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SPECIAL REPORT

# CONGRESSIONAL QUARTERLY

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## HEALTH CARE'S HOUR



*The Problem,  
The Plan and  
The Politics  
Behind the Call  
For Change*



# HEALTH CARE'S HOUR

SPECIAL REPORT

September 25, 1993

Supplement to No. 38



## TURNING POINT

### LEAP OF FAITH ..... 7

U.S. citizens and their lawmakers are about to plunge into a historic national debate over health care. President Clinton has changed the dynamics of the discussion, to be sure, but he is asking voters for something more. Much more.

|                                      |    |
|--------------------------------------|----|
| Rising Medicare, Medicaid Costs..... | 8  |
| A Century of Debate.....             | 9  |
| Paying for Health Care.....          | 10 |

## FRONT LINE

### PRIMARY CARE ..... 13

On a typical day in the main emergency room at the University of Maryland Medical Center, 130 to 150 people arrive seeking all kinds of treatment. It is a window on the world that Clinton and Congress will face in trying to provide coverage for everyone.

|                                                                                               |    |
|-----------------------------------------------------------------------------------------------|----|
| Who Are the Uninsured?.....                                                                   | 19 |
| Evidence of gaps in the health insurance safety net are easy to spot, not so easy to measure. |    |

## OUTLOOK

### A PROMISE OF SECURITY ..... 23

Clinton's proposal aims to reorganize a market that involves one-seventh of the U.S. economy. He wants consumers to enter into new relationships with providers, relationships that would curb the power - and the profitability - of the health industry.

|                               |    |                        |    |
|-------------------------------|----|------------------------|----|
| The Benefit Package.....      | 24 | Other Legislation..... | 31 |
| Clinton's New System.....     | 27 | State Experiments..... | 32 |
| Changes to the Structure..... | 28 | Around the Globe.....  | 34 |

## PLAYERS

### THE GATEKEEPERS ON CAPITOL HILL ..... 37

Their formal hearing rooms may seem remote from Main Street, but to listen to the men and women who will make or break the Clinton overhaul in Congress is to hear the health-care concerns of the country.

|                                                                                                                                                |    |                          |    |
|------------------------------------------------------------------------------------------------------------------------------------------------|----|--------------------------|----|
| Senate Committees.....                                                                                                                         | 40 | The Clinton Team.....    | 44 |
| Key Members of Congress.....                                                                                                                   | 42 | Congressional Staff..... | 45 |
| The Money Line to Congress.....                                                                                                                | 47 |                          |    |
| The health-care industry has its own raft of political action committees ready to provide hefty campaign contributions to members of Congress. |    |                          |    |
| Top Givers.....                                                                                                                                | 49 | Top Receivers.....       | 51 |

## GLOSSARY

### HEALTH CARE, A TO Z ..... 56

Taking part in the debate on health care requires knowledge of medical jargon, institutional acronyms and Washington bureaucratese. Here is an insider's guide.

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# LEAP OF FAITH



Millicent Collins examines Antonio Simmons, 9, at D.C. General Hospital.

**I**n America, good health is a birthright. It stands alongside education and the opportunity to prosper as cornerstones of the nation's promise to its citizens.

Not so health care.

People view good health as a virtue, health care as an expense. Yet the two are powerfully linked, particularly now, when doctors and technology can restore eyesight, replace hips and kill cancers — indeed, create health. But at what cost? Like education, health has a price. And each person who either relies on the health industry or works in it has a different idea of what it should cost.

Now American voters and lawmakers are about to plunge into an unprecedented national debate on what to do with the U.S. health-care system. As they do, they will find a tangled thicket of economic relationships and conflicting expectations. At the heart of the discussion are far-reaching questions about the government's role in shaping the nation's economic and private life: how to pay for health care for everyone, including those who cannot afford it, and when and where to let the free market rule the system. How much can the country afford? Who decides?

These are the questions President Clinton and Congress will be trying to answer over the next year or more.

This is not to say they will be starting from

*People have  
been talking  
about chang-  
ing health  
care for nearly  
a century*

**by Alissa J. Rubin**

nothing. Health-care "reform" has been a regular player on the national stage for nearly a century.

Progressive-era activists pushed a disease-prevention plan in 1915. President Franklin D. Roosevelt promised "health security" in 1944, a year after three lawmakers introduced the first national health insurance bill in Congress. But

entrenched views dominated and deadlocked the debate for decades.

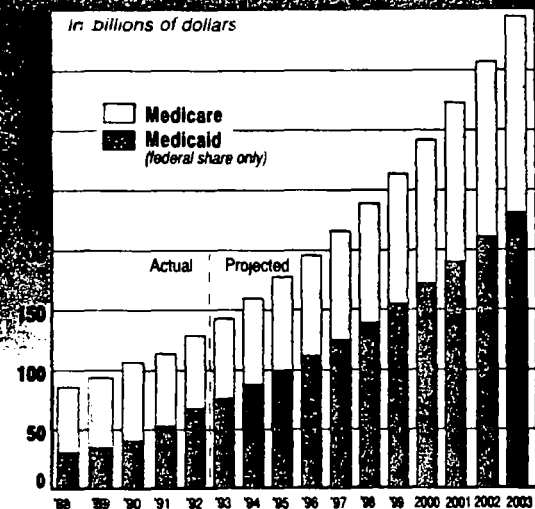
Is something different this year? It is not the system's well-known slights and failures. Indeed, the "crisis in health care" so often discussed in the media — BusinessWeek featured those exact words in a cover story headline in January 1970 — is little worse now than it was five years ago.

What is different is a president who has proclaimed that the defining work of his presidency will be the overhaul of the health-care system and the elevation of health care to a civil right. Clinton's crusade is in the name of economic security and fairness. His appeal is to the country's sense of community and shared destiny, and his goal is to convince people that everyone must give up a little for the greater good.

Also different is the willingness of other players to come to the table. Middle-income workers feel increasingly insecure about health care — indeed, many fear losing the in-

## Rising Medicare and Medicaid Costs

Medicare and Medicaid are the government's fastest-growing entitlements. Medicare spending has soared in the past few years but is expected to reach \$395 billion by 2003. It cost \$129 billion in 1992. Federal Medicaid costs doubled from \$31 billion in 1988 to \$68 billion in 1992 and are projected to reach \$231 billion by 2003.



SOURCE: Congressional Budget Office

MARILYN GATES-DAVIS

health services with a bottomless wallet and an ever-expanding constituency. The programs grew at alarming rates. Now they drive the federal deficit and have dried up the money for other social programs.

At the same time, significant change in health-care delivery will require trade-offs between patient and doctor, provider and insurer, business and government — some of them impossible to imagine. Several proposals

insurance they now have. Employers are feeling squeezed. Doctors are fed up with the paperwork and auditors.

Ironically, the seeds of many of these problems were planted by the government in 1965 when Congress passed this century's most sweeping health legislation, Medicare and Medicaid. Medicare provides government health insurance for the elderly and disabled; Medicaid provides it for the poor. They were created at a time when prosperous Americans believed that big government could cure the nation's ills.

But these programs have since transformed the government into a market force of incredible — and largely unanticipated — proportions. The nation's health-care providers had a buyer of

the doctor a set amount for the visit. But because that amount usually is less than the doctor's cost, the doctor makes up the difference by raising the bills of patients with private insurance. Private insurers boost the price of premiums, which may prompt some customers to drop their insurance. If they drop their insurance and then get sick, they will go to an emergency room, where they will be cared for regardless of their ability to pay. The cost will be covered by the hospital — and, ultimately, by other privately insured patients and taxpayers.

### Consumers and Providers

For most workers and their employers, the system is a web of costs over which they have no control. In addition to out-of-pocket expenses, there are invisible costs: every U.S.-built car includes \$700 for workers' health insurance; 19 cents of every federal tax dollar goes for health care.

The spiral of ever-increasing prices is discouraging to people like Ellen Janssen, the office manager of a small home-improvement company in Wichita, Kan. This year, the company had to abandon its policy of paying for a basic health plan for its employees. It pained Janssen, who negotiated the new plan, that employees who earn less than \$24,000 a year would have to pay for their health insurance. "They are looking at . . . providing for two and three children, and their wives are at home. It's just outrageous what you have to pay for medical care," she says.

It did not used to be this way. When the health insurance business first appeared on the scene in the 1930s, insurance was affordable and widely available. That began to change in the 1960s when advances in medical technology drove up costs.

For the past 10 years, private insurance premiums have galloped ahead of inflation. People are paying more and getting less. Some people cannot obtain insurance at all. Others avoid switching jobs because they fear losing their benefits.

Nevertheless, 85 percent of all Americans still have insurance most of the time. Whether they will embrace fundamental change will depend on how much they trust the government to fashion a system that they can afford and depend on.

Health-care providers, meanwhile, have been resisting change for more than 60 years. With good reason: Almost every sector of the health-care industry has been immensely profitable. Doctors' average net incomes grew by about 6.6 percent annually from 1982 to 1990 — from \$98,000 to \$164,000 — in contrast to the average full-time worker's pay, which grew at a 4.3 percent rate, from \$18,500 to \$25,900.

Hospitals prospered, even in the face of government cutbacks, by sending higher bills to private insurers. Their profit margins have grown 4 percent to 5 percent a year on average

## Clinton's crusade is for economic security; his appeal is to a sense of community.

now under discussion would give more patients insurance but may leave them with less access to high-tech medical tests. Doctors would spend less time filling out forms, but many doctors, hospitals and insurance companies would make less money. No one knows for sure how such changes would affect the overall economy or the job market.

That is because the health-care industry, a vast matrix of local, state and national players, now claims one of every seven dollars in the U.S. economy: 11 million jobs, \$900 billion in annual spending. Change one part, and the other parts shift as well.

Consider how the money flows: When an elderly man in Florida goes to the doctor, he is covered by Medicare, which reimburses

## A Century of Debate

**T**he debate over national health care — and efforts to reform it — began at the turn of the century. The Montgomery Ward Co. in 1910 started the first private health insurance plan for its employees. Progressive-era activists proposed a nine-point reform plan in 1915, emphasizing disease prevention instead of cures. But the issue disappeared for a decade, in part because national health insurance became associated with socialism. It resurfaced in the 1930s during the Great Depression, when Americans could not obtain insurance.



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**1932:** The Committee on the Costs of Medical Care, a privately funded group of physicians and analysts, backs a plan to create community clinics and medical centers across the nation. President Franklin D. Roosevelt later uses the proposal in his drive for national health insurance.

**1935:** Roosevelt's Committee on Economic Security endorses the idea of compulsory national health insurance. Its report is the foundation for the Social Security Act, which passes later that year. But opposition from the American Medical Association sinks national health insurance. The Social Security Act does include money for maternal and child health grants and aid for the disabled, marking the first federal spending on health care.

**1943:** Sens. Robert F. Wagner, D-N.Y., and James E. Murray, D-Mont., and Rep. John D. Dingell Sr., D-Mich., introduce the Wagner-Murray-Dingell bill, which calls for compulsory national health insurance for all Americans, to be financed by a payroll tax. The idea evolves 20 years later into Medicare, the government health insurance program for the elderly and disabled.

**1945-1953:** President Harry S. Truman picks up the campaign for national health insurance. He calls for federal support of new hospitals, maternal and child health, public health and a mandatory universal health-care system. Critics assail the high cost.

**1946-1950s:** Private health insurance companies grow significantly in postwar America and stay strong throughout the 1950s. The idea of national health care is associated with socialism, making it politically unviable.

**1957:** In August, Reps. Kenneth A. Roberts, D-Ala., and Aime J. Forand, D-R.I., introduce HR 9448 and HR 9467, respectively — the first pieces of Medicare legislation introduced in Congress. The bills would provide national health insurance for the elderly, their dependents and survivors, and the disabled. The AFL-CIO supports the idea, but private medical groups oppose it.

**1965:** As part of the Great Society, President Lyndon B. Johnson on July 30 signs into law (PL 89-97) Medicare and Medicaid, the state-federal health insurance system for the poor. The legislation, capping 20 years of congressional debate, is the most important welfare measure since the Social Security Act of 1935. Both programs take effect in 1966.

**1971-1974:** President Richard M. Nixon seeks expanded health maintenance organizations and urges employers to offer health insurance. Congress never enacts the plan.

**1977-1978:** President Jimmy Carter tries to cap the amount hospitals can receive from private and government sources. Congress kills the proposal in 1979 but starts a government commission to study hospital costs.

**1983:** To control costs, Medicare changes the way it pays for hospital care by adopting the "prospective payment system" and "diagnosis related groups," a system that pays hospitals a fixed sum per case based on diagnosis and procedure. The system limits Medicare payments. But hospitals employ "cost-shifting," shifting their unreimbursed costs onto privately insured patients.

**1988:** President Ronald Reagan signs the Medicare Catastrophic Coverage Act into law (PL 100-360), an expansion of Medicare that protects the elderly from catastrophic costs associated with acute illness and provides insurance coverage for prescription drugs. But it forces many senior citizens to pay higher Medicare premiums. They object.

**1989:** Congress repeals the 1988 law (PL 101-230). The budget reconciliation bill puts in place a new system to regulate physician payments under Medicare. Decried by the Physician Payment Review Commission, it is to be phased in from 1992 to 1996. It calculates reimbursements based on the work involved in a treatment and geographical and other factors. Previously, physicians were reimbursed on a "reasonable charge" basis, which did not reflect how much work they did.

**1992:** Health care becomes a hot election issue. President George Bush unveils his health-care reform plan in February, relying on vouchers, tax incentive, insurance streamlining and less red tape. Democrats back several plans, including a single-payer plan and an employer mandate known as "play or pay."

**1993:** In January, President Clinton appoints his wife, Hillary Rodham Clinton, to head the Task Force on National Health Care Reform. He promises a health-care overhaul.

— Brad Wong

## Paying for Health Care

The federal government estimates that typical workers spend about 12 percent of their salaries on their own health care. Here are estimates for 1994 and 2000:

|                                                                               | 1994                                | 2000                    |
|-------------------------------------------------------------------------------|-------------------------------------|-------------------------|
| <b>Average worker's salary:</b>                                               | <b>\$36,299</b>                     | <b>\$50,334</b>         |
| <b>Health bills</b>                                                           | <b>Amount paid for health bills</b> |                         |
| Individual's share of health insurance premiums (employer pays the remainder) | \$969                               | \$1,617                 |
| Medicare payroll tax (1.45%)                                                  | 926                                 | 1,546                   |
| Workers' compensation, disability                                             | 246                                 | 411                     |
| Out-of-pocket expenses                                                        | 782                                 | 1,305                   |
| Other spending at health facilities                                           | 113                                 | 188                     |
| Federal taxes, fees and other payments                                        | 654                                 | 1,092                   |
| State and local taxes, fees and other payments                                | 569                                 | 950                     |
| <b>Total Health-Care Bill</b>                                                 | <b>\$4,259</b><br>(12%)             | <b>\$7,109</b><br>(14%) |

SOURCE: Health Care Financing Administration

MARILYN GATES-DAVIS

since the late 1980s. Pharmaceutical firms posted record earnings during the 1980s, and the health insurance business also has done well.

The turning point came last year, when the three presidential candidates touted reform and Congress signaled that it was going to try to overhaul the system. No group wanted to risk being left behind. Perhaps most genuinely eager for reform were many physicians who, burdened by an explosion of paperwork, had reached a level of disgust with both the government and the private insurance industry. They resent especially the detailed and sometimes irrational measures used to review every aspect of their practice.

Dr. Philip Sumner, a New York rheumatologist, says half of his patients are covered by Medicare, which reimburses him at half the rate of his privately insured patients. Yet Medicare pays the least for the work he considers most significant: a patient's medical history and a careful examination. If he does an X-ray or a more expensive medical test, his reimbursement rate more than doubles. "Ninety percent of what you need to know comes from the history, the physical exam and thinking through the diagnosis," Sumner says. "But Medicare gives you no reward for thinking."

## Government

Then there is the other constituency for change, the U.S. government. Lawmakers want to change the health system because health spending is growing faster than any other part of the federal budget, squeezing out funding for education, public works, environmental safety and other favored causes, including cutting the federal deficit.

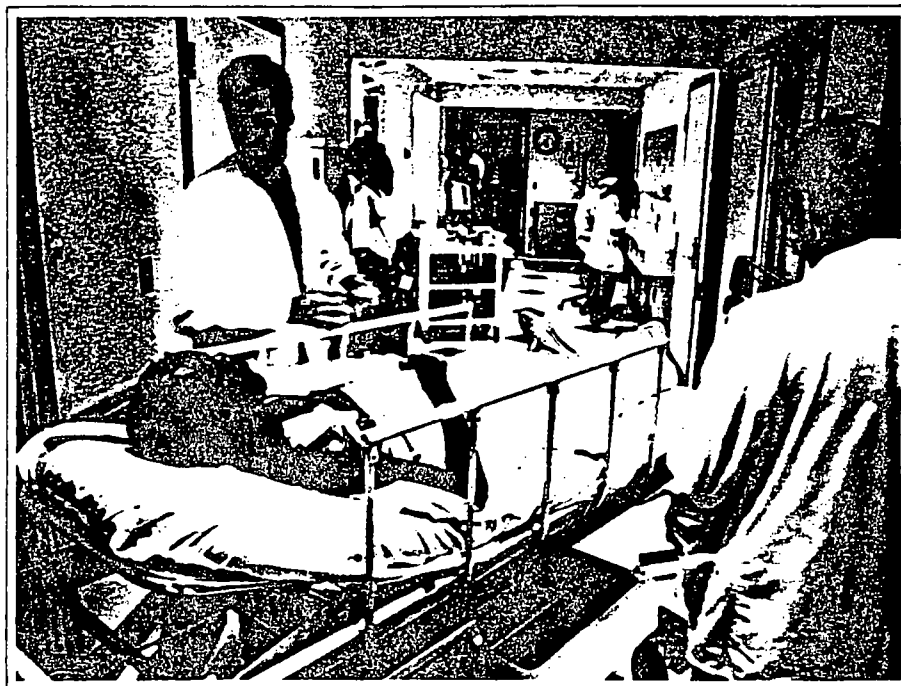
The health system's devastating impact on the federal balance sheet was not anticipated 30 years ago when the government entered the health business. Until then, it had played only a bit part in the health marketplace — paying bills for veterans and federal employees. But Medicare and Medicaid, part of President Lyndon B. Johnson's Great Society, transformed the government into a major force in the health market. Today, these two programs account for nearly 30 percent of the nation's health-care spending.

For that reason, however, Americans have been increasingly suspicious about how much they want the government to protect them from the vicissitudes of the modern-day health-care market. But then, they have a history of such ambivalence. The Social Security program, for instance, emerged in the 1930s at the same time that efforts to create a universal health insurance system died. It seems that Americans who embrace government largess want to rationalize it as a benefit they earned by contributing to society. Hence they accept — indeed,

would not give up — Social Security, unemployment insurance and Medicare. But they often disdain welfare and Medicaid, viewed as handouts to the undeserving.

The tension between market rule and government regulation is further complicated by the subject's emotional valence. When people talk about health care, it is not just a matter of money. It is a matter of who has control over life and death. It touches the deepest human fears. The strong sense that the government needs to do something about costs is set against the fear that more government involvement will leave people unable to control their medical destiny.

President Clinton is asking people to compare what they have now — and what they could lose if they change jobs or become seriously ill — with what they will have under his overhaul plan. But because no one can predict the real world results of his proposal, he must ask the American people to take a leap of faith — much as he did when he ran for election. Whether they take that leap will determine Clinton's place in political history. It also will signal the country's willingness to imagine not a Great Society or a New Deal, but government as architect, completing the circle among the individual, the community and the marketplace.



R. MICHAEL JENKINS

Gordon Jenkins goes to surgery at the University of Maryland Medical Center.

## PRIMARY CARE

**B**ALTIMORE — Tim Holler, 27, sits in the hospital emergency room, wondering aloud how his arm got so swollen.

He is having trouble moving it.

Down the hall, Gordon Jenkins, 52, looks intently at his arm, where a 2-inch lesion has abscessed — the result of 25 years of shooting cocaine.

Close to Holler, a grandmother folds her arms across her chest, staring at the linoleum floor. Her 15-month-old grandson has just been admitted with an AIDS-related seizure.

▼▼▼

It is a typical night in the main emergency room at the University of Maryland Medical Center, where 130 to 150 people arrive daily seeking treatment. The vast medical complex near downtown Baltimore is about a mile from Oriole Park at Camden Yards, home of the Orioles baseball team. Patients come from across the metropolitan area but especially from the nearby West Side urban neighborhood. Some people come from the more

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*by Alissa J. Rubin*

affluent suburbs; they are drawn by the hospital's growing reputation for sophisticated cancer treatment and cardiac care.

A night in the emergency room is a window on the real world that President Clinton and Congress will have to face in fashioning a new health-care system. It is a world of uninsured and underinsured people, where primary and preventive care have been lacking for years, if not generations. These problems abound in big-city hospitals from Atlanta to Seattle and throughout the country's rural areas, where care for children often falls short.

"Health care is expensive in this country because there are no social programs to take care of AIDS, guns, drugs," says Dr. Michael Rolnick, an emergency room physician at the University of Maryland. "What you see here is true primary care, and sometimes it's the only care people ever get."

The Clinton plan assumes that when all Americans have health insurance, they will receive general medical care on a regular basis, creating less need for expensive emergency room visits.

But reducing such visits may be difficult. People afflicted with AIDS and diseases of

poverty — such as drug abuse and tuberculosis — may be unwilling to go in for regular medical care. And emergency room doctors may be inclined to use the full range of medical technology at their disposal to help patients. This can mean a broad use of expensive tests such as CAT scans, a sophisticated type of X-ray. Indeed, the doctors interviewed for this story did not know the cost of an emergency room visit or of any particular test. At this emergency room, the average cost of a visit is \$165.

▼▼▼

**The following events occurred in the emergency rooms at the University of Maryland Medical Center on a Friday night and a Tuesday night in late August.**

**5:50 p.m., Friday:** A call is coming in: A baby is having a seizure; he is being brought directly to the main emergency room instead of being taken to the pediatric emergency room upstairs. Three minutes after the call, paramedics wheel him through the doors. Lying in the middle of the adult-size gurney, he looks tiny; his arms twitch involuntarily. Within seconds, he is engulfed by medical workers: the head of the emergency department, the chief resident and senior resident in emergency medicine, a pediatric resident and nurses. All they know is that he has HIV, the AIDS virus — he got it from his mother — and that he has been treated with the drug AZT. His visit will be paid for by Medicaid, the federal-state health insurance program for the poor.

Byron Browne, physician in charge of the emergency room for the night, looks in on the child. A member of the Air Force Reserve, Browne has an organized and methodical demeanor. A medical traditionalist, he believes that 80 percent of what a doctor needs to know about a patient's condition is learned from the patient, not from sophisticated medical tests. "I listen to everything: what they are saying, what they are not saying and how they talk to you," he says. Sometimes even a gesture can be revealing, he says.

He comes out of the sick bay confident that his team has the infant's seizure under control. "Right now, this is not a terminal AIDS patient," he says.

But the child's grandmother looks fearful. She often cares for the baby because his mother, who is 19, suffers from severe depression. "This is hard," she says. "I lost a son three years ago. He was 11 months old. He had blood clots. He was here four days, and then he died." She looks up with relief when her grandson's doctor arrives; he is one of the hospital's pediatric AIDS specialists.

**7 p.m., shift change:** The nurses, interns and residents coming on for the night

review each case.

Browne oversees the discussion. He goes over every decision, checks up on each patient and wrestles with problem diagnoses. A man with a steady, low-key manner, he often seems the calmest member of the team.

Tonight the patient mix is fairly typical, he says. Of the 20 patients under treatment, five have AIDS-related illnesses, and several more probably have the AIDS virus. He is also treating a kidney-related disorder, a severe case of sickle cell anemia and several aborted suicide attempts.

"We are the safety net for society," says Bob Barish, the chief physician for the emergency department. He rejects the idea advanced by the Clinton administration that if people have family doctors and more primary care, they will make less use of emergency rooms. Under federal law, no one can be turned away from an emergency room or sent to another hospital.

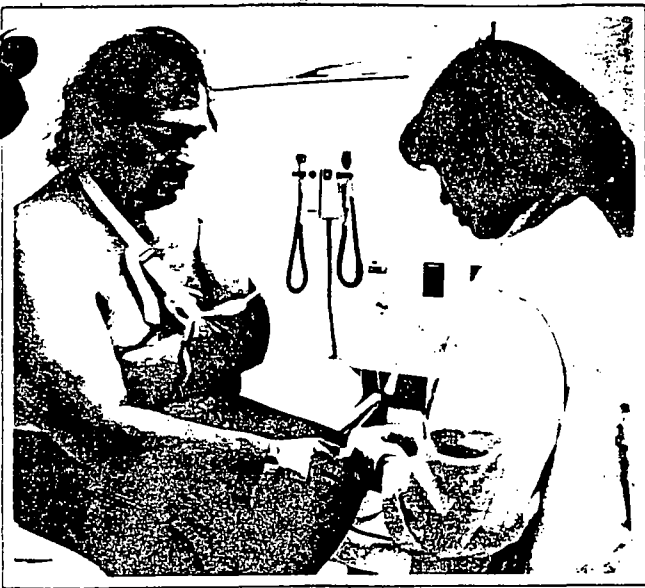
"People want 7-Eleven care," Barish says. "When people want to be seen, they want to be seen."

At this hospital, four emergency treatment areas handle the 40,000 people who come in each year. They include the main emergency room, the pediatric emergency room, the shock trauma center and the "fast track." The trauma center takes those with life-threatening, complex injuries such as those resulting from gunshot wounds and automobile accidents. The fast track deals with comparatively simple problems: broken arms, lacerations, simple infections.

Although an emergency room is the entry point for 40 percent of the hospital's patients, emergency care is hardly a moneymaker. The hospital loses about \$2.5 million on main and fast-track emergency room patients and about \$8.5 million on patients who go to the shock trauma center, according to Bob Chresnik, vice president for finance. Overall, the hospital loses about \$65 million annually on charity care, about

Dr. Brian Browne, emergency room attending physician, reviews patients' conditions with interns and residents, below. Earlier that night, Browne and emergency room physicians had stabilized a baby suffering from an AIDS-related seizure, below, middle.





**I don't make that much money and to have insurance and have a place to live is rough."**

— Tim Holler, patient



PHOTOS BY R. MICHAEL JENKINS

Emergency room staff members look over X-rays taken from patients awaiting treatment, left. Tim Holler, top, came to the emergency room with a swollen arm from an untreated infection. It was his second visit in a week. He works full time as an auto supplies salesman but cannot afford health insurance. Many patients cannot afford medication, so doctors dip into the "drug drawer," above, to give patients free samples left by pharmaceutical companies.

16.5 percent of its billings. Under the Maryland hospital payment system, these costs eventually are borne by taxpayers and patients with private insurance.

**9 p.m.:** Between emergencies, Browne makes rounds, paying special attention to puzzling cases. Although the sickle cell anemia patient could readily be treated by someone

else, he makes a point of seeing her. He wrote the hospital rules for dealing with sickle cell cases and expresses more feeling for them than for any others that evening. The congenital disease, which results in a reduced supply of oxygen in the blood, occurs most frequently in this country among African-Americans.

The sickle cell patient tonight is a 26-year-old black woman. She sits almost motionless in an old leather chair that looks too big for her frail body.

"Where do you ache?" he asks her.

"My legs and back," she says.

"Is this the pain you usually have?"

She nods with difficulty.

"Have you had morphine before?"

Again she nods.

"OK, I'm going to order morphine for you, as much as you want. OK, and we'll find you a bed. You can lie down, and you can have oxygen if you want."

Browne leaves the room. "She is utterly miserable," he says. "Sickle cell is exquisitely painful — every cell in her body is in pain." He shudders. What will happen to her?

"There will be many complications; renal failure is probably developing. And she will die young."

**9:20 p.m.:** Several residents are having trouble figuring out what to do with a young woman with the HIV virus who is having trouble breathing, even with an oxygen mask. She has a deep, rasping cough and keeps spitting up mucus and blood. Browne asks her several questions, but she does not have the breath to answer them. He looks worried.

"Tuberculosis is on everybody's mind with a case like this," he says. It is the one disease that frightens him because it is highly infectious, and the new strains are drug resistant. It can be a killer. "You're not going to get AIDS just by being around a patient with it, but TB, it's infectious. You can get it just by being in the same room; if they are coughing, you are at risk."

**9:30 p.m.:** No one is waiting to be seen. Browne can relax and review patients' charts. But soon the cases pile up again: a young woman suffering from smoke inhalation; a violent man who may be going into shock from a bad dose of PCP, a hallucinogen; a woman with a stroke or an inner ear infection — she is dizzy and having trouble hearing. Close to 11:30 p.m., after supervising another shift change, Browne slips off his white lab coat and heads for home. He has worked nearly 12 hours.

▼▼▼

On another evening the fast track section is almost as busy as the main emergency room. Because of a smaller staff, the wait can be as much as five hours. Tonight, it is close to three hours. Still, the attending doctor, Laura Pimentel, tries to give each patient a few minutes of her undivided attention and care.

The difficulty of treating impoverished patients, however, creates ambivalence among physicians. Walter Bellezza, a second year resident in emergency medicine, says he is frustrated by many patients who use the emergency room as an all-purpose medical center. "Especially in the fast-track area, people misuse the emergency room," he says. "You're caring for a population that won't take responsibility for itself."

But Pimentel points out that the emergency room is open 24 hours a day. "It's true, our patients don't always do what you tell them to. They don't take their medicine, but they are nice, they are grateful. When you stop to hear the stories, some of the living situations some of these people have — the lack of money, the situations that people are in. I find myself often really humbled about how they keep going."

**5:30 p.m., Tuesday:** Little seems to be wrong with Lacey Jones, 20, a mother of two preschool boys who has been vomiting off and on for a week. She is on Medicaid and supports her family with payments from the government's main welfare program, Aid to Families With Dependent Children. She has no regular doctor and uses the hospital's clinics for her kids. Today she arrived for a pregnancy test at the hospital's obstetrics clinic just as it was closing. When no one could see her, she went to the emergency room. Pimentel asks her a few questions



R. MICHAEL JENKINS

Dr. Laura Pimentel, above, puts a fresh bandage on the abscess on Gordon Jenkins' arm. He has been shooting cocaine for 25 years, and his veins recently became seriously infected for the second time.

tion will have to be admitted to the hospital; a woman in Baltimore for a conference caught her heel in the carpeting and fell down several steps at the Marriott Hotel, possibly fracturing her shoulder.

