administration and including underlying eligibility, participation and error

rates.

10. Changes in federal tax income from for profit health plans and physician and other provider income.

11. Details on early retiree policy especially DoD and FEHB early annuitants

12. Interaction of Medicaid and Medicare with the new long term care benefits (part 4-) rules, etc.

13. Treatment of Federal auto and workers compensation — Federal Tort Claims Act, FECA

13. Are those in Federal State and other institutions covered (jails, mental hospitals, juvenile centers, etc.)

15. If calculations are on a CY basis, please provide your methodology for estimating the FY/CY switch.

16. Pleaase provide the cash flow incurred costs, outlay lags and related assumptions.

Please provide a list of contact for each of the items.

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MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	1994	1995	1996	1997	1998	1999	2000
Current Law							
Baseline updated for August CEA economics							
Beneficiary Population							
Per-Beneficiary Outlays							
Less Employer-covered Aged (assumes full-time work for full year)							
Outlay savings							
Beneficiaries opting out							
QMB offset							
Admin. costs							
Early Retiree Coverage Effect							
Outlay Change							
Number of Early Retirees							
Admin. costs							
Revised Pre-Savings Baseline							
Outlays							
Beneficiary Population							
Savings Package Assumed for HCR							
Outlay savings							
Effect on Beneficiary Population							
Change in Admin. costs							
Post-Savings Baseline							
Outlays							
Beneficiary Population							

24-Sep-93
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MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	1994	1995	1996	1997	1998	1999	2000
HCR Effect on Baseline							
Number of enrollees in "standard" Medicare							
QMBs							
Dual Eligibles							
Standard Medicare HMO							
Other/Fee-for-service							
Total							
NON-ADD Supplemental coverage effect on outlays							
Number of enrollees moved to alliances							
QMBs							
Dual Eligibles							
Other							
Total							
Enrollees in VA health plans with Medicare as primary payor							
NON-ADD *Supplemental coverage effect*							
Where does Medicare pay (plan or point of service)							
Admin. costs VA							
Medicare							
Enrollees in CHAMPUS/VA health plans with Medicare as primary payor							
NON-ADD *Supplemental coverage effect*							
Admin. costs CHAMPUS/VA							
Medicare							

24-Sep-93
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MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	1994	1995	1996	1997	1998	1999	2000
Enrollees in CHAMPUS health plans with Medicare as primary payor							
NON-ADD Supplemental coverage effect							
Admin. costs CHAMPUS							
Medicare							
Enrollees in DoD/Champus health plans with Medicare as primary payor							
NON-ADD Supplemental coverage effect							
Admin. costs DoD/CHAMPUS							
Medicare							
Average Federal Medicare contribution for Alliance-based Medicare beneficiaries							
Average Beneficiary Contribution							
Admin. costs							
Average Federal Medicare contribution for DoD plan Medicare beneficiaries							
Average Beneficiary Contribution							
Admin costs							
Average Federal Medicare contribution for VA plan Medicare beneficiaries							
Average Beneficiary Contribution							
Admin costs							
POST-HEALTH CARE REFORM, NET MEDICARE OUTLAYS							

24-Sep-93
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MEDICARE OUTLAY AND BENEFICIARY ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year, and explain key assumptions.

	1994	1995	1996	1997	1998	1999	2000
Related Assumptions							
Drug price growth rate							
Drug premium							
Pre rebate							
Post rebate							
W/O rebate							
Admin costs							
Cost shift/capturing secondary effects							
Revenue affects							
Employer taxes							
Employee taxes							
State and local government taxes							
Medicare Beneficiary Cost-Sharing							
Average for standard plan							
Premium							
Deductible							
Copay.							
Total							
Plus: Drug Premium							
Drug Copay.							
Total							
Effect of supplemental coverage on drug utilization							

September 24, 1993

Health Care Reform Pricing Issues -- Medicare

The cover table and the following list of pricing and policy questions contains significant overlap and duplication. The intent is that the answers to these questions and stated assumptions will provide enough specification to provide estimates of health care reform's impact on Medicare.

On a fiscal year-by-fiscal year basis through the year 2000, what are the assumptions concerning:

- Medicare beneficiary enrollment through the Alliance rather than traditional Medicare? Does the percentage of enrollees gaining coverage through the Alliance increase over time? **(See table; Categories 1 & 2)**
  - What percentage of them enroll in HMOs? **(See table; 2)**
  - Do Medicare beneficiaries pay the surcharges on the premium, or does the Federal subsidy include them? **(1, 2, 3)**
  - What incentives, e.g., differential premiums, will exist to encourage enrollment in managed care settings? **(3)**
  - What is the assumed deductible in health plans for Medicare-eligible enrollees? **(1, 2)**
- How many (and what percentage of) non-working, non-QMB people who would have been in Medicare will elect to enroll in alliances instead? **(1, 2)**
- Does the employer mandate apply to employers of Medicare-eligibles or is employment sponsored insurance merely a mandated option for Medicare-eligibles? **(3)**
  - Does the mandate apply to the cohort of working aged in corporate alliances? **(3)**
  - Suppose both spouses are Medicare enrollees, and only one works. Does the mandate require worker/employer to buy a "couples" policy or a single policy? **(1, 2, 3)**
  - If a Medicare beneficiary is married to a non-Medicare worker, does the worker-employer have to buy a couples policy or could they decide to

Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.

purchase only a single plan? **(2, 3)**

- What limits on enrollee choice of policies/coverage exist? **(3)**

- How will savings accruing to the States be shared between beneficiaries and Medicare? **(1, 2, 3)**

- For the Medicare-eligible alliance enrollees, what will be the total amount the alliances charge, and the average per capita amount, to Medicare?

  - What are the assumptions regarding the amount charged to Medicare, e.g., is it based on the average per capita amount? **(See table; 3)**

  - Is it risk-adjusted to a level lower than the average Medicare fee-for-service level to reflect an assumed better health status and/or younger average age of Medicare-eligible alliance enrollees? **(See table; 3)**

  - Is it geographically adjusted by state? Would Medicare subtract lost premium income from the amount paid to the alliance? How much? **(See table; 3)**

- Are Medicare IME outlays folded into the funding pool for academic health centers, along with the GME payments? Or are they held separate, but at a lower IME rate of payment, e.g., 3%? **(1 & 2)**

  - What are the assumed impacts on Medicare GME/IME payments under the workforce changes contemplated by the 9/7 draft?

- Are those eligible for Medicare through disability enrolled in a separate pool, or do they continue to receive care under Medicare? What are the assumptions about the disabled's enrollment through Alliances and the effect of marriage status? **(1, 2, 3)**

- Are dual eligibles folded into the Alliances along with the rest of the Medicaid population, or does Medicare cover them?

  - Who is the primary payor for prescription drug cost-sharing for dual eligibles, Medicare or the States? **(See table; 1 & 2)**

  - Are States required to cover Rx cost-sharing for QMBs? Is this going to

Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.

be reflected in the MOE calculation? How will the Medicare and Medicaid drug benefits be integrated? **(1, 2)**

- What percentage of QMBs will enroll through Alliances?

- Are there separate assumptions about elderly utilization of health care services under different cost-sharing schemes? If so, what is assumed about Medicare beneficiary utilization with lower cost-sharing requirements, e.g., managed care enrollment with no Medigap allowed? **(2)**

- Will the elderly be allowed to purchase Medigap if they enroll in managed care settings? **(3)**

  - What are the assumptions about reduced Medigap purchasing as the result of the new Medicare benefits/options, e.g., coverage of copayments on drugs rather than the entire drug? **(See table)**

- What income levels are assumed of veterans before Medicare will pay VA for covered services? **(1, 2, 3)**

  - What are the assumptions about the number of Medicare beneficiaries also eligible for VA care? What is the assumption about Medicare payment to the VA for care rendered Medicare enrollees? **(2)**

- What are the assumptions about Medicare beneficiary utilization of VA and DoD facilities? What are the assumptions about Medicare enrollees enrolling in DoD, VA, CHAMPUS, and CHAMP/VA plans? **(2)**

- What assumptions are made about the average out-of-pocket cost for a Medicare-eligible alliance enrollee (i.e., 20% of premium with subsidies for low-income, $200 deductible, some coinsurance), versus the average out-of-pocket cost if they choose to stay in Medicare (i.e., 25% of Part B costs, $676 Part A deductible, $100 Part B deductible, and copays). Are these relative costs taken into account in developing a model to determine how many will opt for alliances versus staying in Medicare? **(See table; 3)**

  - In addition, do the assumptions about how many Medicare-eligibles enroll in alliances take into account the varying levels of income-related subsidies for alliance premiums? **(3)**

Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.

- The plan asserts that States will assume Medicare administrative costs in situations in which Medicare is enrolled into the alliance (pg. 191). If Medicare is not reimbursing the States for these costs, how much administrative savings are assumed for the Medicare program? **(1, 3)**

- What are the assumptions regarding Medicare beneficiaries already enrolled in managed care plans? **(See table)**

  - How many stay in existing plans versus joining plans under the health alliances?

- What are the assumptions regarding beneficiaries joining Medicare point-of-service plans (pg. 193)?

  - How many from current baseline enrollees in Medicare managed care plans will switch to point-of-service networks? How many additional beneficiaries will join point-of-service networks? What will be the average per-capita Federal cost and savings versus the baseline for these plans? What Federal administrative costs are assumed for these point-of-service plans? **(3)**

- What are the assumptions about physician discretion in waiving Medicare coinsurance requirements in cases of "financial hardship and professional courtesy" (p. 120)? What is the induced utilization effect? **(2, 3)**

- What are the assumptions about the effects of Medicare proposals on administrative costs? **(2)**

Category 1: Cross-cutting issue. Category 2: Necessary for budget and scoring purposes. Category 3: Policy decision that could be necessary for drafting legislation.

Pricing Questions Concerning the Medicare Drug Benefit

1. What effect do you assume the drug benefit will have on drug usage and expenditures among Medicare Part B beneficiaries? (2)

2. How many beneficiaries do you assume will enroll in Medigap policies that cover the cost-sharing requirements included in the drug benefit and what affect will Medigap coverage have on drug usage and Federal expenditures? (2)

To: Lew Nichols
From DKK

Kronick 9/22

Ag-HF-3

Medicare As Secondary Payer Policy

Policy questions that need to be answered in order to accurately estimate the size of the 'Offset for Medicare Eligibles in the Alliance':

1+2 1) Is policy that Medicare beneficiaries who are full-time workers must be members of the alliance (either corporate or regional) with Medicare as a secondary payer, or that they can choose to be alliance members with Medicare as secondary payer?

a) If a Medicare beneficiary works for an employer who only contributes the required 80%, then choosing alliance coverage will require an additional payment (20% on average, more for a more expensive plan less for a less expensive). For a single person, this will average $380, for a couple perhaps $800. For most this will be a better value than Medigap has to offer. It is reasonable to require the full-time worker beneficiary to take alliance coverage; however, it is, at a minimum, politically sensitive to require payments for the 20% (more or less) for people who are eligible for Medicare.

If it is decided to require alliance membership for a full-time over-65 worker, it would make sense also to require membership for the spouse of a full-time worker even if the spouse is a Medicare beneficiary.

b) To avoid disruption and reduce expenditures, if a beneficiary is working full-time during annual open enrollment but subsequently stops working, could potentially leave them in the alliance for the rest of the calendar year and provide the 80% retiree subsidy (this would probably be less expensive to the federal till then returning them to Medicare because of the community rating effect). Alternatively, if a full-time worker stops working during the year, could end alliance coverage and return them to Medicare. (If there is thought of leaving them in the alliance, would we require this or leave it as an option?)

c) If a Medicare beneficiary is not working at time of open enrollment but starts working full-time during the year, makes sense to add them to the alliance roles during the year. Same questions about what to do if they stop working during the year.

2) Part-time workers

1+2 a) If a Medicare beneficiary works part-time, could potentially require employer pro-rata payment, require the beneficiary to join the alliance, and provide the retiree subsidy to fill in the unpaid portion of the 80% employer

contribution. Similar issues as for full-time workers on whether we are willing to require such persons to pay the 20%.

3) Modelling, not policy question: If we leave to workers the decision on whether or not to join the alliance and pay (more or less) the 20%, what will OACT and/or others assume about beneficiary behavior?

a) What was assumed, either for policy or behavior, in the estimate that the Medicare offset is $59 billion?

9/24/93
5:15 PM

MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Current Law									
Caseload									
AFDC (under 65)									
AFDC (over 65)									
SSI (under 65)									
SSI (over 65)									
QMBs									
Dual Eligibles									
Other Non-Cash									
Institutionalized (non-add)									
Per Capita Costs (Basic Benefits) 1/									
AFDC (under 65)									
AFDC (over 65)									
SSI (under 65)									
SSI (over 65)									
QMBs									
Dual Eligibles									
Other Non-Cash									

9/24/93
5:15 PM

MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Current Law									
Per Capita Costs (Supplemental Benefits) 1/									
AFDC (under 65)									
AFDC (over 65)									
SSI (under 65)									
SSI (over 65)									
QMBs									
Dual Eligibles									
Other Non-Cash									
Per Capita (Long Term Care) 1/									
Nursing Facilities									
ICFs/MR									
Non-Institutional Care									
Aggregate MAP Costs 1/									
Administration Costs 1/									
Total Medicaid Costs 1/									

9/24/93
5:15 PM

MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Health Care Reform									
Caseload									
AFDC (under 65)									
SSI (under 65)									
QMBs									
Dual Eligibles									
Institutionalized (non-add)									
Former Recipients									
Community-Based Long Term Care									
Alliance Buy-Ins									
Per Capita Costs 1/									
Basic Benefits (Budgeted Premium)									
Supplemental Benefits									
Institutionalization									
Community-Based Long Term Care (new LTC program)									
Aggregate MAP Costs 1/									
Administration Costs 1/									
Total Medicaid Costs 1/									

9/24/93
5:15 PM

MEDICAID OUTLAY AND CASELOAD ASSUMPTIONS FOR PRICING OF HEALTH CARE REFORM

(savings positive, outlays negative)

Note: for all streams, please identify whether estimates are calendar year or fiscal year

	1992	1993	1994	1995	1996	1997	1998	1999	2000
Health Care Reform									
Table Line Items									
Aggregate State Maintenance of Effort									
Liberalized Long-Term Care Eligibility (Institutionalized)									
Offset for Current Law Medicaid Eligibles 1/									
Community-Based Long-Term Care									
Alliance Buy-Ins									
Savings Due to Budget Cap 2/									

Notes

1/ Show State, Federal, and total computable costs where appropriate.

2/ Break out for specific savings provisions, including DSH.

Questions About Pricing of Medicaid Provisions

General.

3 • HCFA is largely dependent on State data to estimate future Medicaid spending and to disaggregate projected, as well as actual, Medicaid spending into particular categories, e.g., acute care spending for AFDC recipients. What data sources have been used in pricing the President's plan, e.g., determining State's maintenance-of-effort contribution, estimating the number of employed Medicaid recipients, and carving out current Medicaid spending for services in the national benefit package?

3 • Will these same sources continue to be used or will there be special State data queries, surveys, or audits to validate currently-available data?

2 • Which Medicaid service categories will be included in the national benefit package and which are defined as long-term care services?

2 • What assumptions were made about the behavior of States in response to the proposed changes in Medicaid? For example, what assumptions, if any, were made about the effect of likely State efforts to reduce Medicaid spending during the year prior to reform or to move individuals from Medicaid to fully-Federally financed low-income subsidies? Also, if the match rate system for financing Medicaid is retained, what assumptions were made about States' ability to generate Federal funds through "costless spending" programs involving provider taxes?

Caseload.

2 • On a fiscal year basis through the year 2000, what are the assumptions regarding the size of the Medicaid caseload in the absence of reform and where these Medicaid eligibles "go" under the President's plan, i.e., how many obtain coverage through:

- their employers?
- low-income subsidies?
- remaining on Medicaid?

(see attached table).

2 • In developing these caseload estimates, what assumptions were made

about the behavioral effects of increased work incentives on the number of Medicaid cash recipients?

Per Capita Costs. Please provide a detailed description of policy, assumptions, and pricing over time.

3 • Will different premiums be computed for AFDC and SSI recipients?

2 • According to page 201 of the 9/7 draft of the plan, annual rates of increase in the per capita payments from Medicaid to alliances will be "subject to the national health care budget." Does this imply that annual increases will be equal to, no greater than, or otherwise related to the budgeted amounts? Please explain how the negotiating process with plans will work and how the budgeted annual increases in State Medicaid payments to alliances will be computed and enforced.

2 • Will Medicaid per capita payments be adjusted to include costs associated with services that will be included in the national benefit package but are not currently covered by Medicaid, e.g., coverage for treatment of persons age 21-65 in institutions for mental diseases (IMDs)?

Wrap Around Coverage.

2 • Will the wrap-around package vary State-by-State, depending on the mix of services each State now provides? Can States alter the package? Who will be eligible for these wrap-around services, who will pay for these services, and how will payments be computed? If Federal funding for wrap-around services is provided through block grants, will the grant amounts be established to approximate the Federal portion of current State spending on wrap-around services?

2 • Will Medicaid recipients in the Alliance be subject to the same cost-sharing requirements as other low-income individuals or would cost-sharing subsidies be included as part of Medicaid wrap-around coverage?

2 • Under the plan, would Medicaid continue to finance the Medicare cost-sharing expenses for Qualified Medicare Beneficiaries and dual eligibles now covered by Medicaid?

Maintenance of Effort.

2 • What are the various components of the State's maintenance-of-effort

(MOE) contribution?

- Does the MOE contribution include States' share of DSH payments, as well as payments for services not included in the national benefit package? If the MOE contribution does not include State DSH spending, will these dollars be netted out of the initial calculation of Medicaid per capita payments to alliances?

- Does the MOE contribution include current State spending for:

  - Medicaid services that are <u>not</u> included in the national benefit package; and

  - for individuals who are <u>no longer eligible</u> for Medicaid, but also not eligible for low-income subsidies, e.g., pregnant women with incomes between 150% and 185% of poverty?

2 • In calculating the annual growth in the MOE offset, what assumptions were made about the level of budgeted growth in States' average weighted premiums?

3

3 • Will States be given an opportunity to appeal the calculation of their initial MOE contribution, i.e., will there be some sort of appeals process for States?

Long-term Care.

2 • Exactly how will State contributions and Federal matching be calculated for new community-based long-term care (both low-income and non-means-tested)?

2 • What will the Medicaid offset be for home and community-based spending folded into the new long-term care program?

2 • How will acute care for Medicaid institutionalized patients be coordinated and financed?

2 • How will institutional long-term care spending be budgeted?

Working (AFDC cash) Recipients.

2 • Will Medicaid continue to buy into employer health plans?

2 • What are the transition payment rules for those moving into and out of AFDC and into and out of employment?

DSH.

2 • What is the schedule for phasing-out DSH?

2 • Medicare DSH payments are computed according to a formula that is based on the number of the Medicaid inpatient days. What assumptions have been made regarding the effect on Medicare DSH payments resulting from the substantial reduction in the number of Medicaid eligibles under reform?

Cash Flow.

3 • What assumptions were made about the effect on Medicaid spending at the point of implementation when States are paying for Medicaid costs that have been incurred by current beneficiaries, as well as paying prospective premiums to Alliances?

Long-term care program questions

By year, how many individuals are projected to receive services from the new community-based LTC program? Please show projections for both the 3-ADL program and the low-income program. How many of these individuals would otherwise have been Medicaid-eligibles?

Will reimbursement rates under the new program be comparable to those under the current Medicaid program? Will there be a difference between reimbursement rates for the 3-ADL program and the low-income program?

What assumptions are being made about the phase-in of coverage over several years?

How will program spending be budgeted? What annual growth rates are assumed?

What assumptions are being made about utilization rates and costs per recipient under the new program? Do these assumptions change over time?

Will Medicare beneficiaries have to pay a premium for the new program? Who will pay and how much will the premium be? What is the projected revenue from premiums?

What will the Medicaid offset be for home and community-based spending folded into the new program?

Exactly how will State contributions and Federal matching payments be calculated under the new program? How much are the State and Federal government expected to spend?

Are the costs of tax credits for the working disabled included in the LTC program estimate, or do these costs only affect the "receipts" line item?

Long Term Care (pp.151-165)

Status: Changed

Budget Issues

- P. 152. It is possible that a portion of the SSI/DI population who are not currently receiving institutional care or home based care would qualify for community based care as under the eligibility standards described. Limited ADLs are used as eligibility criteria for SSI/DI, but this population rarely uses institutional care.

- P. 158 Would the monthly living allowance change for recipient of federal benefits (SSI, VA) change?

- P. 162 This tax deduction would represent a double exclusion for SSI/DI recipients. Work related expenses are deducted from an SSI/DI recipients total income when calculating benefits.

Policy Issues or Clarifications

- Medicare beneficiaries pay a premium toward coverage, with individuals having incomes below 100% of poverty exempt from the premium. Should assets be included in the in the computation of the premium exemption threshold?

- Matching rates: The Secretary of HHS determines matching rates for allowable costs.
  How are administrative costs treated under the matching rate computation?

- Tax treatment of premiums for long-term care insurance. Such premiums for qualified plans are excluded from taxable income.
  Are the premiums excluded for both income and FICA/FUTA payroll taxation? What is the tax treatment for the self-employed?

- Tax incentives for individuals with disabilities who work. Employed disabled individuals who require assistance with daily living receive a 50% tax credit. Is this credit refundable? Does the credit only apply to earned income? How does the credit interact with EITC? Was this considered in pricing.

- SD, RP
(IM branch comments)

23 September 93

Financing for the Under 65 Population

(based on provisions listed in prior drafts,
however these items were mentioned in the President's speech.)

Policy Questions or Clarifications

An employer premium subsidy is limited to firms with 50 or fewer employees. Employers also have a cap on premiums for all employers equal to 7.5% of payroll.

3 • Subsidies for Employers: for firms with less than 50 employees in which the average full-time *wage* is less than certain thresholds, employers receive government subsidies for health premium contributions on workers with wages under certain thresholds. All employers benefit from a cap on premiums limited to 7.5% of payroll.

The eligibility criteria for subsidies for employees and employers, and premium caps for employers could be based on total employee compensation, including fringe benefits, instead of payroll. Large segments of the nation's working population receive employer provided fringe benefits such as health and life insurance, flexible benefit packages, housing, and pensions. Such benefits accounted for 16 percent of total employee compensation in 1989, up from 8 percent in 1960. Most of the growth in employee remuneration over the past 20 years is attributable to the growth in benefit spending. For example, inflation-adjusted benefit spending per full-time employee grew by 63 percent between 1970 and 1989, while average cash wages remained almost flat. The proposed employer subsidy could further encourage firms to pay employees in fringe benefits in order to remain eligible for the government health subsidy, or meet the 7.5% payroll cap.

The President has stated that under the proposed plan, the self-employed will be able to deduct 100% of alliance premiums.

2 • Premiums for Self-employed The self-employed are currently allowed to deduct only 25% of their health insurance premiums for tax purposes. Would the proposal result in a reduction in SECA income to the OASDI and HI trust funds?

Priority Code 2

HCR Administration: Overview

The fundamental issue is to clearly specify the functions that will be performed by each entity, new or existing, and to draw the boundaries between these entities as clearly as possible.

Since there is so much Federal oversight and backup or default control, in the absence of a clear demarcation, we will have to assume the function will be performed at the Federal level, either by an existing agency or the National Health Board (perhaps through a contract with an existing agency).

We intend to provide an estimate of the total administrative cost associated with each function and the portion of that cost that would be borne by the Federal government.

Priority Code 2

HCR Administration Questions
Pricing Issues: Scope & Parameters

(I) Define administration. Is this Federal only? Or system-wide (Federal, State, local, Alliance, plan, corporate, etc.)? Keeping pricing limited to the Federal level makes the task 'easier' (though not necessarily possible), and begets the question of whether Federal costs are being shifted to other levels of the system.

How is this to be measured? Dollars? Staffing? Paperwork burden? All?

What encompasses administration? Is it 'direct only (i.e. Health insurance administration; Provider administration)? Or does it include 'indirect' but essential support functions (i.e. Fraud and abuse investigation and prosecution; Data system management; Data analysis)? What about consumer education, advertising, etc.?

(II) Assignment of administrative functions in the plan. There are a host of administrative functions identified in the plan, but little consistent assignment of these functions to a specific entity, or discussion of how they will be financed.

Examples of unfunded, vague (difficult to price accurately), or unassigned functions: State qualification of health plans. State establishment of demographic service requirements. State Guaranty Funds. Establishment of 'capital standards.' Regional alliance administration. Administration of allocation of consumers to plans when capacity is insufficient. Development of State fee for service schedule. Alliance administration. Federal coordination among principal agencies (DOL, DHHS, VA, DOD), and with States, local grantees, alliances, plans, etc. Health professions loan administration, as well as other Federal programs (training and education oversight and administration). Administration of the Inter-alliance Health Security Fund. Budget administration, oversight, and enforcement. State licensure and certification of plans, health professionals. Federal licensure and certification of 'essential providers.' Survey administration and analysis (outcomes, quality, satisfaction, etc.). Premium tap fund collection and administration. Research and demonstration administration. Income monitoring and subsidy administration. Administrative capacity for Federal assumption of alliance operation for non-starting States or or States in default. Quality control program.

(III) Funding sources. There are numerous, over-lapping funding sources for data-

related activities. Presumably some data costs (capital, maintenance, administration, data processing and analysis, etc.) are funded within alliance or plan budgets. But, PHS also includes some start-up funds for state data systems, as well as separate funds for special surveys (the data from which could easily come from hospital admitting records, coroner reports, etc). PHS also includes funds for data analysis. PHS also has a separate 'administrative cost' category, which we have no idea what is contained therein. These need to be identified.

Are funds for data activities also included under more generic administration funding sources, such as premium taps? What about HCFA ORD? Medicare administration? VA, DOD, and IHS administration? This gets back to assignment of functions to specific entities, and funding sources for each. What is a centralized, Federal function, and what are private responsibilities?

(IV) Medicaid Administrative Expenses

Will current Federal policy with regard to matching of administrative expenses be changed to reflect a smaller, simpler Medicaid program?

Have potential savings from the reduced administrative burden in the Medicaid program been identified? Even if Federal matching policies remain intact, some savings could be expected.

Will States and Alliances continue to administer wrap-around benefits (i.e. current Medicaid benefits not included in the basic benefit package)?

(V) National Health Board

Fundamental questions about the board's functions, responsibilities, and operations require clarification (e.g. contract, in-house..):

Is the board to be advisory to an existing or new Executive Branch agency which is under control of the President or is the board to be free-standing and accountable primarily to Congress?

Will the states be responsible for enforcing budgets within the states (subject to board monitoring), as requested by NGA on 9/23/93, or will the board have both monitoring and enforcement responsibilities?

Will the benefits package be defined in law or by the board, through regulatory rulemaking? Will the benefit package be exhaustively described or

merely sketched out, deferring details to States? Will the Board adjudicate disputes between individuals and plans regarding the benefit package or will such disputes be handled in Federal district courts?

Will data and quality management systems be operated by states and monitored by the board or operated by the board? What will the adjudicatory responsibilities of the board be?

What will be the extent of the board's actions to oversee state plan implementation? How much flexibility will be left to states and how much will this monitoring role resemble the current Medicaid waiver process?

Indicate which portion of each of the functions described above are to be carried out by Federal employees of the board and which may be contracted out.

Priority Code: 2

Questions for Pricing 9/7/93 HCR Package: Public Health

Contacts for Public Health Q's -- Bill Dorotinsky (x 4926; h-301-916-1227)
Richard Turman (x4926; h-301-270-0895)

Part One: Basic Questions on Scope & Parameters

In order to evaluate the PHS funding proposals, we need the following for each proposal or initiative.

(I) Proposed Increases. Exactly what are these funds for? Specific programs? What will these funds buy (number of vaccines, trips to the doctor,etc.)? What are the assumptions for these estimates?

Do these duplicate items funded through the benefit package?

What is the amount of the proposed increase above current appropriation levels? What is the amount of funding in the current 'base' reallocated to each initiative?

How much of the increases and reallocations are for administrative costs versus services? What are the bases for these assumptions? How many more Federal staff will be required for these proposals?

How much money will flow to these activities from alliances, plans, and insurance? (Include basic payment rates, as well as any special incentives to rural/underserved/primary care providers, etc.)

Does initiative funding increase over time? How was the timing of increases determined?

(II) What are the secondary and interactive effects of these proposals? For example, assuming a simple linear relationship between NIH funding and new discoveries, what is the effect of increasing NIH funding on the cost of the health system for new procedures produced? What will happen to the cost of research when we suddenly increase demand significantly (researcher salary, etc.)? If academic health centers receive special subsidies, special grants,

and indirect cost funding through NIH, how many times are we funding the same things? What effect does this have on the cost of research? The type of health innovations produced? What effect do these have when adopted into the health system? Does this excessively favor high-tech medicine?

Or, if we have PHS health professions programs in addition to DME/IME and other provider incentives, what happens to the absolute number of health professionals as well as their distribution by specialty? What happens of we have too many doctors (in Canada, it increases total cost, as each doctor produces roughly the same volume; in Germany, with global budgets, increased number of doctors means lower average physician salary, so physician' associations tightly regulate medical school entry)? How many types of supply-management do we really need?

Or, States are required to establish service requirements for health plans related to the level of service and geographic distribution of service to ensure adequate choice and in low-income and underserved areas. Plans will spend funds to provide access, or face penalties. This is a regulatory approach. What effect, then, do all the PHS 'access' and 'enabling' services have on utilization? Will it increase utilization beyond medically-necessary limits? Is it necessary? (This applies to mental health & substance abuse, as well as general medical care.) And where does personal responsibility come into the equation? How broad is "enabling service" (e.g. public health police)?

(III) Proposed Off-sets. What are the assumptions underlying the proposed off-sets? How were they calculated? How were individual programs categorized between service and non-service aspects? On what basis was this done?

What are the administrative expenses associated with these off-sets? Are administrative costs included in the off-sets? How many FTEs are associated with the off-sets?

Do off-sets increase over time? How was the timing of off-sets determined?

For all facts and figures used in calculations or estimates, please cite the source. Please provide copies of internal studies or documents used to support the proposals or assumptions (e.g. MDS study referenced in HRSA off-set background material).

Part Two -- Questions about Specific Sections of Proposal

"Prevention" Research -- What is the basis for the $1.5 billion (58%) increase in biomedical and behavioral research labeled "prevention"-related. How many more multi-year research projects would be funded? How much out-year funds would commencing so many projects commit? Is there sufficient capacity in the health research system to make such an expansion without requiring massive new capital spending by Federal and university laboratories? What specific connections do these increases have with the implementation of Reform during FY96-2000, since the results of such research funding would not be available until well into the 21st Century?

Health Services Research -- How much of this increase would be spent on each of the categories listed on pp. 138-9 of the draft plan, and what would be accomplished with each allocation? How soon would the results of the consumer choice and decision-making research be available, if funds are appropriated in FY96 and initiated in FY96-7?

Workforce -- Please provide estimate details, including numerical outputs desired and how $204 million would be used to achieve the outputs.

Access

NHSC -- how would the $75 million increase for NHSC be split between state loan repayment, Federal loan repayment, and Federal scholarships? How many more doctors and other health professionals would this bring into the field over a 20-year period, starting in FY96? How much of an increase in field staff support spending would be required in FY2000-2010 to support the increased numbers of scholarships &loan repayment agreements awarded in FY96-2000? What is the cost of maintaining NHSC field staff on a per person basis?

Capacity -- How many additional low-income Americans currently uninsured would these funds help? How many low-income Americans would this funding help connect up to health plans so that they no longer need assistance through publicly-subsidized clinics? How many health plans would this funding encourage to serve rural and other uninsured Americans? How many provider networks would be established? If the design assumes continued maintenance funding as opposed to short-term capacity expansion linked to the implementation of Reform, please describe and explain. Would funding be granted to states or local districts? How many Federal FTE's would be required under either scenario?

School-based Expansion -- How many schools with high proportions of low-income Americans would this funding assist? How many students would be served? How much of clinic funding would be captured from health plan payments for covered services provided through these clinics? What is the start-up costs of opening a clinic? What are the annual costs of maintaining a clinic? What portion of each of these costs would the Federal assistance provide in the first, second, third, etc. years?

Formula grants -- what services would the formula grant support, and how would they differ from the capacity expansion grants? Would funding be granted to states or local districts? How many Federal FTE's would be required under either scenario? How many low-income Americans would be connected to health plans each year through these grants?

Indian Health

> The package states that *tribal* employers are exempt from the national employer mandate. However, the term "tribal" is not defined. Can any employer become a tribal employer by moving to a reservation? Why should tribal employers be treated differently from any other employers?
>
> What mechanism to control costs exist for IHS, since IHS is outside the Health Alliance structure?

Mental health/substance abuse -- what will the additional funds pay for (e.g. short term treatment vs. long-term treatment; residential vs. outpatient; heave users vs. casual users; inside or outside of the criminal justice system, etc.).

If the policy is to provide high-quality, cost-effective drug abuse treatment, will the parameters described meet that objective? Most of the studies on the effectiveness of drug abuse treatment indicate that time in treatment is the most significant indicator of success (as measured by reduced drug use and criminality and increased employment). The substance abuse treatment benefit is capped at 60 days initially, expands by 1998 to 90 days, and by the year 2000 the day limits appear to drop off entirely. The benefit structure appears to provide incentives for 30-day programs, far less than 12-24 months in treatment recommended for heavy users. Moreover, thirty days in a hospital setting can cost than one year in a community-based residential program.

What is the rationale and/or underlying assumptions for placing a day-limit -

-as opposed to a dollar-limit -- on residential substance abuse treatment, given that the community-based programs which tend to provide more days of care cost substantially less than the hospital-based programs that tend to provide fewer days of care? If two of the principles of HCR are **cost-containment** and **quality**, why design a benefit that may encourage higher costs (hospital rates versus alternative settings) and lower quality care (fewer versus more days in treatment)?

"Core" Public Health functions

- **Health-related data collection, surveillance, and outcomes monitoring:**

1) How will funds for these activities be allocated, and who is eligible to receive these funds?

2) Will these funds support Federal data efforts or will States, Alliances, providers, and insurers also receive funds?

3) What exactly will these funds purchase: What kind of data processing hardware would be purchased (computers, printers, network support, dedicated phone lines), and exactly how many of each type of unit would be purchased? What kind of software would be purchased to operate the envisioned hardware?

4) How many and what type of personnel would be hired to support these activities (i.e., computer programmers and operators, epidemiologist, statisticians)?

- For each of the four categories of listed below, please answer questions 1-4:
  Protection of environment, housing, food, and water
  Investigation and control of diseases and injuries
  Public information and education
  Accountability and quality assurance

1) How will funds for these activities be allocated, and who is eligible to receive these funds?

2) Will these funds support Federal efforts or will States, Alliances, providers, and insurers also receive funds?

3) How many and what type of personnel would be hired to support these activities?

4) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

- **Laboratory services**

1) How will funds for these activities be allocated, and who is eligible to receive these funds?

2) Will these funds support Federal efforts or will States, Alliances, providers, and insurers also receive funds?

3) How many laboratories would be supported and which specific laboratory services would be financed?

4) What is the estimated volume of each laboratory service.

5) How many and what type of personnel would be hired to support these activities?

6) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

- **Training and education**

1) How will funds for these activities be allocated, and who is eligible to receive these funds?

2) Will these funds support Federal efforts or will States, Alliances, providers, and insurers also receive funds?

3) How many of each type of health professional would be trained?

4) Would professionals trained using these funds then be hired and supported using Federal funds?

"Priority" Public Health

- **Immunization**

1) How many and what type of personnel would be hired to support these

activities?

2) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

3) Will these funds be used to purchase vaccine, and if so how many doses of each specific vaccine would be purchased?

- For the four categories of funding listed below, please answer two questions:

  HIV/AIDS
  Tuberculosis
  Chronic and Environmentally Related Diseases
  Health-related Behavior and Other Priority Issues

1) How many and what type of personnel would support these activities?

2) What type of equipment or materials would be purchased to support personnel? How many units of each type of equipment or material would be purchased?

PRIORITY 2

9/23/94

National Health Reform
Cost Questions - Veterans Affairs

1. What should be the scope of the VA scoring effort (i.e., should it reflect only reform's impact on VA appropriations or should it include estimates of Federal and non-Federal receipts that VA will receive)?

2. Will VA plans be subject to premium/price restraints that may be applied to private insurance plans?

3. What are estimated maximum allowable national average annual percentage increase is premiums/prices for 1995 through 2000?

4. Please provide the following national average cost data for plans covering individuals as currently assumed in the health care package for 1995 through 2000 (In each case we are requesting dollar amounts, not percentages.)
   a. annual average premium,
   b. annual average employer contribution,
   c. annual average employee contribution, and
   d. annual average employee deductibles/co-payments.

5. What is the current poverty level for:
   a. an individual, and
   b. a family of four?

6. What are the anticipated national average health alliance subsidies for an individual and a family of four for 1995 through 2000 at the following annual income levels:
   a. 25% of poverty level,
   b. 50% of poverty level,
   c. 75% of poverty level,
   d. 100% of poverty level,
   e. 125% of poverty level, and
   f. 150% of poverty level?

7. What is the projected national average health alliance subsidy for 1995 through 2000 for:
   a. an unemployed individual, and
   b. an unemployed family of four?

8. What are the projected national average Medicare part A and B reimbursements for male beneficiaries receiving care for 1995 through 2000? Please break out the part B average further to show the average costs of:
   a. office visits (i.e., outpatient care), and
   b. hospital care.

9. What are the projected national average Medicare beneficiary copayments for parts A and B for male beneficiaries receiving care for 1995 through 2000? Please break out the part B average further to show the average costs of:
   a. office visits (i.e., outpatient care), and
   b. hospital care.

10. What is the anticipated timeline for implementing national health reform in the VA, DOD, PHS and other public health organizations?

11. With regard to the VA revolving fund that would be established with national health reform:
   a. What would these loans fund (e.g., new facilities, expand current facilities, hire additional staff, high-tech equipment)?
   b. Will there be a limitation on the dollar amount an individual hospital can borrow from the fund?
   c. What will be the repayment conditions for hospitals that borrow from the fund?
   d. What happens if a hospital is incapable of repaying the loan it receives from the fund?
   e. Who will manage the revolving fund?
   f. The fund is for the "start-up costs of VA health plans". The fund would continue "without fiscal year limitation". Does "without fiscal year limitation" apply to new loans made, or does it refer to the loan repayment schedule? If it refers to new loans made, why would start-up requirements continue for more than 5 years?

If there are any questions concerning the information requested please contact Todd Grams or Alex Keenan at 395-4500.

PRIORITY 2

September 24, 1993

SUBJECT: Federal Employees Health Benefits Program: Costing Assumptions

1. Medigap: Addressing Medigap the policy reads: "annuitants with Medicare obtain coverage through an OPM-administered Medigap plan." Will OPM develop and price the Medigap plan or are there central estimates to use in pricing the cost to the Government of Medigap for Federal retirees?

2. Early Retirees: Please clarify the policy for Federal early retirees?

3. Annuitants: Addressing coverage of annuitants with or without Medicare, the policy reads: "In both cases, OPM pays a premium contribution sufficient to prevent an increase in annuitants' costs over current fees."

   a) Is the policy that the annuitants' share of the premium contribution or the dollar amount of the premium contribution remains constant?.

   b) If the answer is dollar amount, do we use nominal or constant dollars, and how long would that deal remain in effect?

4. Civilian Downsizing: Should our estimates assume a 252,000 reduction in Federal civilian personnel as called for in the President's Executive Order of September 11, 1993 (while a majority would fall into the retiree/early retiree categories, a portion would be employees who simply leave Government service)?

5. Option to continue coverage: Currently, under certain circumstances employees that would otherwise lose FEHB coverage (including employees that separate from Government service) may elect temporary continuation of coverage at 102% of premium price. Under reform, will Federal employees retain this option or will they be required to move immediately to the alliances?

6. Transition: Are assumptions available about the expected time frame for phasing-in the states?

Christine Lidbury
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PRIORITY 2

o DoD indicates that it has final approval to receive Medicare payments for care provided by DoD to Medicare eligibles. If true, will:

-- the reimbursement be on a fee-for-service basis or only on a capitated basis?

-- DoD have to comply with Medicare rules and regulations including beneficiary co-payments, beneficiary premium payments (for Part B services), and cost-accounting standards?

o Is it the President's intention to sustain benefits significantly higher than the national benefit (and unrelated to DoD's readiness requirements) for new DoD beneficiaries or is the national benefit sufficiently generous for post national reform entrants into the DoD work force?

o DoD will be providing medical services and paying for the care of active duty military personnel. In the case where there is a working spouse of a military member:

- What will be DoD's payment responsibility when the spouse (or the spouse and dependents) choose a non-military health plan?

- What will the private employers responsibility for payment to DoD when the spouse (and family) choose a DoD plan?

o If the DoD health plan functions as a corporate alliance, will DoD have to pay the 1% surcharge to regional health alliances that has been discussed?

o Will DoD have to pay for care for a period of time after personnel separate from the military? If so, what will have to be paid for how long?

o What exactly does the proposed health care legislation authorize?

o Will DoD be treated as any other employer with respect to retirees over age 55 (i.e. will DoD be relieved of the obligation to pay for health care for non-working retirees over age 55)?

J. Fish Ext. 3776

September 20, 1993

Questions on Pricing for Medicare Payment to DoD and VA

We believe that the issue of Medicare payment to DoD and VA facilities warrants further attention. We have raised some of the questions involved below, albeit in a somewhat disorganized fashion. Additional questions and comments will follow.

- Will DoD and VA health plans be required to meet the same standards as other Medicare providers, e.g., cost reporting, JCAHO standards, peer review, mortality and morbidity data collection, etc.? **(3)**

- What does it mean to say that Medicare will only pay for services to higher-income veterans eligible for Medicare? Medicare does not currently income-relate any part of the program and the rationale for implementing this policy on this particular population is unclear. **(1, 2)**

- How will Medicare payment to DoD and VA facilities be calculated and adjusted? VA and DoD pay on a national scale, whereas other facilities will naturally reflect geographic wage differences. **(1, 2)**

- How much care do DoD and VA currently provide beneficiaries who are also eligible for Medicare? What are the five-year outlay projections, broken down by veterans and military retirees? **(1, 2)**

- If a Medicare-eligible individual does not enroll in DoD/VA health plans, but receives care at a VA facility (for a service-connected injury) or at a DoD facility (on a space available basis), is Medicare liable for payment? **(1, 2)**

- What, if any, are the assumptions about adjustments in DoD and VA appropriations to reflect Medicare payments? How will DoD and VA appropriations be adjusted if Medicare is to make payments for such care? **(1, 2)**

- What are the assumptions about beneficiary cost-sharing in these settings? What are the corresponding assumptions concerning utilization? Will DoD and/or VA be required to offer high or low cost-sharing plans? What are the assumptions on subsidies for cost-sharing? **(1, 2, 3)**

  -- Will DoD and/or VA be allowed to offer supplemental, "wrap-around" coverage of cost-sharing liabilities? High cost-sharing plans are required to offer wrap-around policies. **(1, 2, 3)**

  -- What are the assumptions about DoD and/or VA acting as secondary payors to Medicare? **(1, 2, 3)**

  -- How will Medigap and other possible third-parties be treated for cost-

sharing coverage? **(1, 2)**

-- Is Medicaid the payor of last resort for any veterans or their family members? **(1, 2, 3)**

- What benefit packages will these dually-eligible individuals receive? Will the DoD and VA plans be required to offer the standard benefit package? Or will the Medicare benefit package be required to be offered those individuals otherwise eligible for Medicare? **(1, 2, 3)**

- Will Medicare Secondary Payor rules also apply to VA and DoD? Will DoD and VA be required to collect from other parties under TPL guidelines, as well as Medigap and retiree health policies? **(1, 2, 3)**

To: DK
FM: Bill C.
cc: BC

LN Key stuff for Medicaid et al. — D.K.

9-24-93

QUESTIONS REGARDING INSTITUTIONALIZED POPULATIONS

We will need to establish baseline estimates on persons and per capita costs pertaining to any flows between non-institutionalized and institutionalized populations, with focus on the following issues:

1. We assume no first order shifts between Medicaid and institutional populations. However, we need clarification as to:

   - o whether some/all of the voluntarily institutionalized will get 60 days psychiatric care,
   - o whether this would apply only to those newly entering institutions, (again voluntarily).

2. While some involuntarily institutionalized populations have been specifically ruled out of any added coverage costs (eg., prison populations), other populations may need to be dealt with more specifically, e.g.:

   - o the reform school population,
   - o the involuntarily institutionalized in mental institutions.

Schedule

Friday, 9/24	--	OMB delivers list of policy, economic, and technical questions. OMB receives final premium and subsidy estimates from the modellers.
Monday, 9/27	--	OMB receives policy clarifications and economic and technical assumption decisions.
Tuesday, 10/12	--	OMB delivers estimates of health reform plan's effects on outlays and the deficit. (Note: This assumes Treasury supplies new revenue estimates by 10/12.)
Thursday, 10/14	--	OMB delivers estimates of the BEA implications of health reform.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. memo	Leon Panetta and Alice Rivlin to the First Lady, re: Comments on the 8/6/93 Draft of the Health Care Reform Plan (1 page)	09/10/1993	P5
001b. memo	Leon Panetta and Alice Rivlin to Ira Magaziner, re: Comments on the 8/6/93 Draft of the Health Care Reform Plan (5 pages)	09/10/1993	P5
001c. paper	Specific Comments by Chapter (39 pages)	09/1993	P5

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Health - Agency Reviews [3]

Kara Ellis
2006-0810-F
ke1027

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]

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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]

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

September 10, 1993

THE DIRECTOR

MEMORANDUM FOR THE FIRST LADY

FROM: Leon Panetta and Alice Rivlin

SUBJECT: Comments on the 8/6/93 Draft of the Health Care Reform Plan

The attached memorandum to Ira Magaziner responds to your request last week that we provide our comments and suggestions regarding the draft Health Care Reform Plan dated 8/6/93. The memorandum is organized into two parts; the first section provides an overview of some of the areas of the plan where we believe further clarification is needed, while the second section provides detailed, chapter-by-chapter comments about aspects of the policy that are unclear or have Federal budgetary implications that may not have been considered. This detailed analysis was conducted under our supervision by OMB's staff of budget examiners who have the day-to-day responsibility for analyzing the various Federal health programs.

As noted in the memorandum, we are continuing to review the draft plan in order to ensure that it is consistent with the policy assumptions we have made in the preliminary budget estimates that have been used in the modelling process. Because the chapter on financing was incomplete at the time we reviewed it, and several elements of the financing proposal are still evolving, our analysis of this critical element of the draft plan is still preliminary. Our understanding is that the new estimates of the most current financing proposal will be delivered from the modellers next week. We will direct OMB staff to analyze these cost estimates along with the revised 9/7/93 draft of the plan that we have just received, in order to ensure that the estimates are consistent with the policy. We also want to highlight any budget "scorekeeping" issues that we see as a result of this review, so that we will not be surprised by CBO's scoring of the reform plan. We will provide you and Ira with our analysis of these issues as soon as possible.

We appreciate the opportunity to review this draft of the plan, and stand ready to discuss and clarify any of our comments and to work with you and Ira on subsequent drafts.

Attachment

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

September 10, 1993

MEMORANDUM FOR IRA MAGAZINER

FROM: Leon Panetta and Alice Rivlin

SUBJECT: Comments on the 8/6/93 Draft of Health Care Reform Plan

We appreciate the opportunity to review the draft Health Care Reform Plan dated 8/6/93. In general, the draft reads well and reflects the tremendous amount of work that has gone into the development of the plan. You and your staff are to be congratulated for addressing this important issue with such dedication and persistence.

A number of detailed comments and questions, organized by chapter, are attached. The comments represent our initial reaction to aspects of the policy that are unclear or have Federal budgetary implications that may not have been considered. We are continuing to review the draft policy in order to ensure that it is consistent with the policy assumptions we have made in our budget estimates and modelling; however, because the chapter on financing is not complete (and indeed, was still in the process of being discussed with the President last week), our analysis of this critical element of the draft plan is still preliminary. A few more general comments follow here, highlighting major issues that our initial review has uncovered, and that we believe need clarification.

It is my understanding that OMB staff met with you and your staff this weekend to discuss the chapters of the draft plan dealing with public health initiatives. We are prepared to do that with respect to other aspects of the draft plan if a fuller explanation of the detailed comments that follow would be helpful to you.

Allocation of Responsibility

The draft calls for a complex set of responsibilities to be shared by the Federal government, the new National Health Board, States, and Health Alliances. At each of these levels, there is further division of responsibilities as well. For example, within the Executive Branch, responsibilities are distributed across DHHS, Labor, Treasury, Justice, Commerce and others.

We appreciate the essential American traditions of pluralism and decentralized sharing of powers. At the same time, the practical complexity of the interrelationship of the various agencies and levels of government requires more specificity concerning duties, powers, shared responsibilities and -- most importantly -- final accountability. Specific issues related to implementation and long-term management of the Nation's health sector are difficult at best to predict. It is critical that the structure created to manage this reform be well-designed and easily understood by all concerned.

It is certainly the case that the precise allocation of responsibilities will be a primary focus of negotiations with the Congress, and in that sense, leaving the lines deliberately vague is a rational opening gambit. Insofar as we have not had the opportunity to discuss the contours internally very much, we believe it would be productive to focus on this issue and begin to develop our preferred outcome of this distribution before serious negotiations with the Congress begin.

One particular assignment merits mention here: we strongly object to the proposal set forth in the draft plan that the National Health Board will be organized as an independent agency that will issue regulations without the benefit of OMB review (see Chapter 5, p. 48). We believe it would be extremely unwise to cede Executive Branch control over the Board, especially in the early years, when the Clinton Administration will bear sole responsibility for its successes and failures. For example, the Board will be responsible, at least initially, for developing and enforcing the national health care budget. It is far from clear that it would even be possible, much less desirable, for an agency located outside the Executive Branch to assume such responsibility. Further, the purpose and effect of OMB review of agency-issued regulations is to ensure compliance with the goals and policies of the President. Ceding the authority to review regulations issued by the Board, and in general interposing an independent body between the President and the Executive agencies in effect relinquishes control of a crucial policy. As there may also be constitutional issues involved, at a minimum there should be further discussions about this proposal within the Administration.

Federal Budget Risk

Related to concerns about authority and management, the draft plan calls for a number of new programs, policies, and initiatives that involve Federal dollars, either in direct funding or as a "backstop" for a potentially turbulent early implementation phase. Several direct subsidies are mentioned, including premium subsidies for low-income persons, an iron-clad cap for employer premium contributions set at 7.5% of payroll, additional subsidies for small, low wage firms, full tax

exemption for health insurance payments by the self-employed, and subsidies for co-pays and deductibles for low-income persons.

Several new sources of funding or funds (similar in concept to national trust funds) are discussed in the draft, including a national Fund/Risk Pool for the Uninsured, Fraud and Abuse Fund, the Veterans Administration Fund for Development into Health Plans, Long-Term Care Trust Fund, State Plan Guaranty Funds, the graduate medical education All-Payer National Pool, and the Inter-Alliance Security Trust Fund. Some or all of these funds could be substantial, both in terms of new tax burdens or potential outlays of Federal dollars. For example, the risk pool/fund discussed in Chapter 29 could be larger than either the Medicare Trust Fund or current Medicaid funding -- with as many as 50 million newly entitled persons. In most cases, the estimated cost or size of these funds is not specified.

We note that the draft plan itself is a discussion of the policy proposals without detailed budget tables. Of course, we have seen and helped to prepare draft estimates of various pieces of the overall reform plan, including proposed Medicare and Medicaid reductions, but as you know, the net cost of the draft health reform proposal has not been estimated as a total package. This is particularly true with respect to the proposal for financing the subsidies discussed with the President late last week, which we understand is still evolving. Interactive effects can be significant, especially in a systematic reform as complicated as this one. Thus, any numbers we have at the moment must be considered preliminary, and must be so regarded and described.

The further point is that there is quite a bit of irreducible uncertainty in any estimate of the ultimate effects of health reform on the Federal deficit. Given that, it seems prudent to spend more time and detailed effort designing "stopgap" protection for the Federal purse, especially in the early years. We at OMB would be glad to undertake this effort.

Our understanding is that estimates of the current financing proposal will be delivered from the Urban Institute next week. Armed with a fuller appreciation of the reform proposal as a whole, we will direct OMB staff to assess the new cost estimates to ensure that they are consistent with the policy as we understand it and will provide you with our analysis of this early next week.

Global Budget Enforcement

Nancy-Ann Min's memorandum to you dated July 29 expressed our concerns about the preliminary versions of the global budget. Although the guidelines for calculating the global budget have been amended to change the focus from GDP to CPI, the current version of the policy is similar to the one her memorandum

discussed, and therefore our concerns remain. Several dimensions of this policy raise related concerns about the unpredictability of Federal outlays. The Federal health budget enforcement and responsibility for Years 1 through 3 poses a number of challenges, including the following:

- Although the policy calls for Federal enforcement by the National Health Board of each State's global budget, currently there is no reliable state-by-state baseline of spending for the guaranteed benefit package. The only data available are gross estimates of total spending by HCFA's Office of National Cost Estimates, the accuracy and timeliness of which leave a great deal to be desired;

- Premium bids by plans could be skewed by estimates of increased demand for services by the newly-insured, estimates of adverse risk selection, and general market uncertainty. It will be difficult at best -- without better utilization and risk status information -- to assess the extent to which premium bids reflect efficient plans or delivery of services.

Taken together, these factors could have enormous implications for short-term Federal outlays, and thus for our ability to meet the global budget targets. With respect to the Federal health programs in particular, your argument that Medicare and Medicaid continue to grow at a rate higher that the private sector under the plan's scenarios is a persuasive one; but the fact remains that the global budget scenarios call for the growth rates in these Federal programs to be cut in half very quickly. We should not underestimate the difficulty of persuading the Congress that this is possible, and of actually doing it.

Administration of Subsidies

Under almost any plan, the administration of specific subsidies requires a fair amount of complexity and detail, which may in turn be less than helpful to the average reader. Perhaps under separate cover or in the next draft, it would be useful to share the details of the current proposals for the several provisions that imply or directly call for administration or distribution of funds. These include areas such as:

- subsidies to small businesses and/or businesses with low-wage workers;

- subsidies for Medicaid wrap-around coverage, as well as subsidies for co-pays and deductibles for the low-income groups;

- coverage and eligibility rules for the working aged, relative to both the worker and the spouse;

- tax incentives and tax credits for long-term care coverage; and

- transitional policy issues such as moving from a single national payer fund for the uninsured to coverage in private plans under a state-based alliance structure.

We strongly believe that the administration of these aspects of the plan must be reviewed carefully to ensure that there is coordination and streamlining across these administrative structures, rather than duplication and needless fragmentation.

Thank you again for the opportunity to review this draft and provide you with preliminary reactions. OMB stands ready to discuss and clarify any of these comments and to work with you on subsequent drafts.

Specific Comments by Chapter

Chapter 2: Ethical Foundation

- Missing are two ideas: a principle of medical care is that it should be provided only with the "informed consent" of the patient. Informed consent is a means to ensure that treatment is expected to be in the best interests of the patient, as understood by the patient. One concern that has been expressed about managed competition is that it will accelerate the abandonment of this principle. A clear signal to consumers about the importance of their welfare could be made by appealing to this principle.

- The notion of "wise allocation of resources" (p. 11) could be made more informative and specific by adding to it a note about the importance of cost-effective medical care. Presumably reform should help people get well while imposing no **avoidable** costs. Care of a given quality should be delivered at the lowest possible cost.

Chapter 3: Coverage

Categories of Eligibles

- "Long-term non-immigrants": The draft indicates at page 13 that "long-term non-immigrants" would be covered under the plan. It is unclear what is meant by this category. In the long term, the only non-immigrants in this country are Native Americans. They are already covered as American citizens, raising a question about the apparent need for this new category.

  Alternatively, the term long-term non-immigrants may refer to illegal aliens, or undocumented workers. It has been our understanding that these populations were not intended to be covered. Therefore, if this phrase is intended to refer to populations that are in this country illegally over long periods, then it should be clarified and explained in terms of exactly how they are covered and how their coverage is financed.

- Territories: the policy states that individuals who reside in territories of the U.S. receive the comprehensive benefit package "in a manner consistent with their existing systems" (p. 18). What does this mean? Are there alliances in the territories? Does the mandate extend to the territories? Are low-income subsidies available to citizens living in the territories? Non-citizens?

- Employer payment obligations are discussed at page 16 as 80% of the premium, but later there is a discussion that employers can contribute more than 80% to offset any out-of-pocket or cost sharing of employees. To the extent employers contribute more than a flat dollar amount, consumer price sensitivity to choosing the most efficient plans will be watered down. Correspondingly, plans will tend to "shadow price," as well as market themselves based less on efficiency and more on other aspects such as equipment or amenities -- similar to what providers do currently.

Choice

- According to page 14, employed persons choose a health plan through a corporate or regional health alliance. It is not clear whether family members of employed individuals also can exercise choice about the plans in which they enroll. In other words, can spouses who are not connected to the workforce, as well as divorced spouses and their children, voice their plan preferences independently from the employed family member through whom they gain coverage?

Chapter 4: Guaranteed National Benefit Package

Covered Services

- Preventive services: Are the preventive services listed on page 22 illustrative, a minimum, or a maximum for the package? (For example, was a PSA test for prostate cancer discussed?)

  Regardless, it should be considered whether the list of preventive services should be included as a tentative list subject to change, rather than being enacted as part of the American Health Security Act. Changes in the understanding of effective medical practice could easily render this list obsolete. For example, although covered on this list, the Harvard Community Health Plan no longer provides annual medical screenings for its patients since there is no clinical data supporting it. If research were to support the Harvard Community Health Plan's practice, the list of clinical preventive services would be difficult to amend if it were enacted as part of the Act.

- Immunizations: The list of immunizations discussed is fairly comprehensive. If covered, this should be taken into account in Public Health Initiative section which would enhance grant support for immunizations. Additional grant funds for immunizations will not be needed. Since immunizations will be covered,

some of the base funding for vaccine purchase grants could be retargeted to address education, outreach and infrastructure.

Instead, the National Health Board, in consultation with other bodies, should have the flexibility to amend this list based upon the findings of outcomes research on effective practice patterns. As a better understanding of effective practice patterns develops, the types of preventive services that should be covered in a standard benefit package will also have to change.

- The draft at page 32 states that services and procedures will be included in the standard benefit package to the extent that these are found to be "effective". The overwhelming majority of services and procedures routinely covered by insurers -- public and private -- have little or no accompanying evidence of effectiveness. Often these are high volume procedures. Carotid endarterectomy, for example, is performed at a rate of nearly 100,000 per year in the U.S. with little or no evidence of clinical effectiveness.

  The effect of this language is to either raise questions about what is currently covered relative to new procedures (effectively a double standard) or to slow down the process of covering new procedures that would be subjected to multi-year trials. While the latter problem is no different from the current policy for most insurers, whether private or government (e.g., Medicare), it is not clear whether that is the result.

- Clinical trials: Also at page 32, the draft states that the benefit package includes coverage for medical care provided as part of an "approved clinical trial." The text goes on to say that the intention of this provision is to cover routine medical costs associated with an investigational treatment that would occur even if the investigational treatment were not administered.

  Sometimes, however, no costs would occur if the investigational treatment were not administered (e.g., if there is no alternative or the patient would not have been hospitalized), producing no coverage, which seems inconsistent with the intent of the policy. As written, the provision is unclear and invites arguments about what constitutes "routine medical costs."

  A simpler approach more likely to achieve the policy goal could be for the benefit package to cover room and board charges for individuals involved in approved clinical trials. This way, there is no guessing (or cost-shifting) about which portion of the treatment regimen would have been provided anyway and what portion was experimental.

- Research guidelines: The draft states at page 33 that research guidelines will be centralized and promulgated by DHHS. This will politicize scientific inquiry and/or reduce it to a bureaucratically defined straitjacket. It may also slow down willingness to initiate research (e.g., scientists waiting for the release of periodic regulations).

  The Federal government does not currently approve all research, nor is it a desirable policy to establish. A more desirable policy would be to require research trials to be peer-reviewed and consistent with requirements for the protection of human subjects.

  Government funded research: Also at page 33, coverage for investigational procedures is described as automatic for government-conducted research only. This tends to bias interest in the scientific and medical community towards government-funded science only. Again, science will become more politicized, more centralized, and may be less able to accommodate room for truly innovative and new ideas/projects. Secondly, scientific funding may become more vulnerable to annual congressional appropriations and/or changes in ideology in the Executive Branch.

Providers

- The draft plan states that plans "will be expected" to "provide a sufficient mix" of providers. This leaves unstated what the penalties would be for plans that fail to "provide a sufficient mix" of providers.

- The intentional vagueness of not requiring any plan to pay any provider or category of provider makes it very difficult to price the overall proposal. It is not clear, for example, whether or not end stage renal disease is covered under this chapter.

  One alternative is to specify that the same services covered by Medicare are required of all health plans, plus explicitly identified services, i.e., pregnancy-related and preventive services.

Cost Sharing and Limits

- Mental health: Limitations on inpatient and resident mental health and substance abuse treatment are established at 30 days per episode and 60 days annually for all settings (p. 24). The paper should define what constitutes an "episode" of

We question the requirement of special protection for these public funds for the following reasons:

(1) It relieves the private sector of its responsibility to provide these essential services. If public funding is required to be maintained, plans will be able to shift mentally ill and addicted patients onto the public sector by making it difficult enough for enrollees to obtain services that they turn to the public tier, which may be perceived as second-rate. Indeed, the existence of the public tier provides an incentive for plans to avoid treating this difficult population.

(2) It misses an important opportunity to bring the quality of mental health and addiction treatment up to par with other treatments. Without the capitated payment's incentives to improve quality and reduce costs, mental health and substance abuse services will continue to be perceived as inferior to "medical" services in quality and scientific rigor. In addition, the public tier will relieve pressure to expand the mental health and substance abuse benefit in the year 2000, so health plans will never have to deal comprehensively with their enrollees' mental and addictive disorders.

(3) It makes the treatment of mental health and substance abuse services under health reform inconsistent with the comprehensive approach to health care embodied in the basic benefit package. The basic package requires health plans to prevent and/or deal with the whole range of potential illnesses, including mental illness and addictive disorders, because insurers and even many providers do not accept the validity of the connection between medical and mental health. Health reform should not let plans "off the hook" by maintaining a set of public services not on a par to meet the requirements of a capitated, market-oriented system.

HHS now spends some $2 billion annually on two mental health and substance abuse services block grants -- some or all of which could be used to offset an even more generous benefit than the one included in the basic package, and/or to phase-in benefits more quickly.

Chapter 5: National Health Board

writing, implementation, and enforcement responsibilities, leaving the Board to have more of a policy development, audit, and oversight function.

- The discussion at page 44 is unclear as to whether the benefit package can be amended through regulation rather than legislation. Although the words "issue regulations" are included, the draft also discusses "recommendations" to the President and Congress. Our view is that given the fast changing pace of medical treatment, changes in legislation would be entirely too cumbersome or political.

- Clarification of responsibilities: to make the draft consistent with better delineated roles and missions, corrections may need to be made to clarify the Board's responsibilities relative to:

  (1) determining the research agenda for health services/outcomes research (p. 147);

  (2) information systems (pp. 113-127);

  (3) quality standards and management systems (p. 112);

  (4) supervision of corporate alliances through ERISA (p. 49);

  (5) assuming responsibility for out-of-compliance health plans (p. 49);

  (6) ensuring individuals have access to benefits (p. 48);

- The Board will develop state measures of performance. Measures of state performance used in the document as illustrative appear process-based; measures should be outcome-based to the extent possible. This allows more in the way of true state flexibility. We can make recommendations for more outcomes-based measures if that would be helpful.

  There is no discussion of how large the Board might be in terms of authorization monies. It should be considered that, to the extent that HHS' (or other Cabinet agency) responsibilities are reduced, their operating budget and FTE levels could be reduced to offset the costs of the National Health Board.

Chapter 6: State Responsibilities

- Single payer: The draft indicates at page 57 that states that establish a single-payer system would be prohibited from imposing cost-sharing requirements that exceed those charged by regional alliances. Since there are nationally-standardized cost-sharing schedules, it is unclear whether the single payer systems would be held to the rules established for fee-for-service plans or for HMOs.

- Alliance Boards: The specifications for the boards of directors of health alliances (p. 53) may be so exclusionary as to impede effective functioning of the boards. For example, the specifications seem to exclude everyone with any specific knowledge of the health care field even if they aren't connected financially with a health plan (e.g., university professors). We question whether that is what is intended.

- Qualification process: The draft details that "States qualify health plans to participate in alliances," and then lists qualifications of alliances that states will set. The logic for requiring states to qualify plans for participation, instead of alliances doing this using state guidelines, is not clear. The proposed arrangement divests alliances from an appropriate responsibility while lengthening implementation time -- for no obvious advantage.

- Service requirements: States must establish requirements on health plans related to the levels of service and geographic distribution of service to ensure adequate choice in low-income and inadequately served areas (p. 54). Are there any broad standards that should be met (outcomes regarding service level achieved, perhaps determined by the National Health Board), or is it entirely up to the state? Secondly, this new role of the states may help render Federal subsidies for direct provision of services in low-income communities no longer essential.

- State Guaranty Funds: The draft also states that state guaranty funds will provide financial protection to health care providers if a health plan becomes insolvent (p. 56). It is not clear why the entire burden falls on the state, and hence the state's taxpayers. Burden-sharing among losing parties, including providers, should be considered as an alternative.

- Expansion of benefits: The draft addresses ways in which states could finance additional benefits beyond those in the proposed package (p. 57). The draft would place limits on the sources of financing states could tap for these additional benefits. This raises two concerns:

(1) Does this raise constitutional issues regarding the relationship of the Federal government and the states?

(2) Does the requirement that states use revenues "from sources other than those established by this Act [for the] guaranteed benefit" mean that states are limited to those sources of funding for all expenditures under the single-payer system opt-out, or only for the reduced cost-sharing portion of health care expenditures in the state?

- Capital Standards: The concept of "capital standards" is not defined and, because the concept is not in common use, it is not clear what it is intended to encompass.

- State Guaranty Funds: Will there be any minimum standards on the size of the state guaranty funds? Given the experience of state guaranty agencies and the guaranteed student loan program, this should be carefully examined to avoid the possibility of yet another Federal bail-out.

- The last paragraph of the chapter states that "All health plans must participate in a guaranty fund," but the conditions of "participation" are not defined. Does participation mean that all health plans must pay an assessment into the fund?

Chapter 7: Regional Alliances

- Advertising: Rather than get the alliances into the business of premarket approval of advertising why not establish general standards for plan marketing and a post-market penalty?

- Enrollment: The draft sets fixed dates of enrollment at the beginning of the month based on whether or not the application is submitted by the 15th of the prior month (p. 60). Fixed timing of that sort can create unnecessary administrative pile ups. Why not leave this to the alliance to sort out with an absolute maximum on it taking no longer than X days.

- Allocation of consumers to plans: The draft provides at page 60 for random allocation of consumers to plans in the event there is not enough capacity. This This fundamentally collides with freedom of choice, and could be politically inferior to allowing consumers second and third choices.

- Fee-for-service requirement: The plan proposes that every state create a fee schedule and conversion factors for the state's fee-for-service plans. HHS

would develop a national fee schedule, expanded beyond Medicare services to all services, that would serve as a model, or default fee schedule, for states. Aside from the difficulties in developing and implementing such a fee schedule in time for the reformed plan, this approach is overly rigid and we question whether such a regulated approach is consistent with the commitment that each alliance would provide at least one fee-for-service plan. A fee-schedule does not allow the flexibility to adjust fees to respond to changing market conditions. We would suggest an alternative that plans should be allowed to establish their own fee schedules to assure timely responsiveness to the market.

- Alliance administration: It is not clear who is responsible for financing the administration of alliances, nor is the role of the Provider Advisory Board is not clearly spelled out.

Chapter 8: Corporate Alliances/ERISA

- Oversight responsibility: We question the proposal to bifurcate regulatory responsibility between the National Health Board for state plans and the Labor Department for corporate plans.

  Government experience with divided regulatory responsibility arising from political and bureaucratic reasons is bad. This is most notably true in the related case of ERISA, now twenty years old. Because of feuding committees and agencies, ERISA administration is divided in three among the DOL, the IRS, and the PBGC. Sponsors of ERISA benefits plans have to comply with regulations of all three, although for most purposes they have to be concerned about only two:

  (1) the IRS, which must annually certify the tax deductibility of plans for compliance with coverage and participation requirement; and

  (2) the DOL for compliance with fiduciary behavior requirements.

  This division increases regulatory complexity in the eyes of employers that sponsor pension and health plans for their workers. The duplication and resulting complexity probably results in fewer benefits being provided because the cost of regulatory complexity consumes resources available in company budgets that would otherwise be available for benefits.

The division also gives rise to expensive and difficult coordination within the Federal government that too frequently requires Executive Office of the President intervention to coordinate or settle agency disagreements.

In addition, there is the question of agency experience and role. Most Labor Department experience with benefit plans under ERISA has been with pension plans and not with health plans. DOL experience with health plans is limited to collecting information and to some enforcement of ERISA's fiduciary standards among company sponsors and service providers who may profit wrongly from sponsorship or administration of health plans.

For these and other reasons we question the wisdom of setting up a bifurcated system of administration and enforcement. We recommend further analysis of this proposal.

Chapter 9: Health Plans

- The draft states at page 75 that plans with limited capacity can turn away enrollees if/when approved by state. We question this authority being given to the state, when giving this authority to health alliances might be more consistent with other parts of the plan and would probably allow decisions which are more timely and less cumbersome bureaucratically.

- This chapter, at page 80, states there will be 2 levels of cost sharing -- this conflicts with Chapter 4 which states there will be 3 levels of cost sharing.

- The plan allows supplemental insurance to cover cost sharing (p. 81), but also requires that the premiums for these plans cover the cost of any additional utilization caused by the insurance. To be consistent, therefore, this "utilization surcharge" should apply to supplemental cost-sharing plans under Medicare as well.

- Utilization Review protocols must be revealed by plans -- revealed to whom? This could discourage innovative approaches being developed by plans; it would also take away yet one more competitive dynamic between and across plans.

Chapter 10: Risk Adjustment

- The document should state whether the risk-adjustment system will apply to individuals or to groups. Language indicated individual adjustors. Accurate

individual adjustors are not yet fully developed, and will require intensive developmental work.

-- Data have not been refined to the point of yielding great predictive powers on a case-by-case basis.

-- Data often currently available, i.e., past use of health care utilization, may reflect abuse and inefficiency in health care delivery. As a basis for prospective payment of a risk-adjusted amount, past use of health care resources may reward inefficient providers who allow payment for duplicative services and lack strong utilization review controls.

-- As a result, classification schemes that rely on measures of morbidity (e.g., diagnosis) might be more useful that purely utilization. Ambulatory Care Groups (ACGs) and Diagnostic Cost Groups (DCGs) represent two approaches that use a combination of diagnostic information and utilization experience. Both of these approaches demand evaluation and refinement over the next few years if considered for use by Health Alliances.

-- Insurers may continue to find ways to "cream-skim" the "healthiest" sick cases, e.g., a cancer diagnosis early in the disease's progression in any risk category. And providers and/or payers could have incentives to upcode diagnoses and health risk categories to receive a larger payment from the pool and/or pay less into it. These issues imply ongoing monitoring and refinement may be needed.

-- Other administrative issues remain. For example, a purely prospective system could hamper a plan's efforts to be reimbursed for an enrollee who joins half-way through the year. No look-back mechanism appears to exist in the document to address enrollment turnover and will need to be thought through.

-- Risk adjustors are intended to account for an individual's level of risk; they may not necessarily account for the differing practice patterns among regions, which may have heavy influences in the amount of health care resources consumed.

-- Risk adjustors could entail overhead costs in enforcement and implementation for private plans and regulatory bodies; improved

software or actuarial methods being tested by Blue Cross and Blue Shield and HIAA (among others) may minimize these burdens.

The draft plan appears to include community rating, a standard benefit package, and annual open enrollment periods. Inclusion of these elements will add to the "arsenal" available to HA's to prevent or discourage risk selection, though some individual variance will continue to exist.

- Allowing for a waiver if the alliance demonstrates an alternative system as "at least as effective and accurate" could create opportunities in the first few years for waivers.

Chapter 11: Rural Communities in the New System

- The financial incentives for providers seem generally skewed toward physicians specifically, rather than all health professionals generally.

- In describing the infrastructure development grants, it may be clearer to state the level of loan guarantees committed per year (note: the BA level of $16 million per year mentioned on page 86 is probably the estimated subsidy level -- which sheds little light on the actual volume of lending and scope of the program). Does the plan envision an increase in these guarantees or maintenance of the current level of support?

- It is not clear why only community-based organizations would be eligible to receive these guarantees. What about health plans expanding into rural areas?

- Page 87, do the cost estimates for the expansion of the National Health Service Corps (NHSC) take into account the cost of the tax expenditures of the proposed tax incentives? In addition to awarding more scholarships and loan repayments and supporting a greater field staff?

- NHSC loan repayment recipients already receive a payment equal to 39% of the loan repayment award for the purpose of completely offsetting the additional tax liability. Setting up a special exclusion from gross income is not necessary.

- Given that hospitals in rural areas have excess capacity, could some of the excess capacity of rural facilities be converted to serve underserved areas?

Chapter 12: Integration of Workers' Compensation and Automobile Insurance

- The plan should deal more forthrightly with the fact that workers' compensation and health insurance have been set up for different purposes. The purposes of medical, rehabilitative, and care requirements in state and federal workers compensation laws are very broad. The care allowed under most medical care insurance is limited. The state workers' compensation laws are all different, and there are two federal laws (covering longshore and harbor workers and federal workers). Under all workers' compensation laws coverage of treatment and procedures allows for no deductibles. Coverage may even extend, for example, to providing comfort, in addition to unlimited medical treatment, care, and rehabilitation. The different purposes mean that programs of workers' compensation are not usually able to adopt fee schedules of "regular" health insurance.

- Page 89 of the draft plan states that "The [workers' compensation] case manager ensures that ... the health plan complies with medical and legal requirements related to workers' compensation." This suggests that the care provided must suit the purposes of the workers' compensation law that covers an injured worker. On the same page it states that "Health plans are reimbursed by workers' compensation insurance carriers ... in accordance to the fee-for-service schedule in the alliance," and that "alliances are permitted to adopt ... per case capitation payments." It further states (page 90) that "Health benefits for work-related injuries and illnesses continue to be defined by states." These apparent contradictions suggest that the plan should be expanded or clarified so that:

  (1) Alliances are required to have fee schedules that allow for the broad purposes in the workers' compensation laws in effect in the area(s) they cover; or

  (2) The broad purpose of care in workers' compensation state and Federal laws is preempted in the Federal law so that it will match the purposes of health care that will otherwise be under President's plan.

Chapter 13: Inter-Alliance Health Security Fund

- Page 93, what is the average "float" or reserve that will be available to this fund, and how will it be used -- entirely loans? This discussion needs clarification with regard to safeguards.

- Page 94, the Administration component of the Reserve needs to be specified with more detail; in particular, will this reserve be part of the funds flow of the Federal government? Or will it be part of some banking and holding operation in Kansas City, etc.?

- This fund duplicates functions currently performed by the Automated Clearing House for substantially similar activities that collect and disburse funds. The Automated Clearinghouse processes billions of dollars of transactions efficiently, with an established network of corporations and financial institutions. A second, new health payment network, seems unnecessary, duplicative and costly. Use of the Automated Clearinghouse should be considered to route payments from employers to health alliances.

- Creating a separate fund that "holds" billions of dollars of health contributions and payments could engender the gaming of cash flow and other financial techniques that are not efficient in applying these funds to health uses. In an era of budget stringency, the temptation to tinker with this fund may be irresistible, particularly with the commingling of the Funds financial and loan functions.

Chapter 14: Budget Development and Enforcement

Covered Expenditures

- Current version: Medicare and Medicaid expenditures are included under separate budgets. Suggested revision: All Federal direct health expenditures are included under separate budgets. This would include Medicare, the Federal portion of Medicaid, the IHS, DoD, and VA.

Adjusting the Budget Inflation Factor

- Current version: "If, however, an alliance's actual weighted average premium in a given year exceeds its premium target, then the inflation factor for that alliance is reduced for the following two years to recover the excess spending." Issue: Is the two-year "lookback" sustainable from the beginning, particularly with the uncertainty in setting the per-capita premium in the early years? Is it possible to keep track of the "lookback" recovery over a number of years? This mechanism sounds good, but the implementation could be quite complicated if the alliance or state miss the target over a number of years.

Second Level of Enforcement: Compliance with Federal Cost Containment

- Current version: state alliances are in compliance with national cost containment goals if the increase in the weighted average premium falls within a 1% band above the inflation factor. Question: 1% of what? 1% of premium costs, 1 percentage point of the inflation factor?

- Current version: If spending is below the inflation factor plus 1%, the 50% of the unused amount may be rolled over to the following year, up to a 5 percentage point maximium. Suggested revision: Eliminate the 50% roll-over, except with National Board approval. The states, alliances, and enrollees all benefit from coming in "under budget" through lower premium payments in the following year. Allowing premium rates to climb faster than needed in the market is unnecessary.

- Current version: Actual weighted average premium is no more than 10% higher than the per capita budget target for the state. Suggested revision: Narrow the variance from 10% to 1-5%. A ten percent error band is too large a cushion, with the temptation to allow the premium to match the 10% band every year. An alternative is to allow the 10% variance for X number of years to allow for stabilizing the baseline, then reducing the variance to a lower level.

Budgets for Corporate Alliances

- Current version: After the third year of implementation of health reform, each corporate alliance annually reports its average premium equivalent for the previous three years to the Department of Labor. Suggested revision: Instead of the Department of Labor needlessly developing its own health insurance pricing and analysis capability, give the reporting requirements for large corporate employers to the National Health Board. Since it set the corporate alliance premium equivalent originally, it would best be suited to review, and enforce as necessary, the corporate alliance cost performance.

- There is little or no discussion of developing a state-by-state or alliance by alliance baseline. Of course, this does one not now exist so the issue is whether one will be developed to allow enough precision for the National Board to distinguish between appropriate and inappropriate premium targets. If one is not available that can both track spending and adjust for various degrees of risk, it may be both technically difficult and perhaps politically impossible for the National Board and the Federal Government to develop enforceable targets.

Chapter 15: Quality Management and Improvement

- In general: the entire section is very unclear as to who is doing what and instead attributes actions to the program.

- There seems to be unnecessary overlap between HHS functions and the National Board functions regarding evaluation of health care (see p. 106 and p. 119) and assessing the impact on the health care system.

- The discussion (p. 107) of state licensure and certification does not appear to comport with current DHHS initiative to license and certify essential health providers in the PHS sections.

- Is there duplication of effort between the National Quality Management Program of the National Health Board (pp. 110-111) and AHCPR activities?

- Are quality standards of the Indian Health Service, Medicare, VA, or DoD superseded by National Board standards?

- It is unclear who is auditing the plan's measure and disclosure of performance on quality.

- Demonstration projects are to be completed by 1/1/96 for new performance standards and standards will be revised according to findings. Most demonstrations take up to a year to design and implement; as such this timeline may be heroic.

- Regional centers are stated as auditing for data integrity where we were previously told they were only going to serve a switch function.

Relation to Existing Legislation

- OBRA-87 nursing home reforms: this chapter does not the address the requirements of OBRA-87, which created stringent quality standards and enforcement authority regarding Medicaid and Medicare nursing homes. These requirements are responsible for the bulk of survey and certification spending. Annual surveys of all Medicaid and Medicare nursing homes are mandated, and the average cost per survey is approximately $14,000. While the nursing home standards are the most burdensome and costly responsibility for Federal and State quality assurance programs, they also have strong Congressional support. Congress enacted the nursing home reforms in response to widespread concerns

over the treatment of the elderly and disabled. Changing or eliminating the current nursing home survey and certification program will be very difficult politically.

- CLIA: proposed changes to the Clinical Laboratory Improvement Act (CLIA) are extremely vague. This section should address at least the general principles for reform of the program.

Chapter 16: Information Systems and Administrative Simplification

- In general, this chapter does not appear to have been sufficiently vetted. There is a confused division of responsibility between HHS and the National Health Board, not to mention between the States, Health Alliances, health plans and the Federal government.

- Page 115 states that "health providers will use current information system technology as the foundation for the system," which implies that all providers and not just plans will be automated. The sense of the working group was it would be left to the plans and the pressures of a competitive environment whether automation would occur at the point of service. We recommend replacing "providers" with "plans."

- The draft at page 119 assigns responsibility for conducting surveys to a particular department -- DHHS -- which seems to be an unnecessary amount of detail for this document, given its purpose of communicating to a broad public. It would be better to vest authority for such activities in the National Health Board, which will be in the best position to decide how it wants to collect data, etc.

- Consistent with the National Performance Review, consumer satisfaction surveys should be conducted at the lowest possible organization levels, closest to the people being served.

- The privacy section states that the Federal government would stipulate that individuals "have the right to know and approve the uses to which data are put" (p. 121). Although this is an example, it should probably state "non-routine" or "certain" uses. The approval should not create health care delivery inefficiencies.

- At pages 125-127, the draft discusses streamlining Medicare: Medicare data systems are not currently designed to collect information on plans -- only fee-

for-service experience. This is clearly one of the many information challenges facing HCFA. Many of the specific ideas have conceptual merit, but are premature, and should be developed in consultation with HCFA's Medicare Technical Advisory Group (M-TAG). In particular:

-- delete the proposal requiring performance evaluations of carriers by physicians. This appears to involve a direct conflict of interest, because carriers may feel increased pressure to liberalize coverage rules and payment policies to obtain positive evaluations from providers. At a minimum, the current five-state pilot project should be evaluated to determine its effects before deciding whether to commit to national implementation of such an approach.

-- check with the OIG on whether enforcement abilities are weakened by moving from an annual requirement to a one-time requirement for physicians to sign an acknowledgement of awareness of penalties associated with falsifying claims information;

-- clarify that the proposal that "repeals legislation requiring review of at least ten surgical procedures" refers to PRO review;

-- delete the proposal to limit system changes in Medicare and Medicaid to once every six months, and to require 120-day advance notice for major billing procedure changes. This would be administratively costly and burdensome, requiring simultaneous review of thousands of pages of regulations every six months as HHS responds to deadlines with last-minute completions of regulations. The likely effect would be delays in regulatory improvements and fee schedule adjustments (i.e., increases for inflation)by six months every time a deadline is missed. This proposal may inhibit needed actions to live within budgeted amounts.

-- revise the proposal to develop standards for single annual inspections of health care institutions to single, periodic inspections. Some facilities with quality problems may require more frequent inspections, while others may require less frequent inspections. There is no need for uniform schedules among a diverse group of institutions.

- Medicaid: There is little or no discussion about Medicaid information systems. There could be a critical need -- even on an interim basis -- to collect better information on Medicaid experience.

This is especially crucial in the context of Medicaid managed care programs. As states shift their entire Medicaid population to managed care organizations (e.g., New York and Tennessee), HCFA data systems "lose" the ability to track these groups, because current HCFA data systems are designed only to track fee-for-service experience.

- HHS Control of Information: HHS proposes that it control information collection and dissemination in several instances. The National Health Board should assume this function.

- National, uniform standards -- timing: development of national standards for coding and content requirements for all insurance transactions by July 1, 1994 seems ambitious. In addition, the plan calls for "immediate" adoption of national standards by all government health programs. It is unclear whether this means the day after enactment of health care reform, or what may be a more realistic timetable for implementation of this measure.

Chapter 17: Creating a New Health Workforce

General Points

- There is a heavy Federal regulatory role in determining and distributing physician residencies as presented in this section. The approach outlined represents a fairly radical departure from more market-oriented approaches, and it is unclear whether such a system would be politically feasible. These points were raised early on during the tollgates.

- In addition to advocating heavy Federal regulation and control of residencies, this approach will do little over the short term to narrow the gap between primary care and specialists. The goal of the draft's proposed Federally managed system would be to make sure that at least 50% of new physicians are trained in primary care fields (after a five year phase-in period). Yet, even if this goal were achieved, it would take 40 years to achieve the desired distribution between primary care and specialist physicians.

- This section discusses options for tinkering with Medicare's physician payment schedule to create incentives for providing primary care services. First, Medicare is not and should not become the spearpoint of policy for health care reform. The reform package must create incentives for primary care delivery

on a system-wide basis, because Medicare fee-for-service incentives alone will be too weak to change overall physician behavior.

Medicare physician payment on the fee-for-service has already undergone the radical shift toward primary care called for in this section. OBRA 89 enacted the most sweeping changes in physician payment since Medicare was created in 1965. In 1989, Congress required the use of the Resource-Based Relative Value Scale (RBRVS) which fundamentally shifted the distribution of Medicare physician payment away from surgical procedures and toward primary care services. For example, fees for family and general practice services increased by 10 percent when the RBRVS was implemented, while fees for general surgery decreased by 10 percent.

OBRA 93 has put even more pressure on physicians to focus on providing primary care services, and in many cases the provisions of OBRA 93 supersede the specific policies suggested in this section:

- the reductions that will be applied to physician fee increases in 1994 and 1995 will not apply to primary care services, resulting in relatively higher payments for primary care services;

- the separate "expenditure target rate of growth for primary care services" called for in this section has been enacted in OBRA 93. The separate target will eventually result in higher fee increases for primary care services. An arbitrarily higher target for primary care is unnecessary;

- the physician overhead component of the RBRVS was reduced in relative value by OBRA 93, increasing the overhead reimbursement for primary care services relative to other services. HHS is already working on a methodology for basing overhead payments on actual resources used. The FY94 President's Budget proposed that this methodology would be implemented by 1997.

- The Administration and Congress have already created incentives for primary care by drastically altering Medicare physician payment. The other proposals in this section (increasing payments for office visits and bonus payments to primary care physicians in Health Professional Shortage Areas) should also be advanced as Medicare reform proposals, not health care reform proposals. Medicare should not be in the vanguard of health reform, but should take advantage of and build on the successful policies implemented by the health

alliances. The entire section on Medicare physician payment changes is either premature or outdated, and should therefore be deleted.

- The report, instead, should make the point that managed care plans are the best friends of primary care. It is HMOs and other organizational arrangements that have historically valued primary care relative to specialty care -- the report's chapter should be built more around this theme. Medicare payment policies can and should build on integrated networks of care. For example, bonuses should revolve around use of primary care case managers in HMOs or some adjustment to the AAPCC payment. Continued tinkering with fee-for-service bonuses to physicians will only encourage fee-for-service style of medicine which could be both fragmented and volume-driven, placing increased risk on Federal outlays.

  If one end result of health reform is a much broader application of managed care, the demand for primary care physicians should increase. Why wouldn't this market response encourage more medical students to enter primary care, as well as practicing specialists to change over to primary care?

Specific Comments

- Page 130, the draft outlines an approach that would pay teaching hospitals which are required to reduce their residency training positions at a rate of 150% of the national average for direct medical education payments. In essence, these transition payments would reward non-performers more than performers and establish perverse incentives for non-compliance.

