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Folder Title:
Health Care [Folder 2] [3]

Stack:	Row:	Section:	Shelf:	Position:
S	90	4	1	2

Health Care

QUESTIONNAIRE

1. Gender

Male	56
Female	44

2. Age

18-40	32
Over 40	68

3. Education

High School Grad or Less	34
Vocational/Technical/Some College	50
College graduate	16

4. How do you think of yourself with regard to political parties?

Democrat	38
Independent	54
Republican	8

Rate your feelings towards Ross Perot with one hundred meaning a VERY WARM, FAVORABLE feeling, zero meaning a VERY COLD, UNFAVORABLE feeling and fifty meaning not particularly warm or cold. Use any number from zero to one hundred, the higher the number, the more favorable your feelings are toward Ross Perot.

5. Ross Perot . . . . . __59__

	Pre-Speech	Post-Speech
6. Bill Clinton	__51__	__73__

7. Who did you vote for in the 1992 election for President?

Republican George Bush	0
Democrat Bill Clinton	50
Independent Ross Perot	50

8. Do you approve or disapprove of the way Bill Clinton is handling his job as president?

	Pre-Speech	Post-Speech
Strongly disapprove	12	4
Somewhat disapprove	22	10
(Don't know)	4	4
Somewhat approve	58	66
Strongly approve	4	16

9. Do you feel mainly hopeful or mainly doubtful about Bill Clinton?

	Pre-Speech	Post-Speech
Doubtful	36	24
(Don't know)	6	8
Hopeful	58	68

10. Tonight, Bill Clinton will present his program to change the health care system. From what you've heard, do you favor or oppose his health care proposals?

	Pre-Speech	Post-Speech
Strongly oppose	6	2
Somewhat opposed	6	2
(Don't know/Not enough info)	64	2
Somewhat favor	18	42
Strongly favor	6	52

11. Do you believe Bill Clinton's health program will help or hurt your family?

	Pre-Speech	Post-Speech
Hurt	28	12
(Don't know)	26	16
Help	46	72

12. Do you think the program will simplify the health care system or create more bureaucracy?

	Pre-Speech	Post-Speech
Create more bureaucracy	54	28
(Don't know)	10	10
Simplify health care system	36	62

13. Do you think the program will mean higher or lower health care costs for your family?

	Pre-Speech	Post-Speech
Higher health care costs	56	48
(Don't know)	10	8
Lower health care costs	34	44

14. Do you think the program will preserve the quality of health care or undermine it?

	Pre-Speech	Post-Speech
Undermine quality of care	52	34
(Don't know)	16	14
Preserve quality of care	32	52

15. Do you think the program will help or hurt the economy and jobs?

	Pre-Speech	Post-Speech
Hurt economy and jobs	50	44
(Don't know)	14	8
Help economy and jobs	36	48

16. Do you think the program will mean that more or less things will be covered by your insurance?

	Pre-Speech	Post-Speech
Less things will be covered	74	42
(Don't know)	8	8
More things will be covered	36	50

17. Do you think the program will maintain or limit your right to choose a doctor?

	Pre-Speech	Post-Speech
Limit right to choose doctor	60	24
(Don't know)	6	4
Maintain right to choose doctor	34	72

18. Do you think the program will introduce greater responsibility into the health care system or encourage more irresponsibility?

	Pre-Speech	Post-Speech
Encourage more irresponsibility	40	28
(Don't know)	12	8
Introduce greater responsibility	48	64

19. Do you think the program is a risk worth-taking or is it too risky?

	Pre-Speech	Post-Speech
Too risky	22	6
(Don't know)	10	8
Risk worth taking	68	86

20. Do you think the program will mean that you won't lose health coverage for any reason or do you think people will still lose coverage?

	Pre-Speech	Post-Speech
Will still lose coverage	40	26
(Don't know)	8	10
Won't lose coverage	52	64

21. Do you think the program will mainly be paid for by cost savings or do you think the program will require broad tax increases?

	Pre-Speech	Post-Speech
Require broad tax increases	82	62
(Don't know)	6	6
Paid for by cost savings	12	32

22. Should Congress try to pass the Clinton program as soon as possible or should it take a lot more time to consider it?

	Pre-Speech	Post-Speech
Take more time to consider it	64	52
(Don't know)	4	0
Pass program as soon as possible	32	48

23. Based on what you saw tonight, how do you feel about Bill Clinton:

Much worse	2
Somewhat worse	0
The same	32
Somewhat better	34
Much better	34

Health Care

THE WHITE HOUSE

Office of the Press Secretary

Internal Transcript September 21, 1993

REMARKS BY THE PRESIDENT
IN LUNCH WITH COLUMNISTS

Old Family Dining Room

12:55 P.M. EDT

THE PRESIDENT: I think we should start because of the time, even though not everybody's -- we haven't been served yet. We're glad to have you all here. As many of you know, this is a rather busy day at the White House. (Laughter.) We just had a wonderful signing ceremony for the National Service bill, and we've got a couple hundred radio talk show hosts here. Have you been over to see them yet?

MRS. CLINTON: I have.

THE PRESIDENT: Was Limbaugh there?

MRS. CLINTON: He didn't come. (Laughter.) In fact, I read somewhere that he said he said it was a plot for him to have been invited at a time when he couldn't be there. Or something, I don't know. I wish we were that clever. (Laughter.)

THE PRESIDENT: I wish I knew his schedule.

I thank you all for coming. I thought it might be helpful if we just had a little time to discuss the health care initiative and if, at the end of the hour or hour and a half or however much time we have here, you want to ask a few other things, I think that would be fine with me. But I think we ought to try to talk about the health care issue.

I'd like to make two points to open the discussion, one general and one specific. The general point I want to make is that I think profound change has happened in societies when essentially people understand that the cost of staying with the present course of action is greater than the cost of change; that the risks of staying with the present course of action are greater than the uncertain risks of any change.

Franklin Roosevelt proposed the first bill to provide national security in health care in 1943, 50 years ago.

MRS. CLINTON: In '33.

THE PRESIDENT: In '33 -- 60 years ago. And we've been debating this ever since. But I believe very strongly that this is a moment when it is likely to occur, because I think there is a shared consensus that the problems with the system and the escalating costs, and the escalating disfunctions with more and more losing their health insurance every month, are greater than the costs of change.

Beyond that, I see this health care issue as essential to much of what America has to do now. I think that we're living in, self-evidently, an incredibly dynamic time with a range of changes, good and bad, the consequences of which cannot be fully perceived. And it seems to me that my job as President is to try to chart a

course which would enable the American people to take advantage of the changes that are occurring and to minimize the dangers, that there are some things the government can do on it's own, but very few; that most of the things that a president or that this government has to do will be done either in partnership with the Americans in their private lives, or by some summoning them to do something that they should and then setting up an environment in which it is easier for them to do it.

I think that the health care issue is important because it relates to so much else that is going on. And let me describe why. This plan that I'll present tomorrow night is designed, first and foremost, to provide health care security, something that millions of American either don't have or are at risk of losing for reasons you all know very well. They're locked into jobs because somebody in their family's been sick; they can lose their health care if they change jobs -- all the things you know about. Self-employed and can't afford it.

We have to try to provide security in as many fundamental things as we can to people who are doing right, so that we can give them the courage they need to change. Some of you may disagree with me about the NAFTA thing, but I think NAFTA is by and large -- the problem we've got with NAFTA is that the fear factor is so much more powerful than the hope factor because people are so insecure in their own lives, because so many other bad things have happened to them in the last 10 or 12 years and they just can't imagine that a change like this can come out okay.

And anchoring working families and businesses in a secure environment -- secure, meaning, a, you've got a quality and comprehensive health coverage that you cannot lose, and, b, from the point of view of the economy, that costs will not go up as much as they have been going up, so that we will be more competitive is, I think, critical to giving the American people the sense of security they need to face their other challenges. So it's not only the right thing to do on its own merits, but it's important beyond that.

Secondly, Hillary and I can talk about a lot of the details of the plan, but a lot of you -- you or your organizations have written or spoken in great detail about it. The second point I'd like to make is this. In the last few days, a lot of the criticism of the health care plan is centered around whether the numbers are real or not real. I think there are two issues which have been blurred here in this discussion, and I want to try to divide the issues.

Issue number one is: Are the numbers as honest -- honest meaning we're trying to tell you what we think is the truth, and are they well-founded, as well-founded as possible? Issue number two is, even if they're good numbers, is our approach achievable?

The second issue is clearly open to debate and anyone can discuss it. But it's been unfortunately blurred with the first issue. That is, people are saying the approach is not achievable because the numbers aren't real. And I don't think that's right, and I'd like to explain and give Hillary the chance to maybe talk about this more if you want to pursue it.

We decided from the get-go when we began this process that we had to have integrity of numbers, just like I decided when I started this budget process, that we had to have integrity of numbers. We had to try to do that above all else, so that people could disagree with us about the issues. Some people don't think we ought to require the people -- new people coming into the system to pay 20 percent of their own premiums, but I do. Because I think it's important we have that kind of responsibility. People have to understand that this is not free.

deficit and helping businesses. All the talk has been about the problems with the small businesses that don't know insure, or insure at a very minimal level. But the truth is that a lot of businesses in America, and far more than would be hurt will be helped by this because either their premiums will drop immediately and substantially, or between now and the year 2000 they will go up much less rapidly. They will all be better off and that means more investment in other things.

So I'm anxious for this debate to begin and I'm looking forward to tomorrow night.

Would you like to say anything about your health care university? Why don't you just briefly say a little bit about the last two days on that and then answer questions.

MRS. CLINTON: Well, I would only add that I think that the convergence of ideas around what needs to be done in health care has accelerated in the last couple of months. And it is very clear to me that it has occurred also on Capitol Hill among both parties and in both Houses; and that there are far more similarities in approach now than there were at any previous time that I've been able to read about it and told about.

So I'm very hopeful that as we move forward in the discussion, if we keep our focus on the principles that we think should guide this debate, and the destination that we're all trying to get to, that we will have a very fruitful discussion in the Congress and we'll put together a bipartisan majority to pass health care reform. And I'm very hopeful that that's going to happen.

Q Do you think that you're going to get it before the November elections next year?

MRS. CLINTON: I don't want to put a time line on it because I don't know when it will happen. But I think that there is a great deal of energy and motivation in the Congress now, and that we're going to get something in the next -- we're going to get a health care reform plan in the next year at some point. And, you know, what its exact contours will be and how it will be implemented I don't think any of us can predict right now, but I think we will be committed to the basic principles and we will actually be seeing changes beginning to occur.

Q Mr. President, what do you hope to or plan to say tomorrow to reassure people on the cost questions? And can you be credible on the whole program if you don't do that?

THE PRESIDENT: Well, I think you have to reassure them on the cost question. I will say, first of all, we're not talking about cutting the aggregate cost of health care. We're talking about dramatically cutting the rate at which it is increasing, and that the experience of the last 12 years need not be viewed as a permanent experience, the way you've got a health care cost going up at two or three times the rate of inflation every year.

This year we're looking -- in the coming budget year that we're going to start on October 1, we're looking at a 3.5 percent inflation rate and 16 percent increase in Medicaid, with only about a two percent increase in enrollment.

So what I'm going to say to people is, if you put greater competition in the system, if you give consumers more buying power, if you have the discipline of a budget, and if you drastically simplify the administrative cost, which adds about a dime on the dollar more to the American health care cost than any other system we have studied -- that is, we spend about 10 cents more on the dollar in administrative costs than any other heath care system we've

their employer. People who are currently on Medicaid, as we fold the Medicaid system into the overall system, the working Medicaid recipient will be also called on to make a contribution. Even the working Medicare, which is a certain portion of the population. So we have over $50 billion coming into this system from direct payments from those who use it but either are reimbursed -- their cost is reimbursed by the government holding out, or nobody reimburses it.

In addition, as you lower the rate of increase in Medicaid and Medicare, we think we can make better use of those dollars. And this is one of those issues that I think has not been fully explored.

So many people in Congress have argued that the rate of increase in those two programs needs to be reduced for deficit reduction purposes. Whether it's coming from Rudman and Tsongas or from Nunn and Domenici, or from any source. So that there have been all kinds of calls for reducing the rate of increase for years now. And actually, some in the last budget was used for that.

In the major bills that will be considered in this debate, whether it's the single payor alternative or the Senate Republican alternative, they also call for reducing the rate of increase. The issue is not are we going to reduce the rate of increase, it's how far will we reduce it. And there are some, as the President pointed out, who say, well, the President's plan wants to bring it down more than is politically feasible. But there's no question that it can be brought down. We just happen to think it can be brought down a little bit more than some of the others believe.

Q Without pretending an expertise about any of these numerical issues, what I wanted to understand better is what the relationship is between savings as they are achieved and benefits as they are extended. And this isn't you have to collect a dollar, say, and put it in a safe place before you spend it on an expanded benefit. But could you help me understand better what the relationship is between savings and expansion?

MRS. CLINTON: Well, first, I didn't fully answer Jack's question, but there's money in the system that will fund all that. But to your question, part of the dilemma we are faced with because we are dealing with the Congress instead of with most other entities that budget is that you're looking for savings that are scorable as well as savings that are real, okay? And --

THE PRESIDENT: They're two different things.

MRS. CLINTON: And they are two different things, as we have learned. And you can get savings that will be scorable by CBO and other budget watchers in the Congress. And we will have scorable savings in this system. Reducing the rate of Medicare is an obvious example.

We also will have a -- the budget -- the idea of a budget which is linked to some rate of increase in premium costs also gives you scorable savings, enforceable budget of some kind, which is one of the very strong reasons for going with the budget, unlike some of the alternatives that talk about competition and leave it totally to market forces without any scorable savings.

Now, in addition to those kinds of savings, we think there are enormous savings to be had from market forces and competition at work. We can't get any scoring for those, but we can give you big, thick books analyzing how much we will get. And we look to organizations, the likes of which I've just mentioned -- some of the large, well-run health care providers in the country -- as well as doing things like simplifying administration, moving toward a one form system for each of the various components of the health care

system. There are billions and billions of dollars which we will be reaping as we move.

Q But they're not listed in the plan as some line item?

MRS. CLINTON: That's right, they are not. And that's a very important point. I mean, we have -- I mean, the numbers -- part of the reason why we feel confident about these numbers is that they are very conservative if you think that you're only talking about what are federal government sort of approved numbers. We have not taken what we believe will be the savings from competition and added them to those numbers, because we have not wanted to get into the debate that Jimmy Cooper and others are going to get into -- and already have -- arguing about, yes, it will and, no, it won't. We've said, look, we believe it will, but we're going to present you with a plan that doesn't even include those savings. And we think there are billions more in that.

THE PRESIDENT: I think it's also important -- in other words, to answer your specific question, what the government has to do is to pay for the uninsured unemployed -- unemployed uninsured -- and then to pay for the subsidies for small business people and low income workers. That's what we have to do. And then to pay for the net new benefits that are government's responsibility -- that's primarily the drug benefit for the low-income elderly that are above the Medicaid line and then phasing in the long-term care, which can be phased in and has to be.

Now, the reason you know those numbers are good -- and this is the argument we're going to have here --is we just produce slowing the rate of growth in Medicare and Medicaid, and then fill another modest gap which we'll probably propose a combination of sin taxes and something on the businesses that opt out of the system, because they will be making -- they'll get huge reductions in premiums and most of them won't get -- they won't be making contributions to the care of the poor that they are now -- we can close that gap and finance it.

