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**The Health Security Plan
Press Packet**

September 22, 1993

**Health Security Plan
Press Packet**

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THE NEED FOR REFORM

The United States is a world leader in developing new medical technologies and probing the mysteries of disease through basic and clinical research. People from all over the world come to the United States for specialized training and treatment.

...As we undertake this journey of change, we clearly must preserve what's right with our health care system -- the close patient-doctor relationship, the best doctors and nurses, the best academic research, the best advanced technology in the world.

--President Clinton, September 20th, 1993

But the health care system, as a whole, is in deep crisis. Health care spending now consumes 14% of GDP, up from 9.1% in 1980. If nothing is done, by the year 2000, nearly 19% of America's GDP will go towards health care alone.

Some say that is acceptable, because that's what it costs to keep our population healthy. But this means accepting that rising health care costs should consume over 100% of the projected increase in wages, produce 60% of the projected growth in the federal budget, and eat away two-thirds of our projected economic growth for the rest of the decade.

But in fact, we would be spending that money without getting the security, simplicity, and value that would help bring health and expanded opportunity to all Americans.

Because we cannot control health care costs and become further and further behind in our efforts to do so, we find our economy, and particularly the federal budget, under increasing pressure. Just as it would be irresponsible, therefore, to change what is working in the health care system, it is equally irresponsible for us not to fix what we know is no longer working.

--Hillary Rodham Clinton, June 13, 1993

...The ethical imperative is perhaps the most important thing. We have to decide that the costs, not just the financial costs, but the human costs, the social costs of all of us continuing to conduct ourselves within the framework in which we are now operating is far higher than risk of responsible change.

--President Clinton, September 20th, 1993

In short, today's American health care system falls short of providing high quality care and choices for all Americans.

Some things, like universal access, are not negotiable. And that's exactly the way it should be.

--C. Everett Koop, 20 September 1993

A LACK OF SECURITY

- Every month, 2 million Americans lose their insurance. One out of four -- 63 million -- Americans will lose their health insurance coverage for some period during the next two years.
- 37 million Americans have no insurance and another 22 million have inadequate coverage.
- Losing or changing a job often means losing insurance. Becoming ill or living with a chronic medical condition can mean losing insurance coverage or not being able to obtain it.
- Long-term care coverage is inadequate. Many elderly and disabled Americans enter nursing homes and other institutions when they would prefer to remain at home. Families exhaust their savings trying to provide for disabled relatives.
- Many Americans in inner cities and rural areas do not have access to quality care, due to poor distribution of doctors, nurses, hospitals, clinics and support services.
- Public health services are not well integrated and coordinated with the personal care delivery system. Many serious health problems -- such as lead poisoning and drug-resistant tuberculosis -- are handled inefficiently or not at all, and thus potentially threaten the health of the entire population.

RISING COSTS

- Rising health costs mean lower wages, higher prices for goods and services, and higher taxes. The average worker today would be earning at least \$1,000 more a year if health insurance costs had not risen faster than wages over the previous 15 years.
- If the cost of health care continues at the current pace, wages will be held down by an additional \$650 by the year 2000. [OMB]
- More and more Americans have had to give up insurance altogether because the premiums have become prohibitively expensive.
- Many small firms either cannot afford insurance at all in the current system, or have had to cut benefits or profits in order to provide insurance to their employees.
- Only one other industrialized country (Canada) spends more than 10% of their GDP on health care. Japan, France and Germany spend 9% of GDP or less, and their costs have not risen nearly as rapidly as ours.

QUALITY THREATENED

- No one is accountable for the performance of the health care system -- not hospitals, physicians, other providers, or health insurers.
- Quality care means promoting good health. Yet, our system waits until people are sick before it starts to work. It is biased towards specialty care and gives inadequate attention to cost-effective primary and preventive care.
- Consumers cannot compare doctors and hospitals because reliable quality information is not available to them.
- Health care providers often don't have enough information on which treatments work best and are most cost-effective.
- Health care treatment patterns vary widely without detectable effects on health status.
- Some insurers now compete to insure the healthy and avoid the sick by determining "insurability profiles". They should compete on quality, value, and service.
- The average doctor's office spends 80 hours a month pushing paper. Nurses often have

to fill out as many as 19 forms to account for one person's hospital stay. This is time that could be better spent caring for patients.

- Insurance company red tape has created a nightmare for providers -- with mountains of forms and numerous levels of review that wastes money and does nothing to improve the quality of care.
- We have the best doctors who can provide the most advanced treatments in the world. Yet people often can't get treated when they need care.
- Our medical malpractice system does little to promote quality. Fear of litigation forces providers to practice defensive medicine -- ordering inappropriate tests and procedures to protect against lawsuits. Truly negligent providers often are not disciplined, and many victims of real malpractice are not compensated for their injuries.

GROWING COMPLEXITY

- Purchasing insurance can be overwhelming for consumers. With different levels of benefits, co-payments, deductibles and a variety of limitations, trying to compare policies is confusing and objective information on quality and service is hard for consumers to find. As a result, consumers are vulnerable to unfair and abusive practices.
- Insurers have responded to rising health costs by imposing restriction on what doctors and hospitals do. A system that was complicated to begin with has become incomprehensible, even to experts. Each health insurance plan includes different exclusions and limitations. Even the terms used in health policies do not have standard definitions.
- Small business owners -- who cannot afford big benefits departments -- have to spend time and money working through the insurance maze. For firms with fewer than five workers, 40 percent of health care premiums go to pay administrative expenses.
- Administrative costs add to the cost of each hospital stay with the number of health care administrators increasing four times faster than the number of doctors.
- Health claim forms and the related paperwork are confusing for consumers, and time-consuming to fill out.

DECLINING CHOICES

- Insurance coverage for most Americans is not a matter of choice at all. In most cases, they are limited to whatever policy their employer offers. Only 29% of companies with fewer than 500 employees offer any choice of plans.
- With a growing number of insurers using exclusions for pre-existing conditions, arbitrary cancellations and hidden benefit limitations, consumers have few choices for affordable policies that provide real protection.

THE HEALTH SECURITY ACT OF 1993

Health Care That's Always There

Every American citizen will receive a Health Security Card that guarantees you a comprehensive package of benefits that can never be taken away.

Guaranteeing comprehensive benefits that can never be taken away. Controlling health care costs for consumers, business and our nation. Improving the quality of American health care. Increasing choices for consumers. Reducing paperwork and simplifying the system. Making everyone responsible for health care. These are the principles of the Health Security Act of 1993 and they are not negotiable.

In America, rights and responsibilities go hand-in-hand. We will ask everybody to pay something, even if your contribution is small. Everyone must assume responsibility. No one should get a free ride.

Most important, we're going to offer new opportunities and new incentives for people to stay healthy -- and to treat small problems before they become big ones. Our goal should be to keep people healthy, not treat them after they become sick.

What's Wrong With the Current System

The things that are wrong with our health care system are threatening everything that's right with American health care.

- Over the next two years, one out of four of us will be without health coverage at some point. Change jobs, lose your job, or move -- and your insurance company is currently allowed to drop you.
- Today's system is rigged against families and small businesses. Insurance companies pick and choose whom they cover. Then they drop you when you get sick. If you have a pre-existing condition, you usually can't get any insurance at all.
- Insurance companies charge small businesses as much as 35% more than the big guys.
- Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have almost no choice today.
- Twenty-five cents out of every dollar on a hospital bill goes to bureaucracy and paperwork -- not patient care.
- Fraud and abuse are exploding, costing us at least \$80 billion a year. That's a dime of every dollar we spend on health care.
- Our nation's health costs have nearly quadrupled since 1980. Without reform, by the year 2000, one of every five dollars we spend will go to health care.

The Health Security Plan

*Every American citizen and legal resident will receive a Health Security Card. Once you get your card, you can **never** lose your health coverage -- no matter what. If you get sick, you're covered. If you change jobs, you're covered. If you lose your job, you're covered. If you move, you're covered. If you have the courage to start a small business, you're covered.*

***Your Health Security card guarantees you a comprehensive package of benefits that can never be taken away.** The package is as comprehensive as the ones that many Fortune 500 companies offer their employees. And in critical ways -- like paying for preventive care and prescription drugs -- the package gives you more than big companies provide today.*

***You will be able to choose your doctor.** Everyone will have a choice of health plans. You'll be able to follow your doctors and nurses into a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. Your boss or insurance company won't decide how or where or from whom you get your care -- you will.*

Almost everybody will be able to sign up for a health plan at work, like you do today. You'll get brochures that give you easy-to-understand information on several health plans -- which doctors and hospitals are included, an evaluation of the quality of care, a consumer satisfaction survey, and prices. If you're self-employed or unemployed, you can sign up at your area health alliance, which will be run by consumers and businesses and bargain for affordable health care for you.

The federal government will set up a national health board -- a board of directors to set standards and make sure you get the comprehensive benefits and quality care you deserve. State governments will set up health alliances give consumers and small businesses the power to buy affordable care; and the businesses with 5,000 or more employees will be allowed to operate as "corporate alliances."

Insurance companies will be required to use a single claim form to replace the thousands of different forms they have today. So when you get sick, you won't be buried in forms -- and neither will your nurse, your doctor or your hospital.

- **Security of guaranteed, comprehensive benefits.**
- **Health care costs that are under control.**
- **Improved quality of care.**
- **Increased choices for consumers.**
- **Less paperwork and a simpler system.**
- **Responsibility from everyone.**

That's what the Health Security Act is all about.

Principle #1:

Security: Guaranteed, comprehensive benefits.

Over the next two years, one of every four of us will lose health coverage for some time. The Clinton plan guarantees that you will never lose your insurance -- no matter what. All Americans will receive a Health Security card that guarantees you a benefits package that is as comprehensive as those offered by most Fortune 500 companies...and then some. Here's how the plan guarantees security:

- **Makes it illegal for insurance companies to deny you coverage because of "pre-existing conditions."** The Health Security Act also makes it illegal for insurers to raise your premiums or drop you because you get sick. All health plans will be required to accept anyone who applies -- healthy or sick, young or old.
- **Guarantees coverage if you lose your job.** The proposal guarantees that you will keep your health coverage even if you lose your job, with the employer portion picked up by Federal revenues and savings. Under the current system, if you lose your job, you lose your health insurance.
- **Guarantees coverage if you switch jobs, move or start a small business.** You will always be protected -- no matter what. Today, if you switch jobs, move or start a small business, you can find yourself without health insurance -- and risk bankruptcy.
- **Emphasizes preventive care.** The comprehensive benefits package goes beyond virtually all current insurance plans by covering a wide range of preventive services, including mammograms, Pap smears, and immunizations -- **at no charge to you.** It puts a new emphasis on helping you stay healthy, rather than waiting until you get sick. Prevention saves money and improves people's health.
- **Includes prescription drugs.** Many insurance companies and Medicare have failed to cover prescription drugs. But drug costs are breaking family budgets, forcing many older Americans to choose between food and medicine. Health insurance should cover prescription drugs. The Health Security plan does.

All Americans will be guaranteed coverage of :

- Preventive Care (i.e., screenings, physicals, immunizations, mammograms, prenatal care)
- Doctor Visits
- Prescription Drugs
- Hospital Services
- Emergency/Ambulance Services
- Laboratory and Diagnostic Services
- Mental Health and Substance Abuse Treatment
- Expanded Home Health Care
- Hospice Care/Outpatient Rehabilitation
- Vision and Hearing Care
- Children's Preventive Dental Care

Principle #2:

Savings: Controlling health care costs.

Here's how the Health Security Act will control health care costs:

- **Limits how much insurance companies can raise your premium.** Insurance companies will no longer be able to raise your premiums as they please. Today, insurance companies hike your premiums -- sometimes at several times the rate of inflation -- if you get sick, if someone in your family gets sick, and for any other reason.
- **Introduces competition to the health care marketplace.** The Health Security plan will release the chokehold that in today's system, insurance companies have on all of us -- consumers, nurses, doctors, and businesses. Reform will encourage competition -- forcing costs down as health plans compete by offering high-quality care at an affordable price.
- **Cracks down on fraud.** The health security proposal makes health-care fraud a crime and imposes stiff penalties on those who cheat the system. It prohibits doctors from referring patients to outside facilities, like labs, which they own a piece of. It stops the kickbacks that some laboratories give doctors in an effort to get their business.
- **Asks the drug companies to hold down prescription drug prices.** The Health Security plan asks drug companies to take responsibility for keeping prices down, without setting prices. In today's system, overcharging runs rampant -- certain prescription drugs cost Americans three times more than people pay in other industrialized countries.
- **Reduces paperwork.** All health plans will adopt a single, standard claims form by Jan. 1, 1995. Along with other measures to streamline the system and free nurses and doctors from excess bureaucracy, this will reduce paperwork, cut red tape, and save money.
- **Squeezes the waste out of Medicare and Medicaid.** By slowing the growth of these government programs, the proposal uses funds that have been wasted on excessive charges and funnels them into comprehensive benefits. Under reform, Medicare will be expanded to cover prescription drugs, and there will be a new long-term care program to help cover home- and community-based care. Today, Medicare and Medicaid spending keeps going up and up. But the elderly and poor aren't getting any extra benefits. Health security will change that.

Principle #3:

Quality: Making the world's best care better.

- **Emphasizes preventive care.** The Health Security plan puts a new emphasis on preventing illness before it becomes a medical crisis. Prevention will improve the quality of care by helping people stay healthy rather than treating them after they get sick. The benefits package fully pays for a wide range of preventive services; the vast majority of today's insurance plans don't cover a penny.

- **Gives consumers the power to judge the quality of care.** Consumers will receive quality "report cards" that provide information on the performance of health care plans and patient satisfaction. These report cards will hold health plans accountable for meeting high standards. The National Quality Program will help states share information on health plan performance.
- **Reforms malpractice.** The President's proposal will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to use alternative forms of dispute resolution before they end up in court. This will help eliminate the "defensive medicine" that drives up costs and hurts quality -- doctors ordering extra tests because they fear lawyers looking over their shoulders.
- **Encourages cooperation in rural and urban areas.** Rural residents will have access to the latest technology and emergency services through telecommunications links set up between local doctors and advanced networks of specialists and hospitals. In urban areas, the plan will increase investment in public hospitals and community health centers.
- **Provides incentives for more family doctors to practice in rural and urban areas.** The health security plan will give financial breaks to doctors and nurses who work in underserved rural and urban areas. It will expand the National Health Service Corps. Two of three rural counties today do not have enough doctors and 111 rural counties have no physician at all.
- **Increases funding for prevention research.** The National Institutes of Health (NIH) will expand research in areas like children's health, and health and wellness promotion. Preventive care keeps people healthier and saves money at the same time.
- **Promotes research on the effectiveness of treatments.** Today, a lack of information about the most cost-effective methods of treatment often leads to expensive defensive medicine and wide variation in treatments and costs. The plan's investments in research into what treatments really work will help improve the quality of care.

Principle #4:

Choice: Preserving and increasing what you have today.

- **Preserves your right to choose your doctor.** The proposal ensures that you can follow your doctor and his or her team to any plan they might join. Today, more and more employers are forcing their employees into plans that restrict your choice of doctor. After reform, your boss or insurance company won't choose your doctor or health plan -- you will.
- **Increases your choice of health plan.** You will be able to choose from among all the health plans offered in your area -- no matter where you work. Only one of every three companies with fewer than 500 employees offer any choice of health plan. After reform, every employee will be able to choose a health plan.
- **Puts consumers in the driver's seat.** The Health Security Act brings competition to health care -- unleashing the market forces that will lower costs and improve quality. Giving small

businesses and consumers the power to band together in alliances will level the playing field and give them the same bargaining strength as big businesses.

- **Increases options for long-term care.** The President's proposal will make it possible for more Americans to continue to live in their homes and communities while receiving care. Today too many families are split apart when insurance or federal programs only pay for hospital coverage. The plan will help put an end to this situation and give families the options they deserve.

Principle #5:

Simplicity: Reducing paperwork and cutting red tape.

- **Gives everyone a Health Security Card.** The card -- with full protection for privacy and confidentiality -- will allow for electronic billing and the creation of health care information networks. This will reduce paperwork and simplify the system.
- **Requires insurance companies to use a single claim form.** The Health Security Act will reduce the insurance company red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. All health plans will adopt a single, standard claims form by Jan. 1, 1995. It will enable doctors and nurses to spend more time taking care of you -- and less time wrestling with paper.
- **Eliminates fine print.** Everyone will get a comprehensive benefits package -- and what you get will be spelled out in easy-to understand language. If you get sick, insurance companies won't be able to point to fine print and deny you the coverage you've paid for.
- **Streamlines billing reimbursement for doctors, nurses and hospitals.** The comprehensive benefits package, a standard rules and codes for payment, and elimination of excessive government regulations will reduce confusion. Doctors, nurses, and hospitals will have more time to care for patients; and all of us will benefit.
- **Removes the burden on business of negotiating insurance.** Groups of businesses and consumers -- regional health alliances -- will negotiate for high-quality care at affordable prices. This will simplify today's system, where hundreds of thousands of businesses negotiate with more than 1500 insurance companies. The burden of finding insurance will be lifted -- and so will administrative costs -- which can run as high as 40% of total health costs for small business.

Principle #6:

Responsibility: Making everyone responsible for health care.

- **Cracks down on fraud.** The health security proposal makes health-care fraud a crime and imposes stiff penalties on those who cheat the system. It prohibits doctors from referring patients to outside facilities, like labs, which they own a piece of. It stops the kickbacks that some laboratories give doctors in an effort to get their business.

- **Asks the drug companies to hold down prescription drug prices.** The Health Security plan asks drug companies to take responsibility for keeping prices down, without setting prices. In today's system, overcharging runs rampant --certain prescription drugs cost Americans three times more than people pay in other industrialized countries.
- **Emphasizes preventive care.** The Health Security plan puts a new emphasis on preventing illness before it becomes a medical crisis. Prevention will improve the quality of care by helping people stay healthy rather than treating them after they get sick. It offers you full coverage of a wide range of preventive services, but asks you to take responsibility for keeping yourself healthy.
- **Reforms malpractice.** The President's proposal will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to use alternative forms of dispute resolution before they end up in court. This will help eliminate the "defensive medicine" that drives up costs and hurts quality -- doctors ordering extra tests because they fear lawyers looking over their shoulders.
- **Everyone contributes, and no one gets a free ride.** In America, rights and responsibilities go hand-in-hand. Everyone will get a Health Security card that guarantees you a comprehensive package of benefits that can never be taken away. But we will ask everybody to pay something, even if your contribution is small. Small businesses and low-wage workers will get substantial discounts on the cost of insurance, but everyone must take responsibility.

HOW THE SYSTEM IS FINANCED

The financing proposal was developed under the most rigorous and conservative forecasting standards. For the first time, representatives from every federal agency involved in fiscal accounting and financial projections have been brought together to work out the numbers. Then teams of actuaries, health economists and other financial analysts from outside the government served as auditors and consultants, checking and rechecking.

The system is financed from five major sources:

- 1) Medicare savings -- The savings from reducing the growth of Medicare are based on specific, scorable policy proposals. Every penny of these savings will be channeled back into benefits -- prescription drugs and long-term care -- for the people which these programs serve.
- 2) Medicaid savings -- The rate of growth of Medicaid can be reduced primarily by folding the acute care portion of Medicaid into the overall health care system. Since everyone will be insured, there will be savings in "uncompensated care" -- the money that goes to doctors and hospitals to compensate for caring for the uninsured.
- 3) Savings from federal employee health care costs -- As all federal workers are integrated into the overall health care system, there will be less expense to taxpayers to provide for their health care.

4) Reducing the benefits of tax-free compensation -- By reducing the rate of growth for health insurance, the President's proposal lowers the amount of compensation paid as tax-free health benefits, and frees up money for higher wages, wages for new workers, or profits -- all of which are taxable and thus bring in new federal revenues.

5) Sin taxes -- There will be some new "sin taxes," the composition of which is not yet decided.

In addition, there will be other savings. Reducing paperwork and administration, cracking down on health care fraud, and emphasizing prevention will save money in the long-run.

PAYMENT SCENARIOS

As a rule, most individuals and families in which at least one person works will pay a maximum of 20% of the average health plan premium in their area. Those who choose a lower cost plan -- from among those offered in the area -- will pay a little less than the 20% average. Those who choose a more expensive plan will pay a little more, as they do today. Employers who currently pay 100% of health benefits may continue to do so.

Two parent family with children: Two parent families with children -- whether one or both parents work -- pay a maximum of 20% of the family premium offered by the average plan in their area. If both parents work, they choose how to pay their family's share. They can have the share deducted monthly out of either paycheck or write a check to the local alliance.

Couple: Working married couples -- whether one or both spouses work -- pay a maximum of 20 percent of the average plan premium. They can have the share deducted monthly from either paycheck or write a check to the local alliance.

Single-parent family: Working single parents with children pay a maximum of 20 % of the average plan premium for a single parent policy.

Individual: Working single people pay a maximum of 20% of the average premium for an individual policy in their area.

Part-time worker with no unearned income: Part-time workers pay a maximum of 20% of the average plan premium for their policy type in their area.

EXCEPTIONS

Exceptions are provided for: (1) the self-employed and independent contractors; (2) part-time workers who have unearned income; (3) families with incomes below 150% of the poverty level; and (4) seasonal workers.

Self-employed/independent contractors: The self-employed and individual contractors can deduct from their taxes 100% of their health care costs. As with any small business, they pay the employer share. They also pay an individual share. If a firm earns less than \$24,000 a year, it is eligible for subsidies.

Part-time workers with unearned income: Part-time workers with unearned income pay a maximum of 20% of the average plan premium for their policy type -- individual, couple, two parent, or single parent family.

The number of hours someone works determines how much of the premium is paid by the employer and how much by the individual. For example, an employer would pay 40% of the premium for someone who works half-time. Payment of the remaining 40% of the premium depends on how much a person makes in unearned income, with subsidies provided on a sliding scale for those whose incomes are below 250% of the poverty level.

Families with incomes below 150% of the poverty level: Families at this level are eligible for discounted premiums and pay a maximum of 20% of the employee's share of the average plan premium. This applies to individuals making \$10,455 annually; couples with incomes of \$14,145; families of three earning \$17,835; and families of four with incomes of \$21,525.

Seasonal workers: Seasonal workers pay a maximum of 20% of the average plan premium in the area where they reside. Those whose incomes are 150% of the poverty level or below are eligible for discounted premiums. If they have unearned income and are not working, seasonal workers are treated the same as part-time workers.