- Page 131, use of the word "appropriation" is confusing. Does this suggest that the Federal government would appropriate $6 billion or is this what the balance of residency training fund would be?

- It is not clear who would collect the revenue raised from the premium tap on the insurers and on Medicare. It is also not clear what body would administer this fund.

- The draft does not specifically state how much it would cost to administer the fund, as well as the new system for determining the distribution of residencies. It is not clear whether these costs have been taken into account.

- Page 131, the draft also does not specify the amount or the source of financing for the transition payments mentioned. It is not clear whether these costs have been taken into account.

- Pages 132-135, the section on "other workforce related programs" discuss expansion of existing health professions curriculum assistance grants. The draft, however, makes no reference to the current investment of $270 million in these programs, why additional investment in these programs is warranted, and what the net effect of the additional investment.

- The investment in "other workforce related programs" essentially builds on existing health professions programs. However, many of these existing programs have not had much effect in achieving desired policy goals. Could some of these expansions be funded by downsizing low-priority health professions programs?

- An alternative approach would take advantage of changes in physician employment market within the context of health reform and build off of the retraining proposal contained on page 131. Health reform's emphasis on managed care settings will increase the demand for primary care physicians, and reduce the demand for specialist physicians. As health reform takes hold, an increasing number of physicians currently practicing subspecialties will have to be retrained to practice primary care.

- Rather than continue Federal subsidies for training medical students, this alternative would phase-out Medicare GME payments overall and allocate a portion of Medicare GME funds on sharing the cost of retraining specialists for primary care work with HMOs and other managed care providers. Retraining physicians would provide a much shorter "pipeline" -- already practicing physicians would not need the same basic medical training that a medical student receives. Channeling funds for retraining through HMOs and other managed care providers would enable HMOs to determine who to retrain and extent and nature of retraining. Federal cost sharing would decline as specialists gradually met the need for primary care physicians. HMO's and other providers would have to pay back a portion of the Federal cost sharing if specialists did not stay in primary care for at least five years.

Chapter 18: Academic Health Centers

- The draft states that Medicare payments and a surcharge on private health premiums would flow into a pool to support academic health centers. The

analytic justification for this separate funds flow has not been identified, nor is the size of the fund made explicit. Is this in addition to other GME & premium funds? What is the total burden of these "taps"? Is the total dollar flow necessary for the level of academic health centers needed? Aside from this tap, how much increased funds will be flowing to such health centers through increased reimbursements due to universal coverage and due to some experimental treatment expenses being covered through the benefit package? Would any additional tap be required?

The draft would create a separate set of grants to encourage people to have access to academic health centers. Is this necessary, given increased reimbursements, benefit plan coverages, the proposed pool, and existing NIH grants -- and the access initiatives described in another chapter? If access assistance is necessary for these specific type of centers, it should be part of a single assistance package coordinated by the access initiative described elsewhere.

- The document states that plans will be required to provide coverage for routine patient care associated with approved clinical trials. This could be a disproportionate burden to plans, depending upon the relative number of individuals enrolled in trials. Trials tend not to be randomly allocated across areas and providers, but often concentrated in areas in large research institutions and academic medical centers.

  Secondly, plans could discourage patients to either not enroll in trials or else encourage them to disenroll from plans if there was such a burden. This would have the effect of discouraging over time good clinical trial activity.

- There is little or no discussion about rebuilding rural academic health centers. Good empirical evidence to date indicates that rural centers tend to be an effective approach for attracting and retaining a rural workforce of medical professionals.

Chapter 19: Health Research Initiatives

- Page 140-142 lists many, many areas of research interest, implying that all of them will receive additional funding. Text should be modified to present the items on the list as illustrating the types of areas in which investments could be made.

- The draft states that an additional $1.5 billion would be used for "prevention" research. NIH will spend about $2.6 billion (roughly 25%) of its total $10.8 billion FY94 budget on research which can be labeled "prevention-related". It is not clear whether more of this type of research would help Health Reform accomplish its goals. If desired, "prevention" research could be made a higher priority within NIH or within PHS' total FY95 planning ceiling, which would not require additional discretionary financing.

- Page 146 lists specific agencies which would assume responsibility for research on the impact of health care reform. The document states that AHCPR and HCFA/ORD will take the administrative leads in developing new research and demonstration initiatives. The document should note the DOL's contribution and importance in future activity related to employment-based health insurance. Secondly, HHS/ASPE, and OMB have played critical roles in developing and guiding longer-term strategies in these areas, and should continue to do so. Finally, this is not consistent with the chapter on the National Health Board, which assigns ultimate responsibility for determining such details with the Board.

Chapter 20: Public Health Initiatives

- Public Health Service programs: In general, many current Public Health Service programs are "gap fillers," providing services to groups not currently covered by comprehensive health service benefits. These benefits include mental health and substance abuse services, immunizations, prevention, breast cancer screening, community health centers, etc. These services are included in the standard benefits package, and therefore the full array of PHS programs are no longer necessary.

  Rather than phasing-down these benefits, PHS assumes full continuation of current funding levels, as well as expansion of these PHS duplicative benefits by another $3 billion per year.

  These increased Federal health costs are unnecessary and wasteful. These funding levels and programs undermine the objective of health reform --- to lower cost, consolidate disparate delivery mechanisms, and improve quality and access.

- The chapter is written as if public health will continue to be separate from the rest of the reformed health system. This would simply perpetuate the 1930's

model of public health -- a two-tiered system. Re-drafting this section to talk about public health as integrated into a reformed health system should be considered.

- This section calls for the creation of series of new state formula grants for a variety of functions already supported by the Federal government and state public health departments. It is unclear why such additional support for state public health departments would be needed within the context of the reforms mentioned in the other sections of the document.

- The document refers to "core" public health functions, which seems to protect activities that might no longer be essential within the context of a reformed health system.

- Pages 149-152 describe a new block grant that states could use for any of the "essential functions" outlined in the draft. However, the draft seems to ignore current Federal assistance provided to states for many of these same activities. Since most of these responsibilities are not new, why is additional funding required?

- Several of the core functions described on pages 149-152 appear to duplicate investments that would be made elsewhere, including assistance of underserved populations, health data collection and outcomes monitoring, training and education, and quality assurance. It is not clear how funds provided through these grants relate with grants described in other sections of the document.

Chapter 21: **Long-Term Care**

- Clarify the relationship between expanded home and community-based service program and Medicaid. Previous information indicated that this new program would be completely independent of Medicaid home and community-based services. The program had been described as wholly Federally funded. In contrast, this chapter describes funding for the program as a Federal/state match with the state contribution set roughly equal to current state Medicaid spending on the severely disabled. This new information raises several issues:

  -- Are Medicaid long-term care services for the non-institutionalized to be pulled into this program? If so, a significant cost-shift from Medicaid to the new program should be accounted for in our scoring tables.

-- Many individuals currently receiving Medicaid home and community-based care may not qualify for services under the more stringent disability determination standards of the new program. Will these individuals continue to receive services from Medicaid; and if so, should this situation be accounted for when calculating the State contribution towards the new program?

-- The non-cash Medicaid home and community-based care recipients will be moved into health alliances where, presumably, they will no longer receive such services. Should costs for these individuals be counted towards the State match?

-- Will the same rates be paid for both Medicaid and non-Medicaid recipients? If Medicaid rates are increased, the resulting fiscal impact should be scored. If providers are paid lower rates for services to Medicaid recipients, how will the distinction be handled in an otherwise "non-means-tested" program?

-- Alternatively, if current Medicaid home and community-based services are not supplanted by the new program, State spending for these services will double under the match formula.

- Medicare beneficiaries' premium. The chapter indicates that Medicare beneficiaries will pay a premium of $20 dollars per month to help finance the new home and community-based service program. At recent health care reform meetings, HHS policy officials appeared to indicate that Medicare beneficiaries will not pay this premium. The latest budget impact tables are based upon a $10 dollars per month premium. The final draft should reflect the President's decision on this issue.

- "Cash-only" rule. Recent policy documents and discussions have referred to the residual Medicaid program as available only to cash recipients. This draft makes it clear that Medicaid will retain and expand eligibility for non-cash institutional recipients through more liberal spend-down programs. References to the Medicaid program should specify that the "cash-only" eligibility rules do not apply to institutional care. In addition, eliminating Medicaid long-term care services for non-cash recipients who are disabled but who do not meet the 3-ADL standard could create political problems.

- Transfer-of-asset and estate recovery proposals. OBRA 93 provisions regarding transfers of assets and estate recovery overlap with many of the proposals advanced in this chapter. OBRA 93 has already made the following changes:

  -- estate recovery programs are now required in all States;

  -- consecutive (rather than concurrent) penalties are required for transfers of assets;

  -- transfer-of-asset penalties now apply to many transfers of income; and

  -- the lookback period for transfers of assets has been increased from 30 months under previous law to 50 months for trusts and 36 months for all other transfers;

  -- capping transfers of assets to an institutionalized patient's spouse was proposed during OBRA 93, where the provision met stiff Congressional resistance and was eliminated from the bill; and

  -- the proposal to protect additional assets for purchasers of long-term care insurance does not address the OBRA 93 provision making such assets subject to estate recovery. These assets may not be recovered in five "grandfathered" states. Nevertheless, individuals in most states are now unlikely to purchase long-term care insurance in order to protect their assets.

- Demonstration study of acute and long-term care integration: The proposed demonstration could overlap significantly with current HCFA demonstrations involving social HMOs (S/HMOs) and On Lok or PACE projects. While the proposed demonstration may be more comprehensive in scope, differences between it and current projects should be specified in order to avoid duplicative efforts.

- Quality and utilization control: Expanding home and community-based services raises a host of related concerns. The recent explosion in Medicare home health spending indicates the potential for abuse and overutilization in this area. Issues to consider include:

  -- Who will be allowed to provide these services?

-- What, if any, medical authorization will be required before the government pays for these services?

-- Will there be limits on the amount of services individuals may receive?

-- Will there be any utilization review?

-- How will quality care be defined and assured?

- Cash payments to individuals: According to this chapter, the new home and community-based service program will permit States to make cash payments to disabled individuals. Direct cash payments may create a moral hazard problem, reduce government control over quality of care, and significantly increase program participation.

- The Federal match rate formula for home and community-based program will treat states inequitably. Spending for non-institutional, long-term care varies greatly from state to state. For example, New York alone accounts for more than 70% of all Medicaid personal care spending. Basing the Federal matching rate on current state spending creates a bonus for states like New York while penalizing states that have not been big spenders in this area.

- Fiscal impact of eligibility expansions for institutional care. Liberalization of the financial eligibility standards for institutional coverage may significantly increase Medicaid costs. All states would be required to establish medically needy programs for institutionalized patients. Currently, 15 states do not have such programs. In addition, single individuals with up to $12,000 in assets will be eligible for Medicaid. The current asset standard is $2,000 in most states. These changes will make more individuals eligible for Medicaid coverage sooner, thus increasing Medicaid costs. The resulting costs should be taken into account when projecting the Medicaid baseline, especially in light of the entitlement caps requirement and global budget targets.

- Why is the tax incentive limited to individuals with disabilities who work? Why not all individuals with disabilities? Advocates for individuals with disabilities will argue that all individuals with disabilities who can work want to work but have great difficulty finding jobs. They will argue that if the goal of this policy is to encourage individuals with disabilities to get jobs, it is unnecessary; they want jobs. If the goal of this policy is to help individuals with disabilities afford the services they need to live independently, the policy

-- How will fraud investigations be coordinated with quality assurance activities? Will case-by-case quality review be used in abuse investigations? There may be some question whether the same evidence can be used for two very different purposes.

-- The text mentions that funding for enforcement activities will be "supplemented" by monies and assets recovered or confiscated by successful fraud and abuse prosecutions. In which agency will funding for implementation and regular operations originate? Will law enforcement agencies receive funding from the alliances (i.e., from premiums) or will general funds at all levels be diverted or increased to support enforcement activities?

- Will an exception on self referral for rural areas be allowed? If so, the conditions and back-up alliance monitoring mechanisms should be specified.

Chapter 25: Programs for the Underserved

- The draft outlines steps to continue Federal subsidies to selected classes of providers in underserved communities (i.e., community health centers, health care for the homeless centers, family planning clinics, and others). Through an "essential community provider" designation, the draft would also give these providers competitive financial advantages in serving underserved communities. These efforts could discourage other plans and providers from expanding into underserved communities. Maintenance of a two-tiered system would seem to undermine some of the overall goals of health reform.

Chapter 26: Medicare

- Medicare is kept virtually intact in the health reform plan, except for the prescription drug addition. Cost-effective innovations in service delivery will be incorporated into the Medicare program over time, but the consensus is clearly to have Medicare remain a follower, not a leader/experimenter, in health reform. There is plenty of room for reform within the Medicare program itself, but there is also awareness that reform with the elderly and disabled populations should proceed prudently.

- The status of working Medicare-eligible beneficiaries is not clear in this chapter. We understand that the plan assumes $59 billion in federal savings

(from 1996-2000) from workers who would get primary coverage through their employers. This raises the following questions:

-- Does the mandate apply to employers of Medicare eligibles, or is employment sponsored insurance merely a mandated option for Medicare eligibles?

-- Does the mandate apply to the cohort of working aged in corporate alliances?

-- Suppose both spouses are Medicare beneficiaries, and only one works. Does the mandate force the worker/employer to buy a couples policy or a single?

-- If a Medicare beneficiary is married to a non-Medicare worker, does the worker/employer have to buy a couples policy or could they decide to purchase only a single plan?

State Integration

- HHS position: "If only an enhanced benefit package is offered, the cost to the beneficiary still can be no greater than under traditional Medicare."

- Suggested revision: "If only an enhanced package is offered, the cost to the federal government and the beneficiary still can be no greater than under traditional Medicare."

Assurances

- Current position: "Savings accruing to the state are shared with the federal government and/or Medicare beneficiaries (savings may be used to reduce the Medicare Part B premium in the state.)"

- Suggested revision: strike language regarding giveback to beneficiaries, particularly mentioning the Part B premium. If a giveback is allowed, let the state decide how. If the Medicare beneficiaries cost less than expected, the savings should not be applied to "rewarding" the beneficiaries. The following year's lower premium estimates should be sufficient.

Cost sharing

- Current position: the annual deductible amount is set at a variable rate to assure that the same number of beneficiaries meet the deductible each year as during the first year of coverage.

- Suggested revision: the deductible should be adjusted so that the same **percentage** (emphasis added) of beneficiaries meet the deductible each year as during the first year of coverage. This accounts for absolute beneficiary growth.

Prescription Drugs

- Single-pricing. The Medicare drug policy includes a rebate provision, specifically tied to the ratio of average wholesale and retail prices. Medicaid has long had a "best price" drug price rebates. Extending the forced rebate to a larger portion of the market threatens cost shifting. This could then have the perverse effect of eroding large hospital and HMO discounts, especially if further actions (e.g., "single price" policies) are put into place to protect retail pharmacists, as was once part of the short-term cost control strategy.

Chapter 27: Medicaid

- State flexibility. State-option Medicaid benefits seem to be frozen not just for purposes of maintenance of effort, but the specific benefits that are covered. This is not only a change from current policy, but seems to run contrary to State flexibility and the desire to have states develop and run more efficient health care systems. Even if the decision was made to avoid political opposition, perhaps we could have a time in the future when states could again determine what optional benefits are provided. Such a time frame could coincide with the expanded benefits in the year 2000. This does not have to be tied to maintenance of effort. States could be required to redirect the funding for other health care purposes.

- Eligibility. The description implies that both cash and non-cash Medicaid recipients would be enrolled in Alliance health plans and that Medicaid would be responsible for paying specially-determined capitated payments to plans on their behalf. This is inconsistent with our understanding that non-cash recipients would no longer be eligible for Medicaid and would enroll in Alliance health plans at the going rate with Federal low-income subsidies, if eligible. Whether non-cash recipients are "in" or "out" affects the computation of the State maintenance-of-effort requirement, the costs of low-income subsidies, and whether to include a Medicaid savings offset associated with

switching these individuals from Medicaid to the low-income subsidy payment stream.

- Many individuals, particularly pregnant women and children, gain and lose Medicaid eligibility frequently. How will the Alliances assure smooth transitions between payments from employers, Medicaid, and Federal low-income subsidies?

- Apparently, Medicaid recipients could choose any Alliance plan, but would be charged if they chose a plan costing more than the weighted-average premium. Will Medicaid recipients receive a "refund" if they choose a plan that is cheaper than the weighted-average premium?

- State-by-State variation and wraparound coverage. According to the plan, Medicaid will function as a secondary payer, providing wrap-around coverage for Medicaid recipients. Many potential wraparound services are optional. States differ dramatically in what kinds of optional services they offer and in the amount, duration, and scope of mandatory services they provide. Will the wrap-around package vary State-by-State, depending on the mix of services each State now provides? Can States alter the wrap-around package? Will non-cash recipients receive any wraparound services, post-reform? If so, don't they then have to maintain a "dual" eligibility within the Medicaid program?

- Will wraparound services be funded as Medicaid is now, i.e., a Federal/State matching arrangement? Will States or Alliances be responsible for coordinating the delivery of wrap-around services?

- As noted above, Medicaid recipients gain and lose eligibility frequently. How will the States or Alliances that coordinate wrap-around services accommodate a continuing changing eligible population?

- Under the plan, would Medicaid continue to finance the Medicare cost-sharing expenses of Qualified Medicare Beneficiaries now covered by Medicaid?

- There is an apparent inconsistency between the global budget and maintenance-of-effort requirements. Under the global budget, States can spend no more for Medicaid capitated payments to plans than 95% of each State's historic per capita spending for services in the benefit package multiplied by the number of recipients enrolled. Under the maintenance-of-effort requirement, States must spend at least 100% of what they used to spend under Medicaid for these services. If Medicaid enrollment stays constant, the level of State spending

required for maintenance-of-effort would exceed a State's global budget expenditure limit.

- Do the maintenance-of-effort and global budget requirements include disproportionate share hospital expenditures?

- Provider tax limitations. If the match rate system is retained, States will continue to have an incentive to generate Federal funds through "costless spending" programs involving provider taxes. Current provider tax limitations may need to be reviewed to maintain the integrity of the State-Federal financing relationship. Existing limitations were created to apply to the taxing and reimbursing of numerous providers, rather than a small number of plans.

Chapter 28: Government Programs

Department of Defense

- It is not sufficiently clear that DoD beneficiaries cannot obtain health care coverage from both a health alliance and from DoD. It is critical to controlling costs that individuals choose a single plan (either a DoD plan or a health alliance plan) for all of their health care coverage. The VA section (on page 215) makes explicit that an individual may receive health care coverage under only one plan. DoD should do the same either on pages 13 to 15 or on page 213 under eligibility.

- Is the intent to give Alliances real power to certify or refuse to certify DoD and VA plans? The requirements of the plans and the latitude given Alliances in certifying allowable plans should be made very clear.

- The word "centers" in paragraph 2 on page 212 should be changed to "care". There is no debate that DoD must be ready to provide necessary medical care for contingency operations. It is less clear that DoD needs to maintain large numbers of expensive medical centers in peacetime.

- In the second paragraph under "Appropriations and Reimbursement" the word "since" should be changed to "prior to". (p.213) DoD's intention is to protect current beneficiaries, not necessarily future beneficiaries, from any increase in costs. As written, the proposal could be very expensive.

- On page 213, add "Title 10 of the United States Code" after "described in" in the first paragraph, and after the word "under" in the fourth paragraph.

- DoD currently spends an estimated $1.3 billion to provide medical care to Medicare beneficiaries. Most of these costs would be shifted to Medicare under the proposal. In order to control total health care costs and limit the DoD incentive to provide a richer than national reform health care benefit, we could impose conditions that would limit Medicare payment to circumstances in which:

  -- Medicare beneficiaries pay at least the minimum premium and cost share they would pay in a private health alliance; and

  -- benefit levels are the same as the standard benefit package; and

  -- DoD costs, as certified by either HHS, OMB, or GAO, do not exceed the costs of local health alliance plans.

Veterans Administration

Start-Up Costs:

- The plan would establish a revolving fund to provide seed money to VA facilities through a one-time appropriation. The seed money would have to be paid back by the borrowing facilities, with interest, over several years.

- This proposal implies that VA will need a substantial funding increase because of health reform. In the current budget guidance, VA Medical Care is not treated as a priority program. In fact, it is currently funded significantly below what the VA will likely request. The proposed revolving fund could set the stage for VA's requested increase in FY 1995 -- expected to be $2 billion over FY 1994.

- If the one-time appropriation, which is likley to be substantial, is scored as discretionary it will crowd out other discretionary priorities under the "hard freeze" budget caps.

Global Budgets:

- It is not clear whether VA would be included in global budget targets. IF VA is permitted to compete within health alliances, then the VA spending should be

included in global budgets. Otherwise, VA would not be subject to the same level of oversight and pressures for efficiency as its competitors in the alliance.

Exemptions for VA plans:

- The draft states that VA facilities participating in the health alliance must live by the alliance rules, except when the rules are in conflict with laws governing the VA system (Title 38).

- This gives the VA a wide loophole for circumventing reform requirements (e.g., global budgets, providing data for quality management, following rules for enrollment).

- VA should not have exemptions to the rules of the health alliance if they are to compete on a level playing field under health reform.

Indian Health Service

- As described, the proposal is significantly broader (at least $3 billion per annum in additional resources *just for IHS*) than the estimates provided to Bob Anderson (roughly $3 billion per annum in additional resources *for all public health* functions in the first year of reform).

- Duplicate coverage: Current direct Federal coverage through IHS is continued, as well as an employer mandate. Should not working IHS eligibles choose either employment sponsored insurance or IHS but not both, as VA and DoD eligibles are forced to do?

- Duplicate funding: Current direct Federal appropriation, plus added appropriations, plus premium collections, plus reimbursements for services. Multiple, over-lapping financing sources for each individual.

- Open-ended entitlement: Removing Anti-Deficiency Act requirements from IHS, while keeping IHS a Federal agency, allows IHS to obligate current and future funds irrespective of annual appropriations or revenue, and which the Federal Government would be required to finance. Essentially, this creates a separate Indian Health entitlement program. Current budget estimates do not take this effect into account.

- Removes current eligibility rules (p. 218). Traditionally, IHS has provided health care only to American Indians and Alaska Natives living "on or near"

reservations. These rural Indian populations have limited access to medical care, and IHS was designed to fill that role. Urban Indians have access to the same health care as any other American. By removing current eligibility rules, IHS expands its eligible population from roughly 1 million to 2.2 million American Indians and Alaska Natives, urban and rural. Further, this puts IHS in the business of providing direct care in urban areas, which is both unnecessary and wasteful.

(Note: the Health Reform Work Group 16A did discuss building brand-new IHS hospitals and clinics throughout the country, including large "Indian medical centers." Removing current eligibility restrictions, and creating an open-ended IHS entitlement, seems to be heading in this direction.)

- Creating specific organizational positions in this document borders on excessive micromanagement, e.g., creation of a titular Assistant Secretary for Indian Affairs with no line authority.

Questions

- The package states that *tribal* employers are exempt from the national employer mandate. However, the term "Tribal" is not defined. Can any employer become a tribal employer by moving to a reservation? Why should tribal employers be treated differently from any other employers?

- Are IHS facilities capped under the global budget? What mechanism to control costs exist for IHS, since IHS is outside of the Health Alliance structure?

Federal Employees Health Benefits

- In the last paragraph before the heading "Eligibility" regarding enrollees moving, add a new second sentence: "For those moving in the opposite direction, the reverse is true."

- The last point on page 220 reads: "Annuitants will be held harmless." It is not clear what this means for annuitants under age 65, both current and future. If the policy is for government to continue paying the employer share for such annuitants until they reach Medicare eligibility at 65, the text should say so explicitly.

- Under the "Transition" section: last paragraph, last sentence calls for automatically enrolling people from terminated plans in the Standard Option of the government-wide Service Benefit Plan. This assumes that Service Benefit Plan will continue to be available everywhere during the transition. Add: ", or the most comparable plan available, as determined by OPM."

- Under "Contributions during Transition" the first statement should be restated as: "During the phase-out-period, the employer contribution continues at the level provided by current law." The modification is to the end of the statement. This reflects action in 1993 Reconciliation legislation which made a small change in the outyears to the "Big 6" formula that determines the government share of the FEHB premium.

- Under "Employee Health Benefits Fund:" What happens if reserves are not sufficient to pay the remaining claims after old plans close out? Does the Federal government then bear all the risk as the employer, or are remaining plans assessed? If the Federal government has to bear all the risk, it would seem consistent to allow the Federal government to claim all remaining resources -- the enrollees contributed to their health insurance for a specified period, and they were covered for that period.

Chapter 29: Transition

Financial

- States that expedite implementation of the plan would receive some type of relief from the Medicaid maintenance-of-effort requirement. Given that States will be required to pay their current share of Medicaid costs when Medicaid recipients are enrolled into Alliances, how could a change in the maintenance-of-effort requirement reduce States' expenditures? There is either a contradiction in the policy, or some share of assumed maintenance-of-effort should be discounted when pricing the package.

- Medicaid maintenance of effort specifies current levels of financial support from the States. For what year do these current levels refer? Do the current levels remain constant or are they adjusted (e.g., for inflation, changes in population that would have been Medicaid-eligible) over time?

- States are required to match Federal financial support. Is the match dollar-for-dollar or at some other rate?

Timing

- Rulemaking (p.225): The use of interim final rules is likely to impose large costs because it forces immediate compliance while leaving open the possibility of changes between the interim final rule and the final rule. Such changes would likely require costly changes in contractual arrangements. Delays between interim final rules and final rules tend to raise the costs of such changes.

- The lack of court authority over the implementation of interim final rules may be viewed as an affront and result in increased lawsuits rather than decreased lawsuits. Since the Board is not required by the Statute to implement final rules by a particular date, and may be sued only after failing to implement final rules without "unreasonable delay", the effect of this clause is to delay court action for a period of years, but not to prevent it. Such delays raise compliance costs, by prolonging the uncertainty about how to comply with regulations. An inelegant solution would be to require that the final rules be issued by a particular deadline.

- Current: "States that do not begin implementation by January 1, 1995 enter the new health care system either on January 1, 1996."

- Question: What is the assumed alternative to January 1, 1996?

- Current: "Relief from short-term cost controls imposed as part of the transition to reform."

- Suggested revision: If short-term controls are off the table now, a different form of incentive must be found to replace this relief.

- Corporate alliances are given the option to join regional alliances after health reform is implemented in all States. Are there any restrictions on this option? Is this an open-ended option? Are there penalties or incentives for early or late enrollment in the regional alliance by a corporate alliance?

Other

- The concept of "group credibility" is not defined and, because the concept is not in common use, is not clear.

- In the phrase, "the pool is voluntary" -- Voluntary for whom? If the pool is voluntary for insurers' participation, it appears to contradict the previous paragraph regarding insurer assessments. If enrollment is voluntary by individuals seeking health insurance, this should be stated more clearly.

- In the phrase, "[the pool] operates under traditional insurance rating methods" -- "Traditional" rating methods would appear to include rating based on claims experience. However, the next sentence suggests that only age, gender, and place of residence can be used as rating factors. This should be stated more clearly.

- How do the phrases "first year," "second year," and "until full implementation" relate to January 1, 1995; January 1, 1996; etc.?

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. paper	Executive Summary: Treasury Department Comments on the 8-6-93 Draft Health Reform Plan (3 pages)	09/1993	P5
001b. letter	Lloyd Bensten to Hillary Clinton, re: draft health plan (1 page)	09/13/1993	P5
001c. memo	Lloyd Bentsen to the First Lady, re: Health Care Plan (27 pages)	09/13/1993	P5
002. paper	Treasury Department and Internal Revenue Service Page-By-Page Comments On Draft Health Care Plan (23 pages)	09/09/1993	P5

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Health - Agency Reviews [4]

Kara Ellis
2006-0810-F
ke1028

RESTRICTION CODES

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P1 National Security Classified Information [(a)(1) of the PRA]
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DEPARTMENT OF THE TREASURY
WASHINGTON

EXECUTIVE SUMMARY
Treasury Department Comments on the 8-6-93 Draft Health Reform Plan

Outlined below are the major comments and recommendations which the Treasury Department would like to offer regarding the August 6, 1993 draft health reform plan. Review and analysis of the modifications provided to the Secretary on September 8 is underway and additional comments and recommendations will be forwarded as soon as they are completed.

General Comments

I. The Treasury Department understands that under the plan, the Federal government would assume responsibility for guaranteeing new benefits but would delegate control over spending to other non-Federal entities. Further discussion of this issue is recommended.

II. We recommend that before it is made public, the health reform proposal be subjected to rigorous internal cost estimates and budgetary review.

III. We recommend that, because it is central to the cost containment strategy of the proposal, special care be taken in the development of the legislative language relating to the global budget.

IV. The Treasury Department is concerned that the regional alliances may not be able to manage successfully the wide array of responsibilities which they have been assigned under this proposal. In particular, the Department recommends clarification of the relationship between the regional alliances and the State and Federal governments.

V. The Treasury Department recommends that, in order to preserve the capacity of the President to modify the plan if it becomes necessary to do so, the scope of the benefits package be reduced, or phased-in over a longer period of time.

Economic Impact of Health Reform Plan

Treasury believes that, instead of abruptly reducing the percent of gross domestic product devoted to purchase of health care, a more measured cost-containment strategy be followed which would have the rate of growth of private and public spending decline gradually, over the next five years, to a long-run target.

Budget Issues

Cost projections the budgetary impact of health reform are highly sensitive to the underlying economic assumptions used in the estimating process. The Federal budget tables do not yet include the impact of all provisions. The Treasury Department recommends that publication of the final report be deferred until the estimates are complete.

Revenue Issues

I. Premium and provider assessments -- Many of the premium and provider contributions are referred to as surcharges and assessments. Treasury recommends combining, redesigning or dropping some of these provisions to ensure that they are not mischaracterized as revenues.

II. Tax cap -- Further information about specific features of the tax cap will be required in order to design the final provision.

III. Assessments on providers and insurers -- In order to develop the legislation which is critical to the successful enforcement of the global budget, the Treasury Department will need additional detailed information about how these assessments will be determined and administered. The Department also recommends redesigning certain features of the underlying policy to ensure that efficient plans are not unjustly penalized.

IV. Long term care insurance -- The Department recommends that the long term care section of this plan incorporate provisions included in legislation introduced by the Secretary and a bipartisan group of cosponsors during the last Congress. The Department recommends further that there be included in this proposal provisions dealing with the tax treatment of accelerated death benefits.

V. Retiree health issues -- The availability of inexpensive, guaranteed health insurance could have a profound impact on the decision of whether and when to retire. It might also cause more employers to induce early retirement. This, in turn, could have substantial Federal budgetary effects and could impact other Federal policies and programs. To our knowledge, these effects have not been thoroughly explored or their impact on the workforce and on the Federal budget estimated. For these reasons, we strongly recommend that the proposal to provide government-paid health benefits for all retirees aged 55-64 be deleted from the plan.

VI. Subsidies -- To a significant extent, the success of the Administration's health reform plan rests on whether it contains a subsidy proposal which is workable. Therefore, we recommend that the final subsidy proposal be reviewed by all relevant members of the National Economic Council.

Internal Revenue Service

The Internal Revenue Service has identified several significant administrative and operational issues that relate to systems needs, compliance and enforcement, and the design and implementation of the plan. It should be noted that the IRS comments treat these issues generically, and do not assume that the Service would have a prominent role in implementing the new health care system.

Erisa Issues

An issue of particular concern to large employers and organized labor will be whether to allow States to apply taxes to corporate alliances. Treasury recommends that the plan not include such authority for States.

Inter-alliance Health Security Fund

While we understand that the Inter-alliance health security fund may have been deleted from recent drafts of the health plan, these comments are offered in case our information is not accurate.

Further refinement of the provisions that detail the management of the Trust Fund and investment of its holdings is needed. In addition, it is important to include in the enabling legislation a provision to remove the ability of the FDIC to abrogate any collateralization agreements established at banks through which employer and employee contributions are transmitted. Failure to do so could result in financial loss to the Fund.

Miscellaneous

The Treasury Department recommends that further work be done -- at least demonstration projects -- to upgrade provider reimbursement levels under the Medicaid program. We are concerned that lack of parity in reimbursement could impact the quality of care provided low income individuals and families.

Finally, while recognizing the importance of restraining growth in all health care spending, the Treasury Department is concerned that the rate setting proposal to be applied to the fee-for-service sector is heavily regulatory and may be difficult for States to administer. We recommend caution in this area.

DEPARTMENT OF THE TREASURY
WASHINGTON, D.C.

SECRETARY OF THE TREASURY

September 13, 1993

By hand

Mrs. Hillary Clinton
The White House
Washington, DC 20500

Dear Hillary:

I want to thank you for providing me the opportunity to review the draft health plan and for your request that the Department of the Treasury comment on the proposal. The enclosed memorandum and the page-by-page comments highlight those issues that the Department believes may warrant further consideration. I hope you will find these comments helpful both in refining the draft and as a means of identifying issues we believe may be raised in later debate over the plan.

As we discussed last week, I believe that fundamental reform of the nation's health care system is long overdue. It is simply unacceptable to be spending more than 14 percent of our gross national product on health care while at the same time failing to insure all of our citizens and falling short of other developed countries on a whole host of health indicators such as infant mortality rates.

In Bill Clinton we have a leader who is willing to take on this very difficult but critical challenge. There is no issue more important to the economic wellbeing of this nation than reform of its health care system.

Your willingness to develop for the President and the American people a bold and innovative proposal is not just unprecedented. It is a testament to your skill at blending strong policy analysis with concern for the wellbeing of the most vulnerable among up: children, the elderly, the disabled and others whose health coverage will now be secure.

I look forward to working with you and the President to achieve comprehensive reform of our health care system.

Sincerely,

Lloyd Bensten

THE SECRETARY OF THE TREASURY
WASHINGTON

MEMORANDUM FOR: The First Lady

FROM: Lloyd Bentsen

SUBJECT: Health Care Plan

DATE: September 13, 1993

On August 24, we received a request from Ira Magaziner, Senior Policy Advisor to the President, to provide the Treasury Department's comments on the draft Health Care Plan. This memorandum and the attachments [which are cross referenced to the policy notebook] were prepared in response to that request and follow the format suggested by Mr. Magaziner's staff.

On behalf of the Treasury Department I would like to thank you for the opportunity to comment on the draft plan and to reaffirm my standing offer of support in the development of this important initiative.

GENERAL COMMENTS

As the Health Care Plan is prepared for presentation to the Congress, there are five overarching issues which the Treasury Department would like to raise.

I. The Health Care Security Act creates four new Federally guaranteed entitlements, specifically the right of all Americans to a defined set of health benefits; generous subsidies for individuals and firms who are eligible on the basis of certain criteria; long term care for persons with functional limitations; and outpatient prescription drug coverage for the Medicare population. Throughout the plan, the Federal government is the ultimate guarantor in the event that others -- such as a health plan, an alliance, or a State -- default. Treasury finds it worrisome that, having assumed responsibility for guaranteeing entitlement to these new benefits, the Federal government has delegated control over spending -- including the right to draw on the Federal treasury -- to other non-Federal entities. In our judgment, this issue deserves further consideration in advance of its formal presentation to the Congress.

II. We recommend that before it is made public, the health reform proposal be subjected to the same rigorous internal budgetary review applied earlier this year to the President's Economic Plan.

Because opponents of health reform are likely to attempt to discredit and downsize the plan on the basis of faulty cost estimates, we believe it is critical to establish from the start that the Administration's budgetary assumptions and cost estimates are correct. If the Administration's estimates are generally accepted, it will be possible to focus the debate where we would like for it to take place -- on the important improvements in coverage and portability that form the nucleus of the President's plan. If the estimates are not completely defensible, support for the proposal will be weakened and the Administration's credibility on this and other initiatives will be undermined.

Throughout the development of the health care plan, estimates have been prepared by several agencies, both inside and outside the government. To date, this approach has been useful as it has made it possible for staff to work simultaneously on many different provisions of the draft. However, in keeping with longstanding practice, the official Administration estimates of the proposal should be prepared by the actuaries at the Health Care Financing Administration and the Department of the Treasury. The Congressional Budget Office, the Joint Tax Committee, and economists outside the government will look to the HCFA actuaries and Treasury estimators for guidance in evaluating and re-estimating the proposal. It is therefore critical that these agencies be responsible for the estimates provided by the Administration when the plan is released.

III. While each of us is hopeful that the success of managed competition, as envisioned in the draft proposal, will make it unnecessary to invoke the global budget, estimates of the costs of health care under this plan rely heavily on the effectiveness of the global budget provisions. Therefore, we recommend that special attention be given to the development of the description and legislative language relating to the global budget. Since the Internal Revenue Service is critical to the successful enforcement of the global budget, it is important that the Treasury Department participate in the development and legislative drafting of this portion of the plan.

IV. As we have indicated on several occasions, the Treasury Department is concerned about the ability of the regional alliances to manage successfully the wide array of responsibilities which they have been assigned under the proposal. We are especially concerned that these newly created organizations may not have the expertise to handle the volume of contributions they are expected to receive from individuals and employers pursuant to the new Federal requirement. If the alliances are charged with responsibility for determining eligibility of individuals and employers for subsidies under the plan, the problem is further compounded. In designing the premium collection and subsidy provisions, we recommend strongly

that great weight be given to determining whether the alliances have the capacity to administer these features of the proposal.

We are also troubled by the ambiguity of the language in the proposal which describes the relationship between the regional alliances and the State and Federal governments, including the National Board. Resolution of this issue is important because of the need for clear lines of authority and responsibility to make it possible to take corrective action should an alliance be negligent in handling funds.

We believe that the Treasury Department's expertise in monitoring flow of funds and safeguarding the solvency of Federally established programs is unparalleled. We therefore recommend that the Department be assigned responsibility for developing the provisions of the plan that define the fiscal responsibilities of the alliances, including those features of the plan that establish the authority of the State and Federal governments to protect premium contributions.

V. As you know, we continue to be concerned that the scope of benefits included in the standard benefit package is very wide. While we understand and sympathize with the rationale for beginning the debate with a broadly drawn benefits package, and recognize that subsidies will help, we are troubled that small firms and individuals who do not now have coverage will face an immediate and substantial cost increase. In addition, with enactment of this plan, a large number of employers and individuals who are insured will experience an increase in the size and cost of the benefit package which they will be required to purchase.

Although we are firm believers in universal coverage and in requiring employers to contribute toward the cost of insuring their employees, it is difficult to explain a mandate where the scope of benefits is considerably more generous than the Blue Cross/Blue Shield policy currently selected by most Federal workers. Moreover, we are concerned at the inequity of mandating broad coverage for the population under the age of 65 while maintaining a Medicare program for the elderly and severely disabled that is less comprehensive.

In my experience, when health care legislation is considered in the House and Senate, expensive new benefits are added. With this in mind, we recommend strongly that the President's plan include a less expansive standard benefit package.

In the alternative, we would recommend a slower phase-in schedule. If the managed competition or global budget savings to the private and public sectors materialize, then additions to the benefit package could easily be made. If however, the projected

savings do not materialize, a slower phase-in would enable us to protect individuals, employers and the Federal taxpayer from unanticipated costs.

ECONOMIC IMPACT OF HEALTH CARE REFORM

Long-Term Cost Growth Trends:

Cost projections contained in the health care reform package are that American spending on health care will, after reform, grow as or more slowly than total national product--any growth rate of "consumer price index plus population plus one percent" or lower sees health care spending shrink as a share of national product. But as time passes and America becomes a richer country, Americans are almost sure to want more health care services, not fewer.

Rates of increase in health care costs differ widely across countries. But no matter what institutions are adopted, health care spending tends to grow as a share of economic activity. In all industrial economies except four--Germany, Denmark, Sweden, and Ireland--health care spending was a larger share of national product in 1990 than in 1980. Throughout the OECD countries health care spending was a larger share of GDP in 1980 than in 1970.

Note that the upward trend in health care spending as a share of GDP takes place whether the health system is market-oriented or single-payer, whether costs as a share of national product start from a low or from a high base, or whether doctors have relatively high or moderate salaries.

Many economists believe that health spending will inevitably grow faster than other spending. Over time, as average productivity in the economy increases, Americans become richer and seek more health care. But it is difficult to achieve rapid productivity growth in much of health care: the industry is labor intensive--it takes as much time to examine a well baby now as in 1950, and a skilled nurse can monitor and assist only a few more people now than in 1950. Over time wages will rise as the industry must keep its wages in line with the broader economy in order to attract workers. And the difficulty of achieving substantial productivity growth coupled with rising demand will lead health-care costs to rise relatively rapidly, and health care spending to grow as a share of national product.

Given these strong economic forces making for a rising health care share of GDP, it is very optimistic to suppose that the U.S. share will shrink. And it is very optimistic to project that the U.S. can quickly go from being one of the worst in the OECD in terms of containing health care costs to one of the best.

Many who have these trends in the back of their minds will not credit global budget savings. Some who do credit savings will attribute them to the effects of rationing, HMOs that refuse to authorize services that consumers believe they need, or excessive waiting periods. Savings produced not by increased efficiencies but because consumers "pay" for them through diminished service access would not be attractive to the American public.

Treasury believes that a more prudent cost-containment strategy would have the rate of growth of private and public spending decline gradually, over the next five years, to a long-run target. The long-run target should be chosen by a procedure that recognizes the strength of the forces making health care a larger share of GDP -- and the probable desirability of accomodating such an increase given productivity and demographic trends, especially the aging of the population.

BUDGET ISSUES

General Comments:

In the draft that was distributed, an "account" for the Inter-alliance Trust Fund is to be set up at Treasury. From a financial systems perspective, it is important to determine whether the Inter-Alliance Health Security Fund (HSF) is a Federal or non-Federal entity. If it is a Federal entity, it probably should be referred to as a U.S. Government Corporation rather than a "public corporation." If is a U.S. Government Corporation, collections and disbursements would normally be scored in the President's budget as receipts and outlays affecting the deficit and cash transactions would flow through the Treasury's general cash account. If budget scoring is not intended, it would require some special off-budget treatment. (Conversely, if the HSF was established as a non-Federal entity, transactions would be excluded from the Federal budget and cash would normally be held outside Treasury.) In short, the nature of the entity, the budget treatment and the use of Treasury collection, disbursement and investment mechanisms are interdependent to avoid vastly increasing the size of on-budget Federal spending, it would be best if the funds intended to be in the Interalliance Trust Fund were off-budget.

From an operational perspective, an electronic funds transfer and reporting system is feasible -- especially if efficient use can be made of existing Federal systems. However, if new systems were contemplated to reflect unique health care requirements, systems development will necessitate considerable time and expense and the proposed time frames for described for implementation are probably optimistic.

The Vice-President has just issued his report on reinventing Government. In this report, he recommends far-reaching procedures for increasing efficiency, and eliminating red-tape and duplication. The health-care reform proposals call for the creation of new bureaucratic operations for various applications, enforcement and regulations related to the plan. Many of these are clearly necessary, if not vital. However, great care must be taken to ensure that these new procedures are streamlined, efficient, and avoid as much red tape and duplication as possible. In the area of enforcement, particular care should be taken to avoid giving duplicate enforcement responsibilities to two or more agencies.

Of special note is the designation of Treasury to operate a new loan program to assist the development of community-based health plans. While the Federal Financing Bank at Treasury might actually issue the loans, the administration of the loan program more properly should be done by the Department of Health and Human Services which has the necessary programmatic expertise. This will avoid duplication with other HHS programs for community-based health plans.

According to the draft plan, the employer's share of health premiums for the short-term unemployed are to be paid out of the unemployment insurance trust funds. Has any provision been made to move new revenues into these trust funds to prevent the funds from becoming depleted? If general revenues are to be transferred into the trust funds, this could be viewed as undermining the self-financing nature of the Unemployment Insurance program. Consideration should be given to using general revenues to pay for those costs without transforming those general revenues into the Unemployment Trust Funds.

Impact on Federal Budget Deficit

One of the very important and attractive features of the plan is the fact that it is designed to be largely self-financing. The plan contains a large new entitlement program which would provide subsidies to individuals and firms. Yet, no new taxes are required to finance this expansion. This feature will be a critical selling point. But if the final cost estimates for the entire package cause the deficit projections to increase or if CBO and JCT estimate either the costs of the program as much higher than our estimates or the revenue impacts as much different, the Administration will surely lose its credibility.

Mr. Magaziner deserves much credit for coordinating the difficult job of estimating the effects of this comprehensive package on the Federal budget. Tracking the budgetary impact of the health reform package has been an arduous task. As with any major initiative, a number of agencies share the responsibility

of preparing the outlay and revenue estimates associated with the proposals. But among the Administration's domestic initiatives, health reform is unique in requiring significant levels of coordination and cooperation among the responsible agencies. Output from one agency often serves as input to another agency's estimates. For example, the Health Care Financing Administration produces the estimates of the premiums which others (Urban Institute, Treasury) use to produce the estimates of the costs of new Federal subsidy programs and the revenue impact of the mandate.

At this "just before launch" point in the process, we are concerned that the estimates of the budgetary impact of the proposal are highly sensitive to many of the underlying assumptions, and that the final estimates could deviate substantially from those currently used. Because of the interaction among the provisions, a change in one or two of the basic underlying assumptions could trigger significant increases in the deficit projections. For example, if the costs of the basic benefit package were estimated to be higher than the current projections, the Urban Institute's estimates of the costs of the individual and employer subsidies would be understated. In addition, Treasury's estimates of the revenue gains from the mandate would be reduced and possibly converted to revenue losses. We must make sure that all affected agencies are "on board" with respect to these assumptions, prior to the release of the plan on September 22.

We are also concerned because the Federal budget tables do not yet include the impact of all provisions described in the document, nor does the table fully account for the interactions between the proposals. Moreover, new proposals, which were not even mentioned in the document, are still being designed. There is a sizable risk in making important decisions before the costs of the new proposals have been estimated and the final cost estimates have been prepared for the entire package. Finally, the credibility of the proposal to be announced in late September could be jeopardized if final estimates are not available by that date. Release of the final report should be deferred until final estimates are done.

Cost Containment Assumptions:

The costs of the basic benefit plan, and thus both the outlay and revenue estimates for the program itself, may be artificially constrained by unrealistic cost containment assumptions. Based on the evidence presented in the document, it is far from certain that the cost containment proposals can bring health care costs down to the levels contemplated in recent

discussions. Even as currently estimated, the package does not provide for significant deficit reduction until the out years. This means that the package contains no "cushion" if the cost containment efforts fail.

The plan contains at least three distinct types of cost containment efforts:

-- Voluntary cost controls will be effective immediately following the announcement of the plan and will continue through implementation. The purpose of the cost controls will be to prevent firms and providers from raising health care expenditures in anticipation of the passage and implementation of the plan.

-- Insurance companies within a health alliance could be subject to 100 percent excise taxes on the amount by which their bids on the basic health insurance package exceed a pre-determined target. Health care providers could also be subject to a comparable excise tax on payments received from plans with excessive bids. (In subsequent years, both insurance companies and providers would continue to be subject to such taxes if the rate of growth in their premium bids come in too high.)

-- States and corporate alliances could be subject to penalties if the costs of the basic benefit plan grow faster than the statutory rates (currently assumed to be CPI plus population plus one or two percentage points). A state which fails to comply with the rules will be required to pay for a portion of health insurance subsidies received by its residents. A non-complying corporate alliance may be required to purchase health insurance through a regional alliance.

In combination, these cost containment efforts are assumed to reduce the annual growth rate of private sector health expenditures from 6.4 percent to 3.5 percent by 2000. But these growth rates will be difficult to achieve, particularly since many of the enforcement mechanisms are untested and still unspecified. The history of both mandatory and voluntary cost control efforts in this country are instructive. Indeed, precedent suggests that providers will increase costs immediately before the implementation of restrictive global budgets (despite voluntary short-term cost controls) and that they may increase prices in other sectors (such as supplementary health coverage) in order to compensate for constraints in the pricing of basic coverage.

At various times, we have been assured that the cost containment assumptions have been approved by the estimating agencies -- for example, the HCFA actuaries or the Congressional Budget Office scorekeeper. But, while the actuaries and CBO may have approved estimates of discrete provisions, we are advised that neither the actuaries nor the CBO has estimated the total package of cost containment assumptions, and other agencies have not been asked for input on their ability to enforce these efforts.

For example, while they may agree that some savings can be achieved under the plan, we do not know if CBO will score the budget enforcement mechanisms described in the current document as producing the same level of Federal budget savings shown in the Administration's tables. The absence of an enforcement mechanism for non-compliant corporate alliances makes the plan especially vulnerable.

The plan also includes provider and premium assessments (pg. 100) to gain certain assurances from the HCFA actuaries. In the absence of these assessments, the estimates of the costs of the basic benefit package would have been about 13 percent higher. But the document does not provide a clear explanation of how these assessments would be determined and administered, nor are the policy implications of the proposal clear. As a consequence, CBO may reach significantly different conclusions regarding the impact of this provision on the costs of the basic benefit package unless the text contains a clear and defensible explanation of the proposal.

In order to prepare complete and accurate estimates of the costs and/or savings of the proposal, it is imperative that HCFA and Treasury estimators be provided detailed information about the specific assumptions associated with the policy choices which the President wishes to include in his plan.

Other Assumptions Affecting Cost Estimates:

The document contains other proposals which can affect the estimates of the costs of the basic benefit plan and the proposal. However, we have reason to believe that these interactions have not been fully taken into account in estimating the premium costs.

For example, the plan contains a number of new surcharges and assessments on health insurance premiums (pages 57, 108, 131, and 138). These premium taxes are not yet reflected in the costs of the basic health insurance package. However, these premium surcharges will have offsetting effects on the Federal deficit. Presumably, the Federal government will also cover the costs of these surcharges when providing subsidies to employers and individuals, as well as paying its share of the costs of coverage

for government employees.

In other ways, the costs of the subsidy program may be understated. The subsidy estimates also do not now take into account behavioral changes, as firms reorganize in order to qualify for more generous subsidies based on the size of their workforce or "outsourcing" of workers (see discussion below). In addition, we are concerned that the estimates of the subsidies for the unemployed population may not coincide with the description of the policy. Under the description, health coverage would be available to unemployed workers without regard to the reason for their termination. It is our understanding that current estimates assume that subsidies are available only to persons now qualifying for unemployment insurance cash benefits.

Incomplete Estimates:

We are concerned that important decisions about provisions of the plan are being made without complete cost estimates. With respect to tax provisions, certain provisions have not been estimated at all because Treasury only became aware of their existence when we received the policy document. Unfortunately, the document does not contain sufficient information to estimate their impact on revenues (e.g., tax cap; the tax incentives for rural doctors practicing in areas of health provider shortages).

Nor do the Federal budget estimates contain the full administrative costs of the new system. As outlined in another section, the IRS appears to be given new responsibilities, including the enforcement of the requirement that individuals receive basic health insurance coverage. If the IRS is not provided new funding sufficient to undertake these new responsibilities, it will be forced to reallocate resources dedicated to its current enforcement responsibilities -- resulting in a loss of revenue. Moreover, the costs of the premium (and hence the estimates of the subsidy and revenue impacts) may not fully reflect noncompliance with the mandate that will actually occur. In addition, budget estimates may also not fully reflect the costs of the new proposal to subsidize health benefits for early retirees discussed below since all estimates prepared to date are a very rough and preliminary.

Finally, it should be noted that the estimates of the plan are based on the current set of economic assumptions, contained in the President's Budget. Under the Budget Enforcement Act of 1990, estimates must be prepared using these economic assumptions. However, given that health reform will affect about one-seventh of the total domestic economy, macroeconomic effects of the plan will be significant and should be taken into account when the next round of economic assumptions are prepared for the Federal budget.

REVENUE ISSUES

Premium and Provider Assessments

A number of new assessments on both insurers and health care providers appear in the document. These include new authority for States to impose taxes:

-- Broad State authority to impose "nondiscrimatory" taxes and assessments on employers and plans in corporate alliances (p. 74).

-- State authority to require payers to reimburse essential community providers (p. 74).

-- State authority to develop all-payer hospital rates or all-payer rate setting (p. 74).

-- State authority to assess plans an amount of up to two percent of premiums in order to generate revenue to cover claims against failed plans within the alliance (p. 57).

In addition, there are new Federal premium surcharges:

-- A per capita levy on premiums, determined by the National Health Board, to fund technical assistance programs established by the States (p. 108).

-- A surcharge on premiums to fund graduate medical education (p. 131).

-- A surcharge on premiums to fund certain research, development of technology, treatment of rate diseases, etc. in academic health centers and affiliated teaching hospitals (p. 138).

Finally, the document also refers to other taxes on providers and insurance plans (e.g., the tax cap; an excise tax on providers and insurers with respect to excess premium increases; a tax on unearned income designed to recapture from employees subsidies received by employers on their behalf). These are discussed separately below.

Although many of these provisions are referred to as surcharges and assessments, we are concerned that opponents of the plan will likely identify them as new taxes. To prevent (or limit) such charges from being made, would it be possible to combine, drop, or redesign some of these assessments.

In addition, we have specific questions regarding some of these provisions:

- Who would be responsible for determining the level of these assessments, as well as for collecting the funds? It is not always clear how these responsibilities are divided among the Federal government, the states, or the National Health Board.

- What are the tax rates for each of these taxes?

- Shouldn't the budget tables show the anticipated revenue gain for the Federal items?

- Are these taxes reflected in the costs of the comprehensive benefit package or the costs to the Federal government when providing subsidies to employers and individuals and when paying its share of the costs of coverage for government employees?

- How would self-insured plans be valuated, for purposes of applying these taxes?

- Would these premium taxes be deductible by employers? (The revenue raised from the premium tax proposals will be affected by this decision.)

On many of these issues, our staff can offer technical guidance.

Tax Cap:

The materials we have been provided describe a very aggressive tax cap proposal -- including a limit in the "tax exemption" to 100% of the weighted average premium in the alliance and repeal of cafeteria plans for health benefits. This is in conflict with the description of a narrower tax cap proposal that has been provided orally at a number of meetings. Our current understanding of the proposal, based on cursory information, is that any employer payments for the basic benefit package will be excludable, but that all other employer payments will be included in the employees' income for tax purposes. Other details are not as clear, however, or require further analysis. A number of questions will have to be answered in analyzing the administrability and revenue consequences of a tax cap proposal.

- What benefits would fall outside of the cap?

  -- How will benefits outside the basic package be defined? Who will make this determination -- the National Health Board? How, for example, will National Health Board determinations regarding experimental benefits or benefits deemed not to be cost-effective by the National Health Board be applied to corporate alliances providing those benefits?

  - -- Can the employer pay the employee share of premiums on a tax-favored basis?

  - -- Could the employer pay for (or buy an insurance policy) providing for the payment of employee deductibles on a tax-favored basis?

  - -- Could the employer pay for (or buy an insurance policy) providing for the payment of employee copays on a tax-favored basis?

  - -- How and when will the tax cap apply to benefits that are not part of the basic benefit package at the start, but that will be phased-in later, e.g., adult dental and or improved mental health benefits?

  - -- If applied to the individual, will the exclusion be applied for purposes of the income tax, the payroll tax, and calculation of health insurance subsidies?

- How will the tax cap apply to self-employed individuals?

- How will the proposal be applied to Medicare supplemental benefits provided by employers to post-65 retirees?

- What will be the effective date of the cap proposal and what transition relief, if any, will be provided?

  - -- The description of the transition relief for collective bargaining agreements is not consistent with historic practice in this area. Generally, transition relief is provided through the end of agreements in effect on the date of enactment, with a sunset date three years after enactment.

- What will be the impact on cafeteria plans?

- Will flexible spending accounts be restricted?

- Will the medical expense deduction be provided for services outside the basic plan? What will be the deduction treatment for insurance premiums paid on policies purchased to cover expenses not covered by the basic benefit plan?

In particular, we would like to emphasize our very serious concern over one issue that has arisen in the oral description of the tax cap that we have received. A preference has been expressed for a lengthy grandfather (8-10 years) for insurance arrangements in effect on January 1, 1993. We believe that there are significant (and perhaps insurmountable) administrative, policy and political problems with this proposal. We would strongly recommend that, if a decision is made to delay the

impact of the tax cap proposal, it be done on a uniform basis with a delayed effective date, rather than with a grandfather provision that is based on the specifics of existing arrangements that vary across industries, employees and employers. The issues with respect to the tax cap will be central to the public's reaction to the President's plan and we would like to assist you in any way possible in finalizing the details.

Assessment on Providers and Insurers

According to the document, insurance companies within a health alliance could be subject to a 100 percent excise tax on the amount by which their bids on the basic health insurance package exceed a pre-determined target. Payments to health care providers from insurers could be reduced by the percentage amount that the plan's bid exceeded the pre-determined target. In subsequent years, both insurance companies and providers would continue to be subject to such taxes if the rate of growth in their premium bids is too high.

We understand that these taxes were included in the plan in order to lower the estimates of the basic benefit plan. But the document does not provide a clear explanation of how these assessments would be determined and administered, nor are the policy implications of the proposal clear.

We recommend that the discussion of this provision be clarified. For example, the document implies that providers and insurers would each be subject to 100 percent excise taxes on the amounts exceeding the target (either the premium in the base year, or the inflation factor in the subsequent years). In other words, the insurers would be taxed 100 percent on payments to providers, and the health care providers would subsequently be taxed 100 percent on the same income when received. We believe that such excessive penalties are not appropriate and would recommend that the document be redrafted to indicate that the excise tax applies to either the provider or the insurer -- but not to both.

The document is also not clear as to the timing of these excise taxes. In the case of providers, would the taxes be applied to income received in the prior year or the current year? It will be very difficult (if not impossible) to track income received by providers from insurers during the previous year.

As described, this provision could also have distortionary effects on the insurance market. For example, an efficient low cost plan that increases its premium by more than the targeted rate of growth may be subject to the 100 percent excise tax even though after the increase, its premiums are still less than the

costs of the average weighted premium in the alliance. We question whether efficient plans should be penalized in this fashion.

Denial of Employer Deductibility:

Under the draft proposal, the Treasury Department would share responsibilities with HHS for enforcing the requirement that states establish regional health alliances in compliance with Federal law. The Secretary of the Treasury is given the responsibility to decide whether to deny all employers the deduction for health insurance expenditures covering workers within a state that did not meet this requirement. We have also been informed that this could be replaced with a payroll tax. Either provision will strike many firms and workers as unfair, because they could be punished for the failure of a state or local government. Moreover, the Secretary is given broad discretion to determine the amount by which the deduction should be limited. If this enforcement mechanism is included in the final proposal, the mechanics for determining the limitations on the deduction should be specified in the legislation.

We believe that this enforcement provision is redundant and unnecessary. On page 262, the draft states that "Once alliances are established, contributions continue to be tax-preferred only if made through an alliance." If (1) states are required to establish an alliance by a certain date and (2) alliances are defined to include only those in compliance with Federal law, then this provision would ensure that health insurance contributions be made in an appropriate manner. Moreover, this provision would punish only those employers who made contributions to delinquent alliances. It would not affect employers who purchase health insurance coverage through a qualifying alliance within a state.

Employer Subsidy "Recapture" Tax:

It is our understanding that the draft plan has been modified to delete this provision. Such a tax could not be administered fairly if employer subsidies were based on the firm's average payroll.

For other reasons, we believe that this proposal should not be included in the package. Employees will likely perceive a "recapture" tax as unfair, if either their employer does not pass back the subsidy in the form of higher compensation or they are unaware that their wages have in fact decreased less as a consequence of the subsidy. This tax would also have imposed a significant burden on many recipients, who may not have the cash available to repay the subsidy received by their employer.

The provision would also be difficult to administer. To be enforceable, employers must report the amount of the subsidy received on behalf of each individual employee to both the IRS and the employee. In other words, all low-wage workers, whose employers received subsidies, would be notified on their Form W-2 of the subsidy amount. However, only a small number would actually have been required to repay this amount.

We believe that this tax would be difficult to collect and impossible to explain.

Long Term Care Insurance:

The tax provisions governing long term care insurance described in the materials appear to track legislation I introduced last year along with Senators Pryor, Dole and Packwood. I believe that the changes proposed are good ones and support them. Unless specifically indicated, I assume that the proposal will follow that legislation. In particular, I would like to emphasize that tax-favored long term care insurance should not be provided through a cafeteria plan since this would extend what might be perceived as excessive tax benefits. I would also recommend strongly that provisions dealing with the tax treatment of accelerated death benefits be included in the reform proposal. Those provisions insure that terminally ill individuals receiving payments under life insurance contracts will receive fair tax treatment.

Retiree Health Issues:

The document which was provided to us does not contain a description of the early retiree changes that are currently under discussion. We have been told orally that a proposal providing for government payment of 80% of the costs of insurance for retired employees between the ages of 55 and 64 is under serious consideration. Until more details are provided, it is difficult to analyze the proposal, but on its face the government-sponsored early retirement plan being contemplated raises a number of serious policy concerns. The availability of inexpensive, guaranteed health insurance could have a profound impact on the decision of whether and when to retire. It might also encourage more employers to induce early retirement. This, in turn, could have substantial Federal budgetary effects and could adversely affect other Federal policies.

An increase in the number of early retirements could increase Federal budget expenditures for Social Security benefits, decrease Social Security and Medicare payroll tax receipts (if retired workers are replaced with less senior, lower-wage workers), and increase substantially the cost of the subsidy features of the plan. To our knowledge, these effects

have not been thoroughly explored or estimated. Proceeding further without hard estimates of the costs could prove dangerous.

In addition, the proposal would create an inexplicable distinction between those aged 55 to 64 and those 65 and over. The early retirees would receive a very generous government-paid benefit package. Those age 65 and older would receive a more spartan Medicare package. The irony would be that those over age 65 actually "paid" for their benefits in the form of payroll taxes during their working years, whereas those between 55 and 64 would benefit from a clearly labeled government subsidy.

Substantial changes in early retirement could also have a significant effect on retirement security for those affected. The years prior to retirement tend to be the main savings years for many senior citizens. If the proposal reduces the number of those "high savings years" more Americans will retire early and then find that they regret the decision at age 70, when the purchasing power of their pension has been reduced by inflation and their savings have been depleted. Some increase in early retirement is an anticipated outgrowth of universal coverage and the move to pure community rating. However, to increase that impact, even marginally, through an additional subsidy for these early retirees may be difficult to justify and have profound consequences for the elderly population.

It appears that the government-paid early retirement benefit was designed in part to provide a boost to the balance sheets of a manufacturing sector burdened with large retiree health liabilities. The proposal would, however, benefit far more companies than those in the manufacturing sector. The vast majority of retirees do not have employer-provided health coverage. All of these employees would receive the benefit of the government-paid early retirement subsidy. Moreover, the mature manufacturing sector is already receiving a large financial benefit under this proposal. Under the general health care reform proposal, all pre-65 retirees receiving health benefits could now be covered by the regional alliances rather than through the employers' plans. The financial savings to the employers from shifting these retirees into a community-rated system under which many retirees will receive subsidies could be very substantial, even without the government-paid 80% of premiums proposal. Moreover, large employers are given the option of joining the regional alliances. Since many of the older "rust belt" industries have older than average workforces, the cost savings from shifting into the community-rated regional alliances could be significant after the initial phase-in period.

For the reasons outlined above, we <u>strongly recommend</u> that the proposal to provide government-paid health benefits for all retirees aged 55-64 should be deleted from the plan.

Finally, regardless of whether the government-paid early retirement option is elected, the statement that "retirees who receive health coverage through their former employers...continue to receive those benefits" raises a variety of questions and needs to be clarified. Does this mean all employers that provide retiree health coverage as of a particular date are required to continue that coverage or only employers that provide such coverage pursuant to a binding contract? Would the coverage be provided by the regional alliance or corporate alliance, and paid for by the employer, or provided by the employer pursuant to its existing arrangements? If the latter, what if those arrangements are no longer viable after health care reform has been phased in? What happens where the employer-provided coverage is less, greater, or different than the comprehensive nationally guaranteed benefit package: would wraparound coverage be required through the regional alliance or corporate alliance? Would different retiree health coverage rules apply to an employer that forms a corporate alliance? Suppose the employer and the retirees were able to negotiate a settlement of the employer's liability with a view to having the retirees obtain coverage from the regional alliance?

Subsidies:

In view of the decisions made last week by the President, we realize that the document's description of the subsidy scheme is no longer current. Our comments on the subsidy proposal will by necessity be general at this time. Because many issues remain unresolved with respect to the design of the subsidy proposal, we would appreciate the opportunity to comment as the plan is further developed.

To a significant extent, however, the success of the Administration's health reform proposal rests on whether it contains a subsidy proposal which is workable. Consequently, we recommend that the final subsidy proposal be subject to review by all relevant members of the NEC. The detailed design of the subsidy plan will have important economic, administrative, and political ramifications. It is crucial that we understand the implications and have an opportunity to correct potential problems before the publication of the plan.

For example, workers would implicitly subsidize non-workers under the most recent estimating specifications of the subsidy plan. This subsidy arises because non-workers would pay less in total health insurance premiums than would workers and their employers, in combination. We do not understand the rationale for this distinction. More importantly, we are concerned that the final plan could easily contain other cross-subsidies which would be difficult to justify. It is therefore important that we be provided information about the final rules for premium payments to be made by two-earner families, dual job-holders, and

part-time workers.

We are also concerned that the current oral description we have received of the special small employer subsidies will create severe economic distortions. As explained to us, employers with under 50 employees could not be required to pay more than between 3.5% and 7.9% of compensation, depending on average payroll of the firm. However, the proposal seems to include a number of cliffs that will be heavily criticized. For example, we understand that employers with average wages of between $15,000 and $18,000 would pay a maximum employer share of premiums of 4.4% of payroll. For employers with average wage of between $18,000 and $21,000, the maximum contribution would be 5.5% of payroll. An employer with 50 employees and a payroll of $900,000 (average payroll of $18,000) would pay premiums of $39,600. If, however, the employer gave a $1 raise to even one worker (or paid about 15 minutes of overtime), average wage would increase above $18,000 and the employer's health care premiums would increase by $9,900. Similarly, if the employer hired one more worker earning $12,000 per year, premiums would increase from 4.4% of payroll to 7.9% of payroll -- an increase of about $32,500. We strongly recommend that these cliffs be smoothed out to a much greater extent than the proposal currently being contemplated. Similar cliffs seem to exist with respect to the requirement that corporate alliances charge lower premiums with respect to employees earning under $15,000. These types of issues arise frequently in the tax area and we would be glad to work with you in formulating proposals to obtain a result that achieves the policy objectives while removing the potential for economic distortions.

ISSUES RELATING TO THE INTERNAL REVENUE SERVICE

Based on the experience of the Internal Revenue Service as the Federal tax administrator, we have identified several significant administrative issues and concerns that are raised by the plan. The most significant operational concerns relate to systems needs, compliance and enforcement, and the design and implementation of the plan in a way that is not inconsistent with the goals of the National Performance Review effort. Among the most significant issues that need to be addressed are those concerning the privacy and security of information and the determination as to whether an individual is properly enrolled in the health care program.

Systems needs:

To administer the health care program most effectively, it would be necessary to create a single centralized data base comprised of more than 200 million accounts. Such a data base would be significantly larger than the data bases (master files)

currently maintained by the IRS and the Social Security Administration, the largest such data bases in existence. Ultimately, the health care data base would have to contain information not currently available on either of those agencies' master files, interact with existing data bases, and be accessible by regional alliances and other authorized users.

A single centralized data base would be needed because the plan contemplates employer premium withholding and payments to a centralized Inter-Alliance Health Security Fund that would in turn remit the payments to regional alliances. Proper allocation of premium payments among the regional alliances would require detailed individual premium account data. A single centralized data base with individual account data would also be necessary to ensure health system coverage, participation, and portability for all U.S. residents, to facilitate appropriate refunds of excess premiums to employers and employees, to administer subsidies, and to ensure compliance with the premium and coverage mandates.

The IRS is the only Federal (and probably civilian) agency that has had experience in designing and implementing plans for an automated system of the magnitude required. Based on this experience, creating and maintaining a data base of such magnitude in a brief period of time would be a costly and significant undertaking. It would require a substantial investment in technology, systems design, and human capital, an investment far greater than any other ever made to create a data base. Moreover, if any Federal government agency were to be given the task of implementing the comprehensive system contemplated by the plan, relief from current Federal procurement and personnel regulations, as well as a lifting of current budgetary constraints, would be necessary to create the required data base within the time frames identified in the plan. Such relief also would be consistent with the National Performance Review effort.

The plan would also require the creation of other appropriate systems for reporting, paying, accounting for, and collecting mandatory premiums. Many of these systems would be similar to those IRS uses to collect employment taxes, but there would be significant differences as well. For example, until IRS completes its systems modernization effort that is currently underway, it cannot receive individual account information on employment taxes until sometimes as long as a year after those taxes are paid by the employer. The plan probably should require employers to provide individual account data <u>contemporaneously</u> with the payment of premiums in order to track available benefits accurately.

<u>Compliance issues:</u>

The plan envisions a significant role for the Treasury

Department and perhaps, by inference, the IRS, in enforcing compliance with various plan provisions. IRS experience has proven that promoting voluntary compliance is much less costly and much more effective than enforcing laws and regulations after they have been violated. An effective system must build in incentives for complying and, perhaps most importantly, must provide for high-quality information reporting and information matching. Not only do information reporting and matching promote up-front compliance, but they also allow the most effective and least intrusive audit and enforcement activities. IRS experience shows a direct correlation between burden and compliance. Thus, central to promoting compliance is making the health care system (including reporting and payment of premiums) as unburdensome and "user-friendly" as possible and providing education and assistance to everyone involved. This too would be consistent with the National Performance Review effort.

Based upon IRS experience and research, six key compliance concerns for the plan have been identified. These require the development of compliance programs to ensure that: (1) the mandatory participation requirement is satisfied for all employers, employees, self-employed, and other individuals; (2) providers properly serve all covered individuals; (3) all premium amounts are timely and accurately remitted to the Inter-Alliance Health Security Fund; (4) subsidies are made available only to qualified employers and individuals; (5) employers paying premiums in excess of the 80% mandate do not discriminate in favor of highly compensated employees; and (6) global budget caps are not exceeded.

With respect to mandatory participation, the principal issue is how the system will know whether or not an individual is enrolled. Currently, no one source or data base exists that could identify all potential enrollees. Probably the only practical way to develop such a data base would be to begin with the Social Security Administration master file, because it is more comprehensive than the IRS master file. However, the Social Security master file does not include every potential enrollee for the health care system; thus, the principal source for identification of non-enrollees would probably be the providers. To maximize the capacity to keep the enrollee data base current and to handle the input from providers identifying non-enrollees, on-line information reporting systems would have to be developed. Other systems should also be designed to cross-check other data bases (e.g., those of the IRS) to identify non-enrollees.

To ensure that employers and individuals are properly making premium payments, IRS experience in collecting employment taxes is instructive. Outreach and education, effective monitoring, early identification of potential delinquent employers, and intervention before an employer's liabilities exceed its ability to pay should be considered in promoting compliance with the

health care plan. If, however, enforcement becomes necessary, the failure to pay mandatory health premiums should be treated as severely as the failure to pay employment taxes under current law (i.e., penalties and interest against the employer and personal liability for corporate officers for unpaid amounts).

Additionally, a system must be developed under which the Inter-Alliance Health Security Fund or the regional alliances can collect mandatory premium payments from self-employed and unemployed individuals. Self-employed taxpayers have the lowest compliance rate under our federal tax system, and enforcing compliance among this group is extremely difficult. Thus, appropriate sanctions for premium non-payment must be developed to encourage timely compliance. A collection and enforcement function will also be necessary for those individuals not meeting their payment obligations.

Ensuring that employers and individuals do not claim improper subsidies should be a principal focus. To the extent that subsidies are provided based on income information that can only be verified against IRS data files (e.g., earned versus unearned income), it should be noted that until its Tax Systems Modernization program is a reality, IRS would not be able to provide instantaneous verification of income data. Under the current system, such income data would not be available until as long as two years after a subsidy was claimed. Because of this delay and because the population on whose behalf subsidies are claimed will consist of low-income individuals, recapture of improperly claimed subsidies might be almost impossible.

Finally, we note that the draft appears to assign compliance and enforcement responsibilities to a number of agencies. Although it may not be essential to make a single agency responsible for all enforcement, IRS experience suggests that unless responsibility for various compliance issues is clarified at an early date, some issues will "fall through the cracks."

Employee/independent contractor issues:

The proper classification of workers as employees versus independent contractors is one of the thorniest compliance problems faced by the IRS today. The common law factors applicable under current law to distinguish between employees and independent contractors are difficult to administer, and there are inappropriate incentives under current law to misclassify workers as independent contractors. For example, employers currently have an incentive to misclassify workers as independent contractors to avoid employment tax liabilities, unemployment insurance, workers compensation, wage and hour requirements, and other costs associated with employees. Misclassification enables employers to avoid these costs to the extent that the misclassified workers do not obtain a commensurate increase in

their overall compensation package that reflects the costs shifted to them and the benefits denied them. Workers may also have an incentive to be classified as independent contractors because they are no longer subject to withholding on their wages.

Under health care reform, employers will likewise have an incentive to misclassify workers as independent contractors to avoid the mandatory premium requirement, although workers may not have the same incentives for misclassification that they have under current law. In addition, since the proposal would not provide premium subsidies to many employers (including firms in corporate alliances), those employers would have strong incentives to "outsource" certain services they currently obtain from employees (as an alternative to misclassifying the employees as independent contractors). Janitorial, duplicating, data processing, security, cafeteria, and other lower-wage workers could be spun off to smaller independent companies that qualify for subsidies in respect of these employees. This problem could be exacerbated by the requirement that corporate alliances provide direct subsidies to employees earning under $15,000 per year.

The plan proposes a standard under which an individual would be classified as an employee if that individual receives more than 80% of his or her earned income from one source. While this appears simple and objective on its surface, a number of very serious administrative problems associated with this standard can be foreseen.

First, an employer cannot verify whether an individual will be receiving more than 80% of his or her earned income from that employer. The employer would have to rely on worker representations, and the worker might not know his or her proper status until after the end of the measuring period. Moreover, if the 80% test were applied, for example, on an annual basis, based on the preceding year's income or services performed, a worker who satisfied the test with respect to an employer in the preceding year could be classified as an employee of that employer in the current year even if the worker were no longer working for the employer at all. These problems could seriously undermine efforts to collect premiums from the proper party in a timely fashion.

Second, because the 80% standard differs from all others in common use for worker classification purposes, there is no easy way to enforce this standard by cross-checking with IRS, Social Security, or state employment records. Rather than interjecting another layer of complexity that could undermine health care compliance, efforts should be directed toward developing a consistent approach to resolving worker classification issues for both health care and Federal tax administration purposes. Accordingly, we recommend that the health care proposal define

employee in the same way as employee is defined for Federal tax purposes. If the definition is revised, the revision will then apply across the board.

Even with a consistent basis for worker classification, however, because the self-employed ("independent contractors") currently represent the largest group that does not comply with the tax laws, that group will most likely pose a similar compliance challenge for the new health care system. The tax noncompliance of independent contractors is facilitated by the lack of effective information reporting and withholding on payments -- two components that contribute most directly to high compliance levels. If not effectively anticipated, the introduction of health care reform could unintentionally exacerbate the current trend toward employers' considering their workers independent contractors, thereby not only minimizing the employers' taxes but also their health care responsibilities for workers. We are also concerned that certain employers (e.g., Subchapter S corporations) may be able to recharacterize income as dividends in order to maximize subsidies. We would like to work with you in drafting a proposal that would close this potential loophole.

Privacy and disclosure considerations:

The importance of addressing privacy and disclosure issues in the design of the health care system cannot be overemphasized. The amount of information that will be collected and stored in the health care information system will require an integrated government focus on the proper balance between privacy and disclosure. Legal constraints and citizen expectations currently require extraordinary protection of some forms of government-collected information, most notably federal tax information. A health care system will be required to collect additional information of varying degrees of sensitivity. It will also require sharing of information to enable enrollment, accounting, and compliance to be accomplished in the least intrusive way possible.

Because of IRS' role as the tax administrator, we are keenly aware of the tension between the legal mandates to protect the privacy of tax information and the many legitimate efforts to decrease the costs and increase the effectiveness of government by making better use of "government information." The importance of a high-quality health care information capability should provide the impetus for the integrated consideration of these important privacy and disclosure issues so that they do not become barriers to comprehensive health care reform.

ERISA ISSUES

One issue that will be particularly controversial with big business and organized labor is the proposal to allow the states to apply taxes to Corporate Alliances. We recommend that it not be included in the plan.

Large employers and unions maintaining so-called Taft-Hartley plans will perceive the authority for states to tax them as threatening to their continued existence as independent entities. Despite the limitation to the contrary, assessments can and will be discriminatory in nature since the proceeds of these taxes can flow through strictly to the benefit of the plans in the regional alliance. If properly structured by the state, the regional alliance plans could effectively be exempted from the tax.

Moreover, even though this provision has been important to governors in the past, that interest was generated in a pre-health care reform setting where governors often had their "hands-tied" by the ERISA preemption of State laws taxing self-insured plans. After health care reform, the options for reform-minded governors will be substantially expanded and the need for the potential revenue generated by the ability to tax corporate alliances and Taft-Hartley plans will not be as important. For these and other reasons, a working group (involving HHS, Labor, Treasury and the House Education and Labor Committee) rejected this proposal earlier this year. Although this provision alone will probably not determine whether large employers or organized labor support the plan, its inclusion could have the effect of tempering support of the business community since this is a long-standing issue for those groups.

INTER-ALLIANCE HEALTH SECURITY FUND

Trusteeship:

Will this Fund be maintained at the Treasury with the Secretary playing the role of "Managing Trustee" as is the case in a number of statutory trust funds currently managed by the Secretary? This question is relevant only in that it determines the extent of administrative support required from the Treasury.

Investment of the Fund:

Traditionally the Treasury has deferred to the controlling agency/board in terms of the investment and management decisions concerning trust funds. in this proposal the Fund would be a non-profit public corporation controlled by a five member board of directors which we assume would be charged with these kind of investment decisions.

The proposal goes on to provide the Secretary with a series

of approvals which could impact on the expected return to those investment decisions including: approval of the fees charged the alliances for administrative costs (such administrative costs would otherwise be paid by the Fund); and approval of the procedures under which the Fund will make bridge loans to alliances which experience short-term shortages including interest rates charged and maximum maturity.

A potential for conflict exists to the extent the procedures approved by the Secretary interfere with the investment decisions and expectations of the Fund.

Disbursement Procedures:

There appears to be an internal inconsistency as to which agency will establish disbursement procedures. "Disbursements From Alliance Accounts" provides that the Fund establish procedures for "proper authorization of disbursement." While "Regulations" directs the Secretary of the Treasury to issues "regulations specifying . . . collection and disbursement of premium contributions." Suggestion: have the Secretary direct the disbursement procedures with applicable statutory authority.

Collateralized Accounts:

It is important that the enabling legislation remove the ability of the FDIC to abrogate any collateralization agreements established at banks through which the employer and employee contributions would be transmitted. A failure to do so could result in a loss to the Fund of the amounts in excess of the deposit insurance limit. Current FDIC authority can be construed to permit the FDIC to ignore the collateral agreements and seize the collateral for general purposes, in the event of a failure of a financial institution to which contributions have been deposited. The result would be that the collateral would no longer be available and the account would be relegated to the level of a depositor as to the first $100,000 deposited and to a general unsecured creditor for all amounts deposited in excess of $100,000.

MISCELLANEOUS ISSUES

Treatment of Medicaid:

While we are cognizant that cost estimates suggest it will be not be possible at this time to eliminate the distinction between Medicaid and non-Medicaid rates of reimbursement, we remain troubled at the potential for discriminatory treatment by health providers of persons identified as Medicaid beneficiaries. We therefore recommend that the Administration continue to

evaluate the necessity of maintaining this differential, perhaps by undertaking demonstration projects in one or more Regional Alliances. If funding constraints prohibit complete elimination of the payment differential, consideration should be given to raising rates of reimbursement under Medicaid to the Medicare level.

Treatment of Fee-for-Service Providers:

The American Health Security Act requires states to set schedules for fee-for-service reimbursement, and prohibits balance billing. The rationale for requiring states to set rates is to prevent fee-for-service doctors from rejecting patients whose insurance does not provide what doctors view as adequate reimbursement. To protect the freedom-of-choice of those who sign up for fee-for-service plans, the argument goes:

-- Any doctor who accepts some fee-for-service patients must accept all fee-for-service patients.

-- All insurance companies must reimburse doctors the same state-set amount for fee-for-service claims.

Treasury does not find this argument convincing. People who sign up for fee-for-service plans today are not guaranteed free choice of doctor: onerous balance billing or other factors can restrict consumers' effective choice. After reform, people who sign up for fee-for-service plans will not, unless rich, have effective access to doctors who take themselves outside the system.

Requiring states to set reimbursement rates imposes a burden that they may lack the administration capacity to bear. Insurance companies are most experienced at setting rates for private plans, and information should be available to consumers on whether doctors are refusing to accept patients with any one particular fee-for-service insurance plan.

In addition, stringent state rate-setting may have the side effect of undermining the fee-for-service sector. A doctor who accepts three insurance companies could drop one if it became too stingy. But a fee-for-service doctor has little bargaining power against a state rate-setting commission.

If is is one of the principal goals of the HCSA to retain a vibrant fee-for-service sector, it would be unfortunate if it were to undermine fee-for-service medicine. Americans value freedom to choose their own doctors very highly.

TREASURY DEPARTMENT AND INTERNAL REVENUE SERVICE
PAGE-BY-PAGE COMMENTS ON DRAFT HEALTH CARE PLAN
September 9, 1993

Page 13 -- Paragraph 3

What types of controls will be in place to ensure against counterfeit "Health Security Cards?" The cards could be like credit cards with which a provider would verify enrollment status prior to treatment through an on-line system. However, fraud similar to that under the credit card system would be a threat that must be dealt with.

The providers must play a principal role in ensuring that patients are properly enrolled in the health care system and have made timely premium payments in accordance with the plan's requirements. On-line interaction between the providers and/or the Inter-alliance Health Security Fund must be part of an effective program to both ensure that patients properly participate in the plan and reduce the instances of Health Security Card fraud.

Additionally, there is a need to focus compliance efforts on ensuring that providers do not treat patients "under-the-table" (i.e., by accepting cash payments from patients who are not enrolled in the national health care plan). The potential "black market" or "underground cash economy" for health care services to non-enrollees by unscrupulous providers should be appropriately addressed as the plan is refined.

Page 14 - Paragraph 5

Is it contemplated that the alliances would provide information reports on subsidies provided to unemployed workers and their families to the agency charged with compliance and enforcement of the participation and premium mandate? This type of information will be necessary to enforce premium requirements.

Page 15 -- Paragraphs 1 and 2

Is it contemplated that the Medicaid and Medicare recipients would be reported to the agency charged with compliance and enforcement of the participation and premium mandate? This type of information will be necessary to enforce premium requirements.

This comment and the comment regarding "page 14 - paragraph 5" go to the issue of whether the agency charged with compliance and enforcement of the participation and premium mandate will have a data base of all individuals eligible to receive health care coverage under the plan. Such a data base of all potential health care recipients seems essential to the effective enforcement of the premium mandate on both employers and individuals. Using such a

data base of all potential health care recipients, the compliance and enforcement-oriented agency could identify non-enrollees by matching (against the data base) information reports of individuals: (1) on whose behalf gross premiums have been paid; (2) on whose behalf premiums net of a subsidy have been paid; and (3) who are entitled to medical care under Medicaid or Medicare.

Page 15 -- Paragraph 4

The statement that "retirees who receive health coverage through their former employers...continue to receive those benefits" raises a variety of questions and needs to be clarified. Does this mean all employers that provide retiree health coverage as of a particular date are required to continue that coverage? Only employers that provide such coverage pursuant to a binding contract? Would the coverage be provided by the regional alliance or corporate alliance, and paid for by the employer, or provided by the employer pursuant to its existing arrangements? If the latter, what if those arrangements are no longer viable after health care reform has been phased in? What happens where the employer-provided coverage is less, greater, or different than the comprehensive nationally guaranteed benefit package: would wraparound coverage be required through the regional alliance or corporate alliance? Would different retiree health coverage rules apply to an employer that forms a corporate alliance? Suppose the employer and the retirees were able to negotiate a settlement of the employer's liability with a view to having the retirees obtain coverage from the regional alliance?

How retiree health coverage is handled will of course be a major issue for many employers, especially larger firms. The cost of relieving employers of any obligation to pay health benefits for retirees needs to be estimated. Moreover, the possible change in these payments from tax-favored format into after tax payments must be considered in light of whatever tax cap option is chosen.

Page 15 -- Paragraph 5

Questions arise under this automatic enrollment discussion about the level of information reporting from the regional alliances to the agency charged with ensuring that all individuals and employers properly enroll in and pay the health care premiums required under the plan. The agency charged with compliance and enforcement of the participation and premium mandate will need information reporting and information matching generated from the providers and/or the regional alliances to carry out its functions in the most efficient and least intrusive way.

Additionally, the compliance and enforcement-oriented agency will need tools similar to those available to the Internal Revenue Service in collecting and enforcing employment tax requirements (for employers) and income tax requirements (for individuals).

Based on information received from providers and regional alliances, for example, the compliance and enforcement-oriented agency should be able to use civil and criminal enforcement efforts to go after employers and individuals that improperly avoided enrollment in the plan in prior years. For example, is it anticipated that the compliance and enforcement-oriented agency will be able to assess past premiums, interest, and penalties on non-enrollees? Will there be a statute of limitations period beyond which the compliance and enforcement-oriented agency will not be able to seek premiums, interest, and penalties?

Page 16 -- Paragraph 1

Several questions need to be addressed relative to the requirement that employers withhold required premium contributions from their employees' wages. Will requirements similar to those for payroll withholding deposits be imposed on employers? What information reports will accompany the remittance of withheld premiums to the Inter-alliance Health Security Fund? It seems that the Fund would need contemporaneous information reports from employers detailing gross premiums, subsidies, and net premiums by regional alliance and employees within the regional alliances to properly account for and allocate premiums to the health care plans within the regional alliances.

Page 16 -- Paragraph 2

We have been informed that the 1%-of-payroll assessment on corporate alliances has been dropped, and we agree with that decision, as discussed in greater detail in our accompanying memorandum. However, if such a payroll assessment proposal were to be revived, how would it be remitted to the Inter-alliance Health Security Fund? Who would ultimately receive the fee? The regional alliances? The states? How would it be allocated to the recipients?

In general, who will make investment decisions with respect to premium funds received from employers and individuals by the Inter-alliance Health Security Fund and the regional alliances? Will there be a long waiting period between the time funds are received by the Inter-alliance Health Security Fund and the time they are ultimately remitted to the individual health plans?