**6:15 p.m.:** Gordon Jenkins, 52, is surprisingly lucid for a man with an infection that could be life threatening. A frail man with a putrid bandage around his arm, he looks around, alert and polite to anyone who tends to him.

Pimentel looks over his chart. He is an intravenous drug user who has developed an abscess from overuse of his veins. Now he has a gaping, oozing wound, the skin and flesh eaten away to the muscle in his arm; the infection has spread from his wrist to his elbow. She shakes her head; he is one of three such cases she will see this evening.

"I don't think this country is facing up to the fact that we have a horrendous problem in the inner city with IV drug use," she says. "The social problems aside, the medical aspects — the complications — are terrible."

She guesses that the infection in the arm may have traveled to his heart, infecting the heart tissue. The cure involves massive doses of antibiotics, to be given intravenously. For Jenkins, that will mean a one-month hospital stay because doctors do not trust him to come in for daily shots. The cost is likely to be \$30,000, and Jenkins has no insurance. But he is lucky.

"Many times the IV users come in too late," Pimentel says. Untreated, they can lose a limb or even die.

Jenkins insists that although he has taken cocaine for 25 years, he is a "weekends only" user.

But medical resident Steve Lucas is dubious. "Mr. Jenkins is sticking needles into himself several times a day," he says.

and then gives her a pregnancy test.

"I don't think there's anything wrong with her," Pimentel says. "She just wants the test." The doctor says that Jones should return to the clinic for the test, but the policy is not to turn anyone away. She is pregnant. The bill, which Medicaid will pay, will be \$117, about 40 percent more than a clinic visit.

**6 p.m.:** A police officer has brought in a rape victim, a man with a scrotal infec-

Jenkins has an appealing and humble manner. "I know, I have no one to blame but myself," he says. He is proud that he has worked his whole life. "I worked at a filling station, and I delivered newspapers, and then Job Corps got me a job running a crane. I never robbed nobody or nothing," he says.

**8 p.m.:** Throughout the evening Pimentel finds herself hunting through the drawer of sample drugs left by pharmaceutical salesmen for ones that might be suitable for patients. The man she just treated has no insurance but needs an expensive antibiotic. "These are \$7.82 per pill; I don't want to give him a prescription for that," she says. It takes several minutes, but eventually she finds something comparable in the drug drawer that she will give him for free.

The patient, Tim Holler, 27, is a brawny automobile supply salesman, who spends his days selling oil and lubricants to garages. He rarely is sick. But a scratch on his arm became infected, and now his arm is so swollen that he has trouble doing his job.

He has no doctor and cannot afford health insurance. "I don't make that much money and to have insurance and have a place to live is rough." He earns about \$16,500 a year. "My company, they don't do no share in that insurance," he says. "You're on your own, so that's pretty rough, especially with the price of bread and stuff. I'm looking for another job just for the health insurance."

▼▼▼

Three days later, the 15-month-old baby died of liver and kidney failure, complications from his HIV infection.

Could the emergency room have done anything more?

"He had optimal management; they were waiting for him to arrive; the team was ready," said John Farley, his doctor, who works in a pediatric AIDS clinic. "There's nothing you can do when the liver and kidney go simultaneously." ■

# AMERICANS IN NEED OF HELP: A LOOK AT THE FIGURES



Many of the nation's estimated 37 million uninsured are low-income people who nonetheless earn too much to qualify for Medicaid.

**I**t is easy to find evidence of gaps in the health insurance safety net.

Newspapers are filled with stories of parents pleading for help because a sick child needs an operation and the family has no insurance.

There was the prominent case of a National Park Service employee in Washington, D.C., who died of a heart attack following the Fourth of July holiday this year, after working a double shift to clean up the Lincoln Memorial. Despite having worked for the Park Service for eight years, his "permanent temporary" status left him without health or life insurance.

Statistics bear out the anecdotes.

In round numbers, about 37 million Americans — 15 percent of the population — were without health insurance at some point in 1991, the most recent year for which estimates are available.

Most of the uninsured were under 65, because nearly everyone 65 or older

participates in Medicare, the federal government's health insurance program for the elderly. Among the non-elderly population, the portion of those uninsured jumps to nearly 17 percent.

And most of them either worked full time or were dependents of full-time workers.

Beyond those broad numbers, generalizations are difficult because the uninsured can be found in all walks of life. Many are people at the low end of the economic scale who nonetheless earn too much to qualify for Medicaid, the federal-state health plan for the poor. But 10 percent of the uninsured in 1991 — nearly 4 million people — had family incomes in excess of \$50,000 a year.

At the same time, the problem is far more acute for some groups than for others. Blacks and Hispanics, young adults and members of single-parent families tend to be without coverage more often than whites, middle-aged Americans and married couples.

## Questions About the Numbers

Identifying just who lacks coverage and for how long is critical to any plan to overhaul the health-care system. Ascertaining precise numbers has proved difficult.

The problem is evident in the variety of published statistics. Most estimates are based on the Census Bureau's Current Population Survey, in which a sample of the population has been asked every March since 1980 about its health insurance coverage.

The common figure of 37 million uninsured in 1991 (actually, 36.6 million) comes from that study. In its analysis of the data, the Employee Benefit Research Institute (EBRI), a think tank in Washington, says that 36.3 million of those people were under age 65. Using the same data, the Congressional Budget Office (CBO) and others say the number of people under 65 who lacked coverage was 35.2 million.

The difference between those two estimates results from using a slightly different formula in counting children's coverage and may appear relatively insignificant, but other questions about the data are more meaningful.

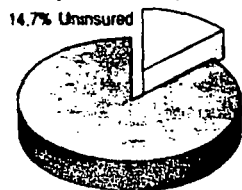
Many experts suggest that respondents to the census survey answer depending upon their insurance status at the time of the survey, not based on whether they were uninsured throughout the year, as the question asks. A separate and more comprehensive census survey of health insurance, last analyzed for a 28-month period during 1987-89, shows that fewer people were uninsured for the entire year of 1988 than the annual census survey showed.

This so-called longitudinal study asked survey respondents about their insurance

## Who Are the Uninsured?

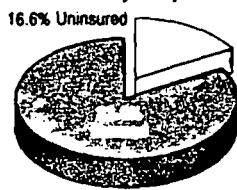
The proportion of the U.S. population without health insurance can be measured in different ways. One method (left) is to measure the uninsured as a fraction of the population at large. Some analysts prefer to remove those who are age 65 and older from the total population, because nearly all elderly citizens are covered by Medicare (center). Others believe a more telling measure (right) is the percentage of the under-65 population who lacked insurance for at least one month during a 28-month span.

**Population snapshot**



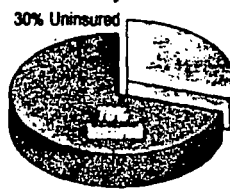
Out of a total population of 249 million, 36.6 million Americans did not have health insurance at some point in 1991.

**Non-elderly snapshot**



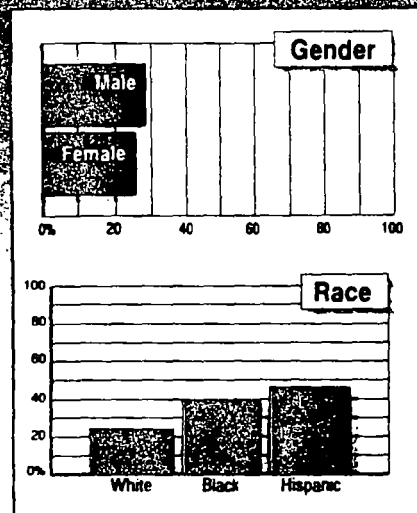
Of the 218 million Americans who were under 65, 36.3 million people did not have health insurance at some point in 1991.

**Non-elderly over time**



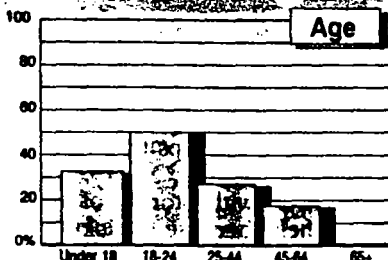
Among the non-elderly population, 61 million people were without health insurance for at least one month during a 28-month period in 1987-89.

## Uninsured Over Time



SOURCES: U.S. Census Current Population Survey; Employee Benefit Research Institute

The 28-month longitudinal survey provides a further breakdown by gender, race and age. It shows that a larger percentage of males lack insurance than do females; that more Hispanics go without insurance than do blacks or whites; and that people 18 to 24 years old are more likely to be without insurance than are other age groups.



MARILYN GATES-DAVIS

status each month.

The longitudinal study also showed that more people than shown by the annual studies may be at risk of losing their insurance. For the 28-month period of the survey, nearly 30 percent of the non-elderly population was found to lack health insurance for at least one month — not 17 percent commonly cited from the the Current Population Survey.

That study "does not capture either the number of people who experience a spell without health insurance during a year or the number of people who are afraid of not having health insurance for a medical

condition in the future," says Katherine Swartz, a professor at Harvard University's School of Public Health and a specialist in health policy statistics.

At the same time, Swartz notes that most people are not without insurance for extended periods. "Almost half of all uninsured spells end within six months and only about 15 percent of all uninsured spells last more than two years," she says.

## Differences Among Groups

A breakdown of the data on who lacks insurance reveals telling differences from group to group.

Often, experts say, differences are related directly to employment: Low-income workers cannot afford to pay their share of coverage; racial minorities find themselves more often in part-time jobs or jobs with smaller companies that do not offer benefits; young adults often take first jobs that do not offer insurance, or choose not to pay for it; older adults often have more stable jobs that provide coverage, or they have children and feel a stronger need to pay for insurance.

**Economic status.** According to CBO, 21.5 million people whose incomes were no more than twice the poverty level had no insurance in 1991. The government defined the poverty level in 1991 as an income below \$14,000 a year for a family of four.

This group accounts for three-fifths of the uninsured and nearly a third of people living at that income level.

According to EBRI, poor two-parent families were more likely to have private health insurance than were poor one-parent families. But the availability of Medicaid made it more likely that one-parent families would have some form of coverage.

**Employment status.** More than half of the uninsured in 1991 resided in families in which the principal member worked full time; only 15 percent had no connection to the work force directly or through a family member, according to EBRI.

But nearly 15 percent lived in families in which the principal wage-earner worked only part time or part of the year, and another 17 percent lived in families that experienced periods of unemployment. And of 20.5 million uninsured workers age 18-64, EBRI says, nearly 13 percent were self-employed and another 40 percent worked for companies with fewer than 25 employees.

At the same time, a fourth of uninsured workers held jobs in companies with more than 500 employees.

by John R. Cranford

# A PROMISE OF SECURITY

**A**t the center of President Clinton's sweeping proposal to overhaul the American health-care system lies an ambitious promise to provide affordable and permanent health insurance coverage for every one.

Not since the New Deal has a president proposed such a grand plan that appears to offer so much to ordinary citizens. But such a system will be expensive, and for a government struggling with an unmanageable deficit, the only way to afford it is to turn to the private sector for money.

Under Clinton's proposal, the government would set in motion new market forces that eventually would drive the system on their own.

His plan would reorganize the market to give consumers the power to control their health-care costs. But to do that, Clinton requires consumers to enter into new financial relationships with health-care providers and proposes restricting the power — and the profitability — of the health industry.

Clinton's plan purports to rely on competitive forces to reduce prices and improve services, but it is backed up by heavy government regulation, including a tight cap on annual increases in insurance premiums.

Administration officials have carefully underscored that the proposal, which has been circulating in Washington since early September, is only Clinton's opening move. But lawmakers say it will frame the debate, much as President George Bush's clean air bill did in 1989. Unlike health proposals by other recent presidents, Clinton's plan is being taken seriously by interest groups and is receiving cautiously optimistic reviews from moderate Republicans, who will be crucial to its passage.



REUTERS

**The first lady and president confer at a White House meeting on Sept. 20.**

*Clinton's plan aims to give consumers the power to control their health-care costs*

**by Alissa J. Rubin**

Preliminary readings produced a barrage of questions on Capitol Hill, signaling that although a majority of lawmakers support reform, they will seek some fundamental changes in Clinton's plan. Among the most controversial issues are whether to include abortion services in the nationally mandated insurance plan and how much employers should be required to pay for their employees' insurance.

Already, White House experts are tinkering with the proposal — the result of about eight months of study by a task force of health experts led by

first lady Hillary Rodham Clinton — to head off criticism from key allies. They made more than 150 changes in the 245-page plan before the president's speech to a joint session of Congress on Sept. 22. "We don't believe that we have all the answers," said Ira Magaziner, the chief White House adviser for health policy. "We're not coming down from the mountain with the tablets."

Despite the lengthy outline, lawmakers and voters may need several months to understand the new system and its impact. The plan does not fit neatly under a rubric such as "managed competition." It draws on aspects of the market-oriented managed-competition system California uses to provide health insurance to many state employees. It takes elements from the Canadian single-payer system, in which the government collects premiums and administers benefits, eliminating the role of insurance companies. And it gives state governments considerable leeway in running their own systems.

## **New Government Requirements**

Anchoring the proposal is an entity created by the government: the regional health

## What Would Be Covered

| Service Covered                                                                  | Definition of Service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Limitations                                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>General</b>                                                                   | Generally, patients in a low-cost-sharing plan such as a health maintenance organization will have to pay a \$10 copayment for each visit to a health-care provider. The maximum an individual would have to pay a year is \$1,500; the maximum a family would have to pay is \$3,000.                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                           |
| <b>Hospital and emergency services</b>                                           | Inpatient, outpatient and emergency room services at a hospital. Includes room and board; therapeutics; and lab, diagnostic and radiology services. \$25 copayment if an emergency room is used in a non-emergency; no other fees.                                                                                                                                                                                                                                                                                                  | No private room accommodations.                                                                                                                                                                                                                                                                                           |
| <b>Physicians and other health professionals</b>                                 | Inpatient and outpatient medical and surgical services, including consultations, in-home, office, ambulatory care or institutional settings. \$10 copayment per visit.                                                                                                                                                                                                                                                                                                                                                              | No private-duty nursing, cosmetic or sex-change surgery, or custodial care. No investigational treatments, but routine medical expenses incurred during an approved research trial would be covered.                                                                                                                      |
| <b>Clinical preventive services</b>                                              | Physicals every three years for those ages 20-39, every two years for those ages 40-65 and annually thereafter. Checkups for young children. Mammograms every two years for women 50 and older. Pap smears and pelvic exams every three years until age 50, then every two years. Cholesterol screenings every five years beginning at age 20. A range of immunizations, including hepatitis B vaccine for children and annual flu shots for the elderly. More frequent tests for high-risk patients. No deductibles or copayments. |                                                                                                                                                                                                                                                                                                                           |
| <b>Inpatient mental health and substance abuse services</b>                      | Comprehensive inpatient mental health services by 2001. Covers inpatient care for psychiatric and substance abuse disorders at hospitals and other residential treatment centers. No deductibles or copayments.                                                                                                                                                                                                                                                                                                                     | Initially, patients would be limited to 30 days per episode, with an annual maximum of 60 days. Health plans could grant more time for patients deemed dangerous. By 1998, the maximum would rise to 90 days. Inpatient care available only when non-residential or less restrictive residential services are inadequate. |
| <b>Non-residential and outpatient mental health and substance abuse services</b> | Partial hospitalization, psychiatric rehabilitation, ambulatory detoxification and home-based services; professional psychiatric and substance abuse services, diagnosis and medical management; substance abuse counseling and relapse prevention; outpatient psychotherapy. \$10 copayment for medical management; \$25 copayment for each psychotherapy session. After 2001, psychotherapy copayments drop to \$10. No other fees.                                                                                               | Greater cost-sharing than with other benefits; this would be phased out by 2001. Initially, outpatient psychotherapy visits would be limited to 30 per year.                                                                                                                                                              |
| <b>Family planning and pregnancy-related services</b>                            | Prenatal and well-baby services. Abortions are covered. No deductibles or copayments specified.                                                                                                                                                                                                                                                                                                                                                                                                                                     | No in-vitro fertilization coverage.                                                                                                                                                                                                                                                                                       |
| <b>Hospice</b>                                                                   | Same as Medicare benefit: nurses' and doctors' care, social services, short-term inpatient care, medical supplies, physical or occupational therapy and speech-language pathology. No deductibles or copayments.                                                                                                                                                                                                                                                                                                                    | Limited to the terminally ill and would be available only as an alternative to hospitalization.                                                                                                                                                                                                                           |

alliance. Funding much of the proposal is a new government mandate: All employers must pay for a portion of their employees' health care.

The health alliance links doctors to patients and moves the money through the local health system. It is not analogous to any existing government or private entity, but it most resembles a public utility board that bargains with the water, telephone and

gas companies to buy services at the lowest price for consumers.

The alliance essentially acts as the broker between consumers and their health care — funneling the money and reviewing the plans to make sure they meet federal requirements. It also gives consumers information about the quality of the plans: whether they satisfied their subscribers and how many customers dropped out. Such an

| Service Covered                                            | Definition of Service                                                                                                                                                                                                                                                                                                                              | Limitations                                                                                                                                                                                                                                                     |
|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Home health care                                           | The Medicare benefit: Nurses' care, social services, medical supplies, physical or occupational therapy and speech-language pathology. The plan would also cover prescribed home infusion therapy and outpatient prescription drugs and biological products. No deductibles or copayments.                                                         | Patient would be re-evaluated after 60 days. Available only as an alternative to hospitalization.                                                                                                                                                               |
| Extended-care services                                     | Inpatient services in a skilled nursing or rehabilitation facility.                                                                                                                                                                                                                                                                                | Available only after an acute illness or injury, as an alternative to hospitalization. Limited to 100 days per calendar year. Custodial care is not covered.                                                                                                    |
| Ambulance services                                         | Ground or air ambulance services. No deductibles or copayments.                                                                                                                                                                                                                                                                                    | Covers air transport only when other means are inadvisable.                                                                                                                                                                                                     |
| Outpatient laboratory and diagnostic services              | Prescribed laboratory and radiology services, including diagnostic services, to those who are not patients of a hospital, hospice or extended care facility. No deductibles or copayments.                                                                                                                                                         |                                                                                                                                                                                                                                                                 |
| Outpatient prescription drugs and biologicals              | Drugs, biological products and insulin. \$5 copayment per prescription.                                                                                                                                                                                                                                                                            | Must be for outpatient use; no special limits on quantities. Health plans would be allowed to establish a list of drugs that physicians could prescribe, and to set up systems of substituting generic drugs, mail-order programs and drug utilization reviews. |
| Outpatient rehabilitation services                         | Occupational and physical therapy and speech-pathology services. \$10 copayment per visit.                                                                                                                                                                                                                                                         | To be used only to restore capacities or minimize limits on physical or cognitive functions after an illness or injury. Must be re-evaluated after 60 days.                                                                                                     |
| Durable medical equipment, prosthetic and orthotic devices | Durable medical equipment; prosthetics that replace internal organs, eyes or limbs; braces for legs, arms, backs and necks; training for these items. No deductibles or copayments.                                                                                                                                                                | Would not cover custom devices. Items must improve functional abilities. No cosmetic orthodontia.                                                                                                                                                               |
| Vision and hearing care                                    | Routine eye and ear exams; diagnosis and treatment for vision defects. Eyeglasses and contact lenses for children under 18. \$10 copayment per visit or per pair of children's glasses.                                                                                                                                                            | No eyeglasses or contact lens coverage for adults; routine eye exams limited to one every two years for people 18 or over. No hearing aids.                                                                                                                     |
| Dental services                                            | Initially, services only for children. Includes treatment for prevention of dental disease and injury, maintenance of dental health and emergency dental treatment after an injury. Adult preventive care would be added by 2001. \$10 copayment per visit. After 2001, \$20 per visit for dental restoration and medically necessary orthodontia. | No cosmetic orthodontia.                                                                                                                                                                                                                                        |
| Health education classes                                   | Education or training that reduces behavioral risk factors and promotes healthy activities. May include: smoking cessation, nutrition counseling, stress management, skin cancer prevention, physical training classes. No deductibles or copayments listed.                                                                                       |                                                                                                                                                                                                                                                                 |

SOURCE: President Clinton's draft proposal

arrangement largely eliminates the traditional role of insurance companies. However, someone still would have to organize doctors, hospitals and clinics into health plans. Insurance companies could do that and handle the paperwork.

State governments would decide how many alliances they need. White House officials said that sparsely populated states such as Montana might have one, while

California and New York might have eight or 10.

Each alliance would bargain with local health plans for low-cost, quality care. Health plans would be made up of hospitals, doctors and other providers, such as physical therapists. Thus, in Toledo, Ohio, almost all consumers in the city and surrounding suburbs would select their health insurance plan from a list provided by the

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The Clinton plan would create a National Health Board, which would set budgets for health alliances and would enforce those budgets.

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Toledo health alliance. The list would include several local health maintenance organizations (HMOs) as well as a traditional fee-for-service plan, in which patients choose their own doctors and hospitals.

Employers, employees and others would pay their premiums to the alliance, which would pass the money to the health plans based on the number of subscribers. The alliance also would monitor the plans to keep premium prices within the budget set by the federal government, which would cap annual increases at the rate of inflation, plus changes in population.

The alliances, to be set up by states, are the first link in a new chain of government oversight. They must be ready to enroll subscribers by 1997.

States must determine where to locate alliances, review the financial solvency of health plans and develop the quality criteria that alliances would use to decide whether to allow a plan to market itself to consumers.

States could opt for a single-payer system in which a state agency would take over the alliance's role; several states have expressed interest in that option.

Backing up the states would be the federal government and another new entity: the National Health Board.

The board, appointed by the president, would set the budgets for each alliance and enforce them. If an alliance exceeds its budget, the board would analyze why. The board would set the national quality standards and update the services that the nationally mandated insurance must cover. Ultimately, the board also would decide what services health plans could cut to meet their budgets.

The following is a look at how the system would work and how money would move through it:

**Patients.** Under the Clinton plan, all citizens would be required to buy health insurance. If they are employed, their employers would pay at least 80 percent of the cost. Part-time workers would be covered by their employers on a pro-rated basis. Retirees from ages 55 to 65 would have 80 percent of their insurance paid for by the government. They or their former employers would pay the rest.

Government subsidies would be available for low-paid workers and the unemployed. Medicaid, the government health insurance program for the poor, would remain in place for poor families and people who receive Supplemental Security Income — the aged, blind and disabled. However, Medicaid patients would obtain their health care through the same health plans as everyone else. Medicare would remain intact for the elderly.

Everyone except illegal aliens would have health insurance by 1997. The insurance, purchased through a local health alliance, would provide coverage for a federally mandated minimum package of benefits — or more. The minimum package is more generous than most plans available today, except for certain union or corporation plans that, for example, require little or no cost-sharing by employees. (*Benefits*, p. 24)

Administration officials underscore that because all providers would offer the same menu of services, consumers would be better able to compare them.

But whether people pay more now or more later depends on what their current plan costs. The employee share of the annual premium would average about \$360 for an individual plan and \$840 for a family plan.

Plans offering a broader selection of doctors or expanded benefits could cost more. A healthy person who has no insurance today clearly would be paying more under the Clinton plan. The reward is that the insurance would be permanent and portable. No one would lose insurance after a job change or loss.

However, those who are out of work would have to pay the full premium — \$360 plus the \$1,440 otherwise paid by the employer. The government would subsidize those who earn less than 150 percent of the poverty level, or about \$10,500 a year.

**Employers.** The Clinton system would be a boon or a burden for employers, depending on whether they currently provide health insurance. For those who do, it could be less expensive; for those who do not, it would cost more.

All employers would be required to pay something toward their employees' health care — regardless of how much they earn and whether they work full time or part time.

Most employers would pay 80 percent of the premium, which administration officials estimate would cost about \$1,440 for a single employee and about \$3,360 for an employee who wants a family plan. Under the proposed financing arrangement for married couples, each spouse's employer would pay only a portion of the total.

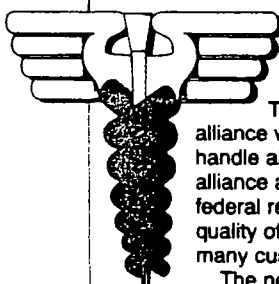
Clinton wants to provide subsidies for employers with fewer than 50 workers, provided employee wages average less than \$24,000 a year.

The portion of payroll that small employers would have to spend on insurance could be as low as 3.5 percent. All employers would be capped at 7.9 percent. Employers currently offering self-insurance plans would have to make their plans conform in most respects to those offered through the health alliances.

# Clinton's New System

## Payers

| Large Employers                                                                                                                                                                                     | Small and Medium-Sized Employers                                                                                                                                                                                      | Consumers                                                                                                                                                                                                                 | Federal Government                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                    |                                                                                                                                      |                                                                                                                                         |                                                                                                                  |
| Firms with 5,000 or more employees can bypass the health alliances and negotiate directly with health plans. They would pay 80 percent of premium costs, up to 95 percent for low-income employees. | An employer pays a health alliance 80 percent of the cost of the average plan. The proportion of payroll that a small company has to pay would have an upper limit, depending on the company's size and average wage. | Consumers join the alliance for their region, paying premiums to the alliance and selecting one of the plans offered through it. The self-employed and those with low incomes would pay a fixed portion of their incomes. | The government pays alliances for coverage for Medicaid and Medicare patients and the unemployed. It would subsidize premiums for those with low incomes and some small and medium-sized employers. |



## The Middleman

### Health Alliances

The new link between patients and their doctors. Each health alliance would represent thousands, perhaps millions, of consumers and handle all the money moving through the local health system. The alliance also would review the health plans to make sure they meet federal requirements. It would give consumers information about the quality of the plans: whether they satisfied their subscribers and how many customers dropped out.

The nonprofit alliance would bargain with local health plans for low-cost, quality care. Sparsely populated states such as Montana might have one alliance, while California and New York might have eight or 10.

Employers, employees and others would pay their premiums to the alliance, which would pass the money to the health plans. The alliance would monitor the plans to make sure they meet budget requirements. The federal government would cap annual increases at the rate of inflation, plus changes in population.

## Health-Care Providers

### Health plans

Health plans offer at least the minimum benefits package prescribed by the National Health Board. The plans could take the form of fee-for-service plans, health maintenance organizations or anything in between. The competition among plans is designed to keep premium costs—and total health-care costs—down. The plans are paid by the alliances.

### HMOs

Private doctors

Insurance companies

Hospitals

Nursing homes, etc.



## Checks and Balances

### Federal government

A new National Health Board would regulate standard benefits packages (as established by Congress) and their costs. The seven board members would be appointed by the president and confirmed by the Senate. The Department of Health and Human Services would oversee the system, determining whether the states are adequately upholding the law. The HHS secretary could dissolve an alliance deemed unfit and could have the federal government take over the system.

### Advisory boards

Several federal advisory boards, composed of health-care professionals and business experts, would be established to deal with such issues as drug prices, doctors' concerns and maintaining quality care.

### State governments

States would be required to implement a plan to provide universal coverage through health alliances by 1997. States would approve all alliance health plans. States could establish a single-payer system, in which a state-run alliance acts as the only insurer. Or states could have several alliances, each with its own territory and each tailored to the needs of its area. State governments would set capital requirements for health plans and would take over if a plan failed.

Marilyn Gates-Davis

## The Wide Reach of Clinton's Changes

The U.S. health-care system would come in for radical changes under President Clinton's proposed overhaul. Here is a snapshot of what would happen to:

### **Antitrust Laws**

Insurance companies would be subject to federal antitrust laws for the first time in more than 50 years. However, the laws would be relaxed for small hospitals that have trouble filling their beds. Joint ventures undertaken by hospitals — such as the purchase of expensive high-technology equipment — would be reviewed on an expedited basis. Similarly, doctors would be able to form networks with hospitals, clinics and other health providers.

### **Auto Insurance, Workers' Compensation**

Consumers and employers would continue to get coverage for auto-related and work-related injuries, but insurers would pay the portion of the premium related to health costs directly to the alliances. Consumers would receive care through their own health plans.

### **Choosing a Physician**

A consumer in an urban area would be able to choose among several health plans. The consumer could choose the plan his or her doctor joins. The type of plan, however, will determine its price. If the doctor works on a fee-for-service basis, the consumer could stay with that doctor but would pay a higher premium. If a doctor joined a health maintenance organization, the consumer could join that plan and pay the standard premium. Otherwise, a consumer would have to choose a new doctor who worked with the plan he or she selected.

### **Employer-Employee Contributions**

Employers would be required to pay 80 percent of the average cost of a health plan in the alliance, with employees paying the other 20 percent. The employee also would pay extra if choosing a plan more expensive than the average. The projected average annual cost of a plan for an individual would be about \$1,800; thus the employer would pay about \$1,440 and the employee, \$360.

For a two-parent family, the employer would pay 80 percent of the average family premium divided by the average number of workers per family in that health alliance. Family premiums are estimated to cost about \$4,200. Thus, for a two-worker family in a region where the average number of workers per family is 1.5 and 80 percent of the average premium is \$3,360, the per worker contribution for each employer would be \$2,240.

Those employees who earn \$10,455 or less a year would receive government subsidies to cover their share of the premium.

The plan would impose a cap on insurance premium increases based on a formula that includes inflation and population change.

Employers with fewer than 50 workers would have their contributions capped at a percentage of payroll —

with the cap ranging from 3.5 percent to 7.9 percent, depending on average salaries. Regardless of size, no employer would be required to spend more than 7.9 percent of total payroll on health insurance.

Large employers who cannot afford to pay for their employees' premiums would be eligible for federal subsidies, which would be phased in over eight years.

### **Health Insurance**

Instead of buying insurance from a health insurance agent or receiving it through an employer, a consumer would obtain coverage through a new entity, a local health "alliance" that would act as a purchasing agent. All plans in an alliance would be required to offer a federally mandated package of health benefits, at a minimum. The alliance plans would have to include at least one fee-for-service arrangement, similar to the kind now paid for by indemnity insurance companies.