Unemployed and non-working: Unemployed individuals and heads of household who make less than 150% of the poverty level are eligible for individual subsidies on a sliding scale. Those with unearned income pay all or part of what would normally be the employer's share of the premium.

Those whose incomes are 250% of the poverty level or less -- pensioners, for example -- are eligible for discounts on what would be the employer's share. They are not eligible for individual subsidies, and pay the normal individual share of the health premium.

HEALTH SECURITY

PRELIMINARY PLAN SUMMARY

The Health Security plan guarantees comprehensive health benefits for all American citizens and legal residents, regardless of health or employment status. Health coverage is seamless; it continues with no lifetime limits and without interruption if Americans lose or change jobs, move from one area of the country to another, become ill or confront a family crisis.

Every American citizen will receive a Health Security Card that guarantees comprehensive benefits that can never be taken away. Fundamental principles underlie health care reform:

- The guarantee of comprehensive benefits for all Americans.
- Effective steps to control rising health care costs for consumers, business and our nation.
- Improvements in the quality of health care.
- Increased choice for consumers.
- Reductions in paperwork and a simplified system.
- Making everyone responsible for health care.

Americans and their employers are asked to take responsibility for their health coverage and, in return, they are guaranteed the security that they will always be covered under a comprehensive benefit.

The Health Security plan creates incentives for health care providers to compete on the basis of quality, service and price. It unleashes the power of the market and puts American consumers in the driver's seat. Consumers choose from whom and how they get their care.

The plan empowers each state to set up one or more "health alliances" that contract with health plans and bargain on behalf of area consumers and employers. Health plans must meet national standards for coverage, quality, and service set by the National Health Board. But each state tailors its approach to local needs and conditions.

The Health Security plan frees the health care system of much of the paperwork and regulation, allowing doctors, nurses, hospitals and other health providers to focus on providing high-quality care. It cracks down on fraud and abuse, reforms malpractice law and policy and outlaws insurance practices that hurt small businesses and imposes the first national standards for the protection of patient privacy and confidentiality in medical information and records.

CREATING SECURITY

The Health Security plan guarantees every American and legal resident health coverage that can never be taken away:

- The comprehensive benefits have no lifetime limits on medical coverage and provides a full range of medically necessary or appropriate services.
- No health plan may deny enrollment to any applicant because of health, employment or financial status, nor may it charge some patients more than others because of age, medical condition or other factors related to risk.
- All health plans must meet national quality standards and provide reliable information to consumers so they can choose their health plans and providers.
- Americans have a broad choice of health plans and providers.
- Elderly and disabled Americans receive outpatient prescription drug benefits under Medicare for the first time and expanded access to home and community-based long-term care services.
- Self-employed workers are able to deduct the full cost of their health coverage from their federal income taxes.

- Workers older than 55 who retire before they are eligible for Medicare receive comprehensive coverage for the guaranteed benefit but continue to pay only the employee share of the premium.
- New investments and loans help improve the availability and quality of health care in rural communities and inner-city neighborhoods.
- School-based and community clinics expand access to care in areas with inadequate health services.
- Financial incentives and expansion of the National Health Services Corps attract health professionals to areas with shortages of doctors and nurses.

CONTROLLING COSTS

The Health Security plan cuts the projected growth in health care costs by increasing competition in health care, reducing administrative costs and imposing budget discipline. Health plans compete to provide affordable, quality care:

- Uniform, comprehensive health benefits and reliable information about the price and performance of health plans encourage informed choices.

Consumers may choose to pay less for lower-cost health plans or more for higher-cost plans, creating incentives for cost-conscious decisions.
- Payments to health plans are fixed, providing incentives to spend resources wisely. Payments are adjusted based on the risk characteristics of each health plan's participants.

If savings attained through competition and reductions in administrative burden fail to contain costs, limits on the rate of growth of insurance premiums provide an emergency brake -- or backstop -- to ensure that premiums remain in line with inflation.

Health reform also reduces the projected rate of growth in federal and state spending for Medicare, Medicaid, and other government programs. Resources conserved from those steps are applied to other aspects of the health care system, particularly the expansion of Medicare benefits to include prescription drugs and for new long-term care services.

The Health Security plan cracks down on providers and institutions that overcharge or engage in health care fraud. It sets tough new standards and imposes stiffer penalties that include:

- New criminal penalties for health care and for the payment of bribes or gratuities to influence the delivery of health services and coverage.
- New civil financial penalties against providers who submit false claims.
- Tighter restrictions to eliminate referral "kickbacks" in the private sector and new standards that prohibit physicians from sending their patients to get services at institutions in which they have financial interests.
- Strong accountability standards that make provider and other misconduct automatic grounds for exclusion from all health plans.

EXPANDING CHOICE

The Health Security plan guarantees consumers a choice of health plans and enhances the patient–doctor relationship.

- Alliances offer an array of competing health plans from which individuals and families choose their health coverage, expanding the range of choice for many Americans.
- Alliances must offer a traditional fee–for–service option in which every patient can see any physician he or she chooses.
- Consumers -- rather than their employers -- choose their health plan from among a menu of plans offered by alliances.
- Doctors and other health care providers also have a choice of health plans and delivery systems in which they may choose to practice medicine.
- Separate programs increase federal support for long–term care and improve the quality and reliability of private long–term care insurance.

ENHANCING QUALITY

The Health Security plan improves the quality of health care. It creates standards and guidelines for health professionals, reorienting quality assurance programs to measuring outcomes rather than regulation, increases the national commitment to medical research and promotes primary and preventive care.

- Health plans are held accountable for delivering appropriate, quality care.
- Regular surveys of consumer satisfaction are used to measure health plans.
- Regular publication of useful and easily understood information about quality and cost allows consumers to make informed choices among health plans.

- A special funding mechanism strengthens the role of academic health centers in research, training and specialized care.
- Increased investment in research advances medical knowledge.
- Changes in Medicare rate schedules and the allocation of federal funds supporting graduate medical education provide new incentives for physicians to choose primary care as the focus of their training.
- Expanded funds for education and new federal action helps remove artificial barriers to practice that hinder nurses and other professionals.
- Investments in public health and medical research improve health protection for all Americans.

REDUCING BUREAUCRACY

The Health Security plan reduces the burden of paperwork and administration, streamlines regulatory, billing and reporting requirements and helps reduce confusion.

- A comprehensive benefits package that covers every American and legal resident reduces confusion for health care providers and consumers.
- Administrative costs caused by multiple insurance policies with different benefits and risk selection disappear.
- Standard forms for insurance claims and billing procedures simplify paperwork and reduce administrative costs.
- Administrative costs for small companies decline as those firms purchase care through regional health alliances that benefit from economies of scale.
- The plan simplifies federal regulatory requirements for Medicare, Medicaid and programs that govern clinical laboratories.

- The plan requires that health care services covered by workers' compensation and automobile insurance be delivered through an individual's health plan reducing duplication and waste.
- Malpractice reform reduces incentives for the practice of "defensive medicine," including unnecessary tests and procedures.

THE HEALTH SECURITY PLAN

COVERAGE

All American citizens and legal residents are guaranteed a nationally defined, comprehensive package of benefits and enroll in a health plan. Coverage continues without interruption regardless of a change of employer, employment status, marital status or medical condition.

Coverage goes into effect -- state by state -- beginning in 1995 and is fully implemented by 1997.

The vast majority of Americans continue to receive their health coverage at work, as they do today. All workers have a choice of health plans, each of which must be certified as meeting quality standards. Unlike today, however, all employers contribute to the purchase of health coverage for their employees, both full and part-time.

Employed individuals receive information about enrollment and health plans either at work or directly from the alliance. Small business owners and their families, employees of small business, the self-employed and the unemployed sign up for the health plan of their choice through the regional alliance office in their area.

Firms or Taft-Hartley Plans with more than 5000 employees may fulfill their obligation to provide coverage for their employees by establishing a corporate alliance or joining the regional alliances. Corporate alliances must meet federal standards for benefits, choice and quality.

Medicare beneficiaries continue to receive all current benefits and, in 1996, receive a new benefit covering outpatient prescription drugs. New long-term care programs also expand access to home and community-based care.

Those people who receive health care through the Department of Defense, the Department of Veterans Affairs and the Indian Health Service may continue to do so.

Medicaid beneficiaries receive coverage through the regional health alliance, choosing among the health plans it offers.

BENEFITS

The health benefits guaranteed to all Americans contain no lifetime limits on coverage, and provide a comprehensive package of medical services delivered in hospitals, clinics, professional offices and other sites. One uniform, comprehensive benefit package replaces hundreds of different insurance products in the market today.

When medically necessary or appropriate, covered services include hospital care, emergency services, preventive care, mental health and substance-abuse services, family planning, pregnancy-related care, hospice care, home health and extended-care services following an acute illness, ambulance services, outpatient laboratory and diagnostic services, prescription drugs and biologicals, outpatient rehabilitation, durable medical equipment, vision and hearing care, periodic medical checkups and preventive dental services for children.

The plan includes coverage for a full range of preventive screening and care often not covered in traditional health insurance policies. Covered preventive care includes well-baby checkups and immunizations for children, periodic physical examinations, routine laboratory work and screening tests, with no charge to the patient.

Additional benefits, including preventive dental care for adults and a more comprehensive mental health and substance-abuse benefit, are phased into the nationally guaranteed benefits by the year 2001.

Individuals or employers who wish to purchase benefits beyond the nationally guaranteed package may do so.

All individuals in a health plan pay the same premium for the nationally guaranteed comprehensive benefits regardless of health status, age, place of residence or employment status. Health plans are prohibited from discriminating based on existing medical conditions and other individual characteristics.

Medicare beneficiaries continue to receive all current benefits and, in 1996, receive a new benefit covering outpatient prescription drugs. Financial support for long-term care also expands.

COST-SHARING

Health plans adopt one of three standard cost-sharing arrangements:

- **Low cost-sharing:** This follows the existing model for integrated health plans, such as health maintenance organizations. Consumers pay \$10 co-payments for outpatient and professional services and do not make additional co-payments for inpatient services, preventive services, or home health care following an acute illness.

To obtain care from providers outside the network, plans may offer a point-of-service option that allows patients to visit any doctor, including those who may not belong to the patient's plan.

- **Higher cost-sharing:** Following the existing model for fee-for-service plans, consumers may choose to see any provider. Individuals pay \$200 annual deductibles before coverage begins; families pay a \$400 deductible. Consumers pay 20 percent co-insurance after meeting the deductible. No individual pays more than \$1500, and no family pays more than \$3000. Consumers are not charged for preventive services included in the benefits package.
- **Combination:** Following the existing model for preferred provider organizations, consumers pay low cost-sharing (\$10 co-payments) when seeing physicians and other professionals in the provider network and higher cost sharing (20 percent co-insurance) when they consult providers who are not participants in the network. Preventive services are provided without charge.

CHOICE OF HEALTH PLANS

The Health Security plan allows individuals, rather than employers, to choose their health plans on the basis of quality and price. Today, only half of employed individuals have a choice of health plans. For the rest, employers choose their health plans, locking individuals and families into a system of care delivery and determining how much they pay out of pocket.

Because the Health Security plan requires that alliances provide at least one traditional fee-for-service plan, it preserves consumers' ability to choose their own doctors and other health providers -- an option that is not available to many today.

Likewise, doctors and other health providers may choose to participate in as many or as few of an alliance's health plans as they want.

Individuals whose employers provide more generous benefits than the nationally defined comprehensive benefits may continue those benefits at their current level without any change in coverage or cost.

SUPPLEMENTAL INSURANCE

Health plans may offer standardized supplemental insurance policies to cover cost-sharing or health benefits above and beyond the comprehensive benefits package. Employers may contribute to purchase supplemental coverage for their employees. Health plans that adopt the high-cost sharing option must offer their participants the opportunity to purchase supplemental insurance policies that cover cost sharing.

Supplemental insurance policies may not duplicate coverage of any services provided under the nationally guaranteed comprehensive benefit package.

LONG-TERM CARE

Existing nursing home coverage under Medicaid continues. Disabled Americans of all ages gain access to a wider variety of home and community-based support services, making it possible to continue to live at home. The Health Security plan also provides the following expansions and improvements in coverage for long-term care:

- Improvements in Medicaid coverage for institutional care expand eligibility for nursing home coverage. The amount of income and assets Medicaid beneficiaries may retain increase to \$12,000 and the \$30-a-month living allowance rises to \$100.
- The establishment of national standards improves the quality and reliability of private long-term care insurance, while tax preferences encourages its purchase.

- Tax incentives also support the efforts of people with disabilities to work, covering 50 percent of their costs for personal assistance and other necessary support.

MEDICARE

Medicare recipients experience no change in how and where they obtain health care or their existing benefits. In 1996, Medicare benefits expand to include coverage for prescription drugs under the Medicare Part B policy.

Medicare continues as a federally run program for individuals over age 65. Once the new health care system is in place, individuals have the option of enrolling in Medicare or remaining in their health plan when they turn 65.

Medicare beneficiaries have a broader range of choice through the expansion of managed care plans.

As the alliance system is fully implemented, states may provide Medicare benefits through alliances, provided the interests of Medicare beneficiaries and the Federal Treasury are safeguarded, and there is no reduction in benefits.

MEDICAID

Medicaid recipients under the age of 65 who are not eligible for cash assistance either through Aid to Families with Dependent Children or Supplemental Security Income no longer enroll in Medicaid. They choose a health plan through their area alliance, with 80 percent of the premium covered by employer contributions if they are employed, or premium discounts if they are unemployed and have low incomes.

Medicaid continues to pay the cost of health insurance for recipients of AFDC and SSI, who also pick a plan offered by the regional alliance. They may choose any plan priced at or below the weighted-average premium without making additional payments.

Like other members of the alliance, former Medicaid recipients with incomes below 150 percent of poverty are eligible for discounts to cover a portion of the cost of co-payments and deductibles if no plan with low cost sharing is available at or below the average premium. Health plans receive the same payment for Medicaid recipients as for other participants, reducing any stigma associated with obtaining coverage through Medicaid.

To pay for services covered in the comprehensive benefits to families that receive Aid to Families with Dependent Children and Supplemental Security Income payments, Medicaid pays health plans a fixed rate for each participant. Payments from the alliance to health plans are risk adjusted.

Medicaid coverage for other services, including nursing home coverage and special services for the severely disabled and supplemental services, continue as a public program.

RETIREEES

Americans who retire before age 65 and were employed for at least the amount of time used as a standard to qualify for Social Security purchase health coverage through their regional alliance and pay only the employee share of the premium for their health plan. The federal government pays the 80 percent employer share.

Although they may choose to pay more, employers whose retirement plans cover health insurance premiums for retired workers are responsible for paying only the employee's share, or 20 percent of the average premium.

CONTROLLING COSTS: MARKETPLACE REFORMS

The Health Security plan controls rising costs and improves the quality of health care by enlisting the power of a competitive market and empowering consumers to make choices that suit their needs.

Reform reduces administrative costs and frees up resources to improve quality and access for all Americans. The Health Security plan:

- Changes incentives in the insurance market so that health plans compete on the basis of quality, service and cost -- not risk selection.

Reform requires health plans to accept all applicants, and it forbids them from dropping anyone from coverage or charging some consumers more than others on the basis of age, gender, or health status or any personal characteristic.

- Empowers consumers to make more cost-conscious decisions by choosing among health plans on the basis of price and quality.

Consumers reap the savings from enrolling in a health plan that delivers the guaranteed benefits for a lower premium. If they prefer a plan that costs more, they pay the difference.

- Promotes the development of health plans that give consumers better value for their money.

In the current system, doctors and hospitals get paid extra for each service they perform. Under reform, health plans become accountable for both quality and price. The incentives change from "doing more" to giving consumers better value.

- Improves information about quality of care.

The program calls for regular monitoring of access, consumer satisfaction and the appropriateness and effectiveness of care. Consumers receive annual performance reports on health plans.

The Health Security plan also expands research related to the effectiveness of medical treatments and courses of care, fosters the development of practice guidelines and provides other information to help doctors, nurses and other professionals deliver more effective care.

- Creates standard reimbursement forms and requirements that simplify the business side of health care.

With some 1,200 different payers of health costs, hospitals, clinics and doctors contend with thousands of forms, conflicting regulations and inspections by a variety of federal, state, local and private agencies. The plan creates standard reimbursement rules and inspection procedures that streamline the system, reducing administrative overhead for providers.

- Lowers administrative costs for small groups and individuals as firms with fewer than 5,000 employees and the self employed join alliances, consolidating administration and purchasing tasks.

These groups currently pay as much as much as 30–40 percent of premiums to support administrative overhead, compared to 5–7 percent for large firms.

ENFORCEABLE CAP: THE BACK-STOP FOR COST CONTAINMENT

While ample evidence demonstrates that competition and increased efficiency control costs, the Health Security plan builds in a back-up measure to control health care costs: an enforceable cap.

The cap is met through capping the growth in insurance premiums paid by individuals and businesses to cover the guaranteed benefits. The Health Security plan guarantees comprehensive benefits and limits the rate of growth in premiums paid by employers and consumers for these benefits. By the end of the decade, insurance premiums are held to the rate of inflation.

Those limits are reasonable and achievable, given reforms that enhance competition in the health insurance market, simplify the system and reduce administrative costs, expand consumer choice and strengthen the negotiating power of employers and consumers through health alliances.

The projected rate of growth in federal and state spending for Medicaid is similarly limited, with coverage for Medicaid recipients provided through regional alliances. Specific reforms hold Medicare to comparable, but slightly higher, limits.

Health insurance premiums pay for coverage in the new system, just as health insurance premiums pay for coverage today. The Health Security plan limits how fast the cost of those premiums increase.

Alliance premium targets are based on the current level of health care spending in each area. They, therefore, vary substantially from alliance to alliance. The National Health Board appoints a commission to explore methods to reduce these variations over time.

In each regional health alliance, health plans bid each year to provide the guaranteed benefits, and alliances negotiate with them over premium levels. Premiums vary from plan to plan.

If the *average* premium across all plans is less than the alliance's premium target -- that is, if premiums, on average, are increasing consistent with inflation -- then no enforcement is triggered.

If the average premium across all plans exceeds the alliance's premium target, the premium, the cap prevents premiums from rising beyond the target. In that case, plans whose proposed premium increases exceed the allowed rate of growth are required to accept lower premiums. The plan must adjust its payment rates to providers or accept lower profits to make up the difference.

CORPORATE ALLIANCES

Large employers that form corporate alliances are expected to comply with the same limits on premium increases as regional alliances. If premiums in a corporate alliance exceed the allowed rate of growth during two of any three years, the Department of Labor may require the corporation to purchase coverage through regional alliances.

STRUCTURE OF THE NEW SYSTEM

A new national framework organizes the market for health coverage; the federal government, states and alliances divide responsibilities as follows:

Federal Government: Sets the basic framework for the system ● Defines guaranteed benefits package ● Determines caps on growth in insurance premiums ● Reforms insurance system ● Establishes quality standards
States: Implement health care reform within federal framework ● Establish alliance(s) ● Certify health plans ● Monitor quality and availability of care ● Implement insurance reform
Alliances: Serve as purchasing agent for employers and consumers ● Solicit competitive bids from health plans ● Distribute consumer information materials ● Collect premiums and pay health plans

NATIONAL FRAMEWORK

The new framework for health security includes these components:

- An independent **National Health Board** acts as the board of directors for the health care system, setting national standards and overseeing implementation of reform.
- **States** establish alliances and qualify health plans. Tailoring the system to local needs, states may create a single-payer system by establishing only one alliance and negotiating directly with providers.
- Regional and corporate **alliances** bring together consumers and employers, acting as their advocates in negotiations with competing health plans over service and price.
- Competing **health plans** deliver health services covered in the guaranteed comprehensive benefit. Each alliance offers a menu of plans, including a traditional fee-for-service arrangement, preferred provider organizations and health maintenance organizations.

FEDERAL RESPONSIBILITIES AND NATIONAL HEALTH BOARD

The National Health Board consists of seven members appointed by the President with the advice and consent of the Senate. The National Health Board assumes certain responsibilities for administering the new health care system, while existing federal agencies assume others. The Board:

- Sets national standards for state plans and ensures access to health care for all Americans.
- Interprets and updates the comprehensive benefits and recommends to the President and Congress changes in the health care system.
- Establishes a new performance-based quality management program and develops valid measures of health outcomes to be used in annual performance reports for health plans.

- Develops and implements standards for a national health information system, using a public-private network to support quality improvement and collects enrollment data and comparative information about cost.
- Implements the safety net of the national health budget.

STATE RESPONSIBILITIES

States ensure that all eligible individuals enroll in a regional or corporate alliance and have access to a health plan that delivers the guaranteed comprehensive benefit. Each state must implement plans approved by the National Health Board by January 1, 1997.

States may begin to implement the new system as early as January 1, 1995. Implementation involves adopting federal standards and establish health alliances.

Within the broad federal guidelines, states exercise flexibility in the design and governance of regional health alliances. States have the option to implement a single-payer system.

States certify health plans, much as they license health providers and insurance companies today. They determine mechanisms for evaluating the quality of health plans, their financial stability and capacity to deliver the guaranteed benefits, as well as compliance with prohibitions against discrimination based on race, ethnicity, gender, income and health status.

Only certified plans may offer health coverage through alliances. In the case of areas where no health plan forms, the state must assure that at least one health plan is available to cover every eligible individual.

HEALTH ALLIANCES

Each state creates one or more regional alliances that organize a menu of health plans, negotiate premiums and enroll individuals in plans. Within broad federal parameters, states exercise flexibility in the design and governance of regional alliances.

The vast majority of people continue to choose their health care coverage through their employers, who provide information on area health plans available through the alliance. The following groups obtain health coverage through regional alliances:

- Employees in firms with fewer than 5000 employees
- Employees of federal, state and local governments
- Individuals who are self-employed
- Part-time workers
- Retirees not yet eligible for Medicare
- Individuals who are not employed.

Health alliances consolidate the purchasing power of individuals, small- and medium-size businesses to secure the best health coverage for the lowest price. Alliances organize and streamline the fragmented insurance system, replacing health insurance brokers, agents and underwriters with consumer-run organizations focused on providing access, service, quality and affordable care.

Alliances drive the competitive forces that make the new system work for consumers and employers. Their mission is to:

- Bargain with health plans on behalf of consumers, business and purchasers of health care services.
- Negotiate premiums and coverage and ensure the delivery of high-quality care while controlling costs.
- Assure that all residents in the area enroll in health plans that provide the guaranteed comprehensive benefits.