But we believe that one of two things is going to happen -- either the savings are going to be much greater than we thought because we don't put in -- if you just close half the gap --let me just give you -- if you just close half the gap in administrative costs between the United States and everybody else --just half the gap in administrative costs, you take $40 billion out of the system a year, of which $15 billion a year is government costs -- maybe $12 billion. Anyway, the ratio is about -- an $800 billion health care system, the last time when it was $800 billion last year. It's about -- it's roughly $550 billion to $250 billion, so you can figure out the numbers.

That's just one example. None of that is budgeted in here. So one of two things is going to happen. Either we'll have even more savings than we thought, or the savings, in effect, will mean that it's very much easier for the health care system -- less strained to meet the budgetary targets that we have.

Q Mr. President, if you believe that, as Mrs. Clinton just described and I know you've described in the past, that given the right incentives, the market will perform in a way that drastically reduce costs, why did you present a plan with price controls on the insurance industry which has become one of the really hot buttons on the Hill? I'm curious about why you feel you need that if you believe the market forces will, in fact, work.

THE PRESIDENT: Well, for two reasons. First of all -- and maybe Hillary will want to add to this -- but I feel pretty strongly about this. I have to tell you this -- reason number one is

if you don't have a ceiling that applies to the government costs -- forget about the insurance companies -- the government costs -- that is, if you don't cap the rate of increase in Medicare and Medicaid, which is a price control -- if you want to say that. You have a budget. I don't -- most people don't call budgets price control, but if we don't propose to control specific prices, we call it for an overall budget. If you don't have a budget on the government side, then you don't have any scorable savings that can be used to finance the government's other responsibilities. So that's what Nunn and Domenici wanted earlier this year, inflation plus population plus two percent.

Q That's the government side of this?

THE PRESIDENT: That's the government side. If you don't put it on the private side, if they don't have to also restrain the rate of increase on the private side, then a lot of the big companies say, listen, we've been paying too much all along. The small business people say we've been paying out the nose all along. We've been paying too much. And now, if you put controls -- disciplined budgets on the government side, but you don't do it on the private side, then we'll just continue the cost-shifting of the past several years where the providers, instead of having to make management efficiencies, will just run up the health insurance premiums of all your employers.

That's the basic problem. That's the substantive argument. And if you can't do them both -- in other words, you can't do one without doing both of them, then you don't get scorable savings. That's the political necessity.

But I believe -- if you look at the rate at which we propose to permit these premiums to increase, I mean, if you just look at it, and if you look at the cost of efficiencies which have been achieved by putting people in big pools, first of all, and simplifying all the administrative costs, that's number one; simplifying administrative costs for insurance companies, for hospitals, clinics; and, number two, by going into managed care networks which force a reexamination of the way all this money is being spent today, all the historical evidence -- to go back to the point Hillary made -- indicates that these ceilings are quite generous.

I mean, if you look at what we've proposed to do, what we propose to do is to stop at 18 percent of GDP on health care by the year 2000 instead of 20 percent. If we do this right, it will go from 14 to 15 percent or something.

So that's my -- there's a practical necessity and I also think a policy argument, not so much for -- I don't think that calling it an aggregate budget, I don't think -- I see it more in terms of price controls imply a whole detailed regulatory apparatus that we don't propose to do. We're going to let people figure out how to live within their aggregate budget. We want -- if anything, we want to have far less federal micromanagement of the kind that HCFA has practiced, for example, in implementing the Medicaid program or having Medicare regulations. We would like to have much less of that kind of federal regulation. Instead of having aggregate budgets, give consumers buying power, free up the providers from a lot of their regulatory burden so they have more time to devote to health care, and then let them figure out how to solve it.

MRS. CLINTON: Could I just add two quick points on this, because I know this will be one of the major areas of discussion on the Hill. We view a budget as a backstop. I mean, if competition works, the budget will never be used. And we have every reason to believe that in most regions of the country, the budget as we're constructing it should work. But we are starting with huge

differences in the cost of care between various regions of the country that we can only slowly begin to try to bring down without dislocating the delivery of care. And we have -- after we've looked at all of the data available, have often remarked that there are some cities of this country where literally it would be cheaper to get first-class fair, to hand out first-class air tickets to people and send them to a place like Rochester, New York, or Mayo Clinic instead of having them get the same care at the costs in those cities.

The second is that if you look at Minnesota -- and I keep going back to that, because I hope all of you will get acquainted with it and we'll giving names of people to visit with up there -- even though they have been further advanced in dealing with costs than the rest of the country in many respects, in this last legislative session under a Republican governor with bipartisan support in the Minnesota legislature, they adopted budget targets for their health care expenditures in the state. They want to see health care expenditures reduced at about 10 percent annually over the next several years once the whole system gets in place.

The budget targets have an enforcement mechanism that is different from what we've proposed. Their budget targets, if you don't meet them, you then fall into price controls. You fall into an all payor rate system. So even though they are further advanced, based on what they know, they believe they can do better and they can't get there without some kind of budget as a means for it.

And then my final example is -- I had a group of hospital administrators in. And the man who was the head of a major general hospital, he said to me, "I'll tell you," he said. "I know a lot of people in my profession are concerned about the budget. But," he said, "I'll give you an example of why I as a hospital administrator, need it." He said, "A cardiac surgeon in my hospital a couple of weeks ago admitted a 92-year-old man for a quadruple bypass. I went to him and I said, 'Do you think this is appropriate care for this patient?' The cardiac surgeon said, 'Of course not.' I said, 'Well, why are you admitting him?' He said, "Because he's referred from a cardiologist who sends me a lot of business, and if I turn this patient away I may not get any more."

The hospital administrator said to me, "I have no way, given the current reimbursement system that runs our health care, to tell this cardiac surgeon that is not a good choice, and for him to tell the cardiologist it is not a good choice."

If we have a budget in my region, I can say, you know, remember when we all got together last year and the cardiac surgeon came forward and said, here's what we want to do and how we want to do it and what it should cost and the hospital staff made those decisions because we're making the decisions again instead of insurance companies and government? We can't do it, we got this budget, which is sort of out there floating somewhere in the stratosphere.

So there's practical reasons that will move the system because of the changing incentives with the budget serving as a backstop.

Q Mr. President, do you propose tomorrow to tell the Congress what kinds of sin taxes you want, and if so, what?

THE PRESIDENT: I don't think it will be any big surprise. I've always said I thought we ought to -- that there ought to be a cigarette tax, and I'll proposed one. But it's going to be a bit part of it. Because we don't need a lot of money. We don't need a lot of money. I think it's important we raise the cigarette tax for other reasons, too, but -- and we'll have some other ways of

raising funds, which I will explain tomorrow and which will be in the plan.

Q Are you going to specify what kinds of alcoholic beverages, for example, you --

THE PRESIDENT: There may not be one. I never said there would be another tax.

Q (Inaudible.)

Q They'll turn into lobbyists, right? (Laughter.)

THE PRESIDENT: I plan to propose more than one way to raise some money, but I can tell you that one of them will be a cigarette tax.

Q Propose more than one way?

THE PRESIDENT: More than one way.

Q You sound like you really have got --

THE PRESIDENT: Tune in tomorrow.

Q Option A and option B for Congress on money-raising? Is that --

THE PRESIDENT: What did you say?

Q You mean, you'll give Congress, here's option A, for instance, here's option B?

THE PRESIDENT: No. No. We're going to tell them how we think we should raise the money to fund what we think needs to be funded. But it won't be -- it's a relatively small part of this overall package.

Q Mrs. Clinton has spoken up on the Hill the last week or two, there are more similarities and we can negotiate a lot of this. Can you tell us what is not negotiable? What is sort of the bottom line that you feel is essential to have the kind of change --

MRS. CLINTON: I think the President is going to talk about that tomorrow. I don't want to spoil his speech when he sort of lays out what he thinks are the principles that we need to guide us as opposed to the details and technicalities. But one thing which I think is not negotiable is universal coverage as soon as possible.

Now, what "as soon as possible" means will depend on other pieces of it, but we have to know whatever is enacted will get to universal in as soon as possible time frame.

Q -- like employee, or employer mandates would not be nonnegotiable?

MRS. CLINTON: I think what is nonnegotiable is a fair and responsible way of funding the system. We think the employer-employee contribution is the best way of doing that, but if there is a better way out there to get it done that is --

THE PRESIDENT: If you look at the alternatives, basically -- you believe everyone should be covered, and I do -- and if you believe that you can't control costs until everyone is covered, because otherwise you will have cost shifting -- because, keep in mind, people in this country get health care if they don't

have coverage. They get it when it's too late, too expensive, and somebody else is paying for it.

There has been only three, as far as I can determine, only three ways proposed to have universal coverage in the country. One is the single payor system -- abolish insurance premiums and raise taxes. The single payor system. That's the Canadian system, that's the, from an administrative system, probably the most efficient administratively; that is lowest administrative costs. But there are other problems with it. You don't have the same direct involvement of employers and employee groups with the health care providers in controlling costs as you do in a mixed system like the German system, for example, where the Germans did quite a good job in the last seven or eight years keeping -- many years keeping their costs below the rate of inflation. So they pay a little bit of the premium, slightly higher administrative costs for a system more like ours except everybody is in it.

Then the other system would be, the one that some have proposed in the Congress, to go from an employer-mandated system that we have now, employer-employee, to a flat employee mandate, just tell individuals they've got to go buy health insurance. But the problem with that -- and the theory is, you know, you make all these other changes, you can make it cheap enough for everybody to afford it. The problem with that is I think you really run a serious risk of seeing the present system, which is working very well for most people who are in it, who don't have the job lock problem and the other problems, disintegrate before your very eyes.

Or the third option would be to build on what we have, which is what we propose to do. So the answer to your question, to go back to Hillary, if somebody's got a better idea to achieve universal coverage that stops the cost shifting and permits us to preserve quality and choice and still control costs, we'll be glad to hear it. But the reason we came up with this position of ours, the premium-based system, is that we've built on the system we have. And we thought most people wanted us to fix the problems with the system we have without undermining what they like about it.

Q Can you just elaborate for a moment on why the system would disintegrate under the Republican employee --

THE PRESIDENT: Not all Republicans came out for an employee mandate.

MRS. CLINTON: We can run through the questions we have. And we have had many conversations with the sponsors of that approach, and they have been handicapped to some extent because they didn't really arrive at it until recently, and they haven't been able to run a lot of the numbers that need to be run to determine what it's strengths and weaknesses are.

But among the concerns we have is that if you have an individual mandate -- and as I understand it, individuals then below a certain percentage of poverty -- it's either 150 or 200, some area in there -- will be subsidized, you have done several things which we're concerned about. You have eliminated any subsidy for all those who fall in the broad middle, who are also either uninsured or underinsured, because the government will subsidize only people at a certain level of poverty. And you have sent a signal to employers that they have no need to continue providing insurance for employees because the government now is not acknowledging the existing system, but instead preferring an individual mandate approach.

That can have several consequences we're concerned about that we have to analyze. One is that employers will further depress wages at the level at which the subsidy kicks in so that they will be relieved from insuring some or all of their work force and the

government will instead provide that subsidy. They can come up with two-tiered systems where the employers will contribute to your insurance, because you're a valuable, highly-paid professional, but the janitor is not going to be insured by the employer, and you will have that kind of further split in what the health care system provides.

Thirdly, we believe that the kind of subsidy system that has got to be designed in order to keep track of individuals is immensely more complicated and costly than a subsidy system aimed at businesses, which is what we are proposing.

Now, it may be, as we work through this with the Senate Republicans and their staffs that they have had some independent analyses done or they have some answers to these concerns, but in our efforts over these last months to create a subsidy system, it is extremely complicated. And it is mind-boggling to imagine keeping track of employment status and financial status of literally millions upon millions of people. It's very hard to predict how much the government subsidy would be, and then added on to it, perhaps the downward pressure that throws more people into that subsidy pool over time strikes us as a bureaucratic nightmare. And so that's why we are concerned about that particular approach.

THE PRESIDENT: Let me just make one other point about that because it relates to more general problems. One of the reasons that I feel very strongly we have to do something about this as soon as we can is that we have lots of evidence that a lot of employers under the pressure of the present system have basically felt forced to deprive their employees of pay increases, sometimes for years, just to pay for the increased cost of their health coverage. And we are very reluctant -- I like the way Hillary answered you better than I do in the sense that I don't -- no one has all the answers to this. These are the questions we have about the employer subsidy. It may not cause the system to hemorrhage, but at least there are serious questions.

But what we had hope to do with this system is to permit employers to -- if they can get control of their health insurance costs, to begin to pass along the benefits of the big increases in productivity that many sectors of our economy are now enjoying. Last quarter, manufacturing productivity up over five percent -- to be able to pass those on to their employees in terms of wage increases, or to be able to have the flexibility to hire more people, which one of the big deterrents in hiring more people now is the extraordinary cost of health care.

Q What are the objections to -- this goes back to the question of whether there's enough money in your plan. What is the objection to phasing in, say, parts of universal coverage, dependent upon whether the savings you expect come in? If you think your numbers are right, in a sense you're not giving up anything because they will come through, and you can have universal coverage. If your numbers are wrong, you have some protection on the budgetary side; obviously not with the people who wouldn't get phased in, but some protection that way. What's the objection to doing it that way?

MRS. CLINTON: There isn't any objection. There is no objection. When I answered Al's question, we want to get to universal coverage as soon as possible. If, after we get into the debate on this and the committees are working it up and all of that, they say, you've got deficit reduction in here in a considerable amount, but we'd be a little happier even having less deficit reduction and more cushion on the side of supporting the system as we phase in the benefits.

We have designed this so that there are movable pieces. I mean, that's the whole reason we have done it the way it is, so

that if, after you go through what we've gone through to price the costs of these benefits packages and to come up with what we think are the most accurate health care numbers that we've ever had in this country. Now, I'm not saying that they're not going to be changed or moved or pushed in the political debate, but I know that there have never been any numbers produced that are grounded in more analysis than these.

But they are movable numbers. I mean, if we lay out a benefits package that we think is comprehensive, and the Congress, in response to your legitimate question, says, we like it, but we don't think we should get there by '97, we'd be happier getting there by 2000 and here's how we'll do it so we'll have a little bit of support in case it doesn't go the way we thought, or it takes longer, these are all the things we are open to talk about.

THE PRESIDENT: Let me say what I would prefer to that. That ought to be a two-way street. That is, the reason we picked the three years for the universal coverage and then a much longer period for dealing with the long-term care is because we realize that even though we're confident we have the best numbers anybody's ever had, because the processes we've gone through, there is some uncertainty in this. So we know that if, even with the three-year period, if you turn out to be wrong along the way, that gives you time for correct action.

So rather than -- I would urge the Congress, rather than say, well, let's take eight years, not three, or five years, not three, or whatever, to basically ratify the procedures that Hillary just described, so that if you achieve -- because we think in many ways we'll achieve greater savings than we say. So that it can run both ways, if you see what I mean. In other words, I think -- let me tell you why that's important. Because you will never get the maximum savings envisioned by this plan until you have universal coverage. Until you have universal coverage, you won't have the benefit of everybody being in bulk buying, and until you have universal coverage, you will not have an end to cost-shifting. So there's a way in which you're damned if you do and damned if you don't in this thing because the longer you take to get universal coverage, the more you have the present cost inefficiencies of the system hurting you.