Insurance companies could be involved in setting up the health plans, which would be made up of networks of doctors and hospitals.

Companies large enough to write insurance policies for employees themselves could buy into a health plan through an alliance if the companies had fewer than 5,000 employees. Companies with more than 5,000 employees could bypass the local alliance and form a "corporate alliance" to bargain with health plans, as long as the plans met national standards.

Part-time workers would be covered on a pro-rated basis. The government would cover the employer share of premiums for early retirees between ages 55 and 65. The retirees would be responsible for the balance unless their employer agreed to continue paying for their health care after retirement. In that case, the employer would pick up the retirees' 20 percent share.

When people travel and need to go to the doctor on an emergency basis, the bill would be sent to their health plan.

### **Malpractice**

All health plans would have to have an alternative dispute resolution arrangement, which members would have to turn to first if they believed they had been injured by a doctor, nurse or other health-care provider. The consumer would have the right to appeal in a court of law. The plan makes no mention of punitive damages awarded by juries.

Several lawmakers who support changes in federal tort laws want to limit the discretion of juries to award punitive damages.

### **Medicaid**

The joint state and federal health insurance program for the poor would continue to subsidize the costs of poor families with dependent children and those who receive Supplemental Security Income: the aged, blind or disabled. That covers about 60 percent of the total Medicaid population. The government would pay both the employer share of the health alliance premium and

subsidize the employee share.

The remaining 40 percent of Medicaid recipients, who include pregnant women and children and people needing institutional care, would go into the local health alliance.

If they were employed, their employers would be required to pay a share of the premium; if they had no jobs, they would receive subsidies from the federal government.

Overall, Medicaid would be cut an estimated \$114 billion over the years 1996-2000.

### Medicare

The government's health insurance program for the elderly would remain intact, but those with incomes in excess of \$100,000 for individuals and \$125,000 for couples would pay higher premiums for the voluntary "Part B" side of the program, which pays for outpatient physician services.

Medicare would offer two broad new benefits: prescription drugs (see below) and some long-term care, including extended home health care. Over the five years from 1996-2000, the federal government would attempt to slow the program's cost growth, saving an estimated \$124 billion.

### Prescription Drugs

The cost of prescription drugs automatically would be covered by all health plans.

However, health plans would be given carte blanche to establish a list of drugs that they will pay for — for instance, using only generics, where available, instead of more expensive brand-name products.

Patients would have to pay a \$250 deductible for prescriptions, after which they would pay a 20 percent copayment up to a maximum out-of-pocket cost of \$1,000 a year.

The elderly, who receive their insurance through the federally funded Medicare program, would be covered in the same way.

### Self-Employed

Self-employed and unemployed individuals would have to pay the employer share of the premium in addition to the employee share, unless they were eligible for government assistance based on their incomes. The premium payment would be 100 percent tax-deductible.

People who are self-employed are considered small businesses and thus would be eligible for federal subsidies on the employer share just as a small business would be.

### Tax-Deductibility

Employers and employees would be able to deduct the premiums they pay for the standard benefit package, but both would be taxed for benefits that go beyond the national standard package.

Currently, employers may deduct all health premium payments. An exception would be made for benefits that were in place in January 1993, which would be tax-exempt for 10 years; this is an issue of special importance to unions that have negotiated con-

tracts with generous health benefits in lieu of pay increases.

### Uninsured

Everyone who qualifies for health coverage — "American citizens, nationals, legal residents and long-term immigrants," as listed in the Clinton plan — would have to enroll in a health plan through a local health alliance.

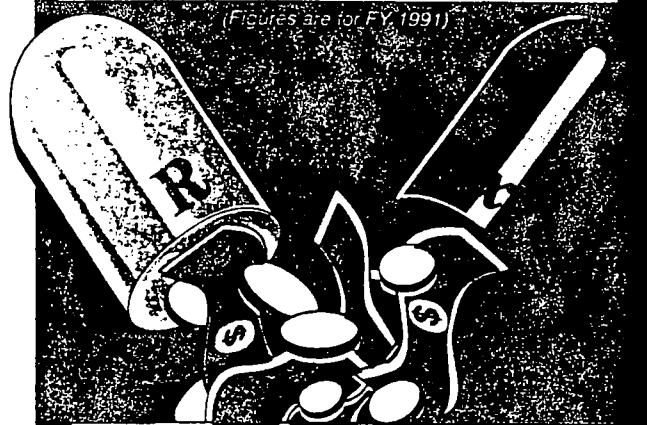
Individuals or families would be required to pay 20 percent of the average premium for the plans offered by that alliance.

Families and individuals with incomes below 150 percent of the federal poverty level would be eligible for federal subsidies. The poverty line in 1993 for a family of three is \$11,890; 150 percent of that is \$17,835.

Illegal immigrants with no regular employment would be prohibited from enrolling in a health-care alliance. However, they still could go to hospitals or outpatient clinics for emergency treatment.

### Health-Care Spending — Public and Private

(Figures are for FY 1991)



Americans pay for health care through 10 sources of money, including private insurance, Medicare and Medicaid. Health care costs about \$900 billion a year. Close to half the funds in the health-care pot are government dollars, paid largely by taxpayers. The other half are private insurance and consumer dollars. Each source covers a certain population and represents an array of political interests.

In billions of dollars

| Government                                |          |
|-------------------------------------------|----------|
| Medicare                                  | \$ 122.8 |
| Medicaid (federal)                        | 65.8     |
| Veterans                                  | 12.2     |
| Department of Defense                     | 12.8     |
| Indian Health Service                     | \$ 1.2   |
| Other federal government spending         | 17.6     |
| Medicaid (state)                          | 44.6     |
| Other state and local government spending | 62.4     |

| Private                         |          |
|---------------------------------|----------|
| Private insurance and consumers | \$ 388.6 |
| Workers' Compensation           | 30.0     |
| Auto insurance                  | 13.0     |

SOURCES: Health Care Financing Administration; American Insurance Association

MARILYN GATES-DAVIS

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Abortion will continue to be a divisive issue. Some lawmakers are upset at the thought of covering abortions in a national benefits package; others would be upset if abortions were not covered.

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**Providers.** The Clinton proposal would have the greatest impact on health-care providers: doctors, hospitals, other professionals, the technology industry and insurers. The new cap on the annual increase in insurance premiums, designed to halve the current 11 percent health-cost inflation rate, would force providers to reduce profits and limit salary increases. Some health professionals — especially non-physicians, such as nurses and physician's assistants — may have more job opportunities, but the health industry in general would see fewer profits. Medical practices would have to become more cost-conscious — a radical change in a culture that traditionally puts care above cost.

Clinton's new marketplace relies heavily on a controversial reorganization of the medical system into "health plans." Currently, most Americans choose their own doctors. If specialized care is needed, the doctor refers the patient to someone the doctor knows; if hospitalization is needed, the patient is sent to the hospital where the doctor can admit patients.

Under the Clinton system, doctors would be pressured to work for managed-care plans — largely because they would cost less than other plans and many patients would choose them. An HMO is an example of a managed-care plan, which features a "gatekeeper" to specialists, expensive tests and hospitalization. Subscribers are required to see primary-care doctors, who refer them to specialists who work for the plan and to hospitals affiliated with the plan. This is a fundamental departure from current practice, and critics say it intrudes unnecessarily on the day-to-day practice of medicine. However, several policy experts say medical practice must be streamlined to save money.

The Clinton plan does include provisions that providers are likely to favor. It cuts administrative paperwork. Doctors would use a single form for billing. The proposal also provides limited malpractice reform and relief from the threat of antitrust action.

#### Financing

Over the next seven years, the government expects to save or raise \$441 billion, spend \$350 billion on new health costs and use the remaining \$91 billion to reduce the federal deficit.

The relatively low price of \$350 billion — about \$50 billion annually — would be achieved largely by relying on the private sector. The government would finance its share through savings in existing programs, "sin" taxes and increased tax revenues — including a payroll tax of up to 1 percent on large corporations that choose not to join a health alliance. The govern-

ment expects that employers would spend less on health care, resulting in higher taxable profits.

Almost every aspect of the financing is controversial. The employer mandate is unpopular on the Hill, although from Clinton's standpoint it avoids a new tax that surely would be rejected beyond the Beltway. "Sin" taxes on cigarettes — up to \$1 a pack — are unpopular with lawmakers from tobacco states.

Under the Clinton plan, Medicare would save \$124 billion over seven years — a cut twice as deep as the one just put in place by the Clinton deficit-reduction bill (HR 2264 — PL 103-66). That would further reduce payments to doctors and hospitals. Many lawmakers have criticized such deep cuts.

Medicaid would save \$114 billion over seven years. A portion of the Medicaid program would cease to exist as beneficiaries entered health alliances. Some of the "savings" would be transferred into the new health system to pay for subsidies for small businesses, the poor and the uninsured.

The plan would give the federal government extensive power to regulate health-care prices and mandate how much money businesses spend on employees' health care.

The federal government would enforce overall budgets and employer mandates. It also would set national quality standards and redirect the medical profession into the field of primary care. State governments also would have broad regulatory powers. Enforcement power over the system as a whole would rest with the Federal Trade Commission and the departments of Labor, Justice, and Health and Human Services.

#### Divisive Issues

The note of optimism on Capitol Hill about the proposal reflects broad support for changing the existing health system. But several hot-button issues stand in the way.

The most obvious include the employer mandate, the Medicare cuts, and the cap on national health-care spending enforced by a cap on insurance premium increases.

Many lawmakers are upset by the prospect of covering abortion services in the nationally mandated benefits package. Others would be equally upset if abortion were not included.

But perhaps most frightening to consumers — and potentially most politically damaging — is the specter of rationing. The Clinton plan describes an expansion in health services, but many economists believe that to meet the tight budgets, individual health plans would have to cut back on medical tests and sophisticated treatments.

"It's going to be a roller coaster," Magaziner said. "There is going to be a crisis a day or a hundred crises a day . . . but we think a coalition will come together." ■

## Plenty of Irons in the Fire

When Congress takes up President Clinton's health care overhaul proposal, dozens of other health bills already will have hit the hopper, each carrying its sponsor's hopes of influencing the reform effort. Clinton's plan most likely will supersede all others. The rest serve as rallying points and help define the debate.

The House breaks down into three general camps: liberal Democrats who support a single-payer system in which the government provides health insurance; conservative Democrats who support solutions close to Clinton's modified managed competition plan; and Republicans, many of whom favor only peripheral changes to the system.

Senate liberals support a single-payer plan; conservatives favor adjustments to the existing system. Among moderates, Democrats support Clinton; members of the Senate Republican Health Care Task Force support a plan similar to Clinton's but with less emphasis on regulation.

### Single-Payer Plans

The leading single-payer plan is legislation (HR 1200) sponsored by Rep. Jim McDermott, D-Wash., under which the government would collect insurance premiums and administer health benefits for everyone. Private insurers could not offer the benefits in the national plan. Supporters say this is the only system that will dramatically cut costs.

McDermott's proposal requires states to set up health security programs to qualify for federal health funding. All U.S. citizens, nationals or resident aliens would be eligible for coverage.

States would issue health security cards and set up ways for people to enroll in the system. People needing medical attention or buying prescription drugs would present the card as proof of enrollment, and the health care provider would bill the state insurance program.

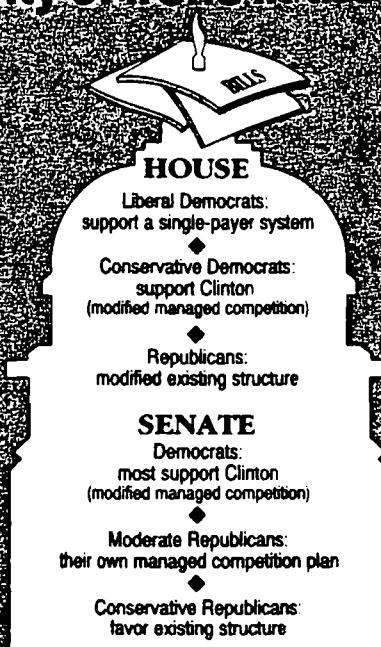
The plan also includes a national health budget achieved through such means as drug price controls. McDermott's plan includes an increase in corporate and individual income tax rates, a payroll tax based on salaries and a surtax on incomes of more than \$1 million.

Paul Wellstone, D-Minn., has introduced a similar bill (S 491) in the Senate.

Another single-payer plan (HR 2610), sponsored by House Ways and Means Health Subcommittee Chairman Pete Stark, D-Calif., would expand Medicare from serving the elderly to serving everyone. Stark includes spending caps through federally mandated payment ceilings for health care and state payment control systems. He expects that the savings from such a system would finance its costs.

### Managed Competition

The managed-competition camp has not introduced a bill; it is awaiting Clinton's plan. A bill introduced the



September 22 by Rep. Jim Cooper, D-Tenn., and the Conservative Democratic Forum (HR 2936) laid out the common ground of many conservatives and moderates. It included the creation of quasi-public health insurance, purchasing of coverage, and universal coverage.

Cooper's plan pays for itself by eliminating the tax breaks for employer-paid health insurance, whereas Clinton's plan funds by mandating that employers pay an insurance premium for their workers, based on wages.

Meanwhile Sen. Nancy Kassebaum, R-Kan., has introduced the bipartisan Basic Care plan (S 751) which would require every insurer to offer a uniform benefits package. It would be paid for by a 2 percent addition to the Social Security tax.

Twenty-three members of the Senate Republican Health Care Task Force, led by John W. Chafee, R-Rhode Island, have released their plan, also due three years from work. The plan supports universal coverage in theory but goes only as far as requiring universal access to health care instead of Clinton's forcible access and the more ambitious task force members prefer restrictions on the tax deductibility of expensive insurance plans.

### Other Plans

Sen. John D. Rockefeller IV, D-W.Va., has introduced a bill (S 145) that would boost the percentage of primary care physicians compared with specialists by restricting to 50 percent the proportion of residencies that could be done in medical specialties. One-third of doctors are primary care physicians.

Of the House's 535 GOP members, 106 have signed on to the leaders' Health Care Task Force report, which renounces the goals of the health care system but makes no major reforms. The plan would require all employers to offer their employees insurance but would not require employers to pay for it. It includes no universal coverage mandate. The plan reform the medical liability system, simplify rules for malpractice and trust restrictions, it limits the ability of insurance companies to refuse coverage or charge different rates to different customers. It allows low-income consumers who do not qualify for Medicaid to buy into the Medicaid system.

The plan pays for itself by raising the federal retirement age from 65 to 67 and by phasing out Medicare subsidies for high-income individuals and families.

Conservative Republicans, such as Sen. Phil Gramm of Texas, favor elements of the current system. Under one proposal, employers would be required to either offer their workers a basic health plan or put the money in a health savings account. If the money were not needed for health costs by the end of the year, employees could withdraw it and use it for other purposes.

— Thomas H. Moore and Matthew T. Phillips

## Some States Get Ahead of the Game

**B**urgeoning costs have led many states to adopt incremental changes to their health-care systems, such as setting hospital rates or expanding coverage for the children of low-income families. But such changes only pick at the problem. Seven states have attempted a comprehensive overhaul: Florida, Hawaii, Massachusetts, Minnesota, Oregon, Vermont and Washington.

The major reforms try to provide coverage for all residents. Some states are moving toward a "play or pay" system, which requires employers to provide a plan for employees ("play") or to pay into a state insurance fund. Other states have adopted "managed competition," in which health alliances are created to organize consumers into blocs that have some leverage when negotiating health benefits with insurance companies.

The federal deficit-reduction bill enacted in August, however, has presented a major obstacle for Minnesota and Oregon. Their plans depended on obtaining waivers from the federal Employee Retirement and Income Security Act (ERISA), which pre-empts state employee benefit plans. The waivers were struck from the bill, although they may be approved in a separate bill this fall.

**Florida.** Florida has adopted a voluntary version of managed competition, which uses group purchasing power to force insurance companies to compete for large blocs of customers. The plan commits little state money. Its goal is to provide universal access to a basic health-care plan by December 1994.

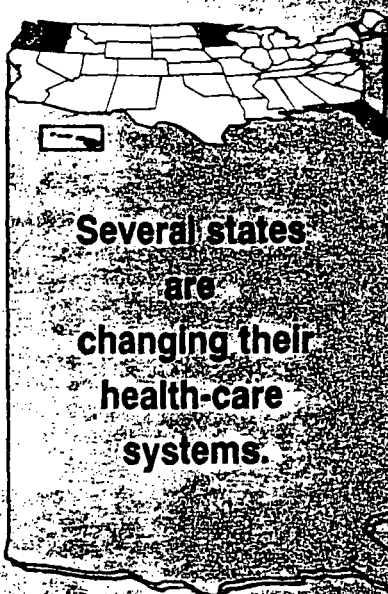
The plan creates 11 Community Health Purchasing Alliances (CHPAs, or "chippas"), which act as matchmakers between insurance plans and employers but do not insure or contract between parties.

Florida is also creating Med Access to provide coverage to uninsured people whose incomes are too high to qualify for Medicaid. Med Access is supposed to cover its costs by collecting premiums from those covered.

**Hawaii.** Hawaii made its first attempt at universal coverage with the Prepaid Health Care Act in 1974. The act required employers to provide health insurance for all employees who worked more than 20 hours a week. Hawaii's plan began before passage of ERISA, which bars states from regulating employers' self-insured health plans. The state was given an exemption.

Hawaii received a Medicaid waiver in July 1993 to create the Hawaii Health QUEST Program, which bundles state and federal health insurance funds to provide coverage to Medicaid clients and the uninsured. It establishes a "managed cooperative" setting pitting managed-care firms against each other in bidding to provide services.

**Massachusetts.** Former Democratic Gov. Michael S.



Dukakis pushed the nation's first play-or-pay plan through in 1988, but the collapse of the state's economy has forced a delay until 1995. This year, the legislature may choose to delay its start-up again—or to scrap it.

**Minnesota.** Last year the state started approving programs that make up its comprehensive reform package, dubbed "MinnesotaCare." Under MinnesotaCare, doctors and hospitals either contract with the state's new integrated service networks (ISNs)—entities similar to health maintenance organizations—for reimbursement or choose reimbursement from a system in which rates are regulated by the state.

Other provisions include publicly subsidized coverage for low-income people without insurance, a state-sponsored health insurance purchasing pool for small businesses and a state tax deduction for the self-employed.

**Oregon.** Oregon's program contains some of the nation's most radical reforms. Its play-or-pay provisions mirror those of Massachusetts.

The most controversial part of the plan would expand Medicaid eligibility, bringing in everyone below the poverty line. The Clinton administration recently approved that expansion. But to pay for it, Oregon plans to strike some medical procedures from the list of what Medicaid covers. The more money allocated to Medicaid by the state each year, the further down the list the state can reach in its coverage. But conditions and treatments below the cutoff would not be funded, leading the plan to be dubbed Oregon's "rationing experiment." For example, in a given year the plan may cover vaccinations, but not organ transplants.

**Vermont.** The state created a commission in 1992 to design models for universal health coverage: a single-payer plan and a managed-competition plan. The legislature will choose one in 1994. The state already requires insurers to offer a single premium to all customers within a geographic market (communitywide premiums) and will begin setting a global health-care budget for the state in 1994.

**Washington.** This plan is closest to the reforms proposed by the administration. By July 1, 1999, all residents will have a minimum package of health-care benefits administered through a managed-care program, in which doctors must follow guidelines on the treatments they can offer. Employers must cover employees and their dependents, with coverage prorated for part-time employees. A system of managed competition is designed to keep down costs by having insurers compete on price. A premium cap will limit what even the most expensive plans can charge.

—Thomas H. Moore

## Health Care Around the Globe

Virtually all other industrial nations provide some form of national health care for their citizens. Here is a sampling of how other countries approach health care.



Canada may have the foreign health care system best known to Americans. It is an example of a single-payer system, in which the government is the sole insurer. The system's broad outlines are dictated by the federal government, but Canada's 10 provinces and two territories handle details and administration. Physicians remain in private practice, and most hospitals are nonprofit rather than government owned. The government raises revenues through personal, corporate and sales taxes.

Canada's system provides ready access to high-quality care at a reasonable cost. It does this through aggressive cost containment, generally by limiting fees that hospitals and doctors may charge. That keeps overall health care costs below a global cap. Canada employs other cost containment techniques, including the rationing of "billing numbers." Doctors need such a number to be reimbursed by the government. Rationing effectively limits the number of practicing physicians; the idea is that with fewer doctors, total health care costs will be lower.



Germany's health system got its start in 1883 and survived the country's battering in two world wars. The big challenge now stems from West Germany's winning the Cold War—and taking in East Germany.

East Germany ran a centralized system, with government-owned hospitals and government-employed doctors. With difficulty, it is now being folded into the West German system, which features independent, nonprofit, government-regulated health insurers, known as "sickness funds." Those funds collect premiums and pay medical bills.

Germans join funds based on where they work or live. Doctors must join one of the regional sickness fund physician organizations, which set standards for medical care and control how doctors are paid. The sickness funds and the doctors groups work closely to make the system work.

The German government imposes a global cap on health expenditures, linked to growth in wages and salaries. The government is otherwise limited to determining the broad outlines of health policy, acting as the final arbiter in disputes and financing hospitals' capital expenses.

Germany supplements its health care plan with one of the world's most extensive social welfare systems. Social security and health care add up to almost a third of Germany's gross national product.



With the fall of the Soviet empire, Great Britain now has the world's most centralized health care system. Most countries place some responsibility for

care on state provisions of the private sector, but Britain is fully administered by the national government.

The system is based on four principles: Care must be universal, free at the point of service, comprehensive and paid for by taxes. The government owns most hospitals and employs most doctors. The system is almost fully financed by general taxes; very little money ever passes between care givers and patients.

The British plan, which expects health care costs to flow proportion of the country's GNP, also produces long waits for some elective services. The government embarked on a reform plan in 1990 designed to provide competition within the system and increase public satisfaction while keeping costs down. These reforms are only now getting under way.



Japan looked to Europe, particularly to Germany, when setting up its health care system early in the 20th century. It has been influenced by other systems as well. Insurance is universal and based on employment. It involves a dense web of private and public payers, financed through a payroll tax and employer mandate.

Japan employs variation on the "pay or pay-into" idea, in which companies must either provide health insurance for their employees or pay into a government-run insurance fund, which also covers the unemployed. Private insurance exists only to cover supplemental expenses.

Like Americans, the Japanese choose their own physicians. But Japan's government plays a much greater role in private health care delivery than does the U.S. government. It sets the rates that employees and employers pay, sets drug over-fee and drug prices, and decides what must be included in health care packages.

Through the combination of approaches, Japan keeps its costs considerably lower than those of the United States. To further control costs, Japan now requires patients to pay a percentage of their bills.



Dutch health insurance has been heavily influenced by Germany. In 1912, a universal coverage plan, filled in with German links, ailing World War II, Germany set up the plan as a way to promote good will toward Nazism.

After the war, the Netherlands kept the system in which employer-based sickness funds cover most people. The wealthy can opt out and pay for private insurance. A separate plan covers government employees. Long-term care is provided by yet another plan into which all must contribute. The sickness funds are financed by income-based premiums from employers, employees, retirement funds and unemployment benefits.

The Dutch are attempting to pull more of their system into the private sector. The government reform blueprint is to move away from comprehensive coverage for most toward basic coverage for all. Individuals could buy private supplemental insurance for items not covered.

—Thomas H. Moore

# THE GATEKEEPERS

*To listen  
to the two  
House panels  
is to hear  
the concerns  
of the  
country.*

When President Clinton sends his health-care legislation to Congress this fall, the men and women who could make or break it will be lawmakers, little-known outside Washington, who sit on a few congressional committees. They will be the gatekeepers to Clinton's effort to overhaul the nation's health system.

Their formal hearing rooms may seem remote from Main Street, but to listen to the members of the two panels in the House — the Ways and Means Subcommittee on Health and the Energy and Commerce Subcommittee on Health and the Environment — is to hear the health-care concerns of the country. The voices of the Houston ghetto mingle with those of Tampa's retirees, while the concerns of Iowa farmers race off against those of affluent suburbanites around San Francisco Bay.

This geographic and demographic diversity offers both a challenge and an opportunity to President Clinton. In many respects, he could not have a better political laboratory for testing his proposals. But from the moment the panels begin working on his bill, Clinton will confront the legislation's political conundrums and entrenched constituencies. Nothing will be easy.

"I think we will examine the president's proposal from every possible perspective — rural, urban minorities, providers, fiscal conservatives," says Henry A. Waxman, D-Calif., chairman of the Energy and Commerce Subcommittee. And beyond the political futures riding on the outcome, each member will feel a personal stake in the debate on health care because it is undeniably an issue that is a matter of life and death.

Waxman has to look no further than his own panel to see the diverse interests that

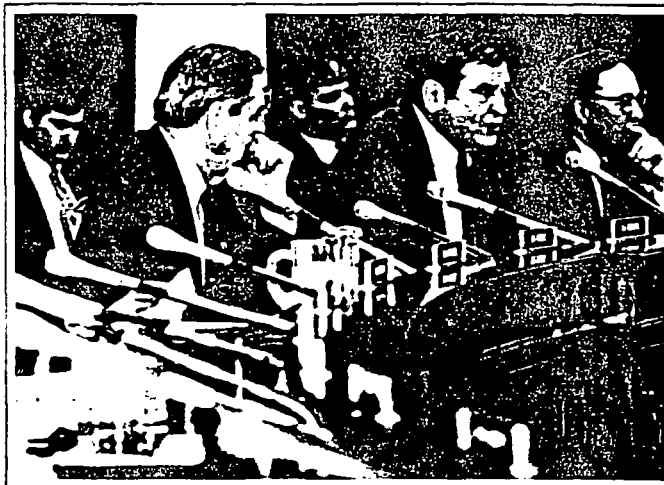
must be satisfied. To his right sits Mike Kreidler, an eager freshman Democrat who represents the bedroom communities east and south of Seattle. An optometrist with a graduate degree in public health, Kreidler speaks as a health professional. But as a representative of Boeing Co. union members and the Tacoma shipyards, he knows that blue-collar workers want to keep their benefits.

Next to Kreidler sits Jim Slattery, a parsimonious Kansas Democrat who represents struggling rural towns with names like Severance, Independence and Enterprise: towns whose residents descended from the pioneers who went out West on the Cheyenne Trail. Doctors and public health clinics are few in the wheat and grazing land of Slattery's district. Improving rural health care will be a key issue for him.

To Waxman's left sits Thomas J. Bliley Jr., the committee's almost shy ranking Republican. A former mayor of Richmond, Va., Bliley recently surveyed his middle-class, urban-suburban district on what changes his constituents wanted in health care.

The answer: to carry over their insurance when they change jobs and to have a guarantee of continued coverage when they get sick. He embraces a gradualist approach to change, as do many Republicans. "I don't believe we can do the big blast in one bill in one year," he says. And he adamantly opposes the one tax the administration advocates to finance the proposal: a cigarette tax. The largest employer in Bliley's district is the Philip Morris tobacco company.

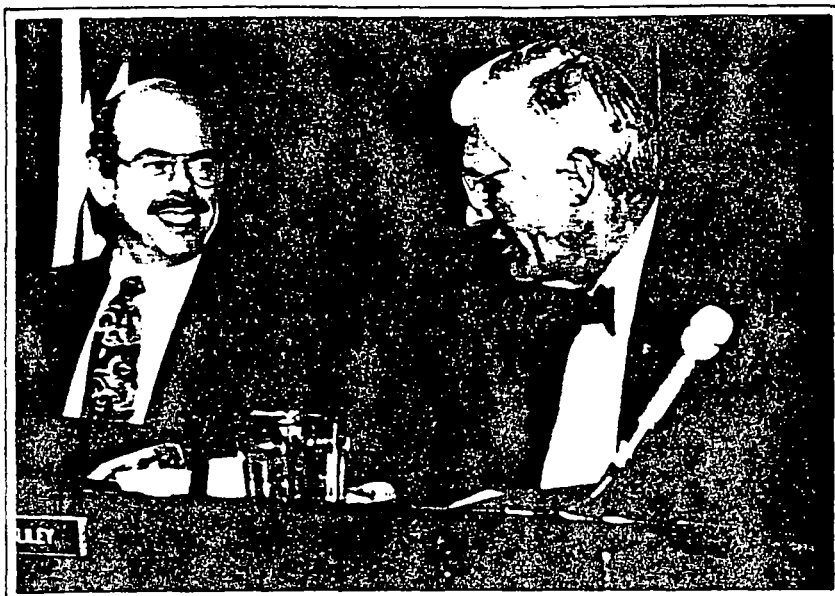
Many other leaders of the major factions in the health-care debate sit on these two panels, making them particularly sensitive barometers of the House. Among those



R. MICHAEL JENKINS

**The first place President Clinton's health plan has to go is to the powerful House Ways and Means Committee.**

**by Alissa J. Rubin**



Waxman, left, says his committee will examine the president's proposal from every perspective; Bailey embraces a gradualist approach to change, as do many Republicans.

members are incrementalists, supporters of a single-payer system, believers in managed competition. Others include leaders of the Congressional Black Caucus, the Congressional Hispanic Caucus, the conservative Democrats and the House Republicans.

"It's safe to say that if you can't build a consensus on our subcommittee, it's going to be hard to build a consensus on the floor," says Ron Wyden, D-Ore., of Energy and Commerce, a health-care moderate who is likely to help broker a deal among the factions.

Because House rules sharply limit the ability of individual members to influence legislation on the floor, crucial decisions will be made in committee.

Major battles are likely between liberals, like Waxman, who push for broader benefits for the needy, and deficit hawks, like Slattery and Alex McMillan, R-N.C., who warn that the country can no longer afford to be generous. A second battle will be waged between traditional Democrats and a bipartisan bloc of moderates about whether to put caps on health spending or otherwise regulate the industry. A third issue involves whether to mandate that businesses pay for health insurance for their employees.