Where inadequate services exist, alliances may organize health providers or use financial incentives to encourage health plans to expand.

Alliances operate as non-profit corporations, independent state agencies or agencies of the executive branch of the state. The board of each alliance includes an even number of consumer and employer representatives but may not include health providers and others who profit from the industry. Each alliance also forms an advisory board composed of health care professionals and providers who practice in its health plans.

Alliances hold an annual open enrollment period during which they offer consumers a menu of health plans, including at least one traditional fee-for-service plan.

Alliances negotiate rates for premiums with each health plan and collect premium contributions. Alliances pay health plans a fixed premium for each individual or family that enrolls, adjusting the total payments to plans to reflect the health status of that plan's participants.

CORPORATE ALLIANCES

Firms employing more than 5000 workers, Taft-Hartley plans and rural cooperatives are eligible to organize corporate alliances, although they may also choose to purchase coverage through regional alliances. Corporate alliances resemble the operation of large employers' benefit departments, arranging premiums and the delivery of services.

Corporate alliances provide health benefits to their employees either through a self-funded employee benefit plan or through contracts with health plans. They operate under the same rules as regional alliances except that the population served is limited to company employees and their dependents. Each corporate alliance contracts with at least one fee-for-service plan and offers at least two other health plans.

The U.S. Department of Labor monitors the operation of corporate alliances, fulfilling the same role that it assumes under the Employee Retirement Income Security Act of 1974 (ERISA).

Organizations eligible to form corporate alliances may exercise a one-time option to have individual establishments with fewer than 100 employees join regional alliances at community rates. Large corporations also periodically have the option to join regional alliances at a risk-adjusted rate, which gradually declines to the community rate.

A new chapter in ERISA establishes fiduciary and enforcement requirements for employers and other sponsoring health benefit plans in corporate alliances.

HEALTH PLANS

Competing health plans provide medical services guaranteed in the comprehensive benefits, delivering them through fee-for-service networks, preferred provider organizations and health maintenance organizations. Health plans may not:

- Deny enrollment to any person based on individual characteristics, health status or anticipated need for health care.
- Terminate, restrict or limit coverage for the comprehensive benefit package for any reason.
- Cancel coverage for any eligible individual until that individual is enrolled in another health plan.

COMMUNITY RATING

Health plans offer coverage at the same rates for all participants, regardless of age, health or other personal characteristics. Alliances adjust payments to health plans to account for the level of risk among individuals enrolled in each plan.

IMPROVING HEALTH SERVICES

The Health Security plan seeks to remove financial and non-financial barriers that limit care for Americans who live in urban centers, rural communities and those who suffer from certain illnesses. Because a disproportionate number of residents of rural communities and urban centers lack health coverage today, universal coverage will bring major new health resources into those communities.

The plan improves access specifically for Americans who live in rural areas through initiatives to:

- Develop communications links between rural health professionals and academic health centers.
- Create incentives to expand community-based networks of health providers and plans, such as long-term contracts for health plans in rural areas and federal loan guarantees for capital improvements.
- Attract health professionals to rural areas through the expansion of the National Health Service Corps, tax incentives to encourage practice in rural areas, and changes that increase compensation for primary care physicians who serve Medicare beneficiaries.
- Expand the rural public health system, including support for transportation, outreach, case management, translation, health education, nutrition, social support, child care and home visiting services.

The Health Security plan makes federal grants and loans available in underserved urban communities for capital investment. The government further supports the efforts of traditional health care providers, such as community-based clinics, to adapt to the new system through designation as essential community providers.

Essential community providers receive special protection: For five years, health plans are required to reimburse these providers for services. At the end of that period, health plans must either demonstrate their capacity to provide access for all participants -- including residents of underserved areas -- or continue contracting with essential providers.

Federal block grants that support community health centers, family planning clinics, health care for homeless families and maternal and child health programs continue. New initiatives include funding for school-based clinics.

TRANSITION

STATE IMPLEMENTATION

States begin implementation of the new system as early as January 1, 1995. Most states come into the system in 1996; the rest are required to begin implementation by 1997.

At the time of state implementation, federal discounts for small, low-wage employers and low-income individuals and families become available. States that expedite implementation receive financial incentives including special start-up funds, and early access to federal funding for discounts.

Organizations eligible to establish corporate alliances must begin providing the guaranteed benefit package by January 1, 1997.

INSURANCE REFORM

To reduce the potential for disruption during transition, interim insurance reform imposes new rules including:

- Prohibitions against dropping consumers from coverage.
- Prohibitions against profiteering.
- Prohibitions against reducing coverage.
- Creation of a national risk pool to assure access to coverage during the transition.
- Assurance of portability of coverage

FINANCING HEALTH COVERAGE IN THE PRIVATE MARKET

The Health Security plan caps employer contributions for insurance premiums as a percent of payroll. The cost of providing health coverage declines for most firms that currently provide insurance.

- The plan eliminates the \$25 billion that employers pay each year to cover the cost for uninsured patients.
- In the current system, many employers pay the entire premium for family policies, while the employer of a worker's spouse makes no contribution. Under reform, both employers share the cost for families in which two spouses work.
- In the current system, health insurance premiums for many employers total more than 10 percent of payroll. Under reform, premiums paid by employers purchasing through regional alliances are capped at 7.9 percent of payroll.

Businesses that employ fewer than 50 workers receive additional discounts on their insurance premiums, reducing their contributions to between 3.5 percent and 7.9 percent of payroll.

- Under reform, employers in regional alliances pay community rates that do not vary according to the age, gender or health status of their workers.

Employer obligations for insurance premiums are calculated based on the average premium among health plans in their area. As competition among health plans -- backed up by national caps on premium increases -- brings the rate of growth in health costs under control, the projected rate of growth in health costs declines throughout the business sector.

EMPLOYER PAYMENTS

- Employers pay 80 percent of the average premium in the alliance toward the cost of the policy chosen by the employee, which depends on the employee's family status.

For employees with a spouse, the employer contribution is reduced to reflect the contributions on behalf of dual wage earners in the alliance region.

- For part-time workers, employers pay a pro-rata share of the 80 percent employer contribution based on the number of hours worked.

CONSUMER PAYMENTS

Working Individuals and Families: Individuals and families in which at least one person works pay a maximum of 20 percent of the premium to enroll in the average-cost health plan in their area.

- Those who choose a lower-cost plan pay less than the 20 percent average.
- Those who choose a more expensive plan pay more, as they do today.
- Employers who currently pay 100 percent of the premium for their employees may continue to do so.

Working individuals and families may have their share of the premium deducted from their paychecks or write a check to the local health alliance.

Consumers pay premiums based on the type of policy they need to purchase:

- Two parent family with children.
- Couple.
- Single parent family.
- Single individual.

Individuals and families with incomes below 150 percent of the federal poverty level -- \$21,525 for a family of four -- are eligible for discounts on the employee's share of the premium.

Part-Time Workers: Part-time workers are responsible for the 20 percent employee share of the premium, and workers with incomes below 150 percent of the poverty level receive discounts.

The number of hours an employee works determines how much of the employer share of the premium is paid by the employer and how much by the worker. For example, an employer would pay 40 percent of the premium for someone who works half-time. The worker is responsible for the remaining 40 percent of the premium, with discounts provided on a sliding-scale basis.

A part-time worker with more than one job receives contributions from more than one employer toward the employer's share of the premium.

Unemployed Individuals: Unemployed individuals and families are responsible for the 20 percent employee share of the premium and receive a discount if their incomes are below 150 percent of the poverty level. They also are responsible for what would be the employer's share of the premium but receive discounts on a sliding-scale basis to help cover the cost.

Self-employed Individuals: The self-employed worker pays the 20 percent employee share of the premium and receives a discount if his or her income is below 150 percent of the poverty level. Self-employed workers also are responsible for the 80 percent employer share and receive the same discounts as small employers. They may deduct from their taxes 100 percent of their health care premiums.

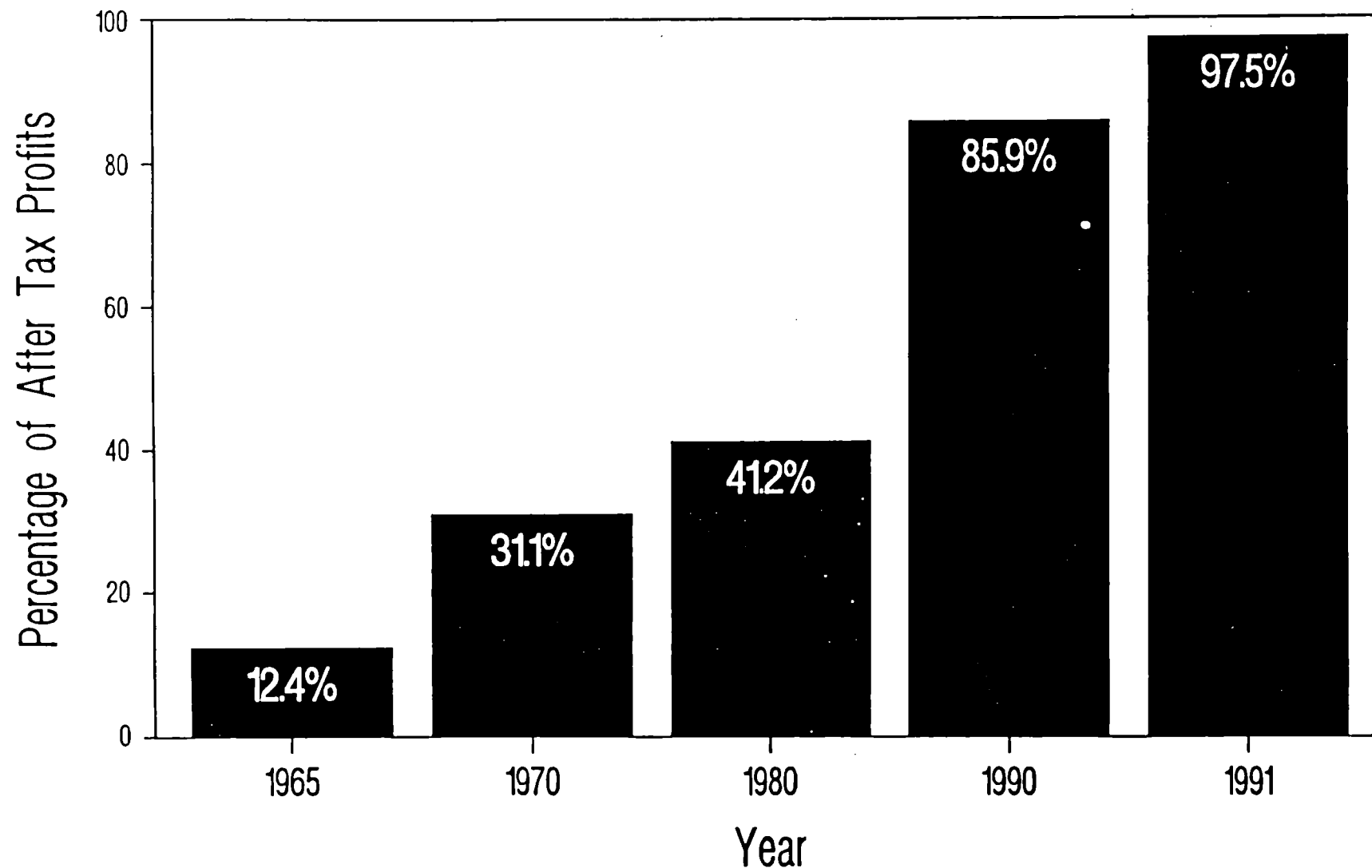
TAX DEDUCTIBILITY

Employer contributions toward the premium and toward cost sharing related to the nationally guaranteed comprehensive benefit -- as well as for additional benefits phased in by the year 2001 -- are fully tax deductible and not counted as taxable income for employees.

Tax preferences continue for benefits in excess of the nationally guaranteed benefit package offered as of January 1, 1993, for ten years after enactment of health reform.

Health Spending Is Eating Up Business Profits

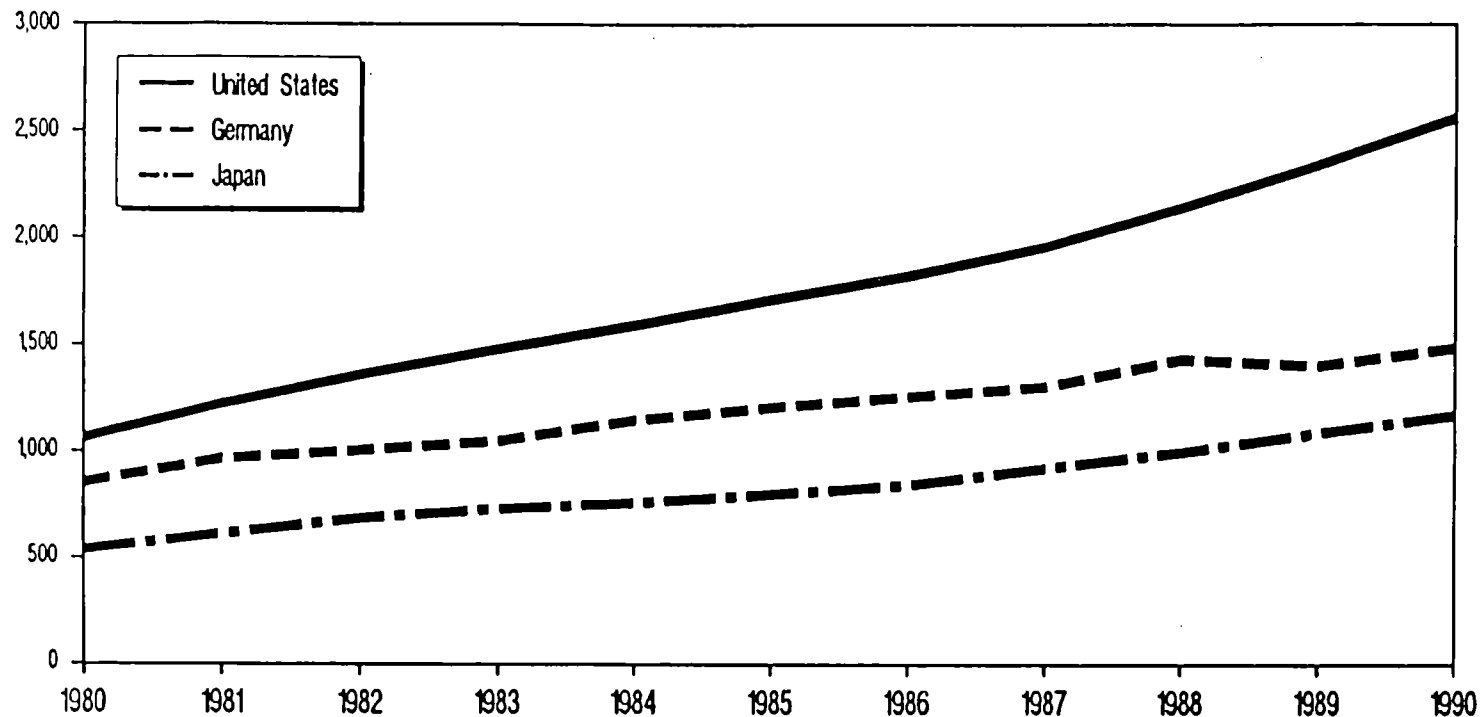
Businesses' health care costs are nearly equal to their after-tax profits.



SOURCE: HCFA, Office of the Actuary

America Pays More Than Any Of Our Competitors . . .

Other industrialized countries provide health security for their citizens and control health care costs.



. . . With Less To Show For It

- Infant Mortality: U.S. ranks 21st out of 24
- Life Expectancy: U.S. ranks 17th for men and 16th for women

SOURCE: Per capita data; *Health Care Financing Review*, Summer 1992

BENEFITS UNDER THE HEALTH SECURITY PLAN

COVERED:

- 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

NOT COVERED:

- 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
- Private Room Accommodations
- Custodial Care
- Personal Comfort Services and Supplies
- Investigational Treatments, (except for Medically Necessary or Appropriate Care provided as part of an Approved Research Trial)

**BENEFITS: THE HEALTH SECURITY PLAN
COMPARED WITH CURRENTLY OFFERED PLANS**

BENEFITS	HEALTH SECURITY PLAN		BLUE CROSS STANDARD, FEHBP	FORTUNE 500 COMPANY
	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS) ¹		
Medical Plan Maximum	No lifetime dollar maximum limit	No lifetime dollar maximum limit	Lifetime maximum for organ/ tissue transplants, mental health and substance abuse	Lifetime maximum for inpatient substance abuse
Out-of-Pocket²	\$1500 / individual \$3000 / family maximum	\$1500 / individual \$3000 / family maximum	\$3000 / individual \$3000 / family	\$1,000 per covered individuals - does not include deductibles
Deductibles	None	\$200 / individual \$400 / family	\$200 / individual \$400 / family	\$200/individual \$400/family
Inpatient Hospital³	Full coverage, no coinsurance no dollar or day maximum	20% coinsurance no dollar or day maximum	\$250 per admission deductible No dollar or day maximum	Full coverage in-network; 20% coinsurance out-of- network
Doctors Office Visits, Hospital Outpatient	\$10 copay per visit no dollar or visit maximum	20% coinsurance no dollar or visit maximum	25 % coinsurance	20% coinsurance
Outpatient Lab	Full coverage	20% coinsurance	25 % coinsurance	Full coverage in-network 20% coinsurance out-of- network
Emergency	\$25 copay per visit, waived in emergency	20% coinsurance	Full coverage within 72 hrs. of accident	Full coverage - required plan notification within 48 hours
Preventive Services⁴	Full coverage, based on periodicity schedule	Full coverage, based on periodicity schedule	25 % coinsurance 100% well childcare	not specified
Prescription Drugs	\$5 per prescription	\$250/year deductible 20% coinsurance	\$50 deductible 40% coinsurance	20% coinsurance 50% coinsurance for drugs for treatment of mental or nervous conditions

1. FFS - fee for service

2. Deductibles counted toward out-of-pocket limits.

3. Mental health and substance abuse have separate provisions, see below.

4. Including well-child and prenatal care, periodic health exams, targeted tests and vaccines.

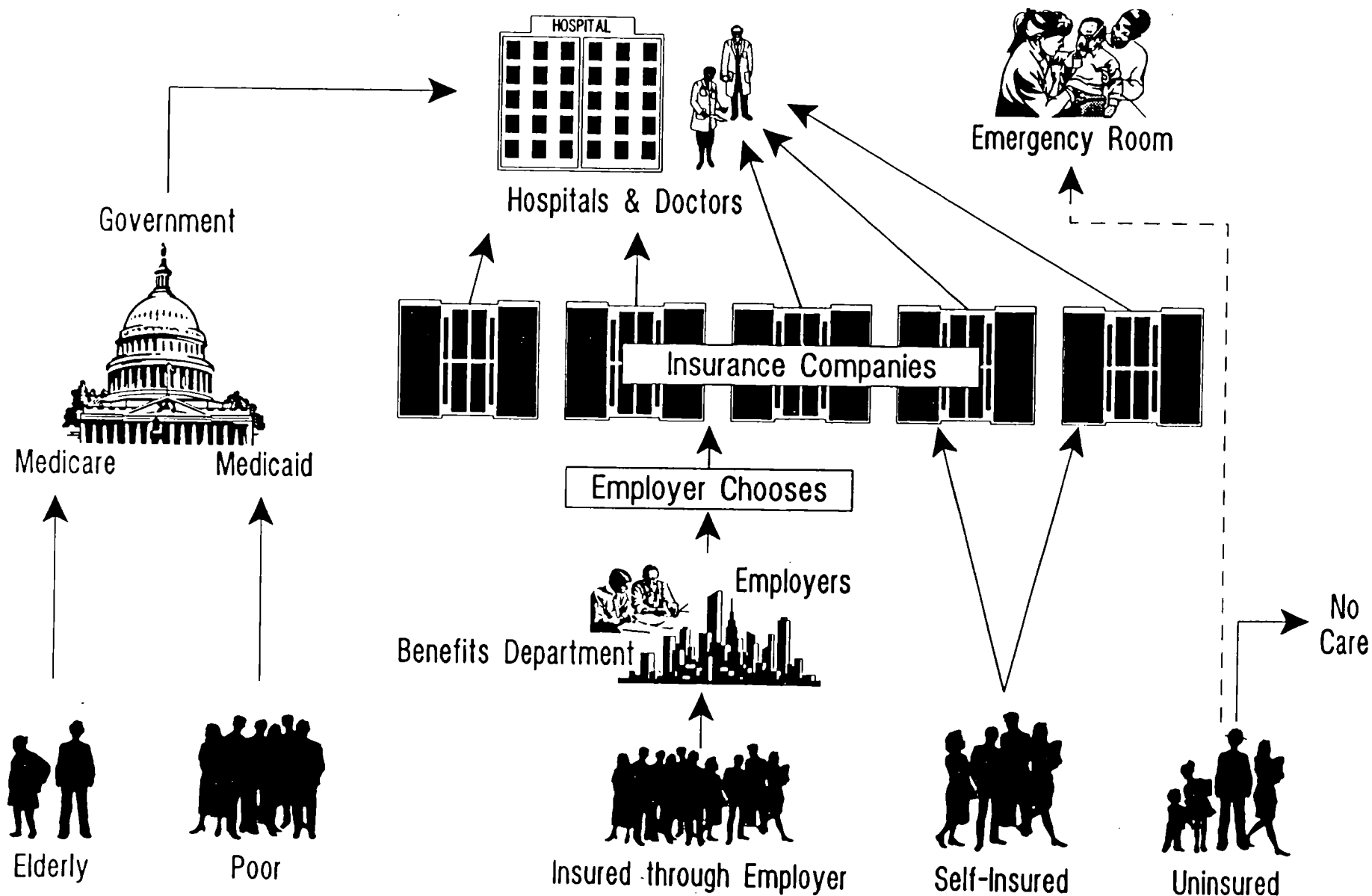
BENEFITS	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS)	BLUE CROSS STANDARD, FEHBP	FORTUNE 500
Inpatient Mental Health (MH) and Substance Abuse (SA) ⁵	Full coverage 30 day limit / episode 60 day annual limit	1 day deductible 20% coinsurance 30 day limit / episode 60 day annual limit	\$250 per admission deductible; 40% coinsurance Unlimited days \$3,000 maximum for substance abuse treatment program - 28 day max. \$50,000 lifetime maximum	20% coinsurance pre-certification required Substance abuse: Full coverage in-network 20% coinsurance out-of-network; 30 days per stay; 2 stays maximum
Outpatient Mental Health and Substance Abuse	All outpatient except psychotherapy - \$10 / visit Psychotherapy - \$25 / visit; 30 visits annual maximum Hospital alternatives - full coverage; 120 day annual maximum	All outpatient except psychotherapy - 20% coinsurance Psychotherapy - 50% coinsurance; 30 visits annual maximum Hospital alternatives - 1 day deductible, 20% coinsurance; 120 day annual maximum	40% coinsurance; 25 visits annual maximum - includes partial hospitalization \$50,000 lifetime maximum	20% coinsurance for employee 50% coinsurance for dependent Substance Abuse: 20% coinsurance, 30 visit maximum
Hospice	Full coverage	20% coinsurance	100% coverage for home hospice; \$250 per admission for inpatient hospice with 5 consecutive day limit	Not specified
Home Health (HII)/ Extended Care (ECF - SNF and Rehab Hospitals)	Full coverage as inpatient alternative 100 day annual limit extended care facilities	20% coinsurance as inpatient alternative 100 day annual limit extended care facilities	25% coinsurance 25 visit limit for home nursing care	20% coinsurance
Routine Eye Exams, Eyeglasses	\$10 per exam, or 1 set of glasses. Glasses limited to children only	20% coinsurance Glasses limited to children only	Not covered	Not specified
Preventive and Emergency Dental ⁶	\$10 / visit Preventive services limited to children <18	20% coinsurance Preventive services limited to children <18	Covered at fee schedule	Not specified
Prenatal Care	Full Coverage	Full Coverage	25% coinsurance	20% coinsurance
Outpatient Rehabilitation	\$10 copay per visit; reassessed at 60 days for continuing improvement	20% coinsurance; reassessed at 60 days for continuing improvement	25% coinsurance 25 visit limit	Not specified
Durable Medical Equipment	Full coverage	20% coinsurance	25% coinsurance	Not specified