Q Mr. President, you gave us an idea of the amount of savings that we would have if we reduced administrative costs halfway to those of other countries. And Mrs. Clinton talked about billions and billions of savings if we can eliminate some of the differentials and costs between apparently identical medical care in different cities. Can you give us a sense -- obviously not a precise dollar figure, but a magnitude sense of the kind of billions and billions we're talking? Are we talking about $50 billion, $100 billion, $600 billion? What are we talking about there? Do we know? What do we think?

MRS. CLINTON: Well, we think that you add up the various pieces, the unnecessary tests and procedures, the administrative costs, other savings that we think will come, you know, we're talking about $200 billion, $250 billion over time.

Q At an annual rate?

MRS. CLINTON: No, not an annual rate. These things won't happen overnight. But Dr. Koop said yesterday that he believes, based on his studies, that there is about $200 billion of what he would call unnecessary care being delivered. Now, that's his figure, not mine. But that is in the ballpark of the kinds of figures that we're looking at in terms of the savings that are in the system.

THE PRESIDENT: That would include unnecessary procedures, outright fraud, waste and a price differential. But you cannot achieve -- we want to be perfectly clear on this -- there is no conceivable way you could achieve that level of annual savings within a year or two. You're going to manage your way to this, which is why I go back to what I said before. E.J. asked a very good question and we tried to write it down so that if in year two or year three the savings didn't match the costs we could string it out, you know, maybe not now but, when the Congress is meeting all the time. But until you get the system in place you can never realize the full benefits that Dr. Koop was talking about in my judgment.

Q Two questions: Have your economic people run any kind of models given the prediction about what in this period of the next five years, say, the effect of this plan is on the economy and jobs?

THE PRESIDENT: They've tried to. And let me tell you what the problems with it are. We have three predictable economic models developed in the past about what happens if you add X amount of cost to per employee for firms in a certain area of the economy with a certain profit margin, with a certain growth or shrinkage history in that section of the economy. So you can get a pretty good feel on what the job reduction might be in that area.

You can get a kind of estimated feel -- although it's hard to know -- on whether if you drastically simplify the system how many people who are clerical workers would be laid off in insurance companies and clinics and hospitals.

We have a pretty good -- offsetting that, we have a pretty good feel for how many 100,000 people would be hired in extra helping health care provisions, that is people who are providing health care are more primary and preventive health care services to the public health clinics.

What there are no presently available models on is where we think the big job generators are, which is if you cut General Motors' premium cost from 20 percent to 15 percent -- let's just say, but they will still be paying virtually twice what the average industry average is -- let's just say it kind of goes from 20 to 15. What happens to that five percent of payroll? Do they hire more people? Do they give their people a pay raise? You're talking about a huge amount of money for General Motors. Do they increase their purchases from their subcontractor, which adds more job to them?

That is to be -- we believe very strongly that rationally it is a net job gainer because we believe that instead of paying more money for the same health care, if people have the same amount of money to invest in something new, that it only stands to reason that in the aggregate you'll have any more jobs created. But there is no -- frankly, no available model for this sort of stuff. You almost have to go into -- because it is theoretically true everybody could take the money and put it in their pocket or put it in the bank, or it could never be invested or recycled or whatever but --

Q -- increased profits.

THE PRESIDENT: Yes.

Q -- say we don't have enough profits and it may not create much in the way of --

THE PRESIDENT: But over the long run it seems clear that they will increase their -- expand their operations, which means either direct benefits to employees or indirect benefits to all the people with whom they contract.

And that's just one example. Keep in mind you're dealing with a -- what happens if you lower the insurance premiums to the self-employed couple who have a flower shop? Do they hire somebody else? Do they buy more flowers? You have to -- there are just not any economic models that I know of that answer all these questions.

Q I had a question that has to do with your speech tomorrow night. You refer to unnecessary procedures. Mrs. Clinton gave the example of the 92-year-old man with a four-way bypass. Are you going to tell people tomorrow night that if this happens some medical care that is now available to people will not be available because it's not rational to provide it?

MRS. CLINTON: No, I don't think you have to say that. I think that what you have to do is create a system in which the incentives for providing the best possible care to the most people at the lowest cost are driving the system, instead of the way the system is driven now. And I think we are going to strongly encourage people to have living wills and advance directives so that we will have better informed decision making in the last years and moments of life from individuals themselves.

And I haven't told my husband this yet, but I was asked this question about did we have a living will, and I said, no, but we will. You know, we will do it publicly because, I mean, it's that kind of thing.

THE PRESIDENT: I need one in my line of work.
(Laughter.)

Q Rationing is a dirty word in all of this. Prioritizing presumably is not. Does this envision prioritizing treatments so that the most --

MRS. CLINTON: Well, I don't think so, based on what we know now, because if you look at the parts of our health care system that are operating efficiently, they are providing better and more comprehensive care to more people.

And I'll go back to Minnesota again. I mean, it has the highest health status in the country and it's not because they were all Scandinavians. I mean, you know, it's the way they organize and deliver health care. And I think that there are so many lessons that can be learned so that until we get to a point where the average bypass in Pennsylvania costs closer to $21,000 instead of $84,000, how do we know what the real cost of delivering cost of health care is?

If you look at other countries that cover everybody at less cost, if you look at a Germany, for example, or a Canada, we have analyzed this data backwards and forwards. There is not much evidence of rationing. You could argue culturally there is more of an acceptance of the inevitability of life's end, but that's not because of the medical system, that's because of the society. And I think that what we have to do is get a health care system that operates cost-effectively and delivers quality care. And individuals, through their own decision-making, like living wills and the like, will begin to see some decisions being made that don't have to be government directed.

THE PRESIDENT: Let me interject. This is very important. In this system we do reallocate, if you will, some resources to more heavily emphasize preventive and primary care. We believe -- and I'm not just trying to be the tooth fairy here. Every system has some rationing. This system has severe rationing. The

system we're in now severely rations care in all kinds of ways that we -- but it's just arbitrary and unnoticed.

But we believe that until we get the pricing system straightened out and have the kind of basic preventive care that we know saves tons of money, we can't reach that question, and we don't need to.

MRS. CLINTON: And Dr. Koop also said yesterday, David -- this is something I had never heard before, but again, I don't know if you all know, but he has been working up at Dartmouth for the last several years with Dr. Winberg. They have some of the best quality analysis work available in the whole country.

Dr. Koop also said yesterday, David -- this is something I'd never heard before, but again, I don't know if you all know, but he has been working up at Dartmouth for the last several years with Dr. Winberg. They have some of the best quality analysis work available in the whole country. Dr. Koop said that an uninsured patient who enters a hospital in America today, for the same ailment as an insured patient of the same age, race, et cetera, is three times more likely to die than the insured patient. That was the first time I heard that.

But those people, the uninsured, they are not organized, they are none of us. They don't have anybody speaking for them. Nobody collects the data on their mortality and morbidity rates and compares it to like people who are insured. But we already have a system in which we are making very difficult choices every day. And we're doing them driven by the way we finance health care instead of physicians, hospitals, and as Dr. Koop said yesterday, the ethical decision-making of a caring society. I want to get to that point. I want doctors once again to make decisions on what they think is best instead of calling some 800 number to ask some insurance executive whether they can give me a blood test. And I think we're more likely to get there going this direction than if we stand still -- do nothing.

Q It's along these lines, but are you at all concerned that, if you say you want to change the incentives and these plans will be competing for buyers, is there -- concern that it would be difficult to sort out what are the necessary procedures, the unnecessary procedures and maybe some necessary procedures are very expensive, but the plan wants to get its price down? And who will make these decisions as to what's necessary, unnecessary?

MRS. CLINTON: Every American and every plan will have to deliver a guaranteed benefits package. And it will look like the standard insurance policy -- it is, you know, inpatient, outpatient and the like. There is a, I think, generally accepted standard of practice and care. And we're going to do more to develop that. We want people in the medical profession to be free of liability, for example, by knowing what is expected of them, whether they're in Maine or in. So we're going to be laying out some quality indicators that the profession is going to help us develop along with others who are concerned about these issues. But most health plans now that deliver health care less expensively if they're well run, if they're the Kaiser Permanente or the Puget Sounds, the Mayor clinics, or Rochester, New York's program, they deliver all necessary medical care. They have the highest patient and consumer satisfaction of health care consumers in the country right now.

We're not concerned about that, but we will have some checks in the system where we will be not only determining whether there's any problems with quality but publishing that information so that when you sign up for your health plan every year you can move. If you hear something you don't like, you move to somebody else.

MS. MYERS: At this point the President needs to go. The First Lady will stay for a few more minutes.

THE PRESIDENT: Thank you all very much.

Q Could we ask one NAFTA question -- what does Gephardt's opposition do to your chances?

THE PRESIDENT: It doesn't help, but I don't think it's fatal. We have --

Q Is there room for --

THE PRESIDENT: Well, I hope so. But that's -- that's really up to him. I mean, he's -- let me just -- first of all, the Speaker and Mr. Fazio are going to have a press conference today, too, so coming out for it strongly, and I think that will be very helpful.

If you listen to the NAFTA debate, the people who are opposed to it, if you really listen to their aggregate arguments, whether it's about the labor standards aren't strong enough or whatever. They are really -- the real complaint is that they think we haven't fixed the abuses of the Maquilladora system. That's really -- if you really listen to it, they're saying that we're not doing enough to close the gap in environmental expenditures or in salaries or wages or whatever -- what I keep telling all the people in the Congress and my friends in the labor movement and everybody else is if we beat this, the gap will be greater than if we pass it. People will still be able to move their plants to Mexico; they'll be able to do whatever they want to do. And there will be no incentive on the other side of the border to increase the environmental standards, increase the labor standards, and we won't be lowering the Mexican tariffs.

We, in fact, have free trade with Mexico now coming out way. We've only got a 4 percent tariff on average. So if you really strip away all the arguments from the people that are against NAFTA, they're saying I wish you were doing more to overcome what I don't like about the present system. And they're making the -- the enemy of the good. There is no question in my judgment that this will put our country on a stronger footing, and it means more experts, including the things like automobiles. And it gives us the chance to attract some investment to Mexico back from Asia, which will mean more contracting jobs for America, too.

Clyde Pretzler had a very good article in The Washington Post in the last couple of days that basically states my feeling about it. I also think that the job generating -- the real job winner for NAFTA over the long run is that it opens the door to Latin America and will put us in a stronger position than we've been there since the Kennedy presidency if we pass it, because all these market economies, all these democracies -- you've got Venezuela, you've got Argentina and you've got Chile, and you've got all these countries that want to be tied into it. And at least psychology they believe that we have to do NAFTA to prove that we're serious about bringing them in.

Q Mr. President, very quickly, Ross Perot, you know, did criticize your health plan until Senator Rockefeller asked him to withhold his criticism. And has since seen a copy of your health plan; and he says he's going to withhold any judgment because he's working on NAFTA. Do you think it makes much difference what he does on the health care?

THE PRESIDENT: Well, I appreciate his withholding criticism -- (laughter.)

Q -- I mean, whether --

THE PRESIDENT: I don't have any idea. I want everybody to be for it.

Q A lot of this is rather complicated -- it's like a VCR, where you sort of understand for the first 10 seconds and two hours later you go back and you can't get it to work. What are you going to say or what is the President going to say tomorrow -- across to the American people in some way that will build support for what he's trying to do. What is he going to emphasize that has enough understandability for a much broader section of the American people -- when you're talking --

MRS. CLINTON: It is a huge audience with many different levels of understanding about the health care system. But when Franklin Roosevelt proposed Social Security, he didn't go out selling it with actuarial tables and books of regulations. I mean, we are living in a much more difficult time for social policy. I mean, if he had tried to do that, it never would have been passed. He basically said, look, here's the deal -- you pay in; you're taken care of; you have Social Security in your old age. If he'd had to have been pressed to the wall saying, well, what about spouse who didn't work and what about somebody who only worked 20 quarters instead of 24 quarters, I mean, we would never have had Social Security.

So, I mean, part of our burden is to keep this debate on two levels at one time. The overwhelming need for the public is to feel that the health security that they will get will guarantee them health coverage at an affordable price with quality and choice for the rest of their lives. They don't care what the size of some of the health alliance issues are. In fact, if they had their way on premium caps, they'd regulate the kind of car a doctor could drive. I mean, the public wants more price controls, bit by bit, trying to control this economy. The fact that we are moving toward what we consider to be a much more market oriented approach is more difficult to explain. I mean, single payer or individual responsibility is a much easier thing to explain.

I would argue, however, as I have over the last several weeks, is that moving from rhetoric in any of these plans to specifics is very difficult. So, yes, we want to be responsive on the specifics, but we don't want to lose the forest for the trees and start engaging in a kind of actuarial debate, when what we should be talking about is the broad social policy we're trying to establish than in the Congress with all the various groups converging, we will be struggling over the technical details.

So that's our dilemma, because --

Q Can you persuade the President --

MRS. CLINTON: Well, I think it's tough, because the other piece of this, though, is the health care debate on an individual level gets specific very fast. Individuals say, well, what do I pay now and how much will I pay in the future. I mean, they want to get as specific as possible against the backdrop of this general assurance. So the President's going to have to strike the right balance. I don't think tomorrow is the time for him to be answering every question anybody might have. I think tomorrow is the time to lay out the general principles and the kind of social contract that underlay this enormous step forward for the country. And then we'll have lots of time in the weeks ahead to dot the i's and cross the t's and explain it. There will be such a hunger for information that we will just be flooding people with information, and they'll be taking out scratch sheets trying to figure their costs

Health Care

THE WHITE HOUSE

Office of the Press Secretary

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REMARKS OF THE FIRST LADY
AT HEALTH CARE UNIVERSITY

Capitol Hill

11:55 P.M. EDT

Thank you very much. I am extremely gratified by this gathering and I want particularly to thank the leadership of both Houses and both parties for their graciousness and cooperation with me and those in the administration who have been working on this proposal for many months. I'm particularly grateful for the help of Congressman Michel and the leadership of the Republican side of the House and also Senator Dole and the Republican Senators. I also am extremely thankful for the good counsel and advice that I received from Senator Mitchell, Speaker Foley and Majority Leader Gephardt. I also want to thank those who put this event together. I think that it's a remarkable event that will in many ways give a boost to the confidence level of the American people that all of us -- Democrats, Republicans -- from different points of view have come together to talk about an issue that is on the forefront of the American agenda. And for this event, I want to thank Congressman Hoyer and Senator Daschle, Senator Nickles and Congressman Armey for enlisting the numbers of people that put an event like this on.

I came from the White House this morning where we had over two hundred leading doctors from around the country, come together to voice their general support for the direction that reform is moving. And former Solicitor General C. Everett Koop has agreed to take a leadership role in continuing to work with physicians all over the country, so that the kinds of concerns that Representative Michel mentioned will always be at the forefront of our consideration. I was personally delighted that not only someone like Dr. Koop, but the CEO of Mayos that heads the numerous of our medical schools, family practice doctors, specialists, those from different kinds of medicine were there this morning to say in a unified voice, "We believe in the principles that underlie reform." We may disagree about some of the details and the technicalities, but to have reached a point finally after sixteen years of effort by both Democratic and Republican Presidents, by leaders in both parties to reach a point where we are agreed that we must make changes in order to preserve what is best about American health care and to fix what

is wrong. It is, indeed, an extraordinary moment in time. And I hope that all of us will approach this opportunity in that way. There is no doubt that there is not any issue that has more hold on all of you as public stewards and members of this body. What I hope we will be able to do is to work through alot of the concerns that many of you have brought to me and to others over the past months. I have personally met over one hundred thirty times with members of Congress here in the Capitol. Others who have worked with me have added many, many hundreds of meetings to that. We have met with over a 1,100 groups of people concerned about health care. Sometimes, many, many times to work out a good approach to solving a problem. What I am struck by is the spirit that has permeated these discussions from the very beginning, which I hope will be maintained as we move toward legislation and actually implementing changes in the system.

