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Health Care Reform - 4/16/91 Kuttner, Porter Meeting on Status, Progress

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Your meeting Monday with Bill Roper offers an opportunity to frame your thinking about where to go with the issues that follow from the President's State of the Union directive to the Secretary of Health and Human Services to study the cost, access, and quality issues of our health care system. At the February Sununu/Darman/Sullivan/Boskin meeting, there was agreement that those same senior advisers should enter the study period with common expectations about the outcome. This memorandum reviews the issues on which those senior advisers should have common expectations.

1. What are our long term goals?

By referring to the "health care studies underway," the President implicitly accepted the agenda framed by those studies. At the same time, the President's relative priorities are markedly different. The President put cost first; the studies put access first.

In that February principals meeting, Governor Sununu said that universal insurance coverage was not beyond the pale as a long term goal. The Rockefeller Commission, reflecting the conventional wisdom among health policy analysts, said we should march towards that goal through employer mandates. The principal options that have surfaced in the debate on universal access are:

- o Mandate employers. Build on the American tradition of health insurance being employment based by requiring employers to provide coverage (or, in some variants, pay a payroll tax instead of providing coverage);
- o Mandate citizens. Follow the auto insurance model, where there is a universal mandate on the citizen to be insured;
- o Universal insurance availability. Expand Medicaid or invent a new public program to provide insurance to all on an income-related basis.
- o Universal access to services. Provide universal access to services, not insurance, through public clinics and contracts for services.

A wide range of options can be created involving various proportions of each approach.

2. What role does the tax code play in our long term goals?

To the extent the government has tools available to make the system pay for increased access, they are found in the tax code. The tax preference for employer provided insurance

deprived the treasury of \$34 billion in 1989. This is the fastest growing tax preference and also the only uncapped employee fringe.

Last year, in the discussions that lead to the President's FY 91 budget, the tax cap emerged. The range of options includes imputing some or all of health insurance costs as income to employees, limiting employer deductibility.

The other side of the coin is the tax code as a tool to subsidize health insurance and health care costs for low income Americans through a tax credit for these costs or enhanced deductibility.

A bold access proposal requires more than a tax cap. It requires fundamental change in the structure of subsidies for health care. How far we are willing to change the tax code is the single largest variable in framing the next question, the role of the Sullivan state of the union study in advancing our long term agenda.

3. What do we seek to accomplish in the study directed in the State of the Union?

The answer to this question falls out from how we see 1991:

- o a year in which the study continues;
- o a year in which we produce a study or policy statement that defines the issues as we see them, possibly putting forth some prescriptions, with big access proposals tied to tax code change put off to the 1992 campaign cycle or the second term; or
- o the year in which we put it all on the table.

The expectations created in the State of the Union and the difficult situation that would result for Secretary Sullivan seem to rule out the first option. The third option deprives the President of an election year initiative, legitimizes putting access first, and also means advancing in 1991 things that could be read as violating the "no new taxes" pledge.

There are a number of other reasons why the second option is attractive:

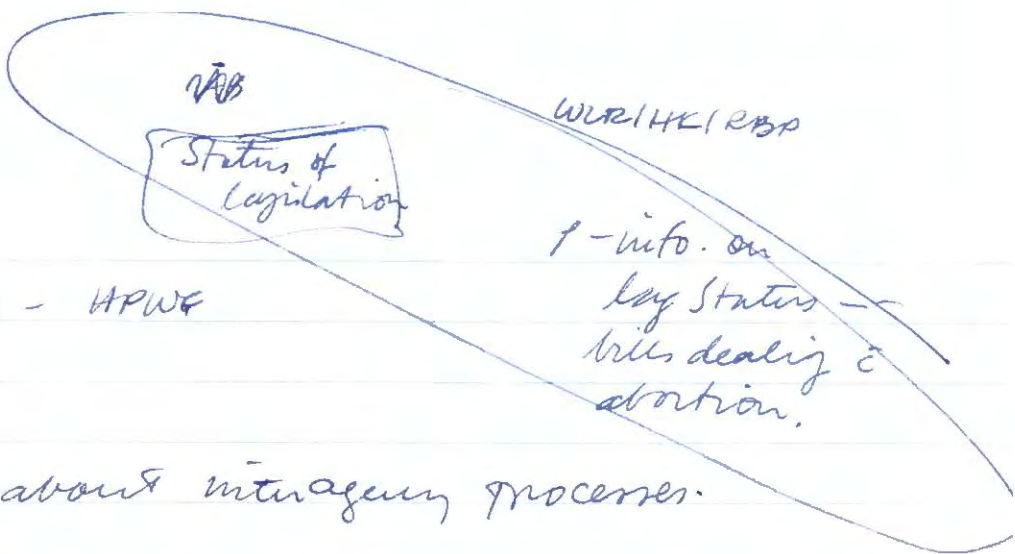
- o It provides a means for us to enter the debate by saying that costs come first.
- o It is a way to fulfill the State of the Union commitment for study without putting down all our cards on access/tax code.