5. In 2001, inpatient and outpatient MH/SA limitations and higher cost sharing are phased out.

6. In the year 2000, adult prevention / restoration, orthodontia.

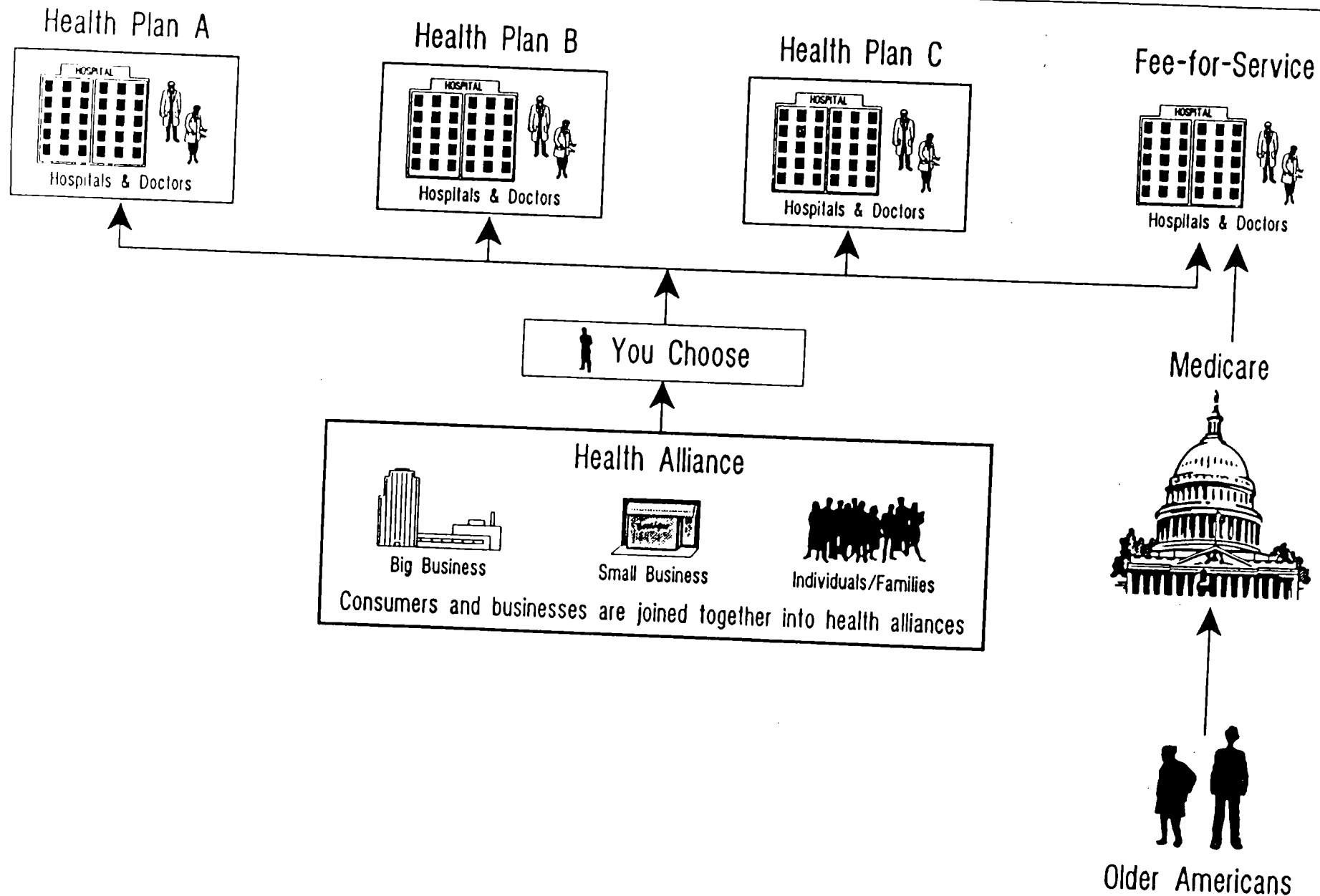
How You Get Coverage: The Current System

Today's patchwork system is confusing, wasteful, and expensive – with many layers of bureaucracy between people and their doctors.



How You Get Coverage: The New System

Health care reform brings people closer to their doctors and the high quality, affordable care they deserve.



FEDERAL, STATE, AND ALLIANCE RESPONSIBILITIES

THE FEDERAL GOVERNMENT

- ▶ Sets the basic system framework
 - Federally guaranteed benefits package
 - Determines budget baseline, increases, and enforcement
 - Insurance reform

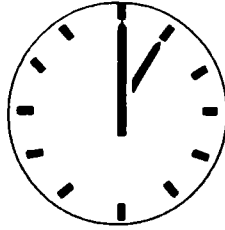
THE STATES

- ▶ Within federal framework, adopt health reform arrangement of choice (e.g. single payor, managed competition, etc.)
 - Establish alliances
 - Certify health plans
 - Monitor quality of and access to care
 - Implement insurance and malpractice reform

ALLIANCES

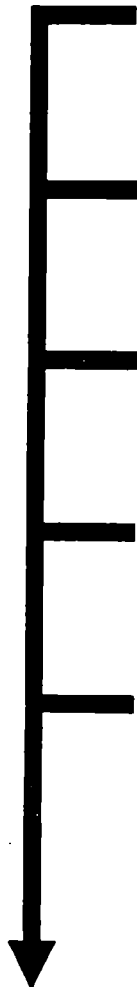
- ▶ Serves as collective purchasing agent for employers and consumers at the local level
 - Solicit competitive bids from health plans
 - Disseminate consumer information materials
 - Enroll all eligible residents
 - Collect premiums and pay health plans
 - May administer subsidies

HEALTH CARE REFORM TIMELINE



DATE

MILESTONE



12/93

Enact American Health Security Act

4/94

National Health Board Fully Operational

1/95

First States Enter New System

1/96

Additional States Enter New System

1/97

All Remaining States Enter New System

ALL AMERICANS HAVE HEALTH SECURITY

**SMALL BUSINESS AND INSURANCE REFORM
THE HEALTH SECURITY PLAN**

In today's system, many employers often charge small businesses more for similar policies or refuse to provide them coverage at all.

TODAY	THE HEALTH SECURITY PLAN
The Hassle: Small business owners spend time and money in a maze of insurance policies, forms, and requirements.	Eliminates Hassle: No more headaches. The employee chooses a plan and the alliance solicits competitive bids, provides information, and enrolls customers.
Small risk pool: Fewer employees mean a smaller pool to share the risk. Insurers frequently charge more for these policies.	Spreads risk evenly: Small businesses can band together in large purchasing pools to give them the same bargaining power as large firms.
The Bait and Switch: Many insurers offer "discount" rates to lure in small businesses, only to charge much higher prices the next year.	Outlaws the bait and switch and ends the days when insurers can raise and lower premiums at their whim.
Occupational redlining: Some insurers simply refuse to cover entire "high risk" industries.	Covers everyone: Everyone is guaranteed coverage that can't be canceled or curtailed.
Refusal to renew: Small businesses often face difficulty obtaining renewal.	Guarantees renewal: Small businesses can drop their insurers, but insurers can't drop them.

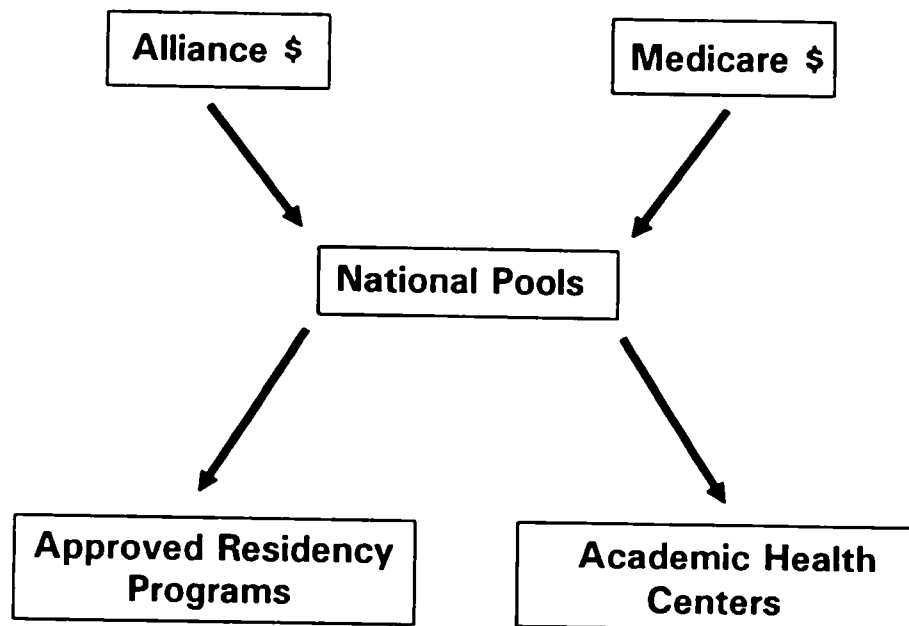
SMALL BUSINESS AND COST CONTROL: THE HEALTH SECURITY PLAN

In today's health care system, small businesses are overwhelmed by higher administrative costs, workers compensation insurance, and an inequitable tax policy that only allows the self-employed to deduct 25% of their health insurance premiums. The Health Security Plan will reduce and control these costs.

TODAY	THE HEALTH SECURITY PLAN
Higher costs from administrative costs and insurance abuses: Small businesses pay as much as 40% in administrative costs. Insurers can charge those with sick employees dramatically higher costs.	Eliminates higher administrative costs. Reforms the insurance system and prevents insurers from discriminatory pricing, raising rates, or dropping coverage after illness strikes.
Faster rising costs: Small business costs are rising faster than other employers' costs -- as much as 50% in any given year.	Aggressively controls costs through market based competition backed up by an enforceable budget.
Inequitable self-employed tax policy: The self-employed businesses can only deduct 25 percent of their health care expenses.	Increases deduction to 100% for self-employed, allowing them to deduct the full value of their health insurance coverage.
High workers' compensation costs: Workers compensation costs are growing even faster than health care costs.	Reforms workers' compensation by treating injured workers through health plans -- lowering costs and eliminating duplication.
Small business owners have little bargaining power over their costs or benefits.	Assures business owners a seat on alliance board to negotiate costs and quality of plan.
Volatile costs: In the small group market, identical benefits packages can vary in price by as much as 350%.	Ensures fair, predictable costs through community rating.

ACADEMIC HEALTH CENTERS AND GRADUATE MEDICAL EDUCATION

- ▶ The Health Security Plan pools funds to support the costs associated with graduate medical education as well as the special functions carried out by academic health centers, over and above the provision of routine care.
- ▶ All payers will contribute a surcharge on health plan premiums to the pool.
- ▶ A National Council on Graduate Medical Education will allocate residency positions with the goal of bringing primary and specialty care into balance.
- ▶ Funds to Academic Health Centers will be distributed through a formula that recognizes each center's contributions to education, research, and specialized patient care.



MEDICAL CLAIM FORM

Health Plan Information

1) Health Plan:

2) Health Plan Number:

Patient Information

1) Last Name:

2) First Name:

3) Middle Initial:

4) Patient Identification Number

5) Gender:

6) Patient Signature:

7) Date:

8) Release Medical Information?

Yes:

No:

Subscriber Information

1) Last Name:

2) First Name:

3) Middle Initial:

4) Subscriber Identification Number:

Treatment

1) Is need for care: a: Employment-related?

b: Auto accident-related?

c: Other accident-related?

d: Appointment?

e: Emergency?

2) Initial Diagnosis:

3) Final Diagnosis:

4) Description of Encounter:

Dates of Service:

From

Through

Place of Service:

Primary

Diagnosis

Code:

Procedure

Code:

Units/Days

of Service:

Covered

Charges:

Non-covered

Charges:

Co-pay

Collected:

Optional

Field:

a.	1/1	1/1								
b.	1/1	1/1								
c.	1/1	1/1								
d.	1/1	1/1								
e.	1/1	1/1								
f.	1/1	1/1								
5) Total:										

Health Care Provider Information

1) Name:

2) Identification Number

3) Signature:

4) Date:

file - Health Care

MEMO

Subject: Health care

TO: David Gergen
Mark Gearan
George Stephanopoulos
Dee Dee Myers

FROM: Ann Walker
Jamie Harmon

DATE: 8/3/93

RE: Parallels Between The Fight For Truman's Health Care Plan and the Fight for Clinton's Health Care Plan

President Harry S. Truman's health care package, which he introduced in 1945, tried to deal with many of the same problems, and he made many points which are similar to those the President is making today.

In his *Special Message to the Congress Recommending a Comprehensive Health Care Program*, delivered on November 19, 1945, he made the following points:

- "Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection."
- "The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is not true only for needy persons. It is also true for a large proportion of normally self-supporting persons. They may be hit by sickness that calls for many times the average cost - - in extreme cases for more than their annual income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good."
- "We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation."

- "Great areas of our country are still without [public health services and maternal child care]. This is especially true among our rural areas; but it is true also in far too many urban communities."
- "In the conquest of many diseases prevention is even more important than cure. A well-rounded national health program should, therefore, include systematic and wide-spread health and physical education and examinations, beginning with the youngest children and extending into community organizations."
- "Under this plan I suggest, our people would continue to get medical and hospital services just as they do now -- on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: whether or not patients get the services they need would not depend on how much they can afford to pay at the time."
- "We are a rich nation and can afford many things. But ill-health which can be prevented or cured is one thing we cannot afford."

The AMA responded to Truman's proposal by organizing the best financed lobbying operation of its day to defeat the measure. In three and a half years, the AMA alone spent over \$26,000,000 (in 1993 dollars). In addition, thousands of smaller groups, including many local committees of doctors and allies such as insurance agencies, spent at least \$12 million (in 1991 dollars).

The AMA bombarded the American people with their message that people should be able to choose their own doctor. Slogans ran from "When You Are Sick, Do You Want Doctors -- or Clerks?" to "Who is for Compulsory Health Insurance? ...All who seriously believe in a socialist state. Every left wing organization in America... The Communist Party." This message was communicated in over 100 million pieces of literature, and in ads in newspapers, magazines, radio, and national magazines.

The campaign was so effective that national health insurance never came to a serious Congressional test.

(Kelley, Stan. *Professional Public Relations and Political Power*. The Johns Hopkins University Press: 1959)

Health Care file

MEMORANDUM

To: Mack McLarty
Bill Burton

From: Dwight

Date: June 22, 1993

Subject: Health Care Decision Group Meetings Reconvening

Since my last memo on the status of the health care plan, the full decision/recommendation group of combined health care and economic advisors had not met until today. The damaging and distorting leaks from the last meeting--which, as you may recall, was extraordinarily positive--combined with the President's necessary focus on reconciliation, have forestalled activity.

Ira is preparing to begin going back to the President for key decisions as soon as mid-July. He is working with his numbers people, with guidance from the economic team, to fully flush out two financing options: 1 premium-based, and 1 payroll-based. Each will in turn be evaluated under two different phase in plans: 1) begin coverage of comprehensive plan in 1996, with some adjustments afterwards, and 2) begin coverage with a "major medical" (catastrophic) plan, and phase up to a comprehensive plan by 2000.

The Options

The issues and options have not changed significantly since the fall. The problem with the payroll option is that it looks an awful lot like a tax. Ultimately, it will serve as a substitute for current insurance payments, and will be less costly than current payments for many Americans. Nonetheless, it will be, in the eyes of most Americans, a tax. [The total payroll payment numbers from Ira have ranged from the 7 to 11% for both employer and employee contribution]

The premium-based option would require employees and employers to pay a certain percentage of an average weighted premium, calculated regionally. The problem with premium-based financing is that you have to subsidize low income employees and small businesses--which is *extremely* complicated to administer. In addition, you have to set up distinct financing for the subsidies, because premium payments will be based on the cost of the health plan, and will not include supplemental payment to cover subsidies.

[With a payroll payment, progressive subsidies are incorporated into system: if you make less money, you pay less tax.]

The Process

Ira is hoping to work through a process for presenting these options to the President with the economic team over the next few days. It's interesting to note that the occasional tension which resulted from the question of whether or not health care might interfere with reconciliation has, naturally subsided.

Addendum for Bill:

[Please share with Mack if you consider appropriate]

I do have one process concern is that the realm of policy questions which will be decided by the President seems to keep dwindling. Initially, Ira started with a decision memo with over a thousand decision points. This shrank [logically] to around 20 in late April. In mid-March, Ira had narrowed his list of Presidential decisions to six key issues. Now we are down to 1 or 2 issues. This whittling down of remaining issues has occurred without any formal decision-making on the part of the President.

While I'm sure Ira has been given guidance from the President and First Lady on these issues, the integrity of the President's decision process--maintained for decision memos by the staff secretary process--is of utmost importance for this awesome issue. If decisions were made without full and appropriate consultation with all relevant senior advisors--especially if these decisions were determined principally by staff momentum--then the integrity of the decision process may have been jeopardized.

My concern is simple: the devil will be in the details in this proposal. If details have been decided upon absent some key advisors, then avoidable devils may be lurking in the plan. Through the conclusion of the process, we must work to ensure full and careful consideration of all details of the plan--not just the big picture items such as financing--by all relevant senior economic and health care advisors.

cc: Mark Gearan

THE CLINTON HEALTH CARE PLAN

THE STATUS QUO

- American families do not have the security they deserve. 100,000 people a month are losing their coverage, and those who switch jobs or have a pre-existing condition are not guaranteed coverage.
- Americans are getting killed by skyrocketing health costs. Without immediate reform, the annual cost of health care for American families will more than double by the end of the decade -- to a whopping \$14,000 per family.
- The current system is broken -- and it threatens your family's future and the future of every American business.
- We must take action now.

THE CLINTON PLAN

President Clinton will soon present a proposal for comprehensive health reform. His plan will fundamentally overhaul the system and increase the quality of care while preserving your right to see your doctor.

The powerful lobbies of the special interests are already lining up to block the President's plan. But with your support, the President will break the gridlock.

The proposal will be based on the following principles:

- 1) Security: The Clinton plan will provide Americans with the security of knowing that they will have health coverage even if they switch jobs, lose their job or have a preexisting condition.
- 2) Choice: The Clinton plan will allow you to choose your doctor. And most Americans will have more choice of health plans. Under the Clinton proposal, your employer or insurance company won't pick your health plan -- you will.
- 3) Quality: The Clinton plan will increase the quality of care. And it will hold doctors and hospitals accountable with a simple consumer "report card" for each health plan.
- 4) Controlling Costs: The Clinton plan will make health care affordable again. And it will control the spiralling costs that are strangling American businesses.
- 5) Comprehensiveness: The Clinton plan will guarantee all Americans a comprehensive benefits package.

- 6) Simplicity: The Clinton plan will reduce paperwork for both doctors and patients, and it will eliminate fraud and abuse. The health care bureaucracy will shrink under the Clinton plan.

THE CLINTON HEALTH REFORM PLAN
Security for Every American

Security for you and your family. That's what the President's health reform plan is all about.

Even if you're one of those people who's satisfied with your health care today, I'll bet you know someone who's not.

Someone who lost their insurance when they switched jobs. Someone who can't afford health insurance. Someone who got terribly sick, and suddenly discovered hidden limits buried in the fine print of his policy. Someone who's paying a whole lot more this year for a whole lot less health care. And someone who can't even find a doctor for her kids.

If so, you're not alone. One of every four of you in this room risks losing the health insurance you have now in the next two years. You might lose it for a month, or two or three, or even six months or a year. And that's a terribly dangerous thing. Because if you or your child should -- God forbid -- get seriously ill when you're not protected -- all of your financial security could be wiped out. Perhaps forever.

[insert personal story about constituent or someone in your family who lost their insurance]

That's what this health care debate is about. Can your family find peace of mind? Can you -- or your child or your mother -- get the highest quality care when you need it most? And get it without going bankrupt? No matter whether you've got a great job or are between jobs. No matter what disease hits or when it hits or who it hits.

To help you get the security and high-quality care you need, here's what the President and I are going to change.

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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Today, if you're sick or your child is sick or you can lose your job or move to a different state, you can lose your insurance. If you've got what insurance companies call a "preexisting condition," you're out of luck. You probably can't get insurance and, if you can, it costs three or four times what other people pay.

Under the President's plan, you'll get health security. Lose your job -- and you'll still be covered. Get sick -- you'll still be covered. Move to a new place -- and you'll be covered. That's what insurance is supposed to be all about.