One of the original ideas behind this gathering was to give members who had not been involved with health care a chance to ask questions and to voice their concerns. Because certainly in the many, many meetings that I have been privileged to have, I have often seen some of you many times over because of the particular committees that you serve on, and I have not seen some of you at all because of the particular committees you serve on. What we hope today, particularly, is that those members who have not been part of the ongoing consultation for whom this may be the very first meeting they have had about health care concerning the proposal and the direction we want to move in, will feel free to ask their questions and will perhaps even be willing to be given the opportunity to ask more questions than those who are so much more familiar with alot of the details. I mean, I have to confess, when I started this eight months ago, I was not in my own mind really sure about alot of these concepts. I won't go so far as to say that I didn't know the difference between Medicaid and Medicare, but I often found myself using one when I meant the other. And I think it's important that all members here who have not been involved in the health care debate, it has not been part of your responsibility, but you are anxious to learn and you hear alot about it from your constituents, feel particularly free to ask your questions and to know that even those who are much more knowledgeable because of what they have done over decades, started off where you are starting off and not to feel in any way constrained from asking whatever questions might cross your mind about what we are attempting to achieve.

What we would like to do this morning is to spend just a few minutes talking, generally about the proposal and then what I would really like to do is to have time to hear your questions so that we can try to respond to them. If we start with the idea that there are certain principles that underlie the President's proposal, then we can move from those principles to the details and technical aspects of it and talk both generally and

specifically about where we are heading.

Let me just briefly run over those principles because you will hear much from both the President and from the members of the Cabinet who are here about how there is so much room for talking through how we get to achieve certain principles. And we mean that very sincerely. We welcome the kind of advice and counsel that you are giving us on a regular basis. We know that many of you already have good questions and suggestions off of the (inaudible) that have already been circulated. So part of what we hope is that this will continue that process. The principles, though, that underlie are: number one, we have to provide health security for every American. That means two things -- it means reaching universal coverage so that every American has the security of knowing that he or she will be able to obtain health care when needed. It also means that we believe every American should be entitled to a guaranteed benefits package. And that package should be available to you as an American, not because of who you work for or whether you've ever been sick before or what region of the country you live in. And it's particularly important that the benefits package try to stress primary and preventive health care. Because in the absence of trying to stress primary preventive health care, we believe we will continue to pay more money in the long run, than we will if we take care of some of these medical problems that could be prevented before they got worse.

The second issue is that in addition to security, the system has to be simplified. It should be simplified for all parts of it, but particularly for those who actually deliver health care -- our physicians, our nurses, our other professionals. We have in both the public sector and the private sector added literally billions of dollars on to the delivery of health care. We have, by adding those billions of dollars, required doctors and nurses to spend literally millions of man-hours fulfilling bureaucratic and regulatory and private insurance company requirements. I don't know if any of you were able to hear what the President and Vice President heard at Children's Hospital on Friday, but I think this point illustrates what we are attempting to achieve through simplification. The President and the Vice President met with the staff of the Washington, D.C. Children's Hospital. As part of their effort to react to reform, they have been doing their own surveys. They have determined that for the average doctor that serves on their staff -- they have over two hundred doctors -- the kind of paperwork requirements that have nothing to do with patient records, but paperwork having to do largely with financing and reimbursing care are so extraordinarily heavy that if you could remove that paperwork from those doctors, they would have time to see, on average, an additional five hundred patients a year. Now, that is their calculation. They believe

that we have so burdened their doctors with unnecessary paperwork that we have deprived 10,000 children from seeing doctors during the course of the year. Now it's that kind of statistic we have run into time and time again in looking at this system, and can give you many more examples of it.

The third principle that comes from simplification is that we believe that there are savings in this system. Now I know that is an issue we should get into and talk about in the question and answer period, because I know that there are members who are concerned about where those savings come from, how we calculate those savings. And we do advocate reducing the rate of growth -- not cutting -- but reducing the rate of growth in both Medicare and Medicaid, and also creating incentives in the private market to reduce the rate of growth in the private sector, health care expenditures. Now one of the key issues about reducing the rate of growth in our public programs is to analyze very carefully where the money now goes. If you conduct that kind of analysis -- as not only have the people we have worked with have done, but many others out in the country have done -- it is very hard to justify the current expenditures in both of those public programs in terms of the range of cost around the country compared to the real cost of delivering health care in those same regions of the country. Let me just give you two examples: the state of Minnesota is much further along than other states in organizing the delivery of health care. So that they have many more of their citizens, than my state of Arkansas for example, who belong to some kind of pre-paid health organization, some kind of health maintenance organization, they literally have most or nearly all of their population now in those kinds of networks of health care delivery. They have many of their Medicare patients in organized health care delivery systems.

In Minnesota the average cost of taking care of a Medicare patient is one half of what it is in Philadelphia. In New Haven, Connecticut, the average cost is one-half of what it is in Boston. And you can go down example after example. If you analyze the expenditures and if you try to hold constant any variation between population, sickness... there is still no adequate explanation for those kind of differentials other than the way the systems are organized and the cost in the various systems and how they compare with one another. So our point is this -- if you look at the rate of increase currently projected for our public system, even after the recent budget reconciliation, Medicare is projected to increase at 11% for the next two years, Medicaid at 16%. Neither the Medicare population, nor the Medicaid population is expected to increase at anything near those percentages. So even if we were to say, we want everyone to have a CPI or a cost of living increase, an

inflation increase; we want to take care of the population that will be getting at Medicare eligible or Medicaid eligible, we believe that there is a significant amount of money in those systems that can be better allocated than being put into the same services as they are currently being paid for by federal government.

There's another issue here. Even though the direct administrative costs of Medicare are significantly lower than the private insurance administrative costs, the costs that doctors and hospitals incur in dealing with the Medicare system are not. So part of what we believe is that we can save money for physicians and for hospitals by better organizing the Medicare system and by integrating into the overall health care system. Medicaid recipients they should be put into an overall health care system just like you and I, they should not be identified, they should not be marginalized and we believe their health care can be delivered more efficiently and, in some ways, with more dignity than the current Medicaid system currently allows.

A fourth principle is choice. We believe that we should not only preserve, but enhance the choice of consumers to choose their health plan. The way current trends are going now, most employers provide some contribution to their employees' health care, for those working Americans who are insured. The employers make the choice. And increasingly employers are limiting the choice of their employees. Yes, you will get the insurance, but you will only be able to use Plan X, or maybe a choice between Plan X and Plan Y. We think the appropriate choice should rest of the individual, that better informed consumers will make better choices. And we also believe that doctors should have the choice as to what plans they will practice in. So we want to prevent the discrimination that is now growing up against doctors, and permit them to practice in several different plans. We think that is important for doctors, critical for consumers.

A fifth principle is quality. If were to do all that we think should be done and it did not preserve and enhance quality, we would not have made a step forward. We believe quality will be enhanced through better organization and better utilization of the money that we are currently spending. We have evidence of the fact that more efficient delivery of health care does not decrease quality, in fact, there is often no difference and maybe even some argument that you have better quality because you are serving more people efficiently. Let me give you an example, the state of Pennsylvania for a number of years, has done an excellent service to its citizens and also to the entire country by collecting information about how much certain procedures cost in different hospitals throughout the state. If you take one particular procedure that is commonly performed, the coronary bypass operation. That operation can be performed in a

Pennsylvania hospital for $21,000 or for $84,000 or for alot of different costs between 21 and 84. Based on the quality analysis of patient outcomes there is no difference. Some of the people that looked at the Pennsylvania data would argue that if there is a difference, it's an advantage for the $21,000, not the $84,000. There is no difference in quality between those operations. And that is holding constant for the level of sickness, the age of the patient, so we're not comparing apples and oranges, we're comparing apples and apples. If there is that kind of discrepancy, which indeed there is, all over the states, not just Pennsylvania, we believe there's a tremendous opportunity for enhancing quality as we work with and educate consumers and physicians about appropriate medical care, the choices that they will make, and more efficient, quality-driven ways for achieving those outcomes. We enhance quality through this proposal, we collect information about the delivery of health care that has never been made public to people before and we will ask health plans to publish report cards so that you as a consumer can determine based on criteria that are important, which health plan you might choose.

The final principle is responsibility. This entire system needs more responsibility. And when I say system I mean everyone in it and all of us who either use it or are potential users of it. There are people, as we all know, who have never paid a penny for their own health care and really don't ever want to pay a penny for their own health care. There are people who are totally without health care and who when they finally do obtain some kind of treatment, do it at the last possible moment at the most expensive cost, which then the rest of us pay for -- through either the public or private insurance system. There are many instances in which physicians and providers make decisions which have nothing to do with being responsible, but everything to do with the reimbursement stream that is pushing them to make a decision. We have people making decisions because of the malpractice problems that aren't responsible physicians, but are being driven to do so because of their fear of litigation. If you go through this system, you can see point after point at every level of it, people making decisions that they will tell you are not the responsible decisions, but which they feel compelled to make. We must require responsibility for everybody. We have a number of features in our proposal that we think enhance responsibility. We think providing preventive health care enhances responsibility. We think financing the system by joint employer-employee contributions, building on our existing system enhances responsibility. We believe changing the reimbursement systems, the malpractice system will enhance responsibility. We believe changing the antitrust laws, some of which we announced a week ago will enhance responsibility because hospitals will, without fear of being sued be able to come together to agree to buy one cat-scan instead of irresponsibly as

they tell us going out each buying their own cat-scan because they are afraid to talk together because of the anti-trust laws. On many, many fronts we can enhance responsibility.

But let me just talk specifically about the one that I know many of you have asked about and that is the employer-employee shared contribution. When you look at all of the systems that are available in the world and the systems that are available in our country in places like Rochester, New York or Rochester, Minnesota or the state of Hawaii or what is happening in Washington and California and Florida and places like that.

There are really in general, only three ways to finance universal coverage. After you strip it all away we're going to get everybody in the system, and everybody being responsible. There are only three ways of doing it. There is a single payer approach which I know is supported vigorously by many in this chamber. It is a sure fire way of getting everybody covered because, we substitute, under the single payer approach the entire private sector investment for tax money that will fund the health care system. And the single payer proposals, particularly the most current version would do just that. It would raise about 500 billion dollars, (through taxing) and totally eliminate the costs to any employer or employee whether its insurance premiums, out-of-pocket, whatever. That is one way of financing health care.

Another approach, which is embodied in both the Senate Republican and the House Republican approach is to put the responsibility on the individual. Either through some kind of IRA or Medi-save or through an individual mandate, which is the core financing principle in the Senate Republican's approach. Similar, as you might guess to what the states have tried to do with auto insurance. Everybody has to have health insurance -- everybody has to get into the marketplace. We applaud the idea of individual responsibility that underlies both of those approaches. We do have and will continue to discuss with our colleagues on the Republican staff side and with the members, how we would actually make those approaches work toward achieving universal coverage.

We have some questions about whether or not that would work, whether or not an IRA would really help produce the kind of preventive health care that we think would save money or encourage people to hold back from care so that they could pocket the remainder. We have some issues about how we would actually subsidize the millions of people that would be needing a subsidy under an individual mandate approach, how we would keep track of them, whether you would have to use the IRS or some other bureaucracy to point them out to make sure that they (give) or don't go over their voucher level and there are alot of technical

issues that we will have to work through and analyze together.

For alot of reasons, we believe that building on the existing employer-employee system that most people who are insured are familiar with does the least to change the existing health care system. As one of our goals, we want to make the new system as familiar to Americans as the old system. In employer-employee systems, you would still get your health care coverage from the work place. But instead of the employer making the choice, you would make the choice as to what plans you signed up for. In the employer-employee, you would not have to worry about any employer either pushing wages down so that the individual was eligible for a subsidy which would relieve the employer of that responsibility. Or even for employers beginning to back off on their insurance contributions because now the government would pick up individuals. In the employer-employer approach, we have tried very hard to be open and sensitive to the legitimate concerns of business - both big business, small business, everything in between, which is why we have constructed a system that would limit the amount of money any business - big or small -- has to contribute and particularly give a significant discount to small businesses with low wage employees under the size of fifty.

The kind of subsidy that we're talking about would enable the vast majority of small businesses that currently insure to save money. We have to, when we think about the small business community, make a distinction between those small businesses who are currently struggling in the marketplace to insure against great odds and those small businesses who have not insured, either because they did not think they could afford in the current market or they don't want to. For those business that do insure, the vast majority will be receiving benefits at an affordable rate that will be no more than they pay now, in most instances less.

For small business that do not now insure, we have a principle response, as well as a practical one. Given our current health care system, you can walk down any main street in any town that you represent. And you can point to a drycleaner that insures and you can point to a car wash that doesn't. You can point to a retailer that does a little bit, but not a lot. You can go down, as we have literally done, talking to individual small business looking at their books, helping them calculate their costs. The problem is that when the employee at the car wash who has no insurance gets sick, the ambulance comes and picks them up, takes them to the hospital, treats them -- we don't turn people away in this country, they get there eventually. And then the costs to the neighbor in the drycleaning store go up. Because that's how we pay for uncompensated care for the working uninsured.

For large businesses, and many of you will have a mixture of large and small like Representative Michel does in his district, for large businesses, big businesses have subsidized small businesses for years with health insurance. They've done it for years with health insurance. They've done it in several ways because they usually have picked up the costs of the uncompensated care, but in recent years they have done it directly because they insure usually the entire family which relieves the business where the spouse works from having to make any contribution whatsoever. There has been a hidden tax on businesses willing to insure for a very long time. And that hidden tax is one thing we want to eliminate. We want to eliminate free riders, we want everybody to be a part of this system, we are open to ways of doing it to (inaudible), we absolutely hold to the absolute zero level the legitimate business concerns that might result in some kind of loss to them. We want to be very open on that, but we think building on the existing system is the fairest, most efficient, most familiar way for individuals to achieve universal coverage and better insurance than they can afford now.

So those are the principles, and as I said, we believe fair financing that leads to responsibility, we can work out details but it has to make sure we get to universal coverage and there has to be these other principles fulfilled along the way. Finally, let me just say that the kind of issues that you are bringing to us are exactly what we want to hear. I have been up on the Hill in the last week ever since the policy got out, and I wish we could take credit for the fact that it is now better read than it ever would have been if we had just handed it out. There's nothing like playing secret or prolonging you people to read it. I'd like to say that was our strategy. But now that we've been up here talking to both Republican and Democrats, the constructive advice about how we all meet these principles has been very helpful and we have already made adjustments on the plan based on what you have told us. And that process, we intend to continue. So with that Mr. Speaker and Mr. Leader, I'd be happy to answer questions that any of the members may have.

END

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release October 21, 1993

The following letter was released today by the White House.

-30-30-30-

NAM

MANUFACTURING HELPS AMERICA GROW

JERRY JASINOWSKI
President

October 21, 1993

The President
The White House
Washington, DC 20510

Dear Mr. President:

I want to express my regrets over the way the NAM handled our press comments on the Administration's health care plan. Because the lead of the press release was negative, and our press office mistakenly released my letter to you, the story turned out much more negative than was appropriate.