Page 17 -- Paragraph 1

The Secretary of the Treasury (apparently through the Internal Revenue Service) would be responsible for enforcing the requirement that individuals receive basic health insurance coverage. But the IRS cannot easily assume new responsibilities that may undermine its ability to accomplish the primary task of collecting taxes. For example, some individuals are not required to file a tax return because their taxable income is below the filing threshold. Many

non-filers are likely to be non-workers or part-time employees. Because much of this population does not have to file a tax return under current filing requirements, the IRS, using its existing systems, would not be able to enforce the health insurance mandate among this population. Requiring tax returns to be filed by this population is inadvisable, however, because the additional burden of millions of new filers would make it more difficult for the IRS to process tax returns accurately and in a timely fashion.

It is also not clear how the IRS's responsibilities would differ from those of the states. On page 52, the states are required to ensure that all eligible individuals enroll in a regional or corporate alliance and that all alliances offer health plans that provide comprehensive benefit coverage. We believe that the states are probably in a better position than the IRS to monitor and enforce the requirement that individuals purchase health insurance.

The IRS is also given authority to impose penalties on individuals who fail to purchase health insurance by a certain date. Again, the states will be in a better position to determine when penalties are appropriate. Further, the amount of the penalties should be specified.

The discussion suggests that only the individual mandate is enforced. Would the individual be penalized for the failure of the employer to offer a qualified health insurance plan? Is the employer also subject to penalties for failure to offer a qualified health insurance plan?

Page 18 -- Paragraph 4

The proper classification of workers as employees versus independent contractors is one of the thorniest compliance problems faced by the Internal Revenue Service today. The common law factors applicable under current law to make the distinction between employees and independent contractors are difficult to administer, and there are inappropriate incentives under current law to misclassify workers as independent contractors. For example, employers currently have an incentive to misclassify workers as independent contractors to avoid employment tax liabilities, unemployment insurance, workers compensation, wage and hour requirements, and other costs associated with employees as opposed to independent contractors. Misclassification enables employers to avoid these costs to the extent that the misclassified workers do not obtain a commensurate increase in their overall compensation package that reflects the costs shifted to them and the benefits denied them. Workers may also have an incentive to be classified as independent contractors because they are no longer subject to withholding on their wages.

Under health care reform, employers will likewise have an incentive to misclassify workers as independent contractors to avoid the mandatory premium requirement, although workers may not have the same incentives for misclassification that they do under current law. In addition, since the proposal would not provide premium subsidies to many employers (including firms in corporate alliances), those employers would have strong incentives to "outsource" certain services they currently obtain from employees (as an alternative to misclassifying the employees as independent contractors). Janitorial, duplicating, data processing, security, cafeteria, and other lower-wage workers could be spun off to smaller independent companies that qualify for subsidies in respect of these employees.

In an attempt to provide clarity and address at least some of these problems, the plan would adopt a standard under which an individual would be classified as an employee if that individual receives more than 80% of his or her earned income from one source. While this standard appears simple and objective on its surface, a number of very serious administrative problems associated with this standard can be foreseen.

First, an employer cannot verify whether an individual will be receiving more than 80% of his or her earned income from that employer. The employer would have to rely on worker representations, and the worker might not know his or her proper status until after the end of the measuring period. Moreover, if the 80% test were applied, for example, on an annual basis, based on the preceding year's income or services performed, a worker who satisfied the test with respect to an employer in the preceding year could be classified as an employee of that employer in the current year even if the worker were no longer working for the employer at all. These problems could seriously undermine efforts to collect health premiums from the proper party in a timely fashion.

Second, because the 80% standard differs from all others in common use for worker classification purposes, there is no easy way to enforce this standard by cross-checking with Internal Revenue Service, Social Security, or state employment records. Rather than interjecting another layer of complexity that could undermine health care compliance, efforts should be directed toward developing a consistent approach to resolving worker classification issues for both health care and federal tax administration purposes. Accordingly, we recommend that the health care proposal define employee in the same way as employee is defined for Federal employment and income tax purposes. If the definition is revised, the revision will then apply across the board.

Even with a consistent basis for worker classification, however, because the self-employed ("independent contractors") currently represent the largest group that does not comply with the

tax laws, that group will most likely pose a similar compliance challenge for the new health care system. The tax noncompliance of independent contractors is facilitated by the lack of effective information reporting and withholding on payments -- two components that contribute most directly to high compliance levels. If not effectively anticipated, the introduction of health care reform could unintentionally exacerbate the current trend toward employers' considering their workers independent contractors, thereby not only minimizing the employers' taxes but also their health care responsibilities for workers.

More optimistically, the benefits of enrollment in health care may create a systemic way to also ensure that citizens are properly enrolled in the tax system. If compliance with a person's tax responsibilities could become a part of the qualification for health care access, the dual goals of access to good health care and significant deficit reduction could be married. For purposes of this analysis, however, the primary concern is that the significance of the current tax system's difficulty with determining and administering the consequences of the employer-employee relationship must be adequately understood, and its impact on the heavily employer-based health care system must be recognized.

Page 18 -- Last Paragraph

"Part-time employees (as defined for purposes of Social Security withholding) would receive coverage through the regional alliance." What definition in the Social Security Act is being referenced?

Page 44

As described, the National Health Board appears to be a Federal entity in the Executive Branch with certain unique authorities. Its responsibilities and authority should be clearly defined.

Page 48 -- Paragraph 1

There is no discussion of how the budget for the Board fits into the Federal budget. By default, this budget would be a discretionary account subject to appropriation each year. This gives Congress a great deal of leverage over the Board if Congress does not like the policies the Board promulgates. It would seem preferable to make the Board's budget some type of mandatory account to provide it with more insulation from easy-to-enact year-by-year changes in its budget.

Clarify that the Board's budget request to Congress includes the Federal subsidies, if that is the intent.

Page 49 -- Paragraph 4

The Treasury Department would also share responsibilities with HHS for enforcing the requirement that states establish regional health alliances in compliance with Federal law. The Secretary is given the responsibility of deciding whether to deny all employers the deduction for health insurance expenditures covering workers within a state that did not meet this requirement. This provision will strike many firms and workers as unfair, because they will be punished for the actions of a state or local government. Moreover, the Secretary is given broad discretion to determine the amount by which the deduction should be limited; this amount should be specified in the legislation.

We also believe that this provision may be unnecessary. On page 262, the draft states that "Once alliances are established, contributions continue to be tax-preferred only if made through an alliance." If (1) states are required to establish an alliance by a certain date and (2) alliances are defined to include only those in compliance with Federal law, then this provision would ensure that health insurance contributions be made in an appropriate manner. Moreover, this provision would punish only those employers who made contributions to delinquent alliances. It would not affect employers who purchase health insurance coverage through a qualifying alliance within a state.

Page 50 -- Paragraph 2

The word "statutory" should be deleted.

Page 51 -- Paragraph 1, and Page 52 -- Paragraph 2

As noted, there is a need to reconcile the responsibility delegated to the states on pages 51 and 52 (i.e., for ensuring that all eligible individuals have access through a health alliance to a health plan and that all eligible individuals enroll in an alliance) with the responsibilities delegated to the Treasury Secretary on page 17 to ensure that individuals enroll in a health plan and that employers provide coverage to individuals through a qualified health plan. Overlapping responsibilities will require overall coordination and communications between the responsible agencies.

To the extent it is determined that the Treasury Secretary has the ultimate responsibility for determining that individuals are enrolled and receiving medical care, information reporting from various state agencies with respect to known instances of non-compliance would be helpful and should be considered as a requirement.

Page 55 -- Paragraph 5

This says that states may not regulate premium rates charged by health plans, except to meet budget requirements or regulate plan solvency. This statement may be overly broad and should be described in more detail since states will expect to regulate premiums as described below. States may regulate premium rates for a variety of reasons, including consumer protection. For example, states are required under Federal law to regulate medigap policies. Similarly, states may monitor premiums to prevent defrauding purchasers. Premium regulation would also continue to be appropriate for supplemental policies, long term care policies and other quasi-health insurance products.

Page 57 -- Paragraph 1

If assessments of 2% of premiums are levied on previously solvent plans in the alliance (to pay for insolvent plans), might not this drive some solvent plans into insolvency? Since a weak economy in the alliance area might affect all plans in the alliance at the same time, this is not a far-fetched possibility. Is the Federal government or some other government should be the guarantor of last resort? In any event, will the premium assessments be counted in determining whether the alliance satisfies its global budget targets?

Page 57 -- Paragraph 3

This provides that a State may not use a payroll tax or another source focusing solely on corporations to pay for additional benefits. But the State could get around this prohibition with a scheme of surcharges and credits on the income tax. Therefore, this needs to be addressed in greater detail.

Page 59 -- Paragraph 1 (Bullet 3)

This bullet suggests a further overlap of responsibilities for determining that all eligible individuals have enrolled in a health plan. In view of this bullet, is it contemplated that the Secretary of the Treasury, the states, and the regional alliances all share this enforcement responsibility? Is this the most effective way of ensuring compliance with the premium and participation mandate?

Page 67 -- Paragraph 6

This paragraph provides that each corporate alliance offers all eligible persons plans that provide the nationally guaranteed comprehensive benefits. If the health reform effort includes a single centralized data base (as we have suggested) that tracks all individuals who should be enrolled in a health care plan, information reporting of all individuals participating in a

corporate alliance plan from the corporate alliance to the compliance and enforcement-oriented agency would facilitate matching against the data base and the identification of non-enrollees.

Page 67 -- Paragraph 8

The text implies that an employer that leaves a Taft-Hartley or rural cooperative plan would be precluded from establishing a corporate alliance. Although in most cases these employers would not meet the size requirement, we assume that there is no intent to preclude larger employers leaving Taft-Hartley plans from setting up a corporate alliance. The language should be clarified to insert "(or through a corporate alliance)" following the words "regional alliance".

Page 69 -- Paragraph 2 (after bullets)

This paragraph addresses a requirement that a health plan that seeks to terminate coverage for a non-paying corporate alliance must notify the Secretary of Labor. Because page 17 requires that the Treasury Secretary ensure that all employers are properly covering their employees under a qualified health care plan, it would seem that notification of coverage termination due to corporate alliance non-payment should also be sent to the Treasury Secretary.

Page 71 - Paragraph 5

How often are the corporate alliances required to make direct payments to health plans? Would this be regulated or would the frequency and timing of payments be governed only by the contractual relationship between the corporate alliances and the plans? If the corporate alliance pays only pay 80% of the weighted average cost of a basic package and the other 20% is paid by the employee, is the 20% paid to the health plan through withholding? Would existing rules apply to limit the corporate alliance's ability to benefit from the use of withheld funds?

Page 73 -- Paragraph 4

The provision indicates that new fiduciary requirements would be established for health care plans. No details are provided. We assume that these requirements will track those agreed upon by the sub-group involving HHS, Labor, Treasury and the House Education and Labor Committee staff earlier this year.

Page 73 -- Last Paragraph

This paragraph calls for the Secretary of Labor to establish fiduciary standards for the withholding of employee contributions and to enter into agreements with the states to enforce these

requirements. Although the flow of funds has not yet been determined, the fund flows would appear to track the system for withholding and payment of payroll taxes. We do not see the need for establishing new Labor Department rules on this issue that duplicate Treasury Department rules and suggest that collection in accordance with the existing payroll tax rules may be preferable. It does not seem necessary to have one set of enforcement rules applicable to the 80% of premiums paid by the employer and another set of rules (enforced by a different agency and then delegated to the states) for the collection of the 20% employee share.

Page 74 -- Paragraph 5

On this page and on the other pages cited below, the proposal would authorize a variety of new taxes -- variously referred to as premium taxes, surcharges, assessments, etc. -- at both the State and Federal levels. These include

1. broad State authority to impose "nondiscriminatory" taxes and assessments on employers and plans in corporate alliances (p. 74)

2. State authority to require payers to reimburse essential community providers (p. 74)

3. State authority to develop all-payer hospital rates or all-payer rate setting (p. 74)

4. State authority to assess plans in an amount up to two percent of premium in order to generate revenue to cover claims against failed plans within the alliance (p. 57)

5. a per capita levy on premiums, determined by the National Health Board, to fund technical assistance programs established by the States (p. 108)

6. a surcharge on premiums to fund graduate medical education (p. 131)

7. a surcharge on premiums to fund certain research, development of technology, treatment of rare diseases, etc. in academic health centers and affiliated teaching hospitals (p. 138)

8. a 100% assessment on both plans and providers with respect to excess premium increases when an alliance's premium exceeds its budget target (pp. 100-101)

9. A Federal tax cap limiting the tax-favored treatment of premium payments (p. 262)

10. A tax on unearned income designed to recapture from employees subsidies provided to their employers on their behalf (p. 263) (We have been advised informally that it has been decided not to proceed with this proposal.)

Many of these proposals are necessary to (or at least consistent with) the general health care reform effort. However, it is important to view them in the aggregate and to weigh the potential cumulative burden they might be expected to impose on employers and plans. Moreover, this array of taxes will be characterized as a violation of the President's statements that health care reform will not require new taxes.

Collectively, the proposals also raise a number of other general concerns.

- These taxes will increase the overall level of premiums, yet, as discussed above, we believe that they are not yet reflected in the costs of the comprehensive basic package or the costs to the Federal government when providing subsidies to employers and individuals and when paying its share of the costs of coverage for government employees.

- Related questions arise as to how these taxes would be included under the global budget and how they would be taken into account in determining the weighted average premium in an alliance.

- The broad authority of States to tax premiums without ERISA preemption will make it difficult for large employers to maintain or determine whether to maintain nationwide corporate alliances. The concerns raised for large employers are discussed in greater detail above.

- The plan does not make clear in each case what the exact nature of the tax would be, how much it would be, or who would collect it. Presumably, new rules, forms, and administrative arrangements would be necessary for purposes of reporting and remitting the Federal premium taxes.

- Applying the premium tax to self-insured corporate alliances creates difficult (albeit not insurmountable) valuation questions.

- The revenue raised from the premium tax proposals would change dramatically depending on whether these taxes are deductible by the health plans and employers.

We also have a number of specific questions regarding particular taxes:

-- Is the surcharge on premiums referred to on p. 131 different from the surcharge referred to in the third paragraph on p. 138? Are these different from the payment referred to at the bottom of p. 138 ("[a]ll private payers also contribute explicitly to the national fund on a proportionate basis")?

-- In the case of certain taxes (pp. 74, 108, 131, 138), is there a limit on the amounts that can be assessed, or are these open-ended grants of taxing authority?

-- Would the Federal premium taxes be imposed on a uniform basis across States and alliances (and regional versus corporate alliances)?

Page 74 -- Paragraph 7

In previous materials, (and in discussions with Labor Department and HHS staffs on this issue), ERISA continued to preempt State taxes on corporate alliances. This provision will essentially allow States to impose premium taxes on corporate alliances at any rate the State desires. The rule requiring that the taxes be "nondiscriminatory in nature", although a logical constraint under the current system, no longer has any meaning under the reformed system. If, for example, the State imposes a 5% premium tax on all plans (inside and outside the alliance) and then takes all the money raised and returns it to plans in the alliance in the form of subsidies, the premium tax is only a tax on the corporate alliances. This ERISA preemption proposal would be very controversial with large employer plans and Taft-Hartley plans.

Page 74 -- Last Paragraph

The meaning of allowing States to require all payers to reimburse essential community services is not clear. What are essential community services? What will the permitted mechanisms be for collecting these reimbursements? What will prevent States from imposing a tax or assessment targeted to corporate alliances?

Page 76 -- Paragraph 2

Who will be responsible for regulating this new type of re-insurance?

Page 81 -- Paragraph 6

The proposal seems to call for extensive regulation of the sale of insurance covering additional benefits, including the "loss of license to sell insurance." This proposal raises a large number of administrative questions. Does this assume a Federal role in licensing the sale of insurance? Does it assume that state regulators will be encouraged or required to ensure compliance with

these Federal standards? Will the NAIC be involved? What will the Federal government's role be in monitoring State regulatory activity? Which Federal agency will be responsible for administering the program?

Page 81 -- Last Paragraph

Although the tax treatment of additional benefits will be addressed on page 262, it might be helpful to address that issue directly in this section.

Pages 86-87 -- Paragraph 5

Until we received a copy of the draft plan, we were not aware that proposals to provide tax preferences to certain health professionals were being considered for inclusion. The proposals are directed at attracting and retaining health professionals in rural areas. These objectives could be achieved more efficiently through grants and other expenditures than through a tax program. The IRS is ill-equipped to define qualifying areas and to determine whether individuals would actually qualify for the credit.

For example, the non-refundable tax credit of $1,000 per month ($500 in the case of health care providers) would reward higher-income physicians (who may be charging excessive fees), while providing little or no relief to health care providers with low or moderate incomes. To receive the full benefits of this provision, a rural doctor must have $12,000 of taxes to offset with the non-refundable credit. In addition, in some cases, relatively high-income health practitioners will be paying little or no taxes. This can, in turn, result in long-range problems for the tax system by confirming the perception that the "rich don't pay taxes."

It is not necessary to also allow up to $5,000 of deductibility of annual student loan interest for providers, since this benefit could effectively be delivered through a higher tax credit. This provision also would open the door to other proposals to allow deductibility of student loan interest.

Revenue estimates have not been requested for these provisions, and thus the Federal budget tables, showing the impact of the plan, do not include the impact of these new tax expenditures. Before providing estimates of these provisions, we will need additional information: e.g., effective dates, transition period (if any), and the definition of a rural area with a shortage of health professionals. Clarification will also be needed with respect to the specification of the proposal. With respect to the tax credit, it is not clear what is to be recaptured during the first five years of practice.

Page 93 -- Paragraphs 1 through 5

The plan ultimately must tackle the question of the appropriate scope of the Inter-Alliance Health Security Fund's responsibilities. Should the Fund be an agency of the Treasury Department? Given the Fund's need for individual premium account data, the Fund should probably be responsible for maintaining the single centralized data base of U.S. individuals referred to in our accompanying memorandum. Because this data base will be necessary to track premium payments and as a source for mandatory participation and premium payment compliance and enforcement efforts, it may make sense for the Fund to also handle the compliance and enforcement efforts under the health care system. Alternatively, any other agency charged with ensuring compliance with the plan's participation and premium mandates should have access to the recommended centralized data base of U.S. individuals to assist in its compliance and enforcement efforts. Obviously, if the Fund maintains the data base but is not charged with compliance and enforcement efforts, it will have to facilitate communications and coordination of the compliance and enforcement efforts with the agency charged with these responsibilities.

Page 93 -- Paragraph 2

Clarify and expand on the statement that "[t]he Fund holds all money received...until paid...." Will funds be deposited in the Treasury? Will they be invested? Will interest come from banks holding funds (similar to the present Treasury TT&L system)? Or will funds be consolidated for temporary investment in securities? What restrictions should be placed on the type of investments (e.g., Treasury securities)?

Traditionally, the Treasury has deferred to the controlling agency/board in terms of the investment and management decisions concerning trust funds. Under this proposal, the Fund would be a non-profit public corporation controlled by a five-member board of directors, which we assume would be charged with these kinds of investment decisions. The proposal goes on to provide the Secretary with a series of approvals that could affect the expected return to those investment decisions, including approval of the fees charged the alliances for administrative costs (such administrative costs would otherwise be paid by the Fund) (page 95, paragraph 1) and approval of the procedures under which the Fund will make bridge loans to alliances that experience short-term shortages including interest rates charged and maximum loan amounts (page 96, paragraphs 2 and 3). A potential for conflict exists to the extent the procedures approved by the Secretary interfere with the investment decisions and expectations of the Fund.

Page 93

The Secretary of the Treasury currently enjoys broad discretionary authority to appoint financial institutions (i.e. local banks) as a depositary or financial agent. The last bullet of the Draft refers to banks which "participate in the Treasury tax and loan depository system" as being eligible for contracting with alliances. The bullet as written could act as a limitation on the number of banks which could participate. Suggestion: refer to banks which have been designated by the Secretary of the Treasury as "depositaries and financial agents."

Page 93 -- Last Paragraph

The Secretary of the Treasury currently enjoys broad discretionary authority to appoint financial institutions (i.e., local banks) as a depositary or financial agent. The bullet in the last paragraph on page 93 refers to banks that "participate in the Treasury tax and loan depository system" as being eligible for contracting with alliances. The bullet as written could act as a limitation on the number of banks that could participate. It is suggested that the text refer to banks that have been designated by the Secretary of the Treasury as "depositaries and financial agents."

Page 94 -- Last Paragraph

Clarify the status of the Inter-Alliance Health Security Fund as a Federal entity, i.e., a U.S. Government Corporation.

Page 95 -- Paragraph 1

Will the Inter-Alliance Health Security Fund be maintained at the Treasury with the Secretary playing the role of "Managing Trustee", as is the case with respect to a number of statutory trust funds currently managed by the Secretary? This determines the extent of administrative support required from the Treasury.

Page 95 -- Paragraph 3

It is important that the enabling legislation remove the ability of the FDIC to abrogate any collateralization agreements established at banks through which the employer and employee contributions would be transmitted. A failure to do so could result in a loss to the Fund of the amounts in excess of the deposit insurance limit. Current FDIC authority can be construed to permit the FDIC to ignore the collateral agreements and seize the collateral for general purposes, in the event of a failure of a financial institution to which contributions have been deposited. The result would be that the collateral would no longer be available and the account would be relegated to the level of a

depositor as to the first $100,000 deposited and to a general unsecured creditor for all amounts deposited in excess of $100,000.

Page 95 -- Paragraph 4

Where do the subsidies for health care premiums that are transferred to the Inter-Alliance Health Security Fund and credited to alliance accounts come from? The General Trust Fund?

Page 96

It is possible that the loans to be made by the Fund to Community-Based Health Plans could trigger provisions of section 504 of the 1990 Credit Reform Act and thus require and appropriation for the "subsidy" provided by the Loan.

The second paragraph of the "Loans to Community-Based Health Plans" refers to an apparent requirement for the Treasury to include in its appropriation request an amount "necessary to provide or guarantee loans and to administer the loan program." It is not clear from the description of the appropriation whether the subsidy amount that might be required would be a part of the Treasury request. It is also not clear what other administration expenses the Treasury would incur under this program given that the Fund will provide the direct loans or loan guarantees.

There appears to be an internal inconsistency as to which agency will establish disbursement procedures. This paragraph provides that the Fund will establish procedures for "proper authorization of disbursements", while the last paragraph on page 96 directs the Secretary of the Treasury to issue "regulations specifying . . . collection and disbursement of premium contributions." We suggest that the plan have the Secretary direct the disbursement procedures with applicable statutory authority.

Page 96 -- Paragraphs 2 and 3

Why are bridge loans to alliances "deducted from interest earned on money deposited?"

Page 96 -- Paragraphs 4 and 5

The first of these two paragraphs states that the Fund is authorized to make loans and guarantee loans to community-based health plans. The second paragraph states that Treasury will include the amount necessary to provide or guarantee loans and to administer the loan program in its request to Congress for appropriations. Is the Fund intended to be on-budget or off-budget along the lines of the Social Security Trust Funds? If the Fund is a Federal entity submitting a budget to Congress, why doesn't it request the funds? What is Treasury's role in "administering" the loan program (and what administrative expenses would the Treasury

incur) when the Fund makes the loans/guarantees? (This section seems to be structured on the assumption that the Fund is a non-Federal entity and cannot receive appropriations directly from Congress.)

It is possible that the loans to be made by the Fund to community-based health plans could trigger provisions of section 504 of the 1990 Credit Reform Act and thus require an appropriation for the "subsidy" provided by the loan. Paragraph 5 refers to an apparent requirement that the Treasury include in its appropriation request an amount "necessary to provide or guarantee loans and to administer the loan program." It is not clear from the description of the appropriation whether the subsidy amount that might be required would be a part of the Treasury request.

Page 97 (Entire Chapter)

This chapter outlines the key assumptions underlying global budgeting. These assumptions affect Treasury's estimates of the revenue impacts of the employer mandate and the tax cap because the growth in the costs of the basic benefit plan is constrained by global budgets. If the global budgets are not enforceable or if the growth rates cannot be achieved, then Treasury's revenue estimates of the proposal will be overly optimistic (that is, revenue gains will be overstated and revenue losses understated). We are especially concerned because there does not appear to be an analytical link between the discussions regarding the enforcement mechanisms and the global budget growth rates. (For example, the global budgets in the corporate alliance do not appear to be enforceable at all.) If CBO or JCT cannot be convinced that the global budget enforcement mechanisms can achieve these growth rates, then their estimates of the proposal will differ greatly from the Administration's.

A critical issue that needs to be focused on at the very highest levels is the impact of non-compliance with the premium mandate on the global budgeting issue and on the revenue estimates for the plan. Currently, despite a mature collection, compliance, and enforcement function within the Internal Revenue Service, tax compliance levels are just over 80%. The approximately 20% gap between a 100%-compliance level and the actual compliance level contributes to a tax gap that has been estimated at $127 billion. Further, over half of this tax gap figure is attributable to self-employed individuals. Because the income and employment tax mandates under the federal tax system are similar in nature to the premium mandates under the plan, the Internal Revenue Service's non-compliance statistics under its mature systems suggest that non-compliance with the premium mandate will be a significant issue.

Page 100 -- Paragraph 1

The assessment will be perceived as both excessive and poorly targeted. The assessment is applicable to plans without regard to why their bids exceed the alliance's target. Thus, plans providing higher quality services are penalized in the same fashion as plans charging outrageous fees. By taxing both the plan and the provider who receives payments from the plan, this proposal is equivalent to a 200 percent excise tax on proceeds above the target level. It is not clear who would be responsible for administering this assessment or whether the assessment is applicable to prior or current year receipts. It is also unclear where the assessments go; who receives them?

The draft also must be clearer as to which year is the first year of enforcement, which year is the baseline year, and how these two are sequenced.

Page 101 -- Paragraph 4

See comments regarding previous page.

Page 104 -- Last Paragraph

Corporate alliances do not appear to be penalized for failure to meet the global budget targets.

Page 114 -- Last Paragraph (First Bullet)

This paragraph discusses the importance of privacy and confidentiality rights under the plan. It should be noted that if the Internal Revenue Service is charged with enforcing mandatory participation, it will need access to the data base of U.S. individuals used under the plan. Because this data base could be a valuable tool for identifying not only non-enrollees under the health care system, but also non-filers under the income tax system, some individuals not meeting their income tax filing obligations may have reservations about enrolling under the health care system and may raise this privacy issue in their defense. Although the Internal Revenue Service is not sympathetic to such a privacy argument supporting criminal, non-compliant behavior under the tax system, the introduction of the Internal Revenue Service into the premium compliance and enforcement picture will likely raise privacy, confidentiality, and disclosure concerns under the health care system.

Page 117 -- Last Paragraph

The electronic network containing enrollment, financial and utilization data sounds like an excellent **idea** that will require extensive coordination among affected parties and major systems development effort. To the extent that uniform standards require

providers, health plans, alliances and employers to develop/revise existing electronic systems, it should be considered a long range effort.

Page 164 - Paragraph 3 (Bullets 3 through 5)

These provisions seem to track the legislation introduced by Secretary Bentsen last year and unless specifically indicated we assume that the proposal will follow that legislation.

A sentence should be added to the end of the last bullet clarifying that "Long-term care benefits could not, however, be provided on a tax-favored basis through cafeteria plans or other similar arrangements".

Page 165

A targeted grant program, instead of a tax credit, would probably better achieve the objective of assisting the working disabled. To obtain the maximum benefits of this proposal, an individual would be required to be highly disabled or able to afford expensive care (and thus have $15,000 of qualifying expenditures) and $7,500 of income taxes. Individuals with low tax liabilities (possibly because of high medical deductions) or unable to afford expensive care would likely not benefit from this provision.

In any event, earlier this spring, Treasury was asked to estimate a similar proposal to provide a tax credit to individuals with disabilities who work. Additional clarification is necessary to ensure that the description of the proposal is consistent with the option estimated. For example, if our interpretation for estimating the proposal is correct, it should be stated that the credit would be non-refundable and only available to persons with high disability expenditures relative to earnings.

Page 223 -- Entire Chapter

Two broad but important points should be clarified more explicitly. First, what is the starting date of the prohibitions against insurers terminating coverage for individuals? Second, are there any restrictions at all on premium increases during the transition period?

Page 233 -- Paragraph 5

Based on the discussions earlier this week, we assume that this provision -- to require payment to the Unites States Treasury of revenues collected by pharmaceutical manufacturers that are attributable to prices in excess of the inflation rate -- has been dropped.

Page 242 -- Paragraph 3

The computation of "an average, full-time wage" of under $24,000 for purposes of employer qualification for a premium subsidy is easily manipulable. The statute should provide specific anti-abuse rules, such as requiring the aggregation of distributions to shareholders of closely-held S corporations and wages in order to determine the average, full-time wage. Absent such a rule, employee-owners would have an incentive to reduce their wages and take amounts out of an S corporation through distributions in order to reduce the corporation's average, full-time wage.

Pages 242 and 243

The whole area of employer (and employee) premium subsidies is a major area of potential non-compliance and exposure under the plan. This point needs to be emphasized at the highest levels. Employers will have a great incentive to overestimate the premium subsidies to which they are entitled. If the subsidies are made available under a self-assessment system similar to that underlying our federal tax system, then an employer's claimed premium subsidies can only be verified well after the fact (and then only for a very small percentage of the employers). By way of analogy, the overall Internal Revenue Service audit coverage level stands at less than 1%; significant resources would be necessary to bring this coverage rate above the 1% level. For example, the Internal Revenue Service estimates that an additional 41,800 examiners would be needed at a cost of $3.3 billion to merely raise the audit coverage level up to 2%.

Page 259

Based on our discussions with the Urban Institute, we suspect that the estimates of the subsidies for the unemployed population may not coincide with the description of the policy. Under the description, the benefits would be available to unemployed workers without regard to the reason for termination. Urban's estimates may have only extended the subsidies to persons now qualifying for unemployment insurance benefits.

If these benefits are to be financed through an increase in the FUTA tax base, we need additional information to ensure that the revenue estimates are consistent with the proposal.

Page 262 -- Paragraph 2

This page describes what appears to be a very aggressive tax cap proposal -- including a limit on the "tax exemption" to 100% of the weighted average premium in the alliance and repeal of cafeteria plans for health benefits. This is in conflict with the description of the tax cap that has been provided orally at a

number of meetings. Since Treasury will be responsible for administering and estimating whatever tax cap proposal is adopted, we would appreciate guidance on exactly what is being considered. We would also appreciate the opportunity to express the Treasury's views on these issues.

Page 262 -- Paragraph 3

This should be modified to read:

> Any premium payment by a self-employed person for the comprehensive benefit package is fully tax deductible for income tax purposes.

The current law 25% deduction is scheduled to expire at the end of 1993. Will this 100% deduction be effective beginning in 1994? Or will the 25% be extended for some period of time? In addition, we recommend that the discussion of any tax cap proposal clarify that any rules limiting the exclusion for employer-provided health insurance (or the employer's deduction) would also limit the self-employed deduction in a comparable manner.

Page 262 -- Paragraph 6

The description of the transition relief for collective bargaining agreements is not consistent with historic practice in this area. Generally, transition relief is provided through the end of agreements in effect on the date of enactment. This draft would provide transition relief for any agreement in effect on January 1, 1997. This goes well beyond any relief that can be justified on policy grounds. In addition, standard collective bargaining relief provides a sunset date, usually 3 years after the date of enactment. This prevents unions and employers from entering into long term (e.g., 10-20 year) agreements on these issues that extend the life of the tax-favored treatment. We recommend that this paragraph be modified as follows:

> In the case of collective bargaining agreements in effect on the date of enactment, additional benefits will continue to be available for the duration of the contract, but in no event for more than three years following the date of enactment.

Page 262 -- Last Paragraph

Are controls adequate over the transfer of account balances between alliances? Does the system depend on individuals detecting errors in account transfers? Could alliance accounts maintained by the Fund be reconciled to individual/family accounts maintained by the alliance? Some type of reconciliation for control purposes is needed.

Page 263 -- Paragraph 4

It is important to impose strict controls on the disclosure and use of confidential taxpayer information. This applies both to the use of copies of tax returns obtained from taxpayers themselves and to the verification of income data with the IRS and other agencies. This concern is magnified by the prospect that alliance employees will not necessarily even be public employees. Our voluntary income tax system depends in large part on taxpayers' confidence that the information submitted will remain confidential and will not be inappropriately disseminated.

Page 263 -- Paragraph 6

We do not believe that the proposal to recapture the employer subsidy should be included in the package. Employees will likely perceive this tax as unfair, if either their employer does not pass back the subsidy in the form of higher compensation or they are unaware that their wages have in fact increased as a consequence of the subsidy. For such a tax to be enforceable, employers must report the amount of the subsidy received on behalf of each individual employee to both the IRS and the employee. We believe that this tax would be difficult to collect and impossible to explain.

Page 264 -- Paragraph 1 (Last Bullet)

After two years, Federal grants to States are based on the initial year's audited subsidies adjusted for certain factors and significant changes. If this method of estimating the subsidy does not cover actual State/alliance shortfalls, is the State liable or are Federal supplemental appropriations required?

Page 269 -- First Bullet

Since electronic funds transfer is being promoted, the statement that employers will "write one check each pay period" should be changed to read, "make one payment each pay period".

Additional Issues Not Mentioned in Materials

• TOBACCO TAXES -- In order to prepare estimates, we will need to know the rate of tax increase; effective date; phase-in schedule; and whether the tax rate will be indexed. It is worth noting that estimates that have been used of revenue raised have not been consistent with Treasury estimates. In addition, we anticipate that certain compliance measures will be necessary to ensure collection of the revenue, and we assume that those will be a part of the package. We are also assuming that the Treasury Department will not have responsibility for designing any subsidy for tobacco farmers. Finally, it would be helpful to know what

types of materials you will be expecting from the Treasury Department to explain this change.

We would also like to note that White House sources have been using tobacco tax revenue estimates prepared by the Coalition on Smoking or Health in their discussions with the media. As a general rule, we do not think it is appropriate to use revenue estimates prepared by anyone other than the official government agency responsible for estimating since it tends to give estimates prepared by outside groups more credibility than they generally deserve and results in unnecessary confusion. Revenue estimates on a variety of tobacco tax options have been provided by the Treasury Department. We believe that the JCT estimates, which the Congress will rely upon, are consistent with Treasury estimates.

• ALCOHOL TAXES -- These issues have not been discussed at length, and we are not certain what we can do to be of further assistance in analyzing these taxes. The Treasury Department would like to be involved in the process of formulating policies on alcohol taxes, and we are interested in how you intend to proceed with this issue.

• CHANGES IN RULES GOVERNING THE TAXATION OF NONPROFIT HEALTH CARE PROVIDERS -- Materials prepared by the working groups discussed options for changing the tax treatment of nonprofit health care providers (e.g., section 501(c)(3) hospitals; Blue Cross/Blue Shield plans; and HMOs). Since we have not seen any indication of changes in these rules and the materials we have been provided do not recommend any changes, we assume that none are being proposed.

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. memo	To Hillary Rodham Clinton, re: Medicare/Medicaid and the budget (2 pages)	12/14/1994	P5
001b. fax	Fax coversheet to the First Lady from Secretary Donna E. Shalala (1 page)	12/12/1994	P5
001c. memo	Donna E. Shalala to the First Lady, re: health care reform (2 pages)	12/12/1994	P5
002. memo	Chris Jennings to Hillary Rodham Clinton, re: Budget/Health POTUS Briefing (2 pages)	05/26/1995	P5

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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]

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b(1) National security classified information [(b)(1) of the FOIA]
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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]

~~CONFIDENTIAL~~ MEMORANDUM

TO: **Hillary Rodham Clinton**
RE: **Medicare/Medicaid and the budget**
DT: **12/14/94**
cc: **Melanne**

In this morning's budget discussion, Alice will lay out where we fall short in achieving the current goals of a tax cut (approximately $50 billion), a worker retraining initiative (approximately $25 billion), and avoiding a deficit problem. Apparently, we face a significant shortfall (particularly when you consider some of our possible assumed savings are unlikely to be politically viable), which will require painful decisions -- decisions that may bring back into play some significant cuts in Medicare and, possibly, Medicaid.

I believe one of the desires of this (and/or previous) meetings has been to come to closure on exactly what is the size/scope of the tax cut, so that the President can talk about it with some specificity on Thursday. The one point I think is important to emphasize is that publicizing a specific number may well signficantly constrain our budget options and may push us to look at significant cuts in the health entitlements for financing. **My primary point here is to suggest that, if finalizing a tax cut policy has the potential to drive other budget numbers, you may consider asking what implications any such decision has on health care savings proposals. For example, does this by definition tie our hands into any specific funding need from the health programs beyond the extenders and, if so, what are the specific implifications in terms of dollars necessary and impact on health policy politics (whether for our budget or in future negotiations on the Hill).**

It is now clear that, as far as Leon and OMB are concerned, both sets of Medicare extenders [$19 billion over 5 years and $125 over 10 years] that we have been talking about as possible health reform financing sources are already being assumed in the budget baseline. In other words, these Medicare savings are being used as funding sources for the non-health care spenders or to help reduce the deficit problem.

Because of the budget pressures, it does not come as a surprise that these extenders are apparently being assumed for non-health purposes in the budget baseline (although some of our supporters, including Senator Kennedy -- who just met with the President today, will be upset). What would create disproportionately greater problems is a move for significantly greater cuts from Medicare and possibly Medicaid to address real or perceived shortfalls.

Apparently Alice will be presenting a whole range of Medicare and Medicaid savings that may amount to over 85 billion dollars more OVER 5 years. I believe she is preparing this information because (1) she thinks we should be placing these on the table now so that we can define ourselves in terms of being willing to step up to the plate and show our desire to both reduce the deficit and have small investments in health reform; (2) she believes Leon and Bob are open to additional Medicare (particularly provider) cuts; (3) she has heard Laura talk about the possible need for an entitlement summit and possible implications of a small Medicare entitlement cap; and (4) she thinks we need money or at least more options on the table to make the numbers eventually work out.

The fears I have about Alice's presentation can be narrowed to one word: **LEAKS. If there is any public perception that we are talking about major Medicare/Medicaid cuts (particularly if they are not signficantly redirected for reform), we will hear a major outcry from our traditional base of consumer advocates and the elderly, the hospitals, and many other providers.** I would like to suggest that you emphasize this point.

You may also want to ask her when we will have the new Medicare/Medicaid baseline numbers incorporated into the baseline (which apparently will lower the deficit -- perhaps by tens of billions of dollars -- and thus hopefully reduce pressure on us to cut programs for deficit reduction). [She is pushing HHS for these numbers now, but their absence means that we will have to recalibrate our deficit numbers and proposed savings numbers in a very short period of time].

Lastly, it is possible that the subject of a Medicaid block grant or other Medicaid savings proposals may come up. There may be some political and policy appeal to these proposals. Because of the states strong desire for flexibility and the Governors ongoing discussions with the Republicans (and the President), the President may understandably be somewhat intrigued. As you know, however, there are tremendous implications with proposals such as these and I would only ask that we have an informed discussion on the matter preceeded by a DPC/NEC Map Group meeting to help us prepare.

In case the Medicaid blockgrant issue is raised, I am attaching some background information and some pros & cons on it for your use. (I do this although I understand from Melanne's intelligence that most of the budget participants -- other than Gene and perhaps the President -- are not seriously focusing on this proposal at this point).

I am sure I am giving you too much, but I thought this information might be helpful for both the morning budget meeting (if you go) and your afternoon meeting with Bob, Alice and Laura.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D. C. 20201

FACSIMILE

PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:

DATE: December 12, 1994

TIME: 5:10p

TO : The First Lady

COMPANY : The White House

FAX NUMBER: 456-6244 TELEPHONE NUMBER 456-6266

FROM: Secretary Donna E. Shalala

OFFICE OF THE SECRETARY
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, D.C. 20201
(202) 690-7000 FAX NO. (202) 690-7595

COMMENTS:

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

DEC 12 1994

MEMORANDUM FOR THE FIRST LADY

As the budget deliberations go forward, I want to emphasize my belief that a specific health reform initiative **must** be included in the President's budget. To leave it out -- or be vague about it -- will expose us to charges that we've abandoned our health care goals. To show that we stand by our commitments **and** that we've heard people's desire to move incrementally, a program that covers kids in working families is the natural first step (or down payment) on the security of affordable coverage we've been promoting for the last two years.

A program for kids achieves the fundamental objectives we've been discussing:

- **Security for working families.** Medicaid provides coverage for kids in poor families; but middle income families cannot count on coverage through their jobs. An expansion of coverage to families **above** the poverty level is protection for families struggling to play by the rules. It also assists in moving families off **welfare**, since they will retain coverage for their kids.

- **Affordability at acceptable cost.** A combination of tobacco tax revenues and Medicare savings can fund a reasonable kids program. These Medicare savings can be largely justified in terms of our belief in **slowing growth in payments to providers**. Our commitment to fiscal responsibility as well as health care is best served by clearly delineating where the dollars come from in the President's budget.

- **Minimizing bureaucracy.** We can build on experience a number of states have had in offering a program that helps families buy **private health insurance** policies. States could be given flexibility to implement programs as they see fit, avoiding the administrative complexity CBO found in the HSA.

Expanded coverage for kids is not without risk, but I believe this risk can be mitigated.

- **Dropping of employer coverage.** Subsidizing families to purchase coverage on their own raises concerns that employers will stop providing that coverage. If that's the case, we will be substituting public for private spending and using scarce public resources to cover the already insured. This is hardly a new problem in health reform and cannot be totally avoided. But it can be mitigated by:

-- limiting 100% subsidies to people with very modest incomes (133% poverty)

-- covering kids who have been without private insurance for a year

-- preventing employers who provide dependent coverage from giving it to some employees (high wage) and not others (low wage).

In my judgement, this issue is getting more attention than it deserves. We're focusing on low income, uninsured kids in working families; if we become overly preoccupied with employers dropping coverage, we can't move coverage forward at all.

Finally, interest has been expressed in cutting Medicaid as a way to produce budgetary savings. Such action would undermine the significant advances we have made in coverage expansions for women and kids in recent years. **On our watch, Medicaid cost growth has slowed, states' flexibility has increased and coverage has expanded.** We should take credit for these achievements. But we must not reverse our direction. **We must not leave any American child behind.**

Donna E. Shalala

HCF
Clinton budget

~~PERSONAL AND PRIVILEGED~~ MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris J.
RE: Budget/Health POTUS Briefing
cc: Melanne

May 26, 1995

Today's budget/health meting is one in a series of budget briefings that attempts to respond to the President's request for a balanced portrayal of the requirements for and impact of a 9-year balanced budget glide path. These meetings are being characterized by Leon and others as purely informational, not decision-making oriented. While this is no doubt true, the definition of "fair and balanced" is of course in the eye of the beholder. Moreover, the meetings will at least contribute to framing the parameters of the decision options.

After I talked with you and Melanne last night, I had long conversations with Jack Lew and Nancy Ann Min. Although I was unable to access the paper that will be presented to the President today, I asked that Jack or Alice forward you their presentation directly to you BEFORE you leave today. (OMB -- under the direction of the President and Leon -- will not circulate any paper to anyone; keeping in mind what type of info is being presented, leaks would be devastating.) My understanding is that in this morning's 7:30 meeting, Alice is going to work out something with Maggie -- she will likely offer to brief you herself (on the health and all other budget related areas, many of which you will want to know about no doubt.) If this occurs, I think you should accept; my only advice is that, at least with the health portion of any such briefing, you ask that I sit in.

Thanks to Maggie, I will be at the meeting today with Leon and then subsequently with the President. I will call you and Melanne to give you two a quick briefing.

I did get an oral briefing from Nancy Ann. Overall, it sounds like the presentation, in the Alice Rivlin tradition, is a bit more detailed than maybe necessary. Having said this, it sounds like nothing in it will be overly surprising.

The discussion will focus on various presentations of sources and uses tables. The uses tables have barely changed from the last discussion we had. The coverage expansion options are threefold: kids coverage, temporarily unemployed, and Alice's Medicaid investment fund.

The uses charts have not changed too much, except that the Medicare savings options are going up. They now have three seven-year Medicare savings and "trust fund strengthening" options: $138.6 billion, $165.2 billion and $187.6 billion. The seven year Medicaid savings number stays at a constant and relatively low $39 billion -- mostly from DSH savings. The tobacco revenue sources options are $33.9 billion (from a 40 cent tax) and $87 billion (from a $1 tax.)

These numbers and packages will float all over the place in this presentation. The most aggressive Medicare/Medicaid combination savings number is about $226 billion (187.6 + $39 billion) over seven years. This represents more than twice what any Congress has ever passed. Having said this, it is about half of the $450 billion or so the Republicans are considering in their comined Medicare/Medicaid budget proposals.

Key Numbers to Watch in Future

If we go to a 9-year balanced budget approach, it appears that we will need a **net** health care savings number of at least $150 billion over sevent years. (It could be as high as $200 billion.) This of course means that any reinvestment for health care would be on top of these figures and would require additional savings or revenues. Therefore, for example, if you assume that we end up needing a $175 billion net number for the deficit glide path, the investment packages that we have been considering would probably require an addition $50 to 70 billion -- in other words, a gross health care savings number of approximately $225-$245 billion

I have been consulting with a wide variety of people I trust to get a sense of outside parameters of what is possible without ruining the programs. In short, and I will explain later, they believe that you can get about $150 billion from Medicare and $50-70 billion out of Medicaid over seven years. (This of course has nothing to do with the political advisability of starting or ending up with these numbers -- a subject I would like to talk with you and Melanne about later.)

Lastly, I am enclosing a one page sheet on the provisions we are tentatively assuming for every package at this point. There really are not too many surprises here, but I would like to go over them with you when you get back. Also enclosed is the FDA release surrounding their interpretation of the GATT/generic issue. I talked with David Pryor yesterday and he knows we (and you) did everything we could considering the circumstances. He will be critical of the decision and will push legislation as soon as the Congress returns. The Administration will be strongly behind it.

Talk to you soon.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. memo	Karen Davis to Hillary Rodham Clinton, re: Notes From 2/7/93 Meeting With President Clinton (1 page)	02/11/1993	P5
001b. minutes	Notes From 2/7/93 Meeting With President On Health Reform And Economic Package (9 pages)	02/11/1993	P5
002. memo	Chris Jennings and Jennifer Klein to Hillary Rodham Clinton, re: Update on Health Policy Developments (5 pages)	04/07/1995	P5

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H- Clinton Budget

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LETTER OF MEMORANDUM

February 11, 1993

TO: Hillary Rodham Clinton

FROM: Karen Davis

RE: Notes From 2/7/93 Meeting With President Clinton

As you requested, attached are my notes from the 2/7/93 meeting with President Clinton on Health Reform and the Economic Package. Let me know if you wish any clarification.

~~CONFIDENTIAL~~ DRAFT

NOTES FROM 2/7/93 MEETING WITH PRESIDENT ON HEALTH REFORM AND ECONOMIC PACKAGE

ATTENDEES: President, Vice President, Hillary Rodman Clinton, Donna Shalala, Lloyd Bentsen, Ron Brown, Robert Rubin, Leon Panetta, Alice Rivlin, Laura Tyson, Ira Magaziner, Bowman Cutter, Alan Blinder, Mack McLarty, George Stephanopolous and other aides (HHS -- Phil Lee, Karen Davis, Judith Feder, Ken Thorpe, Atul Gwande; Policy Development -- Paul Starr; Domestic Policy -- Sara Rosenbaum, Gene Sperling; Treasury -- Marina Weiss; OMB -- Joe Minarik; Economic Council and CEA -- David Cutler, Sherry Glied; others??)

Rubin -- Purpose of meeting is to decide what to include about health reform in February 17 economic speech

Announcements -- Bentsen: follow-on meeting on unresolved investment issues
Shalala: follow-on meeting on immunizations

Magaziner -- Presentation of issue
- Health care costs rising; can't have economic plan or budget plan without a health plan
- Controlling costs needs to go beyond controlling health care prices, to changes practice of medicine
- Crude quick solutions may exacerbate underlying problems
- Without universal health insurance coverage, costs are shifted to government and distortions in health insurance market occur
- Managed competition with global budgets offers long-term promise of changing behavior
- Dilemma is that in next five years, takes time for managed competition to realize substantial savings
- Could ask for standby authority to impose price controls or caps in short-term; indicate that health plan will be submitted in May; short-term price controls will achieve scorable savings and raise funds for deficit reduction and universal access
- Health plan could be merged with deficit reduction plan in reconciliation
- Options for near-term cost containment include price freeze, extending Medicare payment schedules to private sector, revenue cap on hospitals and physician fee schedule, or cap on private health insurance premiums and Medicare growth; followed in long-term by comprehensive reform
- Savings from near-term cost controls are $27 billion

to federal government in 1997, $48 billion to insurers, and $26 billion to individuals for a total of $101 billion.

-- Private sector savings could be recaptured by a tax on insurers to expand coverage to uninsured and assist distressed health institutions hurt by controls

-- Total funds available for deficit reduction and universal coverage: $72-98 billion in 1997, including health care cost containment savings in Medicare and recaptured private savings, Medicare budget cuts of $10 to $13 billion, and $5-10 billion in sin taxes.

-- Problem is timing. Health plan won't be ready in March. Reckless to introduce health care cost controls before whole plan is ready.

President -- Should be develop some pieces such as health insurance market reform, community rating, portability and pass those first

Shalala -- The difficulty is that those measures haven't been developed yet

Magaziner -- The problem is that we are not yet ready with health care reform
It will be difficult to get comprehensive health reform in incremental steps
Near-term cost controls will generate $27 billion in federal savings by 1997, and private insurance savings of $48 billion; this provides $20 billion for deficit reduction and $50 billion for universal access

President -- There is a fundamental error in our thinking
We will give the impression that nothing can be done to control health care spending
$20 billion is an insignificant dent in federal health spending; we are spending about $240 billion a year on federal health programs; this will grow to $332 billion in 1997; $20 billion is only about two-thirds of one-year's increase in federal health spending

Rivlin -- We're not saying that is all that can be achieved
Health care is driving the deficit; the problem is being able to talk about the details of our health

plan for dealing with it before May
We should indicate that health care costs are a major problem, and that we will address it in May

President -- I understand that we don't have a health care plan now, but aren't we going to be criticized if we just let health care costs keep going up; federal health spending will increase by $115 billion between now and 1997 if we wait for comprehensive reform

Panetta -- What you want to do is to give a vision of your plan for health care in the February 17 speech
You would indicate that you have a Task Force in place; it is working to put together a carefully throughout health care reform plan
In the meantime you are achieving credible Medicare savings with the budget cuts that are in the economic package; the Medicare savings will be viewed as legitimate

Stephanopolous -- You don't want to claim greater savings that can be backed up
You can indicate that you believe you can get more savings when you have a comprehensive plan, you will offer a plan in May that will address the fundamental problem of rising health care costs

Magaziner -- I wish that we could present a plan now; the politics of health care reform are better than the politics of deficit reduction
We can achieve real cost savings with near-term cost controls, but they can't be put together in a week
We need to keep health care and the budget linked; they could be brought together in reconciliation
I feel like a contrarian and don't relish being cast in that role

Rubin -- The issue is what to say in the February 17 speech
The budget package will include $18 billion in Medicare savings; if the health reform plan develops another alternative in May, those can be substituted for this $18 billion

Shalala -- Alice Rivlin and I will work this week to develop a set of Medicare budget savings, although it may be somewhat less than $18 billion

Rubin -- What you can do is tie health care cost containment and deficit reduction together by the rhetoric in the February 17 speech
In addition you can decide later whether to tie health reform and the budget package together in a single reconciliation bill

Magaziner -- It's important to succeed at health care reform; if fail you will feel bad
It will be a centerpiece of the Administration
We will try to get some savings out of health care reform to help reduce the deficit
Succeeding at health reform is important; you won't be a failure if you don't do a gas tax but you will if you don't get health reform

Stephanopolous -- The economic plan should just claim credit for $18 billion in Medicare savings

President -- I am still concerned that $18 billion is an admission of defeat; it is only 2/3 of one year's increase in federal health spending; it makes us appear helpless in the face of the budget problem
In the meantime people are suffering; health care costs are bankrupting Americans; and just shuffling more billions of dollars to physicians and insurers
We have to be careful how this is presented

Panetta -- We will make a commitment to doing something about health care costs
Health care must be a vital ingredient of our overall economic strategy

Magaziner -- Medicare rolls are growing, adding to the cost problem

President -- If we don't get health care reform this year, it will be tougher to get next year
It will also be hard on members of Congress running in the mid-term election, if we haven't

done anything on health care
We don't want to send mixed signals
We should do projections for the second four years; the Families USA report did projections to the year 2000 and showed massive savings; more savings kick in during the second four years

HRC -- One of the reasons why Gephardt and Mitchell are strongly in favor of joining health reform and the budget bill in reconciliation is the need to link these issues
We had a very helpful meeting last night; there's been a lot of hard work done
There's no way to get around some kind of cost containment up front
Managed competition on its own will not bring costs down
Whether it's now or later, we've got to figure out how to stabilize the patient
It's a risky strategy, but we can make a better case for deficit reduction to people if health care and deficit reduction are joined
We can start by joining them by the rhetoric used in the February 17 speech

Bentsen -- Do we have to decide now on whether to join health reform and deficit reduction legislatively in reconciliation? I'm concerned there will be 60 points of order raised if we put health care in reconciliation. We could just develop both and let the leadership in the House and Senate and the President decide at a later point.

Vice President -- We have the luxury of waiting on the Task Force to make decisions on a very complex plan since it will include short-term price controls as a longer-term system is being brought in
It's the timing issue that is the problem
We can link health care and budget rhetorically, but it would be dangerous to move forward now by announcing price controls until the rest of the health reform package is known
The pressure from Congress for health care reform is not going to go away

We should make it clear that the days of smoke and mirrors are gone, and we won't take credit for a plan until we have a realistic plan to achieve them

Panetta -- We should view the $18 billion in the budget as a downpayment; and indicate that we are going to move forward with broader reform

HRC -- We should indicate in the speech that the President has directed the Task Force that the health plan must contain several things that people can relate to such as:

- -- Community rating
- -- Exclusion of pre-existing conditions
- -- Job lock

These must be features that people can understand and relate to, have broad popular appeal

Magaziner -- If Gephardt goes to the membership for a hard vote on the budget package, it will be hard to go a few months later for another tough vote

Bentsen -- If we win the first one, there will be increasing momentum; we might lose both if we put health reform and budget reduction together
We don't have to make a decision at this point

HRC -- The health reform plan will be ready by May 3, give or take a day

President -- Point out that budget cuts in Medicare are modest; explain where they come from
Then indicate that can do much better, economic package will be followed by a health package; the health package will have "..." in it; tell them the health plan will be coming; health care needs to have credible deficit reduction to show that Congress works and can act; otherwise those up for election in mid-term will be at risk
Hoping for more significant savings, can't promise more now
Absolute certainty the plan will have features that guarantee that the deficit won't continue to rise in last half of the decade

If these criteria are present in our plan, have humongous savings
Go the route of the Greenspan commission on Social Security
If we get behind genuine cost containment, we will have the structural deficit in hand
In the second four years, we will achieve hundreds of billions of health system savings, including savings in Medicare
This plan will get America to the 21st century in strong shape

HRC -- This needs to be thought of as an eight year plan

President -- We need to prepare people for near-term frustration
The ability of this government to deal with the enormous problems created by failed economic policies of the past is marginal
Health care needs to be put in broader context including the impact of high interest rates on credit crunch for small business, the dislocation of defense cuts
We need to take steps to move to a different future

Phil Lee -- We can develop effective cost containment for the short term and the long term; it needs a lot of work; will need to develop a consensus; we can develop cost containment that is effective; won't take four years to achieve genuine savings; we are doing our best to get it done

President -- The general principle is that it is entirely possible that greater savings can be achieved when the health plan is fully developed
This is a conservative approach
Will reach a reasoned judgment in May in an honest and open way of the best way to achieve health care cost containment
The worst scenario is that the deficit won't go up in the second four years; that's the spin we should put on the speech; the specifics of the plan will have to wait until May

Panetta -- The budget resolution will come in April or May, but reconciliation will be later; all we will need in April are general numbers on defense, non-defense,

entitlements, and revenues

President -- A health care plan could be financed in part by taxes on cigarettes, other sin taxes; if there are $27 billion in federal savings plus $10 billion in sin taxes that provides $37 billion in 1997; how does that get integrated with the budget plan

Panetta -- It is a fundamental decision whether to link packages legislatively or to try to move the economic plan first, with health care on a separate track

President -- The Committees could be consulted; they may decide to substitute some of the savings in health reform for items in the budget package

Panetta -- We need to get the best package we can; the health plan will make big news when it is released; Congress will hold hearings; we can decide then whether to add to reconciliation, can't make that judgment now

Bentsen -- It's similar to the trade bill and plant closings; when separated the two had a better chance of passing both

HRC -- Gephardt indicates there needs to be some language in the budget resolution to keep the option of joining them open

VP -- There can be a plug so long as it is deficit neutral

[Discussion on budget reconciliation rules]

Magaziner -- We will accelerate the work on near-term cost containment and try to have that part ready in five or six weeks

President -- If we do it like we're discussing, I'll have something to say in the February 17 speech

Sara Rosenbaum-- Even if it's an option to save more money and cover all Americans, it will be a tremendously

powerful speech

Panetta	--	We'll draft the speech
Rubin	--	The speech on February 17 is key; more important than a budget resolution bill which often isn't passed
President	--	Need to push for a budget resolution to get serious debate
Panetta	--	The real debate will take place in the context of reconciliation; that will be the real test If we put the economic stimulus and deficit reduction forward, we will force Congress to deal with the issues; the real meat is in reconciliation
[Aide]	--	The budget reconciliation bill won't come until after the health reform plan is introduced; there will be at least a three month hiatus
Panetta	--	The President will have to push to get budget resolution through; House can do it
President	--	Okay, let's go. I've got it.

MEMORANDUM

TO: Hillary Rodham Clinton
FR: Chris J. and Jen K.
RE: Upadate on Health Policy Developments
cc: Melanne

April 7, 1995

We thought you might like an update memo on recent developments related to health care. As yesterday's enclosed Washinton Post editorial illlustrated, we are going to be under increasing pressure to at least appear to be more proactive on the health care front.

The issues that merit particular attention are: (1) Medicare Trust Fund developments, (2) health care developments on the Congressional front, and (3) the current status of our internal health policy development discussions.

Medicare Trust Fund

The Republicans have consistently attempted to draw us into the debate with their repeated "sky is falling" references to the Medicare Trust Fund and attacks on our "lack of leadership." They desperately want us to engage with them on this issue and will be turning up the heat during the recess and immediately after they return. Already, the Finance and Ways and Means Committees have announced Medicare Trust Fund hearings to take place in late April and early May. They have invited all of the trustees (Shalala, Rubin, Reich and Vladeck) to testify and to take a bashing from the Republicans. (As you know, the timing of these hearings happen to coincide with--or just before--the White House Conference on Aging.)

Interestingly enough, because we were well prepared for this past Monday's release of the Social Security Trustees report (and probably because there was more sensationalistic news to report), the media did not give the release all that much attention. To the extent it did receive coverage, we think (as the enclosed articles help illustrate) we came off looking all right -- at least for the moment. For your information, we are enclosing a set of talking points, Q's and A's, and a background summary on the Medicare Trust Fund issue. Also enclosed is some interesting testimony about the current state of the Medicare Trust Fund that was presented by one of our favorites -- Guy King. (He now works for Ernst and Young.)

Congressional Health Care Update

The Republicans are growing increasingly nervous about how their cuts in the Medicare and Medicaid programs are going to fare with the public. (This helps explain how much time Speaker Gingrich allocated tonight to outlining his "devotion" to Medicare and health care.)

The Speaker and the rest of the Republicans understand all too well, however, that they have gone too far with their tax and deficit reduction promises to back-track now. The Committee Chairs are currently reviewing unprecedented Medicare and Medicaid cuts. Although they will be gone most of the month, the Republicans will be working hard to make their case that they are merely reducing the rate of growth in order to strengthen the Medicare Trust Fund. They of course will also attempt to suggest that their "managed care" reforms will not only make the system more efficient, but will also provide more choices to beneficiaries. (As you will recall from our managed care memo, it is virtually impossible to achieve ANY substantive Medicare savings without limiting affordable health plan choices and/or increasing beneficiaries' cost sharing requirements.)

On April 26th, the Senate Budget Committee is planning to start their mark-up of the budget resolution. As of this writing, they are reportedly considering at least $250 billion and $130 billion in Medicare and Medicaid cuts respectively over seven years. In recent days, however, there have been rumors that increasing pressures to throw in some tax goodies for some of the more conservative Members may make the combination Medicare/Medicaid Senate number top the $400 billion mark. The House Budget Committee, which will start later, is likely to get closer to a $500 billion Medicare/Medicaid figure.

In addition to using Medicare and Medicaid as the "cash cows" for their agenda, the Republicans are obviously looking to paste on the term "insurance reform" on any health bill they unveil. They of course want to label their initiatives as "health reform," so they can say they are meeting the President's requirement that any such cuts are done in a broader context.

Questions relating to likely Republican actions are already arising. For example, do we oppose any major health policy change that does not expand coverage? Do we or should we have a ratio of spending to deficit reduction allocation when it comes to Medicare/Medicaid cuts? Earlier today, the President gave some answers to these questions when he publicly reiterated today his desire to expand coverage to at least the temporarily unemployed, while allowing that some savings would be used for deficit reduction. I believe he deftly handled the danger of appearing in a responsive mode by referencing the vision he outlined in the State of the Union and in his December Congressional Leadership letter.

The Medicaid program frequently gets lost in the political shuffle, but I think it's worth noting a couple of points. Every success there is in reducing the Medicare cut number may be at the expense of increases in Medicaid cuts. Whether this occurs or not, the lowest Medicaid cut now being discussed by the Republican Leadership is $130 billion over 7 years; it is just as likely to be closer to $190 billion. This, as you know is particularly significant since the size and scope of Medicaid cuts will almost inevitably lead to actual coverage reductions only a year after we were talking about universal coverage.

As far as the House is concerned, it is difficult to imagine anything other than a Medicaid block grant (with a 5-6% growth cap) emerging from the floor. The Republicans are absolutely sold on the block grant approach because (1) it is easy to understand and explain, (2) they are desperate for the money, and (3) most of the Governors are giving explicit or implicit cover OR they just are not paying attention yet.

The Senate may be a different ballgame. Senator Chafee is opposed to eliminating the entitlement and block granting the Medicaid program. As Chairman of the Finance Subcommittee on Medicaid and, more importantly, as the 11th Republican vote on the 20 Member Financing Committee, he may have a good deal of clout -- if all of his Democratic Finance brothers (and sister) join him. (It certainly is not clear that this is the case, though.)

Chafee is now in the process of developing alternatives to the block grant approach. He is currently playing around with an idea that eliminates Medicaid DSH payments in order to get significant savings. The primary problem with his approach is that it remains unclear whether there is sufficient political support from the provider groups, from Republicans, and even from the Democrats. Because of the retention of the entitlement, the lesser amount of flexibility, and the DSH payment reductions, there is little question that the Governors would oppose it. (Having said this, it is worth following this bill closely; I talked with Chafee's staff today and will keep you apprised of developments.)

As usual, the Democrats on the Hill are in disarray around the health care issue. The only thing they seem to agree on is a strategy to hold back, evaluate and hopefully expose the Republicans "mean-spirited" health care cuts. They, like the "pols" in the Administration, want us to prepare our ammunition but hold back UNTIL the Republicans get more specific. Attached, for your review, is a copy of the current set of talking points the Senate Democrats are using on the Medicare/Medicaid cuts.

Ever since Daschle introduced his health reform bill, he has been fairly silent on the issue. However, if there is any chance whatsoever for any bridges to be built from the Republicans to the Democrats (or vice versa) on health reform, it will be in the Senate. This is primarily the case because the Senate Republicans think they need a positive health care reform spin and many of the Democrats have deficit reduction fever.

Gephardt does not feel the need to develop any specific alternative and seems comfortable attacking (and preparing to attack) the Republicans cuts and lack of progress on health care. (This is of course largely due to the fact that he simply cannot achieve a broad-based consensus on any health reform package.) Leader Gephardt has announced, however, his intention to produce a bill sometime later this year. Andie King informs me, however, that this will be at most a "theme" and "political cover" bill -- nothing that is at all detailed or has any chance of passing. Andie (and Daschle's staff) are very interested in receiving our assistance in preparing back-up, substantive, and brief background on the Medicare and Medicaid cuts. (A copy of our latest -- but not final -- draft of these talking points is included behind this memo.)

Current Status of White House Health Policy Development

No senior level Administration official is arguing that the President should rush out any health reform initiative prior to the time the Republicans release their budget resolution. However, there continues to be somewhat of a split internally about how to proceed in health care.

Leon, Pat and George (among other politicals) do not see any great value and, in fact, see potential danger in the White House policy operation holding high level policy discussions to develop and review health reform options. (The "leak" fear is particularly prevalent if financing options are being considered.) Alice, Laura, Carol, Donna, and most recently Bob think we need to be reviewing our options because they feel we will be pulled in sooner or later into the deficit/trust fund debate. Moreover, they believe we have to be ready to go almost immediately if the President decides he wishes to move rapidly.

Laura, Carol, Alice, Donna and Bob have a growing desire to hold a meeting with Leon in the very near future to open up a discussion about whether or not any of our health care "vision" recommendations to the President are or should be changing. Primarily, I think they desire such a meeting to make certain everyone is still reading off the same page on this issue. Needless to say, NO such meeting will take place in your absence.

Relative to changing policy views, not much that I have to report will shock you. Having said this, the desire to capture some significant savings to go to deficit reduction seems to be intensifying. In other words, although the December policy options the President chose could achieve roughly $60–80 billion in deficit reduction over 10 years, Laura, Bob and Alice constantly point out how miniscule that amount is relative to the numbers the Republicans are talking about -- over $1 trillion in 7 years. They obviously would like to see much more.

Laura has recently suggested thinking about raising tobacco taxes even higher than the President suggested in December. She advocates an "in for a dime, in for a dollar" strategy and would like to dedicate all savings for coverage expansions through the tax code -- perhaps through the use of a tax credit. (This may be Laura's way of getting some money for coverage, while enabling all -- or virtually all -- of Medicare and Medicaid savings to go for deficit reduction.) Laura, Alice and Donna have asked how much coverage we can buy for an increased tobacco tax; as you will recall, we used about a .45 cent tax increase to pay for our kids benefit. Although this analysis is not done, I am certain it would at least pay for the kids and the temporarily unemployed benefits we have discussed.

Laura's tax credit idea has some political appeal since the media and the Republicans are less likely to call it a big, brand new public spending program. (The downside is we have a good deal of policy work to do if we want to pursue this option and Treasury's tax policy division hates this idea -- like the hate every tax credit idea.) The other downside, of course, is that there are probably few to no people in the political wing of the White House who would seriously contemplate a $1 or so increase -- let alone a one cent increase -- in the tobacco tax.

On the Medicare front, there is growing interest among us policy folks in developing a Medicare managed care proposal for the Administration. Such a proposal could show that the Republicans either "have no clothes" when it comes to their savings claims for Medicare managed care OR that they are going to significantly increase seniors' out-of-pocket costs. In recent meetings with the Group Health Association of America (Karen Ignagni's HMO organization) and AARP, it has become clear that the internal managed care proposal we are working on, which would expand managed care choices and is consistent with GHAA's short-term policy priorities, would receive widespread support. Moreover, Members like Chafee, Graham, Rockefeller and others would be likely want to introduce it.

The advantage of doing this is it illustrates that we want to move forward on expanding Medicare beneficiaries participation in managed care. The difference is that we want to do it the "right" way -- through broadened, not economically forced, choices.

The potential downside is that we might not be very good an defining our message. In other words, the "right" managed care approach might well not be enough of a clear contrast with the Republicans' version of managed care.

I think we need to closely evaluate this option. It might be something we might want to consider having the President offer when he addresses the White House Conference on Aging. If he did it, the contrasting message of "their proposal makes you pay more for choice, mine does not" would likely sell very well. It is also something that could be offered independent of broader reforms since it is neither a budget saver or coster.

On the Medicaid front, if alternative approaches to block grants are not found soon, we will witness a quickly passed Medicaid policy that will eliminate the entitlement and significantly reduce tens of billions of dollars to the program. We are reviewing some ideas that would provide unprecedented flexibility to the states, with the only major limitation being they cannot reduce the total number of covered people; however we continue to have trouble producing a politically viable policy that will preserve the best of the program while still achieving significant savings. We will keep you informed. There is a long OMB Medicaid background document floating around here. If you are interested, we will get you the complete set early next week.

Housekeeping

Jen and I would like to meet with you and Melanne about all of the above at your earliest convenience. We would also like to bring you up-to-date on the White House Conference on Aging, including -- Jen tells me -- the mammography event.

Lastly, in your absence, the President asked for the enclosed memo on a recent Families USA report on prescription drug prices. Speaking of drugs, the manufacturers seem to be relatively pleased with the regulatory reforms that were included in the White House/FDA report that we released yesterday. I mention this because I think the next time you sit next to a drug company CEO, they should be happier with the Agency and the Administration.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Robert E. Rubin to Hillary R. Clinton, re: Business Strategy for Health Care (2 pages)	11/30/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Subject Files, A thru C)
OA/Box Number: 13599

FOLDER TITLE:
Health - Business [1]

Kara Ellis
2006-0810-F
ke1031

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]
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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]

Health - Bus.

THE WHITE HOUSE

WASHINGTON

November 30, 1993

MEMORANDUM FOR HILLARY R. CLINTON

FROM: ROBERT E. RUBIN *for RER*

SUBJECT: **Business Strategy for Health Care**

Since our discussion of the other day, I have seen a number of additional CEOS or others involved in the senior management of large companies.

My impression continues to be that there is almost universal acceptance of the view that Health Care legislation will be enacted this year, and a preponderant view that universal coverage in some form and with some phasing is desirable and/or likely. However, there seems to be an almost equally strong view, however misguided, that our plan is too governmental, too bureaucratic and too risky fiscally, and that future Administrations and Congresses could increase the 1% assessment or otherwise modify our plan adversely. As you and I discussed, these views are both analytic and visceral, the latter reflecting skepticism about government and about Democrats, the former reflecting at least in part misinformation and/or faulty thinking.

One person who consulted extensively with the Administration during the process said that there are three differences from his company's initial understandings: (1) the corporate alliances have unexpected costs, (2) the early retirement provisions are thought likely to be repealed by some later Congress, and (3) the overall financing scheme is viewed as suspect.

I specifically asked two people I knew reasonably well whether there was a program of misinformation to undermine our plan and both said no, but one also observed that the frequent interaction of business leaders could well result in a few active opponents having a magnified effect.

The Cooper bill seems to be where these people are gravitating, even while acknowledging that its current form is incomplete and does not provide universal coverage.

I continue to think that we should be able to win a reasonable number of this constituency, but only with a fair bit of thought about substance and tactics.

Just as one example, the issue can be framed differently: not, do you like our plan better than just proceeding on your own, but rather, what plan is best on the assumption that a universal coverage plan will be enacted. Relatedly, we need to emphasize (a) their risk of losing a carve-out option for large companies, (b) the logic of therefore supporting us early rather than holding back over differences that are small relative to the benefits of the carve-out, and (c) the problems other plans will encounter when details are worked out.
My suggestion, as before, is to have an informal meeting with you, Roger, Ken Brody, me, and two or three sympathetic and trustworthy CEOs, to analyze the negative reactions to our plan and devise a responsive strategy.

There may be better ways to think through this big company problem, but if you want to pursue this suggestion, please let us know, and we'll work out the scheduling (we tried the Tuesday before Thanksgiving, but your schedule didn't work).

I do not think we should pursue the idea of an outside study of our numbers, because the outcome of such studies is always unpredictable. I have heard, in fact, that a study is being done under supposedly reputable auspices -- though I suspect this will be an advocacy document that will disagree markedly with us.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. memo	Harold Ickes to the President, the First Lady, and Leon Panetta, re: Health care (1 page)	09/11/1994	P5
001b. paper	Current situation regarding the health care initiative and possible alternatives (8 pages)	09/11/1994	P5
002. letter	Don Pogue to Hillary Clinton [partial] (1 page)	12/18/1994	P6/b(6)
003. memo	Harold Ickes to the First Lady, re: Proposed TV Ad (1 page)	06/23/1994	P5
004. memo	Harold Ickes to the First Lady, re: Proposed TV Ad (1 page)	06/23/1994	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Subject Files, A thru C)
OA/Box Number: 13599

FOLDER TITLE:
Health - Communitcations, Message [2]

Kara Ellis
2006-0810-F
ke72

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]
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Health- Communications - Message

THE WHITE HOUSE

WASHINGTON

11 September 1994

MEMORANDUM TO THE PRESIDENT
THE FIRST LADY
LEON PANETTA

FROM: HAROLD ICKES HI

SUBJECT: Health care

Attached is an 8 page memo, dated 11 September 1994, about certain aspects of health care. We have concluded a 4 week period of drift which began Friday 19 August, with a 5th week to go, unless averting action is taken.

I strongly suggest a meeting this Monday -- Tuesday at the latest -- to determine what course the President wishes to pursue.

The President is scheduled to meet with Mitchell, Foley and Gephardt at 2:30 p.m. Monday and with a broader group of the Democratic Congressional leadership at 6:00 p.m. on Tuesday.

cc: Pat Griffin
Melanne Verveer

9/11/94

Current situation regarding the health care initiative and possible alternatives

The current drift surrounding the pending health care initiative is becoming increasingly politically untenable and is putting the White House in political jeopardy.

All are awaiting the outcome of the Mitchell-Chafee discussions, but the clock is about to run out. Since Chafee will not return to Washington until Wednesday (14 September), and the Senate is expected to recess beginning late Wednesday until next Monday (19 September), it is unlikely that those discussions will be definitively concluded one way or the other, at the earliest, until the rest of the mainstream Senators return to Washington on 19 September. The House will be back this Monday and Tuesday, but will go out on recess this Wednesday until Tuesday (20 September).

Congress is currently scheduled to adjourn Friday (7 October), although that could slip until the following week.

Although from a legislative point of view, we may well want the Congress to stay in until at least 15 October, from the point of view of the '94 general election, it is critical that Congress adjourn no later than 7 October (many argue that a week earlier would be preferable) to permit them to get distance from the morass of Washington and to permit them to develop their campaigns.

Given the current posture of the health care "debate", it is difficult for the White House to squarely blame the Republicans for the failure to achieve comprehensive health reform. To date there has been only modest debate in the Senate, which has primarily worked to the disadvantage of those pressing for health reform, and, more importantly, there

have been no defining votes that permit the White House and Congressional Democrats to lay blame at the Republican door step.

Although the White House can blame special interests for the inability to achieve health reform, this is a double edged argument, because it implies the President and the Democratic Congress were not strong or skillful enough to overcome the interests.

We decided to let the Mitchell-Chafee discussions go forward, during which the White House position on health care has been (a) that the President continues to fight for health care reform and (b) we are waiting for the conclusion of the Mitchell-Chafee discussions. In short we have been in a long drift since 19 August, unable to say anything else. The result of the past 4 week hiatus (with a 5th week still to go) is that neither the press (which universally declared health care dead by Friday 26 August) nor supporters of health care reform, know where the White House stands. Many suspect the White House is waiting to support a probable unacceptable Mitchell-Chafee deal. Others are at a total loss. Many supporters of reform (including many in Congress) would feel relieved if the process were declared ended for this session.

Given that there are effectively 3 legislative weeks left (19 September to 7 October), unless adjournment slips to 14/15 October, the clock is very much against any health care reform this year -- even a so-called minimalist bill. Such a minimalist bill would conceivably cover all kids, would contain modest, but workable insurance reform (e.g. requiring portability, limits on pre-existing conditions, preventing the insured from being

dropped and preventing unreasonable increases in premiums); and, establishing a bi-partisan commission charged with developing a workable plan to put the country on the path to universal coverage, to be reported to the next session of Congress.

Even if a kids bill were achievable within the next 3 weeks[1], many argue the White House should not be seen as promoting it for 2 reasons: (a) to be seen as a White House initiative will substantially reduce the chances of adoption, and (b) were it to fail, it would be one more defeat for the White House.

There are a number of other complications: Dole is reliably reported as developing a modest reform proposal which he and House leaders may introduce when Congress reconvenes, thereby possibly putting the Democrats in a box and on the defensive. In addition, no one (the President, Mitchell or Foley/Gephardt) wants to be the first to declare health care dead for this session -- although weeks ago the press and many others had declared that to be the case. Moreover, the House is in political turmoil, if not complete chaos, regarding health care, and given the pending Gephardt bill, the other legislation yet to be considered, recent statements by single payer McDermott, and other factors, it is doubtful, as of the date of this memo, whether the House has the political will to consider

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[1] There are substantial pieces of pending legislation to be dealt with in the 3-4 remaining legislative weeks: GATT, campaign finance; lobbying reform; superfund; congressional reform; communications; mining reform; banking reform.

In addition, the Haitian situation hovers over all Administration and congressional activity.

and adopt even a modest "kids" bill. Then there are the wide spread reports from members on recess that there is little, if any, pressure in the districts for health reform this year. Not to be forgotten is the President's veto pledge, and how that will intersect with any proposed action, especially action promoted by him. Finally, and perhaps most critical, is the Haitian situation which may completely divert the Congress from any further serious consideration of health reform.

Although it certainly appears that comprehensive health reform is unattainable this session, many continue to strongly urge that a "kids" bill, described above, can be achieved, that it will greatly benefit the country, that it will chart the course for additional legislation toward universal coverage, that it will greatly benefit Democrats in the upcoming midterm elections, that it will benefit the President politically in 1996, even if additional health reform legislation is not enacted by then, and if it is not passed, it will at least unmask the Republicans and permit the White House and the Congressional Democrats to finger them as responsible for the failure to achieve health reform.

Others argue that given the legislative clock and the political situation in the Senate and the House, it is virtually impossible to achieve enactment of a "kids" bill and that the health care debate should be cut short and ended.

In any event, it is critical that we decide on an "exit" strategy early this week. The drift and indecision must be brought to an end. The President must be seen as having taken charge of the process. And hopefully the "exit" will (a) reduce the finger pointing at the

White House, in particular, and Democrats, in general, as the ones who screwed up the chances of any health care reform; (b) shift some blame to the Republicans, rather than to Congress as a whole; (c) prevent the Republicans from outflanking the Democrats in the remaining weeks with their own modest "health reform" proposal ; and (d) hopefully (although unlikely) permit Congress to initiate and adopt a very modest kids-insurance reform - Commission bill that works.

There are several options including:

1. Let the Mitchell-Chafee discussions conclude:

   - If successful, they may produce a bill:

     . That neither the President nor many on the left in the Senate, nor many support groups will be able to support, which would put the President, in particular, on the spot.

     . That will be supported by only 52-55 Senators, which, given the shortness of the remaining legislative session, will permit the Republicans to kill it merely by legitimate sounding debate without a filibuster, thereby preclude fingering the Republicans as killing health care reform.

     . That, even if adopted, will be unacceptable to the House.

     . That given the lack of time remaining, will preclude the Senate from considering a "kids" bill currently being promoted by Harkin, et al., or something similar.

   - If Mitchell-Chafee are unsuccessful:

     . Permits Mitchell to go forward with his pending bill, or to declare health reform unattainable this session.

. Permits the Senate to consider a "kids" bill.

2. Ask Mitchell to terminate his discussions with Chafee this week and try to move a "kids" bill:

- Mitchell may be unwilling to do this since it may cause great political embarrassment to Chafee.

- But it would permit Mitchell either to declare health reform not achievable this session or to continue the debate of his pending bill, or to consider a "kids" bill, thereby precluding Dole, et al. from doing something along those lines, which would permit the Republicans to put the Democrats in a box and on the defensive.

- There are several rumors that Dole, at least, is considering offering a "kids" bill.

- If the goal were to try to have Congress adopt a "kids" bill, coordination between the Senate and House would probably be necessary as well as a strong behind the scenes push by the White House.

- At the very least, having the Democrats move a "kids" bill would put the Democrats in a stronger offensive position, precluding the Republicans from offering similar legislation first - thereby putting the Democrats in a box and on the defensive. If the Republicans vote against a "kids" bill, it unmasks them for what they are and permits the White House and Congressional Democrats to place the blame.

- Based on our conversations with top House staff last week, it is very far from clear, whether the House is able to get a majority for a "kids" bill -- but the attitude of the House may change in this regard depending on action by the Senate.

3. Ask Mitchell to terminate his discussions with Chafee and call for a hard vote on his pending bill (e.g., on the mandate or similar very controversial issue), which would probably lose but which would hopefully force the Republicans into the open about their opposition to any reform:

- Mitchell may be unwilling to take this course.

- Mitchell may well be unwilling to have health care die in the Senate.

- Some in the White House argue strongly against taking a losing vote.

- This would permit the President to take the very credible position that he had fought to the bitter end but he will be back next year and, most importantly, that the Republicans sealed health care's death this session.

- Given that comprehensive reform has been declared dead by the press and many others, to revive debate on the pending Mitchell bill and move for a vote on a difficult but hopefully defining issue, may take great political effort and runs the risk of being characterized as somewhat goofy.

4. Let Mitchell-Chafee discussions continue but urge the House to put together a "kids" bill and attempt to pass it:

   - The politics of the House are very confused and difficult, at best. McDermott, representing many single payers, recently said comprehensive reform was unattainable this session and that his group wouldn't vote for anything less. Reliable information is, however, that Waxman and other liberals want to try to get a modest bill out this session.

   - The House is unlikely to be able to act until resolution in the Senate.

5. The President and the Democratic legislative leaders meet this week, at the end of which they all declare health reform unattainable this year, but will continue the fight the next session.

   - The President should probably do an Oval office speech explaining to the American people what he attempted to achieve, what went wrong, that he will carry on the fight for health reform, but he will not continue to engage in a process that would result in legislation detrimental to the country. (NOTE: Absent other overriding factors, the President may well want to give such a speech no matter which course of action is chosen.)

- This course of action will not permit the White House/Congressional Democrats to lay blame squarely on the Republicans.

6. Let the current process continue dribbling away to oblivion to the end of the session:

- Unless the White House forces action to avert the current process, this is a distinct likelihood.

- To permit the status quo to continue will further permit the Republicans to lay entire blame on the White House/Democrats, and will further jeopardize the political standing of the President and Congressional Democrats. In addition it opens the door to a Republican initiative for modest reform.

THE WHITE HOUSE

WASHINGTON

~~CONFIDENTIAL~~

MEMORANDUM FOR THE FIRST LADY
FROM: HAROLD ICKES
DATE: JUNE 23, 1994
RE: PROPOSED TV AD

Attached are copies of the drafts for the proposed TV ads we heard on Tuesday evening. As I will explain to you in person, Roy's name must be kept out of this. Harry Thomason will probably produce the Harry & Louise and Father knows Best, in consultation with Roy.

Please call when you want to discuss.

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THE WHITE HOUSE

WASHINGTON

~~CONFIDENTIAL~~

DETERMINED TO BE AN ADMINISTRATIVE MARKING
INITIALS: KDE DATE: 06/01/09
2006-0810-F

MEMORANDUM FOR THE FIRST LADY
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Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Harold Ickes to the President and the First Lady, re: Tonight's meeting about health care legislative strategy (2 pages)	06/19/1994	P5
002. memo	Ira C. Magaziner to President Bill Clinton, Hillary Rodham Clinton, and Harold Ickes, re: Slimmed Down Health Plan (7 pages)	06/28/1994	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Subject Fiels, H thru N)
OA/Box Number: 13601

FOLDER TITLE:
Health - Legislative Strategy and Status Reports

Kara Ellis
2006-0810-F
ke1033

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]
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THE WHITE HOUSE

WASHINGTON

19 June 1994

MEMORANDUM TO THE PRESIDENT AND THE FIRST LADY

FROM: HAROLD ICKES (HI)

SUBJECT: Tonight's meeting about health care legislative strategy

Attached is a memorandum, dated 6/29/94, captioned "Possible alternatives for health care legislative strategy with special focus on Senate Finance Committee".

Unless you instruct me otherwise, this memo will not be distributed to anyone at the meeting other than to Pat Griffin.

The purpose of the meeting is to discuss the current legislative situation, especially regarding Senate Finance and Ways and Means. Hopefully at the end of the meeting the President will be in a position to indicate how he wants the Administration to proceed (and the message from the Administration regarding the legislative process) over the next weeks regarding legislative strategy and activity.

There are differences among the group meeting tonight on how best to proceed. Some are for adopting the recommendation in the attached memo. Others are inclined to try making a deal now (which might include both the House and Senate) based on a soft trigger/fast track mechanism.

We are in a very critical stage of the legislative process. It is extremely important the **all** members of the Administration

know what the President wants and that all of us stick to that message and strategy.

Also attached are 2 one page memos, the first one captioned "Universal coverage - why?". The second is uncaptioned.

The "Universal coverage - why?" memo, drafted at my request by Laura Quinn, strongly urges that "universal coverage" must be linked to the security and protection of working middle class families and the principle of rewarding work. In short, this memo urges that we should focus on establishing to the Congress and the media that the President's initiative will ensure that all working American families will be covered and that working Americans who now have health benefits will be secure that they no longer run the risk of losing those benefits in the future. Conversely, those against universal coverage are against the interests of working American families.

THE WHITE HOUSE

WASHINGTON

June 28, 1994

MEMORANDUM TO PRESIDENT BILL CLINTON
HILLARY RODHAM CLINTON
HAROLD ICKES

FROM: IRA C. MAGAZINER

SUBJ: SLIMMED DOWN HEALTH PLAN

This memo responds to the President's request for an update on discussions with Leaders Gephardt and Mitchell on a revised health bill which meets the President's goals, but also meets public concerns about our original bill. Before the President introduced health reform to the nation last September, we talked about the inevitable fact that the bill would undergo substantial revisions as it went through Congress. This is why we proposed emphasizing principles in the President's speech rather than standing behind the details in the bill.

As the debate has proceeded, we have developed alternative approaches in concert with congressional leaders to reach our goals of universal coverage and cost containment. Much of the criticism we have endured is unfair, but we must acknowledge that we have lost the communications battle on many fronts.

Hopefully, Leaders Gephardt and Mitchell will be in position to introduce bills to the Floor that fall within this general framework. When we re-launch a bill for the Floor, we should announce that we have heard the American people and modified our original bill to be smaller in scope, more gradual, less bureaucratic and less regulatory.

We should highlight the following changes:

- Deficit reduction
- Voluntary instead of mandatory alliances
- Less onerous mandates: hard triggers; slower phase-in
- No premium caps: cost control which protects the government
- Streamlining/simplification
- Increased support for academic health centers

DEFICIT REDUCTION

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

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

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

Lowering the Size of Firms Within the Community Rate Which Pay the One Percent Assessment of Payroll: Under the Health Security Act, firms outside the community rate pay an assessment of one percent to offset savings they receive from universal coverage. Lowering the size threshold for firms outside the community rate increases the revenues raised by the corporate assessment.

VOLUNTARY INSTEAD OF MANDATORY ALLIANCES

The original Cooper/Breaux/Boren bill mandated all firms with 1,000 employees or fewer, all government workers, all self-employed people and all nonworkers to buy health insurance through exclusive regional purchasing cooperatives. States had the option to raise the requirement to firms with 10,000 or less employees. We adopted this idea and set ours

at 5,000 assuming we would have to reduce the number.