Today, right now, there are people who are locked into jobs -- people who won't take better jobs because they're scared of losing their health care. That's because some companies offer great benefits -- while others give only bare bones coverage.

Under the President's plan, that won't happen. Everyone will be guaranteed a comprehensive package of benefits, no matter where you live or what you do or where you work.

Today, you're at the mercy of your boss. He can tell you what health plan you've got to use -- and even force you to give up your doctor if your doctor's not part of that plan.

Under the President's plan, you're in the driver's seat. You'll get to choose among health plans -- and if you want to stay with the doctor you see now, fine, no problem.

But that's not all we're going to do. We're going to make sure that what you're charged for health care is brought under control.

Every day, every hour, exploding health care costs are picking all our pockets and handbags. Right now, as you sit here, you're paying for someone who's been forced to go into an emergency room because he or she doesn't have insurance. And the next time you

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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hear about a hospital charging \$20 for a Tylenol, you'll know that you're paying for the patients in the emergency room who will never see a bill -- and couldn't pay it if they did. The Clinton plan asks everyone to help pay their own way.

Right now you're being charged twice as much for health care as someone in Germany or Japan -- but when it comes to the survival rate for heart attacks, the United States doesn't even make the top twenty. Right now, what you're being charged for the drugs you need is rising three or four times faster than in other places -- and yet children in some parts of the Third World stand a better chance of getting immunized than they do here.

So we're going to change the way things work. We're going to crack down on those insurance companies and drug companies that are making high profits -- but not investing in better care. We're going to stop the overcharging and restrain rising costs. Only then can we get this deficit under control, and help our nation compete and win again.

Then we'll be able to give you the security you deserve. The peace of mind that your family will get affordable high quality health care -- no matter when illness strikes. No ifs. No ands. No buts.

And when the new health care plan is up and running, you're going to get a health security card. You carry that card with you. It guarantees you access to a comprehensive package of benefits, no matter where you live or where you work.

And that package won't just take care of you if you wind up in the hospital or have terrible trouble or need a fancy test. It will turn around this crazy system and give you the kind of care that keeps you and your children from getting sick in the first place. In the nation that invented the polio vaccine, that's the very least we can do.

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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You'll be able to choose from a variety of health plans. Stick with the doctor you see now if you like. Or join a network of doctors and hospitals and pay a little less. Or pay a flat fee to a plan that covers all your services for the year. So if you become unhappy with your health care, you'll be able to vote with your feet -- and get your care somewhere else.

You'll be asked what you think of your health plan -- and the results will be displayed in a simple, easy-to-read consumer "report card." So health plans will be held accountable for the quality of their care.

And you'll be able to wave good-bye to the endless, complex forms and all the hassles. Because we're going to scrap a system that produces so much paper that even if you've got the patience to wade through it, you probably don't understand it.

That will be gone. We'll take the forms from the 1500 different insurance companies and make them into one.

Today, families that face the worst illnesses have to spend their time poring over insurance forms to figure out which insurance company is going to cover what -- rather than spending time with their loved ones.

That will be gone.

Today, nurses and doctors are forced to fill out form after form, each one more complex than the last. Some nurses have to fill out 19 forms for each patient -- and then those are checked and checked again.

All of that will be gone. We're going to let medical professionals practice medicine again.

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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Today, companies play games with each other, trying to shift employees onto the other's plan. And if you do get injured on the job, the crazy and costly workers comp system comes into play -- and fraud is never far behind.

That will be gone. We're going to tie everything together and make our health care system whole.

Today, the government has gotten so deep into the business of micromanaging health care that it can't find its way out. The books that tell you whether Medicare or Medicaid will cover something are so big and thick that nobody can understand them. They've got checkers checking checkers. You get the feeling that there are more people writing regulations than doctors delivering care.

And that, too, will be gone. Because we're going to crack down on the waste and simplify the system and make this big mess make sense.

Now let me say to the small business owners in this room that, if you're covering your employees right now, we're going to bring your costs under control. We're going to protect you. We're going to stop the insurance schemes that discriminate against you and drive your premiums through the roof. We're going to let you team up with other small businesses and negotiate for the same rates that insurance companies give the big guys.

And if you're not able now to cover your employees, we're going to help make insurance affordable for you, your family and your workers. We're going to ask everybody - workers and employers alike -- to chip in for health care. We're going to give you the assistance you need but we're going to stop asking the folks who are now paying for insurance to pay for those who don't. Because it's not fair when the dry cleaner who covers

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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his workers has to pay a whole lot more because the owner of the car wash down the street can't pay the price.

The bottom line is simple: everybody benefits if everybody takes responsibility.

[story of small business from your district/state that struggles to cover its employees]

Today, if you live in rural America or in a small town, you probably can't even find a doctor. Maybe it was the ridiculous malpractice fees that forced the town obstetrician to close down shop. Or the fact that this nation is producing thousands of plastic surgeons -- but not enough pediatricians.

Under the President's plan, all that will change. We're going to bring real health care to rural America -- both in person and through technology. And we're going to produce the family doctors and pediatricians that your family needs.

Now there are a lot of people out there who are going to tell you that we don't need to change. They're going to try to scare you by making up all sorts of stories about terrible things. Then they'll tell you that they agree we need some reform -- but only on their terms.

What they won't tell you is that they're the ones who have been lining their pockets while the rest of us have had our pockets emptied. The ones who have caused the gridlock that let this messy system get even more messed up. The ones who have spent their huge profits not on helping people get better -- but on lobbying and figuring out new ways to put health care out of the reach of the people who need it most.

Well, the fact is they can outspend you. But they can't outnumber you. You can win this fight for your family's security.

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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And when we join together and pass the President's plan, you'll have the peace of mind you deserve. A guarantee that you'll never lose your health insurance. Never. That no insurance company's fine print will steal your benefits. That you'll get comprehensive, high-quality care through a doctor or plan that you choose -- without ending up in the poorhouse.

The President and Mrs. Clinton share a deep personal commitment to this issue. Because of their own experiences. And because of the people they've met all over the country. People like you who have had enough of rising medical bills. People who just want things to make sense so they can get high-quality care. People who want peace of mind.

Bill and Hillary Clinton believe that health security is a right. Your right. And when it comes to health care, and when it comes to human needs and human suffering, there are no Republicans or Democrats. There are just Americans.

And every day more American families lose their health insurance -- and even if you're one of the lucky ones who likes what you've got, the odds that you'll have it next year aren't great, and they're getting worse. Every day, what you're charged for health care keeps rising and rising -- and eating up your income and the future of your kids. And every day the special interests back in Washington keep blocking us from helping you.

You deserve the freedom from fear. Our nation deserves the freedom to grow. We all need the change. And we need it now.

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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HEALTH CARE REFORM: QUESTION AND ANSWERS

Q: Will I still be able to choose my doctor?

A: Yes. You will always be able to choose your doctor. And every American will have the choice of a variety of health plans -- you can go to an HMO, join a network of doctors and hospitals, or continue to get care on a fee-for-service basis the way most people do now. It's your choice.

Today, some businesses have limited people's choice of doctor in an effort to control costs. That won't happen under the Clinton plan. No boss will be able to tell you what doctor to go to or what health plan to join.

Q: If I have a good plan through my employer now, will the new plan be as good?

A: Your benefits package will cover at least as much as -- and probably more than -- the one you have now. It's modeled on the packages offered by Fortune 500 companies. And it's guaranteed, so your boss or insurance company can't take away your benefits or tell you to go read the fine print in your policy when you get sick.

Nobody will dictate to you what kind of plan you're on or where you have to go to get care. You choose where you get your care and how you get your care -- your boss or insurance company doesn't choose it for you.

Q: I like my health insurance. Why should I pay to insure others?

A: Like now, you'll be paying to insure yourself and you'll also be getting the peace of mind that, if you lose your job or get sick, you won't lose your insurance.

And remember: right now, you and your company are paying for the people who don't pay for their own health care. That's why you get charged \$20 for a Tylenol when you go to the hospital. Because for every person like you who pays the bill, there's another person who will never see a bill -- and couldn't pay it if they did.

The Clinton plan asks everyone who can to contribute to their own insurance. What you pay will go to your health coverage and your health security -- so that you will never be in danger of losing your insurance.

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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Q: Will the new health system mean that I have to pay higher taxes? How will this reform be paid for?

A: Some people advised us to impose a new, broad-based tax -- such as a national sales tax -- to pay for health care reform. But the President rejected that advice because he believes the middle class is already paying its fair share.

Here's how the plan provides health security to American families: First, it cracks down on the health profiteers who make a killing off the current system. Next, it asks smokers to pay to make up for the high health costs they add to the system.

And finally, it asks every employer and worker to contribute to the cost of their health care. But the money will go to their health plan to provide comprehensive benefits and health security -- the guarantee that you will never lose your insurance. And the government won't collect or spend the money.

Q: How are you going to control costs?

A: Right now, what you're charged for health care is spiraling out of control. Insurance companies are raising your premiums; drug companies are charging high prices for basic prescription drugs; and unnecessary paperwork and fraud are sending the costs of the whole system through the roof.

The Clinton plan will stop all that. It will make sure that what you're charged stops rising four times faster than wages. And it will crack down on fraud and eliminate excess paperwork.

Only if we take these strong actions to control costs can we provide true peace of mind and security to all Americans.

Q: Won't quality be sacrificed for the sake of cost savings in the new system?

A: Absolutely not. That's just an old scare tactic from the special interests that profit from the status quo.

The Clinton plan will improve the quality of American health care. Under the Clinton plan, the best technologies in the world will be put to work for you. There will be more primary care doctors and nurses to give care. And there will be a simple consumer report card -- so that doctors and hospitals are held accountable based on results, not on how many forms they fill out. Most important, the Clinton plan will give American families the security that they will never lose their insurance.

THE CLINTON HEALTH REFORM PLAN

Security for Every American

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Q: Won't this plan kill small business?

A: No, it's today's high cost of health care that's already killing small business. Today, insurance companies either won't cover small businesses and their employees or charge them high premiums that put insurance out of reach. Anyone who has the initiative to start a small business shouldn't have to put their family's health security at risk. It's not right.

The Clinton plan will help and protect small business in three ways: First, it will aggressively control costs and prevent insurance companies from discriminating against small businesses. Second, it will eliminate the paperwork that each small business now has to deal with. And third, it will pool small businesses and individuals to give them the same bargaining power in buying insurance that big companies have.

The plan will be gradually phased-in, with government assistance, to ensure that small businesses that don't currently provide insurance can afford to cover their employees.

Q: Won't this plan cause massive job loss among small businesses?

A: No, although there is likely to be a shift in jobs in the health care industry. When the new system is up and running, more people will be directly giving health care and fewer people will be filling out forms.

The Clinton plan is designed to help and protect small business -- making it easier for small business owners to cover their families and employees. And the plan will be gradually phased-in, with government assistance, to ensure that small businesses that don't currently provide insurance can afford to cover their employees.

The "studies" on potential job loss resulting from health care reform are grossly exaggerated. They make faulty assumptions and were generated by groups ideologically opposed to the President's reform proposal.

Q: What will happen to businesses that provide insurance? Will their costs go up?

A: For many businesses, costs will actually go down. And over time, by getting health costs under control, we'll stop the chilling effect that exploding health care costs have on businesses.

Right now, businesses that cover their employees are paying for those that don't. That's not fair. The Clinton plan is based on fairness and responsibility.

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Every employer has to take responsibility for covering their employees -- giving them the security that they will never lose their insurance.

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Q: Will insurance companies be able to deny me coverage if I have a pre-existing condition?

No. Right now, insurance companies can refuse to cover you if your daughter has asthma or if you're diagnosed with a heart condition -- and they do it all the time. Under the Clinton plan, that can't happen. Insurance companies will have to accept you -- whether you're healthy or sick. And you'll have the security of knowing that no one can ever take that insurance away from you.

Q: Will I still have my health insurance if I switch jobs?

A: Absolutely. Right now, some workers are locked into their job because they fear losing their benefits. If they do switch jobs or lose their job, they place their family's financial and health security at risk. That's not right. It's got to change -- and it will.

The Clinton plan gives you the security that you will never lose your insurance. If you switch jobs, you keep your insurance. If you lose your job, you're still covered. Complete security -- no ifs, ands or buts.

Q: Won't these "health alliances" create more bureaucracy and paperwork?

A: No. Right now, if you own the corner grocery store, you've got to spend half your time doing paperwork and negotiating with insurance companies. The health alliances will replace all that hassle.

The Clinton plan allows businesses and individuals to team up in health alliances and negotiate for high-quality care at an affordable price -- so that you and your family can have a full range of health care choices -- without every person and every business going through the hassle of all that paperwork.

Q: Won't government involvement in health care just mean more paperwork for everybody?

A: No. Right now, doctors, nurses and patients are buried under a blizzard of paperwork. If you go to the doctor, you've got to fill out a bunch of different forms; and the doctor's got to fill out a bunch more. It's a waste of everybody's time and money.

The Clinton plan will take all the forms offered by the 1500 different insurance companies and turn them into one. We'll cut costs and eliminate all the hassle. There will be less paperwork -- and better health care.

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Q: I don't believe you. The government's going to be more involved in health care but there will be less micromanagement of doctors and hospitals?

A: That's right. In the current system, doctors and hospitals have to pass a lot of different inspections and fill out a lot of different forms. But none of it does very much to improve the quality of care.

Under the Clinton plan, the government will set standards -- high quality, choice of health plans and doctor, security that you'll never lose your insurance, controlled costs, universal coverage and reduced bureaucracy. The government is going to provide you with security and make sure you get safe care -- but then get out of the way.

Q: Why are we changing so much about health care?

A: Right now millions of American families live in fear of losing their insurance, getting some of their benefits taken away, or getting sick and stuck with an astronomical bill. The Clinton plan will provide American families with the security they deserve.

We've had too many studies, reports and commissions. We know the system's broke -- it's time to fix it. And only comprehensive reform can fix what's wrong.

The Clinton plan will keep what works -- we'll improve the quality of care and maintain your right to choose a doctor. If you like your health care now, you probably won't see much day to day change after reform.

But the system has got to change. Today the insurance companies have all the power. They pick and choose among consumers -- only covering healthy people and making a healthy profit. The Clinton plan will put consumers in the drivers' seat so that consumers get to pick and choose -- not insurance companies.

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Q: Isn't it true that managed competition is untested?

A: The Clinton plan is not managed competition. It draws on elements of many different ideas that have been put forward to reform our health care system.

It will draw on the best models -- at work today in communities all across America and states -- because what works in North Dakota won't work in New York. The plan will be a uniquely American solution to an American problem.

The plan is based on the following principles: providing security for American families; controlling skyrocketing costs; improving the quality of care; increasing choice of doctors and health plans; and simplifying the system.

Q: What are we going to do to get doctors into rural areas? How can "managed competition" work in places where there is no competition?

A: Right now, two-thirds of rural counties do not have enough doctors. It's no wonder. Rural doctors provide more charity care than any doctors in the country, and they often get paid late. In many cases, rural doctors can't even take a day off because there isn't another doctor for miles around.

The plan will include incentives for doctors to practice in rural areas, and it will help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors.

Q: How will this reform help people that live in cities get high-quality care?

A: First, by providing a comprehensive benefits package to all Americans that emphasizes primary and preventive care. In today's system, too many Americans end up in the emergency room because they didn't get the primary care they needed. That's not right, it costs the system too much money, and we're going to change it.

And second, it will increase the number of doctors in urban areas by providing incentives for doctors to practice in cities and expanding the National Health Service Corps to reach more people in cities.

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Q: Will physicians be able to practice as they do now -- or will Big Brother look over their shoulder?

A: Let's get one thing straight. Under the current system, doctors have too many people looking over their shoulders, second-guessing their professional judgement. And over the past twelve years, increased regulation by the government has meant more time filling out forms and less time caring for patients.

The Clinton plan will change that. It will create a single insurance form -- so doctors don't have to figure out the thousands of different forms used by over 1,500 different insurance companies today. It will simplify peer review and coordinate inspections.

It will protect Americans' health safety and make sure you get the best care possible, but stop Washington from micromanaging doctors. So that doctors will be freed up to do what they do best -- deliver the highest quality care in the world.

Q: Will this plan do anything about all those crazy lawsuits?

A: Yes, it will. In the current system, doctors are forced to spend too much time practicing "defensive medicine" -- performing extra tests because they're looking over their shoulders for lawyers. It's not helping to improve care -- but it is helping to drive doctors out of the profession and make costs go sky-high.

The Clinton plan will include serious malpractice reform that protects doctors and patients but reduces frivolous lawsuits. And it will let doctors return to what they were trained to do -- delivering the highest quality of care in the world.

Q: Will the new system reduce doctors' independence and force them into a group practice or HMO?

A: No. Doctors will be able to continue their private practice, enter a group practice, join a network of doctors and hospitals or enter into several different arrangements. It's up to each doctor.

Q: Will I be able to stay on Medicare?

A: Yes. Older Americans will still be able to receive their Medicare benefits as they do today.

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In fact, Medicare beneficiaries are likely to have more choices after reform -- they can continue to get care the way they do today or they may be able to get their Medicare benefits through different health plans offered under the new system.

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Q: Medicare has the most bureaucracy and red tape in our current health system. If the President's plan retains Medicare, how is the new system going to reduce my paperwork and hassles?

A: The current system is choking on paper. Forms breed more forms. Checkers check checkers who check checkers. Doctors and nurses spend more time with paper than patients; and the quality of care suffers as a result.

The Clinton plan will introduce a single insurance form to replace the thousands of different forms used by over 1,500 different insurance companies today. To reduce some of the difficulties posed by the Medicare program, peer review will be simplified and inspections coordinated. And the Clinton proposal reduces micromanagement of doctors.

Q: How can you have a comprehensive health reform package that doesn't comprehensively cover long-term care?

A: This plan will take the biggest step forward ever to address the need for long-term care. Today, families all over this country live with the constant fear that they're not going to be able to take care of their parents when they get older. And those with severe disabilities face tremendous financial troubles.

The Clinton plan takes vast strides toward covering home- and community-based care with a special emphasis on creating ways for older Americans to continue to live in their own home and communities with dignity and independence. And it gives you the security that your parents or relatives with disabilities will get the care they need as they grow older.

Q: Won't your plan lead to job losses in the insurance industry?

A: Health insurance remains a small piece of the insurance industry. Efficient insurance companies are likely to do well and are likely to go into the business of running health plans. Others will put a greater emphasis on other kinds of insurance.

Looking at the health care industry as a whole, there will be a shift in jobs. More people will be directly giving care, and fewer people will be filling out forms.

Q: Will the plan cover undocumented immigrants?

A: No. Only American citizens and other legal residents will be able to get the comprehensive benefits package. But undocumented residents that currently receive coverage under community-based programs and Medicaid will continue to do so.

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Q: When is the President going to release his plan?

A: The American people demanded action on health care in the 1992 election, and the President is committed to passing health care reform this year. He is still consulting with members of Congress and others on exactly when to introduce his plan.

Q: I heard this plan was cooked up by a bunch of government bureaucrats. Why weren't there doctors involved?

A: More than 100 doctors, nurses and other health professionals were involved with the President's Task Force on Health Care. But the professional lobbyists did not write the legislation. That's why you heard complaints from some of the special interests in Washington.

The Task Force effort was the most thorough and inclusive policy-making process in American history. The process directly involved more than 500 people from all over the country. And Mrs. Clinton, the Task Force, and other members of the Administration reached out to over 500 groups for advice and input.

MDG

It is about time to get
Rockin' on this. The ownership
~~issue~~ issue is more vivid than
ever, as Maggie indicated in an
mtg. the other day. Should I
send a copy of this to Roy?

DCH

-DRAFT-

DETERMINED TO BE AN
ADMINISTRATIVE MARKING

INITIALS: JAM DATE: 5/6/16
2011-0584-F

CONFIDENTIAL MEMORANDUM

To: Mark
From: Dwight
Date: May 1, 1993
Subject: White House Action Plan for Health Care

As the Task Force nears completion on its work, it is time to begin developing a White House Action Plan for promoting the President's health care reform proposals. The action plan should serve to:

- educate White House staff on the substantive and thematic background of the President's proposal;
- underscore White House commitment to this Presidential priority;
- maximize efforts of WH staff and Cabinet offices to promote the plan; and most importantly
- integrate these efforts both internally and with outside supporters to maximize our effectiveness.

Short Term and Long Term Plans

Many offices have been involved in policy development, and the communications department has begun planning for the 3-4 week burst of activity surrounding the announcement of the plan. This short term planning for the announcement period will set the tone of the plan's reception, and is indisputably very important.

However, we need to develop a long-range framework for the 6 months following announcement leading up to, we hope, a December 24 bill signing. It is important to have an initial strategy for this period **now** in order to better understand what we need to achieve during the 4 weeks of the announcement period.

Initial meetings:

First Lady: As Maggie suggested, you should first meet with the First Lady and Ira [or his designee] to suggest that you would like to begin developing a White House action plan (in contrast with the 501C-4) for promoting the plan. Agenda topics include:

- Your proposal for developing plan through 1:1 mtgs, then group, then drafts, etc, (drawing consistent parallels to promotion of economic plan)
- Her thoughts on long term framework: 5/25 - 12/24
- Her thoughts on what we need to achieve 5/25 - 6/15
- Memo to Prez. on promotion of plan? [Did we do this for the economic plan?

Long Term Framework: Stan et al, George et al, Bob, Howard, Rahm, OFL, John?, NEC? Marcia? Alexis?¹: Before developing individual plans for short term proposals, I think you [we all] need to develop a sense of what the long-term framework will be: do we have to have sustained, rapid fire activity for the next 7 months? Assuming the answer is "no," what is our schedule? Obviously whatever we discuss will change and evolve as we go, but as I mention above, I think understanding the long-term framework is central to developing an appropriate short-term plan.

[Alternative: first do this with a very small group: Stan, Bob, George/Ricki, and Howard, then assemble the group listed above]

Policy: At some point, we should get Ira to walk you and Mack through the outline of the proposal. I don't know if you need to do this now, or wait until more details have been decided on.

Individual meeting plans:

After discussing this with the First Lady and developing a general long-term framework, we begin meeting with individual offices to get an idea of where they are in the process and what their office strategy is. I have included a suggested attendee list for each meeting as a starting point. In addition to the people listed, the First Lady's office, Ira's office, and maybe Celia should have an open invitation to attend any of these meetings. The political department is not listed for a separate meeting, but will clearly provide supervision on targeting and key political issues throughout. Each meeting should lead to a framework for a plan, which each department will write-up and turn into you, and update as the plans evolve.