In all these struggles, the health subcommittees will wrestle with another problem: Traditionally, they have been left to work on federal health policies with little interference. This year they will have to be sensitive to the goals of the White House, the diverse Democratic Caucus and the moderate Republicans — a far more conservative spectrum than they usually seek to please.

And they will aim to overhaul not only the government's big Medicare and Medicaid programs, but the entire private-public system of health-care financing and delivery.

"There will be a great deal of pressure

on the committee chairmen to do the work of the party," says Steve Smith, a political science professor at the University of Minnesota who specializes in committee politics. "That's not always true on legislation from those two committees."

### The Leadership

At first glance, it is hard to imagine four more different politicians than the chairmen of the two subcommittees — Waxman and Ways and Means Subcommittee Chairman Pete Stark, D-Calif. — and the chairmen of their parent committees: John D. Dingell, D-Mich., on Energy and Commerce, and Dan Rostenkowski, D-Ill., on Ways and Means.

A closer look reveals common ground. Stark and Waxman — the patrician WASP banker and the Jewish grocer's son — are both Californians. They share a concern for the elderly and believe in the liberal Democratic ethic that government regulation keeps moneyed forces in check. "I don't think Henry and I split our votes even one out of 50 times," Stark says. But whereas Stark is an outspoken iconoclast who lambastes witnesses before his subcommittee and sets himself up as a White House adversary, Waxman is reserved. He says little during debates and has been reluctant to criticize the White House before he sees Clinton's plan.

Rostenkowski and Dingell, at times competitors for power in the inner world of House politics, are brothers under the skin. They are the last of a dying breed of politician: House barons produced in the heyday of machine politics in the Midwestern union strongholds of Chicago and Detroit. They rule their committees with the power of kings, bartering favors — a line in a bill, a special project in a district — for support. They are masters at crafting deals that win the votes to pass a bill.

Both men have a longstanding interest in health care, but for Dingell it is also a personal crusade. It dates to his father's successful battle with tuberculosis and ensuing efforts to create a national health-care system guaranteeing coverage for all. Rep. John D. Dingell Sr. introduced such a health bill in 1943.

All four men share a sympathy for a single-payer system, in which the government would coordinate health-care financing. "If you got those four guys in a room, you could have an agreement on a health-care deal in half an hour," says John Rother, chief lobbyist for the American Association of Retired Persons. "Their styles are different, but in terms of where they would like to see it turn out, you're dealing with a remarkably constant set of values."

But the process does not work that way. These four men cannot write the bill, which must be hammered out first by the panels

they lead. And the members of each panel reflect a much more diverse set of views and values than do the chairmen.

### Ways and Means

Most of the 11 members of the Ways and Means Subcommittee on Health come to the debate with deeply held views on health care. A majority for any plan may be hard to find. The seven Democrats split three ways on the best way to approach the overhaul: adding to the friction are new and deepening partisan divisions. For the past 10 years, former Rep. Bill Gradison of Ohio, a moderate Republican and a health-care expert, served as the panel's ranking member. He worked with Democrats to reach policies both sides could support.

But the new ranking member is Bill Thomas, a conservative Californian from the oil and agriculture-rich district that includes Bakersfield. He seems to enjoy party differences.

Thomas and Stark have little good to say about each other. "Bill Thomas is aggressively partisan; he's a formidable legislator. ... He'll be very divisive," Stark says.

Thomas is hardly more complimentary: "Pete has not been following the 'husband your resources and strike when you think it's right' kind of model," Thomas says drily. He says Stark's sharp criticism of Ira Magaziner, the White House senior adviser for health care, may have given the administration reason to be nervous about leaving a bill in his hands.

Although Thomas is right that Stark's rhetoric makes him sound like a bomb thrower — Stark describes Magaziner as the administration's Rasputin and derides Clinton's approach to health reform as a sellout to big insurance companies — the chairman's actions have been less extreme. He worked closely with Gradison on issues such as catastrophic insurance and changes in the Medicare system of reimbursement for physicians.

"Mr. Stark usually goes to the extreme to get things, but he's ultimately willing to bargain," says Chip Kahn, the panel's former minority staff director. "Regardless of his wild rhetoric, he's always turned out to be a legislator interested in legislating, and when it comes down to it, he's going to want to legislate about health."

So will several other committee members, who see their political identities inextricably tied to their work on health care. The most change oriented of the Republicans is Nancy L. Johnson of Connecticut, who introduced one of the first major bills to overhaul the insurance system and encourage streamlining of government and other paperwork.

A meticulous legislator known for scrutinizing every line in a bill, Johnson's interest in health policy dates to her days in the Connecticut legislature in the 1970s when

she worked to control hospital costs. She is particularly sensitive to the problems doctors face — she is married to an obstetrician-gynecologist — and has immersed herself in analyzing the business aspects of medicine.

Fred Grandy, an Iowa Republican from a rural district, also advocates fundamental change. But he is struggling with how far to stray from the conservative proposal being put forth by the House Republican caucus. The caucus plan is so distant from Clinton's ideas that Grandy fears Republicans run the risk of being left out of the debate, just as they were on the budget process this year.

Divisions cut still deeper on the Democratic side, where Jim McDermott of Washington and Michael A. Andrews of Texas, leaders of two opposing factions, often sit next to each other. Andrews supports the market-oriented managed competition concept. McDermott, a psychiatrist and one of two doctors in Congress, supports a government-centered single-payer system because he is convinced that is the only way to make

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Rostenkowski, left, and Dingell, at times competitors for power, are brothers under the skin. They are the last of a dying breed of politician.

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R. MICHAEL JENKINS

health care available to everyone. He was so committed to pushing his single-payer proposal that he passed up a White House offer to become AIDS policy czar.

The Clinton administration's point man on the subcommittee is Sander M. Levin, D-Mich., whose views reflect both his liberal political origins and his increasingly conservative Michigan district, where Reagan Democrats gave him only a narrow win in 1992. His ambivalence between liberal and conservative approaches to social programs mirrors Clinton's own. Levin — a man who rarely speaks in sound bites — has a personal mantra: Waste must be cut before the government should ask people to pay more for the uninsured.

### Energy and Commerce

Pragmatism marks the 24-member Energy and Commerce health panel. This may be because in addition to the usual quota of lawyers, a doctor, the owner of a grocery

## The Senate Role

In the House, most work is done at the committee level. In the Senate, where the rules allow a single senator to reshape legislation and entire bills can be rewritten on the floor, committees often play a lesser role. Still, the key Senate players in the health-care debate usually can be found on one or even two committees that will have jurisdiction over key elements of the Clinton plan.

The Finance Committee and the Labor and Human Resources Committee will share the front lines of the Senate debate. Finance, like its counterpart Ways and Means Committee in the House, has jurisdiction over taxes, Medicare, Medicaid and the tax provisions of the federal law that governs employee benefits.

The Senate Labor Committee has jurisdiction over public health, biomedical research and medical education. Judiciary, meanwhile, will weigh in on malpractice and antitrust issues.

Many members of these committees will be crucial to the health debate both as individuals and as members of political blocs. Moderate Republicans, for example, could provide a crucial margin for President Clinton when his plan reaches the floor.

### Finance

#### Democrats (11)

Daniel Patrick Moynihan, N.Y.,  
chairman  
Max Baucus, Mont.  
David L. Boren, Okla.  
Bill Bradley, N.J.  
George J. Mitchell, Maine

David Pryor, Ark.  
Donald W. Riegle Jr., Mich.  
John D. Rockefeller IV, W.Va.  
Tom Daschle, S.D.  
John B. Breaux, La.  
Kent Conrad, N.D.

#### Republicans (9)

Bob Packwood, Ore.,  
ranking member  
Bob Dole, Kan.  
William V. Roth Jr., Del.  
John C. Danforth, Mo.

John H. Chafee, R.I.  
Dave Durenberger, Minn.  
Charles E. Grassley, Iowa  
Orrin G. Hatch, Utah  
Malcolm Wallop, Wyo.

### Labor and Human Resources

#### Democrats (10)

Edward M. Kennedy, Mass.,  
chairman  
Claiborne Pell, R.I.  
Howard M. Metzenbaum, Ohio  
Christopher J. Dodd, Conn.  
Paul Simon, Ill.

Tom Harkin, Iowa  
Barbara A. Mikulski, Md.  
Jeff Bingaman, N.M.  
Paul Wellstone, Minn.  
Harris Wofford, Pa.

#### Republicans (7)

Nancy Landon Kassebaum, Kan.,  
ranking member  
James M. Jeffords, Vt.  
Daniel R. Coats, Ind.

Judd Gregg, N.H.  
Strom Thurmond, S.C.  
Orrin G. Hatch, Utah  
Dave Durenberger, Minn.

### Judiciary

#### Democrats (10)

Joseph R. Biden Jr., Del.,  
chairman  
Edward M. Kennedy, Mass.  
Howard M. Metzenbaum, Ohio  
Dennis DeConcini, Ariz.  
Patrick J. Leahy, Vt.

Howell Heflin, Ala.  
Paul Simon, Ill.  
Herb Kohl, Wis.  
Dianne Feinstein, Calif.  
Carol Moseley-Braun, Ill.

#### Republicans (8)

Orrin G. Hatch, Utah,  
ranking member  
Strom Thurmond, S.C.  
Alan K. Simpson, Wyo.  
Charles E. Grassley, Iowa

Arlen Specter, Pa.  
Hank Brown, Colo.  
William S. Cohen, Maine  
Larry Pressler, S.D.

store chain and two former restaurateurs serve on the committee. Although the panel's policies do not necessarily win kudos from those who have to abide by them, the panel's debates have a real world flavor. Many members are sensitive to the plight of the poor. "We've tried to fill in the gaps for people who have nowhere else to go, people who have no insurance," Waxman says.

But almost in opposition to the liberal contingent is a bipartisan bloc of cost cutters. "We have got to get costs under control," says Slattery, a moderate who crusades for deficit reduction.

The man who perhaps speaks most eloquently on behalf of the poor is Craig Washington, D-Texas, one of the panel's three black members. He smiles gently when he hears opponents of health reform say it means care will be rationed. "For the people I am sworn to represent, health care is rationed right now," Washington says. His inner-city Houston district has one of the highest incidences of AIDS in the country. It has high teen pregnancy rates, high infant mortality rates and a disproportionate number of low-birthweight babies. His district surrounds the world-famous Texas Medical Center, but the hospital his constituents go to — and the one to which he took his infant son in an emergency — is the public county hospital, where people wait all night to see a doctor.

Soft-spoken J. Roy Rowland, a Democrat from south Georgia, also knows about care for the poor. A doctor for 28 years in Dublin, Ga., (population 14,000 at the time) he routinely made house calls in the countryside, assuming he would never be paid for some of his care. "I collected about 80 percent of my bills; the other 20 percent was what I owed the community," he says. "It was part of the ethic of medicine; it was part of the responsibility of being a doctor that you gave away some of your services."

Jim Cooper, D-Tenn., a former Rhodes scholar, has come a long way from the flat Tennessee country where he grew up. A quiet man who often can be seen walking alone to floor votes, he has spent hours at the White House working with Ira Magaziner, trying to persuade the administration to adopt his managed-competition approach to reorganizing the health-care system.

"The third-largest federal health program — after Medicare and Medicaid — is the \$66 billion in tax breaks enjoyed by American companies," he says. Cooper believes that if the employer health insurance deduction were limited, it would be an incentive to choose cheaper health-care plans. And although he works closely with insurance industry executives and business groups that framed some of the ideas he now espouses, his passion seems born of a genuine belief in the ability of market reorganization to resolve the system's problems. ■

## Members of Congress

## Key Participants In the Debate On Health Care

**Pete Stark, D-Calif., 61, chairman, House Ways and Means Subcommittee on Health, elected 1972** — An expert on health policy — particularly Medicare, the government insurance program for the elderly and disabled — Stark has made a decidedly liberal mark on both tax and health policy. He calls his subcommittee the Medicare "board of directors" and has made no bones about his interest in turning the nation's health-care system into a giant Medicare system. He shares Clinton's goal of providing health care for all Americans.

Still, Stark often seems more intent on shocking his listeners and lobbing grenades at the administration. He barely disguises his dislike of President Clinton's health-care architect, Ira Magaziner, whom he calls a latter-day Rasputin. Early this year, he ignored Clinton's request to wait for an administration health proposal and put forth a plan to expand Medicare and Medicaid and to impose cost controls through a national health-care budget.

**Henry A. Waxman, D-Calif., 54, chairman, House Energy and Commerce Subcommittee on Health and the Environment, elected 1974** — A strong defender of health-care programs for the underprivileged, Waxman has been a main force in Congress in dramatically expanding Medicaid, the state-federal health insurance program for the poor. Unlike Stark, he tends to be reserved in public, leaving the committee's fireworks to others.

Waxman wields his power through legislation carefully crafted by his staff. He also works well with subcommittee Republicans. So far, he has stayed at arm's length from the Clinton administration but has refrained from the wholesale criticism for which Stark is known. Unlike Clinton, Waxman is extremely wary of allowing the marketplace to sort out public policy; he takes a regulatory approach to government. Nevertheless, like Stark and Clinton, he favors universal health insurance.

**John D. Dingell, D-Mich., 67, chairman, House Energy and Commerce Committee, elected 1955** — The Dingell effort to create a national health-care system dates from his father's years in Congress. John D. Dingell Sr. introduced a bill to nation-

alize the health-care system in 1943. Dingell Jr. believes strongly in a single-payer system but also wants to be a deal maker. He probably will put aside personal ideals to help the president. Nevertheless, he will push for universal coverage and a more regulatory approach. . . . A Detroit native, Dingell has longstanding ties to unions and to the auto companies that have been active players in the health-care debate.

**Dan Rostenkowski, D-Ill., 65, chairman, House Ways and Means Committee, elected 1958** — Known for his ability to broker legislative deals, Rostenkowski should be an invaluable asset to Clinton in getting a plan through the House. He has been implicated, however, in a scheme to embezzle cash from the House Post Office, jeopardizing his future as Ways and Means chairman.

Rostenkowski has a working knowledge of the health-care system's problems dating from his chairmanship of the Ways and Means Health Subcommittee in the 1970s. When President Jimmy Carter sent his hospital cost control bill to Congress in 1977, Rostenkowski crafted the deal that brought it to the House floor, despite broad opposition to caps on hospital spending. He generally supports a single-payer system but is a pragmatist who is looking for the deal that will attract a House majority.

**Richard A. Gephardt, D-Mo., 52, House majority leader, elected 1976** — No one in the House will play as key a role in shaping policy. Over the years, his views on health care have veered wildly. In the late 1970s, he worked to kill Carter's efforts to control hospital costs. In contrast, last year he signed onto a bill that would have created a government-run health-care system. With his leadership position and with several big hospitals and chemical companies in his district, Gephardt receives more contributions from health-care political action committees than any other House member except Rostenkowski.

**Daniel Patrick Moynihan, D-N.Y., 66, chairman, Senate Finance Committee, elected 1976** — Moynihan's chief interest over the years has been in the decline of the American family and in reforming welfare, not health care. But with his new position as chairman of Senate Finance, he has delved into health-care policy. A sociologist and former professor, he has examined the economics of health care and how it differs from other sectors of the



Stark



Rostenkowski



Dingell



Gephardt



Moynihan

## Members of Congress



Moynihan



Kennedy



Rockefeller



Chafee



Gramm

economy. Drawing on the theories of economist William Baumol, Moynihan argues that caring for the sick, like baby-sitting or playing a Mozart quartet, takes approximately the same amount of time today that it took a century ago. As a result, its cost has risen dramatically in contrast to the costs of manufactured goods.

Moynihan concludes that health care's relatively high cost is normal but that its rising costs need to be slowed. He rejects price controls and a single-payer system but steers clear of saying how the government should offset rising costs.

**Edward M. Kennedy, D-Mass., 61, chairman, Senate Labor and Human Resources Committee, elected 1982.** Kennedy has worked for universal health insurance for 25 years. Like Clinton, he has argued for a plan that relies on employers to cover their employees and on government to subsidize the poor and uninsured. He is cool on the idea of managed care but believes that aspects of it may be incorporated in the new plan. Kennedy's committee handles issues such as public health, biomedical research, maternal and child health, and employment mandates.

**John D. Rockefeller IV, D-W.Va., 56, chairman, Senate Veterans' Affairs Committee and Finance Subcommittee on Medicare and Long-Term Care, elected 1984.**

Rockefeller began crusading for health reform several years before his aborted run for the Democratic presidential nomination in 1988. He has spent this year like a circuit-riding Baptist preacher, proclaiming the administration's health-care gospel to conventions of special interest groups such as the elderly and small business leaders. While Senate Majority Leader **George J. Mitchell, D-Maine**, will broker much of the Senate debate with the help of Democratic Policy Committee Co-chairman **Tom Daschle** of South Dakota, Rockefeller will be point man for the administration. He has developed a close relationship with Hillary Rodham Clinton.

**John H. Chafee, R-R.I., 70, Senate Finance Committee and leader of the Republican Health Care Task Force, elected 1976.**

A longtime advocate for health care for the poor, Chafee's stand on health care is more moderate than many Republicans. As leader of the Senate Republican health task force, he has worked to build a consensus among moderates. He has worked closely with **Christopher S. Bond** of Missouri and **Dave Durenberger** of Minnesota, both longtime GOP advocates

of a health care overhaul.

On Sept. 15, 22 Republican senators, including Minority Leader **Bob Dole**, R-Kan., signed onto a Chafee plan setting overall goals similar to Clinton's universal coverage, cost constraints and quality care. The Senate GOP plan avoids a mandate on employers to pay for employees' health care. The plan suggests changing the tax system to limit the deductibility of health care benefits.

**Phil Gramm, R-Texas, 51, member of Senate Appropriations, Budget and Banking, Housing and Urban Affairs committees, elected 1986.** A vociferous opponent of health care proposals by both Clinton and other Senate Republicans, Gramm has taken on the role of bombthrower. He has gathered support from other GOP conservatives, including **John McCain** of Arizona and **Don Nickles** of Oklahoma.

## Other Democrats

**Jim McDermott, D-Wash., 57, a member of the House Ways and Means Health Subcommittee** has put together a bloc of more than 80 legislators who support a single-payer system. A physician, he sometimes spent several hours with potential sponsors, walking them through his plan. **Jim Cooper, D-Tenn., 39, who sits on the House Energy and Commerce Subcommittee on Health, is an evangelist for the system known as managed competition.** He leads the House conservative Democratic contingent. Last year about 30 members sponsored his bill, which includes limits on the tax deductibility of health care benefits and uses that money to provide health care for the poor and uninsured.

## Other Republicans

When Rep. **Bill Gradison** of Ohio, a 20-year veteran, resigned last year, House Republicans were left without an obvious leader on health policy. Now a core group, led by Minority Leader **Bob Michel** of Illinois, has developed a position for the GOP caucus. It tinkers with the existing system but makes no major changes. A few Republicans may reach out to Democrats. These include **Fred Grandy** of Iowa and **Nancy Johnson** of Connecticut. In the Senate, moderate Republicans **Nancy Landon Kassebaum** of Kansas, **John C. Danforth** of Missouri and **William V. Roth** of Delaware are likely to play a crucial role in crafting a bipartisan plan.

## The Clinton Team

**Hillary Rodham Clinton:** The first lady, who was a prominent lawyer in Arkansas and former chairman of the Children's Defense Fund board of directors, chaired the president's Task Force on National Health Care Reform. She made herself a constant presence on Capitol Hill, by all accounts bringing crucial skills to the debate: a good ear for listening to members' concerns, access to the president and an in-depth knowledge of health issues.

**Steven J. Ricchetti:** A former lobbyist and executive director of congressional communications for Blue Cross/Blue Shield, Ricchetti worked for the past two years as executive director of the Democratic Senatorial Campaign Committee, which raises money for Senate candidates. As deputy assistant to the president for legislative affairs, he helps the White House communicate with Capitol Hill.

**Mandy Grunwald:** She makes up one-third of Clinton's political team, along with pollster Stanley B. Greenberg and strategist Paul Begala. They advise Clinton on what to say, when to say it and how to say it. Grunwald is steering Clinton around the national media, targeting the Arsenio Hall and Phil Donahue audiences rather than readers of The New York Times.

**Jeff Eller:** As head of the White House health-care war room, Eller worries little about philosophy but plenty about image. Look for Eller, a techno-whiz with a quick wit, to oversee the administration's "rapid response" to any incoming criticism. He will focus on unconventional methods for advertising the Clinton package, using everything from computerized bulletin boards to 800 numbers to local media coverage.

**Ira Magaziner:** A "friend of Bill" from their Rhodes scholar days, Magaziner is senior adviser for health care. In charge of designing the reform proposal, he is a business consultant from Rhode Island who had little experience in politics before coming to Washington. He has become a regular on Capitol Hill, however, where he has received mixed reviews. Some resent his know-it-all style; others admire his grasp of policy.



Hillary Rodham Clinton



Steven J. Ricchetti



Mandy Grunwald



Jeff Eller



Ira Magaziner

**Carol R. Rasco:** As chief domestic policy adviser, Rasco watches out for the Clintons. Her title belies her clout, which comes from her capability and her relationship with the Clintons, going back to the 1970s. With good ties to the National Governors' Association and a reputation as a broker, Rasco will try to fit Clinton's health care package into the administration's larger domestic policy framework.

**Richard F. Celeste:** A former Rhodes scholar and two-term governor of Ohio, Celeste is running the Democratic National Committee's National Health Care Campaign. A friend of Clinton's since their days as governors, Celeste jumped firelessly for Clinton in 1992. The new job may be an opportunity for political redemption: Celeste's years in office were tainted by top aides' financial improprieties and his hopes for a presidential run were shattered by well-documented extramarital affairs. An eloquent orator, Celeste will be hining the road for the administration.

**Judith Feder:** Feder's grasp of the big picture as well as the minutiae probably is unequalled in the administration, in which she serves as principal deputy assistant secretary for health planning and evaluation at the Department of Health and Human Services (HHS). A former director of health policy studies at Georgetown University, she has ties on Capitol Hill dating from her work as staff director of the bipartisan Pepper Commission, which sought a health-care overhaul formula in 1990. She developed ties with the Clintons during the campaign.

**Bruce C. Vladeck:** As administrator of the Health Care Financing Administration, Vladeck directs the Medicare and Medicaid programs, which help pay the medical bills of 65 million Americans at a cost of about \$29 billion annually. He is sympathetic to single-payer interests and once headed the United Hospital Fund of New York. With a background in health policy and political science, he has a particular concern for people lacking adequate care.

**Kenneth E. Thorpe:** As deputy assistant secretary for health policy at HHS, Thorpe is the chief number cruncher for the administration. He was previously the director of policy at the University of North Carolina.

## Congressional Staff

## HOUSE

**David S. Abernethy:** Now staff director of the House Ways and Means Health Subcommittee's five-person health policy team, Abernethy also has considerable experience outside Washington. He was a deputy commissioner in the New York state Department of Health and the administrator of the Haight-Ashbury Medical Clinic in San Francisco. He also is the co-author of "Regulating Hospital Costs: The Development of Public Policy."

**Ann D. LaBelle:** Trained as a nurse and a dentist, LaBelle held several health policy positions in the Bush and Reagan administrations, including three years as a senior adviser to the secretary of Health and Human Services. She joined the House Ways and Means Health Subcommittee as minority health counsel earlier this year.

**Karen Nelson:** Staff director of the House Energy and Commerce Subcommittee on Health and the Environment since 1979, Nelson is one of three key aides likely to have a major role in the health-care overhaul. She has a thorough command of Medicare and Medicaid, and a close working relationship with Health Subcommittee Chairman Henry A. Waxman, D-Calif. She also has worked for the Senate Finance Committee.

**Howard J. Cohen:** One of two Republican counsels for the Energy and Commerce Subcommittee on Health and the Environment, Cohen brings a doctorate in psychology as well as a law degree to the job, which he has held since 1988. He is a former program director with the American Council of Life Insurance, and he has written several policy articles on health care and insurance.

**Phyllis C. Borzi:** A former high school teacher, Borzi is a veteran Hill aide with an excellent knowledge of the Employee Retirement Income Security Act (ERISA), the 1974 federal law governing employee pensions and benefits. In 1981, she joined the staff of the House Education and Labor Committee, where she serves as the Labor-Management Relations Subcommittee's counsel for pensions and employee benefits. Before that, Borzi worked for a private pension consulting company and the House Pension Task Force.



Abernethy



LaBelle



Nelson



Cohen



Borzi

## SENATE

**David H. Nexon:** Health staff director for the Senate Labor and Human Resources Committee, Nexon is a political scientist trained at the University of Chicago. He is a former assistant professor at the Claremont Colleges in California and was a senior budget examiner at the Office of Management and Budget (OMB). At OMB, he analyzed issues involving the Health Care Financing Administration, which administers Medicare and Medicaid. He has worked for the committee since 1981.

**Andrew Patzman:** A Stanford University graduate, Patzman is minority health care policy coordinator for the Senate Labor Committee. He is working on a bipartisan health care bill of ranking member Nancy Landon Kassebaum, R-Kan. It includes cost controls and a financing mechanism—a 1 percent addition to the Social Security tax.

**Susan B. Foote:** A lawyer and former associate professor at the University of California at Berkeley's business school, Foote is an expert in medical technology issues. She is senior legislative assistant for health to Sen. Dave Durenberger, R-Minn., who sits on three committees that deal with health: Finance, Labor and Human Resources, and Aging.

**Paul Offner:** A politician and a health policy expert as well as chief health and welfare counselor to Senate Finance Committee Chairman Daniel Patrick Moynihan, D-N.Y., Offner served for nine years in the Wisconsin legislature and then was deputy director of the Ohio Department of Human Resources, which runs the state's Medicaid program. Offner would like to see a wider use of managed care, especially in the Medicaid program.

**Christine C. Ferguson:** Legislative director and counsel to Sen. John H. Chafee, R-R.I., Ferguson is a lawyer with experience in Medicare, Medicaid and abortion regulation legislation. Most recently, she helped organize the Senate Republican Task Force on Healthcare. She has been Chafee's legislative director since 1988.

**Shella F. Burke:** Chief of staff for the Senate Minority Leaders' Office, Burke was trained as a nurse. After receiving a master's degree in public administration from Harvard University, Burke worked as a nurse and at the National Student Nurses Association. She has worked with Minority Leader Bob Dole, R-Kan., for 16 years. Some see her as even more partisan than Dole, to whom she is fiercely loyal.

# GENEROSITY OF HEALTH PACs RISES AS OVERHAUL APPROACHES



Michael Roberts of the American Academy of Ophthalmology says his PAC donates in open-seat races "because we know that it is a good way to make our mark."

Rep. Alex McMillan's views on health care did not change much over the past two elections, but his campaign contributions from health interests did. They jumped by 61 percent between 1990 and 1992, to \$68,250.

In the interim, McMillan, R-N.C., won a coveted seat on the House Energy and Commerce Subcommittee on Health. It is a post that gives him considerable opportunities to put forth his maverick views on such topics as regulating hospital payments and loosening hospital antitrust laws. So health interests want his ear.

"If you are on a health committee, the rise is just natural," McMillan said.

The increase in McMillan's contributions parallels a rise in campaign contributions from health-care organizations to all

members of Congress as it prepares to overhaul the nation's health-care system.

In the 1992 election cycle, health-care political action committees (PACs) gave 29 percent more than in the 1990 cycle, according to figures culled from Federal Election Commission data and a study by the Center for Responsive Politics, a Washington group that analyzes campaign contributions.

"Health-care reform is in the forefront of what is going on in various committees this year, and it is on the agenda of various politicians," said Ramona S. Jones, a spokeswoman for Glaxo Inc., a North Carolina pharmaceutical company whose campaign contributions increased from about \$120,000 in 1990 to more than \$175,000 in 1992.

At the same time, most members of Congress are asking for more money because of the spiraling cost of running a campaign: A House race cost on average \$545,000 in 1992, 34 percent more than in 1990, according to the Center for Responsive Politics.

The greatest beneficiaries of the giving were members of the four key panels that control most health-care legislation. In the House, those are the Energy and Commerce Committee and the Ways and Means Committee; in the Senate, the Finance Committee and the Labor and Human Resources Committee. Members who serve on those panels received on average \$51,668 from health interests in the 1992 election cycle, about 67 percent more than those with other committee assignments.

Among PACs, the American Medical Association (AMA) led contributors with \$3.2 million in donations. The AMA is made up of 300,000 doctors, of whom 65,000 are PAC members. The next most generous PACs were the American Dental Association, which represents most dentists and gave \$1.4 million, and the National Association of Life Underwriters, which also gave about \$1.4 million on behalf of its members — agents who sell health insurance and other policies.

Many smaller health-care groups also gave generously. The American Optometric Association, whose chief legislative interest has been inclusion of eye care in government health programs, gave more than \$398,000, a 21 percent increase over 1990. Similarly, the Association for the Advancement of Psychology gave \$273,743, up 64 percent from 1990.

## Strategies of Giving

The increase reflects a convergence of the longtime practice of giving heavily to key committee members and the new awareness that in the upcoming health-care overhaul, every vote will count. It is likely

that at least four or five committees in each chamber — including the Judiciary and Veterans' Affairs committees — will be involved in restructuring the country's health-care system, and that could change the pattern of PAC contributions.

"The health-reform issue is going to be one man, one vote," said Michael D. Bromberg, executive director of the Federation of American Health Systems, which represents private hospitals and in the past has focused its contributions on specific committees. "We've broadened out quite a bit. This is not one little minor issue; this is going to be floor votes, and on the floor every vote is critical."

When PAC directors are deciding to whom to make campaign contributions, they say they look first at whether the member is on a key health committee. If the PAC represents a company, directors look at whether the company has a facility in a member's district or state.

"People on Energy and Commerce and Ways and Means are players on our set of issues," said Richard T. Farrell, vice president for government affairs at Syntex Corp., a California pharmaceutical company. Farrell noted that the emphasis on giving to members of key committees is particularly pronounced in the House, where members "tend to see their parameters defined by their committee assignments."

Another strategy is to give to freshman members in the hope of getting their attention early in their careers.

"We're very active in open-seat races because we know that it is a good way to make a mark," said Michael A. Roberts of the American Academy of Ophthalmology. For similar reasons, the American Dental Association PAC was involved in 90 open-seat races; about half its candidates won, said PAC representative Frank McLaughlin.