- o It challenges the conventional wisdom that 1991 is the long awaited year to finally solve, once and for all, how the US will achieve universal access. A broccoli before desert requirement, cost before access, lessens the chances the Congress will be able to push ahead on its own.

Moving from strategic considerations to the concrete, HHS needs guidance on what final work product is expected in response to the President's directive for a "study." It has no such guidance right now, and as a result, very little work is being done. Some scenarios include:

- o Secretary Sullivan studies the issues through meetings and discussions, with no written product until a DPC paper is put together in the fall. No document becomes public until there is a fact sheet in conjunction with a Presidential announcement.
- o Secretary Sullivan's study becomes a tangible document that looks like a Manhattan phone directory, defines the issues, but stops short of being a "Treasury I." It would be long on analysis, and has chapters on many of the cost issues in the background of the current debate. It can serve as the basis for a set of "first steps" policy pronouncements that respond to expectations that we will advance something in 1991 but push the tax/access questions into 1992 or later.
- o The Sullivan study follows the Treasury I model. While presenting a range of options for Presidential decisionmaking, the options are very bold.

4/16



RBP -

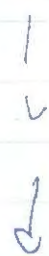
- Intergovernmental Group - HPWG
- Exec CFE.

f - info. on
 Lay Status -
 bills dealing c
 abortion.

IRGD - prominent about interagency processes.

RBP - Analytic products.

- ▶ other HC and other
- ▶ what are those other sources?



- use access / P - shape how he thinks
 about these issues.

PROCESS

- JHS/IRGD/RBP

CONTENT

UNIVERSALITY do you really want to
 for all Am?

MANDATES what do you feel about
 workplace health ins?? [Murd]

TAX CODE Tax code.

SMALLPOX → RBP → JHS

Scowcroft.

1. only 2 respondents
2. freebie
 - always looking for summit type issues.

INTEREST GROUPS

Business

Very few business leaders see a role for government

Health Insurers

Now supportive of intervention in the insurance market to make insurance more available.

Labor

Views costs as a problem to be solved by providers.
Strongly favor employer mandates.

Organized Medicine

Supports employer mandates as well as increased public spending, even if it means raising taxes.

States

Health care is the fastest growing part of state budgets.
Gov. Gardner plans to make health the focus of his NGA chairmanship.

Congressional Democrats

A majority support employer mandates (although a distinct minority does not.) Always ready to outbid the Administration.

Topics for Health Care Study

I. Access

- The problem of those without insurance
- Issues of special population: pregnant women, rural populations, trauma care in large cities

II. The cost and availability of health insurance

- Problems of small business

III. Cost

- Overall cost of health care
- Cost of insurance

IV. Quality

- Measures
- Improving outcomes

V. Malpractice

VI. Long Term Care

Non-standard topics

1. Market imperfections: information, consumer insulation from prices, sources of aversion to price-based competition
2. Public sector investment: public health (preventing the need for services) v. financing (buying services)
3. Principles for prudent public investment
4. Antitrust issues
5. Physician supply
6. Role of research in creating costs