Communications Plan: George, Ricki, Bob, Marcia? [maybe Stan et al] Agenda topics:

- What message[s] do we need to accomplish over announcement period?
- What is the plan?
- Sticky issues plans: abortion, small biz, seniors
- Regional sticky issue plans: CT, NE, IA [maybe this goes into Congressional?]
- Surrogates plan for announcement week
- On-going coordination/war room, like NEC set up

Congressional Plan: Howard, Steve, Chris. Topics:

- Ratification: who will be ready to endorse on Day 1? What are they doing?
- Breathing room: will potential opponents give us the 48-72 hours coasting room we got on the economic plan?
- Targeting: where do you want us on Day 1-4?
- What will be key votes in each chamber [and therefore what are issues we should be prepared for and/inoculate against early on]?
- Who testifies?
- Hearing schedule [the whole WH should be briefed on schedule eventually]
- Testimony from non-federal reps: do we coordinate this?
[see also: *Intergovernmental, public liaison*]
- What is our coalition? [bi-partisan issue]

¹ I think it's important that the department heads attend these first meetings: they must feel fundamental ownership of the long and short term plans for promotion of the plan.

Campaign Plan and DNC Plan: Wilhelm, Craig, Celia, Rahm, Bob, Stan et al?

- Full plans for announcement week [parallel to Economic plan activity]
- detail on long term strategy

Intergovernmental: Hart, Regina, Katie Whelan?

- Report on groundwork: who likes us, who doesn't
- Final consultation/briefing schedule
- Announcement week activity: endorsement press conferences, op eds, talk shows, etc. [think targeting]
- Long-term inclusion/use of endorsers as opinion leaders/surrogates
- Briefing and activity for next tier: State Secretaries of Health, legislature health committee chairs, city health officials, etc.
- State resolutions of support?
- Coordinating testimony on the Hill
[see also congressional]

Public Liaison: Alexis, Mike Lux, Rahm?

- Report on groundwork
- final consultation/briefing schedule
- special issues: small biz, big biz, seniors, etc.
- Announcement week activity: endorsement press conferences, op eds, talk shows, etc. [think targeting]
- Grace period of 24-72 hours after announcement
- Coordinating testimony on the Hill
[see also congressional]
- Long term involvement: how do we sustain interest of our allies?

Cabinet: Christine, Steve, Rahm?

- Departmental idea memos which outline proposals for activity, from local office through Secretarial action.
 - Plan for sub-cabinet level activity around announcement
 - regional office activity around announcement
 - plans for sustained involvement
 - press plans

Full WH Strategy Meetings

After initial plans have been developed, all players should meet to discuss the individuals strategies to integrate efforts, to brainstorm on different/new action, and make sure we are all on the same message. This meeting will also serve to update and add assignments to department staff.

This group should meet occasionally as we near Day 1.

Other issues:

Involving the Chief of Staff: Early on, Mack should take some step to underscore the priority of this enterprise. Maybe he should convene the long-term framework meeting in his office.

Policy Briefing for WH Staff: Ira will need to brief the entire action group on the outline of the proposal at some point. This briefing must highlight the economic impacts and other hurdles we face in the plan--it is imperative that we know the nature of the beast we are fighting, so we can avoid a reprise of our narrowly averted disaster in Chillicothe. We should consider requesting Ira to write a Book of Pain which outlines the worst of the worst, just as Gene developed the 39 Cuts List.

Policy briefing for Cabinet Chiefs of Staff and Press People: Many Cabinet members should be fully apprised of the plan through their participation on the Task Force, but the CoS probably remain in the dark on the political aspects of the substantive proposals. And, of course, we need to brief the 6-8 Departments who are not represented on the Task Force. The sooner this briefing can happen, the better--the substantive knowledge will be helpful in brainstorming for Departmental action around the announcement week. [Boorstin's shop has put some thought into who needs to be briefed immediately prior to announcement.]

WH Counsel: Steve and Bernie should give the full action group a run through of the Do and Do NOTs.

NEC Activity: I did not include a meeting with the NEC on their plans on my list. Their support and action through the announcement period and down the road is central to the success of the plan, but I unclear as to how best to include them--maybe we just treat them as any other WH office involved, or maybe we leave it to Boorstin and Chris Varney to make sure these guys are hitting the road as a part of the communications and Cabinet plans.

At any rate, I suggest you have lunch with Rubin early this week. It would be helpful to hear how he thinks things are going.

Paper for First Lady: We need to decide what you want to take to your meeting with Mrs. Clinton. We could do a clean-up version of this, without my asides, etc.; something shorter, or nothing.

On-going Coordination of Activity: The NEC set up a war room for the period around announcement of the plan to handle immediate research needs, answer questions from the Plane, Cabinet members, and surrogates on the road, provide continuous feeding of the press with factoids, etc. What will we need to do to parallel this effort?

Agenda for Meeting with Stan, Mandy, James:

I. Opening

- Looking for how we can improve message from a management perspective
- Two principle tools:
 - manage substance better
 - manage form better--the theater of who he eats dinner with, to where he's seen during down-time out of the office.

II. Review of upcoming months

- Cultural war
- Introducing lots of new programs: are we a New Democrat?
- Is there too much on the plate?

III. Adjusting the upcoming months:

- Undoing damage done to image during the first 100 days
- Taking the offensive to exploit positive opportunities and build new strength
- Substance:
 - What are the ten biggest substance problems?
 - strategies for fixing
 - What are the top ten form problems?
 - strategies for fixing

[you should get them to do a memo listing a number of "in the can" theater events--dinner, etc]

THE WHITE HOUSE
WASHINGTON

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: JAM DATE: 5/6/16
2011-0584-F

Privileged and Confidential

May 18, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: Mike Lux

SUBJECT: The Politics of Remaining Major Health Care Decisions

cc: Ira Magaziner
Alexis Herman
Bob Boorstin

Mark Gearan ✓
Chris Jennings
Gene Sperling

I thought it important to summarize my thoughts on the politics of our major remaining decisions as we head into this critical week of decision-making. I will begin my comments with an overview on where we are in terms of our longstanding interest group goals, and then a discussion of the specific issues in front of us.

Overview

As I have written in previous memoranda, I have focused my group strategy around three goals: winning a major share of the health industry, especially providers; getting the support of a critical mass of business leaders; and holding our natural base together (our natural base defined as labor, consumer groups, seniors groups, and other traditionally liberal organizations.) I have also emphasized the critical importance of making certain we have the support of specific key groups: among business coalitions, the National Leadership Coalition for Health Care Reform; among providers, the American Nurses Association, American College of Physicians, American Academy of Pediatrics, American Association of Family Physicians, National Medical Association, National Association of Social Workers; among labor, the AFL-CIO, National

Education Association, AFSCME; among seniors, AARP, National Council of Senior Citizens, the Roosevelt Group; among consumers, Consumer Federation of America, Consumers Union, Citizen Action, and Families USA. These are not the only important groups, but they represent the baseline coalition that I believe we must have with us to win this fight.

Because of the kinds of decisions they are, for the most part the remaining macro decisions do not matter a great deal to key provider groups. The one exception is the phase-in schedule: the American Nurses Association, National Association of Social Workers, and key physician groups (especially pediatricians) have pushed very hard for early and comprehensive universal coverage, and would be very disturbed with the major medical phase-in option we've discussed because of its lack of preventative benefits and long phase-in time.

In terms of our goal with business of having a 'critical mass' of business support, it is clear that if we go with a payroll tax - because of the redistributive effects - we will achieve our goal. There would be big winners as well as big losers, and the big winners - mostly in manufacturing - will need no other incentive to come on board enthusiastically.

The other big issue for big business is the opt out issue. We would undoubtedly lose a significant segment of big business if there is no opt out. However, it wouldn't effect the support of the big winners on the payroll tax or the opposition of the big losers, and it wouldn't effect small business at all, so the overall loss of business support on the opt out issue will probably turn out to be fairly modest. Financing - the bottom line - is more important to most CEOs than any philosophical concern about being able to manage their own plan.

With the 'natural ally' groups, we have to make a fundamental political decision along with our policy decisions: do we go for a package at the beginning that has the full and enthusiastic support of our natural allies, knowing that we will probably have to make some adjustments down the road in the Senate to pick up swing votes? Or do we start with a package that has more of the feel of a moderate, bi-partisan package, knowing that the initial rush of enthusiasm and long-term grassroots support from our allies will be significantly lessened?

A strong case can be made either way. I would come down on the side of the faster start out of the gate, with our natural allies fully on board and committed to devoting major resources to a grassroots campaign. My past experience in politics suggest to me that a solid base is no guarantee of victory, but a lack of one guarantees defeat, whether for an issue or a candidate. We know we'll have ferocious enemies: I believe we'll need strong friends to combat them.

The reason I raise all of this is that many of the macro decisions left are ones that deeply effect our ability to get support from labor, seniors, and single payer advocates. With that in mind, here are comments on specific issues:

1. Opt outs for big business. I had been an advocate of allowing opt outs, but placing certain conditions on the businesses opting out, especially including community rating. That struck me as a way to keep our left flank (labor, single payer, etc.) relatively satisfied, while giving big business more options. But with the businesses who care about opt outs not buying that compromise, it looks like we have to choose.

Given that, I would argue strongly for not allowing opt outs. From an interest group point of view, allowing self-insurance without tough conditions - especially community rating - is a base group disaster. It would probably drive several of the single payer groups completely away, and could endanger AFL-CIO support. From a communications point of view, our being attacked as offering two tier coverage is extremely problematic (I think Boorstin, Grunwald and Greenberg would back me up on that point.) And it also bothers me a lot from a policy point of view: it strikes me as an administrative/regulatory problem, and I do worry about the two tier system argument.

2. Benefits package. As I said to you Sunday night, I think too high a deductible limit is problematic from both an interest group perspective and from the point of view of selling the plan to average folks. Remember, single payer groups wanted no deductible/co-pays and many labor union members have no or very low deductible/co-pays. While the single payer no deductible/co-pay position in my view is absurd, I don't think we can afford to go too high.

3. Long term care/prescription drugs. We must have senior group support to (a) educate their members to counter our enemies' fear campaign, and (b) provide us with grassroots pressure to equal National Federation of Independent Businesses and Independent Insurance Agents. Too much fiscal conservatism on long term care and prescription drugs is penny-wise and pound-foolish in terms of getting this bill passed. Chris Jennings and other Hill experts I've talked to fully agree with me on this one: we have to do what it takes to get AARP and other senior groups on board.

4. Phase-in. As I have mentioned in previous memoranda, too long a phase-in period really dampens the enthusiasm of the base for this plan. The major medical proposal would be a big problem with our base groups.

5. Percent of payroll. From an interest group point of view, the 'percent of payroll' option is extremely popular with a wide range of groups. Obviously, National Federation of Independent

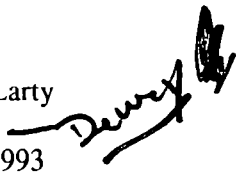
Businesses, the Restaurant Association, and other "losers" in the business community feel differently, but they will oppose us no matter what we do.

Summary

The President's decisions on these issues should reflect in part the strategy decision I discussed earlier. If the decision is to try to line up Republican co-sponsors and widespread big business support from the first day, then this set of decisions is very different. I am advocating the direction I am in part because I think Republicans and many in the business community are going to hang back to see whether our plan gets off the ground. If I'm right, it is urgent that we have a plan that (a) appeals strongly to the middle class, and (b) generates enthusiasm among our base groups. If we put a plan together at the beginning that does that, all the while assuring conservative Democrats and moderate Republicans we'll work with them throughout the process, I think the plan could have a strong lift-off.

MEMORANDUM

To: Mack McLarty
From: Dwight
Date: May 24, 1993
Subject: Damaging Health Care Leaks



There were several extremely damaging stories in the New York Times over the weekend regarding the deliberations of the Health Care Task Force. The articles allege a split in the Task Force between the First Lady and the economic advisors. The stories are based on leaks from a Roosevelt Room meeting last Thursday. I think Ira might want to speak with you today about the leaks to explore ways to stop them.

Background on Thursday's Meeting

Thursday's meeting was intended to present basic issues for deciding how extensive the health care benefits package should be. At Bob Rubin's suggestion, Ira split Task Force staff [policy, economic, and political] into two competing teams: Team A advocated a more modest benefit package, Team B a more expansive package. Incidentally, Team B was represented passionately by Gene Sperling, the President's chief economic advisor during the campaign.

The meeting surfaced concerns regarding deficit reduction impact of each plan, as well as the political impact of each plan. The meeting started, predictably, with most economic staff favoring a more modest package, and most health staff favoring the richer package. Through very lively debate and discussion, however, the President and Vice President moved the group toward consensus by the end of the meeting:

- the more expansive benefits package seems to be a political imperative, BUT
- we must figure out a way to finance the richer package while still achieving substantial deficit reduction.

The group discussed several ways to achieve these dual objectives. The Vice President proposed using cigarette taxes and the savings to be identified in the National Performance Review to fund long-term care and a Medicare drug benefit. This would take these benefits out of the "entitlement" package proposed for the health plan, allowing for savings from the new system to go directly to deficit reduction instead of these new benefits.

The meeting ended on this very positive note, which left economic, health, and political people very upbeat that the group was moving towards resolution of the big issues.

Leaks: A Different Story

Despite a moving appeal from the First Lady to keep the deliberations private, the Times and Post both carried stories on the meeting in Saturday editions. The Times story, as manipulated by the leaker, portrays a house divided distinctly on the lines of economic team vs. First Lady--not economic team vs. health team (which would also be inaccurate), but economic team vs. First Lady. The leaker is successfully communicating the un-true message that the President is saddled with a choice between a good economy and his wife. The Sunday Times carried a "news analysis" story carrying this message.

CC: MDC ✓

The leaks are excruciatingly damaging. The story:

- challenges the President's leadership: no one wants the President having to choose between "his wife and his advisors"
- undermines the First Lady's credibility: "how could she oppose the economic team?"
- severely threatens the process for resolving final decisions.

Ira does not know how to proceed. If the President cannot meet with his closest advisors without a manipulation of the facts appearing in the next day's Times, it will be very difficult for him to resolve the remaining difficult issues. Ira believes--and I agree--that the leaks are occurring at an extremely high level. Restricting meetings to the size needed to ensure confidentiality would require eliminate people who offer essential input for the President's consideration.

From Here Forward

The group is scheduled to meet with the President this afternoon to discuss another key issue: financing.

A White House Fight

On Health Care, It Is Hillary Clinton Versus President's Economic Advisers

By ROBERT PEAR
Special to The New York Times

WASHINGTON, May 22 — When President Clinton put his wife in charge of devising a plan to revamp health care in America, politicians wondered what he would do if she clashed with his other advisers. Now they are finding out.

News Analysis Such a clash over the ambitious plan being developed by Hillary Rodham Clinton emerged at a White House meeting on Thursday. Health-policy advisers support a comprehensive package of medical benefits while top economic advisers question the scope and cost of such generous coverage.

Administration officials said today that Mr. Clinton tended to favor the more generous option but that he had not come down explicitly in favor of one or the other. Instead, he appears to be seeking a middle ground, so that he does not have to choose between his wife and his economic advisers.

At the meeting on Thursday, the health-policy advisers, with support from Mrs. Clinton, called for giving all Americans a comprehensive package of health benefits as swiftly as possible. Budget officials and members of the President's economic team, equally committed to the same ultimate objective, urged him to spend less and go more slowly in the first few years.

Clinton's Inclination

An Administration official said today that Mr. Clinton in his heart favored the more generous, more costly option. But the President was also swayed by the warnings of his economic counselors, including one who noted, "We are accused now every day of being tax-and-spend Democrats."

A White House official who attended the meeting with President and Mrs. Clinton said it was like a graduate seminar on health policy.

"This is not a civil war going on

here," the official said. "It's too simplistic to portray this debate as the economic advisers' cheapskate position versus the health advisers' spendthrift position. And it would be quite wrong to portray the economic team as trying to derail health-care reform. But the economic advisers do feel that too lavish a public program would impair economic growth, imperil the budget and give fodder to critics who would like to kill this program when it's released."

Mrs. Clinton, the head of the President's Task Force on National Health Care Reform, tells Administration officials who disagree with her to "speak your mind." But that is not always easy.

Power of First Lady

"By virtue of her position as head of the task force and by being First Lady and by virtue of her own intellect, which is really quite impressive, she commands a lot of respect and is treated with deference," said a White House official who attended the meeting.

Leon E. Panetta, the President's budget director, has already urged Mr. Clinton to delay releasing his health-care plan to avoid diverting attention from the struggle over tax increases and budget cuts on Capitol Hill. Mr. Clinton has described the overhaul of health care as the second stage of deficit reduction, but Mr. Panetta fears that if the President's plan is too ambitious, it will increase rather than reduce the Federal budget deficit.

His concerns were echoed Thursday night at the White House by Laura D'Andrea Tyson, chairwoman of the Council of Economic Advisers, and the men nominated to serve with her on the council, Prof. Joseph E. Stiglitz of Stanford University and Prof. Alan Blinder of Princeton University.

The three, while mainstream economists, are all on the liberal side of the



Hillary Rodham Clinton, head of the President's Task Force on National Health Care Reform, speaking at Jimmy's Restaurant in Baltimore.

political spectrum. If they have reservations about the cost of the health plan, Republicans and conservative Democrats on Capitol Hill may have even deeper doubts.

The Tough Part: Taxes

After deciding on the scope of benefits, Mr. Clinton must figure out how to pay for them. He has already said he wants employers to pay much of the cost. He is considering two forms of taxation, requiring employers to pay either a fixed percentage of the total payroll or a fixed amount of money for each worker.

At the meeting on Thursday, Mr.

Clinton and his advisers considered variants of these two alternatives. If the President asks employers to pay a percentage of payroll (7 percent is often mentioned), there would probably be a limit on the amount of any employee's income subject to tax. And several thousand dollars of income could be exempt from the tax so employers would pay little or nothing for low-wage employees.

More Disputes Expected

If the President proposes a fixed premium for each employee, workers would have to pay a portion of the cost. But Administration officials say there

would undoubtedly be some type of Government subsidy to help low-income people pay their share.

The spirited debate over the scope of benefits may be a prelude to sharp disagreements sure to emerge when the President considers whether to impose controls on doctors' fees, hospital rates and drug prices. Some of the President's health-policy advisers, unsure whether his strategy of managed competition will actually restrain prices, want standby authority to impose such controls.

But a White House official said, with understatement, "Members of the eco-

nomics team are not greatly enthusiastic about cost controls" imposed by Government decree.

For one, Stuart H. Altman, dean of the Heller Graduate School for Social Policy at Brandeis University, said today: "Even price controls won't bring the growth in health-care spending to a stop. Most of the growth is driven by the volume of services, not the price."

As a result, Professor Altman, a member of Mr. Clinton's transition team, said the problems facing the President now were inevitable. "If health-care reform were easy to do, it would have been done a long time ago," he said.

Marty Katz for The New York Times

MEMORANDUM

To: Bill Burton

From: Dwight 

Date: May 26, 1993

Subject: Health Care Task Force

I thought it might be helpful to provide you with a package of the memos I have written for Mack on health care as we have moved from the initial meetings through our current status. My memos have evolved along with the process--some are very basic, while others go into very subtle issues. I have concentrated on political and/or management issues, discussing substance only when relevant to those issues.

You will find a number of holes in between memos. This results in part from my reluctance to outline certain political dynamics [intra-WH] on paper. I have briefed Mark G. regularly, especially when sensitive issues emerge. I would be happy to walk you through any of these issues at your leisure.

In addition to my background memos, I am attaching a memo outlining a draft WH Action Plan for promotion of the plan. I believe emphatically that the West Wing must assume management of the health plan initiative *very soon* to ensure passage. Maggie has spoken with Mark about the possibility of him managing the White House group much as he did through the initial stages of the economic package. However, these discussions took place before Roy joined us and have not been revisited since then.

I am convinced that building support for the health care plan will be the most important [and most cumbersome] management task facing the White House over the next 8 months. We need early resolution of who will be responsible for this task and we need to begin designing and implementing a strategy for WH Action.

I hope this info is helpful and would be happy to provide more at your request.

cc: Mark G.



MEMORANDUM

To: Mack
Mark

From: Dwight *DW*

Date: May 17, 1993

Subject: Health Care Update

Process

The Task Force began meeting with the President about a month ago, working through a decision book prepared by Ira. It quickly became clear that staff--including Cabinet Secretary task force members--were not in agreement on some of the most basic issues. The President and First Lady decided it would be best for staff to reconvene and develop group recommendations for each of the key decisions. This is the process we have been undertaking through the last 3 weeks.

The group began meeting with the President Sunday in hope of working toward resolution of 6 key issues this week:

- How big is the program: how rich should the benefits package be, how much long-term care should be included, how much money for "infra-structure," etc.;
- Who is in the program: all firms, firms with less than 1,000 employees, other;
- How will premiums be funded: payroll tax or premium-based funding;
- Will there be cost-controls to keep prices down in the early years;
- How will the program be phased-in;
- How will parts of the program beyond premiums be financed, and how much will be raised: sin tax, etc.

From here forward

The President, Vice President, and everyone present was very pleased with the meeting on Sunday. For the first time, Ira presented the basic numbers including costs, savings, and net impact on the deficit of three different programs. Ira also presented options for phase-in which for the first time, as the President put it, made it possible to "imagine getting something we could pass."

Ira is depending on getting final decisions from the President on key issues this week. It is important that this schedule not slip much so that critical groundwork can be completed pre-announcement, currently targeted for June 15. Groundwork needs include:

- political: cutting deals, forming the coalition which will support the plan
- communications: ramp up, to take back the offensive on message
 - with no decisions made, we've been largely reactive with message
- congressional: time for serious consultations
- Governors: President committed to bringing them in time for serious consultation

Nagging concerns

Sunday's meeting was extremely positive. The President, the Vice President, the First Lady, the health care team, and the economic team were all pleased at seeing--for the first time--a complete set of numbers which seemed to point to a realistic price tag for the Federal government. Near the end of the meeting yesterday, the President said that one of the scariest things for him is that he is still learning so much every time he works on this issue. Our goal at this point must be to make sure he achieves the comfort level he must have with the issue before taking the rostrum at a Joint Session of Congress. Some of the nagging concerns I think we must address before he achieves the needed comfort level include:

Winners and Losers: The economic impact of the plan has not yet been presented to the President and/or Task Force. The numbers discussed in yesterday's meeting vary widely. The President and Ira spoke generally about people not paying more for care unless they are making over \$80,000/year. However, rough estimates from the CEA indicate that the cut-off for who's paying more [who loses] could begin with single people earning as low as \$30,000/year. Impacts on businesses, especially small businesses, are likewise ambiguous at this stage.