We lost the communications battle for mandatory alliances early. We developed a voluntary alliance model that preserves the functions of alliances (community rating, greater purchasing leverage, family choice, administrative simplification) for the Kennedy, Dingell, Ford, Mitchell, and Gephardt approaches. Ironically, it is more bureaucratic than mandatory alliances, involving more regulation by state insurance departments and other agencies, but it is workable and at this point, is easier to sell to the public.

Community Rating: The Kennedy, Ford and Dingell committees, under pressure from business groups and insurance lobbies have lowered the size at which firms are required to participate in a community rating pool, from firms with 5,000 workers or fewer to 1,000 workers or fewer. The lower the threshold, the more opportunity there is for insurance companies to compete on risk selection and the higher the premium for firms and individuals within the community rate. The Ways and Means Committee has passed an amendment to reduce the threshold to firms with 100 employees or fewer. We think going below 500 is not desirable, but could make 100 work if it becomes absolutely necessary.

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

Administrative Functions: Administrative costs are still streamlined in most bills through the creation of centralized clearinghouses which collect and administer premiums and subsidies, much as the alliance did under the Health Security Act.

LESS ONEROUS MANDATES

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

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

Due to the political reality that employer mandates have lost ground in the debate, we have developed ways to use hard triggers and partial exemptions for small businesses of 20 or fewer employees or a combination of both. These policies are tricky and run the risk of short-term adverse consequences, but could be workable if designed properly.

Slower Phase-in: Some have proposed delaying universal coverage until 2000 or beyond. Achieving coverage by 2000 is something we could support, but would not recommend delaying much beyond that. If we delayed until 2000, we would recommend strategies to demonstrate progress toward universal coverage before then: for instance, covering all children by 1997 or 1998; or requiring that all businesses above 1,000 employees cover their employees by 1997 or 1998.

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

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

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

Phased-in Benefits: To reduce financial risk for the government, a "catastrophic" type benefit package could be used for the uninsured during a phase-in period.

NO PREMIUM CAPS

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

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

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

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

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

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

Bradley Approach: This replaces premium caps with targets set by the National Board. Health plans which bid higher than the target premium in their region are taxed to cover the increased cost of the federal subsidies created by their high bids. The approach encourages plans to bid at or below the target and encourages employers and families to choose lower-cost plans by raising the price of the higher-cost plans. This approach has some significant drawbacks. It requires a large, explicit tax on high-cost plans. It's administratively complex. And, depending upon the way it was structured, it could allow private premiums to increase so much that a universal coverage trigger might never be pulled.

Opening the FEHBP Pool: Costs could be controlled if the FEHBP was opened to a broader universe of people and if it had the tools and the responsibility to hold down

health plan premiums. Federal subsidies would be pegged to the constrained rate of growth in the FEHBP. A premium constrained FEHBP could increase cost shifting to those outside its pool and it might have difficulty attracting insurers to offer plans at its constrained rate. But with sufficient regulation, an option like this could work. Ways and Means is considering a similar measure using Medicare price controls instead of premium caps.

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

STREAMLINING/SIMPLIFICATION

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

Eliminate Boards and Committees: Our bill has suffered from the label of "big government", in part because it includes dozens of boards and committees. These were established mainly at the request of HHS. We should remove a series of these from our bill.

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

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

INCREASED SUPPORT FOR ACADEMIC HEALTH CENTERS

The Labor and Human Resources committee bill substantially increases the dedicated pools for medical training and creates a dedicated fund for biomedical research.

We expect and would support additional funds going to academic health centers and biomedical research beyond what was originally proposed in the Health Security Act.

These and similar changes could produce workable bills which are worth fighting for. The changes are significant enough to be meaningful, though our adversaries will claim that we have not changed enough.

Majority Leader Gephardt has indicated that a bill like this could pass the House. If we fight for it in the Senate, I believe we have a chance to gain a majority for a bill like this in the Senate.

The alternative is to admit defeat and see the health care fight turned into a route. I do not believe that the Republicans will allow a universal coverage compromise that has a chance of success unless we can succeed in turning the public debate back on them around a re-launched bill.

We may not win the fight if we wage it, but we will be in a stronger position to negotiate if we do fight than if we simply admit defeat.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings and Steve Edelstein to Hillary Rodham Clinton, re: Meetings with Senators Leahy and Pryor (2 pages)	06/14/1993	P5
002. memo	Mike Lux to Hillary Rodham Clinton, re: Recommendations on Medical Malpractice Tort Reform (4 pages)	04/21/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Subject Files, H thru N)
OA/Box Number: 13601

FOLDER TITLE:
Health - Malpractice [4]

Kara Ellis
2006-0810-F
ke1034

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]
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P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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

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~~PRIVILEGED AND CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton June 14, 1993
FR: Chris Jennings, Steve Edelstein
RE: Meeting with Senators Leahy and Pryor
cc: Melanne, Steve, Distribution

Tomorrow you are scheduled to meet with Senators Leahy and Pryor. Escorting them will be Theresa Alberghini, Senator Leahy's health legislative assistant; Theresa Forster, the new Staff Director of Senator Pryor's Aging Committee; and Bonnie Hogue, another Aging Committee staffer.

BACKGROUND

This is a meeting that Senator Leahy has wanted for some time. He has been growing increasingly frustrated over the fact that Senator Jeffords has been receiving disproportionate, as well as favorable, coverage in the Vermont press on health care. Much of this stems from statements by Jeffords that his bill is identical to the bill that he perceives the Administration is crafting. It is also because Jefford's office has publicized any meeting he has held with you or the staff of the White House.

The stated purpose of this meeting is to conduct a discussion with you about the need and desire for state flexibility within the context of national health reform. The desired outcome of this meeting, however, has more to do with illustrating how Senator Leahy has access to you and the White House. It will also give you an opportunity to recognize his (and Senator Pryor's) longstanding work on state-based health reform and the important contribution his past legislation has made to the debate. (As cynical as the above sounds, Senator Leahy's continued strong support of the President's positions on the economic package and health care do merit appreciation.)

Senator Leahy does not have a long-standing history on health issues. To the extent he has been involved, it has mostly been in the area of rural health. His last year's introduction (with Senator Pryor) of S. 3180, the State Care Act, represented his first venture into the national health reform scene. This bill provided for Medicare, Medicaid, and ERISA waivers to states that enact legislation providing universal coverage and cost containment. Then-Governor and Presidential candidate Bill Clinton endorsed this legislation in a letter to Senator Pryor. Attached for your review is a copy of this letter as well as a summary and other background materials on this legislation.

Senator Leahy invited Senator Pryor to participate, in part, because he felt it would increase the likelihood of a meeting but also because Senator Pryor was interested in attending. The meeting will likely revolve around the following issues:

1. **State Flexibility.** Senator Leahy will want to thank you for your continuing assurances that the Administration's proposal will have adequate flexibility for the states to design their own plans which best meet their needs and preferences.

2. **Reintroduction of Bill.** Senator Leahy has held off on reintroducing his state reform initiative, so as not to send the wrong signal on the prospects for reform. However, should reform efforts stall, he will be under increasing pressure from his state to reintroduce this bill. He may wish to discuss this matter with you.

3. **Politics and Communications.** The meeting is unlikely to involve detailed discussions of state-based initiatives. Instead, the Senators will be more interested in discussing the politics of health reform, their views on timing, and communications strategy. I expect that Senator Pryor will be especially interested in addressing these issues. You may want to talk to Senator Pryor about his recent idea to host meetings with Republicans interested in health reform and Administration representatives to discuss health care in a less "pre-arranged" setting.

Lastly, a reminder: Senator Leahy will precede you in addressing the Democratic Governors Association meeting in Vermont on Saturday. (He will be preceded by Governor Dean.) Senator Leahy (and possibly his wife and his staffer) is planning on flying with you to Vermont. We are working on last second details as the memo is being written.

malpractice

THE WHITE HOUSE

WASHINGTON

CORRECTED VERSION

~~**PRIVILEGED AND CONFIDENTIAL**~~

April 21, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

SUBJECT: Recommendations on Medical Malpractice Tort Reform

FROM: Mike Lux

cc: Bob Boorstin
Chris Jennings
Ira Magaziner
Vince Foster

The tort reform working group has met to discuss the political and policy options. Based on the group's discussions, this memo represents my recommendations as to the best path to take on this politically thorny issue.

Political Review

This issue is one of the most troubling from a political point of view because of the closely balanced interests on each side of the issue. On the side of tough tort reforms - including a cap on non-economic damage, a limit on contingency fees, and binding arbitration of lawsuits - are the following:

- Given what we will be asking providers to give up, we need to offer them some high profile, tangible benefits. While the reduction in paperwork and micro-management is a bigger day to day benefit, there is nothing as symbolically powerful as tough tort reforms.

- While this doesn't effect business directly, ideologically tort reform is very appealing to business leaders as well, and clearly helps us win their support.

- From a communications point of view, we can't ask sacrifices from everyone else in the system without asking lawyers to give up something as well. And given public perceptions, lawyers make a great rhetorical opponent.

- Given that we have been promising for a year tort reform would be a component of our health reform package, we will be bitterly attacked in the provider community for not delivering a tough package.

On the other side are some equally powerful arguments:

- On some of the key issues, consumer groups feel just as strongly as lawyers and would fight a tough package vehemently. And we need consumer groups fully on board with the total package: our polling shows them to be the most credible group with the general public on the health reform issue.

- Lawyers and consumers have beaten back twelve years of determined frontal assaults on tort reform by Reagan and Bush. Absent something truly remarkable happening, we would likely lose to them in Congress as well.

- This issue is especially harmful because unlike many other tough issues, it fundamentally divides the Democratic base and causes us major damage with many key Senators and Congresspeople.

- Aside from the health reform battle, this issue can obviously cause us and the Democratic Party a great deal of long term damage. Trial lawyers and consumer groups have been a key part of our electoral and governing coalition to date.

The one bit of good news in this area is that the trial lawyers have begrudgingly dropped their deep seated historic opposition to any federal tampering with tort reform. Both they and consumers appear ready to accept the following in this area:

- making all law suits against health plans, instead of individual providers.

- setting up practice guidelines/standards of care, so that if a provider follows those standards, a lawsuit could be thrown out.

- requiring a doctor's affidavit explaining how a procedure was done wrong before a lawsuit can be filed.

- requiring that contestants try to resolve things through mediation before going to court.

Major Points of Contention

That leaves us with three big points of contention:

1. Binding arbitration to keep lawsuits from going to court.

2. A sliding scale contingency fee limitation.

3. A cap on non-economic damages.

Unfortunately, all of these are highly charged symbolic and substantive issues to everyone concerned.

Options

There are three viable political/policy options - one at either extreme and something in the middle. The two at the extreme:

OPTION A: Make all three of the above listed points of contention a part of our package, and run full scale against lawyers as one of our big rhetorical enemies. Our best case scenario here is that consumers and the trial lawyers allies in Congress oppose us on this issue, but still help us on the overall plan - we'd certainly want to explore that ahead of time if we choose this option. From a communications perspective this is a very appealing option, but politically it's a great deal more troubling.

OPTION B: Do none of the three above mentioned points of contention, but aggressively argue that our chosen malpractice tort reforms were sweeping enough to create real change. The providers would no doubt vehemently argue otherwise.

A middle option, which we are recommending, would be the following:

OPTION C:

Issue 1. Not have binding arbitration as the final step in a malpractice dispute, but make it binding that people go through mediation or arbitration before filing a lawsuit, and perhaps with incentives for both parties to settle early. Allow the jury to know what the non-binding arbitration judgement was before making their decision.

Issue 2. Institute a sliding scale contingency fee limitation, but try to negotiate something acceptable in advance with lawyers so we don't go to war. Unless we do something draconian, I don't think consumer groups would object to doing something in this area.

Issue 3. No cap on damages.

This combination allows us to avoid a holy war with lawyers and consumer groups on their most important issue, caps, while asking for a real sacrifice from the lawyers. If the lawyers do decide to fight us on that narrow issue, I think they would have a very tough time making their case to the public: they really would sound like greedy lawyers. For that reason, I think they will negotiate with us. Providers wouldn't be happy with the lack of caps, but would appreciate our limiting lawyers fees as well as their own.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Arthur D. Ullian to Shirley Sagawa [partial] (1 page)	07/09/1993	P6/b(6)
002. memo	Dawn M. Friedkin to Hillary Rodham Clinton re: Meeting (3 pages)	04/27/1993	P6/b(6)
003a. memo	Shirley Sagawa to Hillary Rodham Clinton, re: Research funding for neurological disorders [partial] (1 page)	06/01/1993	P5
003b. letter	Shawn A. Friedkin to Hillary Rodham Clinton [partial] (1 page)	05/25/1993	P6/b(6)
003c. list	List of attachments [partial] (1 page)	05/25/1993	P6/b(6)
004. letter	Wise Young to the Honorable Tom Harkin [partial] (2 pages)	05/03/1993	P6/b(6)
005. letter	Arthur D. Ullian and Shawn Friedkin to Dr. Phillip Lee [partial] (1 page)	07/23/1993	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Subject Files, H thru N)
OA/Box Number: 13601

FOLDER TITLE:
HEALTH - NINDS [National Institute of Neurological Disorders and Stroke]

Kara Ellis
2006-0810-F
ke91

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]
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MEMORANDUM

To: Hillary Rodham Clinton

From: Shirley Sagawa

Re: Research funding for neurological disorders

Date: June 1, 1993

Attached is a memo from Lynn Margherio discussing research funding in the Health Care Reform bill. Clearly we can ensure that some funding is earmarked for research on neurological disorders as Shawn Friedkin suggests. Of course, there are many competing demands in the research funding -- from breast cancer to AIDS. Chris Jennings thinks that the advocates for research on neurological disorders would be happy with $100 million in additional funds (the Institute received a slight cut in this year's budget). Unless you suggest a different approach, I will continue to work with the health care staff to see that this amount is earmarked.

little attached
Shirley does not think it is
necessary for you to have
another meeting with him
as he requests.
$
Pam

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Stan Greenberg to President Bill Clinton, et al., re: Democrats - 1994 (3 pages)	06/13/1994	P5

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Health - Polling [Folder 1] [5]

Kara Ellis
2006-0810-F
kel035

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GREENBERG RESEARCH INC

516 SECOND STREET NE
WASHINGTON DC 20002
TEL 202 547-3200
FAX 202 544-7020

Date: June 13, 1994

To: President Bill Clinton (1)
Vice President Al Gore (2)
Hillary Rodham Clinton (3)
Tipper Gore (4)
Mack McLarty (5)
George Stephanopoulos (6)
David Gergen (7)
Harold Ickes (8)

From: Stan Greenberg (9)

RE: DEMOCRATS – 1994
Part Two: Taking Charge of the Agenda

To break through the current cynicism, we need a dramatic end-game that deals with our current realities. Up until now, everyone has tied the Democrats' fate to passing health care which, we hope, will change the mood of the country, much as NAFTA did last year. But that approach leaves us hanging in the air, with the members increasingly nervous, without a scenario if health care loses. Meanwhile, the Republicans seem to be holding the cards and controlling the discourse. There is a new confidence on their side of the aisle that they can stop health care and watch the public punish the Democrats for failing.

I want to propose a new way of thinking about this end-game that puts us back in control of the debate. It provides for the possibility of "winning," even if health care does not pass, but also increases the probability that we win health care in the end. To work, this scenario needs a powerful Presidential address at the front-end and welfare reform at the back-end to show that Democrats are fighting and winning for people.

Let me suggest a series of steps, consistent with the survey research and the analysis above, that would allow the administration and our Democratic candidates to be more assertive and positive, to show a fighting spirit and sense of accomplishment.

- **Creating a Leadership Bill.** Develop a moderate, universal health insurance bill in the House to take to the floor and prepare to take the same or a similar bill to the floor in the Senate, by-passing the Finance Committee. (If that threat leads to positive action in the Finance Committee, all the better.)

- **Presidential Address** (Joint Session or Oval.) The President describes the new moderate approach to health care reform -- non-bureaucratic, responsible checks on spending, phase-in, preservation of quality, small business protected and universal (with trigger). He compliments the congressional committees that did serious work; he compliments the Republicans on seriousness and declares health care must pass with support from both parties; this new bill is responsive to criticisms and constructive debate. The President announces that he will take this new bill that achieves real health care reform to the House and Senate. If Republicans choose to filibuster in July or August, the President says he will try to win Republican votes, but if not, he will pull the bill and go to the country in November. (This re-launch period is very important because we must use it to redefine our bill and to put the Republicans on the defensive.)

- **House Action.** Passes the President's bill (perhaps with some Republican votes -- many of whom will expect the Senate Republicans to kill the bill, thus making this the final opportunity to cast a pro-health care vote.)

- **The Senate Filibuster.** The spotlight will be on the Senate in late July or August, given Dole's threat and the President's statement that he will pull the bill and go to the people. The Senate goes into special round-the-clock sessions further dramatizing the filibuster. If the Republicans succeed in blocking action, the President pulls the bill and prepares for the November fight. (If we have succeeded in gaining the upper-hand with the public, this threat might well lead a number of Republicans to break rank and make possible passage of a real bill.)

- **Welfare Reform.** Move immediately to pass welfare reform before the end of session. This would be the most dramatic step Congress could take and could produce a result similar to the passage of NAFTA. This is the Clinton promise that matters most to voters and will capture the public's attention. It will enable voters to see what has been accomplished and will lead them to pay attention to other

actions, like Re-employment or GATT). It is the passage of welfare that enable us to go into 1994 as moderates and with a sense of accomplishment, even as we do battle on health care. (If we end with the health care filibuster, voters might conclude on too negative a note and conclude Democrats and Clinton cannot move the country forward.)

- Health Care: Final Chapter. If our strategy is successful in defining the new bill and in highlighting the Republican filibuster, the Senate Republicans may come back to the table before the end of session to produce a compromise bill.

Welfare provides the end-drama that allows people to get by their cynicism about gridlock. Democrats can go into this election with a strong economy, deficit reduction, a strong anti-crime program, lobby reform and welfare reform (and perhaps GATT and Re-employment). Members of Congress can run for re-election as people who fight and win, as moderates on health care, who are prepared to take on the Republicans who will not allow the country to go forward.

CC:
Pat Griffin (10)
Maggie Williams (11)
Paul Begala (12)
Mandy Grunwald (13)

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Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. memo	Mack McLarty to Ira Magaziner, re: Response To Your "Where We Are Positioned" Memorandum Of October 1 (1 page)	10/14/1993	P5
001b. memo	Ira C. Magaziner to President Clinton and Hillary Rodham Clinton, re: Where We Are Positioned (4 pages)	10/01/1993	P5
002. memo	Patrick Griffin, Susan Brophy, and Steve Ricchetti to the President, re: Plan for Congressional Contact (4 pages)	02/09/1994	P5
003. memo	Norm Ornstein to [Hillary Rodham Clinton], re: Congress and Health Care (7 pages)	11/27/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Subject Files, P thru Z)
OA/Box Number: 13602

FOLDER TITLE:
Health - Positioning

Kara Ellis
2006-0810-F
ke1036

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]
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re-positioning f

THE WHITE HOUSE

WASHINGTON

OCTOBER 14, 1993

~~PERSONAL & CONFIDENTIAL~~

MEMORANDUM FOR IRA MAGAZINER

FROM: MACK McLARTY

SUBJECT: RESPONSE TO YOUR "WHERE WE ARE POSITIONED" MEMORANDUM OF OCTOBER 1

Your memorandum regarding our health care positioning is extremely well done in my opinion, and reflects your insight and political acumen with respect to this critical matter.

I would like to discuss this with you in more detail. Perhaps we can get together after one of our frequent health care meetings.

cc: The First Lady
Maggie Williams

P.S. It would be helpful to me if I knew who else received copies of what I think would be a relatively confidential memorandum. I want to limit my comments about this memorandum to those who received it.

October 1, 1993

MEMORANDUM FOR PRESIDENT CLINTON
HILLARY RODHAM CLINTON

FROM: IRA C. MAGAZINER

SUBJECT: WHERE WE ARE POSITIONED

In my former life as a corporate strategist, it was always important to think backward from the "end game" when setting positions at the outset of negotiations. This often involves putting "in play" proposals which are extreme and are designed to be modified as concessions.

As the dust settles from our introduction, I am increasingly confident that we are positioned correctly for the political discussions ahead.

The overriding political factors necessary for success are:

1. A clear understanding by the public, the Congress and the interest groups that the President is serious about fighting "all out" for health care reform and will not compromise on key principles.

2. A clear sense that we are willing to listen and modify our views on the details as we hear better ideas -- a sense of humility, that we don't know all the answers, we know we are doing something of large scale and that we must therefore be cautious in our approach.

Our challenge has been to span a very broad chasm between single payers and pure managed competition advocates, without falling to oblivion. Had we proposed bare bones benefits for universal coverage or a slow phase-in, liberals would have deserted us. Had we opted for a broad based tax to finance coverage, moderate Republicans and conservative Democrats would be in rebellion. Financing by employer/employee mandate, a sin tax and slowing the rate of growth in costs is both good policy and the best initial political position. I would rather fight a debate with economists about how fast system growth can be slowed than to be accused of "copping out on universal coverage" or being a "tax and spend" Democrat.

This approach led us to a series of additional policy steps to solidify our footing on both sides of the chasm:

- Generous small business discounts to make the mandate affordable.
- A Medicare drug benefit and a good long-term care package to make the Medicare and Medicaid savings possible for the AARP, NCSC, etc. to support.
- The early retiree discounts to solidify large business, labor, senior and state and local government support.
- The 10 year maintenance of tax deductibility as a compromise between managed competition advocates and those with good benefits today.
- The integration of Medicaid into the alliances and the essential provider provisions to assure urban and rural underserved constituencies that capping the rate of growth in Medicaid and Medicare will not hurt them.
- Enforceable private sector caps to go along with Medicare and Medicaid caps -- to avoid cost shift and make entitlements caps acceptable to liberals and private caps acceptable to conservatives.
- Alliances that are large but not too regulatory to bridge the gap between managed competition and single payer advocates.
- Incentives for primary care, administrative simplification and anti-trust relief to hold strong support among many provider groups.
- A malpractice reform which is okay with consumer groups and approaches (if not quite meets) the acceptable range for provider groups.
- A single payer state option to make competition as a national approach tolerable to single payer advocates.

By constructing our package to have "movable parts" and being flexible, we are in a good position to proceed through negotiations on "the Hill," feeling our way to the right mix of "parts" for the majority we need.

The policy we introduce in two weeks should fundamentally not change, though some adjustments are necessary where we have missed the mark.

There are a few hundred detailed suggestions for policy improvements which we should incorporate into the book. I will forward them to you. In addition, we should write the book differently to be clearer and include background and rationale material.

There are only a few major policy changes I would recommend:

- The plan sounds and is too regulatory. We need to remove some of the powers of HHS, the Board and the Alliances. I will forward a list of suggestions.
- We need to smooth out the small business discount schedule.
- We need to spell out the ways patients and doctors will have more choice.
- We should create a consortium of medical schools and academic health centers to be the organizers of the quality system rather than the federal government.

We should announce these and many of the smaller changes so that people know that we are listening and are flexible. The changes should be presented as examples that the Administration listens and responds, not as defeats or retreats.

On financing, we should promote the idea that there are "movable modules" in the plan which we can discuss, as long as our fundamental principles are met.

- Size of Medicaid savings.
- Size of Medicare savings.
- Amount of deficit reduction.
- Rate of growth allowable for private sector caps.
- Phase-in of drug benefit.
- Phase-in and size of long-term care program.
- Phase-in of universal coverage.
- Size of tobacco tax.
- Size of corporate assessment.
- Discount generosity to small business.

- Discount generosity for early retirees.
- Discount generosity for families.

There is plenty of room for us to modify our "going in" proposals as we gain a sense of thoughts in Congress.

At the end of the day, we must get the Republicans and conservative Democrats to agree to real universal coverage in a reasonable period of time which means the employer/employee mandate; we must have some type of budget cap on the private sector; we must eliminate competition based on risk pools; and we must have some Medicare drug and long-term care programs.

To achieve consensus, we may have to agree to make our alliances smaller, to phase-in long-term care and the drug benefit, tied to realized savings (but we cannot make universal coverage contingent), to lesson our Medicare savings, to phase-in universal coverage and the drug benefit a little slower; to loosen our private sector budget somewhat both in phase down and enforcement; and to do more on malpractice.

For now, we should argue our current positions but be open and listen. As the "lay of the land" becomes apparent, we should discuss when to make our moves.

We probably should assemble a small group to meet a few times a week to discuss strategy as the situation unfolds.

H - ~~Congress~~ Positioning

To The First Lady From Mack

THE WHITE HOUSE

WASHINGTON

Desk
Pat
earlier

February 9, 1994

MEMORANDUM FOR THE PRESIDENT

FROM: Patrick Griffin
Susan Brophy
Steve Ricchetti

SUBJECT: Plan for Congressional Contact

The following is a plan for Member contact for the President. We have broken Members down into four categories: those who are consistent supporters of the President who require additional attention from the President; those who we want cultivated as the President's core supporters who are prepared to "walk through the fire with us"; those who require individual attention; and finally a list of members who are targeted because they have been identified as swing votes on health care and other issues.

In each category we are recommending specific activities, timetables and frequency of contact.

A. Consistent Supporters

There are 187 Members of the House and Senate who have supported the President on his major initiatives. (List attached)

We believe a strategy to engage these Members more frequently and in a social setting will continue to ensure their loyalty to the President.

We are recommending two sets of activities:

1. Five dinners with 40 Members and their spouses at each. It will require five weeks, one dinner per week, to accomplish our goal of inviting the President's most loyal supporters to the White House for a social function.

2. We also believe that these social events should be coupled with small substantive meetings with the President to establish an ongoing dialogue about the Administration's priorities. We recommend eleven meetings (one hour), with a maximum of fifteen Members in each, over the course of the next three months (one per week).

B. Fire Walkers

We are suggesting that the President develop a core group of supporters, upon whose advise and assistance he can rely over the long term. We have identified eleven Members of the Senate and thirty seven House Members with whom we believe the President can build durable and sustained personal relationships. This group will serve as the foundation of the President's support in Congress and will help the President be better informed about what is achievable legislatively.

Senators include: Mitchell, Ford, Daschle, Breaux, Rockefeller, Leahy, Pryor, Boxer, Dodd, Hollings and Reid. House Members include: House leadership (Foley, Gephardt, Bonior, Hoyer, Fazio, Kennelly, Derrick, Lewis and Richardson) and the following others - Eshoo, Durbin, Dicks, Mfume, Frost, Lowey, Hamilton, Murtha, Pelosi, Price, Synar, G. Miller, Becerra, DeLauro, Frank, Glickman, Gjedenson, Meek, Flake, Pastor and Rangel.

To accomplish this we recommend that one or more of the following activities be undertaken at least once a month:

1. Informal Friday night dinners;

2. Strategy sessions after work over cocktails in groups of five to eight Members, segregated by chamber; (One per week for six weeks will accommodate all of the Members listed above.)

3. Invitations to movies;

4. Camp David overnights in small groups.

C. Individual Attention

There are six Senators and eight House Members who we believe are so important to the President's political and legislative fortunes that they should be contacted by the President by phone on a weekly basis. In addition, individual meetings with each should be scheduled at least every other month.

This group includes Senators - Mitchell, Dole, Moynihan, Byrd, Kennedy and Breaux, in addition to Representatives - Foley, Gephardt, Rostenkowski, Dingell, Natcher, Stenholm, Brooks and Michel.

In addition, all of the Members listed above should be considered when invitations are extended for the following:

White House dinners for any purpose

Kennedy Center box

Golf

Tennis

Running

Movies

D. Targeted Swing Members of Congress

We have identified this list of Members, some organized by ideological group, for special attention because they represent the balance of power on health care and many other important pieces of legislation. We have listed targeted Republicans from the House and Senate, whom we and Majority Leader Mitchell believe have the potential to support the President.

Our approach to dealing with these Members is as follows: in the Senate, at a working breakfast or lunch, the President should meet with the following group: Exon, Johnston, Bryan, Nunn, B. Kerrey, Heflin, Robb, Kohl, Shelby, Lautenberg, Boren, Campbell and Lieberman. A separate meeting with the following key Republicans should be scheduled: Jeffords, Hatfield, Cohen, Danforth, Durenberger, Kassebaum and Chafee.

In the House we recommend that the President meet with the following four groups: Conservative Democratic Forum, Mainstream Forum, Single-Payer co-sponsors and targeted Republicans. Targeted Republicans include: Boehlert, Shays, Snowe, Lazio, Fish, Walsh, N. Johnson, S. Horn, Gilchrist, Houghton, Quinn, Ramstad, Upton, Roukema, Torkildsen, Regula and Ros-Lehtinen.

As the Speaker and House Majority Leader noted in the health care meeting this morning, we should be cautious in reaching out to these Republicans and our strategy needs to be coordinated with the leadership.

This would require six meetings over the course of the next two months.

E. Health Care

Senate

Senator Mitchell has recommended that the President meet in small groups with every Democratic Member and with key targeted Republicans . We recommend groups of seven with the following breakdown: four co-sponsors, one liberal and two moderate non-co-sponsors.

House

We will continue to meet with the Leadership and Chairmen on a regular basis to discuss legislative strategy for the duration of the Health Care debate. The general membership of the House will be accommodated by the Caucuses and other group meetings outlined in parts D and F.

This would require nine one hour meetings over the next two months.

F. Additional Outreach

To extend the outreach of this congressional relations strategy, we recommend that the President should also meet with the following caucuses and groups: Freshman, Hispanic, CBC and Women. This would require four meetings over the next two months.

G. '94 Elections

Minimally, we believe the President must also have two to three 1-hour meetings per month with members in marginal races from the House and Senate. Joan Baggett is outlining a specific strategy to accomplish this goal.

H. Travel

This plan contemplates that Presidential, Vice Presidential and First Lady travel will be directed both toward targeted members for our Health Care strategy and in accommodating the '94 Campaign strategy outlined by Joan Baggett.

Lists of the groups and caucuses identified in this memo are attached.

Note: This entire strategy can be accomplished by dedicating 12 hours of Presidential time per week during the course of the next 2 1/2 months and can and should be repeated before the August recess.

HCR - positioning

Memo to: HRC
From: Norm Ornstein
Re: Congress and Health Care

November 27, 1993

At the Yale Law School reunion, you asked me about Congress; I promised you a memo. Here it is. I thought I would give some observations about the House, and then the Senate, followed by a few general comments. I will be brief, and candid. Details can follow if you want them. My goal here is to give some insights into how to get a health bill through Congress-- not what kind of health bill we should have.

First, the House. I get a headache-- a migraine-- when I think about the hurdles posed by the committee referral process in the House. I hope it's covered under the plan. I have no doubt that you are frustrated by the process too. To make this plan work politically is going to take strong and tough leadership in the House, and that will not be easy to come by. I know you have tried. As I said to you in New Haven, I worked hard on Speaker Foley to try to get him to create an ad hoc committee for the health reform bill, but to no avail. Now we have to deal with a huge dilemma: three prime committees, each with a claim on a major piece of the bill, each poised to turn the plan into a pretzel, with your task being to take three pretzels, merge them, and straighten them into something both coherent and passable.

I have one major suggestion. It is probably too late to create an ad hoc committee now, but not too late to use an unorthodox procedure for crafting a coherent bill after the pieces emerge from the various panels. You need to lean on the Speaker, and soon, to make it happen. He will resist, but I would use any and every bit of leverage you have, including involving the President. First, the Speaker needs to announce a tight and tough process under a joint and

sequential referral-- strict limits on what jurisdiction goes where, times certain for reporting out their pieces of the bill. The Speaker will say that the committees won't be able to meet the deadlines, and then you'll be needlessly embarrassed-- but the only way to make this work in 1994 is to *force* the committees to meet deadlines. Maybe the best way is to try to round up the other members of the leadership team, including Gephardt, Bonior, Hoyer and Fazio, get them on board, and then try to work on the Speaker in a joint setting.

Now comes the unorthodox part. The Speaker should create a *post hoc*, ad hoc committee-- a panel to take the pieces that emerge from Ways and Means, Energy and Commerce, Education and Labor, and the various minor committees, and merge them into one coherent package. This could be done by an existing committee, making it the primary referral, but each of the three possibilities poses its own problems. You would be far better off with an ad hoc panel that contains a representative membership and leaders with whom you can deal. I would think that putting Gephardt in charge of the ad hoc panel would be a good way to go. You are going to need an effective advocate in the leadership, putting deals together and representing you in the clinches. He is the logical one, and this is the logical spot for him to do so.

This type of ad hoc panel may not fit within the existing rules allowing ad hoc panels. But it should be possible to change the rules, if necessary, in February or March, when congressional reforms hit the House floor. If this idea doesn't work for you, or if you can't convince the House leaders to do it, find *some* way to pull the pieces together before the bill hits the Rules Committee. You must be in command, dealing from strength, by the time you get to the floor. It will be awfully difficult to do so unless you can find a way around the dilemma of committee referrals.

By the way, speaking of reform, be aware that the reforms reported by the Joint

Committee on the Organization of Congress will be up in February or March. Right now, they do little that will affect the organization or jurisdictions of committees, but that could easily change. If the leadership isn't careful, there may be a revolt on the floor, and it could have serious implications for committees like Ways and Means and Commerce. Far more members are not on those power panels than serve on them, and the jealousy level is high. This could have a serious impact on you and your priorities, so have someone keeping track.

A few words about Ways and Means. It would be the logical center for the bill. But it is a huge problem. Perhaps the year will go by with the chairmanship staying in Rostenkowski's able hands; then the problem will not be so large, because he will try to find a formula for a winnable and reasonable bill. But the odds are substantial that we will end up instead with Acting Chairman Gibbons. He is weak, carrying little weight with his colleagues on health issues, and the committee will immediately decentralize. The role of Stark obviously increases under those circumstances. I needn't tell you what a problem that is, especially since Bill Thomas, as ranking member, cannot get along with Stark, and himself carries no weight with his GOP colleagues. It is one of the many frustrations of this process that Bill Gradison, who found ways to mellow out Stark and was a consummate mediator, left the ranking position on health on Ways and Means to move to the HIAA-- moving from a key potential ally to a major adversary.

Without Rostenkowski as a major force (he will still be on the committee, fortunately), the top tier of Ways and Means is exceptionally thin. You almost have to go down to Matsui to find a stable, moderate, reasonable member. You need to find some allies and opinion leaders. Matsui has grown through his role in NAFTA, and may be ready to play a more significant role than he has in the past on health, as a bridge to the moderates in the House; Levin and Hoagland, who

span the ideological spectrum on the Democratic side of the committee, are additional good places to start. But the weakness of Ways and Means makes it imperative that a reasonable process for crafting a total bill be created before any package hits the floor.

On to the Senate: here you have a struggle for supremacy between two committees, Finance and Labor and Human Resources. I know you have some preference for Labor, especially given your experience with Finance over the budget. But I would caution you to tread carefully here. Labor is likely to take a bill to the left, when your ultimate compromise in the Senate will have to be to the center. The House, with fewer potential Republican allies, will probably end up to the left of the Senate, so it is important to create a different balance in the Senate if you are to ensure ultimate successful passage. The central GOP players for compromise are on Finance, especially Dole, Chafee and Durenberger. Dole is the key. If you can work out any kind of compromise with him, you are golden. (The more Gramm is virulent and hardline in opposition, the more Dole will be motivated to show him up and take the reins as the GOP's leader on this issue.) Chafee will probably be the most open and reasonable, but the frank reality is that he will carry very few members along with him. Work with him and cultivate him, but recognize his limitations.

Durenberger is a more interesting case. He was the GOP expert on health before Chafee, but was obviously discredited by his ethics case and indictment. But he will remain a player, and may have more weight because he is leaving the Senate. It would be a wise investment of time to work with him, appealing to his pride: this could be his final legacy as he departs public life.

In any event, Senate rules are such that you cannot avoid a major role for Finance. My

preference would be to make it the lead committee, because it more closely resembles the ideological coalition you will face on the floor. But that may be out of your control at this point anyhow. Mitchell *has* to play an aggressive leadership role here as well-- he has substantial referral power, and he must use it, forcing the panels to agree to dates certain for reporting out the bill and creating a tough joint and perhaps sequential referral schedule, something that should be done soon after the start of the session next year. I would think the best way is to make Finance the lead committee, but give Labor full sequential referral first, reporting back to Finance by sometime early in the spring.

One additional comment about the two houses: remember that nearly everything else the Administration wants next year will have to go through Ways and Means and Finance. Be careful about having your priorities timed so that they don't step on one another! Welfare reform is a key case in point. Don't let it be introduced, and pushed, without carefully thinking through how it will affect the time pressures, resources and internal dynamics of the committees, and what that will do to health reform. The same is true of taxes and GATT-- and, by the way, of environmental matters on Energy and Commerce. This is true in general. Every issue that emerges next year, from the Senate equivalent of Penny/Kasich to the Danforth Kerrey commission, will affect the timing and prospects for health reform. You must be constantly sensitive to the impact of each issue on all others.

Incidentally, although slightly off the subject, I would also recommend pushing the Speaker to create an ad hoc committee on welfare reform. There is a precedent for it; there is no way for Ways and Means to do it while also dealing with its other responsibilities; and, perhaps most important, Harold Ford is not going to be able to produce a welfare reform bill that meets

your goals and needs.

Now a general comment: This is not going to be easy (there's a brilliant insight for you.). It will be very hard to maintain momentum for a year. Most Americans will grow more nervous about losing what they've got, and more skeptical about what they will gain-- assisted in their doubts, of course, by all the health care interests. Congress will grow more nervous, remembering the catastrophic debacle of 1988. You will be pushed and pulled by all the forces inside the Administration, not to mention inside Congress. But passage of a meaningful bill is definitely doable.

You need to focus on one main strategic goal. In the end, the options for Congress have to be limited to two: passing the Clinton health reform plan, or doing nothing. Your model is tax reform in 1986. All the interests were opposed, the parties were weak, it couldn't be done-- but it was. Just before the 1986 congressional elections, with members of both parties nervous as hell about the mood of the electorate, they were faced with two choices: pass tax reform, no matter how tough the vote and how controversial the plan, or fail, and go home to the voters' judgment with gridlock being your basic message. The same thing has to happen next August, September or October. If the choices are two, Congress will opt for passage; even if the bill were to end up a repeat of catastrophic, the consequences won't come until after the election, and can be dealt with in the next Congress. But to opt for gridlock, with United We Stand and Perot fomenting voter discontent, is a recipe for suicide.

That means that the *only* plan defined as health reform is the Clinton plan. You must coopt the other alternatives along the way next year. It means you must make some

accommodations with the Republicans, and form your own centrist coalition-- and prevent an *independent* centrist coalition from forming and posing a potent third way-- an alternative, also widely accepted as health reform, that is more modest and limited and can attract a raft of nervous Democrats to join Republicans eager to pass reform but hand you defeat. Penny/Kasich shows how potent such a coalition can be-- it is frankly even more potent if led by Cooper and Breaux. Even as you try to develop your channels of communication and cooperation with Chafee and Dole, they will talk and work with Cooper and Breaux. You need to find a way to coopt all of them, declaring victory along the way. Don't wait to game through how you can do so; now is the time to figure out which parts of Cooper, Chafee and the other possible alternatives you can accept or modify to make a coalition that works. Don't get to August with one or more serious alternative plans out there opposing your own, if you can possibly avoid it. Compromises that occur on the floor, or very late in the game, leave you with less leverage, and with less credit, than those made early from a position of relative strength.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	Handwritten notes, re: Meeting with Dr. Bob Fiser (1 page)	ca. 12/1994	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Pam Cicetti (Health Care Subject Files, P thru Z)
OA/Box Number: 13602

FOLDER TITLE:
Health - Proposals, Outside Reform [2]

Kara Ellis
2006-0810-F
ke1037

RESTRICTION CODES

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

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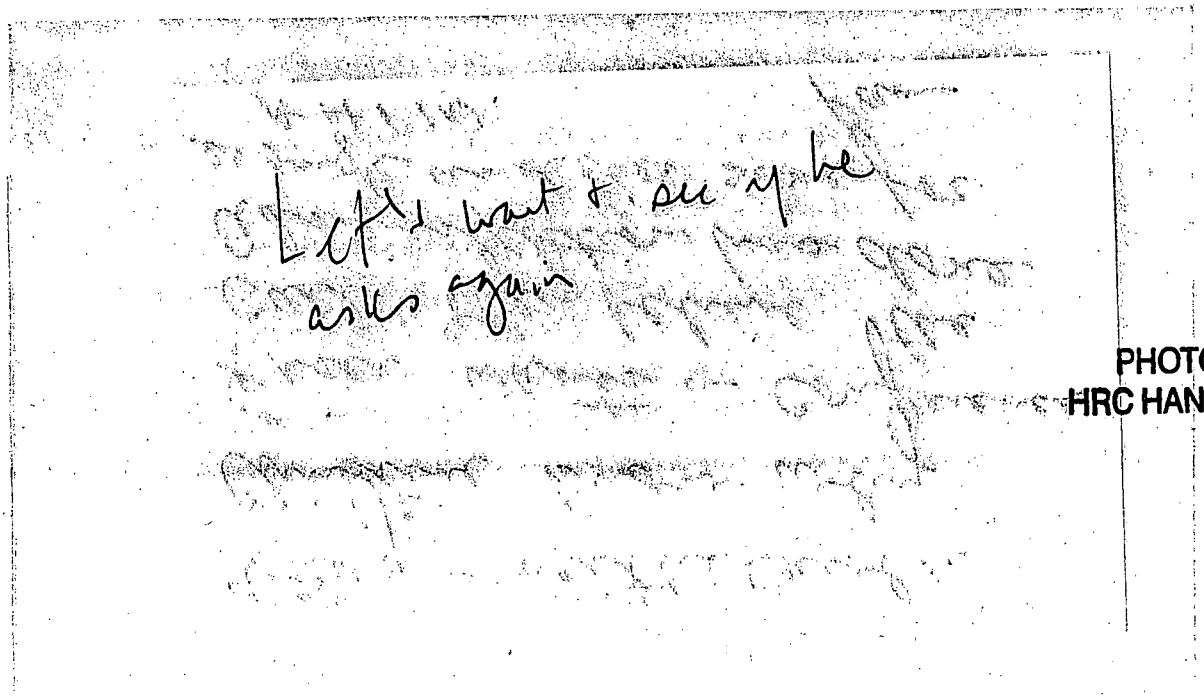
Hillary - neither Carolyn Christine know why Fiser wants a conference call. They believe the Administration has done enough and then some for A+PIN.

Pam



Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Ira C. Magaziner to President Bill Clinton, re: Broder/Johnson Interview (16 pages)	07/14/1995	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Jennifer Klein)
OA/Box Number: 9145

FOLDER TITLE:
Office of the First Lady: [Broder/Johnson Interview] [loose material]

Kara Ellis
2006-0810-F
ke1038

RESTRICTION CODES

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July 14, 1995

MEMORANDUM TO PRESIDENT BILL CLINTON

FROM: IRA C. MAGAZINER

SUBJ: BRODER/JOHNSON INTERVIEW

SUMMARY OF OUR COMMENTS TO BRODER AND JOHNSON

This memo summarizes what we have told Broder and Johnson on various issues they may wish to raise with you.

1. Was the plan too radical or bold?

We always knew that health reform would be difficult. The fact that we failed naturally raises questions about the course we followed. But it is unclear whether an incremental approach would have fared any better, if indeed a sound and effective one could have been designed.

The President promised a comprehensive proposal in the campaign. Almost all the political advice we received from congressional leaders and outside political advisors supported a bold comprehensive initiative. A comprehensive approach made sense on policy grounds. Even Senator Nickles and the Conservative Heritage Foundation, not to mention groups like the Chamber of Commerce, the AHA and the AMA were proposing comprehensive plans that radically altered the financing and delivery of American health care.

Any approach which seriously addressed the issues, even if more slowly phased or smaller in scope would have encountered serious opposition. Any serious approach would still have had to raise money (through an employer mandate or large tax increases), would have had to have scoreable cost containment (through premium caps, direct price controls, budgets or stringent tax caps), and would have had to have some type of community rating (through health alliances or state or federal laws). Any of these would have led to extensive opposition from powerful, determined interest groups. Had we made a less comprehensive proposal we might have lost support from some of our core supporter groups while still engendering the same opposition.

Many states had tried incremental insurance reforms as a way to expand coverage and reduce cost, with very little success. Market-based cost containment requires changes

in the rules for health financing which are by nature complex and interrelated (consumer choice, community rating, standard benefits), no matter how designed.

We always assumed our bill would be scaled back. We made clear from the outset that we had "no pride of authorship" and welcomed congressional rewrites as long as the President's principles were met. As you know from our "endgame memos," if Congress had said, we will achieve the President's goals but we will take ten years instead of five, reduce the benefit levels, constrain costs more gradually, trigger premium caps only if the market doesn't work, have voluntary alliances, tie long-term care benefits to realized savings, we would have been very amenable and not at all surprised. We encouraged Senators Chafee, Breaux and others to seek compromises.

The real test of whether we overreached, however, is whether someone can define what a package could have looked like (even in hindsight) which would have achieved the goals which almost all moderate Republicans and Democrats supported at the time; would have pleased enough of our key opponents without alienating our base supporters; would have been judged financially sound by CBO; and still would have had a decent chance of in fact working.

In light of the "reinvention of history" which is occurring, it is important to reemphasize that no senior official in the Administration spoke up against the basic structure of the bill. Universal coverage, the employer mandate, premium caps, mandatory alliances, etc., were unanimously supported. The only disagreements were about size of benefits, pace of phase-in and stringency of cost constraint.

Virtually every other industrialized nation on earth achieves universal health coverage, almost all with similar or better benefits and health outcomes, all at 50 to 75 percent our cost relative to the size of their economies.

The interesting question is not why we would dare to propose such goals for our country, but rather why the political system of the greatest nation on earth has made such goals seem so bold, radical and unachievable.

2. Was the plan too bold politically?

Our proposals followed the campaign proposals made in the New Hampshire primary and reiterated in a September 1992 speech in New Jersey. In the spring of 1993, they were broadly supported (e.g., see Kaiser poll 3/93) and were considered moderate. The major pieces all were taken from bills sponsored by moderates.

- Universal coverage was supported by all Democratic candidates in the 1992 campaign and by Senators Dole, Packwood and Chafee.

- The employer mandate was considered more moderate than the single-payer financing advocated by traditional liberal groups and by Bob Kerrey and Jerry Brown. Richard Nixon's health plan included an employer mandate; groups like the AMA, HIAA, AHA, Chamber of Commerce, Jackson Hole Group, and candidates like Paul Tsongas all supported one as well.

- Managed competition and community rating were endorsed by the DLC, moderate Republicans, the Business Roundtable, the Chamber of Commerce and many others as a more moderate alternative than single payer or "pay-or-play," both of which created large federal financing pools and therefore, had too much government. We took our community rating and large mandatory alliance proposals directly from a bill sponsored in August 1992 by Jim Cooper, Mike Andrews, David Boren, Sam Nunn and other conservative Democrats.

- Containing the growth in health care costs (particularly the growth of Medicare and Medicaid costs) to the rate of growth in personal income, was controversial among many health experts in Washington and not popular with some liberals. But a wide array of experts including C. Everett Koop, Jack Wennberg, Uwe Reinhardt and others believed it could be done. Groups like the AARP who traditionally opposed caps on Medicare and Medicaid found the President's proposal more acceptable because private insurance premium growth would also be capped and the health system would undergo comprehensive reform.

- The premium caps we used to back up managed competition were necessary for CBO scoring and were taken directly from a bill sponsored by Senators Kassebaum, Danforth and Burns and Congressmen McCurdy and Glickman, all moderates.

- Some like Chairman Rostenkowski and Dingell felt that the plan was not bold enough (see Rostenkowski's Harvard speech in Section 4.)

The consistent indications we had from moderate Republicans and conservative Democrats during the summer and fall of 1993 were that some compromise which met our goals was going to occur, albeit with lower benefits, a less stringent mandate, triggered premium caps, smaller or voluntary alliances, etc.

In discussions with moderate Republicans and conservative Democrats in Congress during the summer and fall of 1993, it became clear that they would want to water down the mandate and scale back the size of the program from whatever we proposed and get credit for doing it. It was part of the "cover" they felt they needed to support an employer mandate and new entitlements. Leading liberals also expected that the ultimate bill would be a scaled down version of what we proposed.

3. Why such a long, complex bill?

We always viewed our bill as a starting point. We knew that no matter what we produced it would have to be rewritten. That's why the President emphasized principles in his introductory speech and said the details were negotiable. He wanted a simpler, smaller bill, but the congressional leadership wanted us to do a full bill and CBO scoring required it.

There were many diverging and strongly held views in Congress about health care reform even among those who shared common goals. We knew we could not please even most people with any bill we initially proposed.

Even if we could have spent more time over the spring and summer of 1993 trying to build congressional consensus over a starting bill (which we couldn't because of the focus we had to have on the economic package), we could not have succeeded in producing early consensus. The Republican moderates wanted to produce their own bill. There was no single bill that Jim Cooper and Peter Stark were going to agree on at the outset or perhaps ever.

Our best strategy was to try to bridge the gap between the single payer and managed competition advocates and try to let congressional leaders modify our proposal to find consensus.

The bill was too long and too regulatory, but that was to some extent the result of CBO requirements, the complexity of today's health system and simply the way legislation is drafted today.

CBO didn't believe in competition as a way to control costs. The premium caps, large alliances, specified benefits package and elaborate enforcement language were in large part necessary to get the actuaries both at HCFA and CBO to score the bill properly.

A large part of the bill involved simplifying and cutting Medicare and Medicaid costs and regulations which are very complicated and modifying existing insurance regulations which are also very complicated. That's why all the bills were long and complex. Mitchell's bill was longer than ours. The mainstream bill was almost 1,200 pages. The original Chafee bill was over 800 pages without any long-term care or prescription drug provisions. Even the Dole bill which did very little was over 600 pages.

Most legislation is long today -- the crime bill, NAFTA and the budget bill were all longer than the health bill.

The President wanted a shorter bill, but it is unclear whether we could have succeeded with it either.

4. Was there a middle of the road approach to achieve the goals?

Those who advocated that we start with a more "middle of the road" approach have not been required to define what this would have included. The Chafee and Cooper bills which were offered as centrist alternatives, avoided public scrutiny. Had this scrutiny occurred, ideas like taxing benefits for all people who didn't buy low cost plans, individual mandates, national certification of all health plans, severe Medicare cuts with no additional senior benefits, and complicated subsidy schemes for over 100 million people would have proved difficult to explain and justify.

A Chafee or a Cooper style bill would have engendered active opposition from labor, seniors groups, single payer advocates, businesses with good benefits packages that would now be taxed and a long list of other supporters of the Health Security Act without picking up substantial support from opposing groups who only used those bills temporarily to oppose ours, eventually backing off them.

The Cooper bill was scored as $300 billion short to produce 91 percent coverage even with its unpopular tax on benefits. Scoring on the Chafee bill was going to be even worse. Imagine if we had proposed a bill with that scoring.

While CBO had criticisms of our bill, they were easy to fix. CBO analysis of the impact of our bill on national health spending was nearly identical to our estimate. They differed with us only on how savings or spending would be shared among businesses, federal government and state and local government. Because our bill produced substantial savings it was easy to make changes to allocate more of those savings to the federal government and achieve deficit reduction and universal coverage. These changes were presented by Senator Mitchell at the Democratic caucus in April of 1994. With the Chafee and Cooper approaches, this would have been almost impossible because there wasn't adequate financing or cost containment.

5. The process for health reform. Why such a speedy timetable? Why have a large task force process? Why the secrecy?

The President made a campaign promise to submit a health plan in the first 100 days of his Administration. Economic growth and deficit reduction in the next decade depended on action on health care early. We knew also that health care reform would be a very controversial issue. The longer it took to introduce a bill, the less likely it would be that we could succeed. In early 1993, there was momentum for reform. We wanted to seize this momentum.

We established a task force mainly because we wanted the policy to work. Too much social policy built on skeletal bills is not well thought out and is the result of political compromises that simply didn't work. While we recognized that whatever bill we passed would have to go through many mid-course corrections and amendments as implemented, the President wanted the framework to be sound.

We didn't want the existing government bureaucracies, by virtue of their knowledge of details, to dominate the policy process. We believed that they were a part of the problem. As a governor, the President had first hand experience with HCFA and found the organization and its many bureaucratic rules frustrating and inflexible. He also believed that a lot of the traditional Washington thinking on health care was stale and that state and private sector innovations were more forward looking.

For all these reasons, the President wanted a health care working group which would include people from outside Washington, practitioners as well as theoreticians. He wanted them to challenge the bureaucracies and the conventional Washington thinking on health policy.

He did not want the health care special interests to dominate the process. He wanted to allow them to be heard, but not to write the policy, as is often done on complex technical issues like health care.

He wanted the health care effort coordinated from the White House. It involved competing interests of many departments. The President had not made health care knowledge a criteria in selecting an HHS Secretary because he planned to coordinate reform from the White House. He knew the economic team would be preoccupied with the economic package, so he encouraged the formation of a separate policy operation.

It was a mistake not to open the policy process more to the press. We were not open enough in general at the White House during that period.

On the other hand, the health care task force has gotten a bad rap on this count. It was one of the most inclusive policy processes ever, reaching out to thousands of people, meeting with hundreds of interest groups and conducting hundreds of meetings with members of Congress (see CQ article.)

6. Why was the First Lady chosen to head the task force and why was Ira Magaziner chosen to run its day-to-day operations?

Appointing the First Lady was a big risk, but she is incredibly talented and appointing her showed that we were serious about health reform. We knew health reform would be incredibly difficult. Many people warned us about this, but we felt we had to take it on. It was too important to the country. If we were going to take it on, we wanted

to give it the best shot possible. Appointing the First Lady did that, though it was risky. Had we succeeded, it would have been viewed as a bold, courageous step.

Ira had managed complex policy development efforts in both the private and public sectors. The Democratic health establishment in Washington was weighted toward single payer or pay-or-play government-oriented solutions. Ira advocated more market-oriented managed competition solutions.

Though he did not have political experience, he had successfully managed the America's Choice: high skills or low wages effort where he built a unanimous consensus among Republicans and Democrats, labor and industry leaders on a bold program for reform (Broder followed this project.) Both the First Lady and the President knew him.

7. **Ira Magaziner may have been a reasonable choice to head the policy development effort on health reform, but he had no legislative or political experience. Why wasn't there senior political and legislative leadership on health reform from the beginning?**

Ira was never intended to play the lead legislative or political role. His title is policy development. The budget battle turned out to be harder and more protracted than we initially anticipated. Senior White House legislative and political officials had to focus on it until late in the summer. Then, Howard Paster made known his intention to leave and Harold Ickes took longer than we anticipated to come on board, so there was a temporary vacuum in health care. We could have had stronger political and legislative leadership from the beginning but it is unclear whether this affected the outcome.

When we introduced our health plan in September and October of 1993, it was widely viewed as a politically astute, successful initiative. Even at the end of 1993, despite much negative publicity, most commentators predicted that we would get a universal coverage bill passed by Congress, the public still favored our initiative by almost 20 points in the polls and by 40-60 points margins when matched up against competing bills. Democrats like Jim McDermott and Jim Cooper and moderate Republicans like John Chafee and John Danforth were all predicting a successful health reform outcome which included universal coverage.

Whatever shortcomings our team might have had in 1993, we successfully launched health reform.

8. **Some have said that the President deserted his own bill and turned the whole process over to Congress, abdicating leadership. Why did you play only a supporting role after the fall of 1993?**

Strong congressional leaders with very successful track records like Mitchell, Gephardt, Dingell, Ford, Rostenkowski and Kennedy were committed to comprehensive health reform. They wanted to play the leading role as far as Congress was concerned. It seemed prudent to follow their lead.

All major social legislation submitted by previous administrations, whether Social Security or Medicare and Medicaid or the Civil Rights Act have always been rewritten by Congress. The President was prepared to lead the public debate and to lead once bills came to the Floor, but we needed strong congressional leadership during the interim period to achieve consensus.

9. Could you have managed the interest groups better?

We had two fundamental and unalterable constraints in our dealings with interest groups.

1. Early on, most believed that comprehensive reform was inevitable and that their best strategy was to help us shape it. When the President's honeymoon was short lived and the economic program ran into trouble, and health reform was therefore delayed, many groups retracted initial offers and became more comfortable opposing change.

2. Our introduction of a bill was only the first step in a long congressional process with many entry points (committees) and many steps. It was not inherently good politics for interest groups to sign on unequivocally to our bill without trying to improve their position further in the congressional process. As a result, groups wanted to push us as far in their direction as possible without locking themselves into an endorsement.

During early 1993, we were hopeful of striking deals with a variety of groups for a bill which would be introduced and passed that year.

We anticipated working with congressional leaders from May through August to negotiate with key swing interest groups, particularly health care providers and business groups, and strike deals which would secure their support or at least acquiescence. We also anticipated being able to "lock in" support from our natural allies -- organized labor, senior groups, consumer groups and selected health provider groups.

When the economic program ran into trouble in April and May, the President's popularity plummeted and health care reform was postponed, we lost that opportunity.

After this, in late-June, we had to pursue a different strategy. We divided the groups into three categories: likely supporters; likely opponents; and swing constituencies.

Supporters

We conducted detailed discussions with the likely supporters throughout the summer and early fall to try to lock in as much support as possible when the bill was released. These groups included the AFL/CIO and its various unions, supportive medical groups such as the College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatricians, the National Medical Association, nurses, social workers; seniors groups such as AARP, NCSC, the Committee to Preserve Social Security and Medicare, the Alzheimers Association; hospital groups such as the Catholic Health Association and the Association of Public Hospitals; and consumer groups such as Citizen Action, the League of Women Voters, Consumers Union, disability groups, disease groups, veterans groups, military dependent groups, mental health advocacy groups, etc.

Most of these discussions were successful, though it took time to gain the agreement we needed. In every case, these groups supported the fundamental elements of our bill. Inevitably, however, they disagreed with some minor elements. Some were single-payer advocates. Many said that they would be supportive but had to see final bill language and secure votes of their boards before they could formally endorse our bill. Many said they would support us but would oppose one or two elements -- the Catholic Health Association opposed our abortion provision and the doctors felt that our malpractice provision should go further.

These discussions were painstaking, time consuming and unavoidable. We secured the support of many of these groups, but often not until late 1993 or even early 1994. Sometimes, their preoccupation with the 10 percent they didn't get in our bill was communicated more forcefully than their overall support.

Opponents

Certain groups had clearly decided to oppose us from the beginning. By late spring, it became clear that the price for support from others would undermine our proposal.

The NFIB made their opposition clear in March. If we had an employer mandate or any substantial taxes, they would oppose us.

The HIAA may have hoped that they could strike a deal with us since they supported universal coverage, the employer mandate and a guaranteed comprehensive benefit package. However, they were unalterably opposed to three provisions of our policy which were fundamental -- consumer choice, community rating and premium caps. Essentially, they wanted insurers to continue to be able to charge different rates to different groups and discriminate against groups that had older or potentially less healthy people; they wanted to market to employers instead of allowing consumers to

choose their health plans and they didn't want any limitations on the amounts by which they could raise their premiums.

In our view, consumer choice was essential to the functioning of a good market and was what most Americans wanted. The practice of insurance companies charging more to higher-risk groups not only went counter to the original idea of health insurance but would also raise government spending dramatically because public subsidies would increase for high-risk people. Without premium caps or some similar backup cost containment mechanisms, CBO would not score cost savings in the bill.

In our discussions with HIAA in the summer of 1993, we tried to explore areas of compromise on these issues, for example, triggered premium caps and adjusted community rating (whereby insurers would be protected against bad risks by a national reinsurance pool), but they did not seem interested in real compromises on these issues.

Mike Bromberg's various clients -- the large insurers and for-profit hospital groups -- opposed premium caps and consumer choice, and state flexibility. In February and March they had seemed open to potential compromises on these issues, but by late summer, their positions had hardened. I explored possibilities for triggered premium caps and limits on state flexibility with them in discussions in late summer and early fall, but got nowhere.

By early fall, we expected these groups to join the NFIB opposition. Some congressional leaders felt that they could ultimately negotiate with Gradison and Bromberg but that it should be done at the latter stages of the congressional process by them, not by us.

Swing Groups

The final category were swing groups like the AMA, AHA, Blue Cross/Blue Shield, the PMA, the Chamber of Commerce and NAM. They supported many aspects of our proposals but opposed others. Unlike the opposing groups, they seemed truly committed to comprehensive health reform. Initially in the spring, they seemed interested in making deals with us to be supportive, but as we delayed, they began pulling back. They were not negative in our discussions with them, but they began emphasizing areas of disagreement and stressing that those would have to be resolved before they could be supportive. In discussions over the summer, they did agree to take a constructive position -- to publicly emphasize areas of agreement, to express a commitment to the President's principles and to make clear their desire to work with us to achieve a good bill.

NAM and the Chamber supported employer mandates, seemed inclined to accept triggered premium caps and favored mandatory community rating and consumer

choice through mandatory health alliances (albeit smaller ones than we proposed). They were most uncomfortable with state flexibility, the new seniors' entitlements, the size of the benefits package and the size of alliances. We assured them that we would work with them on these issues and they agreed to take a constructive attitude toward our proposals, which they did for a period of time.

The AMA lunged from one position to another -- at times being very supportive -- and at other times being very critical. We had good meetings with them in the spring, but by the late summer, they were backing away. We suspect this reflected the tensions within their own membership. We would agree on various points and then they would have a new set of points at the next meeting. Their willingness to work with us clearly dissipated as time went on.

The AHA and Blue Cross/Blue Shield also had discussions with us about more flexible premium caps and smaller alliances; the AHA was also concerned about the level of Medicare and Medicaid cuts. But again, they agreed to be generally supportive.

We discussed in good faith with these groups. We listened carefully to their views and weighed them very seriously. Sometimes we simply disagreed. Other times CBO disagreed.

By the fall, we were not in a position to cut deals with them. In some cases, they had withdrawn from positions they had communicated in the spring and were advocating changes we simply couldn't make without losing core supporters or CBO scoring.

On top of this, the congressional leadership was strongly urging us not to cut deals. We had agreed to support the Chamber's small business discount schedule which was good policy. We pushed hard for a series of anti-trust changes which were also good policy and supported by the AMA and AHA. In these cases and others, congressional leaders were upset with use. They complained that we were making concessions without gaining any votes and that they should cut the deals, not us.

In many cases, when we moved in the direction of these groups, they had a new series of "concerns" they raised with us. After we worked all summer with the AMA on anti-trust, malpractice and other important issues, they returned in September with a new "bottom line" demand to be guaranteed a seat on the national health board. After discussing concerns about the degree of state flexibility in our plan all summer, NAM came in September with a demand for no state flexibility. This bolstered those in the Administration and in Congress who argued that we should not make concessions but rather should wait for the congressional process. We couldn't bring any closure with these groups because they knew they had another "bite at the apple" in Congress.

The Importance of Momentum

Interest group politics in health care is very difficult. There are many sides to all issues, and there are many issues. Sometimes the real concerns for groups are not the major issue but a series of minor issues which have to be treated very carefully.

On any given issue, a decision may please one group and anger four others.

It became commonplace for groups to blame us for not resolving all of their issues. There was no way for us or anyone else to do so.

The real driving factor in our lack of success with many groups had less to do with how we negotiated and more to do with our overall political strength or weakness. Most of the swing groups we faced, have primarily Republican memberships. If the health reform ship, regardless of how battered, was clearly heading to shore, those who represent these interest groups would have argued to their members as they did from November 1992 - May 1993 that compromise with us was necessary.

In the fall of 1993, when strong conservative Republican opposition emerged and we lost momentum from delay and the outcome was less clear, the prudent strategy for most swing groups was to hang back and see how things developed. Finally, in the spring of 1994, when reform was in trouble, preserving the status quo became the safest course for many of these groups.

This overall swing in momentum was more important than any negotiating skills of ours.

10. Why did supportive groups not mobilize better?

Too many groups who supported comprehensive health reform spent their energies trying to alter the 10 percent in our bill they did not like instead of fighting for the 90 percent they supported. We spent months negotiating with all of these groups to meet their specific needs but most never came through with active support until it was too late.

In one sense we were a victim of the early success we enjoyed in the polls during the fall of 1993. Many groups assumed universal coverage was guaranteed and that they should withhold full endorsements until they got changes in details they were seeking. We warned them that the whole bill could be lost and that they would then suffer severe reverses the next year, but they didn't believe us.

The AARP was paranoid about a repeat of the catastrophic debacle. The AFL CIO and consumer groups were spending their energies fighting against NAFTA. They

were the only groups with significant money to spend and large grassroots networks and they didn't become active until the spring of 1994.

We were outspent 20 to 1 by opposing interest groups. They organized well. We may have had many groups supporting us, but the intensity of feeling was stronger on the other side.

11. The impact of Whitewater on health care.

Whitewater did have an effect on the health care debate. There is a direct statistical correlation between the decline in presidential popularity associated with Whitewater and the decline in popularity of the Clinton health plan.

In addition, Whitewater diverted the attention of key White House officials like Harold and Pat from January through April in particular, when their focus on health care was most needed.

12. What impact did talk radio have on health care?

Conservative groups opposed to health reform used talk radio as well as direct mail and phone bank campaigns to raise people's fears about health reform. A tremendous amount of misinformation was communicated this way.

13. What effect did Gingrich's rise in the GOP have?

From February through September of 1993, we had over 20 productive meetings with a Republican House health group appointed by minority leader Michael and headed by Denny Hastert. We also had productive meetings with a number of moderate GOP House members who wanted to work with us on health reform.

When Michael announced his retirement and Gingrich became heir apparent in the summer of 1993, there was a clear change in attitude. A number of House Republicans with whom we had been working told us that they no longer could cooperate.

Gingrich obviously decided early on that not cooperating with us was better politically for Republicans.

14. Why the veto threat in the 1994 State of the Union?

We were signalling a willingness to see our bill rewritten and to compromise broadly on the details of our proposal. Many of our supporters were asking whether we had any bottom line and wanted a commitment that we would stand firm for the principle of universal coverage.

At the time, 23 Republican senators including Bob Dole and virtually all Democrats were saying that universal coverage should be in Dole's words, "a non-negotiable part of any health bill."

In retrospect, of course, we didn't succeed and therefore it seems like a hollow threat. At the time, most observers felt it was a reasonably safe statement to make. It is unclear whether we could have had an easier compromise in the spring if that marker had not been laid down. Supporters of the original Chafee and Cooper bills as well as the original mainstream and finance committee bills backed away from those once they began to be analyzed. It is difficult to find workable partial solutions in health reform that have much of any positive effect without also creating negative effects.

15. How was the final difficult decision to pull the plug made last fall?

The plug was essentially pulled by the Republicans long before last fall. We encouraged the Mitchell/Chafee process but were not optimistic that Chafee could attract more than a few Republicans to a compromise bill and indeed he couldn't.

Even if he could have by some miracle, we would have had a hard time in the House with liberal Democrats. Labor, consumer groups, single payer advocates as well as our business supporters were all opposing the Chafee/Mitchell effort.

16. Why did you tolerate the publicly expressed opposition of and destructive leaks from some senior Administration officials on the reform effort?

Though some Administration officials have been savagely critical of you, the First Lady and me, we have refused to be drawn into any criticism of fellow Administration officials. Broder and Johnson have repeatedly invited us to do so. We have simply indicated that there were good internal discussions on health reform and that all supported the basic structure of the proposals.

17. What role did the health care fight play in the Republican takeover of Congress?

It is hard to say. Health care, as David Broder noted in an article in October 1994, was not discussed directly in most races because neither side knew how it would play. Senator Kennedy was reelected defending what we tried to do in health care. Jim Cooper tried to run on his opposition to our health plan and was slaughtered.

Certainly many people were angered during the health care debate and we lost out going and coming. For some Republicans and Independents, it symbolized Democratic party proclivities for big government, bureaucracy and expensive entitlements. For some core Democrats and Independents, our failure to deliver on the promise of health reform even though we had a Democratic President and Congress worked against us.

18. The role health care will play in the 1996 election.

We have not commented on this.

19. They may ask a series of political and personality questions.

- Did Senator Moynihan hurt or help the reform efforts?
- Why didn't you invite Bob Dole to sit down with you and discuss possible compromises?
- Did Rostenkowski's indictment or Mitchell's departure prove fatal to the effort?
- Did you think Mitchell should have brought his bill to a vote even if you could not pass it?

We have not indicated views on these topics to them.

20. We have in general not characterized your thoughts on any topic, indicating that we cannot speak for you.

There are a few exceptions where we have accurately portrayed positions of yours which show your commitment of which were politically prescient.

- We have told them that you were committed to health reform as an economic as well as social issue and felt strongly about delivering on your campaign promise to produce a health bill which met your campaign goals in 100 days or as soon thereafter as possible.
- Hillary and I both communicated your desire to propose a market-oriented private sector solution rather than the government-oriented "single payer" or "play-or-pay" models favored by most Democrats at the time. We also indicated your desire not to let the bureaucracy or interest group lobbyists write the bill but rather for us to consult broadly around the country in producing the bill.
- We indicated that you warned of the dangers of submitting too detailed a bill -- that it would be picked apart and would allow our opponents to accuse us of big government and too much complexity. You agreed to it only after the congressional leadership strongly recommended it and because of the need for details to ensure reasonable CBO scoring.
- We have told them that you often expressed concern that the bill was in perception and in reality too bureaucratic. I have expressed my own horror at seeing a 200 page policy document grow into a 1,300 page bill after various departmental drafters and CBO had their way and have taken the blame for not

fighting them harder to eliminate a lot of the bureaucratic superstructure of the bill even after you expressed a strong desire to do so.

- We have showed them the "endgame scenarios" which we were working with to demonstrate that we always intended to be flexible and cut a deal in the center and have shown them memos and notes from Breaux, Chafee, Andrews and others which indicate that as late as May, moderates in both parties were discussing with us compromises which were within those endgames.

- We have indicated that you often expressed a desire to try to find a deal and were concerned with having the process drag on too long. You accepted advice from the congressional leadership and your own legislative advisors to go through the normal order, but were always concerned that it might take too long and that the issue might become stale.

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001. paper	Passing Health Reform: Policy and Congressional Summary (16 pages)	ca. 1993	P5
002a. paper	General Targeting Strategy (8 pages)	ca. 1993	P5
002b. list	Appendix 5: Priority Targets (1 page)	12/14/1993	P5
002c. paper	Congressional Timetable (2 pages)	ca. 1993	P5
002d. list	Appendix 1: [Health Security Act Cosponsors] (2 pages)	ca. 1993	P5
002e. memo	Appendix 2: Committee Referrals of the Health Security Act (1 page)	ca.1993	P5
002f. list	Appendix 3: [Committees of Primary Jurisdiction] (4 pages)	ca. 1993	P5
002g. profile	Appendix 4: Profiles of Key Swing Committee Members (15 pages)	ca. 1993	P5
002h. profile	Appendix 5: Priority Targets (3 pages)	12/14/1993	P5
002i. list	Appendix 6: Health Care Timetable (1 page)	ca. 1993	P5

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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]

PASSING HEALTH REFORM

POLICY AND CONGRESSIONAL SUMMARY

PASSING HEALTH REFORM

THE HEALTH SECURITY ACT WOULD SUCCEED IF ENACTED AS WRITTEN. IT WAS ALSO CONSTRUCTED AS A NEGOTIATING DOCUMENT. IT HAS DOZENS OF MOVEABLE PARTS WHICH CAN BE CHANGED AND STILL BRING SUCCESSFUL HEALTH CARE REFORM. IT ALSO HAS VARIOUS LAYERS WHICH CAN BE REMOVED WHILE STILL PRESERVING ITS ESSENCE.

NO MATTER WHAT WE PRODUCED, CONGRESS WOULD WANT TO MAKE MAJOR MODIFICATIONS. WE HAD TO CREATE A DOCUMENT WHICH COULD ALLOW FOR THIS.

OUR POLITICAL STRATEGY

THE WINNING CONGRESSIONAL MAJORITY FOR HEALTH CARE REFORM DEPENDS ON HOLDING ALMOST ALL LIBERAL AND MODERATE DEMOCRATS, WINNING A SIGNIFICANT NUMBER OF CONSERVATIVE DEMOCRATS AND ATTRACTING 8-10 MODERATE REPUBLICANS IN THE SENATE (ASSUMING WE NEED 60 VOTES) AND 15-20 IN THE HOUSE.

THE CLINTON PROPOSAL (WHILE SLIGHTLY LEFT OF CENTER FOR THE CONGRESS AS A WHOLE), IS ALREADY RIGHT OF CENTER FOR THE COALITION WHICH WILL EVENTUALLY COME TOGETHER TO VOTE FOR HEALTH REFORM. IN FACT, WE HAVE MOVED THE CONGRESSIONAL DEMOCRATS TO THE RIGHT ALREADY THIS YEAR. PRIOR TO THE CLINTON PRESIDENCY, DEMOCRATS IN CONGRESS WERE DIVIDED BETWEEN SINGLE-PAYER ADVOCATES AND ADVOCATES OF "PAY OR PLAY" WHICH WOULD HAVE CREATED A HUGE FEDERAL PROGRAM FOR HEALTH CARE COVERING MOST AMERICANS. ONLY A HANDFUL OF DEMOCRATS SUPPORTED MANAGED COMPETITION.

WHY WE STARTED LEFT OF CENTER

IN THE SPRING, THERE WERE TWO POSSIBLE WAYS TO FORM OUR DOCUMENT POLITICALLY;

- IN THE CENTER WITH MODERATE REPUBLICAN AND CONSERVATIVE DEMOCRAT SUPPORT WITH THE INTENT TO NEGOTIATE WITH LIBERAL SINGLE-PAYER AND "PAY OR PLAY" GROUPS TO OUR LEFT; OR

- LEFT OF CENTER WITH LIBERAL AND MODERATE DEMOCRAT SUPPORT AND NEGOTIATE TO THE CENTER.

THE DIE WAS CAST IN MAY WHEN COOPER AND OTHERS ALLIED WITH HIM MADE CLEAR THAT THEY WOULD NOT SUPPORT UNIVERSAL COVERAGE IN THIS BILL, PREFERRING TO COME BACK AND PASS IT IN A FEW YEARS, AND WHEN THE CHAFEE GROUP DECIDED TO PRODUCE THEIR OWN BILL WITH AS BROAD REPUBLICAN SUPPORT AS POSSIBLE AND NEGOTIATE WITH US AFTER VARIOUS BILLS WERE INTRODUCED.

THIS LEFT US NO CHOICE BUT TO GO CENTER LEFT TO ENSURE A FIRM BASE OF SUPPORT FOR OUR BILL UPON INTRODUCTION.

HEALTH CARE REFORM:
THE BOTTOM LINE

HEALTH REFORM WILL BE SUCCESSFUL IF WE ACHIEVE THE FOLLOWING GOALS:

- UNIVERSAL COVERAGE BY THE END OF THE DECADE
- COMPREHENSIVE BENEFITS
- COMMUNITY RATING
- COST CONTROL
- ADEQUATE FINANCING FOR THE PROGRAM

THE NEW SYSTEM WHICH WE CREATE MUST FIT TOGETHER. IMPLEMENTATION WILL BEGIN DURING THE PRESIDENT'S FIRST TERM. THE BILL WHICH PASSES CONGRESS MUST WORK NOT JUST POLITICALLY BUT ALSO SUBSTANTIVELY.

THIS MEANS RESOLVING SUCCESSFULLY 14 MAIN ISSUES AND HUNDREDS OF "SIDESHOW" ISSUES, EACH OF WHICH HAS ITS OWN CONTROVERSIES.

MAIN EVENT ISSUES

A. UNIVERSAL COVERAGE

1. EMPLOYER/INDIVIDUAL MANDATE
2. LEVEL OF DISCOUNTS
3. SUBSIDIES FOR UNDERSERVED AREAS

B. COMPREHENSIVE BENEFITS

4. SCOPE OF BENEFIT PACKAGE
5. MEDICARE PRESCRIPTION DRUG BENEFIT
6. LONG-TERM CARE
7. PUBLIC HEALTH INITIATIVES

C. COMMUNITY RATING

8. INSURANCE REFORMS
9. SIZE AND STRUCTURE OF ALLIANCES

D. COST CONTROL AND FINANCING

10. RULES FOR ACCOUNTABLE HEALTH PLAN COMPETITION
11. INCENTIVES FOR CONSUMERS TO BE COST CONSCIOUS
12. PREMIUM CAPS
13. MEDICARE AND MEDICAID SAVINGS
14. NEW REVENUES

A SAMPLING OF SIDESHOWS

1. SUBSIDIES TO ACADEMIC HEALTH CENTERS AND TEACHING HOSPITALS
2. RESIDENCY SLOTS FOR PRIMARY VS. SPECIALTY CARE PHYSICIANS
3. RELATIVE PAYMENT RATES FOR PRIMARY VS. SPECIALTY PHYSICIANS
4. OVERRIDE OF SCOPE OF PRACTICE LAWS
5. ANTI-TRUST REFORMS
6. ESSENTIAL PROVIDER PROVISIONS
7. CLIA SIMPLIFICATION
8. UNIVERSAL REIMBURSEMENT SYSTEM
9. MEDICARE AND MEDICAID SIMPLIFICATION
10. NATURE OF QUALITY REPORT CARD AND INFORMATION COLLECTION
11. SPECIAL TREATMENT OF SUB POPULATIONS - AIDS PATIENTS, RARE DISEASE PATIENTS, ALZHEIMERS PATIENTS, TWO DOZEN OTHERS
12. WOMEN'S HEALTH RESEARCH FUNDING
13. INCENTIVES FOR COMMUNITY-BASED HEALTH PLANS
14. RISK ADJUSTMENT FORMULAS
15. TREATMENT OF CHIROPRACTORS, PODIATRISTS, ETC.
16. INCENTIVES FOR PRACTICE IN UNDERSERVED AREAS
17. INCENTIVES FOR STUDENTS TO ENTER PRIMARY CARE
18. MEDICAID WRAPAROUND SERVICES
19. NURSING HOME REGULATION
20. TREATMENT OF STATE AND FEDERAL WORKERS
21. STATUS OF INDUSTRY RUN MULTI-EMPLOYER HEATH PLANS
22. ESTABLISHMENT OF FEE SCHEDULES
23. DEFINITION OF A FAMILY
24. TREATMENT OF SUBSTANCE ABUSE
25. DIRECT REIMBURSEMENT FOR NURSES

A SAMPLING OF SIDESHOWS (CONTINUED)

26. NATURE OF MALPRACTICE REFORM
27. MANAGED CARE VS. FEE-FOR-SERVICE
28. PROTECTIONS FOR RURAL AND URBAN UNDERSERVED POPULATIONS
29. SIZE AND NATURE OF "SIN" TAXES
30. FEDERAL CONTROL VS. STATE FLEXIBILITY
31. ABORTION
32. TREATMENT OF UNDOCUMENTED PERSONS
33. PRIVACY ISSUES
34. MEDICAID INTEGRATION
35. MEDICARE INTEGRATION
36. SIZE AND NATURE OF TAX CAP
37. TREATMENT OF UNDER 65 RETIREES
38. PREMIUM AND SUBSIDY STRUCTURE
39. STATE MAINTENANCE OF EFFORT REQUIREMENTS
40. ERISA AMENDMENTS AND WAIVERS
41. RESPONSIBILITY FOR FINANCIAL RISK
42. INDEPENDENT CONTRACTOR RULES

HUNDREDS OF OTHERS

THE END GAME

WE MUST WIN SUFFICIENT CONSERVATIVE DEMOCRATIC AND MODERATE REPUBLICAN SUPPORT BY COMPROMISING FEATURES OF OUR BILL, BUT WE MUST BE CAREFUL NOT TO ALIENATE TOO MANY LIBERAL DEMOCRATS BY GOING TOO FAR.

DEPENDING UPON OUR POLITICAL SKILLS, THERE ARE A RANGE OF END GAMES WHICH CAN RESULT. THE PATH TO NEGOTIATING THESE DEALS WILL GO MEMBER BY MEMBER AND WILL OFTEN INVOLVE MODIFYING PROPOSALS ON THE HUNDREDS OF "SIDESHOW" ISSUES WHICH WILL BE IMPORTANT TO VARIOUS MEMBERS AND THEIR CONSTITUENT GROUPS.

VIRTUALLY EVERY MEMBER WE CONVERT WILL INVOLVE POLICY CHANGES WHICH THE MEMBER CAN CLAIM TO HAVE WON. THERE ARE SO MANY ISSUES EMBEDDED IN THE BILL WHICH ARE SO IMPORTANT TO THE OVER 1,500 HEALTH CARE INTEREST GROUPS AND THEIR CONSTITUENCIES THAT WE CAN MAKE HUNDREDS OF THESE MODIFICATIONS WITHOUT HURTING THE INTEGRITY OF THE BILL IN ORDER TO GAIN VOTES.

END GAME - SCENARIO I

IF WE CAN SUSTAIN THE PUBLIC DEBATE, AND NEGOTIATE WELL, UNDER THE MOST OPTIMISTIC SCENARIO, WE WILL WIND UP WITH THE FOLLOWING TYPE OF COMPROMISE:

- UNIVERSAL COVERAGE PASSED IN THIS BILL ON OUR TIMETABLE WITH AN EMPLOYER/INDIVIDUAL MANDATE AND LARGER SUBSIDIES OR A SLOWER PHASE-IN FOR SMALLER COMPANIES.

- PREMIUM CAPS WHICH ARE SOMEWHAT LESS RIGID THAN THE ONES WE PROPOSE.

- HEALTH ALLIANCES FOR COMPANIES OF 500-1,000 OR UNDER (WHERE THE ONE PERCENT ASSESSMENT GAINED FROM ADDITIONAL CORPORATE ALLIANCES WOULD PAY FOR THE EXTRA SMALL FIRM SUBSIDIES).

- SMALLER MEDICARE AND MEDICAID SAVINGS.

- A SLOWER PHASE-IN OF LONG-TERM CARE AND THE PRESCRIPTION DRUG BENEFIT TO COMPENSATE FOR THE LOWER MEDICARE AND MEDICAID SAVINGS AND A TIE-IN BETWEEN THE SAVINGS AND THE SPENDING ON THESE PROGRAMS.

- A FEW HUNDRED MINOR MODIFICATIONS.

END GAME - SCENARIO II

IF WE ARE ONLY MARGINALLY SUCCESSFUL IN THE PUBLIC DEBATE AND SECURE A LESSER BILL WHICH STILL FULFILLS THE PRESIDENT'S PRINCIPLES, IT MIGHT LOOK LIKE THE FOLLOWING:

- UNIVERSAL COVERAGE ON A SLOWER TIMETABLE -- BY 2000, WITH AN EMPLOYER AND INDIVIDUAL MANDATE WITH THE EMPLOYER SHARE REDUCED (WORST CASE, AS LOW AS 50 PERCENT), POSSIBLY LIMITED TO THE LOW COST INSTEAD OF THE AVERAGE COST PLAN, POSSIBLY WITH A SLOWER PHASING-IN OF THE FULL BENEFITS OR WITH ENHANCED SMALL COMPANY DISCOUNTS.

- LESS STRINGENT PREMIUM CAPS WHICH TRIGGER IF COMPETITION DOES NOT PRODUCE A CERTAIN LEVEL OF SAVINGS BY A CERTAIN TIME.

- A SLIMMED DOWN LONG-TERM CARE PACKAGE WHICH PHASES IN MUCH SLOWER AND A MORE SLOWLY PHASED-IN PRESCRIPTION DRUG BENEFIT, AND A TIE-IN BETWEEN THE SAVINGS AND THE SPENDING ON THESE PROGRAMS.

- LOWER MEDICARE AND MEDICAID CUTS.

- A SMALLER TOBACCO TAX.

END GAME - SCENARIO II (CONTINUED)

- SMALL ALLIANCES -- 100 OR UNDER, POSSIBLY VOLUNTARY, WITH STATES ALLOWED TO GO HIGHER AND A NATIONAL RISK POOL TO REINSURE CASES ABOVE $25 OR $50 THOUSAND PER YEAR.

- REDUCTION OF THE ONE PERCENT CORPORATE ASSESSMENT.

- A FEW HUNDRED MINOR MODIFICATIONS.

TIMING AND NEGOTIATING STRATEGY

THERE ARE THOUSANDS OF NEGOTIATIONS WHICH HAVE TO TAKE PLACE INVOLVING HUNDREDS OF ISSUES BETWEEN LATE JANUARY AND EARLY JUNE. MANY CAN BE DONE ON A STAFF TO STAFF LEVEL.

A WHOLE NEW SET OF DIFFICULT NEGOTIATIONS WILL TAKE PLACE AFTER JUNE WHICH WILL BE MORE CONCENTRATED.

MANAGING THIS PROCESS SO THAT IT KEEPS MOVING FAST ENOUGH TO SUCCEED ON OUR TIMETABLE WILL REQUIRE A HIGHLY ORGANIZED EFFORT ON OUR END.

- WE MUST SPEAK WITH ONE VOICE. A SMALL GROUP IN THE WHITE HOUSE MUST COORDINATE.

- IN COOPERATION WITH LEADERSHIP AND KEY COMMITTEE STAFF, WE WILL PREPARE BY THE END OF JANUARY A WEEK-BY-WEEK SCHEDULE TO TRY TO CLEAR AWAY THE "SIDESHOW" ISSUES SO THEY DON'T BOG US DOWN -- IDENTIFYING ONES WHICH WILL BE USED TO SECURE VOTES LATER IN THE PROCESS.

THE TIMING OF COMPROMISES, WHO THEY ARE MADE WITH AND WHAT WE GET FOR THEM IS PROBABLY OUR FUNDAMENTAL SET OF STRATEGIC DECISIONS.

WE MUST SIGNAL A WILLINGNESS TO BE FLEXIBLE IN GENERAL (THOUGH NOT ON BASIC PRINCIPLES), BUT WE MUST HOLD OUR POSITIONS AS LONG AS POSSIBLE. PREMATURE SIGNALS OF SPECIFIC COMPROMISE COULD DOOM US.

LEGISLATIVE END GAME

THOUGH CAREFUL WORK MUST BE DONE TO CULTIVATE MANY MEMBERS WHO WILL ULTIMATELY BE WITH US, THERE ARE A RELATIVELY SMALL NUMBER WHO WILL BE THE "SWING VOTES." THERE ARE FEW SURPRISES ON THE LIST.

OUR EFFORTS WILL ULTIMATELY FOCUS ON THEM.

THE SENATE

THOUGH OTHERS WILL TAKE CONSIDERABLE WORK, THE FOLLOWING LIST OF POSSIBLE BUT DIFFICULT VOTES WILL BE KEY IN THE SENATE.

DEMOCRATS		REPUBLICANS	
BREAUX	ROBB	CHAFEE	GORTON
NUNN	DORGAN	DURENBERGER	BOND
JOHNSTON	KERREY	COHEN	SPECTER
BOREN	HOLLINGS	PACKWOOD	D'AMATO
BRYAN	EXON	HATFIELD	DOLE
SHELBY	DECONCINI	DANFORTH	BENNET
	HEFLIN	KASSEBAUM	DOMENICI
			BURNS
			HATCH

WE NEED 16 OF THESE 29 SENATORS TO GAIN 60 VOTES (16 OF 20, IF THE LAST COLUMN OF LESS LIKELY REPUBLICANS IS EXCLUDED.)