As I have consistently said to the press, your health care proposal has far more positive elements than problems, and it is the best health care package that has been proposed thus far. I will put even more emphasis on those positive elements in the days ahead, particularly as you release your final plan next week.

I personally am upset with what has happened because Ira Magaziner has made such a special effort to acknowledge our criticisms. On a substantive level our dialogue could not have been more constructive. Moreover, Ira cautioned us about how we expressed our criticisms to the press, and we were the ones who inadvertently failed to be more judicious in our comments to the press.

In sum, your White House staff has been fully responsive on the health care issue, and I regret NAM has not handled our press comments more appropriately.

Sincerely,

Jerry J. Jasinowski

NATIONAL ASSOCIATION OF MANUFACTURERS
1331 Pennsylvania Avenue, NW, Suite 1500 · North Tower, Washington, DC 20004-1703, (202) 637-3106

Health Care - 5 April 1993

Cost estimates

- Subsidy levels - hi for individuals; lo for corporations
- Charts assume Medicaid at community rate.
- Phase-in schedules play a crucial role

- HRC - Gina: Generate a process memo

3 modules

1. universal coverage for all under 65
   a.) Benefit Pckge 20% percentile
   b) 90th percentile pckge

Premiums - in Appendix 2
7½% adm. cost

Net change of $50 BN in ~~fed~~ nat'l spending

Phase-ins being calculated.

President's Health-Care Planners

Still Face Their Most Sensitive Decisions

Continued From Page A1

Already, though, it is clear that Mr. Clinton will propose one of the most far-reaching changes in American social policy in a half-century. The health care industry industry accounts for one-seventh of the nation's economy, and the President's proposal will touch the lives of virtually all Americans.

"Reforming the health-care system will involve Government-led changes on a scale not attempted since Social Security," says Ira C. Magaziner, the manager of Hillary Rodham Clinton's Task Force on National Health Care Reform.

As numbingly complex as it is far-reaching, the proposal is certain to become a focus of bitter debate, and its prospects in Congress are unclear. Some liberals fear that the plan may give too much power to large insurance companies, while some conservatives say it will mean too much government meddling with the freedom of doctors and patients. Hospitals, doctors, insurers, employers and consumers will all be profoundly affected and can be expected to try to reshape the details or the basic approach.

Even some of Mr. Clinton's allies say the initiative may be too ambitious, too complex and too costly.

But Administration officials insist that a comprehensive proposal, reorganizing the entire health system, is necessary for both humanitarian and pragmatic reasons: to aid the millions of people who have inadequate health insurance or none at all, and to control costs that have soared to a level of nearly $1 trillion a year, 14 percent of the national output last year.

Basics Are Decided

The President has decided on the basic strategy: "managed competition" by networks of doctors, hospitals and insurance companies, operating within the framework of a national budget for all health-care spending, public and private.

What that means is a transformation of American health care, offering the prospect of lower costs and more security, in return for less choice by consumers and doctors, most of whom may be forced to join prepaid plans like the health maintenance organizations that many people belong to now.

A snag in the complex process developed over the weekend when Mrs. Clinton's father suffered a stroke. She scrapped her health-care-related meetings today, and the White House said she has not decided when she will leave Little Rock, Ark., where her father is hospitalized, and resume her schedule.

What follows is a guide to issues in the debate and options that are currently being considered.

The Strategy

Health Coverage For Everyone

Some critics of Mr. Clinton's managed competition approach argue that a system like Canada's, in which the Government pays for most health care with tax money, would be simpler and more fair. But that system would collide with strong anti-government sentiment in American politics, while the managed competition approach combines free-market forces with Federal regulation.

The Clinton plan would guarantee coverage for all by requiring employers to provide a package of basic benefits to their workers, with the Government paying for the unemployed. The plan would seek to hold down costs by creating a more competitive market.

At the heart of the plan would be large purchasing groups, representing at least a million people in a state or a geographic area. These, and the big private employers, would shop around for high-quality health care at a low price. The purchasing groups would act as bargaining agents for their members, which would include small employers and individuals, negotiating prices with networks of doctors, hospitals and insurance companies. Most networks would operate like health maintenance organizations, offering a wide range of services in return for fixed monthly payments.

Currently, 40 million Americans are in health maintenance organizations. Under Mr. Clinton's proposal, many more Americans would be pushed into such prepaid group plans, one of the most disputed aspects of the approach.

Health economists say H.M.O.'s offer the best means of standardizing the quality of care and curbing costs. They note that while patients might lose some accustomed freedoms, they could gain peace of mind because the Government would guarantee comprehensive coverage at predictable prices, even if workers changed jobs or developed serious illness.

Consumers could buy extra coverage with their own money. And they would have a wider selection of physicians as more doctors joined the local network.

But many people are apt to resist a change in the family doctor, and some experts fear that competition over price among health groups could lead to dangerous scrimping on care.

The Employer's Role

The Burden Is on Business

By requiring employers to provide insurance for workers and their dependents, Mr. Clinton's plan would have business, not Government, pay most of the bill for covering those who are now uninsured. Roughly 85 percent of the uninsured live in families headed by workers.

Now White House officials are trying to decide how to define "employer" and "employee." The question is important because more and more workers hold part-time jobs, and many small businesses say they cannot afford to pay for health benefits. Mr. Clinton's plan is certain to generate hostility from some small businesses or those that pay low wages. Should an employer have to buy health insurance

Clinton Health-Care Planners Are Facing Delicate Decisions

By ROBERT PEAR
Special to The New York Times

WASHINGTON, March 22 — In a marathon series of meetings over the weekend, Administration officials started to whittle down the options and to draft recommendations for President Clinton's ambitious plan to reinvent the American health-care system.

The President and his health team already know their general approach to curbing runaway medical costs and extending coverage to all Americans: a vast change in the way medical care is organized and delivered. Most people and doctors would join groups like health maintenance organizations, accepting limits on their choices in return for lower costs.

But in the six weeks remaining in the President's timetable, as the planners refine details and begin to confront fiscal reality, Administration officials face some painful choices.

Ideas and Hazards

They have said they want not only to guarantee coverage for more than 35 million people who are now uninsured, but also to include costly items like long-term care, prescription drugs and mental health care among the basic benefits guaranteed to all Americans.

The Health Agenda

6 Weeks and Counting

A status report.

But the politically hazardous prospect of additional taxes, on top of those already proposed in the President's economic package, may force the Administration to scale back its desires, and in coming weeks the health task force and Mr. Clinton may have to drop some cherished goals.

From public statements by officials, interviews with members of the President's health team and internal documents, it is possible to outline many of the main choices that must still be made by May 1, when Mr. Clinton has said he will send his proposal to Congress.

Such a status report discloses that many of the most politically sensitive decisions remain to be made, including what new requirements to impose on small businesses, whether to levy new taxes on employee health benefits and what kinds of cost controls to install.

Continued on Page A20, Column 1

DEAR HARLEY: LIFE BEGINS AT 40. HAVE a Frankly fun birthday — Luv, Mom & Marvin — ADVT

354613

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for an employee who works 17 hours a week? Or 25 hours? Or for an employee earning the minimum wage?

Work papers from the task force say, "Employers will be required to make at least a partial payment for the cost of each worker's health insurance."

The employer's share ranges from 50 percent to 80 percent under the various options. If the employer's contributions were limited in this way, there would be a strong incentive to choose the cheapest plan. Neither employers nor employees would have the option of choosing to remain outside the system.

The Basic Benefits

Health Insurance Becomes a Right

Under the plan being considered, all Americans would have a legally enforceable right to a standard package of benefits. The package will probably be modeled after that now required of H.M.O.'s. It will cover medically necessary doctors' services and hospital care. It will emphasize basic and preventive care, including prenatal care, immunizations, mammograms and routine check-ups.

Congress could prescribe the benefits in great detail, or it could leave those decisions to a national health board. Any forum for discussion of the standard package will be a cockpit for fierce lobbying, as doctors, dentists, podiatrists, equipment suppliers and others, plus consumer groups, seek coverage of particular services and new technology.

If a national board tries to cut costs by eliminating coverage of treatments deemed ineffective or too costly, consumers and patients are sure to complain that the Government is depriving of necessary care.

Administration officials say they also want to cover prescription drugs, mental health care and long-term care. Despite strong political and medical reasons to include such items in the standard package, health-care experts say it is difficult to calculate and control costs of these services.

The Financing

Delicate Debate On More Taxes

Administration officials estimate that it will cost the Government anywhere from $30 billion to $90 billion a year to guarantee health care for all Americans. Businesses will cover most of the uninsured, but new taxes are inevitable because the savings in national health spending under the plan will come slowly and will be spread throughout society.

Mr. Clinton has said he favors higher taxes on cigarettes as a source of revenue. The Federal tax is now 24 cents a package. The Administration is considering proposing an increase to $1 or $2 a package.

The Government collected $5 billion in tobacco taxes last year. A $2 cigarette tax might produce as much as $20 billion a year. But it would also probably reduce smoking, and Federal officials are trying to refine their revenue estimates to take account of that.

Currently, businesses can take a tax deduction for the full amount they pay for employee health plans. The Administration is considering a proposal to

The Language Of Health Care

Employer mandate A requirement that employers provide or arrange health insurance coverage for employees. Typically, such proposals require coverage of workers' families, too.

Fee for service An arrangement under which doctors or other health care providers are paid separately for each service they perform. Some economists say this method of payment may give doctors an incentive to provide more services than needed.

Global budget A limit on all health care spending. The limit could be enforced through regulation of doctors' fees and hospital charges. But such price controls are not always included in the idea of a global budget.

Health insurance purchasing cooperative (HIPC, pronounced HIP-ick). An entity that buys insurance coverage and medical care for a large number of people, including employees of small businesses.

Health maintenance organization (H.M.O.). A prepaid group health plan, which provides a range of services in return for fixed monthly premiums.

Managed care A method of delivering, supervising and coordinating health care, often through H.M.O.'s and other networks of doctors and hospitals. The purpose is to eliminate inappropriate services, control costs and assure access to effective treatments.

Managed competition A health policy that combines free-market forces with Government regulation. Large groups of consumers and businesses buy health care from organized networks of doctors and hospitals, which are supposed to compete by offering low prices and high quality. President Clinton has embraced this idea.

Medicaid Program that provides health care for low-income people, including children and pregnant women, as well as some elderly residents of nursing homes. It is financed jointly by the Federal Government and the states.

Medicare Federal health insurance program for the elderly and the disabled. Eligibility is not based on a person's income.

Tax cap A limit on Federal tax breaks for health insurance, that could apply to employers or employees or both.

2/3

limit such deductions to the value of the standard package of benefits, as offered by the cheapest H.M.O. in a region. This would in theory lead companies to encourage their employees to join low-cost plans.

Similarly, the Government could impose a limit the health benefits that employees receive tax free, but for political reasons, the Administration is unlikely to propose what would be, in effect, a new tax on workers.

While Congress clearly wants to act on health care, many lawmakers will be reluctant to approve tax increases this year beyond those in the President's economic plan.

The Cost Controls

Complicated Search For Spending Limits

To curb the soaring cost of health care immediately, if for no other reason than to staunch the flow of tax money into Medicare and Medicaid, Mr. Clinton may ask Congress for the power to impose "interim cost controls" on doctors, hospitals, drug companies, clinical laboratories and suppliers of medical equipment.

Such a regulatory regime sounds simple, but would be difficult to design and enforce because the health-care industry is infinitely complex and continually changing with the advent of new technology.

Work papers from the task force show Mr. Clinton is considering several options: "an absolute freeze" on prices charged by doctors, hospitals and other health-care providers; Federal limits on increases in private health insurance premiums, or a Federal decree stipulating that private insurers must use formulas for computing payments to doctors and hospitals similar to those established over the last decade for Medicare, the Federal insurance program for the elderly.

By restricting increases in private health insurance premiums, the Government would limit the revenues of health insurance companies, which would then have a strong new incentive to limit payments to doctors and hospitals. Health-care providers warn that such limits may adversely affect the quality of care.

Mr. Clinton also wants to impose an annual limit on all health spending, public and private. His advisers have not decided how to compute or enforce such a limit, which involves formidable questions about the proper role of Government in managing the economy.

The Timetable

Striving to Hasten A Tangled Process

The Administration is determined to make a swift transition to the new health-care system, if only to show some results before the 1996 elections. Work papers from the task force say it will take at least 20 months for the new system to begin operation after a bill is signed into law.

Under one option listed in the documents, the Federal Government would establish health insurance purchasing cooperatives in each state within six months or a year after Congress authorized them. Another option says that "states shall designate" such purchasing groups within six months or a year. The Administration is considering various forms of "financial and technical assistance" to encourage the rapid growth of consumer purchasing groups and networks of health-care providers like H.M.O.'s.

Federal officials suggest that they have no desire to make immediate changes in Medicare, so elderly people can probably keep the doctors they use now. But officials are considering gradual changes to make Medicare compatible with the new program. For example, the scope of Medicare benefits might be increased or decreased, and there would be new incentives for elderly people to join H.M.O.'s.

The Administration is also considering big changes in Medicaid, the Government medical program for low-income people, leading perhaps to its elimination as a separate program. Medicaid recipients would eventually be expected to get private insurance coverage through large purchasing groups, still paid by Federal and state governments.

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CONFIDENTIAL MEMORANDUM

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: JAM DATE: 5/9/16
2011-0584-F

To: Mack McLarty
Mark Gearan
Fr: Dwight
Dt: April 2, 1993
Re: Report from March 31 Political Meeting with Stan

Stan presented summary findings from his initial research to the President on Tuesday. While you have already seen the numbers, I thought you might find it helpful to hear about the discussion.

Initial Support

Stan feels it is very likely that the plan--whatever it entails--will be met with an initial burst of support. Initial support will probably run 6-10 points higher than that for the economic plan, probably in the high 60s. Almost universally, people appreciate the fact that the President is trying: the President's "thermometer" score increases from the beginning of the survey to the end.

People are very supportive of health care reform, but they are also very satisfied with their current health care situation. 75% are satisfied with their costs, and a greater majority are satisfied with their doctor and their quality of care. However, people are worried about what might happen to them: they know someone or know of someone who has been denied insurance or who has been ruined by health care costs, and they are worried it is going to happen to them.

In addition, support for health care reform is laced with extraordinary suspicion of government's ability to fix the crisis without creating a bigger problems.

The combination of these two factors indicate that to win broad-based support for government-sponsored reform, it will be important to highlight how reform will effect them personally. As the President pointed out, he cannot ask people to think about how this will effect the country and not themselves; people want to know that this plan will do something to make their lives more secure.

It is also important to note that health care holds no where near the priority for people that the economic plan holds. 70% of the people Stan polled did not mention health care among their top two priorities.

The plan is popular across different demographic groups of the population, with seniors being the only segment which is notably less enthusiastic about the plan.

Message for Selling

The two principle concerns which hit home with people are security [freedom from worry about not having health insurance] and spiralling health care costs. Stan recommends leading with the security issue for several reasons:

- security is a more durable argument: people don't really believe we are going to control costs, so as you cast doubts on the cost argument, support erodes; and

- the people to whom the cost argument is most appealing are ultimately not very strong supporters of the overall plan.