Once there has been an initial decision on how the program will be paid for--payroll tax or premium-based--the CEA will run a complete impact analysis for individuals and businesses to determine who loses and who wins. This analysis will provide the most vivid insight as to our chances of success in passing the plan. As Director Panetta and others have said, the only question for most people will be:

How much more or less will I pay, and how much more or less will I get?

The "C" Word: One of the phase-in options presented by Ira Sunday includes an intermediary step on the way to universal coverage during which all employers would be required to provide catastrophic insurance. Vice President Gore, Secretary Bentsen, and Director Panetta--all of whom lived through the catastrophic battle of the late 1980s--raised concerns about the wisdom of such a plan. While the deficit reduction possibilities are attractive, a catastrophic plan may offer too little to garner enthusiastic support we will need to pass the plan--even as an intermediary step.

The Numbers: Ira's quantitative group has been bending and stretching to satisfy scoring requirements for savings laid out by CBO and the HCFA actuary. Because the notion of managed competition is relatively new, traditional scoring does not give any credit for savings which should result from improved competition--yet these savings are at the heart of the President's plan. CBO and HCFA are likely to score mainly savings which result from increased regulation.

To meet these needs, the plan has evolved into a fairly regulated structure. While the plan will meet savings targets on paper, strict regulation will impede the goal of increased market-based competition. Some people feel--including some consultants on the Task Force--that the concessions have been so great as to severely effect the plan's chance of working, much less winning political support from the business sector.

The Numbers, Part II: One of the central battles between the HCFA actuary and the Task Force is the cost of including Medicaid in the program. HCFA's estimates are upwards of about \$50 billion more than any other actuary the Task Force has consulted. CEA agrees with Ira that the HCFA numbers are extremely inflated. As a result of the dispute, Ira has calculated program costs leaving Medicaid out of the reformed health system--an option which is, as Ira concedes, politically and substantively wholly unacceptable.

To satisfy the HCFA actuary, the nation's most respected source on Medicaid costs, Ira is working on a regulatory scheme to address his concerns without distorting the reform plan too much.

Other battles with the actuary include the cost of mental health benefits in the program. The two groups are narrowing their differences, but the actuary insists that the MH program will cost substantially more than Ira calculates.¹

Complexity of the System: Bob Boorstin noted very shrewdly at one of the first meetings of the Task Force that if we design something more complicated than the current health care system, we will have failed in the eyes of the American people. With concessions to the numbers people to achieve scorability, and political concessions to constituency groups on issues such as Medicare drug benefits, we run the risk of complicating a system based on the very simple notion that competition can work in health care with some basic rules. It will be especially important to protect the simplicity of the plan as we move to the final weeks of the plan, trying to forge a coalition for victory.

Key Decisions: The list of key decisions Ira plans to present to the President has shrunk substantially. While prioritization is clearly important in an undertaking this massive, the decisions left to the Task Force must still be limited to the truly mundane. While I assume that Ira still plans to seek Presidential guidance on these issues, the current list does not include key decisions such as: whether or not to include Medicare in the system, what type of malpractice reform the plan should include, how states will be required to "maintain effort" at acceptable spending levels, and others.

In addition to key presidential decisions, there are a number of smaller political trouble spots which are woven into the fabric of the proposal, for example:

- **Individual mandate:** There are very few things which people *must do* in this country just for living here. The notion of adding a new individual mandate could be politically explosive and has not been discussed with the President.

- **Medicaid coverage:** The plan, as evolving, will entail a substantial reduction of services for many people on Medicaid, such as poor mothers. These benefits were hard-fought victories for child advocates--such as CDF--and will not be easily erased.

The decision process should include some way to address these concerns appropriately.

Schedule for the Balance of the Week

The Task Group will continue to meet this week, including two meetings with the President, in hopes of achieving resolution of key issues.

Dwight

¹ The HCFA actuary is a career employee and is very independent. He also wielded substantial power in the catastrophic care debate in the late 1980s.

-DRAFT-

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: JAM DATE: 5/6/16
2011-0584-F

CONFIDENTIAL MEMORANDUM

To: Mark
From: Dwight
Date: May 1, 1993
Subject: White House Action Plan for Health Care

As the Task Force nears completion on its work, it is time to begin developing a White House Action Plan for promoting the President's health care reform proposals. The action plan should serve to:

- educate White House staff on the substantive and thematic background of the President's proposal;
- underscore White House commitment to this Presidential priority;
- maximize efforts of WH staff and Cabinet offices to promote the plan; and most importantly
- integrate these efforts both internally and with outside supporters to maximize our effectiveness.

Short Term and Long Term Plans

Many offices have been involved in policy development, and the communications department has begun planning for the 3-4 week burst of activity surrounding the announcement of the plan. This short term planning for the announcement period will set the tone of the plan's reception, and is indisputably very important.

However, we need to develop a long-range framework for the 6 months following announcement leading up to, we hope, a December 24 bill signing. It is important to have an initial strategy for this period **now** in order to better understand what we need to achieve during the 4 weeks of the announcement period.

Initial meetings:

First Lady: As Maggie suggested, you should first meet with the First Lady and Ira [or his designee] to suggest that you would like to begin developing a White House action plan (in contrast with the 501C-4) for promoting the plan. Agenda topics include:

- Your proposal for developing plan through 1:1 mtgs, then group, then drafts, etc, (drawing consistent parallels to promotion of economic plan)
- Her thoughts on long term framework: 5/25 - 12/24
- Her thoughts on what we need to achieve 5/25 - 6/15
- Memo to Prez. on promotion of plan? [Did we do this for the economic plan?

Long Term Framework: Stan et al, George et al, Bob, Howard, Rahm, OFL, John?, NEC? Marcia? Alexis?¹: Before developing individual plans for short term proposals, I think you [we all] need to develop a sense of what the long-term framework will be: do we have to have sustained, rapid fire activity for the next 7 months? Assuming the answer is "no," what is our schedule? Obviously whatever we discuss will change and evolve as we go, but as I mention above, I think understanding the long-term framework is central to developing an appropriate short-term plan.

[Alternative: first do this with a very small group: Stan, Bob, George/Ricki, and Howard, then assemble the group listed above]

Policy: At some point, we should get Ira to walk you and Mack through the outline of the proposal. I don't know if you need to do this now, or wait until more details have been decided on.

Individual meeting plans:

After discussing this with the First Lady and developing a general long-term framework, we begin meeting with individual offices to get an idea of where they are in the process and what their office strategy is. I have included a suggested attendee list for each meeting as a starting point. In addition to the people listed, the First Lady's office, Ira's office, and maybe Celia should have an open invitation to attend any of these meetings. The political department is not listed for a separate meeting, but will clearly provide supervision on targeting and key political issues throughout. Each meeting should lead to a framework for a plan, which each department will write-up and turn into you, and update as the plans evolve.

Communications Plan: George, Ricki, Bob, Marcia? [maybe Stan et al] Agenda topics:

- What message[s] do we need to accomplish over announcement period?
- What is the plan?
- Sticky issues plans: abortion, small biz, seniors
- Regional sticky issue plans: CT, NE, IA [maybe this goes into Congressional?]
- Surrogates plan for announcement week
- On-going coordination/war room, like NEC set up

Congressional Plan: Howard, Steve, Chris. Topics:

- Ratification: who will be ready to endorse on Day 1? What are they doing?
- Breathing room: will potential opponents give us the 48-72 hours coasting room we got on the economic plan?
- Targeting: where do you want us on Day 1-4?
- What will be key votes in each chamber [and therefore what are issues we should be prepared for and/inoculate against early on]?
- Who testifies?
- Hearing schedule [the whole WH should be briefed on schedule eventually]
- Testimony from non-federal reps: do we coordinate this?
[see also: *Intergovernmental, public liaison*]
- What is our coalition? [bi-partisan issue]

¹ I think it's important that the department heads attend these first meetings: they must feel fundamental ownership of the long and short term plans for promotion of the plan.

Campaign Plan and DNC Plan: Wilhelm, Craig, Celia, Rahm, Bob, Stan et al?

- Full plans for announcement week [parallel to Economic plan activity]
- detail on long term strategy

Intergovernmental: Hart, Regina, Katie Whelan?

- Report on groundwork: who likes us, who doesn't
- Final consultation/briefing schedule
- Announcement week activity: endorsement press conferences, op eds, talk shows, etc. [think targeting]
- Long-term inclusion/use of endorsers as opinion leaders/surrogates
- Briefing and activity for next tier: State Secretaries of Health, legislature health committee chairs, city health officials, etc.
- State resolutions of support?
- Coordinating testimony on the Hill
[see also congressional]

Public Liaison: Alexis, Mike Lux, Rahm?

- Report on groundwork
- final consultation/briefing schedule
- special issues: small biz, big biz, seniors, etc.
- Announcement week activity: endorsement press conferences, op eds, talk shows, etc. [think targeting]
- Grace period of 24-72 hours after announcement
- Coordinating testimony on the Hill
[see also congressional]
- Long term involvement: how do we sustain interest of our allies?

Cabinet: Christine, Steve, Rahm?

- Departmental idea memos which outline proposals for activity, from local office through Secretarial action.
 - Plan for sub-cabinet level activity around announcement
 - regional office activity around announcement
 - plans for sustained involvement
 - press plans

Full WH Strategy Meetings

After initial plans have been developed, all players should meet to discuss the individuals strategies to integrate efforts, to brainstorm on different/new action, and make sure we are all on the same message. This meeting will also serve to update and add assignments to department staff.

This group should meet occasionally as we near Day 1.

Other issues:

Involving the Chief of Staff: Early on, Mack should take some step to underscore the priority of this enterprise. Maybe he should convene the long-term framework meeting in his office.

Policy Briefing for WH Staff: Ira will need to brief the entire action group on the outline of the proposal at some point. This briefing must highlight the economic impacts and other hurdles we face in the plan--it is imperative that we know the nature of the beast we are fighting, so we can avoid a reprise of our narrowly averted disaster in Chillicothe. We should consider requesting Ira to write a Book of Pain which outlines the worst of the worst, just as Gene developed the 39 Cuts List.

Policy briefing for Cabinet Chiefs of Staff and Press People: Many Cabinet members should be fully apprised of the plan through their participation on the Task Force, but the CoS probably remain in the dark on the political aspects of the substantive proposals. And, of course, we need to brief the 6-8 Departments who are not represented on the Task Force. The sooner this briefing can happen, the better--the substantive knowledge will be helpful in brainstorming for Departmental action around the announcement week. [Boorstin's shop has put some thought into who needs to be briefed immediately prior to announcement.]

WH Counsel: Steve and Bernie should give the full action group a run through of the Do and Do NOTs.

NEC Activity: I did not include a meeting with the NEC on their plans on my list. Their support and action through the announcement period and down the road is central to the success of the plan, but I unclear as to how best to include them--maybe we just treat them as any other WH office involved, or maybe we leave it to Boorstin and Chris Varney to make sure these guys are hitting the road as a part of the communications and Cabinet plans.

At any rate, I suggest you have lunch with Rubin early this week. It would be helpful to hear how he thinks things are going.

Paper for First Lady: We need to decide what you want to take to your meeting with Mrs. Clinton. We could do a clean-up version of this, without my asides, etc.; something shorter, or nothing.

On-going Coordination of Activity: The NEC set up a war room for the period around announcement of the plan to handle immediate research needs, answer questions from the Plane, Cabinet members, and surrogates on the road, provide continuous feeding of the press with factoids, etc. What will we need to do to parallel this effort?

1999 Chart

The Health-Care Plan: How Much Will It Cost?

Government estimates of various proposals, in billions of dollars a year. Costs would be divided among Government, businesses and households.

	AUSTERE PLAN	MEDIUM PLAN	GENEROUS PLAN
Insurance for the uninsured	\$69.5	\$75.5	\$82.2
Improved coverage for people with meager health insurance	12.5	22.2	38.3
Prescription drugs for Medicare beneficiaries	8.0	9.3	10.3
Long-term care	7.7	13.8	15.0
Upgrading public health programs for the needy	1.8	4.8	4.8
Total	\$99.5	\$125.6	\$150.6

How Benefit Packages Might Look

Possible combinations of benefits. Final decisions have not been made.

	AUSTERE PLAN	MEDIUM PLAN	GENEROUS PLAN
General plan design			
Overall deductible	Individual \$200 Family \$400	\$150 \$300	None
Coinsurance (patient's share of the bill)	20%	20%	\$10 per encounter
Annual out-of-pocket limit per individual	\$3,000	\$1,000	None
Hospital services			
Inpatient	\$250 deductible per admission	Subject to overall deductible, coinsurance	Full coverage
Outpatient	Subject to overall deductible, coinsurance		Full coverage
Surgical services	Subject to overall deductible, coinsurance		Full coverage
Physician services	Subject to overall deductible, coinsurance		\$10 per encounter
X-ray and laboratory tests	Subject to overall deductible, coinsurance		\$10 per encounter
Prescription drugs	\$50 a year deductible 40 percent coinsurance		\$7 payment for each prescription
Mental health services	Details undecided		
Dental services	No coverage	\$25 a year deductible \$1,000 maximum annual benefit for each person. Patient pays 20 percent of the bill for prevention and treatment.	Patient pays \$10 a visit for preventive services, \$25 a visit for treatment

Source: White House, Task Force on National Health Care Reform

TOTAL INVESTMENT

	20TH PERCENTILE	50TH PERCENTILE	90TH PERCENTILE
INSURE UNINSURED	42.6 - 69.5	45.1 - 75.5	49.3 - 82.2
ENRICHING BENEFITS FOR INSURED*	12.5	22.2	38.3
MEDICARE DRUG	8.0	9.3	10.3
LONG-TERM CARE	7.7	13.8	15.0
UNDERSERVED	1.8	4.8	4.8
TOTAL	72.6 - 99.5	95.2 - 125.6	117.7 - 150.6

*INCLUDES INSURING UNINSURED DEPENDENTS OF INSURED HEADS OF HOUSEHOLDS

- NO SUBSIDIES

- NO SAVINGS

Health Care - 16 May

Everyone in Advtges

- Simpler & less admin cost
- Discourages 2 tier syst

Disadvts

takes longer time
Could discourage innovat

Competitive Purchasing - Cooper Plans

#31 Bld Savings - ?, ?, ?

Phase-in Schedule

① Rapid Phase-in -
even if funds avail@ immediately - it
takes time to phase in

- almost all states in by '96
- cards in '96
- under bldgt 1998

Gradual Phase In -

-96

uninsured get base bonus

2000 - all up to some level

As of Jan 96

- vast majority - up + running

97

Some are ready to go -

Mandate take effect = 96

{ o/p - payroll vs. premium
how big a program
size
cost controls

One back - Web/Thurs with options
then refine

Rebuttal - Savings - will be estd
- Untried prog
↳ This argues for phase -

Bankers ^{now leans to}
↳ Wage based %

politically its a tax

Ira - Because of Leah - perception that
it is an addtl 8%

ABT - fact that payments do not go to govt
but to Alliances - makes strong
argument that it's not a tax

BC - We need a Savings sheet
the one we know + don't

[Business People
Actuaries] $\rightarrow$ sales of pro gra

Altman We need to know the
Winners + losers - bus community

Leon - hold Medicaid out

RHB - 20% percentile plan
(will people think it's better)

BC
1) dollar figure

then determine what she be = it

Deciding on timing is critical:

- The week of **June 7** is, realistically, **the latest possible date** we can do if we are going to do health care this year:

- The President cannot announce this less than 3 weeks before leaving the country [in order to leave appropriate time for promotion, etc.]

- The President is out of the country for approx. July 5 - July 11, possible on vacation afterward until as late as July 17

- Announcing after the President returns does not leave enough time to expect a 1993 passage of the bill.

- Congress is out of session in August
 - a July announcement would also limit public impact: July and Aug are vacation months

- **Delaying the decision of when to announce the plan is thus a decision in itself--a decision not to do health care in 1993.**

- The ambiguity of the timing is seriously impairing our effectiveness in several ways:

- Press credibility:** The President's credibility with the press on health care is eroding with each day that a certain date is not set for announcing the plan. First it was May 1, then May 17, then May 25 . . . the press is beginning to believe that health care might get pushed to the back burner.

- First Lady's Role:** The slippage of the date exposes the First Lady to stories that she is battling with the economic team over when we move health care. The NYT ran an article on 4/27 which hinted at this story and suggested that the President was being forced to choose between the First Lady's advice and the economic team's advice. Once we have a date which is agreed upon, firm, and public, this destructive speculation will abate.

- Closing political deals:** Interest groups perceive the delay and open-endedness of the announcement date as a weakness of determination and are not willing to negotiate for their support of the plan until a firm date is on the table.

- Communications ramp up:** The communications "ramp up" framing the announcement and following it cannot be settled upon until a date is chosen. The communications department must know how much time they have to work with, etc.

- Forcing serious decision making:** As long as the ambiguity of the date persists, senior decision-makers in the Task Force and economic team continue to encourage delay and have even suggested [as recently as Monday] that perhaps it would be better to wait until next year to do health care. Once the President is committed to a date-certain for announcement, those eager to stall will come to the table ready to make the final decisions they are currently avoiding.

Task Force Status

- The Task Force is currently scheduled to begin briefing the President for final decisions on May 17.
- The final policy decisions must be made the week of May 17 in order to leave time for substantive, political, and communications adjustments and preparations before announcement the week of June 7.
- There is still **significant** disagreement over **fundamental policy issues** between the economic team and Ira--meaning that unless the current course is altered, it is very likely that the President will not be in a good position to make the necessary decisions during the week of May 17, as required in order to achieve a timely announcement. He may be left with the choice of agreeing with Ira, or agreeing with key economic advisors.
- There is some concern that a two-track process might have developed, which could
 - hamper the President's decision-making significantly,
 - undermine the President's relationship with the economic team permanently,
 - forfeit sincere support of some of the key people who will be testifying on the plan, and perhaps most damaging, expose the First Lady even further to stories that she is at odds with the economic team.

Recommendation for Mack

- Meet with Ira and Bob Rubin separately to get a feel for where they are with this. You may want to meet with Roger Altman also, as he has very grave concerns about the plan.
- Speak with the President to determine how to make a final decision on timing.

- Timing

Health Care file

1. $\text{Team} \rightarrow \text{BC}$

2. $\text{Team} \rightarrow \text{BC} \rightarrow \text{Team}$ (to ensure everyone is involved)

3. $\text{Team} \rightarrow \text{BC} \rightarrow \text{Team}$ (to ensure everyone is involved)

BC w/ly with schedule team or timing?

(1) Schedule $\rightarrow$ new & old

(2) Outstanding issues & options

(3) Groups' strategy

BC to decide is to decide. & by week of May 17

to get team agreement

then structure of meet & group & schedule

THE WHITE HOUSE
WASHINGTON

May 5, 1993

MEMORANDUM FOR MARK GEARAN, ALEXIS HERMAN, MAGGIE WILLIAMS, AND
IRA MAGAZINER

SUBJECT: May 6th Strategy Meeting on Interest Groups
FROM: Mike Lux

I thought it might be helpful prior to our meeting to try to focus on our agenda. There are at least four topics I think are worth doing:

1. Discussion of our "deal closing" strategy with likely allies.
2. Discussion of our business strategy.
3. Discussion of the major interests waiting for us to make certain big policy decisions.
4. Discussion of how we deal with our likely enemies.

THE WHITE HOUSE
WASHINGTON

Mark gearan
Fy 1

DETERMINED TO BE AN
ADMINISTRATIVE MARKING

INITIALS: JM DATE: 5/6/16
2011-0584-F

PRIVILEGED AND CONFIDENTIAL

May 5, 1993

MEMORANDUM FOR HILLARY RODHAM CLINTON

SUBJECT: Closing the Deal With Interest Groups

FROM: Mike Lux

cc: Ira Magaziner
Bob Boorstin
Chris Jennings

Maggie Williams
Melanne Verveer
Alexis Herman

Ira and Maggie both thought it would be helpful for you if I did a memo describing where we are with key groups, and a strategy for closing the deal with them. I will start by dividing key groups into the following categories:

1. Groups which, while they have some issues they care about more than others, essentially are ready to come on board. If I'm reading them right, all they need to close the deal is a final meeting (or phone call) with you or the President (four of those meetings are already set up.) These groups are:

Families USA
National Leadership Coalition for Health Care Reform
Children's Defense Fund
American Nurses Association
American College of Physicians
American Hospital Association
Catholic Health Association
National Council of Churches

2. Groups which are haggling with us over a few key policy details, but which are likely to end up in our camp. With these groups, I would let Ira and I continue to work with them on these policy details, but we would definitely need you for a final meeting to close the deal. Depending on how far we've gotten with them, some of these final meetings will be easy but some of

them might be real toe to toe, final round negotiations. These groups are:

- AFL-CIO
- NEA
- AARP
- National Council of Senior Citizens
- National Committee to Preserve Social Security and Medicare
- National Association of Social Workers
- Citizen Action
- Consumers Union
- Consumer Federation of America
- National Medical Association

3. There are a number of major organizations whose position on our plan is totally dependent on some major policy decisions we have yet to make. Once we make those decisions, we'll know whether we should proceed with a "close the deal" strategy or a "how do we manage the opposition" strategy. This includes the following groups:

- AMA
- Blue Cross/Blue Shield
- The Big Five Insurance Companies
- National Association of Retail Druggists
- National Association of Chain Store Druggists
- American Pharmacists Association
- Pharmaceutical Manufacturers Association
- American Trial Lawyers Association

4. We have a separate business strategy based on the assumption that this is too divisive an issue to get business association support, but that we can get a great deal of individual CEOs to support us. We are working on scheduling you and the President to maximize that kind of support. (Part of that strategy is sending you to this business retreat on the 7th.)

Below are summaries on the organizations you are currently scheduled to meet:

1. Liberal groups pulled together by Families USA

There will probably be representatives from 200 to 300 liberal groups at this meeting: civil rights, women, churches, aging, and consumer groups. The purpose is to close the deal with much of the liberal establishment in D.C.