The largest PACs, such as the AMA, give something to almost every lawmaker and can afford to give the maximum amount — \$10,000 — to particularly supportive members. For instance, the association gave \$9,700 to J. Roy Rowland, D-Ga., a doctor, and \$10,000 to Ways and Means Health Subcommittee member Michael A. Andrews, D-Texas, whose district includes the enormous Texas Medical Center complex in Houston.

Many PAC directors underscore that members solicit them for contributions, not the other way around. A survey by the National Association of Business PACs, which represents 110 groups, found that in 70 percent of donations, the PAC director was responding to a request. "It's been said of some of the old bulls on the Hill that they never remember if you gave; they only remember if you don't," said Steven F. Stockmeyer, the association's executive vice president.

For most lawmakers, health-care PAC contributions correspond to their committee appointments, the magnitude of pending legislation and their positions on the issues.

Rep. Pete Stark, D-Calif., said he rarely received money from health interests until he joined the Ways and Means Health Subcommittee, which he now chairs. But he also notes that more health-care PACs exist now. "It was just a few years ago that the Blue Cross/Blue Shield group didn't have a PAC," he said. "Now they have a PAC, and the midwives have a PAC, and the family therapists have a PAC."

A few health panel members get little PAC money. Some, such as Reps. Jim Cooper, D-Tenn., and Mike Synar, D-Okla., do not accept it. Others hold views contrary to the industry's. Jim McDermott, D-Wash., supports a single-payer system of health care, which would sharply reduce the insurance industry's role. In 1992, he received only \$5,000 from insurance company PACs.

Contributions often rise when a member seeks higher office. Reps. Ron Wyden, D-Ore., and Robert T. Matsui, D-Calif., both considered running for the Senate in 1990. Wyden raised about \$101,000 from health-care interests; Matsui raised almost \$134,000. In 1992, when both dropped their Senate plans and neither faced a tough race, their contributions plunged.

In the Senate, the pattern of giving follows senators' six-year terms, with most senators receiving contributions almost exclusively in election years.

Although regular PAC giving is surging, the real story, according to many PAC directors, is the growth in their grass-roots programs. With the entire health system at stake, members will look first to their districts for direction in casting their votes.

PAC directors are busy teaching PAC members to hold fundraisers in their homes, volunteer in campaigns and meet with their lawmakers. Some groups are running direct mail campaigns, and others are setting up systems to let member groups know when crucial votes in Congress are coming up.

"If you can get 100 people to attend a little fundraiser in your home, and everyone gives \$200, that's a nice little contribution," says dental PAC representative McLaughlin. Individuals can give up to \$200 apiece without reporting it. "Ideally if you get all the dentists to come that would be great; if you get people in the community to attend, that's good, too. It's noted that you took time."

by Alissa J. Rubin



Frank McLaughlin represents the American Dental Association's PAC, one of the most generous contributors.

■ **House Ways and Means Chairman Dan Rostenkowski, D-Ill., was the leading recipient of health-care (PAC) contributions with \$202,350.**

■ **House Majority Leader Richard A. Gephardt, D-Mo., received \$192,489. Pete Stark, D-Calif., received \$160,251; and Henry A. Waxman, D-Calif., received \$157,950.**

■ **In the Senate, Bob Packwood, Ore., ranking Republican on the Finance Committee, received the most: \$247,852. Two other Finance members received nearly as much: Tom Daschle, D-S.D., with \$226,374, and Charles E. Grassley, R-Iowa.**

## Top Givers

The political action committees (PACs) of prominent health-care, health insurance and pharmaceutical organizations have contributed hundreds of thousands of dollars in the past four years to members of the congressional committees with jurisdiction over health-care issues. This chart lists the top contributors from 1989 to 1992 to members of the four most important panels: the Ways and

Means Committee and the Energy and Commerce Committee in the House and the Finance Committee and the Labor and Human Resources Committee in the Senate.

Overall, these interests made campaign contributions totaling \$33.8 million to all members of the House and Senate over the four years, with \$19.1 million of the amount being contributed in the 1992 election cycle.

|                                                                                                                                                                                                                                                                             | House Ways<br>and Means | House Energy<br>and Commerce | Senate<br>Finance | Senate Labor<br>and Human Resources |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------|-------------------|-------------------------------------|
| <b>American Medical Association (AMPAC)</b><br>The umbrella medical association represents about half of the country's 600,000 doctors. The PAC, however, represents only about 65,000 members.                                                                             | \$346,686               | \$397,708                    | \$52,473          | \$54,000                            |
| <b>American Dental PAC</b><br>The American Dental Association represents 75 percent to 80 percent of the country's dentists.                                                                                                                                                | 173,600                 | 142,350                      | 59,000            | 52,000                              |
| <b>American Academy of Ophthalmology</b><br>The academy represents the 17,000 physicians who specialize in eye care.                                                                                                                                                        | 136,383                 | 102,704                      | 53,500            | n.a.                                |
| <b>PAC of the American Hospital Association</b><br>Represents most of the country's hospitals and hospital administrators.                                                                                                                                                  | 106,693                 | 114,241                      | 71,100            | 61,269                              |
| <b>Independent Insurance Agents of America PAC</b><br>Represents 50 state and 1,200 local associations whose members are small-business owners who sell several types of insurance, including health insurance.                                                             | 76,557                  | 99,716                       | 51,977            | 44,211                              |
| <b>National Emergency Medicine PAC of the American College of Emergency Physicians</b><br>Represents a dozen medical specialty societies with members in the United States and Canada.                                                                                      | 61,850                  | 80,640                       | n.a.              | n.a.                                |
| <b>American Health Care Association PAC (AHCA-PAC)</b><br>Represents nursing home associations and long-term health-care facilities.                                                                                                                                        | 61,600                  | 61,600                       | 71,000            | n.a.                                |
| <b>AFLAC Incorporated Political Action Committee</b><br>Represents AFLAC (which owns the American Family Life Assurance Co.), a broad-based supplemental insurance company that sells, among other plans, insurance for cancer and other diseases requiring intensive care. | 60,500                  | 59,500                       | n.a.              | n.a.                                |
| <b>American Optometric Association PAC</b><br>Represents doctors and students of optometry and pays particular attention to eye care as well as general health issues.                                                                                                      | 55,650                  | 77,500                       | n.a.              | 45,000                              |
| <b>Podiatry PAC</b><br>Represents doctors who deal with the diseases and conditions of the foot.                                                                                                                                                                            | 54,300                  | 70,500                       | 45,000            | 53,000                              |
| <b>American Chiropractic Association PAC</b><br>Represents most chiropractors — non-physicians who treat a variety of diseases through muscle and skeletal manipulation.                                                                                                    | n.a.                    | 66,050                       | 63,997            | 71,488                              |

SOURCE: Center for Responsive Politics, Almanac of Federal PACs

\* Another PAC was a top contributor to the Energy and Commerce Committee: Gearing Employees PAC, which gave \$22,500. Gearing glassware is used in the manufacture of sophisticated medical equipment.

\* Two other PACs were top contributors to the Senate Finance Committee: The Federation of American Health Systems (\$22,000) and Equitable Financial Services (\$51,900).

\* Two other PACs were top contributors to the Senate Labor Committee: Travelers Corporation PAC (\$45,019) and the National Association of Independent Insurers (\$43,731).

# Health PAC Contributions

Health-care interests contributed \$19.1 million in the 1991-92 election cycle to members of Congress, a 29 percent increase over 1989-90, according to the Center for Responsive Politics, a Washington organization that studies Congress. The center defines health interests as health professionals and services, pharmaceutical and health product companies, hospitals and nursing homes.

In the House, much of the money was given to members of the Ways and Means Committee and the Energy and Commerce Committee. Both panels have jurisdiction over health issues. A disproportionate amount of money went to members of each committee's Subcommittee on Health.

Senate contributions work differently. Senators are up for election every six years and receive most of their contributions during campaign years.

The following charts show how much each member of these committees received in political action committee (PAC) money from health interests.

## Ways and Means Committee

| Health Subcommittee         | 1989-90   | 1991-92   |
|-----------------------------|-----------|-----------|
| Pete Stark, D-Calif.        | \$139,000 | \$160,251 |
| Sander M. Levin, D-Mich.    | 45,975    | 110,997   |
| Nancy L. Johnson, R-Conn.   | 82,942    | 107,330   |
| Michael A. Andrews, D-Texas | 52,850    | 99,250    |
| Benjamin L. Cardin, D-Md.   | 74,450    | 80,450    |
| Fred Grandy, R-Iowa         | 26,759    | 55,284    |
| Bill Thomas, R-Calif.       | 33,600    | 39,350    |
| Jim McDermott, D-Wash.      | 28,400    | 37,150    |
| Jim McCrery, R-La.          | 17,450    | 33,850    |
| John Lewis, D-Ga.           | 14,100    | 32,029    |
| Gerald D. Kleczka, D-Wis.   | 11,333    | 19,750    |

## Rest of the Committee

|                                   |          |           |
|-----------------------------------|----------|-----------|
| Chairman Dan Rostenkowski, D-Ill. | \$26,500 | \$202,350 |
| Barbara B. Kennelly, D-Conn.      | 68,300   | 84,750    |
| Charles B. Rangel, D-N.Y.         | 75,500   | 83,325    |
| Sam M. Gibbons, D-Fla.            | 60,350   | 73,800    |
| Jim Bunning, R-Ky.                | 35,125   | 70,282    |
| E. Clay Shaw Jr., R-Fla.          | 37,700   | 66,395    |
| Robert T. Matsui, D-Calif.        | 133,583  | 64,923    |
| Bill Brewster, D-Okla.            | 41,824   | 62,599    |
| Don Sundquist, R-Tenn. *          | 71,599   | 60,042    |
| J.J. Pickle, D-Texas              | 57,500   | 52,347    |
| Peter Hoagland, D-Neb.            | 58,403   | 41,450    |
| Mike Kopetski, D-Ore.             | 47,450   | 34,350    |
| William J. Coyne, D-Pa.           | 24,550   | 27,757    |
| Richard E. Neal, D-Mass.          | 18,350   | 27,200    |
| Lewis F. Payne Jr., D-Va.         | 23,387   | 26,750    |
| Rick Santorum, R-Pa.              | 500      | 24,985    |
| Dave Camp, R-Mich.                | 33,600   | 23,600    |
| Mel Reynolds, D-Ill.              | 500      | 18,250    |
| Amo Houghton, R-N.Y.              | 22,850   | 17,250    |
| Mel Hancock, R-Mo.                | 14,350   | 15,400    |
| Wally Herger, R-Calif.            | 13,950   | 13,700    |
| Michael R. McNulty, D-N.Y.        | 17,450   | 10,400    |
| Harold E. Ford, D-Tenn.           | 8,550    | 8,150     |
| William J. Jefferson, D-La.       | 3,600    | 3,500     |
| Phillip M. Crane, R-Ill.          | 1,250    | 0         |
| Bill Archer, R-Texas              | 0        | 0         |
| Andrew Jacobs Jr., D-Ind.         | 0        | 0         |

\* Not seeking re-election

**FOR THE HOUSE STAFF**

Members of the Ways and Means Committee received \$1,423,580 in health PAC contributions in 1989-90 and \$1,889,246 in health PAC contributions in 1991-92. Members of the Ways and Means Subcommittee on Health received \$526,859, or 37 percent of the total in 1989-90, and \$775,691, or 41 percent of the total in 1991-92.

## Energy and Commerce Committee

| Health and Environment Subcommittee | 1989-90   | 1991-92   |
|-------------------------------------|-----------|-----------|
| Henry A. Waxman, D-Calif.           | \$157,750 | \$157,950 |
| Thomas J. Bliley Jr., R-Va.         | 75,518    | 103,350   |
| Michael Bilirakis, R-Fla.           | 60,055    | 92,186    |
| Bill Richardson, D-N.M.             | 81,400    | 89,532    |
| J. Roy Rowland, D-Ga.               | 65,765    | 80,150    |
| Alex McMillan, R-N.C.               | 42,450    | 68,250    |
| Jim Slattery, D-Kan.**              | 49,850    | 67,050    |
| John Bryant, D-Texas                | 43,950    | 61,689    |
| Dennis Hastert, R-Ill.              | 19,400    | 58,200    |
| Bill Paxon, R-N.Y.                  | 41,705    | 51,100    |
| Edolphus Towns, D-N.Y.              | 36,650    | 49,500    |
| Gary A. Franks, R-Conn.             | 27,925    | 47,531    |
| Ralph M. Hall, D-Texas              | 36,630    | 47,200    |
| Frank Pallone Jr., D-N.J.           | 28,450    | 45,800    |
| Gerry E. Studds, D-Mass.            | 2,750     | 42,630    |
| Ron Wyden, D-Ore.                   | 101,411   | 35,425    |
| Mike Kreidler, D-Wash.*             |           | 32,000    |
| Scott L. Klug, R-Wis.               | 6,100     | 31,100    |
| Fred Upton, R-Mich.                 | 29,550    | 30,620    |
| James C. Greenwood, R-Pa.*          |           | 17,100    |
| Sherrod Brown, D-Ohio*              |           | 14,250    |
| Craig Washington, D-Texas           | 11,200    | 8,850     |
| Jim Cooper, D-Tenn.                 | 17,100    | 1,500     |
| Mike Synar, D-Okla.                 | 0         | 0         |

### Rest of the Committee

|                                      |          |           |
|--------------------------------------|----------|-----------|
| Chairman John D. Dingell, D-Mich.    | \$89,850 | \$111,750 |
| Thomas J. Manton, D-N.Y.             | 57,247   | 58,999    |
| Rick Boucher, D-Va.                  | 44,900   | 53,250    |
| Jack Fields, R-Texas                 | 36,400   | 51,750    |
| Cardiss Collins, D-Ill.              | 31,450   | 48,500    |
| Al Swift, D-Wash.**                  | 27,690   | 48,250    |
| Carlos J. Moorhead, R-Calif.         | 46,000   | 46,900    |
| W. J. "Billy" Tauzin, D-La.          | 44,575   | 46,741    |
| Michael G. Oxley, R-Ohio             | 31,450   | 45,250    |
| Richard H. Lehman, D-Calif.          | 8,580    | 43,660    |
| Phillip R. Sharp, D-Ind.             | 46,600   | 42,100    |
| Dan Schaefer, R-Colo.                | 38,900   | 39,550    |
| Joe L. Barton, R-Texas               | 25,350   | 33,250    |
| Cliff Stearns, R-Fla.                | 25,381   | 31,250    |
| Michael D. Crapo, R-Idaho*           |          | 29,796    |
| Blanche Lambert, D-Ark.*             |          | 27,600    |
| Lynn Schenk, D-Calif.*               |          | 27,500    |
| Paul E. Gillmor, R-Ohio              | 33,100   | 16,600    |
| Marjorie Margolies-Mezvinsky, D-Pa.* |          | 13,900    |

\* Freshman

\*\* Not seeking re-election

Members of the Energy and Commerce Committee received \$1,523,082 in health PAC contributions in 1989-90 and \$2,049,559 in contributions in 1991-92. Members of the Subcommittee on Health and the Environment received \$935,609, or 61 percent of the money, in 1989-90, and \$1,232,963, or 60 percent, in 1991-92.

### Methodology

To determine the amount that members of Congress received from health interests, Congressional Quarterly added the contributions of political action committees that represented industries and associations with a direct interest in health care: health professionals, hospitals and nursing homes, health services, pharmaceutical companies and health insurance companies.

The numbers originally were generated by the Center for Responsive Politics using data from the Federal Election Commission. CQ excluded PACs that did not clearly have a direct interest in health care. The result probably is somewhat more conservative than that of other groups that have analyzed PAC contributions.

Many other groups have an interest in the pending overhaul of America's health-care system, including small businesses and trial lawyers. But those groups are interested in many legislative issues, making it difficult to determine the correlation between their contributions and health care.

**QUESTIONS**

Health-care interests contributed \$1,018,471 to members of the Senate Finance Committee in 1989-90. Of that, \$784,312, or 77 percent, went to the four senators who were up for re-election in 1990. Contributions during 1991-92 totaled \$1,330,938. Of that, \$1,150,358, or 86 percent, was raised by the six senators up for re-election.

**Senate Finance Committee**

| Senator                         | Last/Next Race | 1989-90 | 1991-92   |
|---------------------------------|----------------|---------|-----------|
| Bob Packwood, R-Ore.            | 1992/1998      | \$0     | \$247,852 |
| Tom Daschle, D-S.D.             | 1992/1998      | 73,250  | 226,374   |
| Charles E. Grassley, R-Iowa     | 1992/1998      | 11,750  | 224,084   |
| Bob Dole, R-Kan.                | 1992/1998      | 43,300  | 195,507   |
| John B. Breaux, D-La.           | 1992/1998      | 12,200  | 176,041   |
| Kent Conrad, D-N.D.             | 1992/1994      | 32,000  | 80,500    |
| Orrin G. Hatch, R-Utah          | 1988/1994      | 6,500   | 75,580    |
| Dave Durenberger, R-Minn.*      | 1988/1994      | 44,759  | 43,250    |
| Daniel Patrick Moynihan, D-N.Y. | 1988/1994      | 1,500   | 18,000    |
| John H. Chafee, R-R.I.          | 1988/1994      | 3,400   | 14,000    |
| John D. Rockefeller IV, D-W.Va. | 1990/1996      | 307,172 | 12,500    |
| William V. Roth Jr., R-Del.     | 1988/1994      | 0       | 11,000    |
| John C. Danforth, R-Mo.*        | 1988/1994      | 3,000   | 3,000     |
| George J. Mitchell, D-Maine     | 1988/1994      | 2,500   | 3,000     |
| Malcolm Wallop, R-Wyo.*         | 1988/1994      | 0       | 250       |
| Bill Bradley, D-N.J.            | 1990/1996      | 200,000 | 0         |
| Max Baucus, D-Mont.             | 1990/1996      | 195,150 | 0         |
| David Pryor, D-Ark.             | 1990/1996      | 81,990  | 0         |
| David L. Boren, D-Okla.         | 1990/1996      | 0       | 0         |

\* Not seeking re-election

Health-care interests contributed \$839,566 during the 1989-90 election cycle to members of the Senate Labor and Human Resources Committee, which has jurisdiction over certain aspects of health legislation. Of that, \$538,451, or 64 percent, was raised by the six senators up for re-election. In the 1991-92 election cycle, health-care interests contributed \$878,745. Of that, \$639,935, or 73 percent, was raised by the four senators up for re-election.

**Senate Labor and Human Resources Committee**

| Senator                        | Last/Next Race | 1989-90   | 1991-92   |
|--------------------------------|----------------|-----------|-----------|
| Daniel R. Coats, R-Ind.        | 1992/1998      | \$193,044 | \$223,619 |
| Christopher J. Dodd, D-Conn.   | 1992/1998      | 40,212    | 218,703   |
| Judd Gregg, R-N.H.             | 1992/1998      | N/A       | 100,509   |
| Barbara A. Mikulski, D-Md.     | 1992/1998      | 15,100    | 97,104    |
| Orrin G. Hatch, R-Utah         | 1988/1994      | 6,500     | 75,580    |
| Tom Harkin, D-Iowa             | 1990/1996      | 205,303   | 60,250    |
| Harris Wofford, D-Pa.          | 1991/1994      |           | 51,625    |
| Dave Durenberger, R-Minn.*     | 1988/1994      | 44,759    | 43,250    |
| Paul Wellstone, D-Minn.        | 1990/1996      | 6,750     | 6,005     |
| Strom Thurmond, R-S.C.         | 1990/1996      | 112,557   | 1,000     |
| Edward M. Kennedy, D-Mass.     | 1988/1994      | 1,500     | 1,000     |
| Paul Simon, D-Ill.             | 1990/1996      | 115,041   | 100       |
| Clalborne Pell, D-R.I.         | 1990/1996      | 71,800    | 0         |
| Nancy Landon Kassebaum, R-Kan. | 1990/1996      | 27,000    | 0         |
| Jeff Bingaman, D-N.M.          | 1988/1994      | 0         | 0         |
| James M. Jeffords, R-Vt.       | 1988/1994      | 0         | 0         |

\* Not seeking re-election

# HEALTH CARE A TO Z

## A

### Accountable Health Plans

Accountable Health Plans, a concept put forward by a group of health experts who meet periodically in Jackson Hole, Wyo., would provide medical coverage to groups of people. The plans, associated with managed competition, would offer a standard benefits package and issue reports about patient care. Plans could be open or closed. The open plan would provide coverage through a Health Insurance Purchasing Cooperative (HIPC), a private administrative body that would pool individuals together to purchase insurance. It would be for individuals employed by small companies. The closed plan would be for large companies and would not involve a purchasing cooperative. (See *Jackson Hole Group, managed competition, Health Insurance Purchasing Cooperative*)

### Acute Care

Medical care of limited duration for an injury or short-term illness. A physician usually provides the care in an office or hospital.

### Administrative Costs

Non-medical expenditures for health-care management, such as billing, claims processing, marketing and overhead.

### All-Payer System

A system under which the government and private insurance plans ("all payers") pay the same amount for the same service. For instance, federal-state Medicaid insurance programs would not be able to reimburse hospitals at a lower rate than Blue Cross, a private insurer. This would prohibit the health provider from shifting costs from one payer to another.

### Alliance for Health Reform

1133 20th St. N.W., Suite 220, Washington D.C. 20036; (202) 466-5626; fax, 466-6525. The alliance is a nonprofit, nonpartisan organization founded in 1991 by Sen. John D. Rockefeller IV, D-W.Va. It coordinates forums, meetings and seminars regarding health care and disseminates information to media, businesses and legislative staff members.

### American Association of Retired Persons (AARP)

Health Care Campaign, 601 E St. N.W., Washington, D.C. 20049; (202) 434-3828; fax, 434-6477; main number, (202) 434-2277. Founded in 1958, the AARP is a lobbying group for individuals 50 or older. With 33 million members, it seeks to protect the welfare of older Americans. The group's Health Care Campaign advocates improvements in Medicare and Medicaid and equal access to health care for all individuals. It offers consumer information and health education material. AARP members qualify for group health insurance and mail-order pharmacy services.

### American Hospital Association (AHA)

Washington office: 50 F St. N.W., 20001;

(202) 638-1100; fax, 626-2345. The hospital association, founded in 1898, is an umbrella group representing hospitals, health-care facilities and medical administrators. It has 50,000 members, with headquarters in Chicago. The association conducts research and education projects regarding comprehensive care, hospital economics, hospital facilities and design, and community relations. The AHA also monitors legislation and participates with other health-care associations in establishing hospital care standards.

### American Medical Association (AMA)

Washington office: 1101 Vermont Ave. N.W., 20005; (202) 789-7400; fax, 789-7454. The AMA, founded in 1847, represents 297,000 of the country's 600,000 doctors. The organization monitors legislation and regulations on health matters and malpractice insurance. It also provides information on health care. The main office is in Chicago.

## B

### Benefits (See *health benefits*)

### Blue Cross/Blue Shield Association

676 N. St. Clair St., Chicago, Ill., 60611; (312) 440-6000. Blue Cross/Blue Shield is a system of 69 independent corporations that are collectively the nation's oldest and largest private health insurer and the largest third-party administrator of Medicare benefits. Blue Cross/Blue Shield provides direct coverage to more than 67.5 million Americans. Each plan is an independent corporation, and the system is not-for-profit.

## C

### California Public Employees' Retirement System (CalPERS)

CalPERS organizes pension, health and other benefits for state and local government workers in California. It negotiates prices with 19 health maintenance organizations (HMOs) and four preferred provider organizations (PPOs), and monitors the quality of care. Supporters of managed competition cite CalPERS' success as evidence that the approach works. CalPERS has 890,000 members and is by far the largest state health system. (See *health maintenance organization, managed competition*)

### Canadian Plan

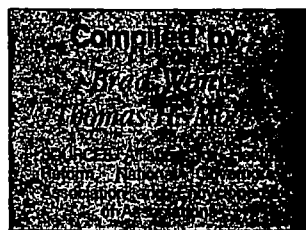
A single-payer system, Canada's national health insurance system covers all Canadians' hospital care, outpatient care and some prescription drugs. Thirty-eight percent of the system is financed by national taxation, 62 percent by provincial taxation. Private doctors in fee-for-service practices bill Provincial Health Ministries monthly, and trustee- or community-owned hospitals negotiate annual budgets with provincial governments. The government sets rates limiting the fees that providers can charge for their services. (See *single-payer system, fee for service*)

### Capitation

Often used by health maintenance organizations (HMOs), capitation is a payment method in which a physician or hospital is paid a fixed amount per patient, per year — regardless of the services the patient requires.

### Case Management

This is one way of handling patients under managed-care systems, such as HMOs. It is also known as "gatekeeping. Under primary care case management, the practitioner de-



## GLOSSARY

termines the quantity and mix of services a patient requires, including access to specialists. Acute care case management usually refers to service for a few high-cost, seriously ill patients. The system has a case manager who monitors services and arranges for alternative treatments. For example, the manager may recommend home treatment instead of hospital care.

### Catastrophic Coverage

This type of insurance pays for high health-care costs, usually associated with accidents and chronic illnesses and diseases, such as cancer and AIDS. The medical circumstances determine the coverage, which is usually expensive and hard to find. In 1988, Congress passed the Medicare Catastrophic Coverage Act (PL 100-360), which provided benefits for those with catastrophic medical problems, capped out-of-pocket expenses and provided coverage for prescription drugs. But Congress repealed the law in 1989 (PL 101-234) after senior citizens objected to paying for the new benefits.

### Catholic Health Association of the United States

Washington office: 1776 K St. N.W., Suite 204, 20006; (202) 296-3993; fax, 296-3997. The association, founded in 1915, is an umbrella organization for more than 1,200 nonprofit Catholic health-care facilities. They aim to care for everyone, particularly the poor and infirm. The association, based in St. Louis, advocates universal coverage with managed competition and a national budget. (See *Universal Coverage, Managed Competition*)

### CHAMPUS

An acronym for the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS is the health insurance program that serves the dependents of active-duty military personnel as well as retired military personnel and their dependents. Health care for active-duty personnel is provided by the Defense Department.

### Charity Care

Charity care is free health care given by doctors, nurses and hospitals, often in conjunction with a religious organization or charity. In 1956, the Internal Revenue Service mandated charity care for nonprofit hospitals to keep their tax-exempt status. That ruling was rescinded in 1969, but many hospitals continue to provide charity care.

### Co-Insurance

This is a percentage of health-care costs, not covered by medical insurance, that an individual must pay. For example, many insurance plans pay 80 percent of hospital and doctors' costs; the individual must cover the remaining 20 percent. A co-payment, however, refers to an actual dollar amount.

### Community Rating

This is a method to determine the cost of health insurance premiums, the yearly amount that individuals must pay for an insurance policy. The community rating premium is based on the average medical cost for all covered people in a geographical area. It does not consider any one person's medical condition. Community rating usually keeps health-care costs relatively low because the method factors a large pool of individuals into the premium equation. (See *Experience Rating*)

### Continuum of Care

This is a range of services and care settings that a patient may require at different stages of his or her illness. A person undergoing hip replacement, for example, might need hospitalization, surgery, nursing home care, rehabilitation services and home care.

### Cost Sharing

A health insurance provision that requires individuals to cover some part of their medical expenses. Examples include co-insurance, co-payments and deductibles. Cost sharing may help hold down costs by deterring individuals from seeking unnecessary care.

### Cost Shifting

This is the practice by which health-care providers offset their losses from treating one group of patients by charging other patients more. For instance, if a certain health insurance company will pay only a specified amount for a particular procedure, the provider may bill another patient a higher fee for the same procedure.

### D

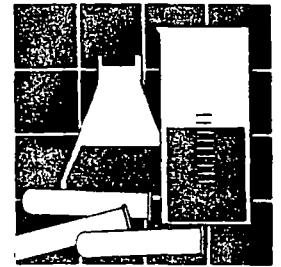
#### Deductible

The amount a patient must pay out of pocket before insurance will cover costs.

#### Diagnosis Related Groups (DRGs)

Adopted by Medicare in 1983,

this is a classification system designed to control costs and set standard Medicare payments. The payments are predetermined based on the patient disease, diagnosis, procedure, sex, age and medical history. After a physician determines what medical procedure or operation a Medicare beneficiary requires, Medicare reimburses the health-care provider based on the system.



#### Direct Employer Coverage

This is health insurance obtained through an individual's employer (current or former), union or family member. Sixty percent of Americans are insured through their employer or that of a family member. (See *Indirect Employer Coverage*)

### E

#### Employee Retirement Income Security Act (ERISA)

A 1974 federal law (PL 93-406) that set the standards of disclosure for employee benefit plans to ensure workers the right to at least part of their pension. The law governs most private pensions and other employee benefits, and overrides all state laws that concern employee benefits, including health benefits.

#### Employer Mandate

A regulation, rather than a tax, directed at employers. One such mandate would be to require that all employers offer and pay for a portion of their workers' health coverage. Many small businesses fear that a health-care mandate would be so costly it would drive them out of business.

#### Entitlements

Government benefits, including health-care benefits, that go automatically to all qualified individuals. They are part of mandatory spending programs. Examples are Social Security, Medicare, Medicaid and food stamps.

#### Experience Rating

This is a method used to determine the cost of health insurance premiums. The cost is based on the previous amount a certain group — such as the employees of a

business — paid for medical services. Indemnity insurance companies most often use experience rating when determining rates for businesses. Small businesses, however, can be hurt by experience rating because one employee's severe medical problems could force the entire group's premiums to increase significantly. (See *Community Rating*)

## F

### Fee for Service

This refers to a billing system in which a health-care provider charges a patient for a specific service.

### First Party

The patient. (See *Third Party Payer*)

## G

### Global Budget

A global budget is an amount, set by an administrative body, that aims to control all health costs. It usually covers government spending and other insurance buyers. Global budgets are most often associated with universal health insurance, in which almost all individuals in a country are covered. The United States currently does not have a global budget, but some politicians are interested in the concept.