As highlighted above, the plan's ability to enhance security must be brought home to people as effecting their lives directly. This cannot be a system change for poor people, middle class people want to know that this plan means they will never again have to worry about whether or not a family member will be care for when sick--without bankrupting the family.

Bringing the security issue home to people will be complicated by the fact that people have only occasional contact with the health care system. It's when a family member is sick that this issue hits home the hardest.

Plan Components

The public attitude about the benefits package is crystal clear: the package must include a comprehensive array of health services. The notion that the plan will result in a "leveling down" of middle class insurance packages is a serious danger. Any indication that the package does not include commonly covered services, and support for the plan fizzles. "If you give on the comprehensiveness of the plan," Stan said, "you undermine the entire structure of support for the plan."

This issue goes both to costs and phase-in of the plan. The more comprehensive the plan, the more costly. And the emphasis on comprehensiveness indicates that it would be a mistake to phase-in the plan according to level of services included in the package: you must begin with the full set up front. It is not clear that this means all services being considered by the plan, including those not currently covered by insurance like long term care, or just medical and health services commonly covered by health insurance today.

Costs and Financing

People expect to have to pay for health care reform. Support for the plan does not erode after informing people that tax increases will be necessary to pay for it. The only specific revenue source discussed in depth was the VAT. Stan tested support of a substantial VAT--12%. Even in the context of eliminating all other payments for health care, support for the plan dropped dramatically to 50%.

Other Issues

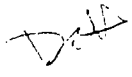
Reproductive rights will be a predictably divisive issue. There is no medical reason for omitting a specific medical procedure or drug therapy such as abortion and contraception. However, the issue will be difficult to navigate with the public and with congress.

Health care for "foreigners" is among the most common and visceral concern people expressed about the plan: people don't want "foreigners"--illegal aliens, resident aliens, foreign-born Americans, etc.--getting free health care with U.S. tax money.

To: MDG
Fr: Dwight
Dt: April 1, 1993
Re: Paster List

Issues for Howard Paster:

* Need for full-time attention now: Richetti full-time?
* Meeting with House chairs?
* Meeting with Senate health care-types?
* Who should testify?



MEMORANDUM

To: MDG
From: Dwight
Date: March 31, 1993
Subject: HC Headlines

Things which need to happen **today**:

1) **NEC:** The NEC needs to begin working toward May 3 completion date, with passage this year as the goal. Alternatively, the President will have to back away from strong public commitment to health care this year.

A Mack-MDG-Rubin conversation will go a long way to clearing this up.

2) **Decision Process** You need to become absolutely comfortable with the Task Force decision process. This is Ira's end of the deal. If the NEC (and others, including legislative and Stan et al) are to be able to do their job right, the decision process will have to involve them on the front end.

I am concerned that Ira's current plan is to present options to the President, then once the decisions are made, present them to OMB, Treasury, etc. for review. His assumption is that the staff level contribution from other government agencies represents full agency review. This will undercut the NEC dramatically and make changes in the decisions exceedingly difficult--there simply won't be time to make serious changes. The new health care system--which will effect literally 240 million Americans--is too important to be subjected to anything but the most thorough in-house review process. This is both a substantive and a political reality.

This will be a touchy issue. Ira has worked out a process with Mrs. Clinton. The process, as agreed to, does not involve decision memos--so Podesta's operation is out of it. Carol apparently talked to the President and Mrs. Clinton yesterday about the process, so this is being discussed at the highest levels. However, I cannot overemphasize how important it is for you to get into this to make sure it works for everybody involved.

The key players who will have to live with the decisions and make them work are:

- NEC
- Paster/Richetti
- Communications/political

If these people are not included in a meaningful way on the front end, they will not be able to provide the important input they can offer which will a) improve the plan and b) make the task of selling the plan achievable.

3) **To Do List:** We need to get moving on the action list which came out of our meeting with Boorstin last week.

MEMORANDUM

To: MDG
From: DCH
Date: March 27, 1993
Subject: Follow up work from Saturday meeting

HHS:

- ~~Is Monday hearing issue resolved~~?
- Relationship issue [Mack]
- Contrarians meeting
  MDG to discuss with Mack, who can feel out with HRC, others
- Who will/can testify on the bill issue
  MDG to speak with Bernie [no paper]

Legislative:

MDG conversation with Howard:
- Need for full-time attention, <u>now</u>: Richetti? Other heavy hitter?
- Meeting with House chairs?
- Meeting with Senate?

WH:

- MDG/DCH meeting with Mack to discuss upcoming needs
- Ira/Bob briefing for Mack
  --what general framework is emerging? what key decisons remain?
  --communications strategy to date
  --dch to prepare memo first? also: pre-brief?
  --John, Ricki would like to attend
- NEC briefing with Mack?
- Loop with FL's office re: beginning White House involvement
  --msg: we're going to start bringing the crowd up to speed in order to have them ready to take this up when the time comes
- MDG briefing with Celia/Bob [DCH to set up] re: campaign
  --Rahm
- Ira to begin attending AP's meeting [after Monday]
- Ira to give brief update to APs [late next week or early the following]
- Initial briefing for WH make-it-happen team: week of April 5

Highlights for Mack:

Background

* beginning to assemble WH team

* will plug in with Celia/Bob/Rahm about campaign

* will talk to Howard about prioritizing
  [alternative: Mack to hold high level come to Jesus meeting for all senior staff who will be involved, outlining plan for you and he to manage the process. In this case, your conversation with HP should follow this meeting]

* Ira to start attending APs meeting

Hot Issues

* NEC-HCTF train wreck
  --NEC needs decision that we are moving this year
  --comfort level with Ira's decision process, with respect to:
    -NEC
    -communications/political
    -congressional

* Shalala issue
  --contrarians
  --personal

Looking Forward

* What briefing do you want?
  --Ira and Bob B.?
  --Bob Rubin/NEC?

* Reports from meetings by DCH?

HEALTH CARE

Meetings

April 1 4-6 p.m.
April 2 4-6 p.m.
April 3 Group decision
April 5 3 p.m.

Starting with President and First Lady
April 6 5-7 p.m.
April 7 4-6 p.m.
April 8 4-6 p.m.
April 14 4-6 p.m
April 15 4-6 p.m.
April 16 4-6 p.m.

Purpose of April 1-5: Prepare a document for delivery to the Clintons the evening of April 5 which outlines to the extent possible:

a. points of consensus this group can reach on specific components of the health care reform plan

b. MOST IMPORTANT: a plan for the next two weeks that outlines decisions to be made, material(s) needed for background, format of the meetings as to presentors, agenda, etc. with assignments

The decisions referred to include: the actual content of the plan, the timeline for presentation.....

April 1: everything out on the table
Saturday meeting time
outline of agenda for Friday, Saturday, Monday meetings

Health Care Mtg - 1 Apr 1993

Rivlin · Tyson · Cutler · Feder · Tipper · Rosenbaum · Weiss · Minerich
B. Nadell

Rivlin - We shld focus on ideal plan first.
Process has started unlike ec plan — what
the probs & how to fix — health care has
been bldg up the details.
Is a present ideal plan — & what it will cost?

What do we want health system to look at
in 199x & how do we walk back?

Tyson Ideal system - relative to objectives
Do we have complete list of probs?

1) Issue of access for uninsured?
2) Security - job lock etc benefits package
3) Budgetary issues.
4) Improve incentives for how system used

Cutler - Here are probs that have alternatives
Suggests we have 2 megachoices.
Construct Chevrolet & Cadillac

Rivlin - We need Cadillac + Chevrolet
- & Cadillac + Lincoln.

- Lear + Bentsen aren't at pt of where basic plan is
managed competn & global budgets

→ They have never been presented with what it is.

Vladek - health of population.

Rivlin - Y & P has moved to managed compn & global budgeting - Bentsen + Panetta have to have chance to question it.

Ina - I've offered to meet & Bentsen & who ago met & Bentsen
I'm happy to brief anybody.

We felt we had marching orders in the transition.

Rivlin - I'm not questioning it. Lear does need to know about it - then what does it cost?

Peter – How everyone is served
- Costs
- Savings
- Analytic description of Δ in delivery system

Rivlin – Hard to grasp ∴ structure & numbers. It's not that we're against it...

Ira – let's have broad based discussion of alternatives & principals – bring in advocates.

Sara K. – Biggest gulf – so talking broad outlines on consensus

Rivlin – Health care xpts have notion of managed comp have clear sense. Those of us who don't – we get boxed into positions.

Ira – Bring in people & different viewpts of debate also – a detailed book from this weekend's tollgate.

Marina – Bentsen wants book; won't read ∴ OEOB.

Ira – Then it's public info

Marina - Bentsen wants to look at component parts
ie portability is a big issue for him

Feder - Books aren't best source for clarifying
positions -
1.) Presentation of options from
working groups
2.) Alternative

Rivkin - At some pt, you're going to have to
tell C + public what it is, & what is costs.
Spell out grand design & cost

Ira - Califano op ed shows difficulty of
certainty of #'s

1) - We shld this whole thing nos. to say
out to get hands around.
#'s will go thru refinements.

2) Broad discussion of whether this approach
makes sense.

Alice - We shldn't go back to campaign
& transition conclusion

Cutter - Managed Comp ō Global Cap
yet — natural mega options

Ira - Let's lay those out -

- Put into packages ō alternatives
- 20 headaches; unresolved P decisions

We can highlight key mega decisions &
put numbers around them.

Marina - Do bottom line first
— then disaggregate it —

Personally reluctant to put precision
to numbers - Put in ranges.
Start ō ideal pckge - what's reqd
in component parts & range of dollars

↳ Don't pick a year.
Look at 5 yr & 10 yr mark

IRA - We will do it.
P suggested - minimum then ideal

Sarah – Problem of relationship of parts

↳ TF threshold issue of how to treat parts of bill = $ impact, yet political & practical impact.

We haven't figure out how many hot buttons we're going to press.

Ira – Outreach groups have done this. It's another overlay.

↳ You can't predict liability

Bruce V. – Assuming significant ec. impact, then major sell job to make it the own

– Strategic Dec on how wide a circle we draw on health care reform

↳ ie. Medicaid: many issues we may not want to get into.

Marina — Clear cut b/tw what is scor@ & not

Carol — No dec. to wiggle part May 3

Cutler — Very, very hard to comfortably get decs. & what has to be done by 5/3.

Debate is like economics pckge 3rd or 18th
Everyone is glad we did it 18th.

Carol — BC conversation.
Chances gd we may rec'd Δ in date.
Impt for Howard to prepare his sense of Hill.

Cutler — We shld ask BC whether we shld design it all for this year.
It's difficult to get thro yr

→ Big reason to believe opp cost of doing it in a yr — he shld consider. Effort may kill off NAFTA + Uruguay Round
a) We don't care
b) Not a trader
c) Plan for health — SOTU '94

3 decisions

Rivlin - May not be all or nothing.
Some pieces this year
+ big reform next year.

Feder - C view is use moment

Tyson - Can't judge cong'l view.

Iva - Bentsen view -

Marian - Bentsen don't have an opinion -
but believes it shld be discussed
- ~~NAFTA~~
- Ee Pckgs

Very serious timing issue
- Slower
- Bite the bullet
- Lay out financing

Clear that LB hasn't made dec, yet
clear it shld be discussed.

Sarah - Scenario of concern is FY
to sent May 3rd
Then it will sit for awhile -
From the x the bill goes - get thru last
Recruit

Sarah Each month/week that ticks by —
it costs

Send it knowing everything will be cleared
so it will be done quickly.

Ira - key strategy group & working this
+ public outreach
. how to set referals

Ira - Do a version for Monday ~ nos.
a version ~ nos on Monday

1) Verbally go thru a version ~ nos.
on paper for Sat

2) Pitch comprehensive for Monday

Description of consensus + headaches

Cutler - for Monday - get roadmap together

(We need to look @ to present from the start a an overview of a package.
I'd prefer it to be a package
- here are 2 alternatives

↳ then disaggregate it in later mtgs.

Keep a running score of costs etc.

↳ So we know how they got

Then we'd have come to a rough view
then we'd shred it / contrarians.

Marina - Step back one -
What is the problem we're trying to address?

Carol - tomorrow - go thru verbal
then Block out divisions -
& what needs to go into presentation

End of mtg - Sat - presentation for Mon.
Sarah will write
- distribute Monday - Review/ Draft

Health Care – 2 April

Ira – wants #1 agenda item with P to be dates when we meet Tuesday

Judy – Coverage + financing

- everyone guaranteed nitty defined benefit package
- comprehensive
  - at issue is cost sharing
  - Co desire to keep it low but also recognize need for service

How everyone gets covered – financing
- broadly understood → fully taxed financed program ie VAT. or
- ER based solution – employee tax; premium based approach

(Structure – ERs pay a share (80%) & EE pays a 20% share. Examine subsidies for both parties.
- concern for small firms

at issue is level of subsidy + sliding scales of EE coverage

HPIC

self employed +
nonworkers guarantd access to some benefit
with potential for some supplement.

GAP

Purchasing Cooperative

- Self insured ERs - could stay outside system
  - allow some 500 - 1,000 outside
    - ↳ if allowed option, EEs still need to have math studds

- Health Security Card -
  go into ER plan or into purchsing cooperative

take Card to ER benefits office or go to P. Coop office to pick plan.
- choice of plans, all of which offer basic guar'd

Card is symbol of your guarantee
it could become a smart card.

Thinking abt open enrollment once a year or some appeals process.

Within every plan – same Consumer Board
to handle appeals, probs
also an Ombudsman

– guarantees health status
job loss
kids

Marian pulled out B/BC card to Leon

Leon – EE suddenly out of work ō
Same card –
You're covered.
For widdl & family – out of work: You're covered

Guaranteed for your plan

If no job – ER notifies you've left.
Track all of movement.

Leon – As system is set up: bdgtng mechanism.
Things that ↑ cost of health care (800 Bn)
100 Bn – waste → unnecssry adm cost
unnecssry tests/procedures
adm cost: insurance costs
: imposition pt on provider orgztns by
ins.
10 yrs ago 25% TODAY: 40%

Fundamentals of Mgd Competition:
- simplification: higher adm
  : one reimbsmt form
  : not micro-regulating
universal coverage: contributes to ↓ cost
  : 12 BIT / charity costs

Budgeting Overall
- Govs fear Medicaid mandates

Ntlly set budget from yr to yr
- states then purchasing coop wld be resp. for budget

Budget – with fixed % ↑
- weighted avg premium

Another issue – ↓ those outside – must file ∈ HPIC

Over + above the budget - people are spending on whatever they want.

Budget

HPIC – premium $ EEs – non-working individ
fed govt co-pays
EEs
States ∟ Fed share

2 possibilities:

1.) Take out COLA + demographics — enormous differences in cost ē states
Florida vs. Montana

→ Base closure comm - like to restructure

→ ?

2) Start ō baselines — but make sure there's good comparative data.

Rejected single payor
1.) 300-700 Bil taxes
BC will refer to Bob Kerrey on 13 taxes
2) Multiply institutional opponents
3) KGB running health care

Polls show people are happy ē what they have negotiated for themselves —

Big headache: if present benefits exceed the util'y gnt'd pckge

It may be less a prob since there + other provides aren't accessible

↳ Maybe a phase-in
- women + children (5+
- bare-bones pckge

Other big issue - what to do with Medicare
Coshare is high -

LT savings from budget + managed competition

V P -
Dist
mail c

TO: President Clinton

FROM: Carol H. Rasco

SUBJ: Health Care Process

DATE: March 31, 1993

Last evening I had a long talk with Hillary about the process for developing the health care reform plan from this point forward since we have now almost finished the topic briefings with you.