Some of the groups there will be single payer, but most are liberal groups who just generally support universal access and are not set on any particular approach.

Major issues: Universal access sooner rather than later.

2. National Leadership Coalition for Health Care Reform

They are a three year old, business-led coalition which is very close to us on the issues. CEOs or Washington reps of over fifty major corporations will be at there, and this meeting could really boost our chances of bringing all of them on board.

We have an excellent relationship with them; they feel very good about their chances for input and about our plan in general.

- Major issues:
1. Financing (They prefer the payroll tax or a VAT.)
 2. Cost controls (They like the idea of voluntary cost controls with a hammer.)

3. National Education Association

The NEA feels very good about the administration overall. While Keith Geiger, President, wants the NEA to support the health package, he is nervous about getting support because there is a strong single payer contingent in NEA. Geiger wants to be able to say he had a direct meeting with Mrs. Clinton.

- Major issues:
1. Not allowing big companies to opt out of HIPCs.
 2. Tax cap.

4. American Association of Retired Persons

We are having this meeting to close the deal. They feel extremely good about their input into the process, and very much want to support the package. They are nervous about how far we'll go on long term care, and how we'll structure a phase-in (they don't want any phase-in). They feel very strongly about including age in the community rating, believing that not community rating age encourages age discrimination.

- Major issues:
1. Long term care
 2. Drugs: include in benefits package; price controls
 3. Community rate by age

5. American College of Physicians

They are the second largest physicians group. They are very sympathetic to us, and this meeting could close the deal.

Their plan looks a lot like ours substance-wise, and they worked closely with us during the campaign. Although Ira Magaziner and several other administration officials have had them in for meetings, they have had their feelings a little ruffled by not being more "inside" the process.

Major issues:

1. Promotion of general practice
2. Administrative simplicity/paperwork
3. Universal coverage
4. Medical malpractice

-DRAFT-

DETERMINED TO BE AN
ADMINISTRATIVE MARKING

INITIALS: JM DATE: 5/6/96

2011-0584-F

~~CONFIDENTIAL~~ MEMORANDUM

To: Mark
From: Dwight
Date: May 1, 1993
Subject: White House Action Plan for Health Care

As the Task Force nears completion on its work, it is time to begin developing a White House Action Plan for promoting the President's health care reform proposals. The action plan should serve to:

- educate White House staff on the substantive and thematic background of the President's proposal;
- underscore White House commitment to this Presidential priority;
- maximize efforts of WH staff and Cabinet offices to promote the plan; and most importantly
- integrate these efforts both internally and with outside supporters to maximize our effectiveness.

Short Term and Long Term Plans

Many offices have been involved in policy development, and the communications department has begun planning for the 3-4 week burst of activity surrounding the announcement of the plan. This short term planning for the announcement period will set the tone of the plan's reception, and is indisputably very important.

However, we need to develop a long-range framework for the 6 months following announcement leading up to, we hope, a December 24 bill signing. It is important to have an initial strategy for this period **now** in order to better understand what we need to achieve during the 4 weeks of the announcement period.

Initial meetings:

First Lady: As Maggie suggested, you should first meet with the First Lady and Ira [or his designee] to suggest that you would like to begin developing a White House action plan (in contrast with the 501C-4) for promoting the plan. Agenda topics include:

- Your proposal for developing plan through 1:1 mtgs, then group, then drafts, etc, (drawing consistent parallels to promotion of economic plan)
- Her thoughts on long term framework: 5/25 - 12/24
- Her thoughts on what we need to achieve 5/25 - 6/15
- Memo to Prez. on promotion of plan? [Did we do this for the economic plan?

Long Term Framework: Stan et al, George et al, Bob, Howard, Rahm, OFL, John?, NEC? Marcia? Alexis?¹: Before developing individual plans for short term proposals, I think you [we all] need to develop a sense of what the long-term framework will be: do we have to have sustained, rapid fire activity for the next 7 months? Assuming the answer is "no," what is our schedule? Obviously whatever we discuss will change and evolve as we go, but as I mention above, I think understanding the long-term framework is central to developing an appropriate short-term plan.

[Alternative: first do this with a very small group: Stan, Bob, George/Ricki, and Howard, then assemble the group listed above]

Policy: At some point, we should get Ira to walk you and Mack through the outline of the proposal. I don't know if you need to do this now, or wait until more details have been decided on.

Individual meeting plans:

After discussing this with the First Lady and developing a general long-term framework, we begin meeting with individual offices to get an idea of where they are in the process and what their office strategy is. I have included a suggested attendee list for each meeting as a starting point. In addition to the people listed, the First Lady's office, Ira's office, and maybe Celia should have an open invitation to attend any of these meetings. The political department is not listed for a separate meeting, but will clearly provide supervision on targeting and key political issues throughout. Each meeting should lead to a framework for a plan, which each department will write-up and turn into you, and update as the plans evolve.

Communications Plan: George, Ricki, Bob, Marcia? [maybe Stan et al] Agenda topics:

- What message[s] do we need to accomplish over announcement period?
- What is the plan?
- Sticky issues plans: abortion, small biz, seniors
- Regional sticky issue plans: CT, NE, IA [maybe this goes into Congressional?]
- Surrogates plan for announcement week
- On-going coordination/war room, like NEC set up

Congressional Plan: Howard, Steve, Chris. Topics:

- Ratification: who will be ready to endorse on Day 1? What are they doing?
- Breathing room: will potential opponents give us the 48-72 hours coasting room we got on the economic plan?
- Targeting: where do you want us on Day 1-4?
- What will be key votes in each chamber [and therefore what are issues we should be prepared for and/inoculate against early on]?
- Who testifies?
- Hearing schedule [the whole WH should be briefed on schedule eventually]
- Testimony from non-federal reps: do we coordinate this?
[see also: *Intergovernmental, public liaison*]
- What is our coalition? [bi-partisan issue]

¹ I think it's important that the department heads attend these first meetings: they must feel fundamental ownership of the long and short term plans for promotion of the plan.

Campaign Plan and DNC Plan: Wilhelm, Craig, Celia, Rahm, Bob, Stan et al?

- Full plans for announcement week [parallel to Economic plan activity]
- detail on long term strategy

Intergovernmental: Hart, Regina, Katie Whelan?

- Report on groundwork: who likes us, who doesn't
- Final consultation/briefing schedule
- Announcement week activity: endorsement press conferences, op eds, talk shows, etc. [think targeting]
- Long-term inclusion/use of endorsers as opinion leaders/surrogates
- Briefing and activity for next tier: State Secretaries of Health, legislature health committee chairs, city health officials, etc.
- State resolutions of support?
- Coordinating testimony on the Hill
[see also congressional]

Public Liaison: Alexis, Mike Lux, Rahm?

- Report on groundwork
- final consultation/briefing schedule
- special issues: small biz, big biz, seniors, etc.
- Announcement week activity: endorsement press conferences, op eds, talk shows, etc. [think targeting]
- Grace period of 24-72 hours after announcement
- Coordinating testimony on the Hill
[see also congressional]
- Long term involvement: how do we sustain interest of our allies?

Cabinet: Christine, Steve, Rahm?

- Departmental idea memos which outline proposals for activity, from local office through Secretarial action.
 - Plan for sub-cabinet level activity around announcement
 - regional office activity around announcement
 - plans for sustained involvement
 - press plans

Full WH Strategy Meetings

After initial plans have been developed, all players should meet to discuss the individuals strategies to integrate efforts, to brainstorm on different/new action, and make sure we are all on the same message. This meeting will also serve to update and add assignments to department staff.

This group should meet occasionally as we near Day 1.

Other issues:

Involving the Chief of Staff: Early on, Mack should take some step to underscore the priority of this enterprise. Maybe he should convene the long-term framework meeting in his office.

Policy Briefing for WH Staff: Ira will need to brief the entire action group on the outline of the proposal at some point. This briefing must highlight the economic impacts and other hurdles we face in the plan--it is imperative that we know the nature of the beast we are fighting, so we can avoid a reprise of our narrowly averted disaster in Chillicothe. We should consider requesting Ira to write a Book of Pain which outlines the worst of the worst, just as Gene developed the 39 Cuts List.

Policy briefing for Cabinet Chiefs of Staff and Press People: Many Cabinet members should be fully apprised of the plan through their participation on the Task Force, but the CoS probably remain in the dark on the political aspects of the substantive proposals. And, of course, we need to brief the 6-8 Departments who are not represented on the Task Force. The sooner this briefing can happen, the better--the substantive knowledge will be helpful in brainstorming for Departmental action around the announcement week. [Boorstin's shop has put some thought into who needs to be briefed immediately prior to announcement.]

WH Counsel: Steve and Bernie should give the full action group a run through of the Do and Do NOTs.

NEC Activity: I did not include a meeting with the NEC on their plans on my list. Their support and action through the announcement period and down the road is central to the success of the plan, but I unclear as to how best to include them--maybe we just treat them as any other WH office involved, or maybe we leave it to Boorstin and Chris Varney to make sure these guys are hitting the road as a part of the communications and Cabinet plans.

At any rate, I suggest you have lunch with Rubin early this week. It would be helpful to hear how he thinks things are going.

Paper for First Lady: We need to decide what you want to take to your meeting with Mrs. Clinton. We could do a clean-up version of this, without my asides, etc.; something shorter, or nothing.

On-going Coordination of Activity: The NEC set up a war room for the period around announcement of the plan to handle immediate research needs, answer questions from the Plane, Cabinet members, and surrogates on the road, provide continuous feeding of the press with factoids, etc. What will we need to do to parallel this effort?

MEMORANDUM

To: Mack McLarty
Mark Gearan ✓

From: Dwight

Date: May 4, 1993

Subject: Health Care Time Line

The Task Force sub-group which has been meeting over the past 10 days continues to discuss recommendations for the President on the key issues outlined in Ira's decision book. While the group is grappling with some of the substantive issues, including Medicare integration and long term care, Ira's quantitative group is working with deputies from the economic team to increase confidence in the cost and savings numbers.

Bo Cutter re-opened the issue of timing for announcement in yesterday's meeting. There are several NEC folks who feel that while we could do health care this year, we could do it better next year. Several of the health care folks concur that it might be advisable to wait some. Ira suggested that the group meet with the President to discuss process and timing. The consensus was that they should wait until they have a better understanding of what the numbers are before even discussing process. The group agreed on the following schedule:

- After May 12 [when the next cut of numbers will be available], decide on a time to meet with the President to discuss timing;
- On May 17 [the unofficial revised deadline], begin oral briefings with the President for final decisions.

Ira underscored that the communications and policy groups will continue working toward May 25 for a Joint Session speech until the process meeting takes place in order to protect the possibility of announcing then.

All discussion of timing takes place in a vacuum from various side conversations which are underway, and thus may ultimately be altered dramatically. We can discuss this further at your leisure.



health care file

To: Mark
Fr: Dwight
Dt: April 27, 1993
Re: Berman Insight

Mike Berman had some interesting ideas on health care strategy:

Scheduling/Communications Issues

- Wait until after Congress comes back to do the Joint Session. He thinks that since opposing providers are better organized than proponents of the plan, Congress will go home to more opposition than support. I suggested that we might get a big enough bounce out of the Jt. Session that we would want Congress to go home then, and he agreed that that is also a possibility.
- Let the bill bubble up through committee during the summer. Keep the issue active, but don't headline it.
- Beginning on Labor Day, take a seven day period where you make it absolutely impossible for any American to avoid thinking about health care. All 4 principles, the entire Cabinet, regional HHS administrators, surrogates, and Task Force Members--40-50 people in all--should go separate ways and spend an entire week on the road. Events should include town hall, editorial board meetings, etc. Days could be divided into certain aspects of the plan, but the overall message would be:

Congress is coming back, they've finished with the budget, and it is time to Health Care happen in America.

Berman thinks, and I agree, that it will take this kind of resource commitment to jumpstart this issue into the prominence and importance needed for Congress to actually feel pressure to do something this year.

Legislative Issues

- The bill must include clearly identifiable components of past Democratic bills to keep the base. Provisions allowing states to go to single-payer and enacting universal coverage probably meet this need.
- The bill must include clearly identifiable Republican components. We are close with Chafee, but probably not enough to guarantee he is on board.

- The President should convene a super-sub-committee working group, including all the relevant chairs on both sides and possibly ranking members, to begin meeting immediately on passage of the bill. As reconciliation nears completion and attention turns to the health bill, this group should ratchet up its work to near daily meetings to report on status and adjustments in the bill and strategy.

- Straight price controls will guarantee a Republican filibuster and should be considered a non-starter. Voluntary controls with stand-by authority for mandatory controls might work.

Let's discuss. If you agree that components of this make good sense--I like the week of travel and the committee chairs working group a **lot**--we should figure out how to promote the ideas with the right people.

cc: Ricki

~~CONFIDENTIAL~~ MEMORANDUM

To: Mack McLarty
Mark Gearan

From: Dwight *Dwight*

Date: April 13, 1993

Subject: Health Care: Beginning the Decision Process

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: *JM* DATE: *5/6/16*
2011-0584-F

Decision Process

The Health Care Task Force has prepared a briefing book outlining twenty preliminary decisions as a starting point for shaping the health care plan. Ira walked the President through the basics of the plan and these decision points today. The book also highlights some of the key potential problems with the plan, and how the proposal addresses these concerns.

--**Wednesday**, the Task Force will brief the President on initial cost and savings numbers.

--**Thursday**, the President will begin addressing the specific decision points.

A summary of the decision points is attached. The briefing book lays out the issues extremely clearly--I recommend that you consider taking it home some evening when you have time for reading. I will write a daily round up summarizing the key issues/decisions made from each meeting.

Key Issues Raised Tuesday

Financing: The fundamental issue is whether the plan should rely on employer-based or broad-based taxes for financing. Employer-based financing, such as payroll taxes, requires extremely complex administration--especially when you consider the need to provide subsidies to both small businesses and low-income and unemployed enrollees.

Broad-based financing--such as a large VAT--eliminates the issue of subsidies entirely. Calculating business and individual share is unnecessary since funds would simply be distributed directly from the Treasury to purchasing cooperatives and on to health plans.

Most participants agreed that if we were starting from scratch, a broad-based tax makes a lot more sense because it is so much simpler and therefore much easier and cheaper

to administer [the difference in administration is (literally) billions of dollars]. However, the politics of introducing a 12-14% VAT are extremely problematic, even in the context of wiping out all current contributions to the health care system [which include taxes, premium contributions for employer and employee, etc]. In addition, most broad-based options--such as the VAT--are very regressive.

Given the politics, I had thought the Task Force had settled on employer-based financing and, quite frankly, was surprised this is still on the table. However, the First Lady made clear that the President should not fully reject broad-based financing yet.

Employer Mandate Threshold: The decision as to what size employer should be mandated to purchase care through the purchasing cooperative requires walking a fine line between substance and politics. The threshold most commonly discussed would allow employers with more than 1,000 employees to self-insure, although many feel that number is too low and would allow too many businesses to "opt-out".

If you allow too many businesses to self-insure, you run the risk of developing a two-tier system, with large business plans representing the "cadillac" and everyone else in the "public plan". On the other hand, if you set your threshold too high, you could jeopardize big business support for the plan. Large employers are extremely anxious to have the option to self-insure because:

- they fundamentally think they can do a better job of running health care than the "government" can;
- many large companies rely on young, healthy workforces--which means the community rating required in purchasing cooperatives would increase the cost of insuring employees for these companies;
- businesses operating in several states will have to contract with a number of state purchasing cooperatives, rather than running a single plan;
- with self-insurance, businesses get to keep their "float" from premiums.

Short term costs/savings: Bob Rubin asked Ira if the plan, as proposed, would definitely require short-term costs. Ira responded that he plans to lay out a number of options, one of which would be a long-range phase-in which would not require new money from the start. He also has a financing mechanism which requires no new taxes, although a substantial burden is shifted to businesses through mandates.

Budgeting: This will be one of the trickiest issues over the next weeks. The basic issue is that many people--including some in the WH--don't believe you can successfully marry the concept of an enforceable budget with the market principles of managed competition. However, for the savings to be scoreable, there must be an enforceable budget.

- DECISION 1: WHAT REMEDIES SHOULD THE FEDERAL GOVERNMENT USE IF STATES DO NOT FULFILL THE REQUIREMENTS OF HEALTH REFORM?
- DECISION 2: WHAT DEGREE OF FLEXIBILITY DO STATES HAVE TO EXCEED THE NATIONAL HEALTH CARE BUDGET?
- DECISION 3: SHOULD THE NATIONAL BUDGET BE SET TO REDUCE DISPARITIES IN SPENDING LEVELS DUE TO PRACTICE PATTERN DIFFERENCES ACROSS STATES?
- DECISION 4: SHOULD TAX INCENTIVES BE USED TO PROMOTE CHOICE OF LOWER-COST HEALTH PLANS?
- DECISION 5: HOW MUCH PRICE COMPETITION IS DESIRABLE?
- DECISION 6: WHICH PRIVATE AND PUBLIC EMPLOYER GROUPS WILL BE REQUIRED TO OBTAIN HEALTH COVERAGE THROUGH THE HEALTH ALLIANCES?
- DECISION 7: SHOULD COMMUNITY RATING BE MODIFIED TO ACCOUNT FOR AGE?
- DECISION 8: WHAT RATING AND CHOICE RULES GOVERN STAND-ALONE PLANS?
- DECISION 9: SHOULD MEDICARE BE INTEGRATED INTO THE NEW SYSTEM?
- DECISION 10: HOW WILL CARE FOR UNDOCUMENTED PERSONS BE FUNDED?
- DECISION 11: TO WHAT EXTENT IS THE RANGE OF REPRODUCTIVE HEALTH SERVICES DEFINED IN THE BENEFIT PACKAGE?
- DECISION 12: SHOULD THE FEDERAL GOVERNMENT CAP NON-ECONOMIC DAMAGES AND IMPOSE OTHER UNIFORM RULES FOR MEDICAL MALPRACTICE CLAIMS?
- DECISION 13: HOW MUCH SHOULD BE INVESTED IN LONG-TERM CARE?
- DECISION 14: WHAT'S THE PREFERRED SCOPE OF HEALTH REFORM; WHAT'S THE MINIMUM WORTH DOING?
- DECISION 15: HOW WILL HEALTH REFORM BE FINANCED?
- DECISION 16: WHO WILL PAY FOR HEALTH REFORM?
- DECISION 17: HOW MUCH NEW INVESTMENT WILL BE MADE IN TOTAL HEALTH-CARE SPENDING?
- DECISION 18: HOW WILL COSTS BE CONTROLLED WHILE HEALTH REFORM IS IMPLEMENTED?
- DECISION 19: BY WHAT METHOD WILL THE TRANSITION TO THE NEW SYSTEM TAKE PLACE?
- DECISION 20: HOW FAST WILL THE NEW SYSTEM BE IMPLEMENTED?

~~CONFIDENTIAL~~ MEMORANDUM

DETERMINED TO BE AN
ADMINISTRATIVE MARKING

INITIALS: JM DATE: 5/6/96
2011-0584-K

To: Mack McLarty
Mark Gearan ✓
From: Dwight D. ✓
Date: April 21, 1993
Subject: Health Care Task Force senior staff meetings

The Task Force began presenting key decision points to the President last week. As I outlined in discussions last week with Mark, I have had several serious concerns with the decisions process:

- Do the decision points raised by the task force ask the right questions?
 - are all the key areas covered?
 - do the questions lead clearly to a coherent plan?
 - will the direction of the plan be clear to the President as he makes the decisions? [ie, are the decisions presented, incorrectly, as independent of one another in such a way that you can't see what you are shaping]
- Do the questions, as presented, highlight the important economic and political impacts of each decision?
- When will the smaller but deadly political landmines inherent in each decision be brought to the table?
- Is there adequate consensus among staff to move to final presentation to the President?

The first meeting with the President last week highlighted some of these problems. Ira's initial intention was to offer the President several options for discussion. At the end of the first meeting, the group decided it would be more helpful for Ira to hold a series of "pre-meetings" with a small group of task force members and staff to prepare recommendations for discussion with the President. These pre-meetings have been extremely productive for a couple of reasons:

- Staff differences are being aired and hammered out. Bruce Vladek is pushing for Medicare to play a strong role in the new system, serving as a single-payer back-up to managed competition. This proposal is probably the source of the rumors that HHS is developing a separate alternative. Bruce and Ira began discussing the pros and cons of this approach yesterday with the group--and hopefully will come to a recommendation everyone can live with. If Vladek and HHS feel their opinions have been aired thoroughly, their objections to the final Task Force recommendations should be minimal.

◦ Political and economic issues are receiving more attention. It's hard to have a free-flowing brainstorming session about various political and economic impacts of certain decisions with the President. These impacts are now being debated in the pre-meetings, so that Ira et al can present the concerns of the group as part of the meetings with the President.

I am still concerned that the decision points raised overlook key issues and that there are political landmines woven deep into the fabric of each decision which may not surface until later in the process. However, the pre-meetings are clearly helpful to get many of the difficult issues which have been lurking in the working documents on the table.

I had a good conversation with Ira this morning about how he thinks we are doing. He also thinks the pre-meetings have proven helpful to bring people on board with the plan. Ira is very comfortable with where we are in plan development and feels that 4 weeks is plenty of time to get the decisions he needs and write the plan. Go Ira!

→ CH

-Meeting schedule attached

Date	Time	Topic
Friday April 16	4:00-6:00	Federal & State roles Structure of Health Alliances Structure of accountable Health Plans
Monday April 19	10:00-12:00	Pages 1-10C on plan outline memo Decisions 1-9
Monday April 19	4:30-6:30	Meeting with President
Tuesday April 20	10:15-12:00	Malpractice Coverage Benefits Pages 11-15 on plan outline Decisions 10-12
Wednesday April 21	3:00-6:00	Cost and Financing of Program
Thursday April 22	11:00-1:00	
Thursday April 22	4:00-6:00	Meeting with President
Friday April 23	4:00-6:00	Transition to New System
Sunday April 25	4:00-6:00 (Tentative)	
Monday April 26	3:00-6:00	Review of two packages based on decisions: 1. Minimum worth doing 2. Ideal plan
Tuesday April 27	3:00-5:00	Meeting with President
Thursday April 29	9:00-12:00	Review of revised packages
Thursday April 29	3:00-5:00	Meeting with President

Please designate one deputy and if needed, one staff person to bring with you to meetings. If you cannot attend a meeting, please ensure that your deputy attends and that you are fully briefed so that we can all remain at similar places in the