THE HOUSE

IF THE VOTES ARE STRUCTURED PROPERLY, WE SHOULD ULTIMATELY HAVE THE SUPPORT ON THE HOUSE FLOOR TO PASS A GOOD BILL. THERE ARE CERTAIN KEY COMMITTEE VOTES WHICH WILL BE PARTICULARLY IMPORTANT.

ENERGY & COMMERCE	
DEMOCRATS	**REPUBLICANS**
SHARP	BILARAKIS
TAUZIN	McMILLAN
RICHARDSON	UPTON
SLATTERY	PAXON
BOUCHER	KLUG
COOPER	GREENWOOD
ROWLAND	
LEHMAN	
PALLONE	
SCHENK	
MARGOLIES-MEZVINSKY	
LAMBERT	

ASSUMING WE GET ALL THE OTHER DEMOCRATS, WE NEED 8 OF THESE 18.

WAYS & MEANS	
DEMOCRATS	**REPUBLICANS**
PICKLE	THOMAS
RANGEL	GRANDY
FORD	HOUGHTON
STARK	
COYNE	
ANDREWS	
McDERMOTT	
KLEZCKA	
PAYNE	
HOGLAND	
NEAL	
BREWSTER	

ASSUMING WE GET ALL THE OTHER DEMOCRATS, WE NEED 8 OF THESE 15.

~~-- CONFIDENTIAL --~~ ADMINISTRATIVE MARKING

INITIALS: KDE DATE: 4/20/09

2006-0810-F

General Targeting Strategy

The Congressional targeting strategy focuses primarily on three groups of Members: Cosponsors, Members of Committees of Jurisdiction, and Members who are influential with other members. (The final category of Members is made up primarily of moderates with the exception of some minority caucus Members.) For each of these groups we have a variety of strategies to build the coalition we need to pass the Health Security Act next year.

We are working to solidify the backing among those who have cosponsored the bill, by making sure they are comfortable with the policy and by events geared to increasing support among their constituents. This strategy is aimed at continuing to build our list of supporters as the year progresses. (See Appendix 1 for a current lists of House and Senate cosponsors.)

Much of the early action next year will take place in the five primary Committees of jurisdiction in the House and Senate. Our targeting emphasizes the key members needed to form the majority necessary to vote the bill out these committees. Since our efforts with the Committees are critical to the success of our legislative strategy, the majority of this memo is dedicated to an assessment of these Committees. (See Appendix 2 for a list of all the Committees to which the bill has been referred, Appendix 3 for membership lists of the five committees which have been given primary jurisdiction over the legislation and Appendix 4 for profiles of the key swing votes on these Committees.)

Finally, our targeting list identifies Democratic Members who do not serve on the Committees but are viewed as important because of their ability to influence other members. These Members may control blocs of votes in caucuses or delegations or serve as bellwethers for other members with similar philosophies. On the Republican side, these members are our most likely moderate Republican votes. As such, they are keys to forging the majority we need when the bill reaches the House and Senate floors. (See Appendix 5 for our priority targeting list.)

1. Cosponsor Strategy

We currently have 31 cosponsors in the Senate and 101 in the House, but it would be a mistake to consider all of these as solid yes votes at this time. While a number of these are committed to reform and supportive of our plan, others signed on out of a sense of loyalty to the Administration, the Leadership or the Party. Others came on under pressure from their Chairmen or the Leadership. Our approach is designed to reinforce their decision to cosponsor the bill by aiding their understanding of the details of the legislation, increasing their comfort in talking about the plan in public settings, providing assistance in building support in their districts and enlisting them to recruit additional cosponsors.

Over this recess period we have under way a number of activities to reach out to our cosponsors. In addition to the "thank you" breakfast held last week, we have contacted each of the cosponsors and offered them the opportunity to have an administration principal either attend a town meeting in their district or to brief a group of their influential health providers in Washington. We are starting to receive responses to this offer and are working to arrange the logistics. In addition, we are working with the Democratic Policy Committee in the Senate and their House Leadership on a series of regional health care summits planned by our key cosponsors in these areas and featuring the First Lady during January and February.

2. Committee Strategy

As the center of the action on shaping the legislation shifts from the White House to the Congress, we must ensure that the Congress takes ownership both of the issue and the substantive details. Over the next several months, this investment will be critical since we will need to rely on the key Chairmen and the leaders to defend reform against well-run campaigns against it. Our efforts also will involve an ongoing dialogue with those moderate and swing Members whose votes will be pivotal on the Committees.

But high profile negotiations with particular Members over the most controversial issues will represent only a small fraction of the decisions to be made by Congress. Most of the action will take place behind the scenes, by House and Senate Committee staff who will shape ninety percent of the final details. As a result, relationships with the Committees cannot be top heavy; they ultimately must be strong, both professionally and personally, at the staff level as well.

While much attention tends to be focused on the Chairmen and the Staff Directors, the technical staff will make many key decisions, and shape the debate of the remaining controversial decisions which are bumped up to the political decisionmakers. To develop the most effective relationships with the technical committee staff, our legislative and policy staff must invest a great deal of effort as soon as possible with the objective of becoming an indispensable resource to them. Otherwise, they will resort to historic relationships with the departments, the think tanks and other outside experts, who may wish to influence the process not to our liking. We need to create a framework which integrates our experts in this process on a daily basis.

With that stated what follows is an assessment of where we stand with the Committees and our targeting strategy for critical and swing Committee Members.

Overall Assessment by Committee -- House

Looking at the three lead House Committees, it seems clear that strictly in terms of getting the votes to report a bill out of Committee, Education and Labor will be the easiest Committee and Energy and Commerce will be the hardest, with Ways and Means in between. In the case of each Committee, assuming that we win no Republican votes, we can afford to lose only four Democrats. This overall view should give you a sense of how the votes must shape up.

Energy and Commerce

While we can only afford to lose four Democrats, our list of possible problems is considerably longer: Hall, Slattery, Cooper, Rowland, Boucher and Tauzin. The possible Republican gains are long shots, with Greenwood being the best bet and Hastert, Klug and Upton on the target list as well. We should be able to limit our loss of Democrats to four or less, but it is clear that this group will have considerable leverage over the shape of the final package. At introduction we have 8 out of 27 Committee Democrats as co-sponsors, with 23 votes needed to report the bill out of Committee.

If it becomes clear that Energy and Commerce cannot report out as comprehensive a package as the other Committees, it may become necessary for the Committees to diverge and then to bring a compromise package together for floor consideration.

The Committee historically has had strong subcommittees, and the Health subcommittee in particular has generally taken the lead on minor and major health legislation. The full committee typically plays a strong role in reviewing subcommittee action, particularly in controversial areas, but most of the details tend to be worked out in subcommittee.

The Chairman has referred the bill to the Subcommittees for a very short time period, only until March 4th of next year. This is to keep the bill on schedule but it also reflects his nervousness about getting the votes to needed in the Subcommittee. We will need to target the Health Subcommittee and its Members for special attention early in the process because it will be the first place there is a vote on the bill. Since we can only afford to lose two Democratic votes in the Subcommittee (and Roy Rowland and Ralph Hall are unlikely to support the bill), we will have to work especially hard on such moderates Slattery, Brown and Pallone. Even with their support, that will leave Congressman Cooper as the final vote for passage. That is why we even need to establish a dialogue with Rowland and Hall in case their votes prove necessary.

Ways and Means

It is likely that at some point Rostenkowsi will shift the action from subcommittee to full committee, which will diminish Stark's role to some extent. Unlike the Energy and Commerce Committee, Ways and Means has a tradition of major issues being worked out in full committee. Tax reform, for example, was handled almost entirely at the full committee level. Also unlike Energy and Commerce, the subcommittee staff works for the full committee chairman.

While it will be necessary to deal with Stark's concerns, he will try to pull the bill as close as he is able to towards a single payer approach. At the same time, the center of the Committee will pull us in the other direction. On the subcommittee Sandy Levin and Ben Cardin will be key to maintaining a balanced approach. In the end, the full committee is likely to refine and alter the approach if the subcommittee fails to reach a consensus on a politically viable approach. When it gets to the full committee, such Members as Matsui and Kennelly are important since they are influential both with the Chairman and on the floor.

The Democrats most at risk are Payne, Brewster and Andrews. Andrews has told us that he wants to support a bill with universal coverage. The most likely Republicans to vote for a bill are Houghton and Grandy, with Johnson in the next tier. At introduction we have 11 out of 24 Democratic members of the Committee as co-sponsors, with 20 votes needed for passage.

Education and Labor

The Democratic majority on the Committee is very strong. The most at risk democratic votes are Members like Rob Andrews (D-NJ) and Gene Green (D-TX), and these votes should be possible as well. The Republican prospects are not very strong, with Steve Gunderson being the most likely. At introduction we have 16 out of 27 Democratic Committee members (including delegates and Resident Commisioner who can vote in Committee) as co-sponsors, with 22 needed for passage.

Overall Assessment by Committee -- Senate

The infighting between the Finance Committee and the Labor and Human Resources Committee over primary jurisdiction illustrates how difficult it will be for these two primary Committees to work out an amicable division of labor. It is now clear that the two Committees of primary jurisdiction will report out their own versions and visions of health reform legislation. The Labor Committee will have a much easier time of getting the votes needed to deliver their bill to the floor and, no doubt, it will look much more like the bill we have introduced than the one the Finance Committee will report out. The Finance Committee will do whatever is necessary to poll out a bill with bipartisan support.

While it will take them more time and possibly be more contentious, the Finance Committee has the institutional leverage to report a bill that will attract a significant number of votes on the Senate floor. In the end, however, the real power brokers will be Majority Leader Mitchell and Minority Leader Dole. They will be the players who will have the ultimate power to decide what goes to the Senate floor for the initial vote. (Obviously, the leadership will not be able to exert much control over the Senate free-flow amendment process.)

Senate Finance Committee

Because of the philosophical/political make-up of the Finance Committee, it will be much more difficult to obtain the 11 votes necessary to report out a bill. However, a bill reported out of the Committee, particularly if it has received the support of some of the moderate Republicans on the Committee, is more likely to receive bipartisan support than a bill out of the Labor and Human Resources Committee. More specifically, it could be argued that such a bill would be less likely to be targeted with an extended (and possibly detrimental) debate and/or fall victim to a filibuster on the Senate floor.

As of this writing, it appears there are 8-9 relatively certain Democratic votes on the Committee. At introduction, we had 8 of 20 members of the Committee as cosponsors. The two that we must be most concerned about are the two we are always concerned about: Senators Boren and Breaux. The Republicans worth paying particular attention are: Senators Packwood, Dole, Danforth, Chafee, and Durenberger. Two of these Members -- Dole and Chafee -- are particularly critical because they control blocks of Republican votes which can provide cover to those Republicans who want to support reform. Two other Republicans who should not be written off are Senators Roth and Hatch.

Of major importance will be our relationship, and the relationship of the Committee Members, with Chairman Moynihan. His primary interest will be to illustrate his ability to report our a bipartisan bill which can gain the support of the state of New York and Governor Cuomo.

Senator Packwood's departure, should he decide to retire, would be a blow to gaining support from moderate Republicans. His likely successor as Ranking Republican would be Senator Roth, with Senator Danforth next in succession. If Senator Packwood does leave, whether Senator Dole chooses a moderate or conservative to fill the seat on the committee may be a signal of his intentions with regard to health reform. (Note: Senators Gramm and Lott, two of the most conservative Members of the Senate. were the runners up the last time there was Republican opening on the Finance Committee.)

Finally, to strengthen personal relationships, as well as to determine the Members' priorities, Senator Rockefeller has initiated a series of Committee Members only meetings. He has hosted at least three meetings and, from all reports, they have gone fairly well. This is a constructive development since the Members will be less likely to be adversarial during the upcoming debate if they have formed stronger personal ties.

Senate Labor and Human Resources Committee

Of all the five primary Committees of jurisdiction in the Congress, this Committee is the most able and willing to work with us and be responsive to our priorities. It also is the Committee that can most easily and quickly deliver a majority of its Members to report out a bill.

While the Committee should have little problem reporting out the bill on a straight party line vote, there are several moderate Republicans Members including Ranking Republican Senator Kassebaum, our sole Republican cosponsor Senator Jeffords and Senator Durenberger. Of some interest, two Republicans serve concurrently on this Committee and the Finance Committee -- Senators

Durenberger and Hatch. It is likely, however, that they will side with the Finance Committee on issues of substance and jurisdiction.

Committees with Narrow Jurisdiction

We will need to work which each of the Committees with narrower jurisdiction as the process unfolds, but in all likelihood, they will act on a more delayed schedule, waiting to see what superstructure their sections will fit into. The referral in the House calls for committees with limited referral to complete action within two weeks after the three lead committees report out a bill. In the Senate, Committees are likely to report out their own bills concurrently, or soon after, the bills start being reported out of Labor and Finance.

Although we frequently think of the Judiciary, Governmental Affairs, and VA Committees, we cannot forget that there are many other Committees who will demand a role. We are currently, conducteing weekly interagency legislative meetings to coordinate our approach with these other committees.

Committee Activities

Over the last few weeks, Ira Magaziner, Roger Altman and representatives of the White House Legislative Affairs staff have met with key moderate Democrats to open a dialogue on health reform. They also are in the process of meeting with the committee and subcommittee staffs to establish a positive working relationship for the coming weeks. Administration principals (Cabinet Secretaries or Senior White House Officials) and Legislative Affairs staff have been assigned to each of the targeted Members to serve as main contacts on health reform and to monitor their status.

3. Influential Members Strategy:

On the House side, we have identified a number of Democratic Members who do not serve on the primary Committees of jurisdiction but we view as important for our prospects in the House. These include caucus chairs such as Jose Serrano (Congressional Hispanic Caucus) and Dave McCurdy (Mainstream Forum and DLC) and members who are keys to important state delegations such as John Murtha of Pennsylvania. It also includes members such as Dan Glickman who will be influential with other moderate Democratic Members.

The most influential Members of the Senate serve on the Fiance and Labor Committees. However, among our priorities are several moderate to conservative Members who do not serve on these committees and will be amongst the most difficult votes for us to hold including Senators Exon, Heflin, Kerrey and Lieberman. The non-committee Republicans include moderates who are strong prospects -- Senators Cohen and Hatfield. It also lists Senators Bond and Bennett who are taking an active and influential role in Dole's Republican Health Care Task Force. and are worth an outreach effort.

We have also assigned administration principals and legislative affairs staff to each of these Members and have offered them the opportunities for events here or in their district. Ira Magaziner and Roger Altman have been meeting with these members one-on-one over the last few weeks. Their assigned administration principals are also to schedule face-to face meetings with them by the end of January.

Appendix 5

PRIORITY TARGETS (12/14/93)

HOUSE COMMITTEE MEMBERS:

WAYS AND MEANS:

Pickle (TX)
Rangel (NY)*
Ford (TN)
Stark (CA)*
Coyne (PA)*
Andrews (TX)
McDermott (WA)
Klezcka (WI)
Payne (VA)
Hogland (NE)
Neal (MA)
Brewster (OK)

Thomas (CA)
Grandy (IA)
Houghton (NY)

ENERGY AND COMMERCE:

Sharp (IN)
Tauzin (LA)
Richardson (NM)*
Slattery (KS)
Boucher (VA)
Cooper (TN)
Rowland (GA)
Lehman (CA)
Pallone (NJ)
Schenk (CA)
Margolies-Mezvinsky (PA)
Lambert (AR)

Bilarakis (FL)
McMillan (NC)
Upton (MI)
Paxon (NY)
Klug (WI)
Greenwood (PA)

EDUCATION AND LABOR:

Miller (CA)
Andrews (NJ)
Roemer (IN)
Green (TX)
Klink (PA)
English (AZ)*
Strickland (OH)*
Baesler (KY)

Goodling (PA)
Petri (WI)
Roukema (NJ)
Gunderson (WI)
Molinari (NY)
Miller (FL)

* = Health Security Act Cosponsor

CONGRESSIONAL TIMETABLE

As discussed earlier, the timetable for Congressional action will be ambitious and create a great challenge for the Leadership and the Congress as a whole. Appendix 6 provides an outline of a feasible schedule of Congressional legislative actions. Since the most important element of these actions will take place at the Committee and Leadership level, this section focuses primarily on this aspect of the process.

Since jurisdiction is divided among several committees in both the House and the Senate, it will be necessary for different, and perhaps conflicting approaches to be stitched together before legislation is brought to the full House and Senate for a vote in the spring. This process will require several weeks after the bill is reported from the committees. The process will require leadership both from the Administration and from Congressional leaders, but the Committees must also be permitted enough room to work out issues independently, and to win a majority in each committee. The Administration must avoid attempting to micro-manage at each Committee, while at the same time providing the technical support and prodding without which the process is likely to bog down.

In the Senate, Majority Leader Mitchell has the authority and responsibility to schedule the timing and substance of what is brought to the floor before the full Senate. In so doing, he (working closely with the Administration, Chairman Moynihan and Chairman Kennedy, as well as -- hopefully -- Republican Leader Dole) must decide what provisions will go into a Leadership amendment to the bill (S. 1757) pending on the Senate calendar.

As of this writing, it is unclear whether the Finance Committee and the Labor and Human Resources Committee will be able to work out an amicable agreement on a division of jurisdictional responsibilities. Regardless, the advantage we have going in is that the Majority Leader has very good working relationships with the two Committees and will not hesitate to push the Chairmen and the Committees, to the degree necessary, to report out their versions of the legislation in a timely manner.

Should there be an unacceptable delay in reporting out the bill, the Majority Leader can always call up the bill directly off the Senate calendar, amend the bill himself and call it up for Senate consideration. (Obviously, this would not be the most preferable action because it would bypass the Committee process and signal a significant lack of consensus.) Under any scenario, when Senator Mitchell makes a unanimous consent motion to bring the bill up for floor consideration, it is extremely likely that some Member will object. As a result, a 60 vote cloture motion will be necessary for the Senate to take up the bill.

In the House, the process will be managed by the leadership through the Rules Committee, which will determine what version goes to the floor, as well as the content and order of amendments that will be permitted on the floor. In the event that any one Committee is unable to report out a full version of the health care plan, the version going to the floor could reflect the high water mark rather than the least common denominator, with the burden then on the opposition to muster a majority to amend the package.

It would be ideal for the Committees to track each other closely, but if they are unwilling or unable to coordinate, the Rules Committee can still fashion a single new bill representing a negotiated agreement, if the leadership is willing to use the powers of the Rules Committee. Since the leadership has firm control over the Rules Committee, provided we maintain a majority in the full House, a bill could not be held hostage even if a problem develops in one or another committee. In the event that a Committee is unable to muster a majority to report the bill to the floor, the Rules Committee could report out a rule that would discharge the Committee from further consideration and clear the bill for floor consideration nonetheless.

Since a rule only requires a majority of votes, not unanimous consent or a supermajority, even substantial opposition would not present an insurmountable obstacle to floor consideration.

The process of reassembling a bill at the Rules Committee will involve many of the most significant decisions and the Administration will want to play a substantial role in the negotiations. To preserve our ability to help shape the final product sent to the House floor, it would be preferable to avoid making unnecessary commitments during earlier committee consideration. It is inevitable that many issues will be revisited when the bills are stitched together again by the leadership at the Rules Committee. At the same time, the Administration will need to provide constant prodding to keep the process moving along, and on many occasions, we will need to help committees develop alternatives to keep the process moving along.

Once the bills pass both Houses, the conference will represent another test for the Congress and the Administration. It is our expectation that the conference will last through the summer and through most of September. And, as is typical with the Congress, only the prospect of the end of the session and the pressure from Members desiring to adjourn to attend to reelection efforts will produce the conference agreement.

Our success in influencing the conference process will depend on the degree to which we were able to establish productive working relationships with the Committee Chairmen and the Leadership earlier in the legislative process. To the degree this occurs, the Chairmen will call on us to referee conflicting opinions and positions. It will also open the door for us to put pressure on the conferees to conclude the agreement prior to Congress going out of session.

Appendix 1
Health Security Act - House Cosponsors

1. Gephardt, Richard (D - MO)
2. Bonior, David (D - MI)
3. Hoyer, Steny (D - MD)
4. Fazio, Vic (D-CA)
5. Kennelly, Barbara (D - CT)
6. Lewis, John (D - GA)
7. Richardson, Bill (D - NH)
8. Dingell, John (D - MI)
9. Rostenkowski, Dan (D - IL)
10. Ford, Bill (D - MI)
11. Waxman, Henry (D - CA)
12. Collins, Cardiss (D - IL)
13. Stark, Pete (D - CA)
14. Williams, Pat (D - MT)
15. Clay, Bill (D - MO)
16. Brooks, Jack (D - TX)
17. Moakley, Joe (D - MA)
18. Abercrombie, Neil (D - HI)
19. Ackerman, Gary (D - NY)
20. Andrews, Thomas (D - ME)
21. Barett, Thomas (D - WI)
22. Berman, Howard (D - CA)
23. Bilbray, James (D - NV)
24. Blackwell, Lucien (D - PA)
25. Borski,Robert (D - PA)
26. Brown, George (D - CA)
27. Brown, Corrine (D - FL)
28. Cardin, Benjamin (D - MD)
29. Clyburn, James (D - SC)
30. Coyne, William (D - PA)
31. de Lugo, Ron (D - VI)
32. DeLauro, Rosa (D - CT)
33. Deutsch, Peter (D - FL)
34. Dicks, Norman (D - WA)
35. Dixon, Julian (D - CA)
36. Durbin, Richard (D - IL)
37. Edwards, Don (D - CA)
38. Engel, Eliot (D - NY)
39. English, Karan (D - AZ)
40. Eshoo, Anna (D - CA)
41. Faleomavaega, Eni (D - AS)
42. Filner, Bob (D - CA)
43. Flake, Floyd (D - NY)
44. Foglietta, Thomas (D - PA)
45. Frank, Barney (D - MA)
46. Gejdenson, Sam (D - CT)
47. Gibbons, Sam (D - FL)
48. Hastings, Alcee (D - FL)
49. Hilliard, Earl (D - AL)
50. Hinchey, Maurice (D - NY)
51. Johnson, Eddie B. (D - TX)
52. Johnston, Harry (D - FL)
53. Kanjorski, Paul (D - PA)
54. Kreidler, Mike (D - WA)
55. LaFalce, John (D - NY)
56. Lantos, Tom (D - CA)
57. Levin, Sander (D - MI)
58. Long, Jill (D - IN)
59. Martinez, Matthew (D - CA)
60. Matsui, Robert (D - CA)
61. McKinney, Cynthia (D - GA)
62. Meek, Carrie (D - FL)
63. Minge, David (D - MN)
64. Mink, Patsy (D - HI)
65. Murphy, Austin (D - PA)
66. Murtha, John (D - PA)
67. Norton, Eleanor (D - DC)
68. Oberstar, James (D - MN)
69. Obey, David (D - WI)
70. Owens, Major R. (D - NY)
71. Pastor, Ed (D - AZ)
72. Payne, Donald (D - NJ)
73. Rahall, Nick (D - WV)
74. Rangel, Charles (D - NY)
75. Reynolds, Mel (D - IL)
76. Romero-Barcelo, Carlos (D - PR)
77. Rush, Bob (D - IL)
78. Sabo, Martin (D - MN)
79. Sawyer, Thomas (D - OH)
80. Scott, Robert (D - VA)
81. Serrano, Jose (D - NY)
82. Shepherd, Karen (D - UT)
83. Skaggs, David (D - CO)
84. Slaughter, Louise (D - NY)
85. Smith, Neal (D - IA)
86. Stokes, Louis (D - OH)
87. Strickland, Ted (D - OH)
88. Studds, Gerry (D - MA)
89. Swift, Al (D - WA)
90. Synar, Mike (D - OK)
91. Thornton, Ray (D - AR)
92. Thurman, Karen (D - FL)
93. Traficant, James (D - OH)
94. Underwood, Robert (D - GU)
95. Unsoeld, Jolene (D - WA)
96. Vento, Bruce (D - MN)
97. Watt, Melvin (D - NC)
98. Wheat, Alan (D - MO)
99. Wise, Robert (D - WV)
100. Yates, Sidney (D - IL)
101. Swett, Dick (D - NH)

Health Security Act - Senate Cosponsors

Daniel Akaka (HI)
Max Baucus (MT)
Barbara Boxer (CA)
Dale Bumpers (AR)
Ben Nighthorse Campbell (CO)
Kent Conrad (ND)
Tom Daschle (SD)
Christopher Dodd (CT)
Diane Feinstein (CA)
John Glenn (OH)
Bob Graham (FL)
Tom Harkin (IA)
Daneiel Inouye (HI)
Jim Jeffords (VT)
Edward Kennedy (MA)
Patrick Leahy (VT)
Carl Levin (MI)
Harlan Mathews (TN)
Howard Metzenbaum (OH)
Barbara Mikulski (MD)
Carol Moseley-Braun (IL)
Daniel Patrick Moynihan (NY)
Patty Murray (WA)
Claiborne Pell (RI)
David Pryor (AR)
Harry Reid (NV)
Donald Riegle (MI)
Jay Rockefeller (WV)
Paul Simon (IL)
Harris Wofford (PA)

Total: 31

Appendix 2

COMMITTEE REFERRALS OF THE HEALTH SECURITY ACT

House:

Energy and Commerce
Ways and Means
Education and Labor
Armed Services
Veterans' Affairs
Post Office and Civil Service
Natural Resources
Judiciary
Rules
Government Operations

Senate:*

Finance
Labor and Human Resources
Armed Services
Veterans' Affairs
Government Affairs
Indian Affairs
Judiciary

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* [Because of the jurisdictional dispute all of the health reform bills introduced in the Senate have been referred directly to the Calendar rather than to the Committees. However all these committees can be expected to report out intiatives within their jurisdiction.]

Appendix 3

HOUSE COMMITTEES OF PRIMARY JURISDICITION

Energy and Commerce Committee

Democrats (27):

John Dingell, MI (Chair)*
Henry Waxman, CA*
Philp Sharp, IN
Edward Markey, MA
Al Swift, WA*
Cardiss Collins, IL*
Mike Synar, OK*
W.J. Tauzin, LA
Ron Wyden, OR
Ralph Hall, TX
Bill Richardson, NM*
Jim Slattery, KS
John Bryant, TX
Rick Boucher, VA
Jim Cooper, TN
J. Roy Rowland, GA
Thomas Manton, NY
Edolphus Towns, NY
Gerry Studds, MA*
Richard Lehman, CA
Frank Pallone Jr., NJ
Craig Washington, TX
Lynn Schenk, CA
Sherrod Brown, OH
Mike Kriedler, WA*
Marjorie Margolies-Mezvinsky, PA
Blanche Lambert, AR

Republicans (14):

Carlos Moorhead, CA
Thomas Bliley, VA
Jack Fields, TX
Michael Oxley, OH
Michael Bilarakis. FL
Dan Schaefer, CO
Joe Barton, TX
J. Alex McMillan, NC
Dennis Hastert, OH
Fred Upton, MI
Cliff Stearns, FL
Bill Paxon, NY
Paul Gillmor, OH
Scott Klug, WI
Gary Franks, CT
James Greenwood, PA
Mike Crapo, ID

* = Health Security Act cosponsor

Ways and Means Committee

Democrats (24):

Dan Rostenkowski, IL (Chair)*
Sam Gibbons, FL*
J.J. Pickle, TX
Charles Rangel, NY*
Fortney "Pete" Stark, CA*
Andrew Jacobs, IN
Harold Ford, TN
Robert Matsui, CA*
Barbara Kennelly, CT*
William Coyne, PA*
Michael Andrews, TX
Sander Levin, MI*
Benjamin Cardin, MD*
Jim McDermott, WA
Gerald Kelczka, WI
John Lewis, GA*
Lewis Payne Jr., VA
Richard Neal, MA
Peter Hoagland, NE
Michel McNulty, NY
Mike Kopetski, OR
William Jefferson, LA
Bill Brewster, OK
Mel Reynolds, IL*

Republicans (14):

Bill Archer, TX
Philip Crane, IL
William Thomas, CA
E. Clay Shaw, FL
Don Sundquist, TN
Nancy Johnson, CT
Jim Bunning, KY
Fred Grandy, IA
Amo Houghton, NY
Wally Herger, CA
Jim McCrery, LA
Mel Hancock, MO
Rick Santorum, PA
David Camp, MI

* = Health Security Act cosponsor

Education and Labor Committee

Democrats (27):

William Ford, MI (Chair)*
William Clay, MO*
George Miller, CA
Austin Murphy, PA*
Dale Kildee, MI
Pat Williams, MT*
Matthew Martinez, CA*
Major Owens, NY*
Thomas Sawyer, OH*
Jolene Unsoeld, WA*
Patsy Mink, HI*
Robert Andrews, NJ
John Reed, RI
Timothy Roemer, IN
Eliot Engel, NY*
Xavier Becerra, CA
Robert Scott, VA*
Gene Green, TX
Lynn Woolsey, CA
Carlos Romero-Barcelo, PR*
Ron Klink, PA
Karan English, AZ*
Ted Strickland, OH*
Ron deLugo, VI*
Eni Faleomavaega, AS*
Scotty Baesler, KY

Republicans (15):

William Goodling, PA
Thomas Petri, WI
Marge Roukema, NJ
Steve Gunderson, WI
Richard Armey, TX
Harris Fawell, IL
Cass Ballenger, NC
Susan Molinari, NY
Bill Barrett, NE
John Boehner, OH
Duke Cunningham, CA
Peter Hoekstra, MI
Buck McKeon, CA
Dan Miller, FL
(vacancy)

* = Health Security Act cosponsor

SENATE COMMITTEES OF PRIMARY JURISDICTION

Finance Committee

Democrats (11):

Daniel Patrick Moynihan, NY (Chair)*
Max Baucus, MT*
David Boren, OK
Bill Bradley, NJ
George Mitchell, ME*
David Pryor, AR*
Jay Rockefeller, WV*
Thomas Daschle, SD*
John Breaux, LA
Kent Conrad, ND*

Republicans (9):

Bob Packwood, OR
Robert Dole, KS
William Roth, DE
John Danforth, MO
John Chafee, RI
Dave Durenberger, MN
Charles Grassley, IA
Orrin Hatch, UT
Malcolm Wallop, WY

Labor and Human Resources Committee

Democrats (10):

Edward Kennedy, MA (Chair)*
Claiborne Pell, RI*
Howard Metzenbaum, OH*
Christopher Dodd, CT*
Paul Simon, IL*
Tom Harkin, IA*
Barbara Mikulski, MD*
Jeff Bingaman, NM
Paul Wellstone, MN
Harris Wofford, PA*

Republicans (7):

Nancy Kassebaum, KS
James Jeffords, VT*
Dan Coats, IN
Judd Gregg, NH
Strom Thurmond, SC
Orrin Hatch, UT
Dave Durenberger, MN

* = Health Security Act cosponsor

Appendix 4

PROFILES OF KEY SWING COMMITTEE MEMBERS

HOUSE COMMITTEES

Energy and Commerce Committee

DEMOCRATS:

CONGRESSMAN RICK BOUCHER (D-VA): Congressman Boucher is a lawyer and former McGovern advance man with one of the most liberal voting records in the Virginia delegation. He is unyielding in his opposition to the tobacco excise tax. On the Energy and Commerce Committee, Boucher played an important role as a member of the "group of nine" in the 100th Congress – a caucus of moderate-to-conservative Democrats who tried to end a Clean Air stalemate between pro-industry and environmental factions. Boucher also serves on the Judiciary Committee and is a member of the Rural Health Care Coalition and the Mainstream Forum.

On health care matters, Boucher will be concerned about black lung disease as well as tobacco. He has voted pro-choice.

CONGRESSMAN JIM COOPER (D-TN): Congressman Cooper is using the press he is gaining on health care as a spring board to his run for the Senate. In last week's profile. TIME magazine described Cooper's reaction to attacks on his plan by the White House: "he's relishing every minute of it." Cooper considers the employer mandate the most controversial element of the plan – "a clumsy and expensive way of achieving universal coverage." He contends that by knocking down the barriers that block poor and sick people from obtaining health insurance, his plan would come close to universal coverage leaving as "few" as six million uninsured. His pursuit of his own plan and stated search for common ground is consistent with his history as a Member who has been instrumental in forging compromises on the Energy and Commerce Committee.

Recent Developments: December 2 USA Today: Regarding Ira's speech to the Chamber of Commerce and offer of compromise, "It's a continuation of their past policy of wanting to discuss options with everyone. You'll see continued discussion among the White House, Chafee, and Cooper."

In the December 3 Wall Street Journal article about Cooper he said: "All our bills are first cousins ... This really is a battle between the Old Democrat and the New Democrat – whether you believe the philosophy of entitlement or the philosophy of empowerment ... I do like to fight for what I believe in. I'm not ashamed to eat crow."

In a December 14 New York Times squib about universal coverage, Cooper complains: "There are 20 other dividing lines they could have chosen."

CONGRESSMAN RALPH HALL (D-TX): Congressman Hall's voting record reflects the rural area he represents. Fiscally conservative, he often votes with the Republicans, as he has done this year in voting against the Administration on all three economic policy votes. He sits on the Health Subcommittee and has been targeted by the health insurance industry.

Hall is a member of the Rural Health Care Coalition and is opposed to employer mandates and cost controls on providers. He is also anti-choice. Hall is sympathetic to physician concerns and supports improvements in organ transplantation. He is close to Chairman Dingell. While it is highly unlikely that Hall will vote for the final package, he might be persuaded to vote for it in committee to get it to the floor.

CONGRESSMAN JIM SLATTERY (D-KS): Congressman Slattery is a moderate to conservative Democrat who has been willing to buck the leadership in order to reduce the budget deficit. As a candidate for governor in 1994 and member of both Energy and Commerce and the Veterans' Committee, Slattery's interest in health care combines both his present federal and hoped for future state role. He is also a member of the Rural Health Care Coalition and the Mainstream Forum. In the 100th Congress, he was part of the committee's "group of nine" on the Clean Air Act. Slattery often works together with Representative Glickman and Long and moderate conservatives look to him for leadership.

Health care is one issue on which Slattery has indicated a willingness to spend more federal dollars. He has sponsored or cosponsored bills to expand Medicaid coverage to poor children, to improve rural access to health care, and to improve the availability and affordability of health insurance for small businesses. In the current health care reform debate, Congressman Slattery is concerned about states and state flexibility, especially with respect to cost containment. He believes the mandate for small business is excessive. He is also very concerned about a payroll tax. Slattery has suggested limiting the deduction for tobacco advertising. While he wants to support the Administration on health care reform, he is strongly anti-choice and might oppose the final package if reproductive rights are included.

Slattery told the AP following the President's speech: "I want to give the President a lot of credit for tackling what I consider the most complex domestic problem we have faced in 50 years." He was specifically interested in funding. He told the Kansas Eagle: "It's going to need more changes ,... to make it fit Kansas."

Recent Developments: The Washington Times reported on October 16 that Reps. Slattery and Cooper were working on a plan that would allow women to purchase supplemental insurance for abortion services at a minimal price.

Slattery told Newsday on October 31: "It's vital the government be candid with the American public about how far the Clinton plan can go ... we are not going to solve this problem ... because we're all going to die."

CONGRESSMAN ROY ROWLAND (D-GA): Congressman Rowland is a key player on health care reform not only because he is a physician and respected southern Democrat, but because he will be a point person for veterans, rural areas, and small business. Chairman Dingell and Rep. Waxman rely on Rowland's credibility and as a go-between for committee moderates and liberals. Rowland is also close to Rep. John Lewis.

Rowland is concerned about financing the plan and is opposed to mandates. After the President's speech he told The Atlanta Constitution, "(The President) talked about a lot of things that I agree with. But I'm uneasy about creating another large federal program when we don't have a way to pay for it and it could be worse than what we have now." He is a strong supporter of preventive health care for children and high-risk mothers. In past legislation, he has authored "anti-hassle" bill to reduce Medicare red tape.

Recent Developments: Rowland told the AP on November 18 that Congress should not take the package apart. "I believe this issue should be tackled in whole." The next day, after introduction of his Community Health Improvement Act, he signalled a possibly different approach when he told the Atlanta Constitution: "I think part of the health care system needs fixing and part of it is working pretty good."

CONGRESSMAN W.J. "BILLY" TAUZIN (D-LA): Congressman Tauzin is a Cooper-Grandy cosponsor. He is known as a coalition builder on the Energy and Commerce Committee, most notably forging a compromise that facilitated the passage of the Clean Air Act. On issues not related to gas and oil, he is often a key swing vote, reluctant to take sides early on and eager to negotiate. He has been targeted by the health insurance industry.

On health care issues, the Congressman is very concerned about the cost of prescription drugs for Medicare and Social Security beneficiaries. He notes that estimates indicate 30-35% of Louisianans are uninsured, and is concerned about rationing. Tauzin is protective of small business employees, and will likely oppose an employer mandate. He favors tort reform but is opposed to coverage of abortion in the plan.

Recent Developments: Speaking about the Cooper-Grandy bill, he told the New Orleans Times-Picayune on October 7: I think it's pretty fundamental that you keep it as close to the private sector as possible. If you go the route of the Clinton Administration, you're talking bigger government and more bureaucracy, which ought to be the last thing on our minds."

REPUBLICANS:

CONGRESSMAN JIM GREENWOOD (R-PA): A former social worker who dealt with children, Freshman Congressman Greenwood campaigned for creating a health care system. He is concerned about rural coverage and small business subsidies and about the employer mandates.

Recent Developments: In a November meeting with Jack Lew, Greenwood questioned the way the premium cap would work in the first three years, believing it looked to him like a total of 15%. He feels there are unrealistically tight constraints in the first three years. He wants to continue to discuss the issue with the administration during the break.

CONGRESSMAN J. DENNIS HASTERT (R-IL): Congressman Hastert was selected by House Minority Leader Michel to be his point person on health care reform. A fellow Illinoisan, Hastert's appointment was a surprise, considering that he is only in his fourth term in the House and his second term on the Energy and Commerce Committee. Congressman Hastert is generally not known to be a mover and shaker in the House or in health care reform. However, he does seem to reflect the "Michel style" of House Republican. While Hastert is a staunch conservative, he is willing to offer proposals and be a part of the process. On health care, however, he seems to be taking a fairly hardline approach.

Congressman Hastert has sponsored his own "Health Care Choice and Access Improvement Act" (HR 150), which would reform the small group insurance market, increase the tax deductibility for the self-employed, and allow employers to establish tax-free Medi-Save accounts.

Congressman Hastert was pleased with and appreciative of the early briefings by Ira and other members of the working groups to Republican members. He has spoken about the need to hold costs down and to open up access. He has indicated a desire to be helpful.

Recent Developments: Hastert told Reuters on October 4 that the Clinton plan establishes a huge new government agency with more than 50,000 bureaucrats at the federal level alone. "Goverment will define your benefits, decide what new medicines and new technologies you can have, and will attempt to control the prices you pay. Another government-run agency like the IRS is not what Americans want." He said Republicans " cannot sign onto a plan we know is flawed just for the sake of appearing bipartisan. I hope the White House will not choose the path of confrontation."

On October 21 he cosigned the letter to the President regarding SBA involvement in health care reform.

CONGRESSMAN SCOTT KLUG (R-WI): Congressman Klug is a Cooper-Grandy cosponsor and a new member of the Energy and Commerce Committee. He is also part of the Tuesday Group, and previously served on the Select Committee on Children and Education and Labor. In comments to AP after the President's speech Klug had two concerns: small business and the National Health Board. He is a rural health advocate and has called for early intervention programs for at-risk children.

Recent Developments: Rep. Klug cosigned the letter regarding SBA involvement in health care reform.

CONGRESSMAN FRED UPTON (R-MI): Serving his fourth term in the House, Congressman Upton is a protege of former Budget Director Stockman. Upton is a member of the Energy and Commerce Committee and the Wednesday Group. He is known to listen closely to local groups.

Upton is concerned about rural coverage, malpractice, and financing of the administration plan. Upton supports abortion to save the life of the mother and in cases of rape or incest.

Recent Developments: On November 5 Upton told the Washington Post that he was worried that "if the auto companies were forced to lay off people, our money (in Michigan) could easily run out with a quarter (of the year) left, thus stranding families that needed care." He said that possibility, as raised in health insurance ads, seemed all too real to him.

Ways and Means Committee

DEMOCRATS:

CONGRESSMAN MICHAEL ANDREWS (D-TX): Congressman Andrews is considering making a statement in support of universal coverage. He sees himself as providing balance on the Committee as Stark moves closer to single player. He is close to Chairman Rostenkowski, as well as Secretary Bentsen and Rep. Stenholm. Andrews is viewed a bellwether for his delegation, He recently announced his intention to run for the Senate in 1994.

Andrews is a new member of the Health Subcommittee and a supporter of managed competition. He supports a tax cap on benefits and the use of the tobacco tax to fund health care reform. He is nervous about the potential power of the alliances and cost controls and the impact they might have on managed competition. He is also worried about too much government intrusion. Andrews's other concerns include children, immunization, low-income women, and rural areas. Congressman Andrews district is known as the health capitol of the world. He is close to the Texas AMA.

Andrews' vote is a long-shot but women's groups could help as he is indebted to them for their help in his last election.

Recent Developments: At a November meeting with Jack Lew and Ira, he stated he wanted the DLC and the Chafee discussion group to make statements supporting universal coverage. He was puzzled by the attacks on Cooper because he believes we have to work on those in the middle-of-the-road. He wants to help us understand their concerns. Andrews believes tort reform is as important to the Republicans as the alliance strcuture.

CONGRESSMAN BILL BREWSTER (D-OK): Congressman Brewster is a conservative and a member of both the Mainstream Forum and the Conservative Democratic Forum. He is close to Reps. Montgomery, Peterson, and Stenholm.

A licensed pharmacist, he is one of five health professionals in the Congress. Congressman Brewster is concerned about the ongoing funding for health reform. He believes the revenue base must be strong and permanent, and he wonders whether sin taxes will be sufficient. He will be a strong supporter of rural health reform and primary care. In addition, he urges that the President's plan endorse utilization review. Brewster likes global budgets. Although he supports universal coverage and reducing the costs to many small businesses, problem areas for him will be health alliances if they are not always available and if they reduce residents options because of costs.

Recent Developments: After the President's speech, Brewster said: "If this bill is done incorrectly, this country will suffer. It has to be a balanced approach. As the old saying goes, the devil is in the details."

CONGRESSMAN LEWIS PAYNE (D-VA): Congressman Payne represents Southern Virginia where his constituents include several thousand tobacco farmers. He is very conservative and is a member of the Conservative Democratic Forum, the Rural Health Care Coalition, and the Mainstream Forum.

He is a consistent supporter of abortion rights and civil rights but voted against a minimum wage increase and the Family and Medical Leave Act. If he supports the President, he will do so on his own and not due to pressure from the Chairman or the Leadership.

REPUBLICANS:

CONGRESSMAN FRED GRANDY (R-IA): Congressman Grandy, who is challenging his party's governor in 1994, has been considered one of the ablest of the younger generation of House Republicans. He is, of course, pushing his own plan and believes the philosophical debate will be between Democrats emphasizing security and Republicans emphasizing choice. He states his goals as universal access and cost containment. Grandy left the Education and Labor Committee to serve on Ways and Means. He calls himself a "knee-jerk moderate." Although Grandy voted against Family and Medical Leave, he remains a White House target on health care.

Grandy is a member of the Health Subcommittee. He is regularly allied with business and against labor interests. He has expressed concern about the need for increased funding for immunizations. He believes too much money is spent in the last months of life and is concerned about coverage for self-employed individuals. He is an abortion opponent.

Recent Developments: On November 5 Grandy said: "I've got to believe that if Leon Panetta were still chairman of the Budget Committee, he'd call time out at this point. We've passed the point of believing the numbers. It's the assumptions we're contending with now. I don't have any problem with Americans paying more for health care. It's not a question of 40% or 30% or 35%, it's this tendency (by the White House) to over-promise and ultimately under-deliver."

In the November 22 New Republic he said: "The more they beat up on Cooper, the more they help him."

CONGRESSMAN AMO HOUGHTON (R-NY): Congressman Houghton is a new member of the Ways and Means Committee and a Cooper-Grandy co-sponsor. He is one of the few House members to vote against repeal of catastrophic. His core issues are the burden on business, rural coverage, primary care, and what happens to those who cross state lines for medical care.

Recent Developments: Houghton is meeting regularly with Ira to discuss the substance of the bill.

CONGRESSWOMAN NANCY JOHNSON (R-CT) - Congresswoman Nancy Johnson is a moderate Republican who can also be angrily partisan. While she wants to be a player in health care and is a Cooper-Grandy cosponsor, she is a high maintenance member and time spent with her will not guarantee her help. Johnson is attending the bipartisan meetings attempting to map out a "centrist" health plan. The Congressional Quarterly has called her "the most change oriented of the Republicans" because of her having introduced "one of the first major bills to overhaul the insurance system and encourage streamlining of government and of paperwork."

Johnson's husband is an oncologist, and she has said repeatedly that doctors are not the cause of the country's health care ills. She questions the costs and bureaucracy of the Health Security Act. She is particularly worried that the plan could be painful to Connecticut's economy. Health care restructuring there has already led to mergers, cutbacks, and job losses. In 1990 Connecticut ranked eighth in the nation in the percentage of its workers employed in health services.

With her seat on the Health Subcommittee, she has focused on Medicare, health, and child care. Johnson is a strong supporter of outcomes research. She does not see insurance reform as the key to cost control and believes that cost controls in the private sector are more advanced than in the government. She also has expressed worry that alliances would be too big. Johnson has stated that she is very discouraged about abortion coverage and that "the problem is not the Republicans' fault. The Democrats are very divided on the issue."

Recent Developments: Johnson cosigned the letter on the Access Initiative. On October 27 she talked about the employer mandate: "Not only is this a new burden at this time for our economy but it's an open-ended burden which has ramifications for small employers in Connecticut."

Education and Labor Committee

DEMOCRATS:

CONGRESSMAN ROBERT E. ANDREWS (D-NJ): Congressman Andrews believes that for the first time in considering health care reform we can get beyond the special interest groups. While portrayed as adamantly opposed to new taxes, his staff told Secretary Reich in November that Andrews could support the Health Security Act provided that someone explained the final budget numbers to him. Andrews will be influenced by Chairman Ford, organized labor and possibly Governor Florio's defeat.

Andrews's district includes both Prudential and pharmaceutical companies and he is likely to be sensitive to their concerns.
At a May meeting with Chris Jennings, Andrews advocated orienting the message toward those with health insurance. He thinks the cost issue is driving the debate. His main point is that the message be simple. He believes it will be difficult to sell but he wants to be helpful.

CONGRESSMAN GENE GREEN (D-TX): Congressman Green is a freshman and a member of the Mainstream Forum. A lawyer, he represents largely working class neighborhoods of Houston. He serves on both Education and Labor and Merchant Marine and Fisheries.

He has changed his opinion on abortion and is now pro-choice. He is concerned about preventive medicine and pediatrics.

Recent Developments: Green cosigned the letter to the President regarding Medicare and medicaid cuts.

REPUBLICANS:

CONGRESSMAN STEVE GUNDERSON (R-WI): Congressman Gunderson is a Cooper-Grandy co-sponsor who serves on the House Republican Task Force on Health and is a member of the Wednesday Group. After the President's speech. Gunderson questioned some aspects of the plan but said: "there's no doubt in my mind that this is the beginning of a bipartisan process toward enactment of a comprehensive solution." Gunderson also noted that the plan contains provision of a rural health reform bill he introduced in January, such as 100 % deductibility of the cost of health insurance premiums for the self-employed.

On health care issues, Gunderson is worried that managed competition could fail rural areas because of the lack of sufficient medical resources. He questions the bureaucracy in the Health Security Act and the plan's impact on small business. He is also concerned about emergency services with waivers and outpatient clinics.

Recent Developments: Rep. Gunderson cosigned the letter regarding Medicare and Medicaid cuts. About possible cosponsorship, he told the Congressional Quarterly in November: "Even if you are a Democrat who wants to help the administration, why sponsor a bill with an employer mandate when the Senate might strip it out? I told her (the First lady) that the problem with a Republican signing on is that it would mean taking myself out of the legislative negotiations. 'You don't want me to cosponsor it now, you want me at the end.'"

SENATE COMMITTEES

Finance Committee

DEMOCRATS:

SENATOR DAVID BOREN (D-OK) – Senator Boren's initial reactions on health care have been cautious – applauding the effort and worried about financing. Like virtually every member of the Finance Committee, Senator Boren considers himself to be a strong supporter of rural health and small business issues. Boren also supports state flexibility within the context of any health reform proposal. He is worried about the employer mandate. Boren has been a member of the bipartisan group seeking to map out a single "centrist" health plan. The health insurance industry has targeted Senator Boren.

Recent Developments: In an October 1 op ed piece in the New York Times co-authored by Senator Danforth, Boren wrote: "Clinton cannot succeed as a centrist if the Administration continues to follow a 'democrat only' strategy ... Health care may be Mr. Clinton's greatest opportunity for bipartisanship. There is much on which Republicans and Democrats agree, ie: Americans deserve health care security; costs cannot grow at three times the rate of inflation; universal coverage. And we agree on some solutions: insurance market reform; managed competition and purchasing cooperatives."

SENATOR JOHN BREAUX (D-LA) – Senator Breaux was not overly active in health care issues until joining Senator Boren to sponsor the Senate companion bill to the Cooper/Conservative Democratic Forum's managed competition initiative. Being a sponsor of a bill that is now being characterized by many in the media as being in the "center" of the debate is very appealing to his desires of being a major "player" in the health care debate. He wants to be one of the primary dealmakers in this debate and he strongly believes he can deliver a number of votes beyond himself.

While being a cosponsor of the Senate version of the Cooper bill, Senator Breaux is not completely comfortable with every aspect of it. For example, he remains concerned about its ability to adequately respond to rural health needs.

Recent Developments: In a mid-November meeting with Ira, Steve Ricchetti, and Chris Jennings, Breaux offered to help work with moderate-conservative Democrats. He stated (though later in the day retracted) his desire to get the CDF Democrats to sign off on the concept that universal coverage had to be guaranteed in whatever legislation was enacted by the Congress. (All along it has been clear that his major

stumbling block would NOT be this issue or the issue of mandates; rather, his major concern is and will be cost containment and premium caps, as well as size and structure of alliances).

During the meeting, Breaux complained that the White House is "out there savaging the Cooper plan all over the country, and the attack is hurting me too." Breaux has repeatedly called the Health Security Act a "gumbo" and criticized it for its reliance on government regulation to control costs.

On December 4 he told the Washington Post: "The question we must now work on, and we are working on, is how and when do we get there (universal coverage). He stated his belief that a phased-in schedule for universal coverage could be a workable compromise.

REPUBLICANS:

SENATOR JOHN CHAFEE (R-RI) - Senator Chafee has been both temperate in his criticism and firm in his desire to move forward on health care reform in this Congress. Chafee comes to this debate with residual feelings that if not for Presidential and partisan politics in the last Congress, there was enough consensus between his and many Democrats' bills to move forward on health reform. He is working with conservative Democrats to shape a compromise.

Recent Developments: Chafee told the New York Times on November 13 that while he would try to get everyone covered by requiring individuals to buy insurance, that approach has the problem of the specter of the IRS. He said that to enforce the mandate on individuals "you will have to show on your tax return that you have health insurance."

In the November 16 Washington Times he said of the possibility of a national cap on health spending, it is "less of an anathema to me ... maybe if nothing else works that's the way you've got to go."

SENATOR JOHN DANFORTH (R-MO) - It is not yet clear how Senator Danforth's decision to retire will affect his ultimate decision of health care reform. He has, however, been consistent in seeking a bipartisan approach and telling the New York Times: "There are points of disagreement, but it's easy to overemphasize them." He is part of the bipartisan group trying to shape a "centrist" plan. Despite admonitions from his staff and other Republicans, Danforth is an advocate of imposing strong federal/state caps on health spending. He also believes that to do so would require explicit rationing.

The Senator has been vocal in opposing the possibility of new taxes for health care reform. He believes that universal coverage is important, but that it should be phased in. He believes the tax cap should apply to both employees and employers.

Recent Developments: Also to the New York Times on October 31: "It is bureaucratic. There are these massive health alliances."
In the November 5 Washington Post he suggested that the costs of the plan would be shaved by making the benefits less generous.

At Monday's conference Danforth stated: "Entitlements cannot be controlled by health care reform alone."

SENATOR BOB DOLE (R-KS) - The Minority Leader has continued to publicly balance criticism of the plan with a commitment to bipartisanship. While it is hard to dispute his September 24 statement to USA Today that health care would be "a long, long tortuous road," there appears to be building pressure on him to remain cooperative. Dole is very effective with two of our key Republicans - Senators Chafee and Kassebaum. His criticisms have focused specifically on the financing of the plan.

Senator Dole has a strong interest in rural health and is currently Co-Chair of the Senate Rural Health Caucus. Legislatively, he has supported initiatives to protect the viability of small rural hospitals as well as to expand civil rights protection and services for the handicapped. His individual concerns include veterans, mental health coverage, and the self-employed.

Recent Developments: To the AP on December 4: "We have different ideas on how to make it work. We don't like price controls, we don't like mandates on small business people, we don't like these mandatory health alliances ... If I had to guess ... I would say that about in April of next year, there will be a new plan. it will be sort of a consensus plan: some of this plan, some of that plan ... some of the Clinton plan. And if that happens, we'll have braod, bipartisan support." On December 13, his Chief of Staff, Shiela Burke, met with Ira, Steve, Chris, Melanne, and Greg. She was very constructive, more positive than usual, and suggested that we continue our outreach work with the Committees.

A Robert Novak column on December 13 lamenting the GOP passiviity on health care said: "Dole is seen by his colleagues as moving inexorably toward cosponsorship with Senate Majorty Leader George Mitchell on a final compromise."

SENATOR DAVE DURENBERGER (R-MN) - Senator Durenberger has been viewed as a possible ally on both Finance and Labor, especially given his close relationship with Senator Rockefeller. However, Durenberger's cosponsorship of the Cooper-Breaux bill and recent comments to Chris Jennings reflect his moving away from, rather than closer to, the Administration. This is especially noteworthy because his public comments have indicated a willingness to seek consensus.

He has raised questions about the employer mandate and cost containment and is nervous about price controls.

Recent Developments: On the turf battle between the two committees, Durenberger told the Washington Post: "I'm a non-loser. I want to see both of them in there" working together.
He told the Wall Street Journal on November 23: "We're for universal coverage, but not until you can satisfy the American people that it can be paid for."

The Minneapolis Star Tribune reported in mid-November that Durenberger had been stunned when a citizens' jury preferred a single payer plan and rejected both his and Administration representatives. Durenberger's chief-of-staff said: "That experience told us we've got to be able to explain in good, simple, clear language what managed competition is about, because people do not want a complicated system."

SENATOR BOB PACKWOOD (R-OR) - The situation with Senator Packwood is, at the very least, awkward. In addition to the serious ethics charges now being investigated, he has never been comfortable with the Republican leadership. During his re-election campaign, Packwood singled out health care as an issue on which he was closer to then-Governor Clinton than his Democratic opponent. Packwood is a strong pro-choice advocate. He is rare among Republicans, and even some Democrats, in that he supports an employer mandate. Packwood is concerned about the limits that the Administration says it would impose on small business subsidies and for low-income individuals to pay for their health coverage.

Recent Developments: On December 6 Packwood told that New York Times that he blocked part of the bill from going to Labor and acknowledged that whatever emerges next year will not be one committee's product but a "collective bill."

Labor and Human Resources Committee

DEMOCRATS:

SENATOR JEFF BINGAMAN (D-NM) – Senator Bingaman supports the managed competition model's focus on market adjustment of health care costs but has also supported an eventual cap on health care spending. He refused to endorse the plan following the President's speech, saying he wanted to scrutinize it for its effect on New Mexico, particularly rural areas and small business. He would like to see additional individual responsibility build into the system and asked in September: "Why does it not make sense to maintain some kind of additonal cost for individual s who choose to smoke or for employers with workforces that choose to smoke?"

He is a strong advocate of prevention and eliminating waste. He will be concerned about the effects of the package on small businesses. At Jamestown he felt that a payroll contribution of 7 – 8 % was too high. Reportedly, Senator Bingaman was unhappy over our language change from "HIPC" to "Alliance." He feels "cooperatives" are rural friendly. In his view, we should lead with cost containment.

REPUBLICANS:

SENATOR NANCY KASSEBAUM (R-KS) – Senator Kassebaum has pushed her Basicare approach as the only bipartisan proposal but has stressed her willingness to work with the Administration on health care reform. While telling the AP she found the President's plan "bold and thoughtful," Kassebaum also said she had "serious reservations" about it, including creating regulatory bodies which manage nearly everything in the health care system. She was concerned about the cost of the plan and the "potentially damaging" effect on employers, particularly small businesses.

Her elderly mother lives at home, so Kassebaum has a particular interest in long-term care.

Recent Developments: On October 28 she told the Detroit News: "It's like a souffle. Both the costs and the benefits keep rising, and there's a danger it will become so top heavy it falls of its own weight."

Appendix 5

PRIORITY TARGETS (12/14/93)

HOUSE COMMITTEE MEMBERS:

WAYS AND MEANS:

Pickle (TX)
Rangel (NY)*
Ford (TN)
Stark (CA)*
Coyne (PA)*
Andrews (TX)
McDermott (WA)
Klezcka (WI)
Payne (VA)
Hogland (NE)
Neal (MA)
Brewster (OK)

Thomas (CA)
Grandy (IA)
Houghton (NY)

ENERGY AND COMMERCE:

Sharp (IN)
Tauzin (LA)
Richardson (NM)*
Slattery (KS)
Boucher (VA)
Cooper (TN)
Rowland (GA)
Lehman (CA)
Pallone (NJ)
Schenk (CA)
Margolies-Mezvinsky (PA)
Lambert (AR)

Bilarakis (FL)
McMillan (NC)
Upton (MI)
Paxon (NY)
Klug (WI)
Greenwood (PA)

EDUCATION AND LABOR:

Miller (CA)
Andrews (NJ)
Roemer (IN)
Green (TX)
Klink (PA)
English (AZ)*
Strickland (OH)*
Baesler (KY)

Goodling (PA)
Petri (WI)
Roukema (NJ)
Gunderson (WI)
Molinari (NY)
Miller (FL)

* = Health Security Act Cosponsor

OTHER IMPORTANT HOUSE MEMBERS:

Chapman (TX)
Condit (CA)
Derrick (SC)
Glickman (KS)
Hamilton (IN)
McCurdy (OK)
Mfume (MD)
Murtha (PA)*
Pelosi (CA)
Pomeroy (ND)
Price (NC)
Rose (NC)
Schroeder (CO)
Schumer (NY)
Serrano (NY)*
Spratt (SC)
Stenholm (TX)
Stokes (OH)*
Valentine (NC)
Volkmer (MO)

Boehlert (NY)
Fish (NY)
Gilman (NY)
Goss (FL)
Horn (CA)
Hobson (OH)
Leach (IA)
Machtley (RI)
Morella (MD)
Shays (CT)
Snowe (ME)

* = Health Security Act Cosponsor

SENATE COMMITTEE MEMBERS:

Finance Committee:

Moynihan* (D-NY)
Boren (D-OK)
Breaux (D-LA)
Packwood (R-OR)
Chafee (R-RI)
Dole (R-KS)
Danforth (R-MO)
Durenberger (R-MN)

Labor and Human Resources Committee:

Kassebaum (R-KS)
Durenberger (R-MN)

OTHER IMPORTANT SENATE MEMBERS:

Exon (D-NE)
Heflin (D-AL)
Hollings (D-SC)
Kerrey (D-NE)
Leiberman (D-CT)
Bond (R-MO)
Bennett (R-UT)
Cohen (R-ME)
Hatfield (R-OR)

* = Health Security Act Cosponsor

Appendix 6

HEALTH CARE TIMETABLE

December / January

Activities: [December 1 to January 25]

- Health Principals meet with priority list members
- Committee Staff /Administration policy resource
- Field Hearings
- President conveves meeting / dinner with Chairs and Leadership
- State of the Union

February / March

Activities: [February 1 to March 28 - (7 weeks)]
Recess: February 14 to Februaury 22

- Subcommittee hearings
- Priority Member negotiations with committee chairs
- Subcommittee and / or full committee mark-up (House committees)

April / May

Activities: [April 11 to May 30 - (7 weeks)]

- Senate Finance and Labor mark-ups
- Leadership reconciliation of different bills
- House Rules Committee mark-up

June

Activities: [June 7 to July 1 - (3 weeks)]

- House floor consideration
- Senate floor consideration

July / August / September

Activities: [July 11 - September 30 - (11 weeks)]
Recess: July 2 - July 11
August 15 - September 6

- House and Senate Conference

October

Activities: [October 3 - Adjournment]

- Final passage

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	Telephone logs, Ellen Shipley and Monica to Lisa Caputo [partial] (1 page)	01/1993	P6/b(6)
002. notes	Research notes (2 pages)	n.d.	P5
003. list	Handwritten list [partial] (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office (Lisa Caputo)
OA/Box Number: 10250

FOLDER TITLE:
Health Care Task Force [Folder 2] [4]

Kara Ellis
2006-0810-F
kel29

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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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]

395-1199 Diane Ramos

- clips on HRC's work

- Room WH CEOB - #102 check open WH mess

- Room 128 - 23

① Clips - Betsey Wright, Ship, Ann Wexler, Mills
② HRC sign off
③ Statement advisory
④ Press Packets
⑤ All Sunday Shows, Capitol Gang, Morning News
⑥ Jock's bio

Bruce Lindsey - ⑧1983
- get Rose Law Firm
- Dem Times - Arkansas Gazette
- Wright, Lindsey, Jennings - 371-0808 Mr. Bygrave
- Monica Bredlove - 375-1290 x32

Bz - Gov's files - storage in N. Little Rock
- Susie Whitaker

Bz - Bonnie Bergmann - pick up 1983

⑦ Sunday, Feb. 7th - CBS Sunday Morning.
- Dan Rather piece
- Mary Low Tisdale - producer.

⑧ Idea - Barbara Stone - 212-888-6610 Roger Ailes
- ⑨ NY Post ⑩ Prime Time Live ⑪ 20/20 ⑫ Morning

(10) Jeff Bambauer, WSJ, 862-9285

(11) Tape unobtained - WACA

- HRC schedule

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton, Revised Final #2 [partial] (1 page)	06/15/1993	P6/b(6)
002. memo	Chris Jennings and Steve Edelstein to Hillary Rodham Clinton, re: Meeting with Senators Leahy and Pryor (2 pages)	06/14/1993	P5
003. schedule	Schedule for Hillary Rodham Clinton, Final-Revised [partial] (2 pages)	06/22/1993	P6/b(6)
004. schedule	Schedule for Hillary Rodham Clinton, Final [partial] (1 page)	06/23/1993	P6/b(6)

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FOLDER TITLE:
HRC Healthcare Book #2: Health Reform [2]

Kara Ellis
2006-0810-F
ke144

RESTRICTION CODES

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

~~PRIVILEGED AND CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton June 14, 1993
FR: Chris Jennings, Steve Edelstein
RE: Meeting with Senators Leahy and Pryor
cc: Melanne, Steve, Distribution

Tomorrow you are scheduled to meet with Senators Leahy and Pryor. Escorting them will be Theresa Alberghini, Senator Leahy's health legislative assistant; Theresa Forster, the new Staff Director of Senator Pryor's Aging Committee; and Bonnie Hogue, another Aging Committee staffer.

BACKGROUND

This is a meeting that Senator Leahy has wanted for some time. He has been growing increasingly frustrated over the fact that Senator Jeffords has been receiving disproportionate, as well as favorable, coverage in the Vermont press on health care. Much of this stems from statements by Jeffords that his bill is identical to the bill that he perceives the Administration is crafting. It is also because Jefford's office has publicized any meeting he has held with you or the staff of the White House.

The stated purpose of this meeting is to conduct a discussion with you about the need and desire for state flexibility within the context of national health reform. The desired outcome of this meeting, however, has more to do with illustrating how Senator Leahy has access to you and the White House. It will also give you an opportunity to recognize his (and Senator Pryor's) longstanding work on state-based health reform and the important contribution his past legislation has made to the debate. (As cynical as the above sounds, Senator Leahy's continued strong support of the President's positions on the economic package and health care do merit appreciation.)

Senator Leahy does not have a long-standing history on health issues. To the extent he has been involved, it has mostly been in the area of rural health. His last year's introduction (with Senator Pryor) of S. 3180, the State Care Act, represented his first venture into the national health reform scene. This bill provided for Medicare, Medicaid, and ERISA waivers to states that enact legislation providing universal coverage and cost containment. Then-Governor and Presidential candidate Bill Clinton endorsed this legislation in a letter to Senator Pryor. Attached for your review is a copy of this letter as well as a summary and other background materials on this legislation.

Senator Leahy invited Senator Pryor to participate, in part, because he felt it would increase the likelihood of a meeting but also because Senator Pryor was interested in attending. The meeting will likely revolve around the following issues:

1. **State Flexibility.** Senator Leahy will want to thank you for your continuing assurances that the Administration's proposal will have adequate flexibility for the states to design their own plans which best meet their needs and preferences.

2. **Reintroduction of Bill.** Senator Leahy has held off on reintroducing his state reform initiative, so as not to send the wrong signal on the prospects for reform. However, should reform efforts stall, he will be under increasing pressure from his state to reintroduce this bill. He may wish to discuss this matter with you.

3. **Politics and Communications.** The meeting is unlikely to involve detailed discussions of state-based initiatives. Instead, the Senators will be more interested in discussing the politics of health reform, their views on timing, and communications strategy. I expect that Senator Pryor will be especially interested in addressing these issues. You may want to talk to Senator Pryor about his recent idea to host meetings with Republicans interested in health reform and Administration representatives to discuss health care in a less "pre-arranged" setting.

Lastly, a reminder: Senator Leahy will precede you in addressing the Democratic Governors Association meeting in Vermont on Saturday. (He will be preceded by Governor Dean.) Senator Leahy (and possibly his wife and his staffer) is planning on flying with you to Vermont. We are working on last second details as the memo is being written.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton , Revised Final #2 [partial] (2 pages)	06/28/1993	P6/b(6)
002. memo	Mike Lux to Hillary Rodham Clinton, re: [Meeting] (1 page)	06/26/1993	P5
003. resume	Stephen Charles Gleason Curriculum Vitae [partial] (1 page)	04/1993	P6/b(6)
004. resume	Patricia A. Ford-Roegner Resume [partial] (1 page)	ca. 1993	P6/b(6)
005. schedule	Schedule for Hillary Rodham Clinton, Revised Final [partial] (1 page)	06/30/1993	P6/b(6)

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Kara Ellis
2006-0810-F
ke145

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THE WHITE HOUSE

WASHINGTON

June 26, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Mike Lux

SUBJECT: Meeting With Steve Gleason, Pat Ford-Roegner and Irwin Redlener

This is a final meeting for the leaders of our Health Professions Review Group to summarize where the providers we brought in are on the key issues. As you probably remember, Steve Gleason was the chair of HPRG, Pat Ford-Roegner and Irwin Redlener were the vice chairs. (Biographies are attached.) This can be a short meeting - thirty minutes will be fine.

The politics on this meeting are a little strange. We really need the enthusiastic support of these three as leaders of the review group, and because all of them are extremely well connected with key members of Congress. I think we will get that kind of support from them, but all have prickly personalities. They all felt mistreated and under appreciated by some of the staff here, and I have had to spend a lot of time trying to keep them positive and focused. They are also all quite independent, verging on loose cannons sometimes.

I think giving them this time with you will make them very happy, and I can use those positive feelings to help channel their energies productively.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Re: Meeting With C. Everett Koop (2 pages)	07/01/1993	P2
002. memo	Lynn Margherio to Hillary Rodham Clinton, Carol Rasco, and Ira Magaziner, re: C. Everett Koop Visit (5 pages)	06/30/1993	P2
003. schedule	Schedule for Hillary Rodham Clinton, Final-Revised [partial] (2 pages)	09/22/1993	P6/b(6)
004. schedule	Schedule for Hillary Rodham Clinton, Final [partial] (1 page)	09/23/1993	P6/b(6)
005. schedule	Schedule for Hillary Rodham Clinton, Final [partial] (1 page)	09/24/1993	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer (Issue Binders)
OA/Box Number: 18535

FOLDER TITLE:
HRC Healthcare Book #3: Health Reform [6]

Kara Ellis
2006-0810-F
ke154

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]

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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]
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Mem to Pres.

file w9/20 folder

JULY 1, 1993

MEETING WITH C. EVERETT KOOP

DATE: July 1, 1993
LOCATION: Oval Office
TIME: 5:30 PM
FROM: Carol Rasco

I. **PURPOSE**

You will meet with Dr. Koop regarding the role he might play in working with the Administration on the health reform plan.

II. **BACKGROUND**

Dr. Koop, the U.S. Surgeon General from 1981 - 1989, has long advocated AIDS research, health promotion and disease prevention. He currently serves as a senior scholar at the C. Everett Koop Institute at Dartmouth.

During the Campaign, Dr. Koop was friendly but felt ill-treated and distanced himself from our efforts. To engage Dr. Koop's support of our plan, we will need to continue to consult with him and do our best to make him feel an important and welcome contributor in developing the plan.

Recently, Ira Magaziner has reestablished ties with Dr. Koop and has consulted him on his views for health reform.

- Most recently, Ira and Roy Neel, at Dr. Koop's invitation, visited him at the Dartmouth-Hitchcock Medical Center this past month where they were shown demonstrations of new and existing health care technologies.

Dr. Koop supports health reform in general and has sent a health reform proposal to Ira which outlines the key elements of reform.

- **A Flexible Federal/State Framework.** He favors letting states decide how to structure their own systems to live within their share of a federally-set budget. The federal government would mandate universal access and provide support services and infrastructure. We agree.

- **Cost Containment through global budgets.**

Managing Care more effectively. He proposes fixed payments to autonomous health plans. These plans compete on the basis of quality alone. Our proposal basically agrees with his, except that plans compete on price as well as quality.

- Increasing the number of primary care physicians. We agree and our proposal has several recommendations for reallocating federal monies for graduate medical education and allocating residency slots to achieve this goal.
- Establishing a national information policy
- Establishing a National Science Policy for Outcomes and Evaluative Sciences research
- Streamlining and standardizing billing procedures.

Dr. Koop would be a strong ally in health reform.

Dr. Koop has suggested establishing a bipartisan commission on health "informatics" to drive the development of a vision for a health information infrastructure. He stressed that he would be happy to help with such an effort.

An idea for later consideration might be to appoint Dr. Koop to head this commission as a way to get him vested in the process.

By appointing him to a visible position, we could greatly benefit from his public reputation. On the other hand, we would be taking a great risk if we were not certain that he would speak positively about the plan. Over the upcoming weeks, we will consult with Dr. Koop to try to solidify his support. We can then judge how best to bring him on board.

III. PARTICIPANTS

Carol Rasco
Ira Magaziner

IV. PRESS PLAN

Closed press. White House photographer.

V. SEQUENCE OF EVENTS

Dr. Koop will spend the day reviewing the draft proposal on health reform. He will dine with Ira at the White House Mess at noon and will meet again with Ira from 3:30 PM - 5:00 PM. He will meet with Mrs. Clinton at 5:00 - 5:30 PM.

/KOOP

MEMORANDUM TO: Hillary Rodham Clinton
Carol Rasco
Ira C. Magaziner

FROM: Lynn Margherio

SUBJECT: C.Everett Koop Visit

June 30, 1993

BACKGROUND

Dr. Koop, the U.S. Surgeon General from 1981 - 1989, has long advocated AIDS research, health promotion and disease prevention. He currently serves as a senior scholar at the C. Everett Koop Institute at Dartmouth where he has been working to foster a "new" kind of medical education - - one that emphasizes better communication between doctors and patients. By better communication, Dr. Koop means educating patients about how to lead healthier lifestyles and teaching new doctors to be sensitive to the economic and social circumstances of their patients. Polling data show Dr. Koop is very well regarded by the American public.

During the Campaign, Dr. Koop was friendly but felt ill-treated and distanced himself from our efforts. To engage Dr. Koop's support of our plan, we will need to continue to consult with him and do our best to make him feel an important and welcome contributor to the development of the plan.

Recently, Ira Magaziner has reestablished ties with Dr. Koop.

- Dr. Koop and Jack Wennberg sent Ira a memo with their views on health reform in mid March.
- Ira had a follow-up dinner with them in May where they shared their views on health reform.
- Most recently, Ira and Roy Neel, at Dr. Koop's invitation, visited him at the Dartmouth-Hitchcock Medical Center this past month where they were shown demonstrations of new and existing medical technologies.

Dr. Koop supports health reform in general and has sent a health reform proposal to Ira (Attachment #1) which outlines the key elements of reform. We agree with many of them.

- **Flexible Federal/State Framework.** He favors letting states decide how to structure their own systems to live within their share of a budget - - setting up a managed competition framework, a single-payor

framework, or multiple payers based on their own unique geographic, cultural and political situations. The federal government would mandate universal access within defined health care budgets and provide support services and infrastructure necessary to effect change while fostering patient-centered systems of care. This relationship is consistent with our proposal.

- **Cost Containment.** Dr. Koop does not believe that managed competition will contain costs without a limit on total health expenditures. He favors imposing an immediate global budget on health care providers -- for example, hospital budgets in FY 94 should be limited to FY 93 levels, adjusted for inflation. Over the next five years, phase in global budgets at the state level calculated on a per-capita basis, adjusted for local prices and demographics. We agree.

- **Managed Competition.** He agrees that care has to be managed more effectively. Rather than having third parties manage care in an open-ended price-competitive market, he would establish a system of capitated prepayments in which autonomous, not-for-profit groups of doctors and patients would agree to operate. These plans would compete for members on the basis of quality, not price.

  Our proposal encourages the formation of community-based networks of doctors, hospitals, and other health professionals that manage their own care delivery. Quality is ensured through better information. Regional foundations will work with plans to continuously improve the quality of their care delivery through education, performance reports and consumer satisfaction surveys.

  Our proposal basically agrees with Dr. Koop's except that plans compete on price as well as quality.

- **Better workforce planning.** Dr. Koop would establish a regional workforce component designed to rationalize the excess capacity in the supply of specialists, achieve service in underserved areas, promote primary care and improve the quality of care. Federal funds from the Medicare PRO program would be reallocated to a state provider organization to set up regional provider entities with this as a mission.

  Our proposal gives these responsibilities to health alliances and health plans. Health alliances ensure that all individuals have access to high-quality care in the areas in which they live, either by requiring health plans to contract with providers in underserved areas, or by creating new health plans in those areas.

Health plans will have the responsibility to manage care delivery within a fixed budget - - they will have a strong incentive to deliver care more efficiently, and engage more actively in workforce and resource planning.

- Increasing the number of primary care physicians. Dr. Koop proposes a national manpower policy to reduce the number of physician specialists and build up the number of primary care practitioners. The National Health Service Corps should also be made more active. Dr. Koop has put forward an additional strategy for encouraging more students to choose primary care: 1) by offering interest-free loans that don't require payment until five years after graduate training is finished; 2) by forgiving school loans; 3) stretching medical school to five or six years, with time off for work-study programs or research fellowships.

  Our proposal also provides incentives for increasing the number of primary care physicians through:

  - Managing the number of post-graduate training positions for physicians. At least 50 percent of new physicians will be trained in primary care, following a 5-year phase-in period.

  - Expanding the National Health Service Corps to reduce the shortage of health care providers in rural and other underserved areas.

  - Federally allocating residency positions to reflect the future workforce needs of the health care system; to ensure adequate geographic distribution; to create and maintain access to primary and specialized health care for populations and regions that traditionally have had inadequate health services.

  - Providing graduate medical education funding to ambulatory and community-based clinics (where more primary care physicians work) as well as traditional acute-care hospitals.

  - Retraining physicians mid-career in primary care.

  - Expanding funding for training of nurse practitioners and physician assistants.

  - Revising Medicare payment schedules to increase payments for primary care services.

- **Better information.** Dr. Koop calls for establishing a national information policy to learn about which treatments benefit patients and which harm them. This information would lead to better-educated doctors, and would also give consumers the ability to choose among health plans and treatment alternatives. We share his view that patients will be better served with better information and in the long run, the system will save money.

- **National Science Policy.** The Federal Government must assume responsibility that the scientific basis of clinical medicine is constantly improved. He suggests consolidating the efforts that are currently spread among the Food and Drug Administration, the Health Care Finance Administration, the National Institutes of Health and the Agency for Health Care Policy and Research. He also proposes that this research be funded by a tax on health care dollars equal to about 0.25%.

  Our proposal gives the National Health Board the responsibility for quality. Part of this responsibility is to coordinate research in evaluative sciences and outcomes research. Ensuring better communications is also critical - - doctors, other providers and patients will be able to access critical information through a health information network.

- **Streamlined administration.** Dr. Koop supports mandating uniform billing procedures, consistent with our plan, with its single claims form and standardized rules for billing.

HEALTH "INFORMATICS" COMMISSION

Dr. Koop also has a keen interest in health "informatics" - the use of telecommunications and other technologies in health care delivery and administration. He has suggested establishing a bipartisan commission on health "informatics" to drive the development of a vision for a health information infrastructure. This commission could be affiliated with the National Academy of Science or its Institute of Medicine. He stressed that he would be happy to help with such an effort. (Attachment 2 - memo to Ira, 6/14/93)

DISCUSSION POINTS FOR YOUR MEETING

Areas to discuss with Dr. Koop would include the following:

- Role of primary care physicians in health reform.
- He finds health informatics a vital element in reforming the health care system. What specifically would he propose doing?
- He mentioned creating a bipartisan health informatics commission. What would the structure of this commission look like? Because he's a leader in this area, would he be interested in playing a role?

An idea for later consideration might be to appoint Dr. Koop to head the commission on health informatics he proposed above as a way to get him vested in the process.

Dr. Koop would be a strong ally in health reform. By appointing him to a visible position, we could greatly benefit from his reputation with the public - - the American people view him as a trustworthy, credible person who can't be bought. This reputation stems from his outspokenness on controversial issues such as AIDS and gun control during the Reagan/Bush years. If he agreed to be an advocate of the Administration's health reform plan, he could use the visibility of his position to convince those who might otherwise be skeptical.

On the other hand, appointing him would be a great risk if we were not certain that he would speak positively about the plan. Over the upcoming weeks, we will continue to consult with Dr. Koop to try to solidify his support. We can then judge how best to bring him on board.

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	Note to the First Lady re: San Francisco reception (1 page)	ca. 10/1993	P5
002. schedule	Schedule for Hillary Rodham Clinton, Final - Revised [partial] (1 page)	10/25/1993	P6/b(6)
003. list	Health Care Reform Project Meeting [partial] (2 pages)	10/25/1993	P6/b(6)
004. schedule	Schedule for Hillary Rodham Clinton, Final-Revised [partial] (1 page)	10/27/1995	P6/b(6)
005. schedule	Schedule for Hillary Rodham Clinton, Final-Revised [partial] (3 pages)	10/28/1993	P6/b(6), b(7)(E)
006. schedule	Schedule for Hillary Rodham Clinton, Final [partial] (3 pages)	10/29/1995	P6/b(6), b(7)(E)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer (Issue Binders)
OA/Box Number: 18535

FOLDER TITLE:
HRC Healthcare Book #4: Health Reform [4]

Kara Ellis
2006-0810-F
ke158

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]
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RR. Document will be reviewed upon request.

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

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Assembly Speaker Willie Brown is expected to attend the San Francisco reception. He will probably ask you to appear at a health care forum he is hosting next weekend (October 29-30). The audience for the event is mostly Democratic state legislators and lobbyists. He has been informed that it is highly unlikely you could attend, but the invitation has not been formally declined.

Brown, an extremely powerful figure in California politics, has a mixed record of cooperation with the administration. You may remember that he openly suggested Democrats might want to nominate Ross Perot in late April of 1992, citing Bill Clinton's weakness. As noted earlier, he also vigorously sided with Governor Wilson against the EPA position on state smog check legislation. On the other hand, he helped us with other important bills in the state legislature and frequently issues press releases supporting the President and his initiatives. He is very close to the trial lawyers, teachers, and other key Democratic constituencies.

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton, Final-Revised [partial] (1 page)	11/01/1993	P6/b(6)
002. briefing paper	From Kim Tilley and Amanda Crumley, re: American Academy of Pediatrics (2 pages)	10/31/1993	P5
003. memo	Lynn Margherio to Hillary Rodham Clinton, re: American Academy of Pediatrics (9 pages)	10/31/1993	P5
004. memo	Lisa Simpson to Lynn Margherio, re: Pediatric benefits in plan (5 pages)	10/29/1993	P5
005. schedule	Schedule for Hillary Rodham Clinton, Final [partial] (2 pages)	11/03/1993	P6/b(6)

COLLECTION:
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FOLDER TITLE:
HRC Healthcare Book #4: Health Reform [5]

Kara Ellis
2006-0810-F
ke159

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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October 31, 1993

AMERICAN ACADEMY OF PEDIATRICS

DATE:	November 1, 1993
LOCATION:	DC Convention Center
TIME:	8:15 a.m.
FROM:	Kim Tilley, Amanda Crumley

I. PURPOSE

To give the keynote address at the Annual Meeting of the American Academy of Pediatrics focusing specifically on how the Health Security Act addresses the concerns of pediatricians and children's hospitals.

II. BACKGROUND

American Academy of Pediatrics

The American Academy of Pediatrics is made up of 45,000 pediatricians whose concerns are the health of infants, adolescents, and young adults. The AAP's largest meeting is their Annual Meeting. The impact of the Health Security Act is a major concern for their members.

According to Mike Lux, the American Academy of Pediatrics (AAP) has been one of the Administration's closest allies regarding health care reform. Among physicians, our three strongest allies are the American College of Physicians, the American Academy of Family Physicians, and the AAP. (During your acknowledgements, Mike recommends that, aside from Betty Lowe, you should acknowledge Jackie Noyes, Director, AAP, and Graham Newson, Assistant Director, AAP.)

As you know, tension between Dr. Koop and the AAP leadership erupted this weekend over who would be introducing you at this forum. The AAP told Mike Lux that during this argument, Dr. Koop told the AAP that the Adminsitration's plan was bad for children and that he was the only one who could fix it, therefore, they had better not upset him.

AAP's concerns

Although the AAP has always felt that the plan will benefit children and adolescents, recently they have been expressing major concern in regards to the periodicity schedule that addresses adolescent and child health preventive services. They feel that the legislation relies on outdated assumptions. The periodicity schedule is the most important part of the plan for them. Their view on our action is that they sent a suggested schedule to you and Ira, and it was agreed upon that it should be changed. They submitted the changes to Administration staff; however, the changes did not make it into the final legislation that went to the Hill. Mike Lux has let the Academy know that we are working on it, but that we have to cost them out first. While Mike

recommends that you stay general in your remarks on this issue and say that we're still working on it. It is our understanding however that others believe the issue needs to be addressed more forthrightly. Additional information follows on the issue and possible ways to speak about to AAP..

Other concerns of the Academy include special needs of children, the restructuring of primary care services (workforce issues) , and Medicaid and medical liability issues.

III. PARTICIPANTS

HRC
Betty Lowe, VP and President-Elect, American Academy of Pediatrics
Howard Pearson, President, American Academy of Pediatrics
Sarah Long, Chair of Scientific Meetings
Approximately 2,200 expected to attend.

Jackie Noyes
Graham Newson

IV. PRESS PLAN

Open.

V. SEQUENCE OF EVENTS

* Howard Pearson announces HRC and Betty Lowe to stage;
* Howard Pearson remarks and introduces Betty Lowe;
* Betty Lowe remarks and introduces HRC;
* HRC remarks (30 min.);
* Work ropeline.

VI. REMARKS

Follow.

For political reasons, the AAP wants you to praise their support in the health reform effort so that their "grass roots" membership will hear the message. They want their membership to understand that the White House has been listening to the Academy and has found their contributions constructive.

The AAP also wants you to recognize that the periodicity schedule needs to be changed, that you have heard the Academy's concerns and are working on changing the schedule. They feel that this is the first question that any of the attending pediatricians would ask you if given the opportunity.

October 31, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: LYNN MARGHERIO

SUBJECT: AMERICAN ACADEMY OF PEDIATRICS

SEQUENCE

Dr. Pearson gives brief remarks and will introduce Betty Lowe. Betty Lowe will introduce you.

Your remarks will be approximately 30 minutes. Before exiting, you will greet people at the rope line.

BACKGROUND

The audience - - 2000+ pediatricians - - will be composed primarily of practicing pediatricians. Most of them operate in private practice - - as solo practitioners, in small group practices, or in multi-specialty practices.

Drs. Koop, Brazleton, Redlener and Simpson (who works with Phil Lee at DHHS) have been consulted about the concerns of pediatricians and health reform. They raised the following misconceptions/fears pediatricians have about how they and their patients will fare under our plan:

- Pediatricians do not want to be swallowed up in HMO networks. They fear a loss of autonomy.
- There will be less choice for patients and physicians.
- Children will be disadvantaged under a system of managed competition.

  Children have historically gotten the short end of the funding stick and quality/access may suffer in a system of managed competition that tries to hold costs down.
- Special needs children - - including those with chronic illnesses - - will not get adequate services.

Joe Sanders

Dr Pearson
Jackie Noyes
Graham Newson

OUTLINE OF REMARKS

I. Remarks about the AAP leadership

The AAP leadership has done hundreds of interviews, written op-eds, letters to the editor and given speeches around the country rallying support for health care reform.

II. Children under current health care system

- About 9 million children are currently uninsured.
- One in five American children had no contact with a doctor in 1992.
- Thirty percent of all children under the age of two, and 50 percent of inner-city children have not been immunized against preventable childhood disease.
- Fewer than half of non-HMO members receive routine preventive services.
- Even in the best-selling HMO packages, over 50% require cost sharing for well baby/well child care.
- Many insurance companies today use preexisting clauses to avoid prenatal care coverage.

III. Children under reform

A. Comprehensive Package of Benefits for Children

Under the President's proposal, every child will have a "medical home". [Per Irwin Redlener - the concept "medical home" is very important to pediatricians. It's one-stop shopping for children - a place where they can get coordinated care.]

- The benefits package provides coverage for ongoing, continuous care, from preventive care through acute care and rehabilitation services.

Preventive care:

No barriers to care. No deductibles, no copays.

- Well-baby and prenatal care

  The proposal calls for 100% coverage of prenatal care services, fully covering the associated testing necessary such as rubella testing and ultrasounds (if medically indicated). The proposal also covers one post-partum visit with no cost sharing.

- Clinician visits
- Immunizations
- TB tests

[Note: the AAP is unhappy with the periodicity schedule. They wanted more extensive clinician visits and tests. See page 8]

Dental and Vision Care:

Dental: Covers preventive and routine checkups for children and some orthodontia. Phase in more comprehensive coverage in the year 2001.

Vision: Covers eyeglasses and contact lenses for children, in addition to office visits.