The plan we have agreed upon is that in a conversation I had with YOU and with Hillary, YOU have asked me to pull together a senior group over the coming days in the absence of the two of you to put together a consensus document that does two things to the extent possible:

a. outlines those areas/topics where the group can recommend to you and Hillary consensus on narrowed options or a single recommendation

b. an outline of the decisions to be reached with dates for consensus meetings/decisions and what is needed in order to hold those meetings, make the decisions.

The group to be working on this is to include: Ira, Judy Feder, Sara Rosenbaum, Donna Shalala with one other from HHS, Bob Ruben (or Bo Cutler as Bob will be out of town for the next few days), Leon, Laura Tyson, Bentsen (realize he will be gone with you), Gores, Melanne, Maggie and me. The group will be kept to this size, no further staff, etc. Hillary has asked me to preside.

FURTHER:

Hillary feels strongly that you and I need to have a discussion which I will plan to do at my 4 p.m. briefing this afternoon on what you mean by the deadline of May 3 for a presentation of the health plan, what plausible rationale do we come up with to delay the final presentation of the plan/ bill. She volunteered that the best thing to do is to perhaps use her time in Ark. as a rationale. I have spoken briefly to George and Paster; George and DeeDee will immediately begin to soften the hardline on May 3 with nothing more definitive, you and I will talk at 4 p.m. today.

MEMORANDUM

THE WHITE HOUSE

WASHINGTON

To: Mack McLarty
Mark Gearan

From: Dwight

Date: March 25, 1993

Subject: Report on NEC Meeting with Health Care Task Force

Background

The NEC held an initial meeting with Ira and several representatives of the Task Force this morning. The meeting was generally a very positive beginning, I think. The NEC people are clearly very focused on the overwhelming impact the plan will have on their work. Ira and his people are for their part very receptive to input from the NEC. My impression is that no one on the NEC has formed any pre-conceptions about the plan as yet.

Issues

The key issues which emerged from the meeting include:

Quantifying savings: Laura and Leon pressed on the need to determine cost savings. Unlike the budget process, however, there is no precedent for re-making the health care system. Managed competition does not currently exist anywhere--so there is no empirical evidence on which to base projections. Projected savings will be based on qualitative speculation about how consumers will behave with greater purchasing power in a system with incentives towards cheaper care--A nice theoretical answer, but how does Leon put it in the FY 95 budget? And how do we convince people the savings are real? Ira expects to have a first cut of numbers by next week.

Savings to the federal government: Ira noted that basic decisions about whether or not Medicare and Medicaid are included in the plan have not been made. The NEC members pointed out that if these budget busters are not brought under control, either within or without the plan, the budget will not work.

Benefits package: The services included in the benefits package play a pivotal economic role: each additional service has a first order multiplier effect on the cost of the plan.

Phase-in: The NEC is focused on the phase-in as a way to maximize initial savings and limit initial outlays in order to help make the budget work. This must of course be balanced with the political need to make a dent in the crisis in the near term.

Correctibility: Several members underscored the importance of building into the plan a way to correct key plan components if cost savings are not being achieved as projected.

MEMORANDUM

To: Mack McLarty, Mark Gearan

From: Dwight C. Holton

Date: March 24, 1993

Subject: Health Care Task Force Update

Looking Forward

The work of the Task Force is moving forward at a frenetic pace. During the next 4-5 weeks, the President will make decisions affecting the future of health care for every American. Each of these basic decisions carries with it substantial budgetary, political, and economic implications.

Given the likely role you will play in managing the strategy for selling the plan, it is important to develop our own strategy for remaining current on decisions and other aspects of the process. Early, thorough involvement is critical to remain abreast of the changing elements of the plan itself, political and economic impacts of the plan, and the evolving strategy for winning approval in the public and on the Hill. Components to track include:

Policy development: policy will take shape through Ira's meetings with the President over the next few weeks. Involvement in the process is important to have a thorough understanding of political, budgetary and economic impact of the plan.

Economic impact: the NEC is beginning a thorough review of economic impacts of the plan's key components. The plan will effect $700 billion or more in domestic spending--small adjustments in the plan will have major economic impact.

Communications strategy: In addition to daily 8am meetings, Bob Boorstin has convened a communications working group, including Ricki, David Dryer, Paul Begala, Mandy, Stan, Carter, myself, and others to begin plotting a communications strategy. The strategy will include scheduling, cabinet and surrogate training and scheduling, press briefs, etc.

Public campaign: Celia Fisher is running the public campaign from the DNC.

Hill strategy: Chris Jennings has been working with members throughout the process and is the principle person responsible for Hill strategy.

Intergovernmental strategy: The Task Force working groups include a number of officials from state governments. John Hart is covering the Task Force for Regina's office.

Update on Task Force Activities:

Policy Process: The fourth Toll Gate meeting ran through most of last weekend. Ira and Judy have the working groups focused on narrowing their components of the plan to 2-3 options for consideration by the President. Ira has already brought several of the key groups over for background briefings with the President. As the President mentioned yesterday in the press conference, he has completed about 12 hours of briefing and has 12-15 more to go before undertaking the bulk of the decisions.

The Task Force will hold its first formal meeting next Monday, March 29. The agenda has not been finalized, but the meeting is expected to go all day.

The "cluster leaders" discussed a list of top twenty "headaches" at their last meeting. Ira assembles this group 2-3 times a week to discuss cross-cutting issues--the meetings are very helpful. The top twenty headaches include both major, cornerstone issues which will require resolution from above--such as what to do about long term care--as well as nagging political issues, such as whether or not to include reproductive services in the benefits package.

Communications: Stan et al have begun research in the form of polling and focus groups. Stan is preparing a memo for the President outlining the issues in detail, and the consultants hope to brief the President on Tuesday. The initial research indicates that there are both a lot of challenges and a lot of opportunities before us:

- While people are very worried about the health care system, they are largely satisfied with their own care. Stan compared this to people's attitudes toward congress: they hate congress, but they love their congressman/woman.

- People are split about 50/50 on which is the bigger danger: the health care crisis, or the result of government intervention to mend the crisis.

- *Security* is what people are looking for in a new health care system: freedom from worries about losing family health insurance. Security outscores concerns about cost, although the two are clearly related.

- The comprehensiveness of the benefits package is essential to winning support. If the package is seen as being less than comprehensive, then people will not trust the quality of the package and will not trust the plan.

- People know a great deal about their health care plans and about the obstacles to full health care access. Most people are aware, for example, that insurance companies often use pre-existing condition clauses to deny insurance.

- Rationing of medical services is not acceptable to a significant majority of people. Rationing services seems fundamentally un-American to people.

- People understand cost shifting--they know that their medical bills are inflated to cover the cost of uninsured people.

- People want to be able to choose their own doctor.

Boorstin et al are working on a communications strategy which both inoculates against potential trouble spots and highlights attractive aspects of the plan. The strategy will include press strategy and scheduling for the four principals, cabinet secretaries, and other surrogates during the upcoming weeks.

The consultants feel emphatically that the plan must include **immediate** steps to alleviate the crisis as middle class people see it. Banning pre-existing clauses and improving the portability of insurance [ability to keep insurance as you move from one job to another] are visible, achievable possibilities.

in house

file:

Health Care

MEMORANDUM

To: Mack, Mark

From: Dwight

Date: February 26, 1993

Subject: Update on Health Care Task Force

Beginning at 7:30 am yesterday and ending around noon today [with an 8 hour sleep break!], the Health Care Task Force held its second of seven "Toll Gate" meetings. The toll gates are used to hear status reports from each of the 20+ clusters working on various aspects of the plan to make sure everyone is working along the same lines.

While the process is still massive--I think more than 400 people are involved--options for the central components of the plan are beginning to crystallize. The toll gate served to bring the key issues to the foreground. Some of the underlying questions include:

--How active a role should the Federal government play in administering the program? This issues gets at fed-state-local relationships, over-regulation vs. ineffectiveness, etc.

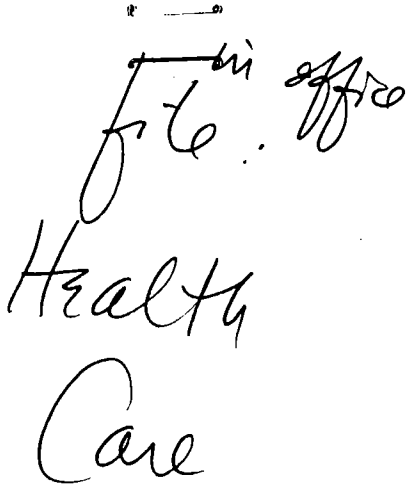
--How do you balance simplicity and fairness? To achieve fairness in the very complicated health care economy often requires a morass of complexity. On the other hand, what people want and need is a simple system. How do you balance these two, or reach a creative approach which lets you have your cake and eat it too. This issues also effects almost all cluster groups.

--Should the legislation be proscriptive or goal-based? There is a careful balance to strike between specificity and local flexibility which must be struck for effective implementation--and political palatability--of the bill.

--What are the economic impacts of different options? The different options being developed have economic impacts ranging from nominal to wholesale economic planning. What incentives are you creating in the economy? For example, if you require coverage of full-time employees only, you inadvertently encourage businesses to shift to part-time employment.

--Who are the winners and losers for each option? This is obviously very closely related to the need for research on economic impacts. Some of these questions started to emerge during the toll gate yesterday. I don't know what the plans are for a full economic and political "vet" of the principle components of the plan, but this is obviously critical to shaping the options for the President appropriately.

Please let me know if you'd like more or if you'd like a specific area clarified. I am staying away from the straight policy questions because they could fill pages, but I'm happy to give you more of an idea of the models/options we seem headed for if you'd like.


Health
Care

MEMORANDUM

FROM: Mike Dukakis

RE: Health Care Reform

The following are some thoughts and reflections on the subject of national health care reform which I hope can be helpful to both the Administration and the Congress. They represent the experience of many years of active involvement in the battle for universal health care; the lessons, both positive and negative, from having led the fight for the first state universal health insurance law in the nation; and deep involvement in the issue since leaving the governor's office in Massachusetts in 1990. In particular, they are based on extensive exposure to and research into the Hawaiian health care system while I was a visiting professor at the University of Hawaii School of Public Health in the spring of 1991.

A. Access

One of the mysteries of the debate over national health care reform, at least until recently, has been the failure of policy makers to give the Hawaiian experience the attention it deserves. We have been subjected to endless debate and analysis of the Canadian, German, British, Dutch, Australian and other national health care systems. More recently, we have been introduced to a new proposal--managed competition--which, while interesting, has never been tested in the crucible of real experience and the tough world of health care politics.

Hawaii is, and remains, the one tested model of near universal health care in America. It is remarkably simple. It builds on the existing system. It has produced the best health outcomes in America. And health costs in Hawaii, where the cost of living is thirty to forty percent higher than it is on the mainland, are about equal to Canada's.

Why does Hawaii work?

Not because Hawaii is "unique" or "different" or because everybody is out surfing at three in the afternoon. Hawaii has all the health problems we have on the mainland, including serious AIDS, drug and other substance abuse problems, and severe chronic health problems in the native Hawaiian and Pacific Island communities.

Hawaii works for three basic reasons.

1. All employers, without exception, must insure their full-time employees with comprehensive, legislatively prescribed benefits.

2. Although small business insurance reform is not legislatively mandated, there is a tradition in Hawaii that insurers will take all comers; offer coverage to all without regard to preexisting conditions; and charge a single community rate to all businesses with 100 or fewer employees and the self-insured. Insurers know that if they violate that tradition, the legislature would act in twenty-four hours to put those principles into law.

3. Hawaii is tough on technology. It takes its DON law seriously. There are, for example, only five MRIs in the entire state--more than enough to serve the needs of a state with a population of over one million people. Compare this to Broward County, Florida, which has approximately the same number of people as Hawaii and where there are at least thirty-seven MRIs--more than in all of Canada.

All of this has not prevented costs from rising in Hawaii, as they have everywhere. But virtually everybody in Hawaii has health insurance; all employers can "play" so that there is no need for an alternative public plan; and costs continue to be substantially below those on the mainland. Even the State Health Insurance Program, which covers the uninsured unemployed, is completely "privatized." While the state provides the funds out of general revenues, coverage for the uninsured unemployed is provided under contract to Blue Cross-Blue Shield and Kaiser-Permanente, the two main insurers in Hawaii.

There are no "public sponsors" in Hawaii; no HIPCs; no additional intermediaries between employers, employees and their insurers and providers. What makes the Hawaiian system work is an insurance market that protects small and medium-sized employers; guarantees coverage at community rates; and eliminates the kind of cherry-picking and experience-rating that is plaguing the system on the mainland.

B. Cost Containment

Hawaii does not have global budgeting, although Govern Waihee may soon ask for standby authority to set rates. And it is anxious to enroll all, or most, of its Medicaid population in existing insurance or managed care plans as part of what the Governor has called "a seamless system of health care."

My own view is that it would be a mistake to delegate the job of setting global targets and implementing them to the states unless individual states specifically ask for the job and demonstrate the capacity to do it. We had a disastrous experience with state implementation of Medicaid in the late 1960's; and I have grave doubts that the states have the ability or the desire to do the kind of job that would be required with a national health care budget.

HCFA currently manages a fairly complicated system. Why not expand its responsibilities--or the responsibilities of the proposed new national expenditures board--to include the implementation of national expenditure target, rate setting, and other aspects of a national health budget. Target levels might well be set in accordance with the National Leadership Coalition proposal, which is probably the best and the most carefully thought through we have.

The new national board might well want to implement the national health care budget on a regional basis through regional office (not unlike the regional Federal Reserve banks) or some equivalent. And nine or ten "regional budgets" are a lot easier to manage than fifty state ones.

There are obviously a host of other steps that could--and should--be taken to get costs down and provide the savings with which to pay for health insurance for the uninsured unemployed.

1. Serious malpractice reform must be a part of any proposed plan, not only because doctors are practicing a lot of defensive medicine but because we cannot possibly expect our doctors and other health care providers to get serious about controlling costs while continuing to subject them to unlimited legal liability. Both Massachusetts and California have done a pretty good job of reforming their malpractice laws. By capping pain and suffering at $500,000 dollars, putting percentage limits on lawyers' fees, and eliminating the collateral source rule, Massachusetts was able to cut malpractice premiums by one-third, and today its doctors are paying substantially less for malpractice insurance than their colleagues in most other industrial states.

2. The United States is the only advanced industrial nation in the world that does not require its people to select a family practitioner who manages their care. There are millions of people in this country--including many elderly people on Medicare--that wander from doctor to doctor self-selecting their specialists and collecting different prescription drugs as they go along. This is not only costing the system billions. It is terrible health care.

Whether or not people choose to join a managed care plan, every American should be required to pick a general practitioner; and specialists should not be reimbursed at the specialist rate unless there is a documented referral from a general practioner. People should of course, have full freedom to pick the general practioner of their choice, but the general practioner should once again become the gatekeeper for the nation's health care.

3. Insurers should be required to create a single payment facility on a regional basis that would process all claims for payment from providers and eliminate the enormous collection costs that currently burden both doctors and hospitals. I have discussed this with representatives of some of the nation's largest insurers. They not only do not have a problem with it. They are, on their own, experimenting with various forms of it. What is needed, of course, is a legislative mandate that requires all insurers to participate in such a facility.