## H

### Health Alliance

This is a quasi-governmental entity under development as part of President Clinton's health-care overhaul. The alliance would pool consumers into a large purchasing group, then bargain with local health plans for low-cost, quality care. Health plans would be made up of hospitals, doctors and other providers. Almost all consumers in a given region would select their insurance plan through a list provided by the local alliance. Employers, employees and others would pay their premiums to the alliance; the alliance in turn would pass the money to the health plans based on the number of subscribers. No one could be excluded from a plan or forced to pay higher premiums because of a pre-existing health condition.

### Health Benefits

These are payments made by a health insurance company to a patient or health-care provider to cover all or some of the costs of medical care or hospitalization.

### Health Care Financing Administration (HCFA)

200 Independence Ave. S.W., Washington D.C. 20201; Administrator: (202) 690-6726; fax, 690-6262; information: 690-6113. HCFA is part of the Department of Health and Human Services. It administers Medicare, the health insurance program for the elderly (age 65 and older) and disabled, and Medicaid, the health insurance program for the poor. HCFA also records Medicare and Medicaid statistics.

### Health Industry Manufacturers Association (HIMA)

1200 G Street N.W., #400, Washington D.C. 20005; (202) 783-8700; fax, 783-8750. Founded in 1974, HIMA serves as an umbrella group for manufacturers of medical devices, diagnostic products and health-care information systems. A primary concern is the safety and effectiveness of medical

devices. HIMA conducts educational seminars and monitors legislation and regulations.

### Health Insurance Association of America (HIAA)

1025 Connecticut Ave. N.W., Washington D.C. 20036; (202) 223-7780; fax, 223-7889. The association, founded in 1956, represents 270 companies that write and sell policies. It monitors legislation, promotes effective cost management and provides statistical information on health insurance issues. Former Rep. Bill Gradison, R-Ohio, serves as its president.

### Health Insurance Purchasing Cooperative (HIPC)

A HIPC, like a health alliance, pools individuals or employees for buying health insurance. A health alliance is quasi-governmental, but a HIPC is a private, nonprofit organization. The concept is a product of the Jackson Hole plan. (See *Jackson Hole Group*)

### Health Maintenance Organization (HMO)

This is a prepaid health-care plan in which an individual pays the HMO a certain amount, usually on a monthly basis, and seeks treatment from affiliated medical staff. The goal is to provide affordable health care through managed care — a system in which a primary care provider acts as a gatekeeper to specialists and expensive medical tests. In general, subscribers pay a small amount at each visit. Under such plans, patients have a limited choice of doctors.

#### ■ Staff Model

Under a staff model, physicians are salaried and work only for the HMO, usually at a single site.

#### ■ Group Model

Under a group model, physicians are organized in an independent partnership, corporation or association that contracts only with the HMO.

#### ■ Network Model HMO

A network model HMO combines two or more other types of HMOs.

#### ■ Preferred Provider Organization (PPO)

Under this contract system, providers, usually organized by "networks" or panels, give medical care for a set fee. Various benefits, such as lower co-insurance and better coverage, create incentives for patients to see "preferred" physicians. Under some PPO plans, individuals are able to visit non-PPO physicians for a higher cost; the providers are compensated directly by an insurance company and co-payments. Not all PPOs cover visits to non-PPO physicians.

#### ■ Point of Service Plan (POS)

A POS is a feature of a health insurance plan in which patients are encouraged to use a select group of providers but are permitted to seek out-of-network care. An individual who selects a POS plan may have to pay higher premiums, co-insurance or deductibles than in a standard HMO. Such a feature enables an HMO to provide more flexibility.

#### ■ Independent Practice Association (IPA)

An IPA is a practice in which physicians can treat both HMO and private patients. HMO patients are charged a negotiated rate, usually on a per capita or fixed fee-for-service basis. Like the POS, it is similar to a PPO.

### Health Plans

The term refers to the benefits offered by health insurance providers to individuals and companies. The term sometimes refers to methods of paying for health care.



### Indemnity Insurance

This is a traditional health insurance plan in which the patient submits the medical bill to the insurance company

## GLOSSARY

for reimbursement to the physician. It differs from other coverage plans, such as those including deductibles and co-payments, in which the insurance company pays part of the bill and the patient pays the rest.

**Indirect Employer Coverage**

Insurance provided by employers to employee family members, who may receive fewer benefits than the employee.

**Integrated Service Network (ISN)**

A type of broad health maintenance organization — one that offers complete health-care coverage — being developed in Minnesota. Quasi-public cooperatives and the state Medicare system will negotiate rates and terms with the networks on behalf of large groups of consumers. Exactly what benefits the networks will be required to offer is under debate, but state officials hope they will be able to include acute care, long-term care and prescription drugs. Traditionally, a medical practice makes more money if it performs more procedures. But because ISNs will receive set payments, the incentive shifts to keeping patients as healthy as possible.

**J****Jackson Hole Group**

This is an informal group of businesspeople and academics who occasionally meet at the Jackson Hole, Wyo., home of Dr. Paul Ellwood to discuss health-care policy. Dr. Ellwood previously worked for InterStudy, a Minnesota health policy research company, but now focuses on Jackson Hole Group issues. The group produced the Jackson Hole plan, which calls for Accountable Health Plans and Health Insurance Purchasing Cooperatives. Group members favor managed competition, taxation of health benefits above a minimum package and mandating that employers provide health coverage for their workers. The group has played a significant role in the national health-care debate, and President Clinton is interested in many Jackson Hole proposals. (See *Accountable Health Plans, Health Insurance Purchasing Cooperatives, employer mandates, managed competition*)

**"Job Lock"**

Under "job lock," people are forced to remain in a job for fear of losing health insurance coverage altogether or because a prospective employer's health plan refuses to cover a medical circumstance, such as a dependent's pre-existing condition.

**L****Long-term care**

This is health care required by chronically ill, physically disabled or mentally disabled individuals. Such patients usually require 24-hour supervision in a hospital or nursing home.

**M****Major Medical**

This usually refers to an insurance policy designed to cover the high expenses associated with serious illness. Typically, policy holders must pay extremely high deductibles before coverage starts. They may also have to pay co-insurance.

**Malpractice**

Malpractice refers to harmful or unprofessional treatment or neglect of a patient by a physician or other health-care provider.

**Managed Care**

This type of health-care delivery aims to control costs by using "gatekeepers" — primary care doctors or caseworkers — to coordinate patients' use of health services. Managed-care networks usually are organized by insurance companies, employers or hospitals. One such network is the type run by health maintenance organizations, in which a patient sees one physician who determines the medical care — both general and specialized — that the patient will receive. A patient's access to medical services is controlled.

**Managed Competition**

A brainchild of the Jackson Hole group, managed competition is a health-care system in which insurance companies and health-care providers would create health plans that would compete with other health plans for large groups of consumers. Under managed competition, individuals would be organized into large health purchasing groups to buy insurance. Health-care providers, organized in a network, would vie for their business. A purchasing group would bargain with a network to obtain the best cost per individual. The concept is popular on Capitol Hill because it promises to provide universal coverage with low costs. Alain Enthoven, a business professor at Stanford University, is considered to be the father of the concept.

**Medicaid**

Enacted into law in 1965 (PL 89-97), Medicaid is the federal-state health insurance program for the poor. It took effect in 1966. Nearly 30 percent of Medicaid dollars are spent on long-term care for the elderly and care for the mentally disabled. The program differs from state to state. According to the Health Care Financing Administration, states spent \$50 billion on Medicaid in 1992 and the federal government spent \$68 billion. The program covered 32.6 million people.

**Medicaid Waiver**

This is a formal process by which a state receives a waiver from certain Medicaid program rules. States request such waivers when they are implementing their own health-care programs for the poor.

**Medical savings accounts**

Accounts similar to individual retirement accounts into which employers and employees can make tax-deferred contributions and from which employees may withdraw funds to pay covered health-care expenses.

**Medicare**

Medicare is the federal health insurance program for the elderly (those 65 and older) and disabled. It covers benefits for hospital care and physician visits. Funding comes from individual premiums, taxes and general revenues. President Lyndon B. Johnson signed Medicare legislation (PL 89-97) into law in 1965. It started a year later.

**■ Medicare Part A**

This universal part of Medicare pays for hospital care. The hospital insurance program covers inpatient care after beneficiaries meet a \$676 deductible. The program also provides short-term nursing care. Medicare Part A cost \$80.8 billion in 1992 and covered 34.4 million people. It is financed by a 1.45 percent payroll tax.



## GLOSSARY

### ■ Medicare Part B

This voluntary part of Medicare, known as Supplementary Medical Insurance, helps pay doctors' bills. Medicare Part B works by covering 80 percent of certain physician and non-hospital services after beneficiaries meet a \$100 deductible. It covered 33.6 million people in 1992, at a cost of \$48.6 billion. It is financed by patient premiums and general federal revenues.

### Medigap

These are private health insurance plans that augment Medicare by paying costs not covered by the federal government. Payments could include co-insurance, coverage of Medicare deductibles and bills not covered by Medicare (including prescription drugs).

### Multiple Employer Trust

A legal trust involving several small and unrelated employers who provide group health coverage through an insurance company or self-insurance.

## N

### National Governors' Association (NGA)

444 North Capitol St., No. 267, Washington, D.C. 20001; (202) 624-5300; fax, 624-5313. An organization representing the nation's governors, NGA studies and makes recommendations to Congress and the president about public policy. NGA has been an active participant in the health-care debate. It was founded in 1908 and currently has 55 members, including governors of states and territories.

### National Health Care

This term refers to a health-care insurance system that covers all citizens and various other residents. It often refers to a single-payer system in which the federal government is the payer. Under many such plans, the government sets all fees for hospitals, physicians and other providers.

### National Health Budget

The national health budget is the total amount spent on health care by government and private payers. In 1992, the United States spent \$832 billion — one-seventh of the entire U.S. economic output. The Congressional Budget Office estimates that the cost will soar to \$1.6 trillion by 2000.

## O

### Oregon Plan (See Rationing)

### "Orphan Drugs"

"Orphan drugs" are medicines for ailments that afflict fewer than 200,000 people. In 1983, Congress passed the Orphan Drug Act (PL 97-414), which gave tax credits and exclusive market rights to medical companies involved in developing such drugs. Many considered the law a success. From 1983 to 1992, the Food and Drug Administration approved more than 60 new medicines, and at least 350 others are in development. However, critics charged that the law gave pharmaceutical companies too much latitude in setting prices and making profits. In 1990, Congress attempted to amend the 1983 legislation, but President George Bush vetoed the bill. Congress made another attempt in 1992, but



the bill (S 2060) never reached the floor. A drug company user-fee law (PL 102-571), however, included orphan drug provisions that permit the secretary of Health and Human Services to waive certain fees for producers of orphan drugs.

### Outcomes Analysis

Outcomes analysis is an evaluation system associated with managed competition that rates medical treatments according to outcomes, or success rates. For a health-care plan to qualify to offer its services to consumers, the doctors and hospitals in the plan must show results that are average or better. Analysts disagree, however, on whether reliable data to assess outcomes exist. The White House says such data exist, but critics point to loopholes and legal pitfalls if a health-care plan receives a low rating.



### Pepper Commission

A 15-member commission led by the late Rep. Claude Pepper, D-Fla. (Senate: 1936-51; House: 1963-1989) that explored how to address the needs of those who lacked health insurance and how to finance long-term care for the chronically ill or disabled. The commission was created by the 1988 catastrophic-coverage law (PL 100-360). In 1990, the commission recommended a "play or pay" plan for employers and a universal plan to cover long-term care services for all Americans. Under play or pay, employers would have to provide health insurance ("play") for their workers, or pay into a government insurance pool.

### Per-Person Premium

This refers to a flat-rate insurance premium that every firm would have to pay for every employee's health care.

### Physician Payment Review Commission

2120 L Street N.W., Suite #510, Washington D.C. 20037; (202) 653-7220; fax, 653-7238. Founded by Congress in 1986, the PPRC recommends Medicare reimbursement rates for physicians. The 13-member commission studies Medicare payment issues and then submits its findings to Congress. Congress sets the policies to be used, and the Health Care Financing Administration sets the actual rate. In addition, the commission holds health care and physician forums, studies Medicaid payment issues, examines medical school financing and undertakes other medical studies. It issues at least three reports to Congress every year.

### "Play or Pay"

"Play or pay" is a universal coverage plan in which employers either provide their workers with a basic health benefits package, or pay into a government insurance pool. It is a combination of employer mandate ("play") and the single-payer system ("pay").

### Pharmaceutical Manufacturers Association (PMA)

1100 15th St. N.W., #900, Washington D.C. 20005; (202) 835-3400; fax, 835-3414. Founded in 1958, the association is a lobbying group that represents 88 companies that discover, develop and manufacture prescription drugs. It provides consumer information on drug abuse, the safe and effective use of prescription medicines and developments in important areas including AIDS. PMA is also a clearinghouse for pharmaceutical industry statistics.

### Pre-Existing Condition

This is a physical or mental condition diagnosed before an individual receives health insurance coverage. Some ins-

## GLOSSARY

urers may refuse to cover someone because of such a condition. Others may increase their rates or refuse to cover the patient for a specific time.

**Preferred Provider Organization (PPO)** (*See Health Maintenance Organization*)

### Premium Tax

This is a state tax on the premiums collected by an insurance company from policyholders who live in the same state.

### Price Controls

Price controls are government-set price ceilings on basic commodities. If the government were to institute price controls on medical products or services, the products would be more affordable to the general public, but medical product companies, doctors and hospitals would be paid less.

### Primary Care

Primary care is the general care people routinely receive when they go to the doctor. It can be delivered by a doctor, nurse practitioner or physician's assistant. Physicians who practice family medicine, pediatrics and internal medicine are considered primary care providers. In some cases, specialists such as obstetricians and gynecologists and practitioners of preventive and emergency medicine are considered primary care physicians.

### Prospective Payment System

Adopted in 1983, this is a pay scale to compensate hospitals for Medicare services. The scale is based on the complexity of services a patient requires and uses the Diagnosis Related Groups, a classification system that sets standard Medicare reimbursement rates. For example, Medicare will pay a hospital only a certain amount for a specific medical procedure. Medicare adopted the system to control costs.



### Qualified Medicare Beneficiary

A person 65 or older whose income falls below the federal poverty line, and for whom the government must pay all Medicare costs, including Medicare Part B premiums, deductibles and copayments.



### Rate Setting

Rate setting usually refers to the system the government uses to reimburse doctors and hospitals for services. It implies strict control of costs. Under Medicare, the government has a complicated reimbursement formula that takes into account the procedure and the provider's cost.

### Rationing

Any system that limits the amount of health care that a person can receive. The best-known example is Oregon's experiment, which ranks medical procedures and conditions and provides Medicaid coverage only to a certain point down the list; thus, vaccinations may be covered but organ transplants may not be. Proponents of Oregon's plan point out that a sort of rationing exists already, based on income.

**Reinsurance** (*See Stop-Loss Coverage*)

### Relative Value Scale (RVS)

Medicare put the RVS in place in 1992 pursuant to a 1989 law in an effort to shift Medicare funding toward primary care and away from specialists. The scale assigns a value to each medical procedure in the new Medicare Fee Schedule,

based on the complexity of the procedure. A simple Medicare office visit may have a value of one, while complex surgery may have a value of three. The RVS uses a conversion factor that translates the number into a dollar amount. Medicare did this to control costs. Under the old system, high Medicare payments went disproportionately to specialists.

### Risk Pool

A risk pool is a group of people seeking insurance; it can refer to people who can afford insurance but cannot obtain it for medical reasons. Under Clinton's plan, the risk pool is everyone within a health alliance or a health plan.

**Risk-Control Insurance** (*See Stop-Loss Coverage*)



### Second Party

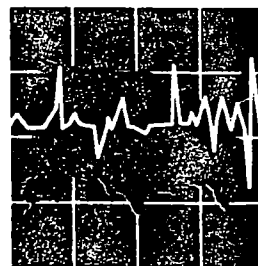
The caregiver or provider. *See Third-Party Payer.*

### Self Insurance

Self insurance is a form of private coverage in which an employer, rather than an insurance company, assumes the risk. Third-party administrators or insurers, however, may administer the plan.

### Single-payer system

A universal coverage plan under which the government collects insurance premiums and administers health-care benefits for everyone in the state or country. It cuts out the role of insurance companies. Proponents argue that it is the best way to dramatically cut national health-care costs.



### Small Group Market

Selling insurance to small businesses is known as selling to a small group market, generally defined as businesses employing fewer than 100 employees. Small businesses tend to face higher per-employee costs for health insurance than larger businesses.

### Stop-Loss Coverage

Insurance coverage purchased by a health plan from an insurance company to reimburse the plan for the cost of benefits paid out to an individual or account that has exceeded what the plan expected to pay out. It stops the insurance company's loss. It is also known as reinsurance or risk-control insurance.



### Task Force on National Health Care Reform

Formed in January 1993 by President Clinton, the task force studied how to overhaul the nation's health-care system. First lady Hillary Rodham Clinton served as its chair; she held more than 100 health-care meetings with members of Congress. The task force included 13 members, mainly Cabinet level officials, and a working group of more than 500 people, including health-care professionals, policy analysts and Capitol Hill aides. The task force did not publish a report but funneled its recommendations and findings to the president. The task force dissolved in May.

### Third-Party Administrator

A person or corporate entity that handles the administrative details of a health-care insurance plan for a self-insured group. The group, not the administrator, assumes the liabilities.

## GLOSSARY

**Third-Party Payer**

Anyone paying for health care who is not the patient (the first party) or the care-giver (the second party). It includes public and private insurance providers such as Medicaid, Medicare, Blue Cross/Blue Shield and most commercial health insurance companies. Generally, the patient pays a premium to the third-party payer, and the third-party payer then pays the bills — or a percentage of the bills — incurred by the patient. Health maintenance organizations are an example of an arrangement with no third-party payer; the HMO collects the money from the patient and HMO doctors dispense the care.

**U****Uncompensated Care**

Care given by a hospital or other care-giver that is not paid for by patients, their insurance companies or the government. The cost of uncompensated care is often charged to paying patients and their insurance companies.

**Underinsured**

The number of people with inadequate health insurance is large, but hard to pin down. A 1992 report by Lewin-VHI Inc., a private health-care research company based in Fairfax, Va., estimates that 15 million people are underinsured.

Health insurance can be inadequate for reasons including: high deductibles that discourage people from seeking preventive care; policies that do not cover needs such as substance abuse rehabilitation or mental health care; and policies that impose a waiting period before coverage kicks in.

Also underinsured are those covered by Medicaid who are unable to find a provider willing to treat Medicaid clients, and pregnant patients unable to find one of the country's dwindling number of obstetricians.

**Uninsured**

A 1991 Census Bureau study found that 14.7 percent of all Americans had no health insurance — 36.6 million people in all. If those over 65 — most of whom are covered by Medicare — are factored out, 16.6 percent of Americans had no coverage. The bureau also looked at a 28-month period from 1986 to 1989 and found that the proportion of people who were without health insurance at some point during that period was even higher — 30 percent. Males, minorities and young adults are disproportionately without health insurance. (*Story, p. 19*)

**Universal Coverage**

A plan designed to give everyone in a country or state access to health insurance. Ways to do that include employer mandates, single-payer systems and "play or pay" systems.

**Volume Performance Standard (VPS)**

The VPS aims to control the rate of Medicare spending increases. It adjusts the reimbursement amount a Medicare physician will receive under Medicare Part B by focusing more on the amount that it costs to operate a medical practice each year than on the number of patients a doctor sees or the number of procedures a doctor performs. This offsets physicians' tendencies to make up for restraints in Medicare fees by increasing the number of services provided.

**Wage-Based Premium**

This is a way of paying for health care. Favored by many liberal lawmakers, it would require that all employers pay a percentage of their payroll to cover the cost of providing health insurance to their employees.

A small portion of the premium would be paid by the employee. People with higher salaries and firms with higher payrolls would pay more than firms with lower salaries. For instance, if the price of a premium were about \$2,000 and the government required that 10 percent of the payroll be paid toward it, the employer of a worker earning \$50,000 a year would pay \$5,000, and the employer of a worker earning \$20,000 a year would pay \$2,000. The \$5,000 — more than is actually needed — would go toward covering the uninsured. The political problem with a wage-based premium is that it resembles a tax.

**Zero-Sum Budgeting**

This term suggests a "deficit-neutral" budget process in which new expenditures are paid for through cuts in existing programs or increases in revenues; the end result is no increase in the federal deficit. In the current health care debate, this concept will be central to all considerations of providing universal health care coverage while also trying to rein in costs.

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## **Clinton Presidential Records Digital Records Marker**

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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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### **CQ – Provisions of the Bill**

Divider Title: \_\_\_\_\_

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To: Distribution (see below)  
Fr: Christine Heenan  
Re: CQ "Provisions of the Bill"

cc to  
OPL

MAR - 9 1994

Alissa Rubin from CQ has met with and talked to Jen Klein, Meeghan, me and others in order to do the type of point by point summary that CQ often publishes on major pieces of legislation.

The summary of the Health Security Act was published in the February 26 issue of CQ. If the collective belief is that this summary is mostly right (which it looks to be) and "on message" we might want to consider distributing it as a brief summary of the plan.

Please let me know what you think.

Distribution:

Ira Magaziner

Greg Lawler

✓ Lorraine McHugh

Jennifer Klein

Meeghan Prunty

Jason Solomon

Bob Boorstin

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Lynn Margherio

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Jack Lew

Melanne Verveer

## PROVISIONS

## Clinton's Health-Care Bill

**P**resident Clinton's health-care bill (S 1757; HR 3600), formally introduced Nov. 20, would change the roles of consumers, doctors, nurses, hospitals, governments, insurers and technologists. The bill is complex, but its goal is clear: to guarantee health-care coverage for all Americans while limiting costs. The bill's promise is that everyone would be covered from birth to death.

Most people would have controversial new financial obligations: Those who could afford to pay would subsidize those who could not. Funding would come from mandatory employer contributions, taxes, individual payments and cuts in Medicare, the government-funded health insurance program for the elderly, and in Medicaid, the program for the poor. Making this system work would require a new framework for the purchase and regulation of health insurance and delivery of health care.

The bill would create that new framework. It would require the federal government to determine health benefits, set the standards of care and reorganize the market. Once the system was in place, the government would be its watchdog and enforcer. Consumers would be organized into

large purchasing blocs to bargain for lower prices from medical providers. Instead of buying health insurance through employers or on their own, consumers in a geographic area would become part of a large group known as a "health alliance."

The alliance would have the role currently played by insurance companies and employee benefits managers: negotiating with health-care providers for the best deals. Providers, instead of working individually, would be organized into "health plans" — groups of doctors, hospitals and other caregivers — who could offer the guaranteed package of benefits to consumers. The alliance would help members choose among plans by supplying them with consumer information. Consumers would pay insurance premiums to the alliance, which would funnel the money to the providers.

Key to Clinton's plan are checks and balances designed to protect consumers' rights and ensure that all players fulfill their responsibilities. For instance, health plans would be monitored by health alliances and by states. Providers would be monitored by health plans but protected — by alliances and states — if plans went bankrupt. Consumers could pursue claims against health plans and would have access to administrative review mechanisms coordinated by alliances and state agencies.

The following are highlights of the bill:

*By Allissa J. Rubin with David S. Cloud, David Masci, Thomas H. Moore, Paul Nyhan, Elizabeth A. Palmer, Illyse J. Veron and Brad Wong*

## The New Framework (From Title I, II, V and VIII)

### Universal coverage

Affordable health insurance would be available to all citizens, and everyone would be required to enroll in a health plan. Payments would vary according to means. Employers would pay about 50 percent of the average local cost of their employees' health plans; employees would pay the balance. The government would subsidize low-income individuals and families, as well as businesses with fewer than 75 employees. Premiums would be more expensive for families than for individuals.

The bill would:

- **Guaranteed coverage.** As of Jan. 1, 1998, guarantee health-care coverage to every American citizen, every legal national and every alien permanently residing in the United States, such as a refugee or a long-term non-immigrant, such as a diplomat.

The bill would not cover prisoners, undocumented aliens or Americans over 65 eligible for Medicare, the government's health insurance program for the elderly and disabled. It is not clear how the bill would treat illegal immigrants' children born in the United States, because children generally enter alliances through parents.

- **Individual mandate.** Require that all eligible people enroll in a health plan and pay their share of insurance premiums.

- **Exceptions to the individual mandate.** Provide exceptions for military personnel, veterans and American Indians. Members of the armed forces could select a Defense Department plan. Veterans and their families could enroll in a veterans plan. Indians could enroll in the Indian Health Service plan.

- **Enrollment.** Prohibit people from being forced out of any plan unless they enrolled in another plan or became eligible for

Medicare. Even if people defaulted on premiums, no provider could refuse to treat them, nor could they be dropped from an alliance.

- **Purchasing insurance outside the system.** Allow people to purchase supplemental insurance for services not covered in the guaranteed benefits package. Those not eligible for coverage could purchase insurance in the private market. Employers could offer additional insurance.

### Benefits

Only the Clinton plan and one other plan (the single-payer Canadian-style proposal) spell out which medical services would be covered. The Clinton benefits package is generally as generous as those currently offered by most large companies.

All health plans would have to offer comprehensive benefits including mental health care, preventive dental care for children and some long-term care. Plans could not charge extra for particular benefits nor could they limit the use of benefits. However, some benefits would be covered fully only with the consent of the plan, meaning that the plan could limit or delay access to that benefit.

The following benefits would be covered:

- **Hospital services.** Unlimited inpatient, outpatient and 24-hour emergency services.

- **Health professionals.** The services of doctors, nurses and other licensed providers.

- **Emergency services.** Emergency and ambulatory medical and surgical services provided by a health facility that is not a hospital — such as a community-based clinic.

- **Clinical services.** Preventive services including all immunizations, AIDS tests and clinician visits, Pap smears and pelvic exams. Annual screenings for women at risk of having venereal diseases. Individuals over 20 would receive booster immunizations and cholesterol screening every five years. Women over 50 would receive mammograms every two years. Women over 65 would receive

flu and pneumonia shots.

• **Mental illness and substance abuse services.** Clinton's goal is to cover mental illness as comprehensively as physical illness. But treatment would be limited for the first four years. Patients would be referred by their health plan for treatment. Outpatient therapy would be limited to 30 visits or 120 visits if the therapy would enable the patient to avoid hospitalization. Inpatient treatment would be limited to 30 days, with another 30 days if necessary.

• **Family planning.** Voluntary family planning services, contraceptive devices dispensed by prescription — such as diaphragms, birth control pills and Norplant — and pregnancy services. Abortion is not mentioned specifically in the bill, but administration officials have testified that they expect it to be covered under the benefits package.

• **Home health care.** Medically necessary skilled services delivered at home, including nursing and physical therapy services and necessary supplies such as equipment to administer intravenous drugs and food.

• **Extended care.** Medically necessary services given in a nursing home environment. Includes skilled services such as nursing and physical therapy needed to recover from an acute illness or avoid hospitalization. Limited to 100 days annually.

• **Medical devices.** Durable medical equipment and prosthetic and orthotic devices such as braces for legs, arms, back and neck, artificial limbs, pacemakers, ventilators and colostomy bags.

• **Dental care.** Cover people under 18 for preventive care, and children 3 to 13 for some orthodontic procedures. Adults would receive emergency dental care only. After 2001, dental care — including checkups, routine cavity fillings and root canal work — would be fully covered for children and adults.

• **Vision care.** Routine eye exams, diagnosis of eye diseases and treatment of defects in vision, such as cataracts.

• **Investigational treatments.** These treatments are primarily for people with terminal diseases, such as AIDS and cancer. They consist of therapies whose effectiveness has not been determined. Coverage would include treatment and other routine care.

• **Other types of care.** Hospice care; ambulance services; extended care limited annually to 100 days in a nursing home or rehabilitation center; outpatient laboratory, radiology and diagnostic services; outpatient prescription drugs and biologicals; outpatient rehabilitation services, including occupational therapy, physical therapy and speech pathology.

• **Optional coverage.** Health education classes, including courses on how to stop smoking, nutrition counseling, stress management, support groups and physical training classes.

• **Not covered.** Services that are not medically necessary or appropriate, such as elective cosmetic surgery, would not be covered. Other items that would not be covered include: custodial care — meaning long-term care for non-medical needs such as companionship — hearing aids, eyeglasses and contact lenses for adults, in vitro fertilization, sex change operations and related services, private duty nursing, or comfort items (such as a television or a telephone in a hospital room).

## Long-term care

No one would be guaranteed coverage for long-term care. However, the bill would create a federal entitlement program for states to pay for home health-care services for eligible individuals. The program would be financed predominantly by the federal government; states would pay a 5 percent to 22 percent match. The administration views this as a down payment toward full-fledged long-term care coverage. Eligibility would not be based on income but would depend on whether an individual met the federal criteria of needing help with at least three activities of daily living, such as eating, going to the bathroom and getting dressed. Nursing home care would not be covered, but the grants would cover an extensive list of home health-care services and adult day care.

Beneficiaries would be charged sliding fees of up to 25 percent of the cost of care if they had an annual incomes that exceeded \$50

percent of the federal poverty level, which is now \$7,360 for a single person and \$14,560 for a family of four. People at or below the poverty line would pay nothing. The administration expects to pay about 70 percent of beneficiaries would be eligible.

## Cost sharing

Clinton's plan would standardize the prices consumers pay for their health care, limiting health insurance premiums to 10 percent of their income. Most consumers would choose among three payment formulas. The low-cost plan would most likely provide care through a health maintenance organization with a limited number of doctors. The midprice plan would offer care through a large network of doctors with an option for consumers to go outside the network, similar to a preferred provider organization. The high-cost plan would allow consumers to choose their own doctors. Premiums would vary by region and by family status, meaning whether a person subscribed as an individual, a couple, a single parent with children or a couple with children. Complex formulas would determine exact payment rates. The amount, however, that each person can would pay would be pegged to employment status.

The bill would:

• **Low-cost plan.** Offer a low-cost plan with no deductible (no minimum payment before coverage starts), a \$10 co-payment for outpatient services (such as doctor visits), \$25 for hospital emergency room care and outpatient psychotherapy, and \$10 for prescriptions. All low-cost plans also would allow subscribers to see doctors outside the network — for a higher premium.