B. Health coverage alone does not equal access to high quality care.

1. Ensuring quality care for all children through:

- Annual report cards will provide parents the information they need to judge how good plans are.

- Commitment to prevention research including child and adolescent health

- Health services research that evaluates how well reform is doing and studies areas important to health of children, including risk adjustment systems, development of clinical practice guidelines, role of primary care on access, costs and quality

2. Children with special needs

- Expanding funds for community health centers and other community-based centers for enabling services - outreach, counseling, translation, transportation, case management - providing children and their families with the support structure/safety net they need to access the health care system.

- Children with chronic illness or severe illnesses have access to specialized services through health plan contracts with centers of excellence.

- Low-income children will continue to receive wrap-around services in addition to the benefits package (according to current guidelines in Medicaid)

- Children with severe disabilities will benefit from the new home and community-based long term care program.

- Continuing comprehensive EPSDT benefits for children and families receiving AFDC and SSI.

- Expanding funds for the development of community-based networks of care. Construction of new facilities/clinics, development of new practice opportunities.

- School based health and health education to reduce teen pregnancy, substance abuse and truancy and lead to healthier behaviors.

IV. Problems doctors and patients face in the current system

A. Employers, not individuals, choose among health plans. Family coverage through the workplace is rapidly eroding. Only 33 percent of employer-sponsored health plans paid for health insurance coverage of spouses and dependent children in full in 1990 - - compared to 40 percent ten years ago.

B. The power rests in the hands of the insurers

1. Insurers have the ability to grant and deny coverage. They compete on their ability to attract healthier patients.

2. Fine print often results in coverage exclusions.

3. Insurance companies second-guess doctors' medical decisions, using a "black box" of utilization review protocols

C. Paperwork and bureaucracy overwhelm providers

"Each doctor practicing in the Children's Hospital - - 200 in total - - spent enough time on paperwork unrelated to patient care every year to see another 500 patients for primary preventive care. That's another 10,000 kids who could have been cared for...whose lives could be better."

D. Current quality system is a "nonsystem". It focuses on punishment rather than ways to improve quality.

V. How reform addresses these problems to improve the doctor-patient relationship

A. Choice

1. Individuals have choice of plans and providers

2. Requiring fee-for-service plans

3. Requiring that HMOs offer a point of service option

4. Lowering the cost sharing in the lower cost sharing plan by 80% for all services - - (or from $10 to $2 for professional visits) - - so that lower income people have more choice.

5. Doctors, too, will have a choice of plan and may contract with one or several plans

B. Changing the balance of power

1. Insurance reforms - universal coverage, no preexisting condition exclusions

2. Antitrust reforms

- The Health Security plan will reform antitrust regulations and level the playing field. Doctors and hospitals will have more freedom to work together to determine the best and most efficient ways to deliver high-quality services.

- Doctors and other health providers will be able to band together to form their own community-based health networks in which doctors will be able to negotiate to reduce interference with their practice.

- Doctors will also be able to negotiate collectively ensuring that they will have a strong say in determining the fee-for-service reimbursement rates, so long as they represent less than 20 percent of the physicians in an area and share in the financial risk.

C. Shifting the emphasis toward primary care and prevention - empowering pediatricians

- Supports the practice of pediatrics by moving our workforce toward a more rational mix of 55% primary care physicians, including general

pediatricians.

- Providing incentives for physicians to go into primary care

  - Loan forgiveness
  - Expanding National Health Service Corps
  - Providing loans to physicians to band together in community-based networks
  - Additional loans and tax incentives for primary care providers who practice in rural or underserved areas

D. Reducing the "Hassle Factor"

We must have a system that simplifies the financing and paperwork attendant upon delivering health care, which drowns our professionals and discourages them from doing what they have been trained to do, which wraps the delivery of health care in a web of regulations and complications that have no place in the doctor-patient relationship.

We know we can do better. We've seen examples of how we can more toward electronic billing, toward a single form, toward eliminating a lot of the unnecessary cost that just drives the health care system to become more and more loaded down with bureaucracy and administration.

VI. How can we afford this?

Something is wrong when we spend 14 percent of our national income on health care when our major competitors and other nations around the world, from Australia to Canada to Germany and Japan, take care of all of their citizens, have higher outcomes on all kinds of national indices of public health, and spend only 8 or 9 percent of their national income on health care. We know that we can do better than we are doing.

AREAS OF CONCERN TO THE AAP

1. **Periodicity Schedule:**

Background:

The AAP had proposed expanding the clinical preventive services for children. They want additional clinician visits for children and some additional tests and immunizations.

Changes in our plan since 9/7 draft:

Since the 9/7 draft, we have added the following:

- One additional clinician visit for newborns
- One additional clinician checkup for children between 3 and 5 years of age

Where this leaves us:

The Health Security Act still falls short of their recommendations in the following areas:

- Children Ages 0-3: they request 2 additional clinician visits, 2 urinalysis, 1 TB, 1 hereditary/metabolic screening, and 1 additional hematocrit.

- Children Ages 6-12: they request an additional 5 clinician visits and additional immunizations and tests.

- Children Ages 13-19: they request an additional 2 visits.

According to a preliminary estimate by the DHHS, to incorporate their recommendations for additional clinician visits would cost approximately $18 per family per year. Adding the 10 additional immunizations and tests would add another $7 per family per year. (This would entail reestimating the premium and we believe cannot be done before the bill gets introduced).

Our rationale for the current schedule: (Lisa Simpson, DHHS)

We devised the preventive clinical services coverage based on the best scientific evidence available - - the recommendations of the U.S. Preventive Services Task Force.

There is no scientific evidence that the additional tests requested (or the particular number they request) are appropriate for all children. The Public Health Service feels that the number of visits in the Health Security Act is sufficient for general pediatric populations.

If a physician deems that additional visits are "medically necessary or appropriate", they would be covered under the benefits package, but would require cost sharing.

As new scientific evidence becomes available, the National Health Board will define populations at risk for certain conditions and may recommend additional/more frequent tests for those populations.

2. Special Needs Children

At least 1 million children in the United States suffer from a severe, debilitating and ongoing chronic illness such as severe cerebral palsy, cystic fibrosis, or chronic lung disease of infancy... Over 10 million additional children have incurred a less serious but longstanding illness such as severe asthma, seizure disorders, juvenile rheumatoid arthritis, or juvenile diabetes.

How these children benefit under the Health Security act:

The Health Security Act does three things for children with disabilities.

- Offers post-acute services for children who need services as a result of an illness or an injury.
- Children with severe disabilities would be eligible for the home and community-based long-term care services.
- While some children with congenital illness will not be covered under the comprehensive benefit package, low-income children will be eligible for wrap-around services beyond the comprehensive package of benefits.

MEMORANDUM

DATE: October 29, 1993

TO: Lyn Margherio

FROM: Lisa Simpson

SUBJECT: Pediatric benefits in plan

I hope this meets your needs. I have summarized where the plan and the AAP differ, included a rationale for the content and schedule of clinical preventive services included in the plan, highlighted how changing the plan would affect cost estimates, and prepared remarks/points that the First Lady may want to use in her speech on Monday.

I have also been informed that both Mrs. Clinton and Ira Maganizer promised the AAP representatives that they met with that the new AAP guidelines on preventive care (Bright Futures) would form the basis for the benefit package.

How the HSA differs from the AAP:

The primary difference between the plan and the AAP is in the number of visits they are requesting. The additional tests requested reflect in general their 1987 guidelines and are either meant *for high risk groups only*, or have actually been dropped from the new draft guidelines. The metabolic screening test is in the plan as part of either the hospitalization or outpatient care, it simply has cost-sharing associated with it. The timing of the immunization in question reflects a long-standing difference of opinion between the AAP and the CDC, but the plan accommodates for provision of this immunization later if necessary.

Thus the issue that is likely to be of greatest concern to the Academy is the number of visits for adolescents.

Basis for the policies in the HSA:

The recommendations of the US Preventive Services Task Force were the basis for all the coverage decisions in the preventive package. There is no scientific evidence that the additional tests requested are appropriate for *all* children. There is also no scientific evidence supporting or contradicting the particular number of visits they are advocating; it is simply based on "expert opinion".

The services itemized in the bill are by no means the only preventive services available. It is also the intent of the plan that the National Health Board will define populations at risk for certain conditions and recommend additional/more frequent tests for

those populations. In addition, all medically necessary or appropriate screening tests, visits, or immunizations are covered (with cost sharing). Finally, it is important to remember that the preventive benefit was crafted to assure flexibility by providing the National Health Board with authority to update or otherwise modify the timing and content of the benefit to reflect changes in the science and practice of medicine. The Board would do this in consultation with "experts in clinical preventive services".

Changes in the schedule:

Each additional clinician visit would increase the premiums by about $2 per family per year. Including all the ones requested would increase the premiums by $18 per family per year, with all the additional tests this would increase to $25 per family per year.

Suggested points for the First Lady to make:

Universal coverage will assure access to the 9.5 million children currently uninsured.

The president's package will provide more fully covered services, including preventive services, to more children than ever before.

- less than half of non-HMO members receive routine preventive services including visits, tests, and immunizations (Newacheck, 1992);
- even in the best selling HMO packages, over 50% require cost-sharing for well baby/well child care (GHAA, 1993).

The plan will assure that all children start life as healthy as possible by promoting early access to prenatal care. The President's plan will remove all financial barriers to prenatal care by banning pre-existing clauses which are used today by many insurance companies to avoid prenatal care coverage. The benefits package also provides 100% coverage for prenatal care services and one post-partum visit. It also fully covers all the associated medically necessary tests during prenatal care, for example rubella testing and ultrasounds, if medically indicated.

The plan covers all medically necessary or appropriate care at any age.

The plan will assure that children receive the highest quality care. Annual report cards will provide parents the information they need to judge how good plans are. In addition, the plan includes a significant increase in our commitment to prevention research and health services research. Prevention research will focus on priority areas including child and adolescent health. Health services research will evaluate how well reform is doing and study many areas important to the health of children: risk adjustment systems; the impact of managed care on health care delivery; the role of primary care on access, costs and quality, the role of remaining non-financial barriers to care; and the development of clinical practice guidelines.

The plan assures that children with chronic illness or severe illnesses have access to the specialized services. Health plans are required to contract with sufficient Academic Health Centers that provide specialized services to assure adequate access.

Poor children will be assured the additional services they need. Children in families receiving AFDC or SSI payments will be guaranteed access to the services they need by continuing comprehensive EPSDT benefits. In addition, the public health initiatives will make outreach and enabling services more available for children who have traditionally had difficulty getting into the system.

Disabled children will receive additional benefits. The long term care benefit will provide services for the most disabled of our children. A new benefit for poverty level children with special health care needs will assure that these children receive high quality, coordinated services.

The plan addresses the needs of some of highest risk children and youth. It provides for new grants to develop comprehensive school health education curricula and school based or school linked health services. Additional funds for public health priorities such as violence, unintended pregnancy, and HIV prevention are also included.

The plan supports the practice of pediatrics by moving our workforce toward a more rational mix of 55% primary care physicians, including general pediatricians; by providing grants for the development of community practice networks in underserved areas; by providing additional loans and tax incentives for primary care providers who practice in rural or underserved areas.

DETAILS OF DIFFERENCES AND POLICIES

VISITS

- Overall, the pediatricians are requesting an additional 8 clinician visits. These correspond to an additional visit at 18 months, and yearly visits ages 6 through 19. Current AAP guidelines (since 1987) only recommend visits every other year for children ages 6-19, however *draft* new guidelines do recommend annual visits.

TESTS & IMMUNIZATIONS

- An additional 10 tests are requested: 3 urine tests, 3 TB screening tests, 3 Hematocrits (to screen for anemia) and metabolic screening. They are also requesting that the timing of one test and one immunization be changed.

Basis for the policies in the HSA:

GENERAL:

- The content and timing of services and tests outlined in the clinical preventive services of the National Benefit Package are based on the recommendations of the US Preventive Services Task Force. The Task Force develops recommendations using an scientific, evidence-based method. When these recommendations have included a range in periodicity, the more conservative choice was generally made.

- The number of visits included in the President's plan was chosen to include time periods when immunizations or tests are required and to provide additional opportunities for guidance during adolescence on issues related to risk behaviors. The Public Health Service feels that the number of visits is sufficient for general pediatric populations. Children who are considered to be at risk or needing additional visits by the clinician can receive these under the "medically necessary or appropriate" clause. The only difference is that there would be cost-sharing for the additional visits.

SPECIFIC:

- The extent of coverage for urinalyses and hematocrits is consistent with the USPSTF and the Canadian Task Force on the Preventive Health Examination (CTFPHE). There is no evidence that additional urinalyses, which are used to screen for urinary tract infections, are effective. There is also no evidence that more frequent hematocrit testing is required for children who are *not at risk for anemia.* In addition, the draft new guidelines for the AAP *do not recommend* routine hematocrits, they recommend them only for specific risk categories.

- The timing of administration of the MMR vaccine (measles, mumps, and rubella) has

been reviewed recently by the USPSTF and they concur with the standing recommendation from the immunization experts at CDC. It is recommended at this time because it will assure the widest coverage of children by linking it to school entry. However, if a child did not receive it during this age range, the plan allows for it to be received during a later age (see section 1114(a)(3) - the "catch-up" clause).

- TB testing is recommended by the USPSTF *for high risk groups only* for ages 2 through 18. The AAP's new draft guidelines also recommend this test *for high risk groups only*.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton, Final-Revised [partial] (3 pages)	11/08/1993	P6/b(6), b(7)(E)
002. memo	Mike Lux to Hillary Rodham Clinton, re: Meeting With Gerry McEntee (1 page)	11/05/1993	P5
003. list	NHCC Produced Documents (2 pages)	n.d.	Personal Misfile
004. memo	Matt Dorsey, NHCC Opposition Research, to NHCC, Re: Three Up, Three Down, Three Out (1 page)	10/29/1993	Personal Misfile
005. memo	Kiki Moore to Governor Celeste and Kent Markus, re: Weekly Communications NHCC Activity Update (2 pages)	10/29/1993	Personal Misfile
006. memo	Linda Sinoway to Kent Markus, re: Weekly Core Staff Report (2 pages)	10/29/1993	Personal Misfile
007. memo	Craig Sutherland to Kent Markus, re: 3 Up/3 Down (1 page)	10/29/1993	Personal Misfile
008. memo	Heather Booth, re: 3 Up, 3 Down, 3 Out (1 page)	10/29/1993	Personal Misfile
009. memo	Kiki Moore to Jon-Christopher Bua, re: Surrogates requested and booked between 10/22 and 19/29 (3 pages)	10/1993	Personal Misfile
010. memo	Linda and April to Kiki, re: Governor Celeste's Press 10/24-29 (2 pages)	10/1993	Personal Misfile
011. fax	Ted Quaday to Kelly Lees (1 page)	10/29/1993	P6/b(6)
012. paper	National Health Care Campaign Media Advisory [partial] (1 page)	10/27/1993	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer (Issue Binders)
OA/Box Number: 18535

FOLDER TITLE:
HRC Healthcare Book #4: Health Reform [7]

Kara Ellis
2006-0810-F
ke161

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]
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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]

November 5, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Mike Lux

SUBJECT: Meeting With Gerry McEntee

This meeting has been set up for two reasons:

1. To have McEntee tell you all the ways AFSCME wants to help on health care (i.e. give money, grassroots, etc.)

2. To get him over the prickliness of the last few weeks on this range of issues on which we've been dealing with AFSCME.

As you probably know, in the last couple of weeks of policy negotiations, we have:

1. Made some technical corrections AFSCME and other labor folks wanted on the tax cap and a few other minor issues;

2. Agreed to AFSCME's requested language on health worker job re-training;

3. Negotiated a deal on the state and local 7.9% cap issue, giving them the cap but delaying until the year 2002;

4. Told them we couldn't give them the 200,000 and above public employee opt-out provision.

Emotions have run a little high over some of these negotiations. Gerry feels like Ira promised him some things on issues 3 and 4, and then took back what he promised.

I think you should have an honest political discussion with Gerry about how even though we can't give them everything they want, we still need them to step up to the plate and help us with the campaign.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Pros and Cons of Appealing or Not Appealing the FACA Decision (2 pages)	ca. 1993	P5
002. paper	Points Raised By Justice Department and Observations On Them (5 pages)	ca.1993	P5
003. note	Handwritten note from Vince Foster to Hillary Rodham Clinton, re: FACA (1 page)	03/14/1993	P5
004. list	Guidelines From Meetings With The President To Discuss Health Care Reform Issues (1 page)	ca. 1993	P5
005. memo	Robert E. Kopp and David J. Anderson to Vincent Foster and Stephen Neuwirth, re: Compliance Issues and Appeal Prospects in Ass'n. of American Physicians and Surgeons v. Hillary Rodham Clinton, et al., No. 93-399 (D.D.C.) (9 pages)	03/12/1993	P5
006. draft	Draft charter of the President's Task Force on National Health Care Reform (3 pages)	03/1993	P5
007. fax	Material regarding the Leadership Institute (5 pages)	02/19/1993	Personal Misfile
008. letter	Holland H. Coors to Miss Carol Keys (7 pages)	12/08/1989	Personal Misfile
009a. memo	David J. Anderson to Vincent Foster and Stephen Neuwirth, re: Issues Relating to the Document Disclosure Provision of the Federal Advisory Committee Act (10 pages)	03/24/1993	P5
009b. fax	Coversheet for to Steve Neuwirth (1 page)	03/24/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer (Subject Files)
OA/Box Number: 10255

FOLDER TITLE:
HEALTHCARE TASK FORCE [1]

Kara Ellis
2006-0810-F
ke206

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]
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THE WHITE HOUSE

WASHINGTON

3/14

Hillary -

1) After a long meeting Sunday afternoon with the Justice Dept lawyer we have worked out guidelines for meeting with the President. They are attached and I will assume they are workable until someone points out a practical problem. I have conveyed this to Ira.

2) The Justice Dept urges an appeal because of the numerous issues concerning compliance and the long-term intrusion on the ~~th~~ President's ability to obtain advice from a group subject to FACA.

a) Their analysis of the compliance issues is attached.

b) Our position on these concerns follows. This is a quick summary of the issues.

c) A talking points memo for Communications should an appeal be lodged is the next item.

3) Assuming the plaintiffs do not appeal by the end of the day Monday we would like to resolve whether to appeal by Tuesday noon.

Vince

Chris Cerf
X 51269

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

DRAFT

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC, AMERICAN COUNCIL FOR HEALTH CARE REFORM AND NATIONAL LEGAL & POLICY CENTER,

Plaintiffs,

v.

HILLARY RODHAM CLINTON, DONNA E. SHALALA, Secretary of Health and Human Services, LLOYD E. BENTSEN, Secretary of the Treasury, WILLIAM J. PERRY, Secretary of Defense, JESSE BROWN, Secretary of Veterans Affairs, RONALD H. BROWN, Secretary of Commerce, ROBERT B. REICH, Secretary of Labor, LEON E. PANETTA, Director of the Office of Management and Budget, ALICE RIVLIN, Deputy Director of the Office of Management and Budget, CAROL RASCO, IRA MAGAZINER and JUDITH FEDER, White House Advisors and THE PRESIDENT'S TASK FORCE ON NATIONAL HEALTH CARE REFORM, et al.,

Defendants.

Civil Action
No. 93-399 (RCL)

DEFENDANTS' MOTION FOR REVISED SCHEDULING ORDER
AND EXPEDITED CONSIDERATION OF CONTEMPT MOTION
AND POINTS AND AUTHORITIES IN SUPPORT THEREOF

Defendants respectfully move the Court to enter an order setting a new schedule governing the matters currently pending before this Court. In support of this motion, defendants state as follows:

1. This matter is currently scheduled for trial on September 12, 1994, on the merits of the claim that the Interdepartmental Working Group constituted an advisory committee within the scope of

the Federal Advisory Committee Act. While defendants remain firmly of the view that the Interdepartmental Working Group was not an "advisory committee," that no violation of the FACA occurred, and that this conclusion would be established at trial, defendants have determined that all documents and records which might be the subject of this action, and which have previously been described to the Court, will be made publically available. Accordingly, not less than twenty-one days from today, all such documents and records will be placed in a public reading room and made available to the public during normal business hours for examination and copying.

2. Defendants submit that their decision to release these documents to the public makes any further proceedings on the merits of the FACA claim moot and defendants will file a motion to dismiss this case on that basis at the earliest date practical. Given that public access to the documents is no longer an issue, there simply is no need for the Court to proceed with its prior order setting the entire case for trial on September 12. Defendants therefore

request that the court remove the trial date from its docket and consider defendants' impending motion to dismiss this case as moot which, defendants believe, will obviate any need for a trial on the FACA claim.

3. While there is no need for an immediate trial on the merits of the FACA claim, there is an urgent need for the Court to address the contempt motion which plaintiffs filed against Ira Magaziner. At the July 26, 1994 status conference in chambers, defendants

requested that this Court conduct an early hearing on the contempt issue, including possible testimony by Mr. Magaziner, to enable him to refute speedily and conclusively the utterly baseless allegations against him. This Court, because it scheduled an early trial date of September 12, indicated that it would either decide the contempt issue based on the evidence at that trial or hold a separate proceeding after the trial's conclusion. Now that a trial on the FACA claim is no longer necessary, defendants request that the contempt issue be promptly disposed of by the Court.

Even though the charges against Mr. Magaziner are wholly baseless and without any foundation whatsoever, their mere existence casts a cloud over his personal reputation and unfairly impugns his integrity. These charges, which are no more than mere allegations by self-interested litigants, have unfortunately been repeated by members of Congress in legislative debates and unfairly portrayed in the press.[1] While defendants vigorously deny these charges, the cloud can not be conclusively lifted until the charges are addressed by this Court.

announced course of addressing the contempt charge either simultaneously with, or even after, a trial on the merits.

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[1] See 140 Cong. Rec. S 11722-23, S 11729 (Daily ed. August 15, 1994) (remarks of Sen. Nickles). At least some of the recent media attention appears to have been generated by the plaintiffs themselves, in communications which may have violated the Court's order on the confidentiality of the settlement process. See "Settlement of Health Task force Suit Rejected," Washington Post, A17, August 16, 1994. While plaintiffs freely repeat their charges, Mr. Magaziner remains without a forum to conclusively refute them.

Instead, defendants request that the Court expedite its resolution of the contempt matters and do so at the earliest possible opportunity. To that end, defendants will promptly file with the Court a motion to reconsider its earlier deferral of the contempt motion, addressing both the complete absence of any evidence to suggest that Mr. Magaziner was anything other than truthful in his prior declarations as well as the propriety of disposing of the contempt issues in the present posture of the case. Should the Court nevertheless conclude that further proceedings are necessary following review of that motion, defendants ask that the Court promptly schedule those proceedings at the earliest possible date available on the Court's docket.

Respectfully submitted,

FRANK W. HUNGER
Assistant Attorney General

ERIC H. HOLDER, JR.
United States Attorney

JOHN A. ROGOVIN
Deputy Assistant Attorney General

DAVID J. ANDERSON

ELIZABETH A. PUGH
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Telephone: (202) 514-3313
Attorneys for Defendants

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Bob Boorstin and David Dreyer to Mrs. Clinton, re: Proposed "Message Meeting" on Health (2 pages)	01/25/1993	P5
002. letter	Michael Manganiello, Special Assistant to Christopher Reeve, to Melanne Verveer [partial] (1 page)	10/08/1996	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer (Subject Files: H)
OA/Box Number: 20035

FOLDER TITLE:
Healthcare (More)

Kara Ellis
2006-0810-F
ke211

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]
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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]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Please Make Copy for Melanne

Memorandum

To: Mrs. Clinton
Cc: Mack McLarty, Carol Rasco, and Ira Magaziner
Fr: Bob Boorstin and David Dreyer
Re: Proposed "Message Meeting" on Health

January 25, 1993

summary. At the earliest possible date, hold a two-hour meeting in the White House, with an inclusive list of attendees, to hear recommendations from outside polling and media advisers on how best to communicate to the public on health.

background. We may encounter a paradox when the time comes to prepare a media strategy on behalf of our Administration's health care reform proposal. The most compelling features of our package in policy terms may not yield the highest public support -- even if communicated well. Some elements of the proposal, which may make the biggest differences in the lives of average Americans, may not prove to be among the plan's most radical policy features. While the "message" will never drive the formulation of the plan, we may find that the priorities of the policy makers and the policy communicators are at odds. We think it would be helpful to start a conversation that leads to a strategic agreement among both camps on how best to sell a health care reform plan that is constructed by the policy people.

Recommendation. We suggest a message meeting at which both policy and message people will hear presentations from polling and media people with experience in the area of health care. We would invite a panel consisting of:

* Dr. Bob Blendon, Harvard School of Public Health, who conducts public opinion polling for CBS/New York Times;

* Ron Pollack/Arnold Bennett, Families USA, who do grassroots communications on health care issues;

* Celinda Lake and Stanley Greenberg; and,

* Jeremy Rosner, Progressive Policy Institute.

These panelists can talk about the effective use of language, which events work to illustrate different features of the health care crisis, pitfalls experienced during the short-lived catastrophic health care debate, how to create a public demand for the Clinton plan, and the anticipated activities of interest groups likely to oppose the plan.

Following presentations of fifteen minutes by each panelist, we would encourage a lengthy question and answer period open to all involved. The meeting would conclude with a discussion on strategy for presenting a plan. This group, or smaller elements of it, could meet periodically as the policy work advances.

Again, we recommend the broadest possible participation of staff people involved. In spite of the size of the audience, we think this meeting would be useful if led in a disciplined way.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Ira C. Magaziner to Hillary Rodham Clinton, re: What Is Ahead And How To Organize For It (4 pages)	05/03/1993	P5

COLLECTION:
Clinton Presidential Records
Health Care Task Force

OA/Box Number: 1229

FOLDER TITLE:
Draft Policy Book] [1]

Kara Ellis
2006-0810-F
ke1043

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]
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THE WHITE HOUSE

WASHINGTON

May 3, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: IRA C. MAGAZINER

SUBJECT: WHAT IS AHEAD AND HOW TO ORGANIZE FOR IT

Health care reform is crucial to the American people, but it will be an awful roller coaster ride on an untested course. Whatever we propose, we and our proposals will be roundly criticized by many.

Much of the criticism will be put forward by people with vested interests who don't want change or who want it to be to their narrow benefit. However, much of it will be legitimate criticism from people who feel we are making mistakes and in some cases they may be right.

The truth of the matter is that we cannot be sure about what will work best. We assembled many of the best experts and practitioners in the country, we consulted with the best of the rest. We analyzed the best numbers available to levels of detail greater than anyone else has done. We have racked our brains to produce the best possible result. Yet we cannot be confident that we have made all the right decisions.

I tell you this not to alarm you, but to be honest about the minefield upon which we will travel these coming months.

This minefield is made particularly treacherous by a peculiar characteristic of people. Often it is when we are least clear about the answers to hard questions that we become most fervent in our devotion to one explanation and one set of answers.

Such is the case in Healthcare. Apart from the special interests trying to promote their own ends, we will find theologians who are prepared to wage holy war on behalf of their own ideologies. We have tried to take the best from all, but may end up satisfying none.

- **Single Payer**
- **Extending medicare to the country**
- **Managing competition with large purchasing cooperatives**
- **Managing competition from insurance reform and incentives**

for managed care

- Controlling cost and providing universal access through individual mandates and economic incentives.

To this must be added the following fights we will enter in to the middle of:

- Non-insured vs. insured businesses
- Pro Choice vs. Pro Life
- Doctors vs. lawyers on malpractice reform
- Federal vs. state advocates on social reform
- Deficit hawks vs. doves on program size and financing
- Economists vs. regulators on cost controls
- Medical specialists vs. generalists on medical education and fee strategy
- Nurses vs. doctors on scope of practice issues

to name a few.

The good news is that since we cannot be confident that we have all the answers, we can be flexible as we negotiate our way through the process.

The bad news is that the building of coalitions will be hard and they will be fleeting.

The chances for failure may be greater than chances of success. That is why this hasn't been done before. The key to success, I am convinced, is momentum. Like sailing a boat across treacherous rapids, one must maintain forward movement. People and interest groups will not "jump ship," if they believe that the ship, battered though it may be, will reach the distant shore. If they have any sense that our ship is foundering, they will find other transportation and help to sink us.

Despite the tough odds, I urge you to go ahead. Healthcare reform as you well know is fundamental for the social and economic wellbeing of the American people. If it does not occur, it will be difficult for the nation and this presidency to succeed. And, the chances are better now than they have been in half a century. The "window of opportunity" may not last.

To succeed, we must organize ourselves. We must create a campaign organization which will work in harmony. We must run this effort centrally in a highly coordinated fashion with a team which coordinates every day and is devoted solely to this

activity. We must put an end to the dissension in our own ranks which has steadily undermined our own efforts.

I. We should expand on the work already underway and set up a coordinating committee with the following functions.

- An interest group organization which has specific people assigned to types of groups.
- A legislative strategy group devoted full time to health care.
- A policy group to lead negotiations with interest groups, governors and Congress.
- A message group to prepare speeches, develop the message, respond to attacks, etc.
- A campaign organization to make best use of your time and that of surrogates.
- A grass roots campaign organization to mobilize people and interest groups who are supporters.

II. We should recruit people who are seasoned to lead some of these teams and to form a coordinating group. We have some people working inside who can play the roles, but we don't have the range of talent we need. We cannot depend on the cabinet or people from the departments alone to run this effort. They have other priorities. Some in the White House are too young.

- We should try to interest Harold Ickes and/or Susan Thomases, to possibly coordinate the campaign organization.
- People like Mandy Grunwald, James Carvile, Paul Begala, Stan Greenberg, and Arnold Bennett should be brought in, some full time, to work on the message, communications, strategy and campaign planning day-to-day.
- We should try to recruit people like Dave Barram and Bob Brandon to help with business or consumer group outreach on a regular basis.

If you would like, I will draw up a work plan for what I believe should be done to get ourselves organized. By May 17, the policy will be done as well as it can be done at this point. It will evolve as we begin negotiating.

I think we should move into the next phase of our work quickly.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Donna E. Shalala to Ira Magaziner, re: Premium Regulation (3 pages)	06/04/1993	P5

COLLECTION:
Clinton Presidential Records
Health Care Task Force

OA/Box Number: 1235

FOLDER TITLE:
[Draft Policy Book] [1]

Kara Ellis
2006-0810-F
ke1044

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]
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P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
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Freedom of Information Act - [5 U.S.C. 552(b)]

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JUN 14 1993

TO: IRA MAGAZINER

FROM: DONNA E. SHALALA

SUBJECT: PREMIUM REGULATION

I understand that the regulation of health insurance premiums as the strategy for short-term cost-containment is under serious consideration. We are preparing a more detailed decision memorandum on short-term cost-containment, and will include this alternative among the options, but I have such grave reservations about premium regulation that I wanted to be sure that we do not go too far down this path before we discuss it with the President. My concerns about this approach are outlined below:

Benefits will be reduced or additional persons will be excluded from coverage.

In order to be sure that they remain within a premium cap, insurers are likely to reduce benefits, increase enrollee cost-sharing, and increase cherry-picking and underwriting. Even if we try to impose a maintenance of effort requirement, our burden in monitoring that requirement would be tremendous, particularly since we have virtually no experience in regulating private insurance at the federal level, and most of that experience has been bad. The result will be an extensive bureaucracy placing massive administrative burdens on consumers and insurers, which is still likely to be ineffective. While I am familiar with -- and agree with -- much of the criticism of "command and control" regulation of provider prices, at least we know how to do that, and have an existing, effective administrative infrastructure in place.

Lack of adequate available data with which to measure compliance.

The federal government does not now collect the needed data on insurance premiums and only a minority of States collect even partial data. Although rates of increase could be established and premiums perhaps monitored in the future, we have no data with which to establish a baseline, and several years would be required to collect it.

Insurance reform will distort results.

Reform of the small-group insurance market will be phased in during the early stages of implementing Health Care Reform. As insurance companies begin to eliminate underwriting for pre-existing conditions and move toward community rating, there will be no way

to determine how much of premium growth is due to reform and how much to inflation. With premiums currently varying as much as 300 percent, movement toward the middle under community rating will move some premiums significantly up or down, regardless of the success or failure of efforts to hold down costs.

During this period, we can also expect to see substantial movement of enrollees from one plan to another. Without an accurate health risk adjuster -- which we are unlikely to have in the near future -- we cannot adjust premium growth to accurately reflect changes in the demographics of an insurer's enrollee population.

Inaccurate caps could lead to unnecessary bankruptcies and decreased insurance coverage.

Because of our inability to establish accurate baselines or to accurately account for the impact of insurance reforms and changes in enrollee demographics, we could inadvertently set some caps too low and cause unnecessary insurer failures. As a result, increased numbers of persons could suddenly find themselves without insurance coverage.

Premium caps could omit large segments of the market -- the self-insured.

Self-insured plans represent more than half of total commercial health insurance business. These plans, of course, have no premiums, and while we could use the Internal Revenue System to cap the rate of tax-advantaged growth in employers' health care expenses, this would pose yet another set of administrative burdens and bureaucratic costs.

Insurers lack the tools for controlling costs.

In the short term, prior to full implementation of Health Care Reform, insurers will not have the tools or authority to affect provider prices or behavior. Without market competition or price regulation, insurers will be asked to control premiums but without the ability to control providers. The only methods available to them will be those described above -- benefit cuts, cherry-picking, etc.

Premium caps are untested.

Neither the states, nor the Federal government have very much experience with premium controls in health care. Efforts to control premiums for automobile insurance, a much simpler product, have produced results that have been at best, mixed.

CBO may not credit savings to premium regulation.

For all the reasons listed above, we have been given to believe that CBO would not attribute any system-wide savings to premium regulation.

My staff and I would be happy to discuss these concerns with you in greater detail if you so desire.

cc: Hillary Clinton, The First Lady
Leon Panetta, Director, Office of Management and Budget
Laura Tyson, Chairman, Council of Economic Advisers
Lloyd Bentsen, Secretary, Department of Treasury
Robert Reich, Secretary, Department of Labor

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Bob Boorstin and David Dreyer to Mrs. Clinton, re: Proposed "Message Meeting" on Health (2 pages)	01/25/1993	P5
002. draft	Statement of President Clinton [partial] (1 page)	01/25/1993	P6/b(6)
003. paper	Re: First Lady's Image (9 pages)	n.d.	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer (Subject Files: H)
OA/Box Number: 20035

FOLDER TITLE:
Health Reform [3]

Kara Ellis
2006-0810-F
ke208

RESTRICTION CODES

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

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Please Make Copy-For Melanne

Memorandum

To: Mrs. Clinton
Cc: Mack McLarty, Carol Rasco, and Ira Magaziner
Fr: Bob Boorstin and David Dreyer
Re: Proposed "Message Meeting" on Health

January 25, 1993

summary. At the earliest possible date, hold a two-hour meeting in the White House, with an inclusive list of attendees, to hear recommendations from outside polling and media advisers on how best to communicate to the public on health.

background. We may encounter a paradox when the time comes to prepare a media strategy on behalf of our Administration's health care reform proposal. The most compelling features of our package in policy terms may not yield the highest public support -- even if communicated well. Some elements of the proposal, which may make the biggest differences in the lives of average Americans, may not prove to be among the plan's most radical policy features. While the "message" will never drive the formulation of the plan, we may find that the priorities of the policy makers and the policy communicators are at odds. We think it would be helpful to start a conversation that leads to a strategic agreement among both camps on how best to sell a health care reform plan that is constructed by the policy people.

Recommendation. We suggest a message meeting at which both policy and message people will hear presentations from polling and media people with experience in the area of health care. We would invite a panel consisting of:

* Dr. Bob Blendon, Harvard School of Public Health, who conducts public opinion polling for CBS/New York Times;

* Ron Pollack/Arnold Bennett, Families USA, who do grassroots communications on health care issues;

* Celinda Lake and Stanley Greenberg; and,

* Jeremy Rosner, Progressive Policy Institute.

These panelists can talk about the effective use of language, which events work to illustrate different features of the health care crisis, pitfalls experienced during the short-lived catastrophic health care debate, how to create a public demand for the Clinton plan, and the anticipated activities of interest groups likely to oppose the plan.

Following presentations of fifteen minutes by each panelist, we would encourage a lengthy question and answer period open to all involved. The meeting would conclude with a discussion on strategy for presenting a plan. This group, or smaller elements of it, could meet periodically as the policy work advances.

Again, we recommend the broadest possible participation of staff people involved. In spite of the size of the audience, we think this meeting would be useful if led in a disciplined way.

The next six months will be critical to redefining this Presidency, and you must be positioned to help that process. The good news is that you can make a huge difference without receding into the woodwork or abandoning the causes and values you believe in.

The clear message from discussions last week is that you have three key tasks ahead: First, to help the President sort out his options and focus on a single well-defined, well-articulated 24-month strategy; second, to reduce negative perceptions of the President and you; and third, to build, energize, and expand your natural base.

Although these goals are potentially contradictory, you can achieve all of them if you focus on issues and events that underscore your humanity and compassion and enable people to see a side of you that too often was obscured during the past year.

BACKGROUND

In general, the problem we face is that American voters sense a collapse of the middle class and see no evidence of a new one replacing it. Today, the middle class might be more aptly defined as "the anxious class." To them, the economic recovery is a cyclical event -- one too brief and too superficial to solve a deeper, structural crisis. Because of their own experiences -- job insecurity, employers who seem disloyal, and all the other stresses of modern life -- many working Americans view Administration claims of an economic recovery as utterly divorced from reality.

More specifically, the President has been so undermined by the press and others that he now has a severe image problem. According to pollsters, he is not viewed as decisive, bold, visionary, vibrant, or having a moral foundation for his Presidency. Rather, the prevailing view is that he has no backbone, that "there's no there, there."

Even when voters focus on the President's agenda, they don't view him as a leader determined to empower hard-working Americans, but as a "big government liberal." However fallacious, that image was cemented during health care reform and now colors the view of his Presidency overall.

Antipathy among Republicans and conservatives for this Presidency is strong, deep, and very visceral -- worse than liberals felt for Nixon in the early 70s or blacks felt for Reagan in the 80s, according to pollsters.

IMAGE PROBLEMS YOU MUST COUNTER

It's no surprise that some Americans can't handle smart, tough, independent women. And that's the image most Americans have of you (even die-hard supporters, who view those characteristics as positives). Few Americans think of you in personal terms (warm, caring, funny, kind, maternal) or have a sense of your deep love of children. Given such a distorted view of who you are, your "very negative" rating in the most recent sampling was higher than the President's -- 27 percent compared to 25 percent. Obviously this is partly the handiwork of the Radical Right and the radio talk show hosts who have much to gain by painting an unflattering portrait of you.

Most problematic is that the stronger you appear, the weaker the President appears. Conversely, if he seems weak, your intelligence, strength, and decisiveness increasingly are viewed as negatives because they are portrayed in contrast to him.

This was not always the case. At the outset, most Americans had a favorable impression of you. They saw you traversing the country, listening to ordinary people's concerns. They focused on your background as a children's advocate and a voice for family values. Even if they weren't used to your role as First Lady, they grudgingly respected your boldness, your intelligence, and your moral passion.

Two events allowed the misperceptions to take hold.

First, the legislative battle over health care reform, when you were rarely seen talking to ordinary folks, but more often seen conferring with Senators on Capitol Hill, leading the fight (as the official chair of the President's task force) to change the health care system. In some people's minds, you were no longer the caring leader of a public outreach effort but the protagonist in a partisan, political drama. Negative references in the press and elsewhere about your role as chair of the task force reinforced that view.

Second, the commodities stories. However unfair and untrue they were, they did damage by lending the impression that you were cut off from real people. And they created a wholly inaccurate notion that you were elitist, wealthy, and a person who grew up in an environment of total privilege.

HOW TO SOLVE THE IMAGE PROBLEMS

Softening your image does not mean being someone you aren't. It means being careful about language and tone and revealing more of your personal qualities. The general prescription is straightforward and should not prevent you from expressing your opinions and ideas:

1) Pick issues and events that help accentuate your personal rather than your political, wonky side.

2) Stay away from heavy policy debates and issues with ideological content.

3) Return to what you did at the beginning of the Administration, when you were viewed as the ultimate "listener," someone who soaked up the misery of hard-working Americans and provided them an empathetic and sympathetic ear. (During the outreach phase of health care you were very successful at weaving real people and their stories into the President's vision for America and his agenda for change).

In short, your actions and words should convey very powerfully that "the First Lady is listening."

SOFTENING THE IMAGE

Your staff and friends know you're an extremely warm, down-to-earth person, but the public doesn't know it. To counter impressions that you're only a tough-talking, businesslike lawyer, you can show more flashes of humor and reveal more about yourself, especially when your own experiences mirror the experiences of hard-working Americans. This doesn't mean giving away deep dark secrets or compromising your privacy or integrity. It means letting people in on the fact that you worked summer jobs to get through school (something most of your staff doesn't know), took some time off when Chelsea was born, or made sure that new mothers on your staff were given the flexibility they needed to do their jobs.

It also means allowing the public to see you do everyday things that they can relate to: shopping frantically for Christmas presents, caroling (maybe with Chelsea and some of her friends) during the holiday season, working out, making scrambled eggs for Sunday brunch, going to a local arts and crafts show, relaxing on the sofa with a magazine, or having friends over for a casual meal or picnic.

It also would help if Americans had a stronger sense of the First Family as family -- not through contrived photos, but perhaps by releasing photos from time-to-time that depict all of you together in informal settings.

Finally, Americans must be reminded of your love of children. This can be accomplished by focusing on issues relating to children (more on that later), and by making sure your interactions with children don't go unnoticed. It might also be nice to host some specific children's events at The White House.

In your official role as First Lady, there are several win-

win opportunities.

Honorary Chairs -- Accepting honorary chairs is important because you look accessible and are viewed as participating in good causes. But when you turn down honorary chairs, it's inexplicable to most people (except when the cause simply doesn't make sense). Honorary chairs play to your strengths by reminding people that you have a long history of service, of giving, of volunteering, and of caring about people's problems.

Establishing a connection to your Washington community -- There are families, children, schools, and institutions struggling for survival here. Minutes from the White House there are endless opportunities to showcase your concerns, as well as underscore your openness and compassion for people in difficult circumstances. This would help galvanize women and minorities, both of whom are crucial to the Administration. And it would help undo impressions that you are aloof and stand-off-ish, or oblivious to the problems and tragedies of real people. (NOTE: In The *Washington Post* on Sunday, Sally Quinn has a long piece in Outlook about the city's infant mortality problem. In it, she pushes the idea that Marion Barry should enlist your support. In an interview with her, he expresses great enthusiasm about getting you involved).

Host White House Events that reflect your personal interests and concerns -- Events like the R & B night, or a mystery writers dinner, or an evening of children's stories. Also, building on the choice of Maya Angelou as Inaugural Poet (a tremendous symbol of inclusion for women and minorities), it might be nice to host a series of cultural/artistic events that showcase the diversity of American culture.

These sorts of activities will give people a stronger sense of you as a person, rather than as an "official" who is making policy decisions. They also will help insulate you from likely attacks from the Religious Right and the new House leadership, who have begun caricaturing you and the President as countercultural lefties. Allowing people to know you as a person will be of particular importance during expected hearings on Whitewater.

ENERGIZING YOUR BASE

The trick is how to do all of the above (e.g. soften the image) and still energize and expand your natural base. The best way is to focus on families, children, and women.

Obviously, women are key. In races where women voters were energized in the last election, Democrats won. Chiles, Kennedy, and Robb all held large margins among women voters. But Democrats fared poorly if they didn't reach out to women voters on choice,

personal safety, or economic issues. And overall, we lost non-college educated women, who should be part of our base.

It's important to remember that you can't focus on women to the exclusion of men. You need to speak to women's concerns in language that also resonates with men. That can be done by stressing families and children ahead of women, and particularly by focusing on economic, family, health, and personal security.

In reaching out to the so-called "new middle class," you also need to adopt a Populist edge that shows you are fighting for working families, not for the powerful. Your role should not be connected to Congress or be dependent on Congress in any way. You must be viewed as helping people, lending support, but not running the government.

ISSUES AND THEMES THAT REFLECT YOUR CONCERN FOR FAMILIES, CHILDREN AND WOMEN

1. VIOLENCE (against children)

You can become the most visible and articulate voice against violence in the country by listening to and articulating people's concerns about violence. Violence in general, and particularly violence in schools, is a constant worry for almost all parents today. Parents fear they will not see their children at the end of the school day or that their kids will not live long enough to reach adulthood.

This issue has enormous emotional content for women and blacks. By focusing on violence at a time when the GOP will exploit class and race warfare on social issues, you can be seen as a force for coming together. You can also highlight benefits of the crime bill, such as recreation centers and expanded school programs, and demonstrate that violence is an issue the Administration takes seriously. And you can return to your own important theme of personal responsibility.

However, you shouldn't use violence as a vehicle to go after the NRA or a specific policy, but to show you are listening to people's fears and spotlighting how real people struggle to keep their families secure.

You can talk about violence on a human scale, and as a public health issue. For example:

-- Visit a family or community that has lost a child to violence (like the family of the 16-year-old boy who was beaten to death outside Philadelphia last week, or the kids who were in the swimming pool here in DC when the gunshots rang out last summer).

-- Highlight efforts being made by communities, neighborhoods, and institutions to curb violence -- particularly ones benefiting from the crime bill, the Brady bill, or other anti-crime efforts we've made. For example, the Department of Education and HHS have a partnership on a community school initiative that enables schools to stay open 24 hours a day to provide recreations and programs to kids who might otherwise be on the streets. The funding goes to community-based organizations whose work helps keep their communities secure and encourages schools and the larger community to work together.

-- Highlight the work of specific organizations, such as Mothers Against Violence (maybe even join them one night for a phone-a-thon), the Catholic Bishops (who released a letter last week underscoring community projects), black churches, police officers, Neighborhood Watch groups, and so on.

2. BLOOD, SWEAT, AND TEARS (JOB DOWNSIZING AND ECONOMIC ANXIETY)

Job downsizing today mostly affects men, but job insecurity among men and women threatens the health and well-being of many families. Often, having two parents in the workplace is the only means of economic survival for a family. Even with jobs, parents find themselves with inadequate health insurance, living on a shoestring, and worrying constantly about the child care arrangements they've made for their children.

Hearings on Family Stress and Job Downsizing -- Following up on Women Count, you could participate in hearings across America in which you listen to men and women articulate their anxieties about jobs and families. You could even expand on the Women Count survey and highlight the results in forums around the country.

Child Care -- This is probably as emotional an issue for American women as abortion. And it certainly is a source of great anxiety for all working parents.

While there are programs providing federal assistance for child care (which are critical to welfare reform and, no doubt, will be under attack as emblematic of the welfare state), the accent must be on middle-class workers. Here government can play a vital role with health and safety guarantees. There are joint initiatives with HHS and the CDC which can be highlighted as examples of "government working for you."

You also can visit places that are creative and successful in developing new child care strategies. Los Angeles has set up after-hours care to help their police officers cope with family obligations. You can visit corporations like Stride Rite whose family-friendly work policies extend to day care at the work site. Or you can talk to women who must leave for their jobs so early in the morning that they phone their kids from work in the

morning to wake them up. (The editor of *Working Woman* magazine highlighted this issue at the magazine editors' luncheon with you at the White House).

Working Women -- Issues affecting working women need to be couched in the context of family. As Betty Friedan said, "We need to advance the economy for men and women."

Even so, as part of a year-long scene-setter for Beijing, it is crucial that we dispel notions (sure to be perpetuated by the Religious Right) that you are part of some feminist cabal meeting in China to plot a takeover of the world. Everything you do leading up to Beijing must reinforce the fact that the conference is for all kinds of women and reflects the concerns of families as well.

Keeping that in mind, you could meet with women in different forums to build on the idea that "The First Lady is Listening" to their concerns and forwarding them to the President. You can relate women's real life experiences to your own -- just as you did so powerfully in the Women Count press conference. You need to show that you identify with the average woman's work life and experience.

One way might be to have "workdays" where you do different jobs alongside women -- at a check-out counter, day care center, hospital, library, farm, or even with a stay-at-home mom.

On a quieter note, you could meet with NGO women and other groups that will be crucial to future outreach efforts.

You could also convene regional meetings to showcase the women of the Administration and what their agencies are doing on behalf of women.

(In conjunction with the 75th Anniversary of the Women's Bureau, DOL is working on Women At Work television gala).

3. WOMEN'S HEALTH

The health issue is still yours and your best moments were listening to Americans on why our health care system needs to be fixed. Celinda Lake said you still poll as the most credible voice on health care.

Several fronts are of particular concern to women: breast cancer, menopause hormone treatments, surgical procedures (such as hysterectomies), preventive care, prenatal and neonatal care, stress, depression, osteoporosis, and independent living and elder care.

These issues cut across all economic and ideological lines,

and you have many options for how to further your own involvement.

-- A White House Conference on Women's Health with a hook-up to regional locations, and perhaps with a role for women's magazines.

-- Forums you could attend around the country to highlight specific women's health issues.

-- A meeting with all of the co-chairs of the Breast Cancer coordinating committee that the Administration established to address all issues relating to breast cancer, from research to prevention to treatment. It's a wonderful example of government pulling together the key players.

-- Focus on adolescent girls' health. Issues such as prevention, self-esteem, eating disorders, exercise, nutrition, mental health, teen pregnancy, and so on. This is the least addressed segment of the population in terms of health care. Your efforts to illuminate the special problems of teen health could be joined by girls' magazines, the YWCA, Girl Scouts, the Junior League, and others.

-- Elder/Adult Care -- This issue is critical to women between ages of 50-65. According to the AARP, the numbers are off the charts. There is real concern not just about quality of care but about the poor treatment of employees, who work under horrible conditions for minimum wage salaries. We need to find out if there is a way to tie Medicaid reimbursement to nursing homes for better treatment of workers. This issue not only will resonate for families in need of elder care but also will help us with labor.

-- Possible government initiatives:

* A 1-800-NUMBER you could launch for women that would be a clearing house for health information.

* Medicare only covers mammograms every other year for eligible women. We are exploring the possibility of changing that to guidelines we used for HSA -- every year when medically appropriate or necessary. [You have a list from Chris Jennings of other possible Medicare changes].

* On the issue of breast implants, the FDA has taken action to approve implants solely for women who join a clinical trial. There is a class action suit in progress for the women who are currently plagued with adverse consequences. (Let us know what kind of specific information you want).

4. CHILDREN

Children are woven into many of the above topics, particularly violence. But as the GOP targets programs that directly or indirectly affect children, your voice as an advocate for children becomes even more crucial.

Clearly, this is an issue on which you have great credibility and one in which your leadership should be beyond question. Keeping a strong focus on children not only is an important cause, but it can focus public attention on your long involvement with children and your wonderful track record on these issues. Further, it can help us outflank the Religious Right as they seek to label you and the President "countercultural," "anti-family," and so on.

Most immediately, you need to appear in settings with children that remind Americans of your concern, commitment and experience.

-- Visit schools and meet with parents to talk about the importance of their involvement. That will underscore an Administration initiative on parental involvement in schools and will enable you to enhance your status as a "listener" and a compassionate figure.

-- Visit a successful Head Start program to show the Administration's progress in meeting parents' needs, improving quality of care and instruction, and demonstrating how communities are involved in making improvements in programs.

-- Go to health clinics to publicize immunization programs, particularly as the Administration program kicks in.

-- Hold a forum for kids where they can talk to you about their fears, hopes, and anxieties.

5. COLLEGE POPULATIONS

We lost ground with young voters in the mid-term elections. One reason appears to be that they, like older adults, are panicked about their economic futures.

Given your appeal as a role model for young women, along with the Administration's financial aid reforms and launching of AmeriCorps, there are great opportunities for you with this constituency.

-- Large forums on campuses (in targeted states), combined with smaller, more personal meetings where students get a sense of your personal warmth and concern.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Mike Lux to Marilyn Yeager; RE: Work on Health Care (2 pages)		P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Liz Bowyer (HRC State by State Health Care Files)
OA/Box Number: 3986

FOLDER TITLE:
HRC Date File 5/25/94 - 11/11/94: May 12 [Health Care Events

Debbie Bush
2006-0810-F
db2278

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]

HI

THE WHITE HOUSE

WASHINGTON

June 9, 1993

MEMORANDUM FOR MARILYN YEAGER

FROM: Mike Lux

SUBJECT: Your Work on Health Care

Given where we currently are on the health issue, I would suggest that the following three projects would be very helpful to us:

1. Being the point person for our individual CEO endorsement strategy. Attached is a list of the businesses that I think are our most helpful targets for a CEO endorsement. They come primarily from three sources:

- member businesses of the National Leadership Coalition on Health Care Reform

- member businesses of Businesses for Social Responsibility

- businesses where Ira Magaziner has had conversations with the CEO that made him optimistic

I have asked Alexis Herman, Caren Wilcox and Amy Zisook to add any businesses that they think are good targets based on a good relationship with the President or other factors. It would be worth checking with Mack, Rubin, Commerce and Treasury for additional ideas.

These businesses - their Washington reps and their CEOs - need to be worked one-on-one. My recommendation is that you:

a. Do an initial call to each of them (maybe the Washington rep) to get a sense of how they are currently feeling about health reform.

b. Work on a phone and meeting strategy involving yourself, myself, Amy, Caren, Alexis, Mack, Bob Rubin, Treasury, Commerce, SBA.

c. Think through other high priority meetings for the President or First Lady.

d. Keep adding to the potential business supporters list.

2. Managing the necessary follow-up with all the business associations with which we've already had meetings. We've done a good job meeting with a wide range of business associations over the course of the last few months. It's important in the end game that we don't drop the ball and tick people off. You should make sure and touch base with government relations directors or the executive director of each association at least once between now and announcement. Attached is a list of all business associations with which administration officials have met.

3. Be the free safety with provider groups. Ira has done an outstanding job working with the big provider groups. We need to make sure that the medium sized groups (ACP, AAP, CHA, etc.) feel good about us - I think they do - and also deal with crises or requests that come up. Because of your knowledge of this constituency, you should plan an active trouble-shooting role in this area.

I hope this is a helpful beginning as we think through your health care work. Let's talk soon about any additional or different ideas you have on this topic.

cc: Alexis Herman
Steve Hilton
Amy Zisook
Ira Magaziner

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Patrick Griffin et al. to the President; RE: Plan for Congressional Contact (4 pages)	02/09/1994	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer (Books)
OA/Box Number: 14722

FOLDER TITLE:
Health Care Targeting [Binder] [2]

Debbie Bush
2006-0810-F
db2279

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

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THE WHITE HOUSE

WASHINGTON

February 9, 1994

MEMORANDUM FOR THE PRESIDENT

FROM: Patrick Griffin
Susan Brophy
Steve Ricchetti

SUBJECT: Plan for Congressional Contact

The following is a plan for Member contact for the President. We have broken Members down into four categories: those who are consistent supporters of the President who require additional attention from the President; those who we want cultivated as the President's core supporters who are prepared to "walk through the fire with us"; those who require individual attention; and finally a list of members who are targeted because they have been identified as swing votes on health care and other issues.

In each category we are recommending specific activities, timetables and frequency of contact.

A. Consistent Supporters

There are 187 Members of the House and Senate who have supported the President on his major initiatives. (List attached)

We believe a strategy to engage these Members more frequently and in a social setting will continue to ensure their loyalty to the President.

We are recommending two sets of activities:

1. Five dinners with 40 Members and their spouses at each. It will require five weeks, one dinner per week, to accomplish our goal of inviting the President's most loyal supporters to the White House for a social function.

2. We also believe that these social events should be coupled with small substantive meetings with the President to establish an ongoing dialogue about the Administration's priorities. We recommend eleven meetings (one hour), with a maximum of fifteen Members in each, over the course of the next three months (one per week).

B. Fire Walkers

We are suggesting that the President develop a core group of supporters, upon whose advise and assistance he can rely over the long term. We have identified eleven Members of the Senate and thirty seven House Members with whom we believe the President can build durable and sustained personal relationships. This group will serve as the foundation of the President's support in Congress and will help the President be better informed about what is achievable legislatively.

Senators include: Mitchell, Ford, Daschle, Breaux, Rockefeller, Leahy, Pryor, Boxer, Dodd, Hollings and Reid. House Members include: House leadership (Foley, Gephardt, Bonior, Hoyer, Fazio, Kennelly, Derrick, Lewis and Richardson) and the following others - Eshoo, Durbin, Dicks, Mfume, Frost, Lowey, Hamilton, Murtha, Pelosi, Price, Synar, G. Miller, Becerra, DeLauro, Frank, Glickman, Gjedenson, Meek, Flake, Pastor and Rangel.

To accomplish this we recommend that one or more of the following activities be undertaken at least once a month:

1. Informal Friday night dinners;

2. Strategy sessions after work over cocktails in groups of five to eight Members, segregated by chamber; (One per week for six weeks will accommodate all of the Members listed above.)

3. Invitations to movies;

4. Camp David overnights in small groups.

C. Individual Attention

There are six Senators and eight House Members who we believe are so important to the President's political and legislative fortunes that they should be contacted by the President by phone on a weekly basis. In addition, individual meetings with each should be scheduled at least every other month.

This group includes Senators - Mitchell, Dole, Moynihan, Byrd, Kennedy and Breaux, in addition to Representatives - Foley, Gephardt, Rostenkowski, Dingell, Natcher, Stenholm, Brooks and Michel.

In addition, all of the Members listed above should be considered when invitations are extended for the following:

White House dinners for any purpose

Kennedy Center box

Golf

Tennis

Running

Movies

D. Targeted Swing Members of Congress

We have identified this list of Members, some organized by ideological group, for special attention because they represent the balance of power on health care and many other important pieces of legislation. We have listed targeted Republicans from the House and Senate, whom we and Majority Leader Mitchell believe have the potential to support the President.

Our approach to dealing with these Members is as follows: in the Senate, at a working breakfast or lunch, the President should meet with the following group: Exon, Johnston, Bryan, Nunn, B. Kerrey, Heflin, Robb, Kohl, Shelby, Lautenberg, Boren, Campbell and Lieberman. A separate meeting with the following key Republicans should be scheduled: Jeffords, Hatfield, Cohen, Danforth, Durenberger, Kassebaum and Chafee.

In the House we recommend that the President meet with the following four groups: Conservative Democratic Forum, Mainstream Forum, Single-Payer co-sponsors and targeted Republicans. Targeted Republicans include: Boehlert, Shays, Snowe, Lazio, Fish, Walsh, N. Johnson, S. Horn, Gilchrist, Houghton, Quinn, Ramstad, Upton, Roukema, Torkildsen, Regula and Ros-Lehtinen.

As the Speaker and House Majority Leader noted in the health care meeting this morning, we should be cautious in reaching out to these Republicans and our strategy needs to be coordinated with the leadership.

This would require six meetings over the course of the next two months.

E. Health Care

Senate

Senator Mitchell has recommended that the President meet in small groups with every Democratic Member and with key targeted Republicans . We recommend groups of seven with the following breakdown: four co-sponsors, one liberal and two moderate non-co-sponsors.

House

We will continue to meet with the Leadership and Chairmen on a regular basis to discuss legislative strategy for the duration of the Health Care debate. The general membership of the House will be accommodated by the Caucuses and other group meetings outlined in parts D and F.

This would require nine one hour meetings over the next two months.

F. Additional Outreach

To extend the outreach of this congressional relations strategy, we recommend that the President should also meet with the following caucuses and groups: Freshman, Hispanic, CBC and Women. This would require four meetings over the next two months.

G. '94 Elections

Minimally, we believe the President must also have two to three 1-hour meetings per month with members in marginal races from the House and Senate. Joan Baggett is outlining a specific strategy to accomplish this goal.

H. Travel

This plan contemplates that Presidential, Vice Presidential and First Lady travel will be directed both toward targeted members for our Health Care strategy and in accommodating the '94 Campaign strategy outlined by Joan Baggett.

Lists of the groups and caucuses identified in this memo are attached.

Note: This entire strategy can be accomplished by dedicating 12 hours of Presidential time per week during the course of the next 2 1/2 months and can and should be repeated before the August recess.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Chris Jennings to Hillary Rodham Clinton; RE: Senator Kennedy's Employer Mandate Bill (2 pages)	04/17/1998	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer (Subject Files: H)
OA/Box Number: 20035

FOLDER TITLE:
Health Care HMO [Health Maintenance Organization]

Debbie Bush
2006-0810-F
db2280

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]
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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]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

fill health care

MEMORANDUM

TO: Hillary Rodham Clinton

April 17, 1998

FR: Chris Jennings

RE: Senator Kennedy's Employer Mandate Bill

cc: Melanne, Jen

Next Wednesday, Senator Kennedy is planning on introducing a health insurance mandate bill. This legislation, which is strongly supported by the Labor community, would require all firms with 50 or more employees to provide health insurance that is equivalent to the Federal Employees Health Benefit Plan's Blue Cross/Blue Shield standard option.

Senator Kennedy would of course love you or any other high ranking Administration official to join him in the introduction of his "Health Care for All" bill. However, his office indicated yesterday that they do not have great expectations that we will be able to do this. They are hoping and requesting, however, that we be as positive as possible about our public statements about the legislation. This memo provides some background information on the strengths and weaknesses of the bill, as well as my suggestion for our public position on it.

BACKGROUND

By requiring firms of over 50 or more employees to provide health insurance, Senator Kennedy's 8½ page bill would help less than half of the 41 million Americans who are uninsured. Covering so many Americans so quickly would be a remarkable achievement; it would be a much more efficient way to cover large numbers of the uninsured than the state incentive approach we took with the new Children's Health Insurance Program.

As you will recall, however, the hardest to reach and most disproportionately represented uninsured do not work or have families who work in these larger firms. As such, at least 20 million uninsured Americans would not be covered by Senator Kennedy's bill. Moreover, because his approach does not cover all employers or employees, it might well accelerate the trend for medium sized businesses to split or subcontract out to avoid providing health benefits. In addition, because it does not provide for any subsidies or cost containment provisions, some of the workers who would be required to pay 25 percent of the premiums might well find the insurance to be unaffordable.

Spending much capital on a bill that carries the "heavy lift" of an employer mandate, has serious policy shortcomings and has no chance of passing seems ill-advised. It could distract attention away from the "Patients' Bill of Rights" and play right into the hands of Republicans who are desperate to score political points using their "Clinton-Care, Government take-over" rhetoric.

RECOMMENDATION

We cannot and should not ever run away from our commitment to develop approaches to assure access to affordable, quality health coverage for all Americans. As such, even though Senator Kennedy's legislation is far from perfect, we clearly cannot not be critical of his bill. Having said this, there are ways to position ourselves that maintain our fundamental commitment to universal coverage without providing an outright endorsement of Senator Kennedy's bill. I would suggest that our public position on this bill should be something like this:

We welcome Senator Kennedy's bill to provide insurance coverage to millions of Americans. His commitment to this issue has been unwavering for decades, and we commend him for his work. Because we recognize that this Congress will not likely take up, much less pass, Senator Kennedy's bill, we believe we should focus most of our efforts this year on those initiatives we have the opportunity to pass this year -- tobacco, patients' bill of rights, and the President's Medicare buy-in proposal. As always, however, we stand willing to work with Senator Kennedy and other members from both sides of the aisle to develop new and long overdue insurance coverage options.

I hope you find this information to be useful. Please advise me if you have any concerns with the above recommendation.

p.s. We are working on the outlines of your Harvard Medical School commencement address. We will be talking with Ira, Paul Starr, Uwe Reinhardt, and others early next week to go over some ideas.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Jennifer O'Connor to David Watkins et al.; RE: Meeting today with Staff of House Appropriations Treasury, Postal Subcommittee (1 page)	03/12/1993	P5
002. list	Working Group 17 - Bioethics; RE: Addresses, SSN's, DOB's, and phone numbers [partial] (5 pages)	n.d.	P6/b(6)
003a. letter	EE. Richard Brown to Ira Magaziner; RE: Address and SSN [partial] (1 page)	02/15/1993	P6/b(6)
003b. paper	Stouffer Mayflower Hotel; RE: Address and phone numbers [partial] (1 page)	02/13/1993	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Maggie Williams (Misc. Subject Files)
OA/Box Number: 10813

FOLDER TITLE:
Other Information [2]

Debbie Bush
2006-0810-F
db1787

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]
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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]
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Recurring / Regular — Health care T.F.

March 12, 1993

MEMORANDUM TO DAVID WATKINS
HOWARD PASTER
MARK GEARAN
PATSY THOMASSON

FROM: JENNIFER O'CONNOR

SUBJECT: MEETING TODAY WITH STAFF OF HOUSE APPROPRIATIONS TREASURY, POSTAL SUBCOMMITTEE

For your information:

Ron Rasmussen (Director of Financial Management at the Office of Administration) and I met today with the staff of the House Appropriations Treasury, Postal Subcommittee. It was described as an informal meeting for us to brief new staff about how the Executive Office of the President is set up and works.

The meeting was fairly hostile, both from the minority and majority staff. Their issues were:

1. Health Care Working Group

   Apparently, last year, this committee had a bitter battle over the Council on Competitiveness. The minority staff indicated to me that they believe that the HCWG is the same thing and they want to raise the roof about it to make up for last year's fight.

   They want to know the fine details about how many people work full time on it; who pays for all of their expenses from printing to rent to phones; who supervises the staff; where the offices of the 500+ people reported to be on it are, etc. They repeatedly emphasized the fact that they believe it is the same animal as the Council on Competitiveness.

   At the moment, I am working with Steve Neuwirth to figure out the funding mechanism for the HCWG.

2. Supplemental

   Hoyer's staff said they feel strongly that they do not want to have to defend a straight supplemental. They think we need to request dollar for dollar transfers for any extra money we need.

   The minority staff said they want our computer and phone requests to be "reasonable" and that "a bunch of 23 year old yuppies" should not come into the White House "expecting to see the Johnson Space Center."

3. Jogging Track

   They just have basic questions about how much it costs, who is donating to it, etc.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule; RE: Phone numbers, USSS, and manifest [partial] (3 pages)	11/08/1993	P6/b(6), b(7)(C), b(7)(E)
002. memo	Marla Romash to the President; RE: Additional Health Care Information (1 page)	11/06/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 2466

FOLDER TITLE:
Health Care Reporters, DSCC [Democratic Senatorial Campaign Committee] Dinner, Washington, DC - Nov 8, 93

Debbie Bush
2006-0810-F
db1729

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]
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November 6, 1993

MEMORANDUM TO THE PRESIDENT

FR: MARLA ROMASH

RE: Additional Health Care Information

I. BACKGROUND:

Here is the additional information you requested at this morning's briefing for "Meet the Press."

II. RECOMMENDATION

A. On the insurance companies: while the memo that follows reviews some of the incremental reforms portions of the industry have been willing to consider, it is important that you do not get into this level of detail. Your responses should be guided by the language in the two-page Health Security themes memo you received and its emphasis on security.

That is:

The insurance companies don't like the plan because it makes it illegal for them to indiscriminately raise rates, illegal for them to deny you coverage because you get sick, illegal for them to put a limit on the benefits you can receive, taking away coverage when you need it most. They've forgotten why insurance companies were created in the first place and they've abandoned the old-fashioned principle that was at the industry's foundation: insurance is about sharing risk and everyone taking responsibility.

B. On the shift from welfare to work: because of the issues raised in the memo that follows, it is important that your comments be carefully worded. The recommendation is that if you make this point it should be to say:

One study suggests that universal coverage could reduce welfare caseloads by up to 25 percent.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule; RE: Phone numbers, manifests, and USSS [partial] (7 pages)	03/14/1994	P6/b(6), b(7)(C), b(7)(E)
002a. list	Meeting with Hillary Rodham Clinton; RE: DOB's and SSN's [partial] (2 pages)	03/14/1993	P6/b(6)
002b. briefing paper	Linda Moore; RE: Fundraiser to Benefit Democartic Candidates for Statewide Office (3 pages)	03/11/1994	Personal Misfile
002c. memo	Steve Edelstein, Maureen Shea to Hillary Rodham Clinton [partial] (1 page)	03/11/1994	P5
003. letter	Webster L. Hubbell to the President (2 pages)	03/14/1994	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10225

FOLDER TITLE:
U [University] of Colorado, Schroeder Health Care Forum, Colorado National Guard, Denver, CO, 3/14/94

Debbie Bush
2006-0810-F
db1734

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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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]
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~~PRIVILEGED AND CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton
FROM: Steve Edelstein, Maureen Shea
RE: Notes and Profiles for Colorado Health Care Summit
DA: March 11, 1994

Colorado Notes: In February the Federal Trade Commission said it wanted to block a hospital merger in Pueblo on antitrust grounds. It is a move that is considered to have major implications for other hospital consolidation plans.

Also, the Colorado Health Care Summit where the First lady is scheduled to speak is one of those organized by The Columbia Institute. These are the "stacked" town halls which the Washington Post featured on March 7.

The Denver Post included a feature story February 13 on Jo Ann Matthews who wrote to the First Lady and Rep. Schroeder about her plight. She is 65 and over the past 10 years has suffered from multiple chemical sensitivity (MCS). She has been cut off by Medicare and has depleted her life savings with $100,000 in medical bills. An Administrative Law Judge has ruled that she was psychologically dependent on [illegible] and that MCS was a "controversial diagnosis" and therefore not covered by the regulations. She would like the law changed. The story stated that Matthews received a reply from the First Lady which said: "Mrs. Clinton greatly appreciates your expression of trust and confidence in her," and that Schroeder's office has simply passed the case back to the people who denied it. The story concluded: "Matthews, off the oxygen for a couple of hours, sniffled, 'Obviously no one read my letter. It is so humiliating. They're grinding me down.'" (story attached)

CONGRESSWOMAN PATRICIA SCHROEDER (D-CO): The Co-Chair of the Congressional Caucus on Women's Issues, Congresswoman Schroeder is in her 11th term representing metropolitan Denver. She has not cosponsored any of the overall health reform bills this Congress but has been strong in her insistence that reproductive rights be part of the package. Schroeder voted for Budget Reconciliation, NAFTA, and National Service. She worked hard to pass the Family and Medical Leave Act and child care legislation and can always be counted on as a strong voice for the concerns of women and families.

Schroeder is particularly effective with the press, shaping the debate in sound bites, and articulating her message in easily understandable terms. Within the Congress itself, she is more of a loner and not necessarily involved with the nuts and bolts of ongoing legislation. Schroeder can be difficult for the leadership. Attempts to moderate legislation to attract more conservative members of the Democratic Caucus are sometimes opposed by Schroeder. Majority Leader Gephardt does not count on her to even vote for the final health care reform bill. She will probably be with the President for something this important, but she will need a lot of attention. Congresswoman Schroeder will not support a bill that does not include coverage for

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Ira Magaziner to President Bill Clinton, First Lady Hillary Rodham Clinton; RE: Health Care Reform and the Economic Package (7 pages)	03/07/1993	P5
002. memo	Ira Magaziner to Hillary Clinton [partial] (1 page)	03/31/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10249

FOLDER TITLE:
Magaziner Health Care Memos [1]

Debbie Bush
2006-0810-F
db2283

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]
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37-93

March 7, 1993

MEMORANDUM FOR PRESIDENT BILL CLINTON
FIRST LADY HILLARY RODHAM CLINTON

FROM: IRA C. MAGAZINER

SUBJECT: HEALTH CARE REFORM AND THE ECONOMIC PACKAGE

Many of your advisers question the desirability of wrapping health care reform legislation up with the economic package in reconciliation. They point out, quite rightly, that doing so may compromise the possibility for quick passage of the economic package. They understand "the President's got only one vote" mentality on the Hill, and their advice is that something is better than nothing: health care can be next year's project.

Others believe that decoupling does not necessarily mean that your health care bill must be put off until next year. They feel that the momentum of an early victory will add to your ability to push for a vote for health care, and that the continued urgency of the issue will keep the heat on members to pass it this year. Though they acknowledge that 60 votes is a lot more difficult to get than 50, they don't believe it's impossible.

I am not a congressional strategist. However, I am concerned about the risks of reducing the chances for health care reform to be passed this year. I believe that if it is not passed this year, the possibility of passing comprehensive health care reform during your first term may be severely diminished. As James Carville put it in a meeting last week, "the more time we allow for the defenders of the status quo to organize, the more they will be able to marshal opposition to your plan, and the better their chances of killing it."

There are five key operative questions:

1. Economic gains may not be felt by the American public in 1996 if we have not reformed health care.

2. Keeping health care out of reconciliation may virtually guarantee that health care doesn't happen this year.

3. Delaying action on health care may erode the possibility of passage during your first term.

4. We should not accept a situation in 1996 where the economic

plan has passed but health care reform has not.

5. There may be a way to introduce a placemarker for health care without endangering the budget resolution.

1. Economic gains may not be felt by the American public in 1996 if we have not reformed health care.

You have long known that the future of the health care system and the economy are inextricably linked.

Recent figures developed by David Cutler of the National Economic Council and Sherry Glied of the Council of Economic Advisers estimate that increased health care spending will consume 64% of the total projected per capita growth in GDP between now and 1998.

This doesn't tell the whole story.

Workers pay, either directly or through taxes, a significant share of the health care expenditures for children and the elderly. Numbers produced by Ken Thorpe, health economist at HHS, indicate that increases in health care spending will take up well over 100% of the total increase in worker compensation over the next five years.

Also, neither of these estimates assumes we invest to insure the 37 million uninsured American.

If there is no health care reform, most Americans may well feel that their living standards have not improved in 1996.

The health care system may theoretically advance during that time. However, having more frequent, more sophisticated tests, filling out more medical forms or even being cured more quickly than would otherwise be the case does not register with most Americans as improved living standard in the same way as does more money in a paycheck or better ability to afford a house or a car.

You know all of this. You also know that increased health care spending accounts for 40-50% of total projected increases in federal spending and that health care was 2/3 responsible for "breaking the back" of the 1990 budget agreement.

Unchecked, rising health care costs may overwhelm economic growth and hinder attempts at deficit reduction. As costs rise, companies may continue to respond by cutting back on, or eliminating, coverage for employees and retirees. The Medicaid rolls may continue to expand at a rapid pace.

2. Keeping health care out of reconciliation may virtually guarantee that health care doesn't happen this year.

There are reasons why comprehensive health care reform has not been enacted despite commitments by every Democratic President since Franklin Roosevelt to do so.

- The issues are complex;
- The lobbying powers for the status quo are powerful and widely dispersed;
- The financial implications of any change are staggering;
- Any change must be dramatic if it is to make a difference.

The only significant health care reform -- Medicare/Medicaid -- came after Lyndon Johnson had won a landslide victory and made it his top priority for his first year.

The enormity of the task suggests why so many of your advisers feel that it will take time to pass health care reform and why they feel it is so risky to tie it to the economic package. Their judgments are prudent.

Looking at the history and the powerful forces arrayed against comprehensive reform, how on earth do we think we can achieve health care reform under any circumstances?

The possible answer lies in an historic opportunity which has been created by recent events.

- The health care crisis has really hit home to many middle-income Americans these past few years.
  - Health care costs skyrocketed while the rest of the economy slumped;
  - Many companies for the first time went after health care costs in a serious way, cancelling benefits, increasing co-pays, etc;
  - Many white-collar employees lost their jobs and their benefits.
- Your emphasis on health care in the campaign following on the heels of Harris Woffords' victory kept the issue front and center in the political debate.

- Your appointment of the First Lady to head the Health Care Task Force persuaded many in Congress, in the health care community, and in the public at large that you were serious about health care reform.

- Your willingness to take on the drug companies showed political courage.

- Your impassioned and eloquent statement about health care reform in the State of the Union address drove home your seriousness.

The results of this building crescendo have been dramatic to those of us who are working on health care every day.

Interest groups, afraid of being left behind in a reform effort, now believe reform may well happen this year, and are coming to the table with incredible offers to support positions they have historically opposed. The American Medical Association, other physician groups, the American Hospital Association, groups of large insurers, large and small business groups, drug companies, have all been in my office these past two weeks proposing ideas on short-term controls to hold health spending to inflation while a new system is implemented. They have demonstrated a willingness to support employer mandates under certain conditions and a willingness to support budgets for health care over the long term.

I am not so naive to think that all these groups will ultimately be with us, but they are running scared. We have them on the defensive. We have a possibility to achieve a breakthrough.

<u>It is important to note that the fear that has coerced their cooperation is bred from the speed of your actions on health care thus far in your presidency.</u> I cannot guarantee that this momentum will be sustained, nor that it will ensure the passage of the health care plan. But I feel that the likelihood of passage may well diminish as time passes.

We will be in a better position to know our chances in May after our plan is developed and released.

3. <u>Delaying action on health care may erode the possibility of passage during your first term.</u>

Those who have argued for decoupling health care reform from the budget have made convincing arguments for the threats that coupling brings to the budget package. They have <u>not</u> made convincing arguments that health care reform has a serious chance

of passing if it is decoupled from the budget package.

Here are the risks.

1. If we do not include a placeholder, it may signal to members of Congress and health care interest groups that we are not serious about health care reform this year. They may begin retreating from our efforts. Even supporters such as the elderly might be angered by the Medicare cuts in the absence of a health care package.

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

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

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

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

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

4. <u>We should not accept a situation in 1996 where the economic plan has passed but health care reform has not.</u>

The initial popularity of the economic program started a train to accelerate the passage of a budget resolution and of the budget itself in reconciliation in record time. Looked at from the point of view of the economic package, "waiting" for health care, even accommodating the possibility of joining them by putting in a placemarker for health care, muddies the waters of a package that otherwise seems guaranteed quick and (relatively) painless passage.

Many of your advisers make compelling arguments for passing the economic package this summer and postponing health care reform, guaranteeing you at least one victory rather than risking the single-package approach and failing. Combining the two in the budget reconciliation process is risky -- if you lose this one, you may lose everything.

Further, if you score a victory with the Congress on the economic plan, you'll win points with the American people by breaking the gridlock that has characterized this nation's government for too long, and could perhaps translate that support into support for your health care reform bill.

But, you may only get one shot to pass comprehensive legislation this year. No member of the leadership nor any Committee Chair or Subcommittee Chair that we've met with thinks it is possible. They, without exception, characterize the decision of whether or not to include health care in reconciliation as the decision of whether or not to do health care this year.

The American people are supporting the economic plan, even though it calls for sacrifice, because they believe that you are true to your vision to stimulate the economy, to provide better jobs, to ensure health care for everyone. They expect a brighter future.

Your economic plan accomplishes three things: 1) it reduces the budget deficit; 2) it fills some gaps in programs for the poor and underserved; and 3) it redistributes income. It is a good plan.

However, rising health care costs may undermine it. In 1996, the vast majority of Americans may not have experienced rising real incomes. They will have sacrificed, but they may not be much better off than they are today.

Most of your senior economic and political advisers are understandably focused on the economic plan. The health plan is still weeks away from even a first full draft. They quite rightly feel uncomfortable holding up their plan for a health care plan they neither have seen nor have confidence they or the American people would support.

Even though the health care plan is not yet fully formed, however, a threat to its chances should be taken with equal seriousness as a threat to the economic plan.

My main concern is that you don't let the focus on pursuing this economic plan keep you from taking steps which, in the long run, will be far more important to the nation and your

presidency.

5. There may be a way to introduce a placemarker for health care without endangering the budget resolution.

I suggest that we explore whether a compromise is possible. If we can make certain decisions about the effect of health care on the budget, could we perhaps preserve the flexibility of a placeholder in the budget?

- We could decide that the health care plan be deficit neutral.
- We could assure that all new revenues will be limited to health care sector recapture and perhaps to cigarette taxes or other "sin tax" groupings.

Ultimately, if we are likely to reject a massive new middle class tax to finance health care, let's just say so.

This leaves us a choice between how fast to phase in universal coverage versus how fast we move to control costs. If we make these decisions soon, that can better inform the work of the policy groups and guide our plan's development appropriately.

Great presidencies are defined by a few major achievements. You should pick the ones that really count and plan for them carefully.

Comprehensive health care reform is clearly one that has such potential.

Reducing the deficit to $200 billion, though very important, may not carry the same historical significance.

I urge you to look at the big picture and to think long-term when deciding on your legislative strategy.

The members of the NEC are still very nervous about the whole undertaking. They have sent people to the numbers group over the past two weeks (which swelled from 15 to 29 people as a result) and have been sitting-in on some of the briefings with the President.

Once we lay out the full set of numbers next week, the anxiety born of uncertainty may lessen, though their concerns about trying a comprehensive reform will likely remain. I will keep working with them and their people as intensively as they will allow.

5. I had a good meeting with Secretary Brown at Veterans Affairs and we are in agreement on a policy which he believes will be popular with veterans and which is very well integrated into the total plan.

6. Secretary Shalala remains uncomfortable. I have found it difficult to get an appointment with her, though I hope to get on her calendar tomorrow.

Her discomfort appears to have many sources, some related to her role and some related to a philosophical disposition to a more regulatory approach to health care reform. She appears to favor a more stark-like approach of extending Medicare and rate regulation to the nation as does Alice Rivlin.

She has suggested bringing Karen Davis and one or two others who would represent that point of view to brief the President so that he can see an alternative view. Judy Feder and Phil Lee who are both inclined more to the approach we are taking have tried to make her more comfortable with our process and policy direction.

In general, I believe she wants to be leading the process, has never made peace with my role, accepts your role but has felt slighted that the Vice President has assumed public leadership in your absence.

You will need to talk with her at some point, to get her fully on board and resolve her concerns.

7. The Vice President has been excellent during your absence. He has actively participated in all meetings, has been devoted to the process and has made real contributions. Having him stand-in for you was a great idea.

Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Ira Magaziner to Mack McLarty, et al.; RE: Health Care Reform Timing (2 pages)	07/22/1993	P5
002. memo	Ira Magaziner to M. McLarty, et al.; RE: Staffing (4 pages)	09/27/1993	b(2), P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10249

FOLDER TITLE:
Magaziner Health Care Memos [3]

Debbie Bush
2006-0810-F
db2284

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]
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July 22, 1993

MEMORANDUM FOR MACK McLARTY
DAVID GERGEN
GEORGE STEPHANOPOULOS

FROM: IRA C. MAGAZINER

SUBJECT: HEALTH CARE REFORM TIMING

The American public wants health care reform and expects President Bill Clinton to do it. Early this year, polls found overwhelming support and a confidence that the President could "pull it off." This feeling intensified after the State of the Union speech.

The "stop and start and stop again" nature of the health care decision process, the pernicious leaks and the constantly changing deadlines -- early May, late May, late June, late July, September -- have seriously slowed our momentum, undermining our credibility with Congress, interest groups, the media and the American people.

In the absence of action from us, we are having to fight daily to persuade the media not to write the what went wrong stories -- "too complex or secretive a process devised by Magaziner," "a plan being watered down," "a feud between the First Lady and the economic team," "a program where $100 billion+ of new taxes can't be sold," "a President who can't make decisions," etc.

Interest groups who were offering support and a willingness to compromise on long held positions are now backing away. Congressional leaders eager to support health reform are questioning whether we are serious and are getting nervous that we will leave them "high and dry." The business community already angered by the economic package grows increasingly worried about reputed huge taxes in health care reform.

We can regain the momentum and triumph, but we must be focused, unified and resolute.

You questioned last Thursday night, whether there was somehow a "separate White House" waiting to "move in" to do health care reform after reconciliation. On the contrary, we have been trying since February to capture the attention of the rest of the President's senior White House staff to prepare for

this initiative which has always, since early in the transition, been viewed as next in line after the budget.

Health care reform is complicated and politically difficult. It contains many policy choices with no right answers. It engenders opposition from very powerful interest groups. It is difficult to communicate effectively.

Despite these difficulties, it is among the nation's most pressing problems. We can succeed in solving the problem and accomplishing historically important goal.

To succeed, we need a sustained effort from the President and from all of you to make the final hard decisions on policy, to help organize for the communications and legislative efforts required and to help mobilize the whole Administration in support of the effort.

The President and First Lady are "way out in front" on the health care issue. It's hard to imagine a retreat from it without severe adverse consequences for this Administration.

Even worse than backing off, however, would be to do the job in a "half assed" way and to have the health care initiative crash shortly after launch.

If we don't release and go all out beginning in September, we will fail at health care reform. If we have a half hearted release of principles with a couple of speeches and then postpone serious considerations of our bill until January, we risk being beaten so badly that it will be embarrassing. The Republican bill will contest the single payer bill and we will be viewed as bumblers who are irrelevant.

We need a clear "green light" or a clear "red light" soon and to begin executing a strategy for either choice.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	RE: Going Forward on Health Care (6 pages)	11/01/1993	P5
002. memo	Ira Magaziner to Hillary Rodham Clinton; RE: Health Care Reform (4 pages)	11/01/1993	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10249

FOLDER TITLE:
Magaziner Health Care Memos [4]

Debbie Bush
2006-0810-F
db2285

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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11-1-93

GOING FORWARD ON HEALTH CARE:

ORGANIZING OURSELVES

This memo suggests how to organize ourselves for the rest of the health care debate in order to secure passage of comprehensive health care reform legislation.

The technical corrections to legislation, "numbers compendium", policy rationale and "section by section" documents should be done this week. Policy development will be completed.

Going forward, we will require a coordinated campaign which is different in character from what we have done so far in health care and also different then what was required for the budget or for NAFTA.

The following activities are required:

1. Guiding the bill as it goes through Congress.
2. Developing and implementing a public campaign to rally public support.
3. Administrative coordination.

1. <u>Guiding the Bill</u>

Health care reform is complex and detailed. There will be negotiation required on hundreds, perhaps thousands of items. There will be perhaps 15 or 20 major items to be negotiated.

The negotiations will be conducted with a wide variety of members and interest groups over a protracted period of time. We will have to educate members, help them to convince key supporters in their districts and influence them in a variety of ways, health care related and not.

Through it all, we will have to decide when and on what to change our position and when to hold firm.

We must be coordinated as an administration. This will be especially difficult, because there are differing views in the administration on various issues and some in the administration continue to "freelance", undermining administration decisions through their discussions with members of Congress and the press.

We need a unified, White House coordinated structure to guide and implement this effort.

- Legislative Lobbying

The legislative liaison group will have responsibility for the following:

- Implementing member by member activities to build support for the bill.
- Helping "flesh out" members bottom line concerns and designing means to address them.
- Prioritizing member contacts, district support activities, etc.
- Preparing for committee hearings.
- Negotiating with members.

Steve Ricchetti, Christopher Jennings and Jack Lew should coordinate a team of legislative lobbyists from HHS, Treasury, OMB, Labor, Justice, Veterans and Defense. An additional two people from HHS, and one from Treasury and Labor should be assigned full time to the effort.

The legislative lobbying operation should include two junior staff to respond to requests from members for written materials or answers to questions and to prepare briefings. Two dedicated phone lines with receptionists who are continuous throughout the year are needed so that there is continuity and relationships can be established with clerical people in members offices.

All committee hearings should be planned, monitored and preparatory briefings provided by health care team members.

- Policy

The policy group will:

- Develop policy in response to suggestions or critiques.
- Brief administration officials and members of Congress on the policy.
- Evaluate congressional proposals and help develop administration stands on the proposals.
- Provide surrogate speakers.

- Advise the communications and rapid response groups on policy issues.