4. Taxing benefits and capping tax deductions.

In my view the Administration and the Congress should avoid these two proposals like the plague. The notion, for example, that there is something wrong about an employer and a union agreeing to a health care package that includes dental benefits, even if they are not required under the proposed plan, is absurd. Dental benefits are hardly a luxury. To tax employees for them is not only unfair--it is very bad public policy.

Furthermore, the idea that employers are lavishing health benefits on their employees because they can deduct them on their corporate tax return is equally absurd. If we are going to require employers to insure their employees, then we certainly ought to permit the full deduction of those benefits. And if those benefits include supplemental coverage for, say, dental services or home health care, are we going to penalize the employer that has enough sense or compassion to provide them, even if they are not required under the new plan?

5. Medicaid benefits

I have always had a difficult time trying to understand why Medicaid recipients should not be covered by comprehensive insurance or, better still, good managed care plans rather than 50 state-run plans of various quality. Not only would this relieve the states of the responsibility for micro-managing Medicaid benefits. It would also mean that Medicaid recipients who find jobs could continue their existing health care arrangements in most cases. We began that process in Massachusetts before I left office; well over half our Medicaid recipients are now enrolled in managed care plans; and by all accounts it is working well. Bruce Bullen managed our Medicaid program for me. He has continued to do that for Governor Weld, and he would be an invaluable source of information on how it is working.

6. Employee contributions

Most people agree that employees should contribute something to the cost of their insurance. Hawaii handles this problem in a very sensible and equitable way. Employees can be required to contribute up to fifty percent of the premium, or 1.5% of gross wages, whichever is lower. This does not, of course, preclude an employer from voluntarily covering all or a substantially greater portion of the premium than is required by law, and many of them do.

C. Paying for universal coverage without new taxes

If an employer mandate is fully implemented, we will have about ten million uninsured people left in the United States. At an average cost of approximately $1500 per person, that will require the expenditure of approximately 15 billion dollars for comprehensive insurance and/or managed care that, in my view, should be purchased for them, just as Hawaii does for its uninsured unemployed. With a regulated insurance market that requires companies to take all comers and charge community rates, there should be no need for an alternative public plan.

Hawaii pays for the uninsured unemployed out of general revenues. Massachusetts does it with a surcharge of $16.80 per employee on the unemployment compensation tax.

There is, however, as the attached article points out, a practical alternative to the use of general revenues or the imposition of a new tax. Today, as everybody knows, health insurance premiums include, directly or indirectly, a substantial surcharge that pays providers for uncompensated care. In Massachusetts, for example, it is 8.5% In the states where the number of uninsured people is much higher, it is substantially more.

If all employers are required to provide their employees and their dependents with health insurance, the amount of uncompensated care will drop dramatically. In a study that I co-authored at the University of Hawaii in 1991, we estimated that approximately four percent of the premium base could finance comprehensive health insurance or managed care for the remaining "gap group." Although this would require a continuing surcharge on premiums, it would be much less than the amount that is currently being added to premiums for free care, either explicitly or in form of increased doctor and hospital charges.

Furthermore, it should not be difficult to find at least fifteen billion dollars in savings in the non-governmental health sector to offset this small but continuing surcharge. In fact, the notion of a premium surcharge offset by equivalent savings is a perfect way to implement the President's strongly expressed desire to pay for coverage for the uninsured by eliminating waste and inefficiency in the existing system.

Moreover, using the surcharge/offsetting savings approach to insure the uninsured make it possible to apply all Medicare and Medicaid savings to the deficit. In short, it ought to be possible to make a significant dent in the deficit from reductions in the cost of Medicare and Medicaid while fully insuring the uninsured unemployed out of savings in the rest of the health care system.

THE STATES AND HEALTH CARE REFORM

In 1945 Harry Truman became the first president in U.S. history to propose a universal health plan for all Americans. Forty-seven years later, the American people are still waiting.

True, we have made some progress since the days when a massive lobbying effort by the American Medical Association and the nation's insurers shot down the Truman plan. But two Republican presidents who supported universal, employer-based health insurance in the 1970s could not get their proposals through Congress. President Carter preferred to focus on cost containment in health care rather than on universal coverage. And neither Ronald Reagan nor George Bush has been willing to support the kind of universal coverage that both Richard Nixon and Gerald Ford advocated some 20 years ago.

Now Washington gridlock has produced another year of frustration. Congress will not support the Bush proposals to reform malpractice and small-business insurance. President Bush is adamantly opposed to any plan that makes Medicare universal or requires all employers to provide basic health insurance for employees and their dependents.

Meanwhile, Congress and the President have not hesitated to expand Medicaid coverage for the poor by mandating additional benefits and increased eligibility. But virtually nothing has been done in Washington to contain the explosive costs of health care that are driving virtually every state budget into the red. On the contrary, in seeking to contain Medicare costs, the President and the Congress have succeeded only in shifting some of those costs onto the backs of the employers, consumers, and state governments who must pay the bills.

Little wonder, then, that the 1989 annual meeting of the nation's governors exploded in bipartisan anger over what all this was doing to the efforts of both Republican and Democratic governors to balance their budgets and pay for other important priorities, such as public education. And little wonder that a number of state governments are now trying to devise ways to provide greater access to high-quality health care for their people and control costs at the same time.

Hawaii: The Pioneer

Long before any of the mainland states began thinking about comprehensive health care reform, Hawaii had adopted its Prepaid Health Act and was moving ahead with a system of near-universal access to health care. Curiously, only within recent months have some of the nation's policy makers taken time off from endless debates over the Canadian, German, and other national systems to explore in detail the experience of the nation's 50th state.

What they have found is impressive.[1] Hawaii has for nearly 20 years done what Presidents Ford and Nixon were proposing in the early and mid-1970s. Since 1974 all Hawaiian employers have been required to provide their employees with a comprehensive package of health insurance. Employees can be required to contribute 50 percent of the premium or 1.5 percent of their gross wages, whichever is lower. Hawaii does not require employers to cover their employees' dependents, but a large majority of them do so voluntarily.

By 1989 all but 50,000 Hawaiians were insured by their employers or through Medicare or Medicaid, or received health care as members of the armed forces or their dependents or through the Department of Veteran Affairs. In that year the Hawaiian legislature created the State Health Insurance Program, which is designed to provide coverage for all those not otherwise covered under existing law. The program is funded by general state revenues and is managed under contract by the Hawaii Medical Services Association (HMSA, the local Blue Cross affiliate) or Kaiser Permanente, the dominant health maintenance organization in Hawaii. Approximately 18,000 people have already been insured under the program, and Hawaii expects to achieve its goal of universal coverage soon.

Currently, a majority of Hawaiians are insured by HMSA. An additional 19 percent are members of Kaiser Permanente. For all businesses with 100 or fewer employees, HMSA and Kaiser Permanente have a single risk pool each, and those businesses pay a single community rate. The fact that two insurers dominate the Hawaiian health insurance market has had a substantial impact on costs. Although Hawaii's cost of living is some 30 percent higher than that on the mainland, Hawaiian health care costs are lower, about equal to Canada's. Moreover, Hawaiians are now the healthiest people in the United States.[2] Life expectancy is the highest in the nation. Hawaii is tied with Massachusetts for the lowest infant mortality rate.

Hawaii is not resting on its laurels. Governor John Waihee and State Health Director John C. Lewin have announced plans for what they call "a seamless system of health care services." They want to make the primary care physician the health care system's gatekeeper. They also want to create a new state commission on health costs that will collect data, certify insurance rates, and have standby authority to set provider rates.[3]

Other States

Hawaii has been far and away the national leader in health care reform. Although several other states have now joined the fray, they have not yet fully implemented their plans for reform. Massachusetts approved its universal health care law in the spring of 1988.[4] Approximately 100,000 additional Massachusetts residents, including students, severely disabled adults and children, and the uninsured unemployed, all qualify for and receive basic health insurance.

Moreover, Massachusetts, one of the few states that have approved comprehensive malpractice reform, has eliminated double payments for medical expenses, limited attorneys' fees, and imposed a $500,000 cap on compensation for pain and suffering.[5] Malpractice

premiums have dropped by 25 percent, and Massachusetts doctors and dentists now pay substantially less for their malpractice insurance than many practitioners in other industrial states.

Unfortunately, a combination of strong opposition by small businesses to the law's mandate for employer contributions, a new governor, and economic recession has brought progress toward the implementation of the new law to a standstill. Governor William Weld has repeatedly attempted to repeal the mandate for employer participation. Although he has so far been unsuccessful, the legislature has agreed to postpone implementation of the law for another three years.

Oregon followed Massachusetts with its own version of universal health care legislation. Like the Massachusetts law, the Oregon law includes an employer mandate that is scheduled to take effect in 1995. Unlike the Massachusetts law, it also includes a rationing scheme for those covered by Medicaid that has been rejected by the Bush administration.

Minnesota, Vermont, and Florida have all passed important new health care legislation this year that in a variety of ways seeks to move over the next two to three years toward the goal of universal coverage at an affordable cost. New York's Governor Mario Cuomo recently signed into law a sweeping reform of small-business health insurance. Dozens of other states are wrestling with the same issues and drafting their own health care legislation. The Minnesota plan is discussed elsewhere in this issue of the *Journal*.[6]

What Can We Learn from the States?

Hawaii's success and the troubles of Massachusetts and Oregon teach us some important lessons for the future and should provide the president who takes office in January 1993 and the new Congress with a better understanding of the possibilities and pitfalls of comprehensive health care reform. The lessons are outlined below.

Universal, employer-based coverage can work, and work effectively, provided steps are taken to protect small and medium-sized employers from the kinds of discriminatory practices that are bedeviling them in most states. The Hawaiian health care system is an impressive example of how to provide universal coverage at relatively reasonable cost through the private market and with a minimum of government bureaucracy and interference. Moreover, it is a reminder that providing everyone with basic primary coverage is itself an important contributor to cost control. Hawaiians visit the doctor more often than most of us on the mainland do. But they spend a lot less time in the hospital, and that has substantially lowered costs.[1]

One of the principal reasons for the success of Hawaii's employer mandate and its acceptance by small businesses is the kind of protection that Hawaii's single risk pool provides to small and medium-sized employers. Furthermore, a regulated insurance market that requires insurers to accept all comers at a single community rate eliminates the need for a large alternative public insurance plan. In Hawaii, every employer can "play."

A limited number of insurers and managed-care organizations, working in concert with health regulators, can substantially reduce the administrative expenses of the health care system and use their market power to keep costs under control. One of the impressive features of the Hawaiian system has been its ability to keep costs down despite the fact that the state has one of the highest costs of living in America. HMSA in particular has enormous influence over hospital and physicians' rates because Hawaiian health care providers are under no illusions about who the principal payer is in the Hawaiian system.[1]

This should confirm the views of those who believe that a health care system with a single payer or a relatively small number of insurers can do a much better job of holding down costs than one with hundreds of insurers and managed-care organizations, many of which are cherry-picking the market for healthy risks. On the other hand, the fact that HMSA is competing with Kaiser Permanente is important, too. Although the two organizations seem to get along reasonably well, the competition for subscribers between them is intense, and it adds to the pressure to keep costs down.

Any plan for universal coverage must include primary as well as catastrophic coverage. A number of proponents of health care reform have suggested that we begin with catastrophic care and then move gradually to full coverage. Hawaii's experience suggests that such an approach would be a serious mistake. Most observers in Hawaii believe that one of the reasons for its lower health care costs is the fact that good primary care is almost universally available under Hawaii's health care law. They believe that Hawaii's lower rate of hospitalization is the direct result of the widespread availability of primary care for virtually all Hawaiians.

It is time once again to make the primary care physician the manager of health care in America. There has been a good deal of debate recently over the idea that the family physician should be the gatekeeper for our health care.[7] That principle is part of the health care system of virtually every other advanced industrial nation in the world. Forty or 50 years ago, it was an accepted part of the U.S. health care system.

My father, for example, was a general practitioner in Boston for more than 50 years. He worked seven days a week and made house calls. But woe unto any of his patients who saw another doctor without getting his approval. If he found out about it, he invariably told them to find themselves another physician.

Hawaii is seriously considering a plan that would, in effect, restore the system that most of us accepted as a matter of course when my father practiced medicine. Governor Waihee's recommendations would prohibit the reimbursement of specialists at the specialist rate without a referral from a primary care physician. Waihee's recommendations would also pay the general practitioner a small fee for managing the patient's care.

A universal, employer-based plan can provide coverage for the uninsured without new taxes. One of the most difficult problems facing policy makers in Washington and state capitals is how to provide health insurance for the people who remain uninsured even after an employer mandate is implemented. Hawaii, for example, has decided to pay for such coverage with general revenues. But even Hawaii is now being forced to consider cuts in programs as it prepares its budget for the next fiscal year.

There is a practical alternative to the use of general revenues or the imposition of a new tax, however. Today, health insurance premiums include, either directly or indirectly, a substantial surcharge that pays providers for uncompensated care. In Massachusetts, for example, it is approximately 9.5 percent. In other states, where the number of uninsured people is much higher, it is substantially more.

If all employers are required to provide employees and their dependents with health insurance, the amount of uncompensated care will drop dramatically. In a study at the University of Hawaii in 1991,[8] it was estimated that approximately 4 percent of the premium base could finance comprehensive health insurance for the remaining "gap group." Although this would require a continuing surcharge on premiums, it would be much less than the amount that is currently being added to premiums for free care, either explicitly or in the form of increased doctor and hospital charges.

By themselves, the states cannot possibly provide all Americans with access to health care at an affordable cost. Louis Brandeis called the states the laboratories of social and economic change in America — and so they are. Almost no important domestic legislation in this country has been approved by Congress before some state or group of states has taken the lead and tested it.

Health care reform is no exception. While Washington seems paralyzed on the issue, the states have moved ahead in a variety of ways. We have the impressive results of Hawaii's first-in-the-nation plan, the successes and failures of Massachusetts, the extraordinary process of citizen participation that preceded the passage of Oregon's health care law, Minnesota's bipartisan effort, Vermont's creation of a state commission that will attempt to impose global budgeting on its health care system, and Maryland's all-payer system of hospital cost control. These and efforts in many other states should be studied carefully as we consider proposals for national health care reform.

But universal access to affordable health care for all Americans cannot possibly be achieved on a state-by-state basis. For one thing, the efforts of any state to impose additional burdens on its employers and citizens will immediately be met by protests from the business community that it is being required to shoulder burdens that are not being placed on businesses in neighboring states. Hawaii may have an advantage over other states in that it is harder for businesses to relocate.

State efforts to control costs through some form of global budgeting will face similar objections. Consider states like Massachusetts, for example, that have high health costs largely because they are internationally renowned medical centers with many teaching hospitals and research institutions. If we in Massachusetts attempted to impose system-wide limits on health care spending without nationally imposed ceilings that applied to all states, we would be met immediately with the argument from our teaching and research centers that we were putting them at a serious competitive disadvantage in their efforts to attract and hold the world's finest researchers.

In short, comprehensive health care reform that guarantees all Americans access to good health care at reasonable cost will not be achieved through state initiative alone. The president and the Congress must act — and act together. In so doing, however, they can learn much from the experience of states that have been willing to take the plunge into uncharted waters.

Northeastern University
Boston, MA 02115 MICHAEL S. DUKAKIS

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