• **High-cost plan.** Offer a more expensive cost-sharing plan with a \$200 deductible (\$400 for a family) and a \$250 deductible for prescription drugs. Enrollees would pay 20 percent of the cost of doctor visits, 50 percent for psychotherapy and 40 percent for dental services.

• **Combination plan.** Offer a combination plan in which enrollees would pay a nominal co-payment when using network providers. But when they used providers outside the network, they would pay the same deductible and other payments as under the high-cost plan.

• **Spending limits.** The plan would limit out-of-pocket spending to \$1,500 for an individual plan and \$3,000 for a family plan. Payments and co-insurance for medical services and prescription drugs would count toward an individual's annual limit. But neither the premium nor the deductibles would count.

## Employer and employee responsibilities

Employers would be responsible for about 80 percent of the costs of the average health insurance plan in their area for employees. Employers who already pay for employee health benefits would likely pay less than they pay now because other employers would shoulder some of the burden. Premium prices paid by employers and employees in the regional health alliances would reflect these costs, including premiums for those who default on alliance payments, alliance administrative costs, premiums for non-working family members, graduate medical education and federal subsidies for the so-called teaching hospitals, where doctors do their training.

The plan would divide employers into three categories: small, defined as those with fewer than 75 employees; large, defined as those with more than 5,000 employees; and all others. Taxes, subsidies and other financial responsibilities would vary among these groups. Self-employed people would be treated as small businesses and would be eligible for the same subsidies. The employer share (80 percent) of the premium as other small businesses.

Employees would be responsible for about 20 percent of the cost. However, the portion of the premium paid by employees would vary depending on employment status (full time, part time, self-employed or retired), income and family status — single, married or married with children.

The bill would:

• **Employer payments.** Require employers to pay no more than 80 percent of the area's average insurance premium cost for full-time employees and a pro-rata amount for part-time workers.

• **Additional benefits.** Allow employers to supplement employee health benefits by paying more than 80 percent of the average premium or by providing coverage for services not covered under the uniform benefits package. Supplemental benefits would be exempt from taxation until 2003. It is expected that most employers operating unionized workplaces would continue to cover any benefits that they now cover regardless of whether they were in the standard benefits package.

• **Caps.** Cap the premiums of employers with fewer than 5,000 workers who are in regional alliances at 7.2 percent of payroll. Premiums for employers of more than 5,000 who opt to join regional alliances would not be capped for the first five years that the plan was in effect, from 1998-2002. There would be no cap on employers of more than 5,000 in a corporate alliance. (Corporate alliances in 1996.)

• **Large companies.** Allow certain large employers to form their own alliances, to be known as corporate alliances. Such employers would include those with more than 5,000 workers, large unionized insurance plans, rural electric and telephone cooperatives and the Postal Service. Corporate alliances would contract with health plans themselves instead of going through regional alliances. This would allow large multistate corporations to avoid keeping track of different regional alliance systems. They would have to follow the same rules as alliance plans. Alternatively, large firms and unions could opt to join the regional alliance.

• **Mandatory participation.** Require firms with fewer than 5,000 workers to join regional health alliances.

• **Small-business subsidies.** Offer subsidies to firms with fewer than 75 workers if average annual wages were below \$24,000. Such firms would have to spend 3.5 percent to 7.9 percent of their payroll on health insurance. The bill contains no adjustment to reflect the effect of inflation on wage levels over time, so fewer and fewer employers would qualify for the subsidies over time. Despite the cap, employers would have to pay a charge known as the "employer collection shortfall add-on" to help alliances cover premiums owed but not collected. No one knows how much this might be.

• **Offsets.** Require all employers to pay an additional charge to offset amounts owed to alliances but not collected. This would be known as the "employer collection shortfall add-on."

• **Cafeteria plans.** End the tax deductibility of health benefits currently offered through company-sponsored "cafeteria" plans, in which employees choose from a list of covered benefits. Both employers and employees enjoy tax benefits from cafeteria plans because the money spent on the plans is deducted before federal and state taxes are levied. Thus a tax such as FICA (the 15 percent Social Security tax), jointly paid by employers and employees, would be levied after reducing total wages by the amount the employee spent on the benefits. Federal agencies have different estimates of how much money the government does not get annually in tax revenues as a result of deductions through cafeteria plans. The General Accounting Office estimates \$3.1 billion; the Congressional Budget Office estimates that the amount will rise from \$1 billion in 1997 to \$4 billion in 2000. The administration has even higher estimates.

• **Flexible spending accounts.** Eliminate the option of paying for health care with flexible spending accounts. Such accounts are similar to cafeteria plans. They must be set up by employers and allow employees to use pre-tax dollars to pay for health care. They reduce the taxable income of both employers and employees.

• **Employee premiums.** Require full-time workers to pay about 20 percent of the average premium in their area. ("Full time" includes anyone who works more than 30 hours a week.) Employees who enroll in a plan with a premium above the average would pay the difference between the employer's share and the premium. Employees could enroll as individuals, as a couple or as a single parent or couple with children.

• **Part-time workers.** Require part-time workers to pay both the 20 percent (individual) share of the premium and the portion of the employer share that the employer does not pay. For instance, someone who works 60 hours a month would be responsible for half

the employers' share of the premium, the employer would pay the other half. However, anyone who earns less than 150 percent of the federal poverty income would be eligible for subsidies to meet the employer share. It is expected that many part-time workers' insurance policies would be subsidized. Part-time employees are those who work 10 to 30 hours a week.

• **Early retiree plans.** People ages 55 through 64 who retire would pay no more than 20 percent of the cost of health insurance. If they worked for a company currently providing health insurance, the government would pick up the employer's share (80 percent) and the company would pay 20 percent. If the retiree had no coverage, the government would pay 80 percent and the retiree would pay 20 percent and would be eligible for subsidies. To avoid giving a windfall to companies with early retiree programs, the government would recapture some of the savings those companies would realize by imposing an assessment on them from 1998 through 2002 that would be equal to about half their 1993 retiree health costs.

• **Wealthy early retirees.** Require early retirees who earn more than \$90,000 as individuals or \$115,000 as couples to pay 80 percent of the premium; their former employers would pay 20 percent.

## National Health Board

A new federal entity, known as the National Health Board, would oversee the new system, setting quality standards and reviewing the benefits packages. It would act as a clearinghouse for information about the new system's problems and would approve state plans. Without National Health Board approval, no state could receive federal subsidies.

The bill would:

• **National Health Board.** Require the president to appoint the seven-member board with the advice and consent of the Senate to serve overlapping terms lasting four years each, except in the initial years. Board members would be selected on the basis of their experience in relevant subjects, including medicine, nursing, health-care financing and delivery, state health systems and consumer protection and delivery of care to vulnerable populations. However no member of the board could have a financial interest or any official relationship with any health-care plan, health-care provider, insurance company, pharmaceutical company, medical equipment company or other affected industry. The board would have a staff of more than 200 employees. All states would submit their plans to the national board for approval. The board would make recommendations to Congress on changes in the new system.

• **Risk adjustment.** Require the board to design a financial system to do risk adjustment — the accounting method used to determine how much each health plan must be paid, based on patients' health status. Risk adjustment is a poorly understood science, and in the early years of the plan it would be difficult to determine how much to adjust premiums.

• **Assessment.** Require the board to design a method of measuring and interpreting the quality of care received by consumers in health-care plans nationwide. The system would be used by health alliances nationwide.

• **Grievances.** Require the board to design a health plan grievance procedure.

• **Benefits.** Require the board to decide which of the benefits scheduled for expansion in 2001 and 2002 could be expanded and what extent they should be dropped or made optional.

• **Data collection.** Require the board to set up a vast health care data collection system so that the federal government could measure how the new system was working and its cost-effectiveness. The presentation of data would have to be as uniform as possible. The board's standards would pre-empt any existing state laws on data collection.

## Other federal responsibilities

The Department of Health and Human Services and the Department of Labor would oversee the new system jointly. Health and Human Services would oversee alliance enrollment policies, premium and cost-sharing discounts and the alliances' overall

financial management. The health department would set up a board, called the Advisory Council on Breakthrough Drugs, to review new drug prices. It would publish information about the reasonableness of prices and the cost-effectiveness of new products compared with existing treatments. The Labor Department would enforce the sections of the bill that deal with employer premium payments and the creation and operation of corporate alliances. The department also would set up an insolvency fund. If a corporate alliance failed financially, the fund would be able to pay providers and ensure that enrollees continued to have care. The fund would be paid for with an assessment on corporate plans not exceeding 2 percent of their premiums.

The bill also would establish a National Quality Management Council charged with developing national performance measures to be used to assess every health plan in the country and its provision of health-care services and consumers' access to those services. In consultation with states, health plans and others, the council would collect data and disseminate information in the following areas: access to health services by consumers; appropriateness of health care services; outcomes of health care services; prevention of disease; consumer satisfaction and health promotion. The council would take periodic surveys of consumers to get information on health care. All health alliances would have to publish clear information for consumers on how local health-care plans were doing in terms of the national quality measures.

## State Role

States would have new powers and responsibilities, including the power to choose between a single payer, Canadian-style system or a managed-competition system. Once a state chose a system, state flexibility would be limited by federal rules and standards designed to ensure that despite state differences, residents would have comparable choices.

States would have an ambiguous role. They would be responsible for making the new system work but would have little latitude to adjust the system's design. States would monitor the local health-care industry, enforce new laws and continue to finance health-care services for poor Americans. However, several state laws would be pre-empted.

The bill would:

- **Setting up the new system.** Require states to submit a proposal to the National Health Board explaining how they would comply with the national system to give all eligible residents access to a choice of health plans. Each state would first decide whether to set up alliances, a single-payer system or in which the state is, effectively, the only health alliance or an all-payer system in which all payers — government and private insurers — pay the same amount for the same service. It would designate an agency to oversee the program. Each state would decide whether to allow its legislature to draft its plan or implement it by gubernatorial fiat. Federal matching grants totaling \$50 million would be available to help states plan their systems. Federal matching grants would also be available to help states implement their plans. The bill would authorize \$313 million in fiscal 1996, \$625 million in fiscal 1997 and \$313 million in fiscal 1998.

- **Timetable.** Require all states to join the national system by Jan. 1, 1998. If a state did not have a plan by 1998, the federal government would step in to ensure that the nationally guaranteed benefits package was available to all state residents. If a state's certification were taken away or if the government had to run the state's system, the federal government would charge as much as an additional 15 percent on premiums to cover the administrative costs.

- **Setting up alliances.** Require a state that elected to set up an alliance system to incorporate one or more regional alliances within its borders. The alliances' geographic boundaries could not overlap. They would have to be drawn so as not to discriminate by age, race, language, religion, national origin, socioeconomic status or disability. The number of alliances in a state would depend on its population. Most alliances would have at least 1 million enrollees.

No portion of a state could be outside an alliance. However, neighboring states could coordinate their alliance boundaries and

collaborate on contracting with health plans and setting fees for providers within their respective alliances. The coordination might be helpful when, for instance, metropolitan statistical areas are located on state lines such as in Kansas City, St. Louis, New York, Philadelphia and St. Louis.

- **Certification of health plans.** Establish standards for entering health plans, which would include criteria for assessing whether plans are financially solvent. Plans would have to have assets of at least \$500,000 and be staffed well enough to deliver the benefits package. The alliance would have to accept all health plans that meet state criteria. It could refuse to accept a plan if its rates exceeded by 20 percent the average rate set by the alliance. (*Health plans, p. 496*)

- **Alliance support in income evaluation.** Require states and health alliances in determining whether a person qualified for subsidies under the Clinton plan. In addition, states could offer financial incentives to people who live far from medical care and not speak English.

- **Guarantee fund.** Establish a guarantee fund that would pay providers if a plan failed. A state could assess up to 2 percent of premiums on other plans within the alliance to generate revenues to cover outstanding claims against a failed plan.

- **Alliance assistance in enrollment.** Require states and health alliances enroll all eligible citizens. States could supply financial incentives if necessary to ensure that alliances enrolled the disadvantaged.

- **Subsidy programs.** Require states to administer subsidy programs for low-income residents and ensure that Medicaid beneficiaries have access to the same benefits they now have. Under Medicaid, ancillary services such as translation and transportation to health-care providers are covered. These services would not be covered in the national standard benefits package.

- **Quality control.** Require states to monitor the quality of the health-care services provided by the plans and ensure that the plans are providing the benefits package.

- **Cost containment.** Permit states to assume responsibility for health-care cost containment.

- **State pre-emption.** Pre-empt certain state laws. (*Antitrust provisions, p. 500*)

## Health Alliances

Set up by the states, the alliances would be quasi-governmental entities that would coordinate the health-care system for residents in a region, replacing the current role of insurance companies and employee benefits managers. A regional alliance could be set up as a private nonprofit corporation or as a state agency. Generally, a regional alliance's enrollees would primarily be full-time and part-time employees of businesses of fewer than 5,000 workers, the self-employed, and both the working and non-working poor whose health care would be subsidized by the government. The alliance would be the fiscal heart of the new system, in many states handling hundreds of millions of dollars annually.

All states would permit "corporate alliances" — health-care buying groups set up either by companies with more than 5,000 employees, by unions or by the Rural Electric and Rural Telephone Cooperatives. The rationale would be to allow large multi-state employers to avoid having to keep track of many different states' health insurance laws.

The bill would:

- **Alliance governance.** Require alliances to have a board of directors consisting of an equal number of employers and consumers. No health-care provider, employee of a pharmaceutical company or medical supplier, insurer or insurer's representative could sit on the board. However, the alliance would have to have a provider advisory board consisting of providers such as doctors or representatives of local hospitals or clinics.

- **Alliance enrollment.** Require alliances to enroll all eligible members of the area and allow family members to enroll in the same plan. Alliances would set up a system to ensure that new alliance

idents enrolled in a plan.

- **Switching plans.** Allow alliance members an annual open enrollment season when they could switch plans.
- **Health security cards.** Require the alliance to issue health security cards to all alliance members. Each card — likely to resemble the kind used in automated teller machines — would have information about the identity of the cardholder, the health plan in which the individual is enrolled and supplemental policies that the individual maintains. The bill would give the National Health Board leeway to decide how much health-care information could be encoded into a health card. The card could be used only to help an individual obtain health-care services.
- **Contracting with health plans.** Require the alliances to contract with eligible health plans to provide the standard benefits package to all alliance members. No plan could be turned down unless its premium was more than 20 percent above the per capita premium target set by the federal government or it had a history of failing to adequately provide services. One of the health plans would have to be a "fee for service" plan unless alliance members expressed too little interest in subscribing to one. The fee-for-service option would allow enrollees to choose their own doctors but likely would require higher out-of-pocket payments.
- **Limits on plan enrollment.** Allow alliances to stop over-subscription in health plans. If a plan was filled, the alliance could ask enrollees to select another plan.
- **Setting fee schedules.** Require alliances to negotiate a fee schedule for providers who participate in the fee-for-service plan unless the state negotiated a fee schedule for all fee-for-service plans in the state.
- **Consumer information.** Require alliances to supply information to consumers about the plans offered through the alliance, including comparative data on price, the availability of health professionals, any limits on access to providers and services, and a summary of each plan's rating according to federally set quality standards whose measures would include outcomes of treatment and surgical procedures and access to services.
- **Review of plans' advertising.** Require alliances to approve all plans' marketing materials and ensure that they meet federal guidelines.
- **Ombudsman.** Require alliances to set up an office of ombudsman to handle complaints from alliance members.
- **Plans to serve disadvantaged, inner-city or rural areas.** Allow alliances to create a health plan to serve disadvantaged or remote areas and to arrange favorable financing to encourage the formation of such a plan.
- **Premium collection.** Require alliances to collect premium payments from individuals and employers and subsidy payments from the state and federal governments to help low-income workers, non-workers and small businesses.
- **Premium calculation.** Require alliances to calculate the amount that workers and employers would have to pay based on the price of each plan, the amount needed to contribute to academic medical centers whose services would be available to all Americans, the amount needed to subsidize the needy and the amount needed for staffing.
- **Risk adjustment and health plan payment.** Require alliances to pay health plans after making risk adjustments reflecting the number of people enrolled in a plan and their health status.
- **Alliance administrative costs.** Allow alliances to charge up to 2.5 percent of the total premiums to finance the cost of staff and services.
- **Corporate alliances.** To ensure the solvency of corporate alliances, require the federal government to set up a guarantee fund, financed by an assessment of no more than 2 percent of the premium payments for each plan offered through an alliance. Corporate alliances would also have to pay an additional assessment to help fund academic medical centers.
- **Revisions in the Employee Retirement Income Security**

**Act (ERISA).** Revise the 1974 ERISA law, which pre-empted state law and regulates worker benefits — including benefits from self-insured health plans sponsored by multi-state companies. The revision would require companies of more than 500 workers who want to operate self-insured plans to form corporate alliances.

These alliances would have to ensure that the comprehensive benefits package is available to their employees. Companies would have to offer employees a choice of at least three health plans. Companies forming corporate alliances would continue to have the right to avoid state regulation under ERISA — so that they could avoid dealing with different states' health-care systems. The Department of Labor would oversee compliance of corporate alliances with the law. Corporate alliances may be able to purchase insurance based on the health status of their employees — thus avoiding community rating, which bases premium prices on the health status of the insured population in an area. If the corporate alliance's workers were young and healthy, this would be an economic advantage.

- **Single-payer states and ERISA.** Allow states that adopt a single-payer health insurance system to apply to the Department of Health and Human Services for permission to require corporate alliances to become part of the state health-care system. In other words, the ERISA pre-emption of state law would not necessarily apply in single-payer states.

## Health Plans

The Clinton plan would spur dramatic changes in the current health-care marketplace. Currently, most people who have insurance select a doctor, who then can recommend specialists and hospitals; patients send the bill to their insurer, who generally pays at least half the cost.

Under the Clinton bill, most consumers would select a health plan rather than an individual doctor. The plan would be required to offer a package of guaranteed benefits. To do that, a plan would provide subscribers with access to a group of doctors (primary care physicians and specialists), hospitals, non-physician care providers such as physical therapists and outpatient clinics that offered services such as mental health treatment. Several plans probably would organize as health maintenance organizations (HMOs) or similar networks. Plans could be organized by health-care providers or by an insurance company.

Plans could not turn down any subscriber for any reason, nor could they force anyone to pay a surcharge because of an illness or disability.

The bill would:

- **Benefits.** Require all health plans to offer the comprehensive benefits package.
- **Exclusions.** Require plans to accept every applicant. Plans could not target their marketing to attract or exclude anyone on the basis of personal characteristics such as age, race, occupation or health status. The only permissible limit on enrollment would be if a plan had more subscribers than its staff and resources could handle.
- **Discrimination against providers.** Prohibit plans from engaging in any form of discrimination against a provider on the basis of sex, age, language, race, national origin, disability, socioeconomic status or the health status of the provider's current patients. The goal is to ensure that a doctor who treats AIDS patients could join a plan even though the patients might drive up the plan's costs.
- **Unintentional discrimination.** Allow a plan or plan director to take an action that results in a discriminatory practice if the action is the result of a business judgment and not intentional discrimination. This provision appears to contradict the anti-discrimination and exclusion provisions. The reason is not clear.
- **Permanent coverage.** Prohibit plans from terminating, restricting or limiting coverage for any reason, including non-payment of premiums.
- **Doctor choice.** Require all plans to offer the option of using doctors outside the group, although plans could charge more for that option. This would allow subscribers to choose their own

specialists at the same time they went to a primary care doctor within the group.

- **Grievance procedures.** Require plans to set up a grievance procedure for consumers. Consumers also would be able to lodge grievances with their regional alliances.

- **Community rating.** Prohibit plans from charging subscribers higher rates because they have illnesses or disabilities. The only variation in charges permitted would be to reflect differences in family status (single, couple, one-parent family, two-parent family). No providers could charge amounts in excess of the fee schedule negotiated with the health alliance.

- **Supplemental insurance.** Require plans to offer a supplemental insurance policy to cover deductibles and co-insurance — but not co-payments.

- **Additional benefits and services.** Allow health plans to offer additional insurance for benefits that are not covered in the basic package or for which coverage is limited (such as mental illness or dental care). The bill would set standards and regulations for the sale of supplemental policies.

- **Workers' compensation and auto insurance.** Require health plans to supply the medical services offered as part of workers' compensation and auto insurance plans at the rate paid for fee-for-service providers.

- **Community providers of medical services.** Require plans to contract with "essential community providers" to offer health care to people who are difficult to reach. Alternatively, plans would have to pay community providers on a fee-for-service basis for each visit by an enrollee.

Community providers include migrant health centers, community health centers, homeless program providers, family planning clinics, AIDS providers under the Ryan White Act and rural health clinics. Also included are private and nonprofit hospitals that care for underserved populations.

- **Pre-emption of existing state laws.** Overturn state laws that inhibit the formation of HMOs. These include state laws that prohibit plans from limiting the number and type of providers; requiring enrollees to obtain care from participating providers; requiring enrollees to obtain referrals for specialty treatment; establishing different payment rates for network and non-network providers; creating incentives for the use of participating providers; and using one source for pharmacy services, medical equipment and other supplies. The goal is to remove any legal barriers to the formation of HMOs. The bill also would overturn state restrictions on the independent practice of non-doctor health professionals (such as nurse practitioners) and allow them to perform any duties for which they are trained.

- **Abortion waiver.** Permit doctors, nurses or other health professionals to decline to perform any service if they objected to doing so on the basis of a religious belief or moral conviction.

- **Truth in advertising.** Prohibit false or misleading information in health plans' marketing materials and require plans to submit advertising material to the regional alliance for approval before distribution.

- **Selective advertising.** Prohibit plans from targeting advertising campaigns at selected groups or areas. All advertising would have to circulate across the alliance area.

- **Marketing information.** Require plans to provide all eligible enrollees with information about plan cost, participating providers, cost control procedures that doctors would be required to follow, quality management programs, rights and responsibilities, and information on the rate at which people dropped out of the plan.

- **Quality standards.** Require all plans to measure and disclose their performance rating, which would be based on criteria set by states, regional alliances, corporate alliances and the National Quality Management Council. The council would develop performance measures for assessing health services and access. The council's measures would have to provide information about access to health services, appropriateness, outcomes, prevention of disease and consumer satisfaction.

## Physician Training and Public Health (Title III)

### Doctor Training

The Clinton health-care system would require a major change in the culture of the medical profession. Instead of rewarding medical specialists, the new system would reward physicians who practice preventive medicine and primary care. The bill aims to encourage hospitals that train doctors to reverse the current trend of sending specialists to primary care doctors. By 2000, the bill would require that the percentage of doctors completing their residencies be 50 percent specialists and 55 percent primary care physicians. Hospitals that did not comply would be prohibited from participating in regional alliances. The administration aims to encourage doctors to enter primary care areas by providing financial incentives. Under the bill, the bill would finance such doctor-training subsidies through appropriations, which means they would compete for dollars with other programs.

The bill would ensure that sophisticated medical centers received a steady flow of financial support, but it would require funding. To rationalize giving public funds to academic centers, the bill aims to ensure that all citizens would have access to top center resources. But it is unclear how that would work. Under the bill, many Americans likely would be in managed-care health plans, such as HMOs, which generally restrict the use of the most sophisticated care offered by academic centers.

The bill would:

- **National council of graduate medical education.** Create a national council to oversee the transition of the medical profession from specialty practice to primary care. The council would designate the number of people who could enroll in each specialty annually, starting in the 1998-99 academic year. It would recommend to each residency program how many places to reserve for each specialty. In recommending slots, the council could consider the underrepresentation of minorities in the field of medicine generally and in the specialties.

- **Primary care.** Require that by 1998, at least 55 percent of all graduate medical students (students out of medical school who are entering hospital residency programs) train in the field of primary health care. Primary care includes internal medicine, family medicine, pediatrics, and obstetrics and gynecology. Individual programs could have a different ratio because the bill requires 55 percent only in the aggregate — not program by program.

- **Physician training.** Create a health profession work force account that would partially pay the cost of training doctors in residency programs. This fund would replace the direct medical education account that currently funds medical education. Hospitals with residency programs would have to apply for grants from the fund. The fund would be fed by three sources: the premium charged by health alliances, a 1 percent tax on corporate health care premiums and a transfer from the Medicare program's trust fund. Set up as an automatic payment, it would not require an annual appropriation. It would pay out \$3.2 billion in 1996, \$3.6 billion in 1997, \$4.8 billion in 1998 and \$5.8 billion in 1999. It is not clear whether this would funnel more money into physician training.

- **Nurse training.** Create a graduate nurse training program parallel to the physician training program. It would be administered by a similar advisory council and would allocate slots for nurse practitioners, nurse midwives, nurse anesthetists and other nursing specialties. It would be funded starting in 1996 at \$100 million annually.

- **Academic health centers.** Entitle academic health centers — meaning hospitals affiliated with medical schools or other training institutions — to apply for payments to help cover costs associated with their specialized research and care. Teaching hospitals generally incur higher costs than do other institutions for two reasons. Residents tend to order more tests than do experienced physicians and severely ill patients who need the most care are often referred to academic centers. These payments would replace Medicare's

Direct medical education payment, which currently helps teaching hospitals pay for costs associated with residency programs and highly specialized care. The entitlement would be \$3.1 billion in the 1996 calendar year, rising gradually to \$3.8 billion in 2000. The funds would come from the Medicare trust fund, a tax on corporate alliances and payments to regional health alliances.

• **Access of patients to academic health centers.** Require regional and corporate alliances to ensure that health plans contract with centers so that consumers could be referred to them when they had conditions needing specialized treatment.

• **Research on health reform, health promotion and disease prevention.** Authorize appropriations of \$150 million in fiscal 1995 and \$500 million in each fiscal year from 1996 through 2000 for research on health reform by an arm of the Department of Health and Human Services (HHS). The bill would also authorize \$400 million in fiscal 1995 and \$500 million annually for each fiscal year from 1996 through 2000 for the National Institutes of Health for behavioral research on promoting health and preventing disease.

• **Additional primary care training.** Authorize an additional \$400 million annually for HHS to further encourage training or retraining in primary care for midcareer physicians and physician assistants. It would also fund programs to increase the number of minority doctors and to support midlevel nursing training and some nursing specialties.

• **Health-care work force retraining.** Authorize \$200 million a year for the Department of Labor to create retraining programs for health-care workers to help them adjust to changes in the work force under the bill.

• **National institute for health-care work force development.** Create a national institute, jointly under the secretaries of Labor and HHS, to make recommendations regarding the supply of health-care workers needed to staff the new system and the impact of the bill on health care, health-care workers and their training.

## Public Health

The bill would redesign funding of the public health-care system to create a block grant program for states. The grants could be used for collecting health data, environmental protection (such as lead hazard abatement), violence reduction programs and public education about the hazards of tobacco, drugs and behavior that increases the risk of AIDS. States already engaged in those activities would be required to maintain the same level of funding that they had in the year before the first year in which they received a grant. The total authorized for grants would be \$325 million in fiscal 1996, \$450 million in fiscal 1997 and up to \$750 million in 2000.

A separate program would allow the secretary of Health and Human Services to authorize grants to encourage the prevention of disease. The grants would be available to state and local government agencies, private nonprofit organizations and group coalitions to create community programs on health promotion and disease prevention. The bill would authorize \$175 million in fiscal 1996 and \$200 million from fiscal 1997 through 2000.

## Health Services for Medically Underserved Populations

Because rural areas and inner cities often lack medical services, it will be difficult to ensure that people in those areas get care, even if they have guaranteed coverage. To help ensure that services are available, the bill would augment funds to train providers to work in such communities and create loan and grant programs to enable community health centers to set up networks and expand programs.

The bill would:

• **Migrant and community health centers.** Authorize an additional \$100 million for migrant and community health centers for fiscal years 1995 through 2000. In fiscal 1994, migrant health centers received \$59 million, and community health centers received \$604 million.

• **Community health plans and networks.** Authorize grants to

help providers form health plans and networks to serve underserved areas where there is a shortage of doctors, nurses and medical facilities. Loans also would be available to public and private entities for the capital costs of developing qualified community health centers. The plans would have to eliminate local barriers to care. For example, if clients did not speak English, the plans would need to hire translators. Grants would be authorized at \$200 million in fiscal 1995, \$500 million in fiscal 1996, \$600 million in 1997 and \$700 million in 1998. Then funding would drop, on the assumption that plans had been formed, to \$500 million in 1999 and \$200 million in 2000.

• **Enabling services.** Authorize the HHS secretary to make grants to community health groups to provide services to help poor people obtain health care. Such services would include transportation to and from clinics, translation, community and patient outreach, and patient education.

• **National Health Service Corps.** Authorize additional grants to the corps. The program would pay — through grants and contracts — to educate doctors and other health professionals in exchange for their promise to practice in underserved rural or urban areas, or on Indian reservations. Beyond existing appropriations (\$127 million in fiscal 1994), the bill would authorize \$50 million in fiscal 1995, \$100 million in fiscal 1996 and \$200 million from 1997 through 2000.

• **Payments to hospitals serving vulnerable populations.** Limit to \$800 million the amount that hospitals serving low-income patients could receive. Under current law, hospitals with a disproportionately high number of poor and uninsured patients can get money through a federal-state program known as the disproportionate share program. Designed to cover hospital shortfalls, it currently spends \$16 billion to \$17 billion annually in federal dollars. Under the new system, the disproportionate share program would be eliminated and all hospitals would be covered. But the administration would leave in place a small fund to help hospitals that serve a disproportionate number of illegal immigrants who would not be covered under the national program.

• **Mental health and substance abuse.** Authorize grants to states for substance abuse and mental health-care services of \$100 million in fiscal 1995, \$150 million in fiscal 1996 and \$250 million in fiscal years 1997 through 2000. These funds would augment spending through the Substance Abuse and Mental Health Services Administration, which received \$2.1 billion in fiscal 1994.

## School Health Services

The bill would encourage healthy behavior at an early age by establishing health education programs in schools and by authorizing up to \$400 million annually by 1999 for school-related health services. Priority would be given to communities with the highest level of need among 10- to 19-year-olds as measured by poverty, the presence of a medically underserved population, a shortage of doctors and other health providers, and a high proportion of children with special needs, such as those who are pregnant, members of gangs or exposed to drugs and alcohol.