Nancy Ann Min should coordinate this group which should include policy experts from the White House, OMB, HHS, Treasury, Labor and Justice. People who should be assigned full time include:

Judy Feder	David Cutler
Ken Thorpe	Arnold Epstein
Walter Zelman	Risa Lavizzo-Mourey
Rick Kronick	Steve Finan
Paul Starr	Richard Veloz
Larry Levitt	Lynn Margherio
Gary Claxton	Judy Whang
Len Nichols	Lisa Simpson
Robyn Stone	Bernie Arons

- <u>Policy Outreach</u>

The purpose of this group is to:

- Conduct policy discussions with interest groups and state and local governments to integrate their concerns into the policy process.

- Coordinate lobbying strategies with supporting groups and update information on activities of opposing groups.

Mike Lux, John Hart, Glenn Hutchins, Susan Otrin and Deborah Fine should work in this group.

- <u>Coordination and Decision-making</u>

Greg Lawler and I would chair a meeting Monday, Wednesday and Friday of each week with a policy advisory group to discuss potential policy changes. Periodic meetings with Cabinet Secretaries (semi-weekly moving to weekly when things heat up) can serve as a decision-making forum with important decisions going to the President and First Lady.

The invitee list to the three weekly meetings should include:

George Stephanopoulos - WH	Robert Rubin - NEC
Alice Rivlin - OMB	Carol Rasco - DPC
Roger Altman - Treasury	Nancy Min - OMB
Alan Blinder - CEA	Mike Lux - Public Liaison
Steve Ricchetti - L. Liaison	John Hart - Intergov'ml
Judy Feder - HHS	Ken Apfel - HHS
Tom Glynn - Labor	David Gergen - WH

- Requirements for Success

For this effort to be successful, all negotiating on the health care bill will have to go through this operation. All testimony should be pre-reviewed. All contact with lobbying groups, state and local officials, members and their staffs must be coordinated with and reported to this operation.

2. Public Campaign

We have to plan a proactive campaign to rally public support and sustain our message around the country. I think Harold would be a good person to head this operation.

Currently, we are primarily in a response mode. We must launch the campaign in a serious way very soon or there is a danger that public support will waver even more.

- Communications Strategy

We should form a communications strategy group which plans public events, develops and implements an educational strategy for reporters, prepares materials to support other activities and continues to hone the message.

I suggest that we ask Paul Begala, on a full time basis, to coordinate this operation. Jeff Eller, Bob Boorstin, Julia Moffett, Meeghan Prunty, Jason Solomon and others who work with them should be involved. Stan Greenberg and Mandy Grunwald should consult with this group.

Someone should have an explicit responsibility for long-term education of the media and there should be a "buddy system," whereby some of our senior people are assigned to the 50+ reporters and commentators who will help shape this debate in the media. The object here is not to fool anybody. I am convinced that if people have a full understanding of what we are proposing, we can win their support. This effort is designed to educate the reporters so that they will accurately understand and report on the plan.

This group should send weekly briefings to officials across the administration.

- Rapid Response

The 1-48 hour rapid response effort which now drives the "delivery room" should be a separate operation which implements our message day-to-day, works on daily stories and keeps opponents on the defensive day-to-day.

Marla Romash would be a good person to run this, with Christine Heenan and Meeghan Prunty rotating in and out. In a sense, this operation would be focused on what the economic "war room" did in its three weeks of operation on the budget.

It is important that this operation function aggressively, but that it does not overwhelm the longer term activities as is now the case.

- Political Organization

We need a better operation to relate to the various interest groups who back health care reform. This operation should be working with the DNC and others to help educate the public about health care reform and the President's plan.

This operation would interact with the field directors of the interest groups while the policy group will interact with the policy directors.

This group would also coordinate with the DNC health care activities.

Joe Velasquez could be a choice to run this operation.

- Requirements for Success

If we win the communications battle, we will win health care reform. Unfortunately, the reverse is true as well.

The details of the plan can change. We have signalled that already. We must, however, win on the principles and not allow opponents to pick apart our details and discredit the whole plan.

We have a harder job than our opponents. They have fear to sell and they are assisted by people's distrust of government.

- The plan will cost too much -- "it is impossible to believe that any government program will save money."
- The plan will be bureaucratic -- by definition, anything the government does is bureaucratic.
- The plan's numbers don't add up and the plan will raise taxes -- the government's numbers never add up and government always raises taxes.

- If even 15 percent are going to pay more, everyone will think they are part of the 15 percent.

We must fight these to a draw and win on our themes of security and the risks of maintaining the status quo.

To succeed, the whole administration must speak with one voice and we must have people from the outside speaking with the same voice.

Only if there is a hard driving, well organized campaign effort will we succeed.

3. Administrative Coordination

There needs to be a chief of staff type administrative position to handle relationships with other departments, personnel problems and the myriad of legal and logistical issues which are now occupying everyone else's time.

We must recruit someone who is mature, a good manager and can interact well with people to carry this out.

Harold and I will have our energy sapped by these activities if there is not someone in charge of them.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	RE: Ultimate Congressional End Game [partial] (2 pages)	01/20/1994	P5
002. memo	Ira Magaziner to President Clinton, et al.; RE: Cost Containment (2 pages)	02/03/1994	P5
003. memo	Ira Magaziner to Mack McLarty; RE: Some Additional Thoughts (2 pages)	05/23/1994	P5
004. memo	Ira Magaziner to President Bill Clinton, et al.; RE: Where we go from here (5 pages)	06/10/1994	P5
005. memo	Ira Magaziner to President Bill Clinton, et al. RE: The Finance "Rump Group" Proposal (5 pages)	06/28/1994	P5
006. memo	Ira Magaziner to President Bill Clinton, et al.; RE: Slimmed Down Health Plan (7 pages)	06/28/1994	P5
007. memo	Ira Magaziner to President Bill Clinton, Hillary Rodham Clinton; Re: Comprehensive Health Reform (5 pages)	07/18/1994	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
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FOLDER TITLE:
Magaziner Health Care Memos [5]

Debbie Bush
2006-0810-F
db2286

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]
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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).
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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]
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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]

If this analysis is correct, we have to plan for a few possible scenarios.

Scenario I: We can gain Dole's support for some version of our policy end game.

Scenario II: We cannot gain Dole's support for an acceptable plan but we can split off enough Republican senators to achieve 60 votes without him.

Scenario III: We cannot gain Dole's support and we can't split off enough Republican senators to get 60 votes.

Scenario I

This is obviously the preferred alternative. It might make sense for the President to have a meeting with Dole in early February to sound him out, assure him of our desire to work with him and not to exclude him from the process, etc. I don't think this meeting will produce any substantive result, but it would signal good will on our part.

We will then have to take periodic soundings and to try to engage him as often as possible so that we can gauge his ultimate intentions as soon as possible. If by May, he is not talking seriously with us, we probably will have to assume Scenario II or III. We must make clear that we will not sign a bill that does not meet our principles and we must stick to this. If Dole is convinced we won't move off these principles, he may move to an acceptable compromise or at least we may know sooner that he will not.

Scenario II

This is also a good alternative, but may well not be a likely one. According to Chafee, there are nine Republican senators who would vote for an employer mandate in some version, but it is unclear how many Republican senators would vote with us without Dole.

It is unlikely that Packwood or Kassebaum would stray from Dole. If Dole is in clear opposition, it may be tough to free even Chafee, Hatfield and Cohen.

We would have to find ways to exert very strong "home" pressure on Republican senators from states whose population is likely to be supportive of our bill -- Specter in Pennsylvania, Mack in Florida, Gorten in Washington, etc.; and to convince Chafee, Cohen, Hatfield, Danforth and Durenberger to make the move towards us.

Scenario III

If Dole decides to "stonewall" and enough Senate Republicans won't come over to give us 60 votes, we have two options:

- Try to move the bill in reconciliation ... difficult to do, though perhaps the financing, cost control and Medicare and Medicaid pieces might be separated out and voted with the budget. This is worth investigating even if it is unlikely.

- To pass a bill in the House and move forward with 50-55 votes in the Senate and let the Republicans filibuster. We could then focus attention on their blockage of health security, mass supporters at the capital and try to embarrass them away from thwarting the will of the majority. If we did this, either the Republicans would cave in or we would have begun the campaign of 1994. Although this is a risky strategy, I don't think Dole and the moderate Republicans would want to be put in this position. If they know we are firm and prefer this confrontation to compromising on a minimalist bill, they may have to go to Scenario I or II. It is important that we have a sense of likely end game before we cut too many deals, because the deals we cut may impact upon the end game we choose. If we believe we may have a confrontation at the end, we want to be sure to maintain bill provisions which keep our senior, disability and labor support excited.

Winning and Losing

The public campaign is fundamental to whether we win or lose and which of these scenarios is likely. If the public loses faith in the President's plan, we could wind up with a minimalist plan and the President will be blamed.

Our energy must be focused on gaining public momentum over the next eight weeks.

2-3-94

February 3, 1994

MEMORANDUM FOR PRESIDENT CLINTON
HILLARY RODHAM CLINTON
PATRICK GRIFFIN
HAROLD ICKES
GREG LAWLER
GEORGE STEPHANOPOULOS

FROM: IRA C. MAGAZINER

SUBJECT: COST CONTAINMENT

Achieving universal coverage without cost containment could lead to significant increases in the budget deficit and in the proportion of GDP going to health care.

We believe that managed competition and the change in incentives proposed in our bill, the Cooper bill and the Chafee bill will ultimately be the main driving force to limit the growth of costs in most parts of the country.

However, few think it will be sufficient on its own in all parts of the country. Oligopolies may develop. Gaming may occur. Competition will take time to develop in some places and may never develop efficiently in some parts of the country.

The Cooper and Chafee bills provide a backstop to competition by providing a strong incentive to lower benefits. These bills remove the tax deductibility to companies (Cooper) or individuals (Chafee) for benefits above the nationally guaranteed package and for insurance purchased at any plan which is not the low cost plan (Cooper) or low cost 1/3 of plans (Chafee) in an area. Both bills, particularly Chafee, allow for a reduction in the national benefits packages if costs rise too rapidly.

We recommend the premium cap as a backstop which puts pressure on health care providers and insurers instead of on workers with good benefits.

Premium caps are hard politically because they are opposed by health care providers and insurers and by many businesses (for ideological reasons). They are also out of fashion in economic circles.

A tax cap on deductibility is hard politically because it is opposed by consumer groups, labor, seniors, businesses now providing good benefits and many providers who fear it will drive people into low cost, low quality HMOs.

The easiest route politically would be to do neither. This would be a big mistake. If costs run out of control as health care reform is being implemented, the economy and this presidency could be in jeopardy.

As we have discussed before, premium caps that are less stringent and/or triggered may well be an acceptable compromise if structured properly.

5-21-94

May 23, 1994

MEMORANDUM FOR MACK McLARTY

FROM: IRA C. MAGAZINER

SUBJ: SOME ADDITIONAL THOUGHTS

I have had some additional thoughts since our meeting.

- I believe we can still win the public debate on health care once we have a new vehicle to back. Despite being pounded for nine months by arguably the most intense negative lobbying effort ever, the opposing team has barely tied us.
  - The key elements of our plan are still backed by large majorities of people even though the public is split in its support of "The Clinton Plan" as now constituted.
  - People trust the President and Democrats in general far more than the Republicans or Senator Dole on health care.
  - We have learned a lot about how to present our position.
- It's my impression that Americans support the President's goals of guaranteed private insurance, an end to insurance discrimination, etc; but they want the goals accomplished more gradually with less government and less cost. I would recommend that we take a public posture that we have heard the American people and have scaled down some of our original proposals to meet their concerns.
- The Vice President was right on the mark last week when he said that the ante is too high for us not to fight for a universal coverage bill. It would be a terrible blow to the nation and this presidency to do otherwise.
- As with the budget and NAFTA, it must be an all-out fight with a unified Administration waging the battle. The veto threat must not be doubted by our allies and foes alike. There can be no "winking" or "nodding" in private by senior administration officials about suggestions that the President is willing to

compromise on an incremental bill. (I say this because we are getting calls from news organizations quoting senior Administration officials presenting this line.) This type of problem has plagued health care for a year now and has undermined our effectiveness more than any external force. We could not have won the budget or NAFTA if similar problems persisted on those issues.

- It is premature to consider signing a bill that is incremental. If we face certain loss at some point on a universal coverage bill, then we can have that discussion. We have always known that some members would back off of the hard health care votes if we let them, just as with the hard votes on NAFTA and the budget. If they perceive that we are "waffling," we will experience a rapid retreat.

- We should still have our discussion on premium caps. It is a difficult and counterintuitive subject. We must be sure that universal coverage is not achieved at the expense of getting health care costs under control. The economic imperative of doing the latter is what drove me into this minefield in the first place. I want to be sure that political expediency and ideology do not drive us to a solution which allows health care costs to continue to hurt our economic competitiveness.

6-10-94

(17)

June 10, 1994

MEMORANDUM TO PRESIDENT BILL CLINTON
VICE PRESIDENT AL GORE
HILLARY RODHAM CLINTON
MACK McLARTY
HAROLD ICKES
GEORGE STEPHANOPOULOS
PAT GRIFFIN

FROM: IRA C. MAGAZINER

SUBJ: WHERE WE GO FROM HERE

Our Situation

We have been losing the public battle on health care for some time now. The public wants universal coverage and the various other goals the President has outlined, but has become increasingly confused, apprehensive and skeptical about the Administration's ability to achieve these goals without upsetting or even destroying what they have today.

Many Republicans now believe that they can fight the President on health care and "bring him to his knees" without negative public consequence. They believe that they can successfully argue that they want health reform which is prudent, as opposed to his "radical, bureaucratic government takeover of the health care system which will destroy American health care."

Making a Deal

Negotiating a deal requires two parties of good faith who are willing to negotiate something which serves both of their purposes.

In a non-politically charged environment, House Democrats and moderate Republicans could probably put together 220-230 votes supporting a workable universal coverage bill. Senators Chafee, Jeffords, Durenberger, Packwood, Danforth, Kassebaum, Hatfield and Cohen might join 52 Democrats to provide 60 votes for a workable universal coverage bill. The swing votes in both Houses would have to be pushed hard, but could probably be persuaded.

In the real political world we are now in, however, there is a deadly chain whose links threaten any deal short of a presidential surrender:

Republican right → Senator Dole → moderate Senate Republicans → moderate Senate Democrats → moderate House Democrats.

The Republican right and many mainstream Republican interest groups want to defeat the President on health care. They pressure Senator Dole so he can't move. He now smells blood and also wants to defeat the President. He convinces the moderate Republicans who otherwise would support universal coverage to hold back, beat the President and build reform off of a Republican/conservative Democrat bill which will fragment the Democratic party. Senator Dole has unusual influence over Senator Packwood (Ethics Committee), Senator Kassebaum (Kansas connection) and Senator Chafee (his leadership roles on Senate health and environmental issues depend on Senator Dole). Senators Danforth and Cohen won't move without Senator Chafee. Senator Durenberger won't move without the managed care insurers where his future lies. The Republicans view the Finance Committee as their best shot to beat the President and so they will make their stand in that committee.

Some moderate Senate Democrats want a handful of Republicans on a bill they support so they can have cover. Many House Democrats want to wait for the Senate to move, so that they don't get "btu'd." Because this is an election year and the President is not popular in many of their districts, they are not likely to be easily swayed. The result is that we are frozen in the Senate Finance Committee.

On Senate Finance, Senators Boren, Breaux, Bradley and Conrad want Republicans before signing on to a bill. Senators Breaux, Bradley and Conrad could possibly be persuaded to support a bill which achieves real universal coverage even without Republicans. There are doubts as to whether Senator Boren would support a bill under any circumstance without Republicans.

Because the ultimate anchors of this chain, the conservative Republicans, want outright capitulation, the threshold keeps moving away from us whenever we probe what it would take to get a deal. In eight weeks, they have moved from a slower phase-in of the mandate to carve outs for small business, to hard triggers and now to soft triggers.

We should probe Senators Chafee, Durenberger and Danforth to see if they are willing to break the chain and bargain in good faith for a real universal coverage bill in the Finance Committee. If they are, then that is what we should do. If not, we should approach Senator Boren to see if he will help get us out of Committee with a universal coverage bill and thereby allow us to negotiate from a position of greater strength on the floor with Senator Chafee and the moderates. If we make a sincere approach to Republican Senators and are rebuffed, then perhaps Senator Boren would agree, if indeed he wants to see the President win rather than lose.

If this does not work, then there is no quick deal to be cut and we must fight.

A Fighting Strategy

As the Vice President said at our last meeting, the President has a lot at stake on health care. I don't believe that the media or the Republicans will let the President get away portraying a capitulation as a victory, even if we wanted to do it, which I hope we don't.

If we slip quickly into a deal which has the President repudiating his own plan, starting with a Republican plan or one that does not achieve universal coverage, he will not be able to claim victory for health reform. The summer will be filled with who lost health care and White House ineptness stories possibly fueled by sources in our own Administration. The President will be accused of lacking backbone by many democratic constituencies and the media. We will face a summer of Whitewater hearings and health care failure which will guarantee retaliation against Democrats this November.

We are better off fighting.

Fighting requires preparing a new vehicle which is a joint bill from the President/First Lady and Congressional leadership. It should be launched by saying that we have heard the American people, we still want to achieve the goals the President laid out last September, but others have had good ideas on how to improve our original approach which we are now adopting. We are going to move ahead with a more cautious mandate -- less government, less bureaucracy etc. -- but still guarantee universal coverage.

We should focus the White House on this effort much as we did last summer on the budget. Without that kind of attention, we will not succeed.

We should try to persuade some moderate Democrats who are not on our bill to come along. We should ask Senator Mitchell to approach the swing Senate Democrats and try to sound them out on an acceptable bill. They include Senators:

Feinstein	Breaux	Shelby
Kohl	Bradley	Kerrey
Ford	Conrad	Nunn
	Heflin	
	Bryant	
	Dorgan	
	Exxon	
	DeConcini	
	Lautenberg	
	Lieberman	
	Hollings	

Under this scenario, we fight for 51 votes and constantly extend a hand to Republicans to work with us on a universal coverage bill. If we gain some strength the Republican moderates may move to negotiate seriously instead of demanding surrender. If we can pass the House, obtain a majority in the Senate and run a public campaign over the summer, we will have momentum to fight in November instead of entering November with our tail between our legs.

Under this scenario, if Republican Senate Finance members won't negotiate and Senator Boren won't cooperate, I would probably let Senate Finance deadlock and simply bypass it.

The risks of this approach are significant. If we fail to get enough Senate Democrats for a majority, the President could wind up facing a choice of "no bill" versus signing a bill that produces only incremental reform. On the other hand, that could result in any event, even without a fight.

The Content

We probably will not know the exact content of the bill we need until Senator Mitchell consults with the swing Senate Democrats, much the same as Representative Gephardt has done in the House. He can do this informally, even as Senate Finance is trying to do its work.

In all likelihood, we would be facing a hard trigger, modified premium cap and a scaled-down benefits scenario.

Next Steps

1. Phone calls by the President this weekend to Senators Chafee, Durenberger, and Danforth to see if they wish to talk, to Senator Boren to sound him out and to Senator Bradley to encourage him.

2. Presidential meeting with Senators Packwood and Moynihan on Tuesday to see if Packwood is interested in serious discussion.

3. If progress is made through these calls and meetings, then encourage Senators Moynihan and Mitchell to negotiate through the Finance Committee and give the process a week or two. Mitchell should sound out swing Democrats not on the Committee through a series of informal meetings in case the committee deadlocks.

4. If the calls and meetings do not show progress by this Tuesday, then Senator Mitchell should discreetly take soundings and we should focus on the development of a bill

based on Kennedy's version with further planned compromise through floor amendments from swing Democrats.

5. Either way, we should encourage the House to proceed through committees as they are now doing according to Representative Gephardt's strategy.

6-28-94

June 28, 1994

MEMORANDUM FOR PRESIDENT BILL CLINTON
HILLARY RODHAM CLINTON
HAROLD ICKES

FROM: IRA C. MAGAZINER

SUBJ: THE FINANCE "RUMP GROUP" PROPOSAL

The health care team has analyzed the Senate Finance "rump group" proposal. We all agree that it contains serious policy and political flaws. Not wishing to slow the Senate Finance Committee down, I am not voicing the concerns in this memo to anyone and we are being constructive in our dealings with members on the committee.

While we may want to agree to the passage of the proposal from the Senate Finance Committee, we should not support its elements. The proposal will alienate our base democratic supporters and will potentially hurt many middle-class Americans.

Personally, I believe that the whole approach is so seriously flawed that the nation would be better off with a minimal reform which accomplished insurance reforms and expanded Medicaid or public health. Spending so much government money to accomplish so little cannot in my view be justified.

The proposal has the following significant features:

- Modest insurance reforms, voluntary health alliances for firms of 100 or less, and subsidies to low-income people up to 240 percent of poverty, phased in as affordable.

- Subsidies which reach over $100 billion per year are paid for by significant cuts in Medicare and Medicaid, a $1 increase in tobacco taxes and a tax on high price insurance plans.

- Two standard benefit packages set by a National Board -- one equivalent to the Blue Cross standard package in FEHBP and one catastrophic package.

- An assessment on plans that bid premiums in the highest priced 40 percent in their region. The assessment is equal to 25 percent of the difference between a target premium (established by a complex formula) and the premium bid by the plan.

- Target to achieve 95 percent coverage by 2002 (OMB and Urban Institute analysts believe that 89 percent is a more likely outcome of this proposal with a range of 86-92 percent possible). If the target is not met, the National Board must make recommendations to Congress on how to achieve that level of coverage. Congress does not have any obligation to pursue any specific course of action.

- Significant Medicare cuts but no significant benefits for seniors. There is no long-term care program, no Medicare drug coverage nor any benefits for early retirees.

- Modified community rating adjusted for age and six-month waiting periods for people with pre-existing conditions. Firms above 100 employees do not participate in the community rate.

- Medicaid becomes a capped entitlement and remains a separate program. Disproportionate share payments are eliminated.

1. Little Progress on Coverage

OMB and Urban Institute analysts believe that the proposal will leave about 30 million people uninsured (vs. 39 million today) by the year 2002.

Managed competition theory never assumed that universal coverage could be achieved through market mechanisms. The Jackson Hole Group advocated employer mandates to accomplish this goal. They have backed off the mandates under pressure from their industry funders because universal coverage is not their priority.

Demonstration projects in 13 states which used market mechanisms and premium subsidies to make health insurance more affordable had limited success in extending insurance to the uninsured.

The Finance proposal contains elements which make increased coverage even more tenuous. Subsidies to low-wage individuals and shifting the tax incentive from the company to the individual could encourage employers to drop coverage for their employees or not offer coverage to new hires. Requiring that firms that offer insurance to any full-time employee must offer to all full-time employees prevents companies from dumping their unhealthy people into public pools, but may encourage

some partially insuring companies to simply drop coverage. A few highly publicized cases of employers dropping coverage due to the national health plan could make the plan unpopular.

Under the proposal, the number of uninsured middle class people may continue to rise between now and 1997, despite significant Government expenditures. This may cause disillusionment among people who don't have coverage.

2. Very High Cost to Achieve Small Improvements in Coverage

The program involves very high government spending for very small increases in coverage. In the year 2002, 10 million new people have coverage at a cost of almost $100 billion in subsidies or close to $10,000 per person. This occurs because significant subsidies will go to people who are currently insured and because the proposal lacks cost controls. This could give rise to calls for repeal since the program produces marginal results for the money.

3. Disrupting Those With Good Insurance Today

One of the great fears people have about health reform is that they will lose or have to pay more for the good health insurance policies they currently have.

Under the HSA, if efficiencies do not achieve sufficient cost savings, providers would earn lower incomes. The Finance proposal to place an explicit tax on high-cost plans could result in an increase in premiums for many who are now happy with their coverage rather than increased plan efficiencies, or lower provider income. Further, such an assessment may limit the availability of fee-for-service plans. They tend to be more costly than HMOs to begin with and their prices would be forced up even higher by the assessment.

High cost health plans would undoubtedly let their customers know that the President's health initiative is responsible for their higher prices.

4. Making Insurance Unaffordable

In the Finance proposal, many middle class families will have to pay a higher proportion of their income for their health insurance. Government subsidies are capped but premiums aren't. As premiums rise, subsidies will diminish as a percentage of premiums.

For example, at the outset, a family of four earning $30,000-$35,000 a year would

have to pay $5,000-$6,000 for health insurance or 15 percent of their income. As premiums rise faster than wages, insurance will become even less affordable for that family.

5. A Bad Deal for Seniors

Though senior groups have been largely silent supporters of our efforts, they will likely be opposed to the Finance proposal.

The HSA has significant cuts in Medicare, but also contains significant investments in a Medicare drug benefit, in long-term care and in enhanced early retiree benefits.

The Finance proposal has significant Medicare cuts, but no Medicare drug benefit, no long-term care, no extra early retiree benefit and a continuation of age rating so that older people continue to pay significantly more than younger people.

6. Not Universal Coverage

The Finance proposal claims 93 percent coverage (our analysts believe that 89 percent is more likely) and says that if 95 percent coverage is not achieved by 2002 then Congress takes another look.

I don't believe that we can credibly claim this to be universal coverage. We have always been clear that we meant to guarantee coverage to all Americans, even if we know that realistically one or two percent of the population may never get coverage. Aiming at 95 percent runs the risk of having us appear "slippery."

7. Not Comprehensive Benefits

To allow catastrophic coverage during a transition period may make sense. Instituting a permanent catastrophic option raises the premium for those choosing comprehensive benefits, keeps a higher level of cost shifting in the system, increases administrative complexity and discourages preventive care. And, some employers may be encouraged to drop coverage for their workers down to the catastrophic package.

8. States and Hospitals Serving the Poor Will Be at Great Risk

The plan caps Medicaid, cuts Medicare, phases out disproportionate share payments but has no essential community provider provisions, no mechanism to spread lower Medicaid payment rates across all providers, no pools for academic health centers and

no universal coverage to make up the difference. This will put greater burdens on the states and on large city and rural hospitals.

Our supporters -- the unions, seniors, consumer and some provider groups -- will seriously oppose this proposal.

What to Do

If the Senate Finance proposal becomes accepted as the "moderate" bipartisan bill and the President is viewed as tacitly supporting it or as an obstructionist for not supporting it, health care reform could collapse and we will be blamed as having sold out our democratic constituencies.

We cannot win a public fight in July and August if we are forced to support a bill which seniors, labor and consumer groups oppose and ultimately which we think doesn't work.

If we decide to encourage a non-universal coverage bill to come out of the Finance Committee, we should ask Senator Mitchell to propose a blend (see accompanying memo) between the Finance and Kennedy bills to take to the floor which at the very least has:

- a hard trigger to real universal coverage (not 95 percent) by 2000 with joint employer and individual requirements.
- some cost control
- some benefits for seniors
- a more workable transition to the trigger.

This bill can use the Finance Committee compromise as its base, but must achieve real universal coverage and control cost growth. We are working on some ways to build on the Finance construct to make it into a decent proposal, but some substantial modifications are necessary.

The Senate bill will be weaker than the House bill, but it must be substantial enough so that we can support it.

We have to leave ourselves in a position to get back to a decent bill on the Senate floor, or we will lose our moral and political grounding.

If we lose the fight in July and early August, we can revisit what type of backup bill, if any, would be desirable. Even in that case, this proposal is not likely to be a desirable choice.

6-28-94

June 28, 1994

MEMORANDUM TO PRESIDENT BILL CLINTON
HILLARY RODHAM CLINTON
HAROLD ICKES

FROM: IRA C. MAGAZINER

SUBJ: SLIMMED DOWN HEALTH PLAN

This memo responds to the President's request for an update on discussions with Leaders Gephardt and Mitchell on a revised health bill which meets the President's goals, but also meets public concerns about our original bill. Before the President introduced health reform to the nation last September, we talked about the inevitable fact that the bill would undergo substantial revisions as it went through Congress. This is why we proposed emphasizing principles in the President's speech rather than standing behind the details in the bill.

As the debate has proceeded, we have developed alternative approaches in concert with congressional leaders to reach our goals of universal coverage and cost containment. Much of the criticism we have endured is unfair, but we must acknowledge that we have lost the communications battle on many fronts.

Hopefully, Leaders Gephardt and Mitchell will be in position to introduce bills to the Floor that fall within this general framework. When we re-launch a bill for the Floor, we should announce that we have heard the American people and modified our original bill to be smaller in scope, more gradual, less bureaucratic and less regulatory.

We should highlight the following changes:

- Deficit reduction
- Voluntary instead of mandatory alliances
- Less onerous mandates: hard triggers; slower phase-in
- No premium caps: cost control which protects the government
- Streamlining/simplification
- Increased support for academic health centers

DEFICIT REDUCTION

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

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

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

Lowering the Size of Firms Within the Community Rate Which Pay the One Percent Assessment of Payroll: Under the Health Security Act, firms outside the community rate pay an assessment of one percent to offset savings they receive from universal coverage. Lowering the size threshold for firms outside the community rate increases the revenues raised by the corporate assessment.

VOLUNTARY INSTEAD OF MANDATORY ALLIANCES

The original Cooper/Breaux/Boren bill mandated all firms with 1,000 employees or fewer, all government workers, all self-employed people and all nonworkers to buy health insurance through exclusive regional purchasing cooperatives. States had the option to raise the requirement to firms with 10,000 or less employees. We adopted this idea and set ours

at 5,000 assuming we would have to reduce the number.

We lost the communications battle for mandatory alliances early. We developed a voluntary alliance model that preserves the functions of alliances (community rating, greater purchasing leverage, family choice, administrative simplification) for the Kennedy, Dingell, Ford, Mitchell, and Gephardt approaches. Ironically, it is more bureaucratic than mandatory alliances, involving more regulation by state insurance departments and other agencies, but it is workable and at this point, is easier to sell to the public.

Community Rating: The Kennedy, Ford and Dingell committees, under pressure from business groups and insurance lobbies have lowered the size at which firms are required to participate in a community rating pool, from firms with 5,000 workers or fewer to 1,000 workers or fewer. The lower the threshold, the more opportunity there is for insurance companies to compete on risk selection and the higher the premium for firms and individuals within the community rate. The Ways and Means Committee has passed an amendment to reduce the threshold to firms with 100 employees or fewer. We think going below 500 is not desirable, but could make 100 work if it becomes absolutely necessary.

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

Administrative Functions: Administrative costs are still streamlined in most bills through the creation of centralized clearinghouses which collect and administer premiums and subsidies, much as the alliance did under the Health Security Act.

LESS ONEROUS MANDATES

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

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

Due to the political reality that employer mandates have lost ground in the debate, we have developed ways to use hard triggers and partial exemptions for small businesses of 20 or fewer employees or a combination of both. These policies are tricky and run the risk of short-term adverse consequences, but could be workable if designed properly.

Slower Phase-in: Some have proposed delaying universal coverage until 2000 or beyond. Achieving coverage by 2000 is something we could support, but would not recommend delaying much beyond that. If we delayed until 2000, we would recommend strategies to demonstrate progress toward universal coverage before then: for instance, covering all children by 1997 or 1998; or requiring that all businesses above 1,000 employees cover their employees by 1997 or 1998.

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

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

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

Phased-in Benefits: To reduce financial risk for the government, a "catastrophic" type benefit package could be used for the uninsured during a phase-in period.

NO PREMIUM CAPS

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

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

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

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

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

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

Bradley Approach: This replaces premium caps with targets set by the National Board. Health plans which bid higher than the target premium in their region are taxed to cover the increased cost of the federal subsidies created by their high bids. The approach encourages plans to bid at or below the target and encourages employers and families to choose lower-cost plans by raising the price of the higher-cost plans. This approach has some significant drawbacks. It requires a large, explicit tax on high-cost plans. It's administratively complex. And, depending upon the way it was structured, it could allow private premiums to increase so much that a universal coverage trigger might never be pulled.

Opening the FEHBP Pool: Costs could be controlled if the FEHBP was opened to a broader universe of people and if it had the tools and the responsibility to hold down

health plan premiums. Federal subsidies would be pegged to the constrained rate of growth in the FEHBP. A premium constrained FEHBP could increase cost shifting to those outside its pool and it might have difficulty attracting insurers to offer plans at its constrained rate. But with sufficient regulation, an option like this could work. Ways and Means is considering a similar measure using Medicare price controls instead of premium caps.

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

STREAMLINING/SIMPLIFICATION

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

Eliminate Boards and Committees: Our bill has suffered from the label of "big government", in part because it includes dozens of boards and committees. These were established mainly at the request of HHS. We should remove a series of these from our bill.

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

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

INCREASED SUPPORT FOR ACADEMIC HEALTH CENTERS

The Labor and Human Resources committee bill substantially increases the dedicated pools for medical training and creates a dedicated fund for biomedical research.

We expect and would support additional funds going to academic health centers and biomedical research beyond what was originally proposed in the Health Security Act.

These and similar changes could produce workable bills which are worth fighting for. The changes are significant enough to be meaningful, though our adversaries will claim that we have not changed enough.

Majority Leader Gephardt has indicated that a bill like this could pass the House. If we fight for it in the Senate, I believe we have a chance to gain a majority for a bill like this in the Senate.

The alternative is to admit defeat and see the health care fight turned into a route. I do not believe that the Republicans will allow a universal coverage compromise that has a chance of success unless we can succeed in turning the public debate back on them around a re-launched bill.

We may not win the fight if we wage it, but we will be in a stronger position to negotiate if we do fight than if we simply admit defeat.

7-18-94

July 18, 1994

MEMORANDUM FOR PRESIDENT BILL CLINTON
HILLARY RODHAM CLINTON

FROM: IRA C. MAGAZINER

SUBJ: _____

You must decide in the next few days whether to fight for comprehensive health reform or to retreat. If we linger much longer without deciding, circumstances will overtake us, options will diminish and we will suffer a massive defeat.

There are a number of questions whose answers should form the basis for your decision:

1. Can we win passage of a comprehensive bill given the reluctance of Democratic and Republican moderates to vote for one?

2. Is there an incremental policy which allows us to address many of the nation's health care problems and not do harm so that the fight we have waged achieves some of its objectives?

3. Can a retreat be with honor, or will the President suffer a blow which harms his presidency in a debilitating way?

Can We Win?

I believe that with the same type of effort we expended on the budget and NAFTA, we can secure 50 or 51 votes in the Senate for a sufficient triggered mandate and cost containment. Once this is achieved, the political dynamic will change in our favor and we can break the defeatist attitude which has gripped so many people these past few weeks.

- Chris Jennings and Steve Richetti believe as do I that with the normal level of backbreaking work required of any serious initiative, we can secure 43-47 votes in the Senate for a "hard trigger" with some form of cost containment.

Assuming that Senators Chafee, Durenberger and Danforth will not join us at this time, we start with 57 possible votes. (56 Democrats plus Senator Jeffords). We will likely lose Senators Shelby, Nunn, Boren, Johnson, Kerrey and Bryan. We can afford to lose one more. I don't believe we have to lose anyone else, even though a number of others would prefer not to vote with us.

We can construct the votes so that Senators like Lautenberg, Feinstein, Leiberman, Robb, Kohl, and others who are skittish can offer amendments which lighten the load on small business or take other steps which can give them some cover for their votes.

- If Senator Mitchell can put a good bill to the Floor and we can sustain it when the Republicans try to strike the trigger provision, I believe the House can then move. Passing a serious bill out of the House will not be easy either, but should be possible once members see that the Senate is moving.

- Senator Dole and the moderate Republicans will then face a decision on whether to filibuster. I don't think that they can sustain a filibuster nor that moderate Republicans will even want to do so. The public debate will, I believe, shift our way once the Republicans are put in the position of having to obstruct universal coverage.

  - Editorial opinion is overwhelmingly on our side on universal coverage -- the New York Times, Washington Post, USA Today, Philadelphia Inquirer, Boston Globe, Atlanta Constitution, Detroit Free Press, Los Angeles Times and many others are supportive.

  - Most groups support universal coverage and employer requirements.

  - The public overwhelmingly supports universal coverage and employer requirements.

Even if one is skeptical about our chances to achieve 50 votes, we should go all out and try. We will have no strength in the debate unless we do.

Incremental Policies

Health care reform is a frustrating issue because the kinds of partial solutions which appeal to the political world, often have adverse effects on the real world. Past decades are littered with attempts at partial solutions which had little or often even negative effects.

- Attempts to control costs such as DRGs or numerous state insurance revisions which either failed altogether; succeeded in one sector (hospitals) but caused a skyrocketing of costs in other sectors (home or outpatient clinic) costs; or shifted costs from one set of purchasers to another (large companies with buying clout to small companies with no clout).

- Insurance, quality and consumer protection reforms with loopholes which made them ineffective but contributed to the growth of bureaucracy and paperwork.

- Insurance market reforms and subsidy programs designed to increase coverage, which mainly had the effect of increasing costs, decreasing coverage for working people and on occasion marginally assisting poor or sick people.

It is difficult to design programs to do good, do no harm and use resources efficiently in the absence of universal coverage, comprehensive cost containment and the elimination of insurance company "cherry picking."

Many politically savvy people with little knowledge of health care policy presume that there is a continuous loaf of bread which can be sliced to give a bigger or smaller piece but will taste good either way. This is not the reality.

The partial programs which have been proposed by Senators Dole, Cooper or Chafee or the Senate Finance Committee all have adverse effects on important democratic constituencies, are all underfunded, will all increase coverage marginally at great Federal cost, will lessen choice and increase cost to many who now have insurance.

If these partial reforms are enacted, many will be angry when they lose coverage, see higher costs or lose choices due to health reform. The President will be blamed if he embraces these solutions.

If we give up on universal coverage and real cost containment, we can still design an incremental program which will increase coverage for children, some poor people and some workers in between jobs. However, the program will increase system complexity dramatically, will require significant additional Federal spending which may increase dramatically over time if the program remains funded, will not do much for the middle class and will leave most problems unsolved.

Designing programs which increase coverage for middle class working people and their families without encouraging employers to drop coverage of current workers is not easy. The whole process can be like trying to build sand castles in quicksand.

On top of this problem, financing even these incremental programs will anger key constituencies to accomplish relatively little. The Dole plan uses Medicaid and Medicare

money in ways which puts states and the poor at great risk and give nothing to seniors or rural and inner-city hospitals and is still underfunded.

Senate Finance is also seriously underfunded, relies on significant Medicare cuts with little senior benefits and taxes plans now held by many workers with good health insurance which will raise their prices significantly, all to achieve a modest increase in coverage.

The Cooper bill is $300 billion short to achieve 91 percent coverage even though it takes the tax deduction away from most existing health plans.

The bottom line dilemma stems from the following risks:

- In the absence of cost containment, health care costs may continue to row influencing firms to drop coverage.

  Cost containment comes at someone's expense -- either doctors, hospitals and insurers must become more efficient or suffer declines in pay or profit; or consumers must have their benefits, services or health care choices limited.

  Under the HSA, we put the insurers and providers at risk and protect consumers and employers. If the health industry achieves modest productivity improvements, their incomes continue to rise; if not, there may be a slowdown in the rate of increase of pay (which has been six times higher then average over the past 15 years).

  Under the Senate Finance, Cooper and Chafee bills, employees and/or employers with good health plans are put at risk and the cost control is only marginally effective.

- Increases in coverage with comprehensive benefits must be financed. If universal coverage is not achieved, cost shifting continues from the remaining uninsured so these savings which are available in a universal system can only partially be achieved.

  No method of financing is painless:

  - Ways and Means has an employer mandate plus significant Medicare cuts (much higher than in the HSA) a taxation of premiums paid for dual worker families; and tobacco taxes and achieves universal coverage. Hospitals and seniors will oppose the Medicare cuts. Employers will also oppose the tax and cost shifting inherent in the proposal.

  - Senate Finance taxes high cost plans, has a bigger tobacco tax than the

HSA and Medicare and Medicaid cuts to increase coverage marginally. Seniors and hospitals will oppose the Medicare cuts; unions and many large employers will oppose the tax on high cost plans.

- Insurance reforms in the absence of comprehensive reform do little good and can do harm.
  - They raise rates for those who currently have insurance.
  - They can increase the number of people who drop coverage.
  - They are hard to keep free of loopholes.
  - Those with good risk pools -- most major corporations -- as well as the insurance industry opposes them.

The Consequences of Backing Down

I don't believe it will be easy for the President to sign an incremental bill without putting himself in jeopardy politically. I also don't believe it will be possible for him to veto a bill which expands coverage for worthy populations.

I understand that Stan's research shows that people will give the President credit for trying even if he backs down and signs a partial bill that does not achieve universal coverage.

I question whether this reaction will be stable when the media and the Republicans start trumpeting the story that the President has failed on his most important domestic priority.

We could face a summer of Whitewater hearing stories and who lost health care stories which drown out good economic news and the crime bill.

Core constituencies could feel betrayed. White House ineptness, a President with no backbone, etc. etc.; would fill the airways. I am not sure that Stan's polling and focus groups would come out so well after this type of pounding.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	From Julia Moffett for Distribution; RE: Draft Health Care Calender for Discussion Purposes Only (4 pages)	01/04/1994	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10250

FOLDER TITLE:
1994 Health Care Communications

Debbie Bush
2006-0810-F
db2287

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]
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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]

PURPOSE OF MEMO

Attached is a **draft** proposal for the public strategy/organization of health care through Easter. Its purpose is to generate discussion in hope of coming to some initial closure soon so that we can get planning underway. This plan reflects only public events and media engagements, leaving all private meetings and congressional obligations off.

Please add your comments and return to me so that we arrange a meeting to discuss the revised plan. Please return by Thursday afternoon.

GOALS OF PUBLIC STRATEGY OF HEALTH CARE

This plan assumes that our goals are to (1) restate the problems of the current health care system immediately around the State of the Union; (2) use the period from the speech to March 4 (when mark-ups begin) to continue to "draw a line in the sand" about our non-negotiable issues as well as to illustrate why our plan is best; and (3) to use the post-mark-up period to travel to targeted areas and to remain flexible enough to respond and defend some of the key issues which will come under attack during this time.

PLAYERS

This memo reflects suggestions for Presidential and First Lady activities. Once an initial plan is signed-off on, a condensed version could also be useful for Cabinet members, Members of Congress and surrogates as they look to plan their health care activities.

AUDIENCE

The events listed below are primarily geared toward the general public, although a few are Congressional events and for more specific constituency groups. Additionally, some of the themes can be expanded to appeal to opinion leaders. As further planning for specific events takes place, appeal to a certain audience, i.e., union families, middle-upper income households, women, etc...can happen.

ISSUES

The following issues are presumed to be the focus of the Congressional debate on health care, at least in this first segment. The calender that follows has attempted to address all of them in a timely fashion. The asterik denotes issues which should be aimed at the general public versus specialized groups or Congress.

1) Universal v. non-universal coverage*
2) Small business and the employer mandate
3) Comprehensiveness of the benefits package*
    Is it spelled out in advance?
    Emphasis on preventive and primary care
4) Education of structure of system--alliances, etc...(role of government)
5) Premium caps--how we control costs*

BREAKDOWN OF TIMING

This proposal covers next week through Easter, with some areas more filled out than others. Next week will be dominated with the President's trip abroad, and we should discuss how much news we feel we can make, or need to make, on health care as a result. No activity is presently reflected on the schedule.

PROCESS–PROBLEMS

We have a tendency to immediately pursue "presidential events" whenever we can. We have seen, however, that we cannot always guarantee that they "break through", that the audience and message are perfectly matched, or that we don't come close to repeating the "EITC event" relationship with the press. I believe we are in a situation as we begin a new year and a new phase of selling/educating about health care, and as we recognize the duration of this mission, to refrain from being so Presidentially schedule driven, and instead become more creative, calculated and effective. Far too many resources are used for some of these events which get us nothing.

*As health care events have become more frequent, we have risked being uncreative or not so thought out. This has led to events which have not had maximum effect because of poor timing or conflict with other news. While we cannot always control, or protect, the health care story, we should not knowingly create events which won't break through or will be buried. It is one thing if an event is targeted to a regional or specialized audience, but another if an event is put out there without a strong news hook. One of the most successful events I think we have done in this first phase was the simplification event at Children's Hospital. We unveiled a new, important piece of the plan, our visuals were excellent, we had "real" people offering testimonials to the problem, the President was able to have the problem illustrated to him first-hand, and his remarks were sharp and focused. The coverage was wide, positive and educational.

*On a similar note, our internal communication has broken down on occassion. It seems that the public and event strategy is being discussed in a multitude of places and not being properly conveyed to the people who need to implement it. Additionally, the implementers have often had pertinent information that should be heard during the formulation of the plan, but which is not. This has led to missteps such as the seniors' event in the Oval Office which

became a photo opportunity at the last minute due to a lack of internal communication.

*In the past, our public activity has not always been tightly coordinated with our legislative strategy. We have had several missteps in the planning of trips on the Congressional side that end up being more damaging than helpful. Additionally, the lack of advance notice to members has, again, ended up hurting as opposed to helping.

*Coordination with the First Lady's schedule has also lacked the efficiency it could have. It is proven that her events are always good and well planned in terms of generating press. We need to take better advantage of that and need help in fully integrating her schedule into the main one. Additionally, this plan reflects many suggestions for her schedule. I am unclear as to how we get these suggestions represented and in the mix.

*The sign-off process is still ambiguous. It is unclear how proposals are made, who is involved in the process and whose word is final. This has led to constant revisiting of plans. Additionally, we have had many situations where we thought something was signed-off on by the principals when it fact it wasn't.

*There is no sense that health care people are at the table when plans are being proposed to the principals. This has resulted in ideas being rejected without a "full-hearing" about the rationale for them.

PROCESS–RECOMMENDATIONS

*A weekly health care planning meeting specifically for the public plans of the President and First Lady. From there, a subsequent meeting can be held to get the Cabinet and surrogates on board without all of the people in the first meeting needing to be there. The goal should be to get far ahead enough that we are actually discussing two weeks ahead so that the necessary planning can be done.

*A system by which we can integrate and plan the health care calender with knowledge of the non-health care calender. If this does not happen, we are planning in a vacuum, which is a waste of time.

*In some instances there are a few events which need sign-off unusually far ahead of time, i.e., the AARP/AHA Town Hall. We need to establish a mechanism for doing this--the results will be worth it.

*During the planning for the launch in September, we had several "coordinated press meetings" with Bob Boorstin, Lisa Caputo, Jeff Eller, Mark

Gearan, David Gergen, Julia Moffett, Dee Dee Myers, Patti Solis and George Stephanopoulos. These enabled us to identify ways to make news without creating events. In many instances we were able to identify press opportunities to really help drive a particular message. The meetings allowed for a clearinghouse of all media proposals floating around "out there" and were very useful for everyone's planning purposes. One every two or three weeks would do it.

*As I am sure everyone has experienced in different situations, having adequate briefing time with the President has made all the difference in the world. The remarks are clear and focused and all the connections that we work hard to create with these events are realized and maximized.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Ann Lewis to HRC [Hillary Rodham Clinton]; RE: Talking about Health Care (4 pages)	09/28/1994	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10250

FOLDER TITLE:
1994 Health Care Talking Points [1]

Debbie Bush
2006-0810-F
db2288

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]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

To: HRC

From: Ann Lewis et al

9/28/94

Talking about Health Care: Questions and Answers

RULES OF RESPONSE

1. Be ready with your "hinge" or "what went wrong" statement and use to reframe obnoxious questions. For example:

I agree that we should have done some things differently. I think we were naive; we should have brought the press in earlier, as part of our outreach efforts;

*We underestimated the degree to which partisanship made compromise impossible; (while avoiding naming the John Chafees and Dave Durenbergers by name, this is an opportunity to remind people that health care was hailed as the Administration's best example of bi-partisan outreach for a long time...point out that "we were very optimistic because there seemed for a time to be a genuine bi-partisan interest in solving this problem....**I'm disappointed,** of course...I believed that people would stick to what was right and what they saw and we saw the country needed (use anecdotes about actual stories from visits you made with Members..sitting around the kitchen table on the x family farm in Minnesota...) Another example would be to name Republican staff like Sheila Burke as no doubt being as disappointed as you are.*

And we underestimated the amount of time it would take to achieve such a large scale change on an issue that is so important to so many people. We never ran out of trying; we ran out of time. (The consensus of the group was that this resonates well with the broader audience, who still support reforming health care but think it should be done over a longer period of time. Use examples of recent legislative victories -- like crime bill, NAFTA, Brady bill, Family and Medical Leave, that took several years but eventually got done)

In addition to recounting some of the stories you experienced and talking about the people you met, also talk about some of the President's stories and health care anecdotes.

2. Don't personalize; do use humor to deflect more outrageous questions, especially about your state of mind:

I am so glad you asked me that question. When I read some of the accounts of my mental state, I feel like Mark Twain when he read his own obituary. The accounts of my passing are definitely premature!

3. Bring in the voices and experiences of other people whenever possible: the families you met, the people who have written, and continue to write; the health care providers who are out there doing their best. Get out of won/lost questions by talking about the American people. (Again, the stories should include some of the President's as well as yours.)

4. Talk about the President, both in terms of your health care assignment and future projects.

Responses to specific questions _

1. See Rule # 1, above. If you get a repeat or follow up:

As I said, I think we were naive. We underestimated the extent of the opposition. I don't think we were arrogant to try to bring about change on an issue that is so important in the lives of so many people. We may have been over-optimistic.

2. I think the impression that this was a secret process proves shows that we failed to tell people how hard we worked to bring them in. We met and listened to and worked with thousands of people. But we should have done a better job of explaining what we were doing.

3. *If you get both questions 3 and 4, this may be the time for some humor:*

We clearly didn't do everything right, but can I point out that we could not have been both secretive and chaotic? In fact, we tried to design a process that would bring in the largest number of people and the largest amount of information in the shortest possible time.

4. Well as I've said, we may have underestimated the power of the opposition.

But I don't think the fact that we submitted a long bill indicates anything other than the fact that we felt strongly about giving the public the facts -- how it would work, how people would be effected, and how it would be paid for. You know, major legislation never makes for light beach reading. The crime bill that passed last month was more than 1500 pages. NAFTA legislation was literally thousands of pages. Long legislation is not a new phenomena, nor is it limited to health care.

The plan we came up with as a recommendation was just that -- a recommendation. We tried very hard to work with members of Congress who had other suggestions, to find a compromise. As the President himself said many times, we have no pride of authorship. We welcomed better ideas.

5. We discussed every aspect of this plan with the head of this administration: The President. I took this assignment at his request, and I was and am very conscious of the fact that we were

working for him. This is his administration, and this was his administration's recommendation for health care reform.

6. I think we had very good support from people who agreed with us about the importance of universal coverage. A lot of very good people worked very hard on this project. I was proud to work with them. Maybe I should have worked harder; they certainly did their part.

7. I am sorry that we were unable to get Republican support at the end of this Congressional session, but I think that had a lot to do with changing dynamics within that party. You may remember that at the beginning of this process, we tried very hard to work with Republicans on health care. I had a number of meetings with congressional Republicans, and we had many very serious discussions. Unfortunately, it seems the hardening nature of the partisan debate finally made the cooperation we hoped for impossible.

8. *Compromise answer again....*

9. I wish I could bring here the people I talk to all over the country who are so eager for health care reform - from families concerned about what is happening in their lives to health care providers who are trying so hard to meet the needs of their patients. As I've said before, I don't think we were narrow; we may have been naive. And then we ran out of time.

10. Ira is a very able public servant who has worked very hard. I am proud to work with him. I think as more information becomes available about the efforts we made, and how hard he worked to reach out and find a workable compromise, that his contribution to this project will be appreciated.

11. I agree that we did not succeed in reaching enough people. The importance of health care reform has always been what it means for working families, people in the middle class who are being squeezed by rising costs. Unfortunately those families are still at risk today, which is one very important reason why I will continue to speak up about the need for health care reform.

12. Did we have a failure to communicate? Yes, we did. And when I think of the people I met with over the last two years, the many families I've talked with, the people who have sent me letters about what is happening to their own families ... when I think how important this question is to them, I am really disappointed that we were not able to do more.

That's why we're going to keep on focusing on this issue. Maybe I can learn to communicate better.

13. *See Rule # 3 -- and smile.*

14. I don't score this as a personal defeat or a political defeat for me. The people who had the most at stake in this debate don't live at the White House: they live all over this country. I've

been talking with them, meeting with them, reading their letters -- and I know how important this issue is to them. That's why I'm going to keep trying.

15. *Similar to 14, above. Questions about future projects should also refer to the President.*

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. draft	RE: Talking About Health Care (1 page)	n.d.	P5
001b. draft	RE: Goals of the Plan (2 pages)	n.d.	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10250

FOLDER TITLE:
[1994 Health Care Talking Points] [binder] [1]

Debbie Bush
2006-0810-F
db2290

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]
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DRAFT

Talking About Health Care

The following is a guide to talking about our health care proposal with an eye toward communicating as clearly and consistently as possible.

From now on, we should start referring to the proposal as "The National Health Security Act." It should not be referred to as the "health security proposal," or as "the President's health security plan." The word "proposal" is preferable to plan (too definite) or program (too bureaucratic). If we call it a "plan," it might be confused with the plans that are offered in every region.

General Points

1) Avoid the academic debate. Do not use terms like "managed competition," "single payer" and the like. If pressed on these approaches, talk about the National Health Security Act as a blend of different approaches -- a uniquely American solution to an American problem. And then move on to explain how the proposal will affect consumers.

2) Humanize everything. Using your own story or individual stories is the best way to communicate about health care. Concrete examples lead to understanding.

3) Don't stress "managed care" or "HMOs." When you refer to health plans, emphasize choice and remind people that they have the option of paying each time they go to a doctor (getting their health care just as they do today), or choosing a network of doctors and hospitals that provide care. We are not going to force anyone into any kind of health plan.

4) Stress bipartisanship. Health care reform is an issue above partisanship, above politics. Political differences should be set aside for the sake of providing health security to American families. This is an issue on which Democrats and Republicans must and will unite.

5) Put everything in the context of the status quo. When talking about parts of our proposal, first talk about the problems of the current system. Then go on to talk about how reform will improve the status quo.

6) Emphasize preventive care. Prevention is one of the cornerstones of the National Health Security Act. Preventive services are covered fully in the comprehensive benefits package, which will lead to long-term savings and a healthier nation.

This is not an argument about "access" or "universal coverage" or "extending coverage" or "the uninsured." We should not even talk about "37 million uninsured" because that is not who the proposal is designed to protect. **The National Health Security Act is designed to guarantee that no one will ever lose health coverage**. It is therefore aimed at the vast majority of middle-class Americans who have insurance but live in fear of having it taken away.

Savings

Here we are speaking to many different audiences at the same time. For the consumer, we do not promise to "lower" or "reduce" health care costs; we will, however, **stop the overcharging in the current system, limit how much you can be charged for your health care, and limit how much insurance companies can raise your premiums.**

For small businesses, we should stress that they will be able to **get a discount on health coverage for their families and employees**. If asked why small businesses should pay, you might use the following example: "It's just not fair that the gas station on Main Street that insures its employees ends up paying for the car wash down the street that doesn't. When that car wash employee gets sick, he walks into the emergency room and we all pay for it: in higher health premiums, higher hospital costs and higher taxes."

For the nation, we do not promise to "lower" or "reduce" health care spending, but we will **control the growth of health care costs.** We should not refer to "strict budgets" or "budgets" in any way; again, we should discuss this in terms of limiting the growth of health care costs.

We should not over-promise on deficit reduction; we should say that our goal is to eventually reverse the trend of health care adding to exploding deficits.

When discussing Medicare and Medicaid, we do not talk about "cuts," but about savings that we get when we slow the rate at which the programs will grow and get people off Medicaid.

Simplicity

We should talk about reducing paperwork that is choking the system and cutting through the red tape. The United States spends more on health care bureaucracy than any other nation; with reform, we can do better.

Emphasize the single claim form that replaces the forms from the thousands of different insurance companies as an important step to reducing the forms that clog today's system.

Whenever possible, health alliances should be downplayed, because they add to the illusion of more complexity in the system.

Quality

We should talk about *improving* the quality of American health care, not about maintaining or preserving it. One of the cornerstones of improving quality is emphasizing preventive care -- **keeping you healthy before you get sick**. Another is providing consumers with the information they need to hold doctors and hospitals accountable based on the quality of care they give.

You might say: "Armed with consumer report cards on each health plan, for the first time consumers will be able to choose doctors and plans based on quality and price."

We should not refer to "unncessary care" ; instead we can refer to care that is inappropriate and potentially harmful. Remember: people think you can never spend enough money on health care (either individually or as a nation) and never get enough tests. People believe the reason we spend so much on health care is because of inefficiency, waste, and fraud -- not because of the proliferation of technology and expensive tests.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. draft	RE: Health Care University Concept/Implementation Proposal (5 pages)	n.d.	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10250

FOLDER TITLE:
[1994 Health Care Talking Points] [binder] [3]

Debbie Bush
2006-0810-F
db2291

RESTRICTION CODES

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

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Preliminary Draft

HEALTH CARE UNIVERSITY CONCEPT/IMPLEMENTATION PROPOSAL

Majority Leader Gephardt, Majority Leader Mitchell, and Senator Daschle have repeatedly raised concerns about the limited education level of Members as it relates to health care. Senator Daschle and Congressman Gephardt have promoted the establishment of a kind of "health care university" for Members of Congress. They believe the "classes" should be **open to Members of both parties.** The First Lady believes that the Leadership's suggestion is excellent and should be implemented as soon as practical and advisable.

Mrs. Clinton has asked that the following proposal for a series of health care briefings (she would prefer to use a title other than Health Care University) by Administration health policy and legislative affairs representatives be given to and reviewed by the Congressional Leadership and their staffs. **Before proceeding with the outline, however, we wish to stress that the Administration believes these important presentations should be viewed as a supplement to, and not a substitute for, the consultations that have and will continue to take place with the Congressional Leadership.**

We believe that the establishment of a health care university-like entity (from now on referred to -- at least temporarily -- as **health care briefings)** has great potential. If done well, it the process should:

(1) Reinvigorate the "need for action" mentality that, until very recently, had been effectively fanning the flames of desire for comprehensive health reform in the Congress;

(2) Ease Congressional concerns about, and raise Member comfort levels with, the President's proposal to address the problems;

(3) Better enable prospective Congressional supporters to explain, defend, and sell the President's proposal; and

(4) Be utilized to help educate surrogates in home Congressional districts.

Achieving success in briefing Administration, Congressional, and other influential individuals will depend on the ability of the health care briefings to: (1) communicate our message in a simple, understandable way; (2) utilize staff resources most effectively; and (3) be responsive to the information needs and time constraints of those we will rely on to support the President's health reform initiative. To develop and implement an effective educational briefing process we will have to successfully:

- **Target the Issues**
- **Target the Best Personnel to Make Presentations**
- **Establish a Staff/Intake and Scheduling Process**
- **Prepare the Briefing Materials and Presentations**
- **Brief and Train the Briefers**
- **Develop a Workable Timetable**

TARGET THE ISSUES

The briefings should convey a simple, concise message and be responsive to what we know to be **the major thematic priorities and interests of the majority of the Congress.** As a first cut, we propose limiting the briefings to no more than 10 broad-based issues:

(1) **An Overview of the Plan, its Design and its Philosophy;**

(2) **Consumers in the New System;**

(3) **Cost Containment and Budgets;**

(4) **Savings, Costs and Financing;**

(5) **Small and Large Businesses in the New System;**

(6) **Health Care Providers in the New System;**

(7) **Federal/State Roles;**

(8) **The Elderly in the New System;**

(9) **Rural Communities and the New System; and**

(10) **Urban Communities, Underserved, and the New System.**

Issues such as Medicare, Medicaid, Veterans, Federal Employees Health Benefits, medical malpractice, anti-trust, quality, public health, benefits, etc. would be incorporated into the above mentioned categories. Special and more detailed briefings on these and the whole range of other issues would be provided to Administration representatives, Congressional Members and staff on an as-needed and requested basis.

TARGET THE BEST PERSONNEL TO MAKE PRESENTATIONS

Briefing Members of Congress always has the potential for great benefits, as well as great risks. The key is for Members to leave the presentations both impressed with the substance of the information given and the competence (and likability) of the presenters.

Included in the definition of a competent Congressional briefer is knowing -- going in -- what are the historic sensitivities of the Members present, in other words, to know what to say and how to say it and to know what not to say. If the personnel chosen meet these criteria, the benefits of these briefings are almost boundless. If, on the other hand, Members leave presentations with a sense that briefers are either incompetent, arrogant, condescending, and/or disrespectful, an effort with the best of intentions could well turn out to be a total disaster. All of this is to say that the personnel chosen for Congressional briefings is critically important.

Policy Expert Resources

Within the White House health care working groups and the Departments (in particular, HHS), the Administration has an impressive array of health care policy experts who could serve in briefing roles extremely well. (In most cases, Ira and Judy -- in particular -- have been, and likely will continue to be, very well received.) Having said this, the other briefers that we will need must be evaluated carefully -- keeping in mind not only how competent they are, but how well they will be received by different collections of Members. (We have prepared a tentative staff resource list linked to the ten topics previously mentioned, but it is undergoing final review by the White House and HHS -- Jerry Klepner's shop; in any event, it will be a continually updated list based on the briefers' performance and Congressional reception.)

Legislative/Policy Resources

We strongly advise that those most familiar with the Congress and their predilections -- the Administration's Legislative Affairs staff -- play a major role in briefing the Members and the staff on this issue. The White House and Departmental Legislative Affairs staff (particularly at HHS) have strong and long-standing relationships with the Members and staff that should be utilized to the benefit of the Administration's health reform effort.

At every briefing, there should be one Legislative Affairs Administration representative who has equal status to the policy presenter. This is absolutely necessary to best assure that no situation gets out of hand, that there is a politically sensitive individual always present, that there are careful notes of the meeting, and that responsive follow-up occurs.

ESTABLISH A STAFF AND SCHEDULING PROCESS

The scheduling of the university and other requested briefings should be coordinated out of the War Room. This work should be closely coordinated with the Department of Health and Human Services' Office of the Assistant Secretary for Legislation (and other Department ASLs as necessary). In addition, we should work closely with the House Democratic Caucus and the Senate Democratic Policy Committee to help coordinate topics, schedules, and rooms. The schedule of all briefings should be updated daily, provided to Steve Ricchetti/Melanne V./Chris J./Jerry K./Karen P., and announced at the morning Communications meeting.

To ensure that the briefing operation is a success requires an experienced and politically sensitive staff person who can work closely with the Congressional Leadership and Administration personnel in meeting the scheduling and substantive needs of the Members. We propose that Steve Edelstein take on this role (in addition to his other responsibilities) and work with Lori Davis and other staff at HHS to assist him. Depending on the volume of and desire for briefings, additional staff (perhaps a full-time intern who is mature and responsible) may be required.

PREPARE THE BRIEFING MATERIALS AND PRESENTATIONS

In order to ensure the delivery of a consistent, simple, understandable message, we need to prepare educational materials for the presenters in advance of the briefings that all staff can and should use. Educational materials should include charts, graphs, detailed outlines to guide presentations, questions and answers as appropriate. These materials and presentations should be user friendly and targeted to specific audiences.

Working with the initial approval of Ira and Judy, as well as the Legislative Affairs staff, Steve E. will assign one policy expert to each of the issues chosen for briefings to take the lead in preparing the substance of the briefing materials and their presentation. He will make certain that each presentation is finalized on time and in the best format possible. The Communications staff will review and edit the briefing materials for clarity, directness, and consistency of message.

The presentations will also be screened by Legislative Affairs staff to ensure that they meet the needs of the audience. (They will know who is attending because we propose to limit the size of each briefing to between 25-35 Members and have them signed up in advance of the briefing; we believe that such a small structure will best assure a less lecture-like atmosphere and better encourage a give and take constructive discussion.)

Each "class" will be structured to briefly outline the problem(s) with the current system, how the President's proposal addresses the problem(s) (if relatively non-controversial), and the rationale behind the Administration's proposal. The briefings will be designed to last no longer than 60 minutes: 20-30 minutes (at most) of presentation and 30-40 minutes for questions and answers. On an as needed basis, these classes will be repeated.

Substantive and detailed presentations about the most controversial policy recommendations -- if they are even available -- of the President's proposal should be avoided. There is great concern among the Congressional Leadership that controversial recommendations -- such as financing, exact cost containment mechanisms, etc. -- could lead to public and potentially problematic disclosure. Instead, the Majority Leaders have suggested that we detail the **options** we are considering to address the most challenging issues.

BRIEF AND TRAIN THE BRIEFERS

Communications staff will be needed to provide guidance to all briefers on how to orally deliver their presentations in an easily understandable manner. In addition, before each presentation, the Legislative Affairs staff from either the White House or the appropriate Department (usually Jerry Klepner's shop) will brief the presenters on who will be in the audience, what issues are particularly sensitive, what issues to highlight, and how best to present complex, potentially controversial materials.

DEVELOP A WORKABLE TIMETABLE

We need to make a final decision as to when it would be most appropriate and useful to commence the health care seminars. Senator Daschle originally envisioned the "classes" beginning after the legislation had been introduced. However, he and Majority Leader Gephardt (and we believe Majority Leader Mitchell) thinks it may well be advisable to begin to brief Members before the release to reinvigorate their desire to be involved in the health reform debate and to create a greater comfort level with what the Administration is doing in this area. We also need to determine when it would be most appropriate to incorporate Rebublicans into the briefings, i.e., would it be best immediately prior to or immediately after the President's unveiling of the plan?

If the President is going to unveil his package by not later than late September, the implementation of the start-up recommendations for the health care briefings must occur almost immediately. The following outlines a possible workplan timeline to help with tentative scheduling.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Jay Rockefeller to Hillary Rodham Clinton; RE: Health Care Reform Communications (24 pages)	05/26/1993	P5
002. draft	RE: Health Care Communications Strategy (6 pages)	n.d.	P5
003a. memo	Jason Solomon, Rebecca Martin to Jeff Eller; RE: Briefing Calendar (5 pages)	06/03/1993	P5
003b. memo	Julia Moffett to Jeff Eller; RE: Health Care Calender/Launch (3 pages)	06/01/1993	P5
004. memo	Lisa Caputo, et al. to Hillary Clinton; RE: Updated Health Care Communications Strategy (2 pages)	03/14/1993	P5
005. memo	Lisa to Hillary, Maggie, Melanne; RE: Media Strategy for March (3 pages)	03/01/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10250

FOLDER TITLE:
Health Care Press Strategy

Debbie Bush
2006-0810-F
db2292

RESTRICTION CODES

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

P1 National Security Classified Information [(a)(1) of the PRA]
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MEMORANDUM

~~CONFIDENTIAL~~

To: Hillary Rodham Clinton
Fr: Jay Rockefeller MDRW
Da: May 26, 1993
Re: **HEALTH CARE REFORM COMMUNICATIONS**

I. OBJECTIVES

II. CURRENT PERCEPTIONS

III. HOW WE CHANGE CURRENT PERCEPTIONS TO ACHIEVE OBJECTIVES

IV. UNPACKING THE POSITIVE MESSAGE

V. UNPACKING THE MAIN ATTACKS

VI. GRASSROOTS ORGANIZATION

V. MEDIA

VI. ROLL-OUT with Calendar

APPENDIX A. POLICY SALES TEAM

APPENDIX B. "STRATEGY FOR WINNING" SALES TEAM

CTIVES

To Keep and Mobilize Public Support:
- Expose the magnitude of the problem, those responsible, those who have profited, and the cost of inaction
- Build trust in the reformers and the reform process
- Generate positive reviews from trusted opinion-makers
- Provide broad understanding of reform benefits and burdens

** LOSE by focusing on mechanical details

To Recruit and Mobilize Opinion-Makers:
- Expose the magnitude of the problem, those responsible, those who have profited, and the cost of inaction
- Provide understanding of how benefits will be delivered
- Provide understanding of how burdens will be shared
- Provide understanding of strategy for winning public support and passage

** LOSE by failing to make them part of the information flow

To Undermine Opponents, they must be:
- Shown as perpetrators and beneficiaries of the problem
- Exposed as divorced from the interests of average Americans
- Exposed as promoting delay to subvert reform
- Isolated from each other to prevent increased credibility through combination

** LOSE by allowing them even one day without scrutiny

II. CURRENT PERCEPTIONS

The Problem:
- Widespread recognition that the system is in crisis and middle-class well-being is threatened
- Increasing understanding of the cost of the status quo

WJC and HRC:
- Seen as sharing the real-life concerns of average Americans and interested in practical solutions
- HRC events have very effectively, but almost solely, carried the reform message

Reform Concepts:

- Administration silence has created a news vacuum
- Vacuum has been filled by opponents and haphazard leaks
- Choking off information has made leaks more valuable and given them exaggerated importance
- Concepts introduced have not been defined by the Administration:

Payroll Premium	Health Alliances
Guaranteed Benefits	Price Controls/Budgets
National Health Board	Managed Competition
Insurance Reform	etc.

Opinion-Makers (who are or should be allies):

- Have not been made part of a crafted information flow
- Are not armed to validate Clinton definitions of concepts
- Are not energized to recruit their own constituents and colleagues

DPC, DSCC - Senate	DSG, DCCC - House
Democratic Governors	Democratic Mayors
Moderate Republicans	Neutral Economists
NHPC (Gleason)	NHLC (Redlener)
People for the Am. Way	NEA, AFT
NAACP, La Raza	Women's Organizations
AARP	State Party Chairs
AFL-CIO, Machinists	AFSME, UAW, CWA, ILGWU
Small Business United	Small Business Leg. Council
Chamber of Commerce	National Leadership Council
Health for America	National Asso. Manufacturers
Chamber of Commerce	Washington Business Group
Council of Seniors	Mental Health Asso.
CDF	Families USA
Family Physicians	Consumer Union
Nurses	Pediatricians
Social Workers	American Hospital Asso.
Medical Students	Psychologists
Emergency Physicians	American Public Health Asso.
Ob/Gyns	College of Physicians
Community Health Ctrs.	Catholic Health Asso.
Religious Organizations	etc.

The Press:

- Have not been made part of a crafted information flow
- Have been antagonized without purpose
- Are being forced to negatively review and translate the reform plan

The Task Force:

- Seen as a secret cabal of Washington policy "wonks"
- Motivations and methods are mysterious and divorced from the experiences of average Americans
- This strength has been turned into a liability

III. HOW TO CHANGE CURRENT PERCEPTIONS TO ACHIEVE OBJECTIVES

A. Pre-Unveiling

Before the official unveiling, the Administration has the upper-hand. Opponents must try to attack without a clear target, and are vulnerable to being exposed as selfish, short-sighted and callous -- divorced from the interests of average Americans. **A tremendous opportunity will have been lost if the following steps are not taken before the plan is unveiled.** This period must be used to:

1. **Continue to highlight the problem, those who caused it, those who profit from it, and the cost of inaction.**

2. **Build trust in the reformers:**

   - Continue to give WJC and HRC opportunities to empathize with the real-life struggle of average Americans with the current health care system, and show WJC and HRC keeping the focus on real-life practical solutions.

   - Focus attention on the real-life motivations of the members of the task force and working groups.

   - Aggressively market their personal stories.

   - Guide them in what information to move, rather than choking off access and creating a vacuum.

3. **Build trust in the reform process:**

   - Demonstrate independence by publicly challenging ideologues and characterizing those excluded from the working groups as "professional lobbyists."

   - Aggressively market stories about thoroughness and integrity (show examples of contrarian process, data-base research, consultation process, number crunching, etc.) to reassure public that all options were exhausted before sacrifice was even considered.

(4) 4. **Impeach the credibility of opponents:**

- insurance + pharmaceutical
- avoid attacking doctors + nurses
- expose lobbyists

- Avoid partisan targeting. Demonstrate that opponents are advocates of delay or inaction, regardless of party affiliation. Moderate Republicans must be broken from conservative ranks.

- Expose opponents as "professional lobbyists" with values and interests divorced from average Americans (document salaries, perks, ideological extremism, and provide all to the media).

- Use classic opposition research to expose their selfish and short-sighted motivations, and obstructionist tactics (collect mailings, track ad campaigns, investigate expenditures, and provide to the media).

- Document how much opponents will gain by delaying or halting reform.

(5) 5. **Recruit opinion-makers: [SEE APPENDIX A and B]**

Surrogate Teams
1) National
2) Local + grassroots

- Use two "sales SWAT teams" to initially recruit and then regularly update opinion-makers -- one team sells the plan and related policy concepts, and one team sells the strategy for winning public support and passage. Use slick presentations, slide shows, poll numbers, the whole nine yards, and chose the "salesmen" for their sales talent -- this is no place for anyone with an arrogant or secretive approach.

- Inform and arm opinion-makers and give them specific missions: so they are able to positively review the reform plan; validate the Administration's definitions of key concepts; and woo their own colleagues and constituents.

- Form a network of opinion-makers and tap into their organizational information networks to delivery the message (via computers, fax exchanges, regular briefings, local staff organizations, etc.). WJC and HRC media events (network and/or local) CANNOT succeed alone -- there must be a chorus of supporting voices. Deliver message with a fire hose, not an eye dropper.

- Daschle's university or Congressional school - [illegible] should be a [illegible] from HRC. [illegible] before + after [illegible] of the plan.

6. **Control definition of concepts:**

- Concepts should be defined before the plan is unveiled. Use opinion-makers, and their information networks, to spread the

(6) School System - sessions for surrogates [illegible] set up [illegible] for [illegible] post. Have [illegible] set up a parallel system to educate 25 people. [illegible] or [illegible] a team of people.

Administration's definitions and protect against opponents who will undermine reform legislation by destructively characterizing underlying concepts.

- Brief the press <u>immediately</u> after briefing opinion-makers. Do not allow others to translate your concepts to the elite and health beat media. Diminish the value of leaks by filling, not creating, news vacuums.

- <u>Prepare</u> events, language, etc. that highlight policy concepts that:

  Continue to set the **CONTEXT** - (1) Exposing how bad the problem is, who caused the problem, who benefits from delay and inaction, and the cost of inaction. (2) Build trust in reformers and allies.

  Deliver the **POSITIVE MESSAGE** - How reform will deliver (1) peace of mind (security), (2) an end to fine print and forms (simplicity), and (3) an end to over-charges (savings). DESCRIBE CONCEPTS <u>NOT</u> MECHANICS.

  INOCULATE against main attacks - which are (1) reform will cause layoffs (small business); (2) we cannot afford reform (deficit/taxes); (3) reform will ruin what is left of the system (choice/quality).

B. <u>Post-Unveiling</u>

After the official unveiling, opponents could gain the upper hand if they are able to determine which concepts and details the Administration becomes absorbed in explaining and defending. It is essential that the Administration use its events and other activities to determine the focus. If the Administration is only prepared to offer broad generalities, others will determine the underlying conversation about concepts, and eventually this will turn the debate away from the Administration's over-arching themes and message. Therefore it is essential that during this period:

1. **Continue to brief and give message delivery missions to opinion-makers through an established network.**

2. **Relentlessly deliver the over-arching message:**

   - "Reform will guarantee that you will never lose your health protection; you will never have to battle insurance company fir print and forms to get the benefits you pay for; and the brakes will be ut on overcharges and spiraling costs."

   - Constant reminders about the costs of delay, and who profits from delay.

3. **Roll-out the events prepared before the unveiling that highlight policy concepts (NOT mechanics) that:**

   - **(1) continue to define the CONTEXT**
   - **(2) deliver the POSITIVE MESSAGE**
   - **(3) INOCULATE against the main attacks**

4. **Apply pressure on undecided Congressional votes with intensive message delivery through their home state or home district media outlets.**

   - Recruited opinion-makers and the message delivery network should be activated in the home states and home districts of Congressional swing votes prior to key Committee or floor activity.

   - Before key Congressional activity, national and local events should be "linked" for maximum effect in home states and districts.

   Example of a "linked" local/national event (8 steps):

   i. Simultaneous state rallies with Governors and Mayors (local and regional coverage).

   ii. At each rally, introduce a state delegation of local citizens (5-6 people) being sent to Washington for a national health reform day.

   iii. Press conference at the airport or train station when delegates depart for Washington (local coverage).

iv. Converge in Washington with others from across the country (bulk of crowd built locally) for mid-morning Capitol rally (network coverage).

v. Delegates visit Congressional offices (bureau coverage).

vi. Delegates conduct afternoon conference call with home state papers and radio stations.

vii. Evening live one-on-one satellite interviews with every home state TV news programs. Targeted states would have local residents speaking from Washington to every local news program in their home state saying something like: "I went to see Senator X to ask him to support health care reform, and I believe he will because he cares about people like me and will do the right thing."

viii. Another press conference when delegates return to their state the next day (local coverage).

Result: Three-four days of saturation local coverage in all targeted states and/or districts, tied to national events with network coverage -- all featuring "real" people with "real" stories.

Proposal: Four national/local "linked" events:
Youth town meeting in September (target deficit hawks)
Town Meeting series in October (target Committee vote)
Lobby Day series in November (target floor votes)
Rally series in December (target Conferees)

III. UNPACKING THE POSITIVE MESSAGE

A. Security - You Will Never Lose Your Health Protection

"I can't enjoy my good health, for fear of bad health" -- WV worker

Concepts: (Opinion-makers need briefings and briefing materials on the message and mechanisms behind each concept below)

- Coverage cannot be cut off no matter what
- Coverage for care at home
- No longer need to spend down into poverty for LTC
- Coverage not affected by job changes
- Medical benefits cannot be cut despite income or employment status (guaranteed benefits package)
- Insurance premiums not affected by health status

Events: (Local or national)

- Visit family/family business with insurance problems
- Visit seniors struggling to live at home
- Visit workers locked in jobs when they should move
- Talk with uninsured graduating college students
- Visit maternity ward & talk with uninsured mothers
- Congressional hearings on insurance abuses, drug pricing, and hospital overcharging

B. Simplicity - You Won't Have to Battle Fine print/Forms

Underlying message: "Nurses and doctors spend more time on paperwork than patients. Most of us don't know what we're covered for until our claims are rejected -- if this makes sense, why is it all hidden in fine print?" -- WV worker.

Concepts: (Opinion-makers need briefings and briefing materials on the message and mechanisms behind each concept below)

- Standard claim form processed electronically
- Elimination of Medicaid and its regulations
- Alliances do shopping for insurance
- Electronic billing through insurance cards

- Insurance cards encoded with medical records
- No more insurance investigations of health, etc.
- Medical benefits cannot be cut
- No fine print
- No more intrusion in doctor/patient relationship

Events: (Local or national)

- Visit family ruined by rejected insurance claim
- Fill out forms with nurses
- Work in a hospital billing department
- Pile up all the forms a doctor fills out in a year

C. <u>Savings</u> - **Brakes on Overcharges and Spiraling Costs**

Underlying message: "I don't expect health care to be free, but I don't expect it to be the biggest piece of my budget -- bigger than my mortgage, bigger than my car payment, bigger than school for my kids or what I put away for my retirement." -- WV worker.

Concepts: (Opinion-makers need briefings and briefing materials on the message and mechanisms behind each concept below)

- More purchasing power for consumers
- More competition between insurance companies
- Limits on insurance, drug and medical profits
- Fewer frivolous lawsuits
- More prevention
- More personal responsibility
- More information on what works medically
- Less paperwork and waste
- Crackdown on overcharges and fraud

Events: (Local or national)

- Visit company with no-smoking incentives
- Go on rounds with medical students
- Review malpractice insurance bills with doctors
- Visit members of existing insurance purchasing pools
- Work through bills with a family at kitchen table
- Pile up all the free items with a drug company logo received by a doctor's office in one year
- Trace a drug from factory to medicine chest

PACKING THE MAIN ATTACKS

Expose opponents general strategy: death by delay or throwing "logs" on the road to reform. They will use four major lines of attack -- four kinds of logs to cause delays and distraction.

A. Attack 1: Reform will cause layoffs

Attackers: small business lobbyists; economists

Response concepts: (Opinion-makers need briefings and briefing materials on the message and mechanisms behind each concept below)

- Subsidies and tax credit for small business
- No more paying for free-riders (cost shifting)
- No more begging insurance companies for coverage
- No more trying to decipher insurance plans
- No more billing or claims paperwork
- No more premiums set by business size or health
- Worker's comp., auto and health insurance combined
* Expose lifestyles, tactics and motives of small business lobbyists

Response Events: (Local or national)

- Join CEOs to highlight job loss from status quo
- Visit shop owner & family with insurance problems
- Shop for insurance with a shop keeper
* Expose lobbyist salaries, perks, etc.

B. Attack 2: Do not spend one more dollar for anything

Attackers: deficit hawks; no new taxers

Response concepts: (Opinion-makers need briefings and briefing materials on the message and mechanisms behind each concept below)

- Savings to average Americans
- Savings to small businesses providing insurance

- Savings to big business
- Savings to state and local governments
- Property tax savings
- Deficit savings from reduced Medicare & Medicaid
- Improvement in international trade position
* Immediately attack numbers used by opponents

Response Events: (Local or national)

- Youth town meetings to link reform & deficit cuts
- Endorsements by key opinion-makers
- Visit with any example of someone who will save
* Challenge the expertise of their number-crunchers

C. <u>Attack 3: The "cure" will make it worse (trust)</u>

Attackers: government bashers; medical professionals (on rationing, choice and quality); militant single-payers

Response concepts: (Opinion-makers need briefings and briefing materials on the message and mechanisms behind each concept below)

- WJC and HRC understand the real-life problems, and they are focused on finding practical solutions
- Reformers are average Americans interested in real-life solutions, not ideological system fixes
- Reform process was thorough - all options tried
- Reformers were independent - experts, not lobbyists
- Reform process had integrity - real numbers
- Safeguards on quality
- Safeguards on choice
* Expose lifestyles, tactics & motives of lobbyists

Response Events: (Local or national)

- Personal profiles of reformers
- Display research, contrarians, number-crunchers
- Endorsements from medical professionals
- Testimonials from victims of the current system
- Highlight new medical research initiatives
* Expose lobbyist salaries, perks, etc.

D. Attack 4: Abortion

Attackers: ideologues

Response concepts: (Opinion-makers need briefings and briefing materials on the message and mechanisms behind each concept below)

- Full reproductive services
* Do not engage on this topic

V. GRASSROOTS ORGANIZATION

Two approaches:

A. **Partisan:** Create a new organization staffed by Democratic organizers to recruit a cadre of supporters in targeted states who will endorse the Clinton reform plan, and serve as local spokespeople. Local cadres would be coordinated by a local paid staffer. This organization (whatever its legal status) would be identifiably partisan through its staffing, fundraising, and membership.

Advantages:

- Great deal of central control.
- All needs (recruiting opinion-makers, free media account, and opposition research) would be under one roof.

Disadvantages:

- Could not recruit credible opinion-makers who were moderate, Republican or neutral. AARP, most physician groups, etc., would be unable to coordinate through this organization. This would deny the possibility of effectively tapping into the information dissemination networks of many of these organizations.

- The health care reform effort would take on a much more political taint -- which would make the goal of a dozen Republican votes in the Senate even more difficult to reach.

- This organization's activities and fundraising would be a lightning rod (without protection) for opponents' scandal-mongering.

- This organization would have to reinvent the wheel in one month. A wide spectrum of credible opinion-makers (and their organizations) must be recruited BEFORE the plan is unveiled.

- Local campaign staff, or even a cadre of recent ad hoc recruits, CANNOT substitute for opinion-makers and their networks to organizations and constituencies. We must use the structures and information networks of existing organizations -- from the DGA to the Chamber.

B. **Non-partisan:** The National Health Policy Council is the most obvious existing organization to be expanded for this purpose.

Advantages:

- NHPC already has a wide spectrum of membership spread across 45 states, and they are already respected in the health reform community. Reinventing the wheel would not be necessary -- and valuable time BEFORE the unveiling of the reform plan would be saved.

- A high-profile announcement of the decision to take this "aggressively non-partisan approach" would be extremely helpful in building public confidence and support in the reform effort -- and in opening a channel and sending a signal to moderate Republicans in Congress.

- Recruitment of moderate/neutral/Republican board members could begin immediately (e.g. C. Everett Koop, Antonio Novello, Governor Castle, etc.).

- Neutral organizations (AARP to CDF) could participate fully, allowing greater direct access to their information dissemination networks.

- General public would recognize this as a clear attempt to break through partisan politics and gridlock.

Disadvantages:

- Less central control.

- This organization would recruit and coordinate opinion-makers. A paid media campaign could be attached to this organization or delegated to the DNC. Opposition research would have to be handled by the DNC -- with no association to this organization.

* NOTE: Just so you understand, I have been involved with NHPC, as honorary chair, for nearly two years. I can attest to their effectiveness and their breadth both geographically and politically. I have considered other existing organizations, but I believe NHPC would serve your needs best, in part because I know that the people involved are prepared to do anything you would ask of them.

Whatever the make-up of the organization:

- It is crucial that formation of a board and fundraising begin IMMEDIATELY -- hopefully before the organization becomes highly politicized, if that is the course taken.

- Recruiting and informing opinion-makers and accessing their organization's pre-existing information networks should be the major focus of the grassroots effort -- and must occur BEFORE the unveiling of the plan.

- Paid staff is needed in targeted states to coordinate with local opinion-makers and their affiliated interest groups. Staff can help investigate and implement local events and local pieces of national/local "linked" events.

VI. MEDIA

- **Briefing the media regularly is essential.** We cannot afford to let others define concepts or set context with the media. Although we can "leap" past the national press and health beat press to local news organizations, failing to attend to the elite and beat media will ultimately undermine our efforts on the local level. **Embargoed briefings on the plan IMMEDIATELY BEFORE the unveiling of the plan are crucial.**

- **Guidance and cooperation in news planning is essential.** Right now every news organization (MTV to JAMA) is planning expanded coverage of health care. News directors, planners and editors, and features producers and editors are anxious and willing to receive guidance on how to time and shape their coverage. **White House communications staff should be meeting with every major news organization to gain as much insight and offer as much guidance about coverage as possible.**

- **Paid Media.** Fundraising must begin immediately. I am frankly surprised that I have not been contacted or shown a plan for fundraising and media expenditures. Radio must be up in targeted markets by October. Television must be up in targeted markets throughout November and December.

VII. ROLL-OUT

(*) marks assumptions about Congressional schedule

STAGE 1: Now through the unveiling

* COMPLETION OF RECONCILIATION
Consultations to soften and recruit opinion-makers
Build network for information flow to opinion-makers
Regularly and relentlessly brief the press
Define policy concepts for opinion-makers and press
Prepare SWAT team presentations
Prepare materials for distribution to opinion-makers
Start roll-out of events that set context and inoculate
Prepare events that will deliver positive message

STAGE 2: Unveiling through July

* BILL INTRODUCTION & COMMITTEE REFERRAL
Unveiling in joint session speech (challenge Congress)
National network speech (cost of inaction)
Release of detailed plan document
SWAT team presentations to recruit opinion-makers
Opinion-maker materials distributed
National events with Administration principals
(bus tour, etc.)

STAGE 3: August

* CONGRESSIONAL RECESS
National opinion-makers recruit local opinion-makers
Build local organizations
Local opinion-maker materials distributed
Local events with local opinion-makers

STAGE 4: September and October

* SENATE & HOUSE COMMITTEE ACTION
Begin targeted radio ad campaign

Congressional hearings
Linked national/local event (Town Meetings)

STAGE 5: late October until Thanksgiving

* SENATE & HOUSE FLOOR DEBATE AND PASSAGE
Begin targeted TV ad campaign
White House principals on tour with local organizers
Network televised speech (cost of delay)
National events and saturate network shows with
Administration principals and surrogates
Linked national/local event (Lobby Day)

STAGE 6: late November until Christmas

* CONGRESSIONAL CONFERENCE COMMITTEE ACTION
Continue targeted TV campaign
Linked national/local event (Rallies)

STAGE 7: Christmas Eve until News Years Eve

* FINAL CONGRESSIONAL PASSAGE
Bill signing

* OR SPECIAL SESSION UNTIL PASSAGE

see attached calendar

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
May	23	24	25	26	27	28	29	RECRUITMENT OF OPINION-MAKERS' BRIEFINGS
June	30	31 (HOLIDAY)	1	2	3	4	5	
	6	7 BRIEFINGS →	8 →	9	10	11	12	
	13	14	15	16	17	18	19	
	20	21	22	23	24	25	26	
July	27	28 NETWORK SPEECH	29 JOINT SESSION SPEECH	30 BUS TOUR →	1 →	2 →	3	UNVEILING + ENDORSEMENTS BRIEFINGS
	4 (HOLIDAY)	5	6	7	8	9	10 TALK SHOW BLITZ →	
	11 TALK SHOW BLITZ	12 RELEASE DOCUMENTS	13 INTRODUCE LEGISLATION	14 ENDORSEMENTS →	15 →	16	17	
	18	19	20	21	22	23	24	
	25	26	27	28	29	30	31	
August	1	2	3	4	5	6 DISTRIBUTE RECESS MATERIALS	7	
	8	9	10	11	12	13	14	LOCAL ORGANIZING
	15	16	17	18	19	20	21	
	22	23	24	25	26	27	28	
September	29	30	31	1	2	3	4	
	5	6 (HOLIDAY)	7	8	9	10	11 TALK SHOW BLITZ	COMMITTEE ACTION
	12 TALK SHOW BLITZ	13	14 STATE YOUTH TOWN MTGS.	15 YOUTH DELS. DEPART	16 YOUTH TOWN MTG (MTV)	17 YOUTH DELS. RETURN HOME	18	
	19	20	21	22	23	24	25	
	26	27	28	29	30	1	2	
October	3	4	5 STATE TOWN MTGS.	6 DELEGATES DEPART	7 NAT'L TOWN MTG.	8 DELEGATES RETURN HOME	9	
	10	11 (HOLIDAY)	12	13	14	15 COMMITTEE ACTION COMPLETE	16	
	17	18	19	20	21	22	23	FLOOR DEBATE
	24	25	26	27	28	29	30	
November	31	1	2	3	4	5	6 TALK SHOW BLITZ	
	7 TALK SHOW BLITZ	8	9 STATE HEALTH CONFERENCES	10 DELEGATES DEPART FOR D.C.	11 HEALTH REFORM LOBBY DAY	12 DELEGATES RETURN HOME	13	
	14	15	16	17	18	19	20	
	21	22	23	24 HOUSE + SENATE PASSAGE	25 (HOLIDAY)	26	27	CONFERENCE
December	28	29	30	1	2	3	4	
	5	6	7	8	9	10	11 TALK SHOW BLITZ	
	12 TALK SHOW BLITZ	13	14 STATE HEALTH RALLIES	15 DELEGATES DEPART FOR D.C.	16 NAT'L HEALTH REFORM RALLY IN D.C.	17 DELEGATES RETURN HOME	18	
	19	20	21	22	23 FINAL PASSAGE	24 BILL SIGNING	25 (HOLIDAY)	
	26	27	28	29	30	31		

APPENDIX A

Sales team on policy: Ira Magaziner
Judy Feder
Walter Zellman

High energy, high-tech presentations that inform, energize and mobilize opinion-makers by giving them (1) an understanding of the magnitude of the problem; and (2) an understanding of how the reform plan will deliver benefits and distribute burdens.

A. Describe the magnitude of the problem and the urgency of passage this year.

B. Explain the cost of doing nothing and how various opponents (regardless of party) profit from delay.

C. Explain how the plan will work by answering 20 questions:

1. How will you guarantee I can never lose my medical protection?
2. How will you eliminate all the loopholes and fine print?
3. How will you stop all the overcharging by insurance, drug and medical corporations?
4. How much will my own insurance cost?
5. What medical benefits will my coverage include?
6. What will be different when I am in a health alliance?
7. Will prescription drugs be covered?
8. Will long-term care be covered?
9. Will mental health be covered? Mental illness?
10. Will I be able to chose my own doctor? How?
11. How will small businesses afford this?
12. Will big businesses be treated the same?
13. If I lose my job am I still covered? What if I work part-time? What about my

children?

14. Will rural areas be treated differently? Cities?

15. How will you change Medicare? Medicaid? The VA?

16. Will abortion be covered?

17. What kind of malpractice reform is in the plan?

18. What will happen to states that have different systems?

19. When will the whole plan be totally phased in?

20. How will you pay for all this? How can you give more for less?

** I have thoughts on these answers, but I will not commit them to paper here.

APPENDIX B

Sales team on winning: Paul Begala
Arnold Bennett
Celinda Lake
Celia Fischer

High energy, high-tech presentations that inform, energize and mobilize opinion-makers by giving them (1) an understanding of the strategy for winning public support and passage; (2) the materials they need to carry the message themselves; and (3) an ongoing method for receiving additional information.

1. Explain what the public perceives and why.

2. Explain what opponents are doing to shape perceptions.
   - Delay and distraction tactics
   - How they are profiting from delay

3. What we must do to change perceptions.

4. Outline the media campaign.
   - Paid media strategy
   - Earned media strategy including "linked" national/local events

5. Give each audience a "mission."
   - Examples of helpful earned media events
   - Examples of other activities -- speakers bureaus, op-ed writing, endorsement letters, Congressional lobbying
   - Distribute talking points, etc., to supplement presentation

6. Outline Congressional strategy.

7. **Establish a system for continuing flow of information from the White House --** briefing schedule, fax broadcast, etc.

HEALTH CARE COMMUNICATIONS STRATEGY

I. OBJECTIVES

To Keep and Mobilize Public Support

- Emphasize the cost of inaction and inadequacy of incremental reform
- Generate positive reviews from trusted opinion-makers
- Provide detailed description of benefits of reform expressed within broad concepts/understanding of current problems
- Continue to expose those responsible for the problem and those who have profited

** LOSE by focusing on mechanical details instead of concepts

To Recruit and Mobilize Opinion-Makers:

- Develop two groups: surrogates and elite policy experts
- Emphasize the cost of inaction and inadequacy of incremental reform
- Bring them in for full briefings on the plan with time for detailed Q & A
- Provide detailed understanding of how benefits will be delivered
- Provide detailed understanding of how burdens will be shared
- Have top health advisors call them to discuss plan and ask for support
- Let them in on strategy for winning public support and passage

** LOSE by failing to make them part of information flow and failing to make them feel included

To Undermine Opponents, they must be:

- Shown as perpetrators and beneficiaries of the problem
- Exposed as divorced from the interests of average Americans
- Exposed as promoting delay to subvert reform
- Isolated from each other to prevent increased credibility

** LOSE by allowing them even one day without intense scrutiny

A. Pre-Unveiling Strategy

Before the unveiling, opponents of reform have the upper hand. They are already defining the plan and setting the terms of the debate before the President does. WE must take control of defining the debate before the unveiling. We have some advantages: opponents must try to attack without a clear target, and are vulnerable to being exposed as selfish, short-sighted and callous. **A tremendous opportunity will have been lost if the following steps are not taken before the plan is unveiled.**

1. **MAKE PUBLIC TRANSITION FROM THE TASK FORCE TO PRESIDENT CLINTON**

- Generate positive "how the package came together" stories
- Photos to show the President is clearly in charge of the process -- making decisions about the health care package

2. **DEFINE THE PROBLEM AS LACK OF SECURITY:**

- Set this up as the main problem -- in speeches, materials, media stories, events -- and use personal stories and hard statistics to back it up.

3. **DELINEATE THE PRINCIPLES OF REFORM:**

- Define concepts and set the terms of debate before the plan is unveiled. We need to sharply define how reform will affect people's daily lives and why we are undertaking it.

- Provide detailed description of **benefits (and burdens) of reform** -- expressed within broad concepts/understanding of current problems.

- Use opinion-makers, and their information networks, to spread/validate the Administration's definitions and protect against attempts by our opponents to set the agenda for us or negatively characterize our underlying concepts

- Brief press immediately after briefing opinion-makers. Do not allow others to translate your concepts to the elite and health beat media. Diminish the value of leaks by filling current news vacuums.

- Prepare materials and develop language to:

  a. **FRAME THE DEBATE**, and set the agenda, in our terms. Our reform will provide continuity and make it possible to preserve the best parts of the current system, which must be strengthened before it falls apart. Without these comprehensive reforms, we will lose the health care we now rely on. Always bring the discussion back to the larger question of comprehensive reform and its benefits; refuse to be continually entangled in defense of individual policy options.

  b. Continue to set the **CONTEXT** by exposing the magnitude of the problem and those who have profited. Emphasize the costs of inaction and the inadequacy of incremental reform. Build trust in reformers/reform process.

  c. Deliver the **POSITIVE MESSAGE** -- How reform will: a) deliver peace of mind to all American families; b) protect small businesses from rising costs; c) end fine print and multiple forms (simplicity); and d) control overcharges and rising costs (savings). DESCRIBE GOALS NOT MECHANICS.

  d. Keep control of the debate by **INOCULATING** against principal attacks: a) reform will cause layoffs (small business); b) we cannot afford reform (deficit/taxes); c) reform will ruin what is best in the current system (choice/quality); d) this plan is too drastic -- all we really need is...

4. EMPHASIZE THE COST OF INACTION AND THE DANGERS OF INADEQUATE ACTION

- Build the case for reform and the arguments for urgency by highlighting what will happen (to families, small businesses, U.S. competitiveness, etc.) if we fail to reform the system this year

- Structure the debate so that all calls for delay come under immediate suspicion/fire. Point to the professional lobbyists who profit from delay.

- Begin to develop the arguments against partial reform, pilot projects, state solutions, etc. Frame our proposal in historical context ("piecemeal reforms have never worked", etc.) -- highlighting previous social legislation (social security, child labor laws) that were bitterly opposed but now are the foundation of our social contract. Point out that these are not "radical surgery" solutions or untested theories but rather ideas that have been around for some time and have been proven successful when tried.

5. PREPARE A CALENDAR OF EVENTS TO:

- a) frame the debate; b) set the context -- the cost of inaction and the profiteering of the status quo; c) deliver the positive message; and d) inoculate against attacks.

- Events should be built for HRC, BC, AGJ, and MEG as well as national and local surrogates and cabinet members.

- See Appendix A -- Communications Calendar (Julia??)

6. REGULARLY AND RELENTLESSLY BRIEF THE PRESS:

- We cannot afford to let others define concepts or set the context within the media. In addition, the media has been known to create stories when none are offered to them. We must set up a press briefing calendar: **Embargoed briefings on the plan IMMEDIATELY BEFORE the unveiling of the plan are crucial.** We should also prepare materials for distribution to them.

- We should also be meeting with every major news organization to gain as much insight as possible and offer as much guidance as they want about the expanded health care coverage they are planning.

7. CONTINUE TO EXPOSE THE MAGNITUDE OF THE PROBLEM, THOSE RESPONSIBLE, AND THOSE WHO HAVE PROFITED

DO NOT: Focus on mechanical details instead of concepts.

8. INTEREST GROUP MONITORING AND RESPONSE; IMPEACH THE CREDIBILITY OF OPPONENTS:

- **Avoid partisan targeting.** Demonstrate that opponents are advocates of delay or inaction, regardless of party affiliation. Moderate Republicans must be broken from conservative ranks.

- Keep media **spotlight on our adversaries.** Expose opponents of reform as "professional lobbyists" with interests divorced from average Americans

  To Do: Document salaries, perks, ideological extremism and provide all to the media.

- Use **classic opposition research** to expose their selfish and shortsighted motivations and obstructionist tactics. Gather enough information -- as far as membership, history, financing/lobbying patterns, campaign against us -- about various health care special interests so that we are well informed about their intentions and resources and have analyzed and prepared the best manner in which to respond to their attacks.

  To Do: Identify one person who will coordinate a comprehensive and innovative interest group monitoring/opposition research shop. This will involve: 1) monitoring Congress to see lobbying that has taken place on the Hill: by whom? to whom? saying what? distributing what?; 2) monitoring interest/industry groups: getting publications, newsletters, and mailings; 3) monitoring ad campaigns; 4) preparing Background notebooks on groups most likely to attack; 5) disseminating that information to media/interested parties

- Document how much opponents will gain by delaying or halting reform

- DO NOT: Target doctors and nurses.

9. RECRUIT AND TRAIN SURROGATES (NATIONAL AND LOCAL):

- Develop an **opinion-maker press strategy** including recruitment and briefings. Concentrate recruitment efforts at the middle band of opinion-makers -- "objective undecideds" such as Henry Aaron, not "opposed-no-matter-what" such as Stuart Butler, nor "already supportive" such as Stuart Altman. **Inform and arm opinion-makers** and give them specific missions: so they are able to positively review the reform plan; increase their comfort level about the policy process; validate the Administration's definitions of key concepts; legitimize our plan; and woo their own colleagues and constituents.

- It is with these opinion-makers that we should continue to **build trust in the reform process** (inclusive, comprehensive, honest) and those involved in it (MDs, nurses, etc.). We should continue to aggressively market the personal stories of the working group members as well as stories about the thoroughness and integrity of the process (audit groups, contrarian process, data-base research, consultation process, number crunching, etc...)

- Prepare extensive **briefing calendar** -- highlighting both the policy, the inclusive process, and the message -- for: friendly interest groups, state and local officials and technical people, Members of Congress and staffs, White House officials, opinion-makers, etc. [See Appendix 2 -- Briefing Calendar]

- Establish the **"Health Care University"** that Daschle suggested. Set up a three-pronged curriculum: 1) policy: lay out the details of the plan, prefaced by the process: how it was developed; 2) message: how to talk about the plan; 3) strategy: Q & A defending the plan. HRC gives the graduation speech -- demonstrating how to talk about the plan. Rockefeller's two "sales SWAT teams" can be used here (and for the briefings described above): one team to explain the plan and related policy concepts and one team to explain the strategy for winning public support and Congressional passage. We should utilize sophisticated presentations, slide shows, poll numbers, etc. Handouts should also be prepared.

- Set up a **network in the states**, with state parties and local contacts, to serve as both a warning and an information-gathering system.

- Set up a **network of opinion-makers** and tap into their organizational information networks to deliver the message (via computers, fax exchanges, regular briefings, local staff organizations, etc.) WJC and HRC media events CANNOT succeed alone -- there must be a chorus of supporting voices.

To: Jeff Eller
Fr: Jason Solomon, [redacted], Rebecca Martin
Re: Briefing Calendar
Date: June 3, 1993

BRIEFING CALENDAR

The attached documents show what we are doing about the briefings before the plan.

Attached are the following:

1) press briefing strategy

2) Congressional briefing strategy

3) overall briefing calendar

The overall calendar includes:

-- Congressional briefings

-- intergovernmental briefings

-- Task Force review group briefings

-- health care opinion leaders/economists briefings

4) a few pages from the media strategy that Laura Quinn wrote as part of Sen. Rockefeller's memo to HRC. It describes how we might brief people that are with us so they can go out and talk up the plan. Each group would get a policy briefing and a briefing on how to help win public support. This is obviously just a proposal -- the people who brief and content of the presentations are likely to be somewhat different.

Also, as the calendar reflects, groups that are not likely to be allies will only get a straight policy briefing -- with no briefing on how to help win public support.

4. **Impeach the credibility of opponents:**

- Avoid partisan targeting. Demonstrate that opponents are advocates of delay or inaction, regardless of party affiliation. Moderate Republicans must be broken from conservative ranks.

- Expose opponents as "professional lobbyists" with values and interests divorced from average Americans (document salaries, perks, ideological extremism, and provide all to the media).

- Use classic opposition research to expose their selfish and short-sighted motivations, and obstructionist tactics (collect mailings, track ad campaigns, investigate expenditures, and provide to the media).

- Document how much opponents will gain by delaying or halting reform.

5. **Recruit opinion-makers: [SEE APPENDIX A and B]**

- Use two "sales SWAT teams" to initially recruit and then regularly update opinion-makers -- one team sells the plan and related policy concepts, and one team sells the strategy for winning public support and passage. Use slick presentations, slide shows, poll numbers, the whole nine yards, and chose the "salesmen" for their sales talent -- this is no place for anyone with an arrogant or secretive approach.

- Inform and arm opinion-makers and give them specific missions: so they are able to positively review the reform plan; validate the Administration's definitions of key concepts; and woo their own colleagues and constituents.

- Form a network of opinion-makers and tap into their organizational information networks to delivery the message (via computers, fax exchanges, regular briefings, local staff organizations, etc.). WJC and HRC media events (network and/or local) CANNOT succeed alone -- there must be a chorus of supporting voices. Deliver message with a fire hose, not an eye dropper.

6. **Control definition of concepts:**

- Concepts should be defined <u>before</u> the plan is unveiled. Use opinion-makers, and their information networks, to spread the

APPENDIX A

Sales team on policy: Ira Magaziner
Judy Feder
Walter Zellman

High energy, high-tech presentations that inform, energize and mobilize opinion-makers by giving them (1) an understanding of the magnitude of the problem; and (2) an understanding of how the reform plan will deliver benefits and distribute burdens.

A. Describe the magnitude of the problem and the urgency of passage this year.

B. Explain the cost of doing nothing and how various opponents (regardless of party) profit from delay.

C. Explain how the plan will work by answering 20 questions:

1. How will you guarantee I can never lose my medical protection?
2. How will you eliminate all the loopholes and fine print?
3. How will you stop all the overcharging by insurance, drug and medical corporations?
4. How much will my own insurance cost?
5. What medical benefits will my coverage include?
6. What will be different when I am in a health alliance?
7. Will prescription drugs be covered?
8. Will long-term care be covered?
9. Will mental health be covered? Mental illness?
10. Will I be able to chose my own doctor? How?
11. How will small businesses afford this?
12. Will big businesses be treated the same?
13. If I lose my job am I still covered? What if I work part-time? What about my

children?

14. Will rural areas be treated differently? Cities?

15. How will you change Medicare? Medicaid? The VA?

16. Will abortion be covered?

17. What kind of malpractice reform is in the plan?

18. What will happen to states that have different systems?

19. When will the whole plan be totally phased in?

20. How will you pay for all this? How can you give more for less?

** **I have thoughts on these answers, but I will not commit them to paper here.**

APPENDIX B

Sales team on winning: Paul Begala
Arnold Bennett
Celinda Lake
Celia Fischer

High energy, high-tech presentations that inform, energize and mobilize opinion-makers by giving them (1) an understanding of the strategy for winning public support and passage; (2) the materials they need to carry the message themselves; and (3) an ongoing method for receiving additional information.

1. Explain what the public perceives and why.

2. Explain what opponents are doing to shape perceptions.
   - Delay and distraction tactics
   - How they are profiting from delay

3. What we must do to change perceptions.

4. Outline the media campaign.
   - Paid media strategy
   - Earned media strategy including "linked" national/local events

5. Give each audience a "mission."
   - Examples of helpful earned media events
   - Examples of other activities -- speakers bureaus, op-ed writing, endorsement letters, Congressional lobbying
   - Distribute talking points, etc., to supplement presentation

6. Outline Congressional strategy.

7. **Establish a system for continuing flow of information from the White House --** briefing schedule, fax broadcast, etc.

MEMORANDUM

TO: JEFF ELLER
FROM: JULIA MOFFETT
DATE: 06/01/93
RE: HEALTH CARE CALENDER/LAUNCH

Attached are three scenarios for the roll-out of the health care plan:

1) Scenario I is a two week lead-in to the speech on June 22. Activities then continue until July 2, when POTUS leaves for Japan. This plan is somewhat unrealistic, as reconciliation is supposed to be done 6/15 at the earliest.

2) Scenario II is a one week lead-in immediately following reconciliation with the speech still on June 22. Activities would also continue until July 2 when he leaves for Japan.

3) Scenario III is a one week lead-in to the speech which would begin on 7/15 when POTUS returns from Japan. The speech would then be scheduled for 7/20. The period after the speech would be totally contingent on what we needed to accomplish both with the public and Congress before their recess on 8/5.

There are several points to be made in conjunction with these draft schedules.

1) For sake of brevity, these calenders do not go into detail about each individual event. I have tons of information and ideas about each event, but thought I would wait to discuss until the general concepts are signed off on.

2) As I mentioned above, after the initial post-speech bus trip, we need to determine the goals and message of POTUS activity. Once that is done, I can throw together ideas for events very quickly.

These schedules reflect some preliminary consensus arrived at in meetings with Mandy, Stan, David, Bob, et al...These assumptions are listed below, but should probably be revisited and signed off on one more time before we move forward. They are:

Assumption #1:
We want to unveil three pieces of the plan prior to the speech in order to reduce the amount of information people must digest on Wednesday after the speech and also to innoculate ourselves from attacks. The three policy components are single-form insurance, malpractice reform and voluntary drug price controls. We would also like to do a business event and cost-shifting event if time warrants.

Assumption #2

If we have two weeks for the lead-in to the speech, we would like to spend the first week restating the problem for people through the creative generation of press in conjunction with BC and HRC events. The next week would then be spent showing people how we intend to fix them. It is also important that we sign off on how we will talk about the problems before we determine the events--are they security or cost or portability, etc...? This, however, is only possible in one of our scenarios.

Assumption #3

We want POTUS to travel out of D.C. heavily ~~before~~ after the speech. This has been initially cleared through Marcia.

Assumption #4

Health-care related cabinet-members will travel to regional watch parties for the speech to the joint Session.

Assumption #5

We will do a national network town hall on the Thursday following the speech.

Assumption #6

We will do a St. Louis-Kansas City bus trip following the speech.

Assumption #7

In most cases, crowd events will be substituted for more "educational" events.

In addition to these basic operating assumptions, I would like to raise a few issues that I feel are unresolved and should be discussed at some point:

1) As I mentioned before, I think we should explore new formats or ways of doing town halls so as to set health-care apart from our other initiatives and to enable POTUS to get his message across more effectively.

2) I have reservations about the post-speech bus trip. It is so short that I think it questions the purpose of bus trips- in part to cover a lot of ground and see a lot of people. Because it will be our first bus trip since the election, and in the July scenario the first anniversary of the bus trip, I am afraid that "bus trip" stories will overwhelm and detract from the health-care message--a message we all agree needs to be clear, direct and educational. Lastly, because crowd events are not entirely appropriate for this issue, I am very concerned that the events on the bus trip will lack energy and will seem very unpresidential. As we all know, crowds made so much of the success of the past bus trips.

This topic, I believe, leads into a larger unresolved question which could use another discussion or two--have we decided the exact role of POTUS in this campaign and have we decided what type of a campaign this should be? I am still unclear whether this should be POTUS on the road "selling" this in a concentrated way, or whether we have more of a combination scenario in which he is here leading the fight in a more strong or traditional manner?

3) I think we should have a separate conversation about how we interact with Congress in the lead-in period and immediately following the speech. Once this is determined, events can be added into the schedule. I am supportive of several events so that we don't leave members going home for recess without incentive or confidence.

4) One unresolved "big picture" issue that affects the calender is how we interact with and speak about special interests which support us. Do we show us standing hand in hand with them or do we distance ourselves? I am speaking primarily about consumer, senior, doctor groups.

5) In instances where we can travel, I have used Celia's targeting list to identify states. This needs to go to the next level for House districts. The list, however, is not too instructive until we have the plan for members to react to.

6) I believe strongly that other principals, especially HRC and Donna Shalala, can play a very large role in getting out messages we need to send if we target and isolate their appearances. For instance, if previewed enough, Shalala's commencement address to Harvard Medical School could unveil a piece of the policy.

TO: Hillary Clinton
FR: Lisa Caputo, Anne Lewis, Bob Boorstin
RE: Updated Health Care Communications Strategy
DT: March 14, 1993

You have received very good press coverage over the past month with regard to your involvement in the health care issue. Two images repeatedly appear in the media coverage of the health care issue: 1) stories related to your appearances, which frame the challenge of health care reform as arising from the experience of real Americans and convey your empathy as a compelling motivation for this effort 2) stories related to the working group and its process, which frame this effort as faceless and secretive. In light of the string of stories on the "secrecy" of the workings of the Health Care Task Force as well as the recent news reports resulting from leaks, we need to develop the next phase of our communications strategy.

The Task Force is beginning to wrap up the consulting stage of its process and move into the process of developing the policy. We must decide what parts of the policy we would like to put out to the media to inoculate and what parts of the policy we feel we must save until May. In addition, we must be aggressive and counter the secrecy issue by putting a human face on the task force work.

We propose the following the strategy over the next few weeks:

1) You should do three briefings with three groups of health care press. This will be three 30 minute briefings that will be on the record. We will split the groups up into 3 groups of 10.

2) You should do a health care event in Michigan with doctors. By being seen with doctors who call for reform, we can begin to inoculate.

3) We pick 4-5 members of the working groups and set them up with select media interviews to talk about their personal commitment to health reform and give "faces" to the task force.

4) We allow photographers to photograph select people in the working groups reading and responding to mail.

5) We have a doctor do the Brazda breakfast, a breakfast with health care reporters.

7) We do a press release on newsworthy exchanges between you and participants in the Robert Wood Johnson Foundation Forums.

8) You and the President jointly participate in the Kiwanis International's child immunization psa campaign. Child immunization month is in April so we would need to cut the psas

right away this month as soon as you and the President sign off. Participating in the Kiwanis International's campaign will entail cutting a radio psa and a television psa, recording a 15-minute education video to be shown in health clinics across the country, and writing a 1,000 word column for Kiwanis magazine. The psas and the video need to be recorded in March.

9) You should do a one on one interview with Business Week's Susan Garland.

10) You should do a one on one interview with Hillary Stout of the Wall Street Journal.

11) You should participate in NPR's Talk of the Nation as part of your public outreach in health care. They would conduct a public forum over the radio in which you would talk to listeners about their views on health care issues. They would not ask you questions; you would ask the listeners questions. You would do the show for 30 minutes between 2pm and 4pm on Monday, Tuesday, Wednesday or Thursday. We would work with NPR to screen the listener calls.

12) You should do a roundtable with the small business trade press.

13) You should do the Hunt dinner (off the record) or the Hunt lunch (on the record).

14) You should consider doing the New York Times editorial board in light of their recent editorial and stories about the "secrecy" of the Health Care Task Force operations.

15) The President and the Vice President should each do a health care event. The President should do a major health care policy address or visit an example of a success in the health care system (ie. Puget Sound).

TO: Hillary, Maggie, Melanne
FR: Lisa
cc: Boorstin, Neel, Karen
RE: Media Strategy for March
DT: March 1, 1993

Your press has been excellent over the past month with regard to your efforts as chair of the President's Health Care Task Force. Your favorabilities as reported in the media are very high. People like you and think you are doing a good job.

Because you are riding so high, I believe we must set forth a strategy over the next month to protect you from the negative press attacks that are likely to come in response to your positive press. The press will begin to take some knocks at you. The first will be Nightline, which is doing 3 6-7 minute taped segments for their show Friday. The segments are: The Hillary phenomenon, Hillary and Health Care, Hillary's Power and Influence in the White House. The fact that Nightline is doing three separate segments is an indication that the press are looking to know you down in some way. We must take some steps to counter the knocks.

I propose the following press strategy over the next month:

National Press:

1) Do a sit down interview with Ron Fournier of AP on health care. This should be done in the White House, perhaps over tea. This is an essential interview to do because AP's outreach is widespread. In addition, Ron Fournier likes you and has the institutional memory of what you did in Arkansas.

2) Do the next scheduled off the record health care briefing, which will probably be the week of March 8th. As you know, we have set up off the record briefings with health care reporters with Ira and Judy and members of the various working groups. The point of these briefings is to de-mystify the workings of the Task Force and also to attempt to bring the press around to what we are doing. We are attempting to inoculate now.

3) Do a one on one interview with Susan Garland of Business Week. Susan Garland will write a very fair story. Maggie and Melanne know her and like her a great deal. She covers health and childrens issues for the magazine. We should target the Business Week audience because I feel we need muster their support as well as send them a message.

4) Do a one on one interview with Hillary Stout of the Wall Street Journal. Hillary is the health care reporter for the Journal. The reasons for targeting the Journal are the very same ones for doing Business Week.

5) Do a television magazine show, preferably with NBC or CBS because we have done two major shows with ABC (Prime Time Live and the Children's Town Meeting with Peter Jennings), that will air sometime in May. We should use this window before the Health Care Task Force recommendation is made because then the political and more in depth substantive questions will be asked of you to address. If we use this window now, we can have more control over the story. This show should be about the balancing act that you do which represents what most American women are doing across the country. I envision this story would be comprised of the following components: 1) you in action in the field as chair of the health care task force attending public forums listening and talking to real people about health care; 2) your involvement in planning the first official dinner -- selecting the menu, flowers, etc; 3) optional -- b-roll of you attending one of Chelsea's soccer games or making a run to the local supermarket. 4) One on one interview.

The reason to do such a show is to show the person you are -- someone who is doing it all. My suggestion is that we either do this show with Deborah Norville of CBS Street Stories, Jane Pauley of NBC Dateline, Maria Shriver of NBC First Person. I lean towards Maria Shriver since she has committed doing an hour long show, has a large audience and says she does not need a sitdown interview. She does not see this as a conversation with Hillary Clinton, but rather showing you in action doing the balancing act.

6) Invite one of the morning shows to carry one of your upcoming public forums live (Iowa, Florida or Michigan). It would not be a town meeting. The idea would be to have the morning show carry the interaction and exchange between you and people talking about health care. Ideally the show would devote a half hour segment to health care and the forum. The segment should include an interview between you and the anchor.

7) NPR's Talk of the Nation has expressed an interest in having you participate in its show as part of your public outreach on health care. What they have proposed is conducting a public forum over the radio, in which you would talk to listeners about their views on health care issues. They would not ask you questions; rather you would ask them questions. Our office would work with NPR to screen the calls. The proposal would be to do the show for 30 minutes between 2pm and 4pm on Monday, Tuesday, Wednesday or Thursday.

8) WGBH, a PBS affiliate, has proposed putting together a health care forum with the First Lady which would be carried nationally by PBS. We would also arrange to have NPR carry it live. WGBH is putting a proposal together and we will proceed from there.

9) Judy Woodruff of MacNeil-Lehrer has proposed doing a 25 minute piece at the end of May after the Task Force makes its report on how the process was conducted. This would entail Judy

traveling to some events and also filming some of the working group sessions. Judy wants to show the stages of the Task Force's work and hlep the public understand how the Task Force reaches its final goal in May.

10) Nightline would like to show the internal workings of the Task Force, similar to what Judy Woodruff wants to do. I feel that we should choose between Nightline and MacNeil-Lehrer.

11) Kiwanis International has proposed that you do their child immunization psa campaign. I would suggest that this be given to the President.

12) Do a roundtable with the small business trade press. Boorstin and I would coordinate together.

13) Mirabella is doing a health care issue in June that will publish the results of a survey conducated by the Society for the Advancement of Women's Health Research. Susan Blumenthal is a member of this group. The magazine very much wants to empahsize prevention. In addition to the results, the magazine will run an article in which experts will address various women's health issues one by one (ie. breast cancer, ovarian cancer, etc). There will also be a large pull out section in which experts will make suggests on what women should be doing to stay healthy and take precautions at different stages in their lives. The magazine envisions that this is something that would be pinned to the refrigerator or on a bulletin board. Mirabella would like you to be a part of this issue by putting you on the cover and also doing a brief interview with Grace Mirabella talking about the importance of prevention.

14) We should schedule meetings during March with the five columnists I suggested. It is important to see these people now, well before the health care proposal is announced. I think that we should lock them down now: David Gergan (done), Mark Shields, George Will, David Broder, Michael Kinsley.

<u>Local Press</u>:
1) Satellite Feeds -- You should begin to do regular satellite feeds into regions you will be visiting to do health care events. We should do these feeds at least two days out from the trip.

2) Media conference calls -- You should do 2 20 minute health care conference calls with radio stations and major newspapers in a particular region that you are planning to visit. Again these calls should take place 1-2 days before you go into that region.

3) Editorial Writers -- I think it is important for you to spend time with local newspaper editorial writers when you make your trips into different state so that we make an attempt to gain an endorsement of the Task Force efforts.

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Bob Boorstin to Mrs. Clinton; RE: Transition from Task Force's Plan to President's Plan (2 pages)	04/17/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10250

FOLDER TITLE:
Health Care Schedules

Debbie Bush
2006-0810-F
db2293

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]

To: Mrs. Clinton
Fr: Bob Boorstin
Re: Transition From Task Force's Plan to President's Plan
Date: April 17, 1993

As we have previously discussed, there must be some point at which the public sees that the health-care proposal is no longer the work of only the Task Force but also of the President. Originally, we (the communications team) had envisioned some kind of "handing over of the baton," perhaps in a formal event. However, we now feel that it might be preferable to make the transition less clear-cut.

Below are a few options for this transition.

1) Public event around May 17 with you and the Task Force literally handing off your work to the President

This is what we had originally envisioned. The handoff would publicly demonstrate that you had completed your assignment, and it would then become the President's plan.

However, such an event raises several questions. What would the work be? Would it be a single set of recommendations or a set of options? Wouldn't the report have to be released to the press given the charges of secrecy already levelled against us? And wouldn't such a report then be picked apart that week before the President's speech? Wouldn't such a limited time between the report and the President's speech raise questions about the extent of the President's involvement in formulating his health-care plan? Given these questions, we considered option 2.

2) Public event around May 3 with you and the Task Force literally handing off your work to the President

Under this scenario, we would have several photo ops of the President meeting with health advisers, economic advisers, Congressional leaders, and other groups in an effort to show the President's extensive involvement in trying to come up with a health reform proposal that works for people. This option leaves plenty of time to show the President involved with the process. However, it leaves the problem of putting out a report that would be scrutinized. And the differences between your Task Force's recommendations and the President's proposal would give the press a field day.

3) Informal transition without public event (now the group's preferred option)

This transition could start in about two weeks. We could use photo ops as described above to show the President's involvement, but we would not have any kind of report. The series of photo ops would show Task Force working meetings on a number of different issues, similar to meetings held before the announcement of the economic plan. It would be clear that this was truly a team effort, but one led by the President.

There would likely be questions about a final product from the Task Force. However, we could maintain that the Task Force generated no paper; only the working groups provided papers for use in the development of the President's proposal.

Congressional

Interest Groups

Leadership dinners - 3 dinners to Spring - Roosevelt or Clinton office May 6/8 dinner

* Health Care People Reception - April 29th

* HHS - HRC to talk to people who worked plant

May - 1st or 2nd week - Pres + Task Force Mtg

** → Federal Register - Steve Newman ←

- Spring and week's mtgs

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	RE: "Hot" Button Issues (2 pages)	n.d.	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
First Lady's Press Office (Lisa Caputo)
OA/Box Number: 10251

FOLDER TITLE:
Lisa Caputo's Health Care Reference Book [Binder] [2]

Debbie Bush
2006-0810-F
db2294

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]
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   When dealing with this community, you may prefer to use the terms "LEGAL RESIDENTS AND CITIZENS" together and in that order at all times. This will help avoid an adverse reaction to the term "CITIZEN" which connotes excluding a large part of the Hispanic population.

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   SUGGESTED RESPONSE: Under reform, we will retain current law that covers "undocumented persons" and we will strengthen the safety net programs for vulnerable populations.

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ISSUE: The United States/Puerto Rico relationship is an emotional issue to Puerto Ricans. Although Puerto Rico is a territory and a part of this country, residents fell that they are treated as second class citizens. They want to be treated equally and included in the new health care system.

SUGGESTED RESPONSE: All legal residents and citizens will be guaranteed coverage without regard to where they live, how much they earn, whether and where they are employed, and whether they have a so-called preexisting condition. Puerto Ricans are United States citizens and therefore will be treated as such.

(You may prefer to avoid reference to the status of Puerto Rico as a territory or as "dependent" on the United States to avoid an adverse reaction.)

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001a. paper	RE: Talking Points on Health Care Task Force [partial] (2 pages)	02/03/1993	P5
001b. paper	RE: Talking Points on Health Care Task Force [partial] (2 pages)	02/03/1993	P5

COLLECTION:
Clinton Presidential Records
First Lady's Office
Lisa Caputo (First Lady's Press Office)
OA/Box Number: 10251

FOLDER TITLE:
Lisa Caputo's Health Care Reference Book [Binder] [3]

Debbie Bush
2006-0810-F
db2295

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]

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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]
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2-3-93

Talking Points on Health Care Task Force

(Prepared by Lisa, Maggie, Vince and Steve)
WITH HRC REVISIONS

- Hillary Clinton is the chair of the President's Health Care Task Force. The task force consists of Cabinet members from the Departments of Defense, Commerce, Labor, HHS, and Veterans Affairs as well as the OMB Director, the President's Domestic and Economic Policy advisors, the Chair of the Council of Economic Advisors and the President's Senior Advisor for Policy Development, White House Staff and other government officials.

-Ira Magaziner is leading a working group which will provide information to the Health Care Task Force. The task force will review information from the working group and make recommendations to the President.

-The working group will be consists of government employees.

-The working group will consult with a wide range of citizens, representing the public and private sectors.

-On January 25, the President announced the formation of the Health Care Task Force and defined its mission. It has not yet held a meeting.

-The task force is planning to hold some public meetings. Those meetings have not been scheduled.

Note: In response to the question: Does FACA apply to the Task Force? In the opinion of the Counsel to the President, it does not.

In response to the question: Did the Task Force violate FACA?
1. In the opinion of the Counsel to the President FACA does not apply.

2. The Task Force has not met, nor taken any action to date.

Note: ONLY USE POINT THREE IF PRESSED.

3. The participation of the first Lady, does not create "a presidential advisory committee" subject to the Act.

In response to the question: Does FACA apply to the working group? No.

Note: TRY TO AVOID QUESTIONS ON FOIA.

In response to any questions on FOIA: Any requests under FOIA will be reviewed by the White House Counsel at the time that they are made.

* Mrs. Clinton is a consultant to the working group and is coordinating the activities of the working group.

* Bruce there is we want to inform health care let's not lose sight of that.

* Hillary is not a member of the working group, she will be a consultant to the working group.

** As a member of the Task Force, she will be working with the working group + Ira. All members of the Task Force.

2-2-93

Talking Points on Health Care Task Force

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- Hillary Clinton is the chair of the President's Health Care Task Force. The Task Force consists of Cabinet members from the Departments of Defense, Commerce, Labor, HHS, and Veterans Affairs as well as the OMB Director, the President's Domestic and Economic Policy advisors, the Chair of the Council of Economic Advisors and the President's Senior Advisor for Policy Development.

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-The working group will be consist of fulltime government employees, most of whom have been selected to serve on the working group by members of the Task Force.

-The working group will consult with a wide range of citizens, representing the public and private sectors.

-On January 25, the President announced the formation of his National Health Care Task Force and defined its mission.

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in public but that determination will be made as its work progresses.

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In response to any questions on FOIA: Any requests under FOIA will be reviewed at the time that they are made.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Christine Heenan to Communications Group; RE: Casting Health Alliances in a postive light [partial] (2 pages)	04/06	P5
002. memo	Chris Jennings to Hillary Rodham Clinton; RE: Senate Republicans to Target as Possible Supporters and Senate Democrats to Attract and Keep on Board (4 pages)	03/22/1993	P5
003. paper	RE: "Hot" Button Issues (2 pages)	n.d.	P5
004. memo	Carolyn Gatz to Ira Magaziner; RE: personal [partial] (1 page)	03/08/1993	P6/b(6)
005. list	Health Care Communications Team; RE: Phone numbers [partial] (1 page)	n.d.	P6/b(6)

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db1744

RESTRICTION CODES

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FYI -
Lisa

ch draft 4/6

To: Communications Group
Fr: Christine Heenan
Re: Casting health alliances in a positive light

Background:

Under the proposed system, most Americans will buy their health insurance through health alliances (a.k.a. "purchasing cooperatives", "HIPCs", "CHIPAs", etc.). These health alliances will negotiate premium rates with competing plans and will offer a range of health plans to individuals and families. These alliances may be government agencies, quasi-public agencies, or private non-profit organizations.[1]

The Challenge:

health alliances, or whatever we call them, are unfamiliar structures to most people, and could easily be perceived as an additional layer of bureaucracy imposed between them and their doctor or health plan. For employed people who will now get coverage through the health alliance, it could be argued that the health alliance is not a new layer: it simply replaces the Benefits Administration office in their company. That too may be a problematic sell-- the connection to an internal benefits office seems more direct and intimate; it's where you get your life insurance, your 401k or pension plan, etc., as opposed to an external organization, particularly one run by the government. "health alliances are a new layer of bureaucracy" is also a likely attack from providers or insurers who perceive that the existence of these "group buyers" will undercut their current function or their ability to make money.

Possible strategies:

There are two approaches: either we try to make them invisible, and constantly downplay their role in the new system, or we try to assign them an identity that will create a positive, non-bureaucratic association for people.

1) <u>Downplay the role of health alliances</u>

If we accept that health alliances are difficult to explain or redefine in a way that will result in a positive association for most people, we could choose to ignore them in our description of the system. We can make the point about the pooled purchasing

---

[1] These decisions haven't been made-- it may be that states get to decide how they want HIPCs structured, with federal guidelines dictating only what they <u>can't</u> be.

power buying better products at better prices without referring to the entity that does the negotiating and buying. We could describe the system as one in which individuals are pooled into large groups and offered a choice among different health care plans.

2) Redefine health alliances

These health alliances have a few basic functions:

They negotiate price for a health care product. With the collective bargaining power of 50-100% of the consumer market, they will negotiate with accountable health plans to get the best price possible for the specific product they're buying.

They purchase health care products. After having negotiated a price, they actually "buy"-- they contract with the plans for the provision of care to enrolled consumers.

They guarantee the quality of the product they sell. Health alliances will be responsible for enforcing quality standards, gathering, comparing, and publishing outcomes data among plans, and for making sure all necessary and appropriate care is provided by contracted plans.

They sell health care products. Individuals, businesses, and government will purchase health plans through the local health alliance. (The alliance will be to whom they pay premiums).

They pool groups of people and offer them a service. Individuals and public and private sector employees will all buy insurance through the health alliance. In turn the alliance will provide them with quality products at prices negotiated based on the size of the larger group, not just that individual or firm. The alliance will collect and distribute premiums, monitor plan performance, possibly handle enrollment, disenrollment, etc.

Depending on which of these functions, (or which group of them) is most palatable to people, we could associate the organizations with that role.

health alliance as coalition of businesses
health alliance as champion of the consumer
health alliance as bargainer
health alliance as health care store
health alliance as quality guarantor
health alliance as club

APPENDIX 4

M E M O R A N D U M

TO: Hillary Rodham Clinton March 22, 1993
FR: Chris Jennings
RE: Senate Republicans to Target as Possible Supporters and Senate Democrats to Attract and Keep on Board
cc: Legislative/Congressional Distribution List

As you know, it is now virtually certain that the President's health care proposal will require at least one 60 Member vote to have a chance of passing the Senate. (If the proposal is merged into reconciliation, 60 votes will be required to waive the Byrd rule; if it is a free standing bill, 60 votes will be required to achieve cloture on debate and to bring an end to a likely Republican fillibuster).

With the above in mind, and because we cannot count on all 57 Democrats (possibly 56 by the time of the roll call) to vote with us, we must build on and improve our ongoing efforts to attract a core group of Republicans to vote with the President on his health reform proposal. Similarly, we must attract and retain support from a fairly sizable list of Democrats who, for a variety of reasons, may be nervous about voting with us.

In an effort to pool the information we have on the target Senate Members, we convened a group including Steve Ricchetti and his staff, Melanne, Christine Heenan, HHS's Jerry Klepner, Karen Pollitz and Alan Hoffman, DNC's Celia Fischer, and Steve Edelstein and his War Room staff. (The group now meets every Friday). We found ourselves to be in significant agreement on which Senators we currently believe that the Administration and the DNC should target; I have attached a list and some cross-referencing information about this list for your use. In addition, the information we produced through this discussion will be summarized and distributed in short order.

The 14 Republicans we chose are the ever-shrinking number of Members who -- because they are viewed as moderates, have special populations to worry about, and/or are coming up on an election or retirement -- are the most likely to cross over and support us. (FYI, according to Republican staff, these Members will attempt to stick together in a block so as to strengthen their bargaining leverage IF any such minority block of Republicans forms; in other words, they plan to exert tremendous pressure on one another to block "straggler" Republican support).

The Democrats we chose are those who are historically moderate to conservative Members or who, because of their constituency or Committee assignment, are particularly sensitive to specific special interest concerns. It is important to stress that, as we are targeting these Members, we must not ignore or alienate our relatively solid progressive support base.

REPUBLICANS

	Senator	Relevant Committee Assignment
1.	Christopher Bond (MO)*	Appropriations Committee
2.	Conrad Burns (MT)* XX	Appropriations Committee
3.	John Chafee (RI) XX	**FINANCE COMMITTEE**, Health Care Task Force Chair
4.	Bill Cohen (ME) XX	Judiciary Committee
5.	Alfonse D'Amato (NY) XX	Appropriations Committee
6.	John Danforth (MO)	**FINANCE COMMITTEE**
7.	Dave Durenberger (MN) XX	**FINANCE** and Labor Committees
8.	Mark Hatfield (OR)	Appropriations Committee
9.	Jim Jeffords (VT) XX	Labor Committee
10.	Nancy Kassebaum (KS)	Labor Committee, Ranking
11.	Connie Mack (FL)* XX	Appropriations Committee
12.	Bob Packwood (OR)	**FINANCE COMMITTEE**, Ranking
13.	Bill Roth (DE)* XX	**FINANCE** & Gov. Affairs
14.	Arlen Specter (PA)* XX	Appropriations and Judiciary

* Although all will be a great challenge, these 5 Senators will be the most difficult to get on board.

XX Notably, 9 out of the 14 targeted Members have Democratic Senator counterparts. (In fact, 11 of 14 have Democratic Governors). If these Dems are on board, it will make it much more difficult for Republicans to oppose the Clinton plan.

NOTE: Seven out of the 14 are either Finance or Labor Committee Members or both (in the case of Durenberger) -- the two primary Senate health committees. Five of these Members serve on the all-important Finance Committee.

Lastly, although highly doubtful supporters, significant efforts should be made to make the following influential Members uncomfortable about engaging in active opposition: (1) Bob Dole (KS, Minority Leader, & Finance Committee Member), (2) Alan Simpson (WY, Minority Whip, Judiciary Committee), (3) Orin Hatch (UT, Finance and Judiciary Committee, Ranking Member), and (4) Pete Domenici (NM, Budget Committee Ranking Republican and Appropriations Committee).

DEMOCRATS

	Senator	Relevant Committee Assignment
1.	Max Baucus (MT)	Finance Committee
2.	David Boren (OK) *	Finance Committee
3.	Bill Bradley (NJ)	Finance Committee
4.	John Breaux (LA)	Finance Committee
5.	Richard Bryan (NV)	
6.	Dennis DeConcini (AZ) *	Appropriations, Judiciary
7.	Chris Dodd (CT)	Labor and Human Resources
8.	Jim Exon (NB) *	
9.	Wendell Ford (KY)	
10.	Bob Graham (FL)	
11.	Howell Heflin (AL) *	Judiciary Committee
12.	Earnest Hollings (SC)	Appropriations Committee
13.	J. Bennett Johnston (LA) *	Appropriations Committee
14.	Bob Kerrey (NB)	Appropriations Committee
15.	Herb Kohl (WI)	Judiciary Committee
16.	Bob Krueger (TX)	
17.	Frank Lautenberg (NJ)	Appropriations Committee
18.	Joseph Lieberman (CT)	
19.	Daniel Patrick Moynihan (NY)	Finance Committee
20.	Sam Nunn (GA) *	
21.	Harry Reid (NV)	Appropriations Committee
22.	Charles Robb (VA)	
23.	Richard Shelby (AL) *	

* Indicates the 7 Senators who probably will be the most difficult to get on board.

TOTAL STATES/MEMBERS TARGETED IN THE PRELIMINARY SENATE STRATEGY

	State	Senator(s)	Governor
1.	Alabama	Heflin and Shelby	Hunt (R)
2.	Arizona X	DeConcini	Symington (R)
3.	Connecticut	Dodd and Lieberman	Weicker (I)
4.	Delaware	Roth	Carper (D)
5.	Florida	Graham and Mack	Chiles (D)
6.	Georgia X	Nunn	Miller (D)
7.	Kansas	Dole and Kassebaum	Finney (D)
8.	Kentucky X	Ford	Jones (D)
9.	Louisiana	Breaux and Johnston	Edwards (D)
10.	Maine X	Cohen	McKernan (R)
11.	Minnesota	Durenberger	Carlson (R)
12.	Missouri	Bond and Danforth	Carnahan (D)
13.	Montana	Baucus and Burns	Raciot (R)
14.	Nebraska	Exon and Kerrey	Nelson (D)
15.	Nevada	Bryan and Reid	Miller (D)
16.	New Jersey	Bradley/Lautenberg	Florio (D)
17.	New Mexico X	Domenici	King (D)
18.	New York	D'Amato and Moynihan	Cuomo (D)
19.	Oklahoma	Boren	Walters (D)
20.	Oregon	Hatfield/Packwood	Roberts (D)
21.	Pennsylvania X	Specter	Casey (D)
22.	Rhode Island	Chafee	Sundlun (D)
23.	South Carolina X	Hollings	Campbell (R)
24.	Texas X	Krueger	Richards (D)
25.	Utah	Hatch	Leavitt (R)
26.	Vermont X	Jeffords	Dean (D)
27.	Virginia X	Robb	Wilder (D)
28.	Wisconsin X	Kohl	Thompson (R)
29.	Wyoming X	Simpson	Sullivan (D)
Total Number of Senators:		41*	20 out of 29 are Dem Govs.

* This includes the 4 additional target Republican Senators of Dole, Simpson, Hatch, and Domenici.

NOTE: If the DNC does not have the resources to target all 29 states, they should choose (generally) to eliminate first those states that have only one target Senator and whose Senator does not serve on the Finance Committee. There are 12 such states marked with an X, but my 6 lowest priorities would be Georgia, Kentucky, New Mexico, Texas, Wisconsin, and Wyoming. (I can talk about others if necessary; in addition, exceptions to the Finance and/or 2 Member rule might be Delaware, Utah, and Alabama).

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Press List; RE: DOB's, SSN's, and passport numbers [partial] (14 pages)	03/26/1993	P6/b(6)
002. memo	Stanley B. Greenberg to Bob Boorstin; RE: Positioning the Health Care Initiative (24 pages)	03/31/1993	P5

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Lisa Caputo (First Lady's Press Office)
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FOLDER TITLE:
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Debbie Bush
2006-0810-F
db1745

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GREENBERG·LAKE
THE ANALYSIS GROUP INC

515 SECOND STREET NE
WASHINGTON DC 20002
202 547 5200

~~CONFIDENTIAL~~
(7 of 11 copies)

DATE: March 31, 1993

TO: Bob Boorstin

FROM: Stanley B. Greenberg

RE: POSITIONING THE HEALTH CARE INITIATIVE

The administration is in a strong position to present a health care plan that will excite the nation and lay the basis for long-term support. Positioned properly, the health care plan can prove even more popular than the economic program -- marginalizing opponents, generating enthusiasm and even a touch of bipartisanship. But people's feelings about health care are complicated, as reflected in these surveys. To sustain support over 6 months will require a campaign of change and reassurance, which is the subject of this memorandum.

The observations and recommendations here are based on the health care survey and focus groups conducted for the Democratic National Committee. The author also had access to a number of other surveys that he used freely to develop the best possible action plan. The research base is outlined below:

Greenberg Research	national survey focus groups (IL and CA)
Service Employees International Union Celinda Lake	national survey focus groups (IL)
Novalis Corporation	national survey
NBC/Wall Street Journal Peter Hart	national survey
Medica Foundation Greenberg/Quinlan	Minnesota survey
Kaiser Foundation Lou Harris	national survey focus groups (small business)
Insurance Industry Melman-Lazarus	national survey

The health care initiative must be bold, reflecting the public's desire to overhaul the system; it must touch on powerful emotions that keep people focused on the possibility of change. At the same time, it must offer critical reassurances to maintain broad support for the plan over a long campaign. Some of the findings and recommendations are highlighted below:

- Use the anticipated burst of support for the economic plan to establish confident presidential leadership, build bipartisan support in the country, and foster unprecedented public pressure on Congress.

- The public is very concerned about health care, but it is a weak second to the economy. It will require a sustained campaign to keep the public focused over more than 6 months.

- People want big change, but they are scared of it: as many people worry about what reform will bring as worry that the status quo will go unchanged. People hate the system, but they are protective of their own health care situation. The campaign must promote change but our goals must also include security and stability -- "peace-of-mind" in a changing world.

- The plan should be "phased-in" -- not as a matter of necessity, but as the best way to reassure the public and minimize the risks of change. The plan itself must preserve familiar relations in medical care and self-consciously promote the joint governmental-private sector role.

- The campaign should center around "health security" -- a powerful and personal concept that people will fight for -- making sure that people can never lose their insurance, ever.

- Health security will prove more enduring than cost in sustaining a 7 month campaign: people think it can be achieved (they doubt costs will be contained); health security is more vivid to people; people hold on to it, even when faced with a trade-off with doctor choice; it holds up better under fire; and finally, health security is more emotional ("scary" and "peace-of-mind").

- The campaign must prove ever vigilant against the prospect of downscaling. Skepticism leads voters to think these reforms are for the "masses" and "uninsured" -- diminishing the importance for middle America. Health security cannot become access; it must always mean never losing your insurance. Health security must contain costs -- bringing this out-of-control system under control. And Health security must remain "comprehensive" -- never slipping to basic or minimal.

- A phased-in program should begin with some broad reforms: never losing insurance when changing jobs, helping small business afford insurance, and freezing drug prices.

- The public seems prepared for a tax increase as part of health care reform. Indeed, the expectation game may lead to enlarged support, as happened on the economic program. The "recapture option" garners the strongest support, though there is also broad support for the 1 percent payroll surcharge to guarantee insurance. There is considerable openness to various "premium reforms" (10 percent/3 percent and 80 percent/20 percent)

- While there is broad support for cigarette and other targeted taxes, voters seem to prefer across the board simplicity to some combination of taxes. It is possible to gain tolerable support for taxing benefits above the comprehensive package.

- The double digit VAT fails badly and would endanger the entire health reform package.

- Managed competition is not a wildly popular concept, though about 40 percent of the public seems to have accepted the concept of limits in health care. The package gains its popularity from the add-ons: crack down on health care fraud, never being denied insurance, and preventive care.

- The strong attacks on the plan do not bring a collapse of support for health care reform. However, the most effective attacks center on illegals and foreigners, taxes, rationing and waiting lines, small business failures and loss of doctor choice.

- To maintain the middle class character of health care reform, there must be a strong emphasis on responsibility -- including people paying some portion of health care, restraint of law suits, and concern for small business.

- There must be targeted attention to those on Medicare and union members with full coverage who are very nervous about change and the plan.

The Clinton Plan: Burst and Protection

The public is ready to support a Clinton health care plan, and they are likely to be protective of it for some time after the "Joint Session" announcement. Support for the economic plan has held up over a month -- about 6 to 10 points below the initial peak -- and a similar pattern should be evident in health care. Indeed, the initial surge is likely to be stronger and more bipartisan, thus changing the dynamic somewhat in our favor.

Before knowing anything about the plan, voters are prepared to support it -- by at least a 2-to-1 margin (55 to 24 percent). When voters hear the plan described, support leaps toward 70 percent: 67 percent in favor and 27 percent opposed; 57 percent believe it will help them personally, while only 27 percent think it will prove harmful. (In the SEIU poll, their description, based on newspaper accounts, produced 71 percent support; the Kaiser description produced 81 percent). There will clearly be a burst of support -- 5 to 10 points stronger than for the economic program.

The burst of support should allow us to build walls around the program. First, the program, unlike the economic program, wins bipartisan support: 45 percent of Bush voters favor the plan (12 points above support for the economic plan); and 65 percent of Perot voters are supportive (16 points higher than for the economic plan). We need to reinforce the broad bipartisan character of our support to place the program above politics.

The bipartisan support for the Clinton plan is won on an uneven playing field. The Republicans lack the credibility to offer their own plan, and thus must seek some kind of role with the administration. In the NBC/Wall Street Journal poll, the Democrats enjoy an astonishing 57 to 9 percent advantage over the Republicans on health care. The best Republican plan (tax credits, malpractice, etc.) loses to the Democratic plan by more than 2-to-1 (SEIU). The Republicans dare not be left behind, lest they defend their opposition far into the future.

Second, voters are looking to Congress to support the Clinton health care plan: in the SEIU survey, 48 percent said they were more likely to vote for their member of Congress if he or she supported the plan; 19 percent were less likely -- a net advantage for voting with Clinton of 28 points. Members of Congress should face twice as much pressure (compared with the economic plan at its high point) to support the president. Public vigilance over Congress should permit us a powerful argument: the public will be

unforgiving if Members choose to stand on the wrong side of history.

Third, voters are protective of the overall health care plan, regardless of the specific criticisms. People want this change to happen. After the plan is attacked for rationing, waiting lines, high taxes, small business failures, and limits on doctor choice (without any response), support remains very high -- 63 percent in SEIU and 58 percent in our own survey. The plan retains the support of 78 percent of Democrats and 56 percent of Perot voters. Astonishingly, after the attacks, Clinton's thermometer score goes up 2 degrees, while trust measures remain steady. Voters want change and respect Bill Clinton for trying. They are protective of his efforts.

Not surprisingly, the plan wins and holds strongest support from the 1 in 10 who lack insurance (74 percent at the outset and 65 percent after attacks). Much more important is the strong support from the 1 in 3 who depend on company insurance but make some personal contribution (69 percent and 62 percent). The plan also fares well with the 1 in 6 who have fully funded company plans (64 and 61 percent).

The plan is weakest with the 1 in 5 covered by Medicare (63 percent at the outset and 57 percent after attack). We will address the concerns of seniors below, for that is a central task if the plan is to maintain overall support.

Health Care in Perspective: Keeping the Public Focused

The public is certainly concerned about health care, and 78 percent believe the system has failed most Americans (NBC/Wall Street Journal). A quarter of the public wants to completely "rebuild it," and another half wants to make "major changes." So there is a clear public demand for action.

But health care is a second-order problem to the economy. In a CBS survey prior to the Dan Rather interview, voters were three times as likely to want to ask questions about the economy and jobs as about health care (48 to 17 percent). In our survey, just 30 percent mentioned health care as the first or second most important problem (half the rate of mention for the economy and jobs).

The second order importance of health care means the health care campaign must work aggressively to maintain public focus. We should not assume the same level of public attention and durability as evident on the economy. Moreover, the Clinton plan wins

overwhelmingly among those concerned with health care (who are 2-to-1 Democratic). The key will be maintaining and sustaining support among the 70 percent who do not list health care as a major problem.

The Principal Tension: Personal Satisfaction and Systemic Failure

The public can slide in and out of this issue because of the tension between their own personal health care situation and their critique of the health care system as a whole. In surveys, people express an extraordinarily high level of confidence in their health insurance situation: 74 percent are satisfied with their current plan and 78 percent with how much they pay (insurance industry poll); 74 percent are happy with the availability of health care to themselves personally (NBC) and 74 percent are satisfied with the quality of care (Novalis). Our own surveys put personal satisfaction in the 75 percent range, though somewhat lower on cost (64 percent) and security (66 percent).

Yet, amidst this apparent personal contentment, is a powerful anger about the system as a whole. The same insurance industry poll shows 71 percent dissatisfied with the health insurance system. Our survey shows 64 percent dissatisfied (including 33 percent very dissatisfied). What is going on? To maintain support for reform, we have to keep people focused on the discontent, which means addressing a number of personal issues.

First, people experience the health care system in spurts -- leaving the problems hanging in the air as a prospective, theoretical difficulty. Almost half of the respondents say they spend less than $500 a year in all health care expenses (including deductibles, co-pays, out-of-pocket expenses, etc.). Over two-thirds have had no contact with the health care system in the last month. An effective critique that joins the personal and systemic will have to make the prospective problems more real and immediate. We cannot assume that personal problems are top-of-mind.

Second, people are conservative and protective of their own personal health care situation which has been negotiated amidst considerable instability. Their "satisfaction," therefore, is quite relative -- compared to other people and to what might have happened. There is reason to believe that people understand the profound insecurities underlying the deals that they have made to get by. But people's tendency to protect what they have is a central part of the health care reality. Indeed, the more uncertain the overall situation, the more protective people tend to

be of their own packages, as reflected in these focus group comments:

> I'm satisfied with mine -- from what I've had. Our company went through several different companies and you had to go to a certain doctor ... And that didn't work out too well. So now, we've got Blue Cross PPO, and everybody seems to be happy.
>
> Well, I'm satisfied. I take things into perspective. I look at what everybody else has, and I say, well, this is pretty good compared ... So, as far as ... in an overview of everybody that I know of, it's fantastic.
>
> Well, it's hard for me to really judge because I'm not affected that much. ...
>
> We have real good insurance now, but my husband won't get a raise for 5 years. It was a trade-off -- a 5 year contract with no raise for 5 years, but we got the benefit.
>
> I'm satisfied. We've had a major health care problem recently and because of coverage that we changed, unless I get surprises with them not allowing my claims, I'm very satisfied.
>
> I just happen to feel that I'm in a pretty good position, because my health plan is locked in right now. Of course, it can change.
>
> I have terrific insurance. It's wonderful, but I pay through the nose for it. I wouldn't have it any other way.
>
> I've never used it in 10 years. ... I'm pretty happy with it.
>
> I'm very happy with the health plan I have for myself and my family, but the frustrating thing for me is for 15 years, I didn't pay into that health plan because it was cheap enough for the company to pay. Now, because health costs have soared, most companies make the employees now share in health coverage and that hurts.

As a consequence, people are cautious about the risk of change. We cannot assume that people have accepted change as better than the status quo. We must make that case. In the SEIU poll, 47 percent said the greater danger is that things will stay as they are in health care, but nearly as many, 43 percent, say they worry that things will change too much. In our own survey, somewhat more, 53 percent, say they fear an unchanging status quo with health costs rising and problems with insurance; but a considerable 41 percent say they worry about the government creating new problems when trying to reform health care. One-third of Democrats and 40 percent of Perot voters are more worried about change than the status quo.

It is helpful that people understand the underlying instability in which they negotiate health care and the continuing pressure to erode their benefits. Even as people express "satisfaction," they note the "high deductibles," the growing element of surprise, finding yourself "thrown out" or not covered for cancer; they speak of being at "high risk" and not knowing what could happen; they speak of aging parents facing unbelievably expensive monthly premiums. There is a sense that "all of a sudden" your company changes plans, and you face uncovered expenses, new requirements for approved doctors and a waiting line "for prescriptions at Walgrens"; "they told us that our coverage would be the same, and it's not"; "it just seems like its always changing; they're always looking for new companies."

Third, voters want the government to take the initiative to fix the system, yet jump at solutions that keep the private insurance system (private doctor network) intact. Voters want the assurance that, after big change, their personal health care system will remain familiar. Thus, over 70 percent want a new national health care system (NBC), and over 60 percent want the government to take the initiative to bring about change (Medica). But over 70 percent want the solution to be a mix of government and private insurance; just 23 percent support government control over health care (NBC). Over half are open to tax credits for companies and individuals, as a substitute for a larger governmental role (Medica).

We need to propose big change in this package -- reforming all the externalities, but for the purpose of conserving some things that are fundamental to the individual. So, for example, there is overwhelming support for capping costs, eliminating bureaucracy and red tape, freezing drug prices and mandating insurance coverage. Those reforms are meant to save and protect, not undermine, the private doctor-patient relationship. Our reforms are meant to give something back to the patient and the doctor. Our goals include

security and stability and tradition -- "peace-of-mind" in a changing world.

Phase-in

That voters want both change and caution is reflected in their sense of timing when it comes to the health care initiative. At each point, voters say move forward judiciously:

- Just 43 percent say pass the health care program now, while 48 percent say move slowly (SEIU).
- Voters would raise fewer taxes and phase the program in over 5 to 8 years (70 percent), while only 26 percent would raise taxes to achieve a more rapid implementation (Kaiser).
- Just 43 percent want immediate implementation of the plan, while 51 percent say phase it in -- and that is after respondents hear a description of the plan and two-thirds support it.

The phase-in is particularly important for those people who have a reason to be risk-averse: people with private insurance (37 percent immediate and 55 percent phase-in). Half of the plan's supporters want to phase it in.

Voters would move immediately on broad-based initiatives: making sure people who change jobs do not lose their insurance (24 percent), creating larger insurance groups to help small business buy insurance (22 percent), and freezing the price of drugs (20 percent). There is less interest in ending pre-existing conditions (12 percent) and in extending insurance to all children and pregnant women (15 percent). The insurance industry's research shows strong support for moving immediately on immunizing all children.

Health Security

Our proposal for reform must touch powerful emotions -- ones that enable voters to join their private and public views of the health care system and that allow them to entertain new financial and medical arrangements. We must offer people something that makes the status quo unacceptable and that allows people to act on their desire for change.

There is a temptation to focus on cost, as that goal seems to involve the middle class directly in reform. In most surveys, cost is a more pressing problem than lack of insurance: 48 to 35 percent in NBC and 39 to 27 percent in SEIU. Indeed, even in our own survey, attacking costs wins out over attacking the loss of coverage, 52 to 41 percent. Getting costs under control is very important, to be sure, and the initiative must show that it worries about middle class America's struggle with rising costs; skyrocketing and catastrophic costs must become security issues that threaten coverage. But the cost argument by itself is not powerful enough to carry the initiative. But health security will. That is where we would put our money.

First, practicality: people believe that it is possible to guarantee health insurance coverage for everybody; they are not sure that reform can get costs under control. By 61 to 19 percent, people expect Clinton's health care reforms to make things better, not worse. They think it can happen. But people are uncertain about our ability to attack costs. By a small margin, 41 to 33 percent, people expect overall costs to get better after reform, but not the costs that people themselves pay (27 percent better and 35 percent worse). Even after the entire package is unveiled, voters only split evenly on the prospect of an improved cost situation (31 percent better and 32 percent worse).

Second, vivid impression: people are much more likely to mention security rather than cost elements when recalling the health care initiative. Security is what sticks in people's minds. When asked how things might be different in the NBC poll, 34 percent cite coverage issues ("easier to get," "coverage for everyone"); 27 percent mention costs being controlled or insurance becoming more affordable. In fact, the cost recall is further offset by the large number (11 percent) who recall that costs will go up. After we read the Clinton health care plan, 34 percent recalled health security or coverage for all Americans; 24 percent recalled costs under control.

Third, trade-offs: people are quick to trade off cost reforms when they clash with other valued things, like doctor choice. But people hold on to health security, even when it clashes with something valued:

- Costs under control **versus** freedom to choose a doctor — 47 to 46 percent
- Never losing coverage **versus** freedom to choose a doctor — 52 to 37 percent

The trade-off in favor of security is made by those without coverage (53 percent) and the larger group of those who contribute to a company plan (54 percent); it is strong for the critical group of voters who support the Clinton plan, but who are nervous about change (59 percent, security over doctor choice).

Fourth, under fire: health security arguments stand-up under fire. In the NBC/Wall Street Journal poll, the argument for reform (centered on keeping coverage no matter what) wins out over a strong attack (centered on taxes and limits on doctor choice) by 56 to 33 percent. The coverage argument holds up both among Clinton (69 percent) and Perot (58 percent) voters, and does respectably with Bush voters (38 percent), leading Peter Hart to recommend a security-based rationale.

In fact, it is very difficult to hold on to those voters who turn to health care reform for cost reductions alone. Half of them are core Republicans, compared to 38 percent among those focused on security. Those concerned with cost are twice as likely to express strong doubts about various aspects of the plan and to pull away.

Our campaign must focus on the plan's supporters who are worried about change (15 percent of the electorate): these voters opt strongly for security over cost reduction by 58 to 37 percent.

Fifth, emotion: voters who worry about security are more likely to rally to the Clinton plan (71 percent), compared to 62 percent among those who want to control cost. Dissatisfaction and the desire for change is much more strongly correlated with the desire for health care security: 42 percent are very dissatisfied with the health care system, compared to only 28 percent among those focused on cost.

The power of health care security is rooted in its emotional content -- "scary" when you do not have it and "peace-of-mind" when you do:

> If you got health insurance, everything is basically okay. If you don't have it, it's a disaster.
>
> Because my insurance is already covered, I don't have to worry about anything. ... If I lost what I have now, oh my.
>
> I'm very scared. I'm scared and angry also, because I do work, and I still am not covered. I don't know what would happen if I would need to go to a hospital.

> [Someone adds] Make you go to County ... the County facilities are so bad.
>
> I could be in debt for a long time, if I don't have it. I could be even bankrupt. [Someone adds] That's one of the reasons why people are homeless because of medical bills overriding their families and their housing.
>
> You're gonna worry all the time if you don't have it.
>
> I changed jobs last year, and I was uninsured for a whole month. That was scary. [Someone adds] It's scary. ... Just one time can wipe you out.

After hearing about Clinton's health security proposals, the sense of relief is palpable: "that no matter how sick you get, you'll be secure"; "gives me a good feeling." One of the men in Chicago concluded, "maybe you can better yourself, and the whole country would be better if that was one less worry."

We have to make security mean something powerful and personal for all those who currently have insurance -- making sure that people can always keep their insurance. No more losing insurance when changing or losing a job; no more being denied coverage because of a pre-existing condition; no more threat from skyrocketing costs that erode benefits and leave you defenseless. The core of the Health Security program is a comprehensive package of health care benefits guaranteed to every American.

Political Dangers in Health Security

The design of the health care campaign must reflect three major dangers that could threaten our control of the discourse. Each in their own way push our motivation downscale and limit our ability to speak to the great majority of Americans about their own health care.

Danger one: access. The first danger in health care security is its reduction to access. Access means reforming the health care system in order to extend coverage to the uninsured. There is precious little interest in that concept. But the pundits are apt to describe health security as the desire to insure the uninsured. If that happens, we lose the power of health care security.

Danger two: cost. We dare not lose the cost argument, for the erosion of benefits under the status quo is one of the biggest sources of insecurity. People believe the system is "out-of-

control." Failure to change and enact health care reform, will leave people more and more insecure before rising health care costs and the constant attempt by employers to renegotiate coverage. Part of ensuring security is bringing this out-of-control system under control.

Danger three: comprehensive package and downgrading. Voters are very supportive of a guaranteed set of comprehensive benefits that cannot be lost. And voters are serious about "comprehensive." To mean something and to be trusted, the comprehensive package must cover "everything" -- "no matter how you get sick, what you get sick from, they will cover it"; "I hate to sound greedy, but I agree, almost everything, anything that happens to you physically"; "comprehensive to me means everything, it would mean total"; "it lets you sleep at night"; "comprehensive means you're covered."

In that context, voters are very supportive of the core idea in the program: "more people will have access to medical care"; "health care for everyone"; "he will give everyone the chance to have insurance"; "equal health care for all people"; "fair to everyone."

But the support for equal and comprehensive coverage can slip very quickly, if the package or health care looks substandard. There is danger in even the words "core" or "basic" package: "very limiting"; "like minimum wages"; "just the bare necessities"; "sounds like a median"; "I think it's just like the minimum"; "simple package, ... minimal, ... the Yugo."

There is great danger in the public's tendency to downgrade the comprehensive coverage -- limiting its coverage, its genuine middle class character and broad appeal. When voters begin to associate the reforms with helping only the needy, support begins to drop-off, along with people's openness to change. There is a great worry that "insurance for everyone" will become "health care for the masses." "Health care will become more limited and hurt my family"; "run it like Medicare for any age! Big mistake"; "everybody covered minimally"; "a safety net basic health care plan for everyone paid for by taxes"; "control insurance costs to give the low income family a chance to have insurance"; "change toward health care to masses"; "more free clinics"; "it needs to take into consideration all classes, not just the lower classes."

Taxes and Financing

About half the public now believes that some kind of tax increase will be "necessary" as part of health care reform, even

when reminded that Clinton just raised taxes for his economic changes. In fact, 42 percent of Bush voters think a tax increase will be necessary, and support for a tax increase may be growing. One survey shows 56 percent in favor of a tax increase -- up 6 points in a year (Novalis).

In fact, voters seem ready to raise taxes to finance health security: 66 percent support it in the NBC/Wall Street Journal survey -- up an astonishing 19 points since June 1991 (NBC). Our description of the Clinton health care plan concludes with this sentence: "to finance universal coverage, the plan includes a broad and major tax increase, with the revenue dedicated to a health care trust fund." Support for the program reached 67 percent, suggesting that a visible tax increase is possible in the context of health security.

There is every chance that the President may benefit from the expectations game -- if people's direct taxes go up only moderately. When voters are told of a "big tax increase" (but before any details of the plan), support for health care change drops to even, with just 44 percent in favor. However, when voters are told the tax increase will be "small or moderate," support jumps to 66 percent. We have every reason to replicate what happened in the economic plan: pre-announcement worries about taxes assuaged, as the president demonstrates his commitment to minimize the impact on average Americans.

Voters are not quite ready for broad sacrifice when it comes to financing health care. A majority believe that all the necessary revenue can be raised from the abusers of the current system -- insurance and drug companies and doctors. However, there is a considerable bloc, 43 percent, that believes contributions will be necessary from everybody if there is to be a truly comprehensive system. That is a fairly respectable starting point, if the president is to build a national majority for financing health care.

The "recapture" option -- price control over 2 years with a tax on insurance companies to fund the health security trust fund -- wins the broadest public support (66 percent in favor and 26 percent opposed). The exact wording of the finance option is presented below:

> The proposal would limit increases in doctor, hospital and drug prices to the rate of inflation over the next 2 years which could reduce what insurance companies pay out. But the plan would then impose a tax on insurance

companies and use the money to build-up the trust fund to guarantee insurance for everyone.

Support for the recapture option carries across all groups, including Perot voters (62 percent) and conservative Democrats (84 percent). It wins crucial support among those who contribute to company insurance plans (67 percent).

There is significantly less support for all other financing options that seem to hit real people more directly. Nonetheless, there is broad support for simple across the board options, like "a **1 percent payroll surcharge** on all employers to create a fund to guarantee insurance for everyone": 61 percent in favor and 30 percent opposed. There is somewhat less support among tax sensitive voters, but still at a high level -- conservative Democrats (72 percent in favor) and Perot voters (56 percent). But support is high among the one-third of the electorate that contribute to private plans (68 percent).

There is also some support for a proposal to eliminate entirely premiums paid by employers and individuals and, instead, "provide that employers pay a 10 percent premium on payroll and employees a 3 percent premium on wages to cover health insurance" (59 percent in favor and 33 percent opposed). Adding a cigarette tax on top of that, to finance the uninsured, complicates the issue, and drops support to 50 percent, a dangerously low level. There are clearly benefits in simplicity.

There is slightly more support for a universal premium system -- at least 80 percent by the employer and up to 20 percent by the employee: 59 percent in favor, rising to 62 percent when exempting the first $8,000 and capping the contribution at 3 percent of wages or salary. The fixed premium option (80/20) has twice as much strong support as the percentage of payroll option (10/3 percent). Given the reluctance of many voters to remake their personal health insurance situation, we might lean toward policy options that leave familiar structures in place.

We can fight taxing benefits above the comprehensive package to a draw, though this is dangerous territory. As straight policy, it wins plurality support, 47 to 42 percent; when described as mainly a tax on upper-income individuals to fund universal coverage, support rises somewhat to 54 percent (with 38 percent opposed).

The double digit VAT fails badly and would endanger the entire health reform package. The basic policy is described below:

> The proposal would eliminate all health insurance premiums now paid by employers and individuals and, in its place, impose a 12 cent value added tax, a kind of national sales tax of 12 percent on all purchases, except food.

In half the sample, we added a salary give-back to employees, but it did not help. Just 46 percent favored the idea -- 20 points below the recapture option -- and 48 percent opposed it. A fifth of the electorate emerges as "strong" opponents. The proposal hurts us across the board, but especially in the Democratic base where support barely reaches 50 percent.

The VAT option nearly kills the overall Clinton health care proposal -- before it's even attacked. Support drops 12 points to 55 percent, with 37 percent opposed. That is a dangerous starting point to begin the campaign for health care reform.

The public is willing to support a number of specific taxes, though voters clearly like simplicity and grow concerned with piling-on. (Note the sharp drop in support when we add cigarette taxes on top of the 10/3 percent option.) The Kaiser survey found broad support for a $1 cigarette tax (74 percent), a $1 dollar tax on a six pack (79 percent) and a tax on guns and ammunition (75 percent). In a Minnesota survey, there was support for higher taxes and premiums for smokers (77 percent) and higher premiums for non-helmeted bikers and non-seat-belted drivers (73 percent) and those with DWI convictions (69 percent). However, there was much less support for taxing handguns (41 percent) or setting higher premiums for the overweight (34 percent) (Medica).

Managed Competition: Limits on Limits

There is modest evidence that people are growing a touch more realistic about unlimited coverage for all procedures and technologies, though only a touch. A minority of 39 percent oppose the concept that every person should be able to receive all the medical services they want -- up an impressive 15 points in a year. A Minnesota survey showed 46 percent who now believe reform will require new limits, including limits on the freedom to choose a doctor and order up any procedure (Medica). Respondents recalled important phrases, like "sacrifice from everybody" and "everyone taking responsibility." (More on that later.)

Keep in mind, however, that 56 percent believe in health care without limits (Novalis), and 53 percent say do whatever is necessary to save somebody's life, even if they have only days or

a week to live; 40 percent would entertain ending life-supports (NBC). While seniors have complicated views about ending life-support, they are generally extremely wary of limits on the right to choose a doctor.

The public is still inclined to leave these life and death decisions, regardless of cost, with the patient and family: by 56 to 36 percent, Michigan voters oppose the new law to limit Dr. Kervorkian from assisting suicide; 36 percent strongly oppose it (MRA).

Managed competition is a system of limits within a system of choice. Yet people are not very enthusiastic about a system where they enroll to gain access to an approved set of doctors. In the Minnesota survey, just 28 percent express willingness to enter such a system. The Kaiser study found broader support (64 percent) for such a program -- covering more insurance costs for those agreeing to join lower-cost managed care plans that limit the choice of doctors. But support was nearly 20 points below a program centered around an employer mandate.

Men are more open than women to limits, as are younger and better-educated segments of the population. Those most reluctant before these changes include older people, those in traditional families, downscale women and "middle brows" (those with some post-high school education). Seniors are strongly opposed to limits on the freedom to choose a doctor.

It is possible to describe a managed competition system that wins public support -- if you combine the basic managed competition principles with other things that people value. The insurance industry survey shows 65 percent support for such a program. But add-ons are the key (listed in rank-order below):

	appealing	extremely appealing
crack down on health care fraud	89	49
never denied insurance if change or lose a job	86	40
preventive care	84	34
insurance from health care co-op, if not insured by employer	80	33
No denial for pre-existing		

condition	78	38
eliminate red tape	74	29
small businesses given same bargaining power as big companies	73	28

In general people tend to support limits that do not save a great deal of money and hesitate before limits that really change health care practices. For example, they are strongly supportive of malpractice reform (76 percent) and government price setting (87 percent) (NBC); they may be willing to require that people see a general practitioner first (49 percent, with 34 percent opposed) (Medica). There is some willingness to consider limits on tests and the availability of advanced equipment: the public is basically split on these questions.

Support drops off, however, when we get to limiting choice of doctors (28 percent willing and 55 percent unwilling) (Medica); limits on high cost surgery for those who cannot benefit (27 to 57 percent, with 42 percent strongly opposed); setting priorities on procedures, as in Oregon (16 to 64 percent); and delaying the development of new drugs and technology (17 to 69 percent, with 48 percent strongly opposed).

Attacking the Clinton Health Care Plan

The Attack

The plan raises taxes again on the middle class and employers -- on top of the taxes already proposed in Clinton's economic plan. It hits small business particularly hard which is why the Chamber of Commerce is so concerned. The mandated insurance payments for even the smallest businesses means that many will be forced out of business, costing jobs. The American Medical Association and private doctors are concerned about new government regulations that will severely limit people's choice of doctors, forcing many people into HMOs and clinics. In fact, government regulation and budget controls will mean limits on necessary procedures and waiting lines at hospitals. This is radical change that Americans cannot afford.

The electorate, as we have seen earlier, is fairly protective of the health care plan. Even the strongest composite attack

raises serious doubts for just half of the people (including only 18 percent who express very serious doubts). The broadside above, with the full authority of the Chamber of Commerce and the AMA, followed by a series of unanswered specific criticisms (on abortion, taxes, waiting lines, bankrupt small businesses, free care for foreigners) only drops support for the Clinton health care plan to 58 percent, with 32 percent opposed. There is an impressive, durable majority for reform.

People like Bill Clinton for trying to change the health care system, despite the critiques. At the end of the survey, Bill Clinton is more popular than at the outset (59 to 61 degrees). There is little change in his overall image (in fighting for the middle class and in trusting him to do the right thing).

The specific attacks in rank-order importance are set out below:

- **Illegals:** This plan will cover illegals and foreigners who will come here to get health care, subsidized by working Americans (24 points net negative, serious doubts minus few doubts; 40 points net negative among Perot voters). This may sound like a crazy critique, but the subject was volunteered in 3 or 4 focus groups which is why we added the question here. People spoke of foreigners coming across the border to have babies, "free of charge"; "please don't make us pay for health care for illegal people."

- **Taxes:** This plan will impose a massive 12 percent federal sales tax on the middle class -- on top of those already imposed by Clinton's economic plan (24 points, net negative).

- **Rationing:** The plan provides for big government controls that will mean rationing, long waits for medical care and a decline in the quality of health services (23 points, net negative).

- **Jobs:** This plan will bankrupt many small businesses and impose many new taxes which will hurt the economy and cost jobs (19 points).

- **Choice:** This plan will force people into approved health plans and HMOs and will limit the right of patients to choose their own doctor (16 points).

The people that pull back from the plan single out tax increases as the biggest problem. They are largely non-college women (45 percent of the shifters) or younger non-college (41 percent). **Those who pull back are much more concerned than other voters that Bill Clinton may not be fighting for the middle class:** 38 percent say he is for the middle class, compared to 54 percent of all voters. This is a rhetorical issue, to some extent, but it is also one where Clinton must show empathy on costs and values.

Missing Components: Reassurance

There are a range of things that can be incorporated into the plan or the presentation that would address many of the concerns expressed in this report. Almost all of the suggestions address the fear that change will itself get out of control and endanger things that matter. Right now, participants like the plan and like Bill Clinton for proposing it, but there is a growing perception that he is a big spender: up 7 points during the course of the survey (SEIU). Our campaign must seek to assure, even as it promotes bold change.

Sky-rocketing costs. We dare not lose sight of health care costs -- even as we build our central rationale around health security. More people are concerned with costs, particularly those nervous about taxes. Showing that we will attack costs aggressively is critical to preserving broad support for the program. The public strongly favors price controls. People are overwhelmingly supportive of attempts to recapture the 25 cents of every dollar wasted on administrative waste; there is real emotion in attacking fraud, red tape and bureaucracy (74 percent say that is a convincing argument to support reform, SEIU).

> The power of the "waste" argument is somewhat mitigated by people's skepticism about government reducing bureaucracy. They think the proposal has "government written all over it"; "you got one bureaucracy eliminated, but its creating another one, you're eliminating one but creating 50"; "just another bureaucracy created."

Quality. The Task Force will have to offer the obvious reassurances about preserving health care quality. But there is a special need to reassure people on the quality of the comprehensive package. Comparisons to Xerox, Blue Cross and other packages are very comforting and enable the Task Force to make the case that this is a middle class package -- not a

basic plan for the "masses." We cannot allow people to give into their fears and downgrade the program.

Responsibility. The public overwhelmingly believes (88 percent) that everybody should pay some portion of their health care. It is extremely important that people see a president demanding responsibility of everyone. It is a sense of shared responsibility that allows people to entertain new limits on use of medical services and new taxes. Responsibility is important to the middle class character of this proposal.

Small business. The concerns about small business are real and constitute a potential Achilles heel for the overall proposal. A sense of rising burden and job losses could very quickly heighten people's aversion to risk. We should remind ourselves that twice as many voters are worried about the economy as health care. Yet there is already some concern that health care reform will hurt rather than help small business and the economy. Over half believe our health care proposals will hurt small business (up 6 points at the end of the SEIU survey) and a third believe they will hurt the economy (up 6 points). We must highlight proposals that advantage small business, as we are working against conventional assumptions about the consequences of reform.

Freedom of choice. A private doctor of choice is very important to people: in some studies, two-thirds say preserving choice is more important than controlling costs (Novalis). Over three-quarters say they have a personal doctor, and they are reluctant to see that relationship compromised. Some just say flatly, "I'm not giving up my doctor"; "I like my doctor, I wouldn't go to anybody else." And people are not fools: 42 percent believe HMOs give people less choice, while just 5 percent think more (Insurance Industry poll). We must be able to say, believably, that our health care reforms will preserve, even expand choice. But those on Medicare or with fully-funded company policies will be very skeptical.

Lawyers and malpractice. Lawyers are a principal villain of the piece -- people who act irresponsibly, encourage greed and drive up costs in the system. Attacking malpractice is enormously popular, but it also sends the right signals that the president will demand responsibility of everybody.

Pockets of downscale privilege. There are special problems with seniors -- 42 percent end up opposed to the plan, no doubt reflecting their concern with limits, taxes, change and

other matters. Union members are extremely cautious about change: just 31 percent say the greater danger is not changing the status quo, with the remainder more fearful of government reform (33 percent) or unsure. In health care reform, it is the non-union worker who is focused on change: they think the status quo is the greater risk by almost 2-to-1.

> The Task Force must consider some highly targeted components that re-assure these target groups -- perhaps coverage for prescription drugs for seniors; perhaps an active campaign by the unions themselves to address the concerns of workers.

Limits of macro arguments. The public has little interest in broad arguments about GNP, deficits, and total health care costs. This is a personal issue and must be addressed at a personal level, drawing on powerful emotion concepts, like health security. If anything, people believe that health care reform will increase spending and perhaps weaken the economy. By better than 2-to-1, people believe health care reform will worsen the deficit (SEIU). Obviously, the president will seek to educate the public, but the macro arguments cannot become the primary reasons for change.

Abortion. There is little to be won here. The public is split evenly on whether abortion should be included in the comprehensive package (44 to 44 percent), though the opponents are much more intense in their opposition (25 percent strongly opposed). Those who pull back from the plan are 2-to-1 opposed to including abortion in the package. Indeed, there was some tendency in the focus groups, particularly among downscale women, to think that health care reform would end up funding "abortion as a form of birth control."

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