## Medicare and Medicaid (Title IV, Title II)

### Medicare

The framework of Medicare, the government's health insurance program for the elderly, would remain unchanged. Beneficiaries would have additional coverage for prescription drugs and access to expanded home health-care funding. However, the price of Medicare coverage would rise sharply for wealthier beneficiaries. The program's rate of growth would be sharply reduced, with most of the cuts to be borne by doctors and hospitals. The working elderly and their spouses would be required to buy health care through alliances rather than through Medicare. (*Long-term care, p. 493*)

The bill would:

• **New benefits.** Provide coverage for prescription drugs, which

would be financed in part by charging beneficiaries for the first \$250 of drug costs and 20 percent of all subsequent prescriptions. The bill would also expand coverage for home care through the expanded home and community care benefit. The bill also would allow the elderly poor who are eligible for Medicaid to keep more of their savings while still qualifying for Medicaid-subsidized long-term care.

- **New charges.** Increase the premiums charged to wealthy beneficiaries for Medicare Part B, which covers physician services. Individuals who earn more than \$90,000 a year and couples who earn more than \$115,000 would pay 75 percent of the premium's cost instead of the approximately 25 percent they pay now. Most beneficiaries would also be required to pay a 20 percent co-insurance fee for all laboratory services (such as X-rays) and a 10 percent co-payment for the average costs of home health visits. Currently, Medicare requires no payment for either service.

- **New Medicare-related taxes for state and local employees.** Require those state and local employees who currently are exempt from paying the hospital insurance tax that pays for Medicare Part A to pay the tax. This would affect only those employees hired before 1986. Others already pay the tax.

- **Reductions in reimbursements for physicians.** Reduce the annual increase in physician payment rates (except for primary care physicians) and other payment rates by \$38 billion between fiscal 1995 and 2000.

- **Reductions in reimbursements for hospitals.** Require reductions in payment rates for hospital care totaling \$59.1 billion from fiscal 1995 to 2000. About 30 percent of the savings would come from a new system for paying hospitals to train physicians.

- **Other Medicare savings.** Reduce payments for programs in Medicare that are paid for jointly by Medicare Parts A and B by \$15 billion from 1995 to 2000.

- **Coverage of working Medicare beneficiaries through health alliance.** Require all workers over 65 and their spouses to be covered through health alliances, but entirely subsidize their insurance. Employers would pay 80 percent of premiums, and Medicare would cover the balance. Workers who retired at 65 but who wanted to continue to be covered through an alliance plan could stay in it rather than switching to Medicare.

- **State option to allow all Medicare beneficiaries to enter alliances.** Permit states to apply to the secretary of Health and Human Services to integrate Medicare beneficiaries and payments into the regional alliance system over time.

## Medicare Outpatient Prescription Drug Benefit

The bill would provide coverage for prescription drugs for Medicare beneficiaries for the first time. This is the only major change to Medicare benefits in the bill. Under the existing system, patients buy prescription drugs, and insurance companies reimburse them to the extent of their coverage. Under the new system, the federal government would pay drug manufacturers directly.

The bill would:

- **Included drugs.** Cover most outpatient drugs approved by the Food and Drug Administration — including insulin — for uses approved by the government.

- **Deductible and co-payment.** Require the patient to pay for the first \$250 in drug costs each year, then require the government to cover 80 percent of any costs beyond that until the patient reached the out-of-pocket limit.

- **Out-of-pocket limit.** Include an out-of-pocket limit, set at \$1,000 in 1996. The government would cover 100 percent of a patient's drug costs after a patient had paid out the year's limit.

- **Drug manufacturer rebates.** Require drug manufacturers to refund at least 17 percent of the average manufacturer's price to the federal government for drugs bought through the Medicare benefit. In other words, the government is mandating that it gets a 17 percent discount on drugs. The rationale is that the government, by offering prescription drug coverage, is increasing the number of

people who will be able to afford drugs.

## Medicaid

Medicaid, the federal-state health insurance program for the poor, would be subsumed by the new health alliance system. Medicaid currently pays for medical care for families on welfare through Aid to Families With Dependent Children (AFDC) people who receive Supplemental Security Income benefits, the aged, blind or disabled as well as poor and low-income pregnant women and children from low-income families whose incomes are too high for AFDC. Overall, the federal government pays about 17 percent of Medicaid costs, and states pay about 43 percent. Medicaid beneficiaries must go to a doctor who accepts Medicaid payments — and many physicians decline to accept them because the program reimburses doctors at a much lower rate than private insurance. *State maintenance of effort, p. 501.*

Under Clinton's bill, everyone would receive care through a health plan offered by a health alliance. Medicaid patients would receive the same benefits package as other Americans. That would mean extra services for some Medicaid beneficiaries who currently receive assistance with transportation, translation and rehabilitation. These benefits either are not part of the national benefit package or are not covered to the same extent. Medicaid patients would be required to enroll in the least expensive plan offered by an alliance.

The payment mechanisms for each class of Medicaid beneficiaries would vary, but overall, spending for Medicaid would be sharply reduced. However, since many former Medicaid beneficiaries would be eligible for government subsidies, it is unclear how much the government would save. For instance, all working beneficiaries (such as low-income and pregnant women) would be covered by their employers. But if they earned less than 150 percent of the federal poverty level, they would still qualify for subsidies.

The bill would:

- **Cash, welfare beneficiaries.** Require that the state and federal government pay health alliance premiums for families on AFDC, but only totaling 95 percent of the premium cost for the average benefits package. The government would pay less than 50 percent to keep spending down.

- **Supplemental Security Income.** Treat people on SSI the same as those on AFDC.

- **Low-income children, pregnant women and other beneficiaries who are not on welfare.** Cover low-income pregnant women through a combination of employer contributions and government subsidies. States would continue to contribute their care indirectly through payments into the subsidy pool. The amount would match what the state currently pays, updated for inflation.

- **Changes in spend-down provisions for long-term care.** Allow states to increase to \$12,000 the amount that a recipient must keep in savings and still be eligible for Medicaid-subsidized long-term care. Under current law, Medicaid pays for long-term care of the extremely poor, but has stringent eligibility rules requiring people to spend all but \$2,000 in savings before they can receive the care. States would also be required to allow Medicaid beneficiaries who are nursing home residents to keep at least \$50 a month of their Medicaid payment for personal needs. Currently, about half the states allow residents to keep only \$30. Because this provision would mean that some beneficiaries would contribute less to the cost of their care, the federal government would pick up any additional costs in Medicaid.

- **Extra benefits for children.** Create a program for poor children with special needs to ensure that disabled children not covered under Medicaid continue to have access to coverage to deal with long-term disabilities.

- **Disproportionate share hospital payments.** Term would all but \$800 million annually of the \$16 billion to \$17 billion in disproportionate share payments to hospitals that treat a high number of uninsured people and Medicaid patients. The rationale is that everyone would be insured, so those hospitals would no longer need additional federal aid for uncompensated care. The \$800 million would be used primarily by hospitals that care for high

Numbers of illegal aliens, who are not covered by the bill.

## Legal Issues (Title V)

### Medical Malpractice Claims

Under the Clinton plan, each health alliance would seek to avoid going to court over malpractice claims by adopting an "alternative dispute resolution" system. These systems could include mediation, arbitration or early offers to settle out of court.

The bill would:

- **Alternative dispute resolution.** Prohibit medical malpractice claims against a regional or corporate health alliance from going to court until final dispensation of that claim under the alternative dispute resolution system adopted by each alliance. Such a system could include mediation, arbitration or early offers of settlement. An enrollee dissatisfied with the outcome could then bring suit in state court if a qualified medical specialist determined that the enrollee had a reasonable and meritorious claim.

- **Limitations on contingency fees and awards.** Limit attorney fees in a medical malpractice case to one-third of the amount recovered by judgment or settlement. A plaintiff's monetary damages in a malpractice liability case would be reduced — dollar for dollar — if the plaintiff also received payments from federal, state or private benefits programs as a result of the same injury.

### Fraud and Abuse

The Clinton plan would set up a program aimed at preventing health-care fraud and abuse. The bill would:

- **Fraud and abuse control.** By Jan. 1, 1996, create a program to coordinate efforts between the Justice Department and the Department of Health and Human Services to prevent, detect and control health-care fraud and abuse. Activities would be coordinated with other federal, state and local agencies and with each health alliance and plan.

- **Anti-Fraud Account.** Create an Anti-Fraud Account to fund the fraud and abuse control program. It would include money from health plan criminal fines, civil penalties and damages. The fund could accept outside gifts.

- **Exclusion from health plans.** Exclude individuals or entities convicted of health-care crimes or patient abuse from participating in any health-care plan for no less than five years. Those convicted of health-care fraud could be excluded from participating in any health-care plan for a certain period, depending on the severity of the offense.

- **Civil penalties.** Impose civil penalties for such infractions as: denying enrollment on the basis of medical condition; inducing enrollment under false pretenses; providing incentives to enroll in a plan; and unlawfully terminating enrollment. Generally, penalties would not exceed \$50,000 for each offense. The secretary of Labor and each state could also initiate civil actions against health-care alliances or plans, with the approval of the attorney general and secretary of Health and Human Services.

- **Criminal penalties.** Impose fines or prison terms up to 10 years for people convicted of defrauding or attempting to defraud a health alliance, health plan or someone connected with the delivery of health care. Anyone convicted of making false statements or falsifying information could be fined and sentenced to no more than five years in prison. Anyone convicted of bribing or attempting to bribe health-care officials could be fined and sentenced to prison for no more than 15 years. The same would hold true for those health-care officials demanding bribes. Anyone convicted of stealing or embezzling the property of a health alliance or health plan could be fined and sentenced to no more than 10 years in prison. Anyone convicted of requiring the use of the health security card or health identification number for a purpose not intended under the Health Security Act — to prove legal status, for example — could be fined and sent to prison for no more than two years. Proceeds derived

from health-care fraud or other health related crimes would be forfeited and returned to the injured party.

### Antitrust Exemptions

The bill would repeal the McCarran-Ferguson Act of 1945 which exempts the insurance industry from federal antitrust law if the industry is regulated by a state. In fact, all 50 states do regulate their insurance industries, effectively supplanting federal antitrust law nationwide. Under the Clinton bill, insurance companies would be subject to federal antitrust law.

The bill would also:

- **Loosen some antitrust rules.** Allow doctors and other health-care providers to join together to negotiate fee schedules for the fee-for-service plans offered by health alliances. The aim is to even the playing field so that doctors bargaining individually with the large alliances would be at less of a disadvantage. They would be prohibited, however, from colluding on a boycott or threat of a boycott of an alliance because they felt its proposed fees were too low.

## Finance (From Title VI, VII, IX)

### Premium Caps

The bill seeks to reduce government health-care spending as well as overall national spending. It takes two approaches to reducing national spending: market reforms and caps on the amount that health insurance premiums could rise annually. To reduce government spending, the bill would limit the amount the government could spend annually on subsidies for employers and individuals.

The controversial premium caps would limit the annual rise in consumers' costs by controlling the percentage that premiums could rise. The health-care industry dislikes the caps because they would force health plans to limit payments and profits to doctors, hospitals and suppliers of medical equipment and pharmaceuticals. Although the Clinton proposal would give the marketplace the flexibility to decide where to make cuts, the caps would leave little room for industry expansion and would reduce its rate of growth by half in the first year. No health-care system in the developed world and no other reform bill has as tight a limit on annual cost increases.

The only other method of cost containment that Clinton could have selected would have been to have the government set reimbursement rates for doctors, hospitals and all other health-care goods, as it does for Medicare. Clinton opted for the cost containment method that would leave many cost-cutting decisions up to market forces.

The bill would:

- **National baseline premium.** Require the National Health Board to determine the average premium nationwide by Jan. 1, 1995. Based on medical expenditures in 1993 and inflated to 1995 costs, the amount would be used to calculate a target premium for each alliance.

- **Regional alliance premiums.** Require the national board to determine a target premium for each alliance (about 200 expected) including an inflation factor and taking into account the percentage of people who are uninsured or underinsured in the region and variations in the proportion of expenditures for academic health centers. If the average premium bid made by a health plan (a network of doctors and hospitals) and accepted by a regional alliance for a year exceeded the target, then for the next two years the target would be reduced.

- **Premium inflation factor.** Require the National Board to publish each year an inflation factor for each alliance. The inflation factor would be the general health-care inflation factor, adjusted to take into account changes in the demographic and socioeconomic characteristics of the alliance population and to reflect any changes in the value of the benefits package. The general health-care inflation factor from 1996 to 2000 would be the increase in the Consumer Price Index — 2.7 percent in 1993 — plus: 1.5 percent in 1996; 1.0 percent in 1997; 0.5 percent in 1998 and nothing in 1999 or

2000. This is one of the bill's key cost containment provisions.

- **Health plan bidding.** Require regional health alliances to obtain bids from health plans to provide the benefits package at a certain price. The alliance would report to the national board, which would determine the average premium that had been bid for the alliance. If the amount was greater than the alliance's premium target (set by the board), the board would notify the alliance with the aim of reducing the premium bids from plans that were above the target. Once a plan started bidding, it would have to accept any reductions demanded by the alliance — making the system unlike bid negotiations in the business world. If an alliance reduced a bid, affected plans would reduce providers' pay rather than reducing services to consumers.

- **Cost containment authority.** Allow states to decide whether they would enforce the cost containment measures or leave that responsibility to the federal government.

- **Cost control enforcement for health plans.** Require alliances to reduce payments to plans to bring per capita payments in line with the target set by the National Health Board.

- **Corporate alliance payments.** Require the National Health Board to calculate a formula by 1998 for computing the annual amount per person that corporate alliances would have to spend for the benefits package and the amount that corporate alliance premiums could rise annually. If a corporate alliance's premiums exceeded the corporate inflation rate, the employers would be forced to join the regional alliance and would not be eligible for premium subsidies for the first four years.

- **Single-payer states.** Require the board to compute a state-wide per capita premium target in the same way that it would determine the regional alliance premium.

## Premium-Related Financing

The bill lays out the formula that would be used to determine the amount of the premiums that would be paid by individuals, families and employers. Individuals would be responsible for their health insurance premiums but also would receive a credit from their local alliance covering 80 percent of the average cost of their premium. Employers would pay 80 percent of the average cost of workers' premiums. Smaller employers would qualify for subsidies.

The bill would:

- **Family payments.** Require every family enrolled in an alliance health plan to pay the "family share" of the premium — about 20 percent of the cost. It would be calculated by adding the cost of the family's health plan plus a small charge to help alliances pay for premiums owed but not paid. It would subtract the "regional alliance credit," equal to 80 percent of the average alliance premium. In addition, low-income families (earning up to 150 percent of the federal poverty level, now \$14,800 for a family of four) would qualify for income-related subsidies on the family share (20 percent) of the premium. For working families, the alliance credit would be paid in large part by employers.

- **Employer payments.** Require employers to pay about 80 percent of the average cost of insurance for all employees, based on their family enrollment status. Employers would pay different premiums for each class of employee: individuals, couples, single parents with children and couples with children. The amount an employer paid would be adjusted to reflect the average number of workers in each class. For instance, if the average number of workers per couple in the regional alliance were 1.5, the employer would pay the premium for the couples class, divided by 1.5. The result is that two-worker couples and their employers would subsidize the cost of insurance for one-worker families.

- **Self-employed individuals.** Classify self-employed individuals as "small businesses," making them eligible for subsidies on the 80 percent employer share of the premiums, the same as businesses of fewer than 75 employees. They also would be eligible for subsidies for the 20 percent individual share if they earned less than 150 percent of the federal poverty level. A self-employed person earning \$10,000 a year (which is less than 150 percent of the poverty level of \$7,360 a year) would be eligible for subsidies as a small

business and as an individual.

- **Corporate alliance employers.** Require corporate alliance employers to pay for at least 80 percent of an employee's health care either through payments to a corporate alliance health plan or to a regional alliance plan, if an employee is enrolled in a regional alliance.

- **Payments to health plans by regional alliances.** Require alliances to pay plans on a per capita basis a premium that reflects both the price the plan charges working people for their premium and the amount the government pays to subsidize poor people. Since the per capita amounts that the government would pay for the poor would be only 95 percent of the plans' costs, plans would always have a shortfall.

They presumably would be expected to economize to make up the difference. The amount a plan would be paid would be adjusted to reflect the health status of its subscribers minus the administrative allowance for the regional alliance (not to exceed 0.5 percent) and the 1.5 percent of alliance premiums that go to finance academic medical centers and graduate medical education. In addition, states could charge plans directly up to 2 percent of premiums to pay for the guarantee fund that states would maintain to cover the costs of failed plans.

## Government Payments

The existing mix of programs that distributes state and federal dollars for health care for the poor would be reshuffled. Overall, states would pay less than they do now. But some states could pay more, particularly for services no longer covered by Medicaid, such as transportation to clinics. States and local governments also would face new spending as employers, because they would have to pay for their employees' health insurance. The federal government's subsidy payments for the poor and for low-wage firms would be capped.

The bill would:

- **State maintenance of effort.** Require states to continue to contribute to the cost of care for Medicaid beneficiaries who under the bill would no longer receive coverage through Medicaid. These beneficiaries would include low-income children, low-income pregnant women and several other groups.

States also would contribute to the cost of additional services such as translation and transportation to clinics, for children of welfare beneficiaries. Those services would not be covered in the benefits package. The state contribution, which would be paid to the regional alliances, would equal the amount that states paid in 1993 for those beneficiaries' care, increased to reflect inflation and other factors.

- **Federal subsidy cap.** Limit the amount the federal government would pay for welfare and Social Security insurance recipients and for subsidies for the poor and small businesses. The capped amount would be allocated among the regional alliances on a per capita basis. The amount would be capped at \$10.3 billion in fiscal 1996, \$28.3 billion in fiscal 1997, \$75.6 billion in fiscal 1998, \$74.9 billion in fiscal 1999 and \$81 billion in fiscal 2000. This is one of the key provisions to control government spending.

- **Subsidy shortfalls.** Require the secretary of Health and Human Services to alert the president, Congress and regional alliances of shortfalls in the amount of subsidies available. The president would have to submit legislation that would eliminate the shortfalls, presumably either by reducing federal responsibilities for payment or by increasing revenues. Congress could consider the president's proposal on an up-or-down vote.

- **Borrowing authority.** Authorize the HHS secretary to make loans to the regional alliances to cover cash-flow shortfalls. The total amount that could be borrowed at any one time would be \$3.5 billion. The interest rate would be determined by the secretary of the Treasury based on the current average rate on U.S. Treasury notes — a rate well below that set by commercial lenders.

- **Women, Infants and Children (WIC) fund.** Set up a special fund that would make automatic payments annually to ensure full funding for the Women, Infants and Children program, which gives poor women vouchers to buy food, diapers and other child-care

sions. The fund would be used only if Congress appropriated insufficient amount to fully fund the WIC program.

## Taxes

The bill would.

- **Cigarette tax.** Raise the excise tax on cigarettes by 75 cents a pack, effective Oct. 1, 1994, bringing the federal tax on cigarettes to 99 cents. Taxes on other tobacco products, including cigars, pipe tobacco, snuff, chewing tobacco and cigarette rolling papers, would be subject to comparable increases. A tax would be instituted for so-called roll-your-own tobacco, equal to \$12.50 per pound. The bill would also change the way the tobacco excise tax is applied. For example, the bill would repeal tax-exempt sales to cigarette manufacturers' employees.

- **Corporate alliance tax.** Require corporations of more than 5,000 employees that choose to provide health care through their own alliance to pay a tax equal to 1 percent of their total payroll. The assessment would begin Jan. 1, 1996. It would help fund academic medical centers, which are now funded through Medicare

- **Early retirees.** Impose an assessment on employers who currently pay health insurance for early retirees, ages 55 to 64, but would not pay it under the Clinton plan. The assessment would be equal to 50 percent of a retiree's average health costs in 1991-93, or the amount by which the employer's health costs were reduced by enactment of the Health Security Act, whichever is greater. The assessment would apply in 1998, 1999 and 2000.

- **Wealthy elderly.** Require wealthy taxpayers who enroll in Medicare Part B, the portion of the government's insurance program for the elderly that subsidizes physician care, to pay more on their individual income taxes. The additional amount in effect would raise the amount these taxpayers pay for Medicare Part B from roughly 25 percent of the program's costs to about 75 percent. Individuals with income of \$90,000 or more and joint filers with income of \$115,000 or more would be affected. Those thresholds would be determined by combining adjusted gross income (including taxable Social Security benefits) and tax-exempt interest income. This would take effect Jan. 1, 1996.

- **Subchapter S.** Require shareholders in certain service industry Subchapter S corporations, which are closely held businesses, to pay self-employment Social Security tax on non-wage income from the corporation. Shareholders with 2 percent or more of an S corporation stock would be eligible, and limited partners who materially participated in the business would be taxed similarly.

- **State and local government employees.** Require all state and local government employees and their employers to pay the hospital insurance portion of the FICA (Social Security) tax, making them eligible for Medicare coverage. Currently, some state and local government employees are covered by separate health insurance plans. This would take effect Oct. 1, 1995.

- **Academic medical centers.** Impose a 1.5 percent assessment on premiums purchased through regional alliances to help underwrite academic medical centers and medical education. This would begin Oct. 1, 1995.

- **Income calculation.** Require individuals who receive certain health benefits from their employers to include them in their annual income for the purpose of calculating taxes owed. The aim would be to promote cost consciousness. Beginning Jan. 1, 1997, individuals would have to count health benefits delivered through cafeteria plans as income. In cafeteria plans, employees choose specific kinds of coverage from a range of choices. Beginning in 2003, employees would be taxed on supplemental health coverage paid by employers.

- **Self-employed tax deductibility.** Permit self-employed people to deduct the entire cost of premiums paid to a health alliance for the benefits package. The current 25 percent deduction would continue until a taxpayer's state of residence established a regional alliance, at which time the 100 percent deduction would take effect.

- **Independent contractors.** Give the secretary of the Treasury authority to issue regulations defining who is an independent contractor. That provision is intended to prevent employers from avoiding health-care premiums for employees they illegally classify

as independent contractors. The penalty for not reporting a payment made to an independent contractor would be set at \$50 or 5 percent of the payment, whichever was higher.

- **Retiree health premiums.** Require higher-income taxpayers who retire between the ages of 55 and 64 to repay subsidies provided for the employer share of their health insurance premiums. Repayment would be required for individual taxpayers with incomes over \$90,000 and couples making above \$115,000. Calculation of income includes the taxpayer's adjusted gross income (including taxable Social Security benefits) and tax-exempt interest income. Repayment of the premium subsidy would be carried out through tax returns. This would take effect after Dec. 31, 1997.

- **Retiree medical accounts.** Prevent employers from receiving a tax break for contributions to so-called retiree medical accounts, used for medical expenses as part of a pension plan. Funds already contributed would continue to receive beneficial tax treatment.

- **Blue Cross/Blue Shield.** Remove certain special tax benefits provided for Blue Cross/Blue Shield organizations, which they currently receive because they provide open enrollment on a community-rated basis. The bill would eliminate a provision in which Blue Cross/Blue Shield plans are taxed at the alternative minimum tax rate of 20 percent, rather than the full 35 percent corporate tax rate. Certain Blue Cross/Blue Shield organizations with high community ratings would receive special tax treatment that would allow them to continue to receive the 20 percent tax rate for an additional two years after enactment of the bill. In addition, Blue Cross/Blue Shield would be required to include 20 percent of the annual change in unearned (or uncollected) premium reserves in its taxable income. Currently Blue Cross/Blue Shield may deduct all unearned premiums.

- **Leaving a job.** Eliminate the requirement that companies offer continuing health coverage to employees who leave their jobs. The repeal would take effect on Jan. 1, 1998, or on the date that all states have a regional alliance in effect, whichever is earlier. Prior to repeal, coverage for affected employees and their beneficiaries would end when they were eligible to receive health care through an alliance.

- **Alliance tax exemption.** Exempt regional health alliances established under the bill from federal income tax.

- **Bond rules.** Specify that bonds used by a health-care alliance or state guarantee fund would be for private business use. That means that proceeds of bond issues more than 10 percent of which went to finance activities of the alliances would not be tax-exempt.

- **Tax deductibility of long-term care insurance.** Permit individuals to claim a tax deduction on premiums for qualified long-term care insurance. This would be effective Dec. 31, 1995. In addition, taxpayers would be permitted to exclude from their taxable income up to \$150 a day for benefits paid through long-term care policies. The \$150 cap would rise with inflation.

- **Employer tax deductibility.** Allow employers to claim a tax deduction on premiums paid on behalf of employees for long-term care coverage. The employees would be able to exclude the value of such employer-paid coverage from their income for tax purposes.

- **Disabled people.** Permit incapacitated people to claim a deduction for qualified long-term care expenses.

- **Terminally ill patients.** Lift income taxes on accelerated payments of life insurance benefits to terminally ill patients. This would be effective Jan. 1, 1994.

- **Tax credits for physically impaired.** Provide a tax credit of up to \$7,500 to help defray the cost of certain services related to daily living purchased by the physically impaired. The credit, which provides a dollar-for-dollar reduction in taxes owed, would be equal to half the taxpayer's earned income but no more than \$7,500. Taxpayers with adjusted gross incomes of more than \$70,000 would not be eligible. The credit would be non-refundable, meaning it would not be available to taxpayers too poor to owe taxes.

- **Underserved areas.** Provide a tax credit to encourage physicians to practice in areas that are short of doctors. The credit, which would provide a dollar-for-dollar reduction in taxes owed, would be for up to \$1,000 per month for up to 60 months. Qualified doctors would have to work in the area for five consecutive years to receive

the full credit, although a partial credit would be available for two consecutive years. A less generous credit would be available for nurse-midwives, nurse practitioners and physician's assistants in underserved areas.

- **Medical equipment.** Increase the amount that purchasers of medical equipment could deduct from their taxes in the first year to \$27,500, an increase of \$10,000.

- **Prepaid health-care premiums.** Limit the deduction that taxpayers could claim for prepaying health-care premiums. Specifically, if a taxpayer paid a premium for medical care which provided benefits beyond 12 months after the payments, the deduction would have to be claimed over the full period of the coverage. This provision, which would take effect after Dec. 31, 1995, would not apply to qualified long-term care premiums.

## Other Government Health Programs (Title VIII)

### Military Health Care

The bill would not establish a new military health-care system, but would give the secretary of Defense authority to design a new system once a national health system was in place.

The plan gives wide discretion in fashioning a new system, allowing the secretary to use existing military hospitals and clinics in conjunction with civilian health plans.

The bill would set basic ground rules for any new military health-care system. It includes a provision that would, for the first time, allow the Defense Department to be reimbursed by outside health plans, including Medicare. Military family associations have been fighting for years to allow retirees eligible for Medicare to continue using the military health-care system after they turn 65.

The Pentagon currently operates a two-tiered military health-care system. Active-duty military personnel get free care at Defense Department facilities. Military retirees and their dependents and spouses of active-duty members can use those medical facilities if there is room. If not, they use the military's insurance system, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). They pay no annual premiums for CHAMPUS, but do pay up to 35 percent for doctor visits and procedures.

The bill would:

- **Active-duty soldiers.** Maintain virtually free health care for active-duty soldiers. Members who have been on active duty for at least 30 days would pay only "subsistence charges" for their health care. Out-of-pocket expenses for spouses, children and retirees would be capped. The military health-care plan could not charge more than other health plans.

- **Uniform benefits.** Require any military health-care system to provide beneficiaries with the same benefits package available under the overall national health plan.

- **Waivers.** Allow a Defense secretary who decided to include a civilian health plan as a part of the new military health-care system to award the contract without going through the usual Pentagon competitive-bid process.

- **Medicare recipients.** Allow Medicare recipients who are military retirees to use the military plan. It also would require Medicare to pay the Defense Department for all beneficiaries who use the military health system. Under current law, military retirees who become eligible for Medicare may no longer use CHAMPUS, although they may use military hospitals if there is room.

- **Pentagon payments.** Require the Defense Department to pay the employer's share of insurance premiums for people eligible for the military health-care plan who choose to join another plan. But if, for example, the spouse of an active-duty soldier were employed, the employer would have primary responsibility for paying the employer share of the premium.

The Defense Department would not make such premium pay-

ments for people enrolled in the Department of Veterans Affairs or the Indian Health Service plans.

- **Pentagon financial account.** Establish a fund to allow the Pentagon to take in all money paid to the Defense Department by Medicare and other health services.

- **Congressional report.** Require a secretary of Defense who chose to establish a new plan to describe the plan to Congress 60 days before issuing the rules to carry it out.

- **State pre-emption.** Pre-empt state laws. A state could not impose its standards on the military plan nor deny it certification.

### Federal Employees Health Benefits

Federal civilian employees worldwide would be asked to keep their current health-care coverage until 1997, when all regional alliances are due to be running. Unlike other Americans, the 1.5 million federal employees, retirees and their dependents will not have to join the new state-based plans as they become available.

The administration proposed such a phaseout in 1994, but unions partial to the highly praised Federal Employees Health Benefits Plan (FEHBP) fought to keep it as long as they could. FEHBP annually offers federal workers up to a dozen choices of fee-for-service and health maintenance organization (HMO) plans. Each year workers can switch plans during "open season" in March.

After 1997, federal employees will have to enroll in one of their home state's health plans. About 200,000 employees living in Washington will choose from the District of Columbia plans. Temporary and lower-paid federal workers will receive discounts to pay for health insurance.

Administration officials say FEHBP subscribers will not experience a significant change because the alliances and state single-payer plans are supposed to operate much like the federal government. They will provide consumer choice and ban waiting periods or exclusions because of pre-existing conditions or new illnesses.

Under the Clinton plan, the government will contribute 40 percent of the premium, rather than an average of 72 percent currently provided to FEHBP subscribers.

However, unions fear that the premium savings could be offset by higher deductibles and copayments. D.C. residents also wonder if the city's high-risk population will force premiums up.

The bill would:

- **FEHBP termination:** Terminate the Federal Employees Health Benefits Plan (FEHBP) on Dec. 31, 1997.

- **Enrollment:** Require the government to treat federal employees and others who would have been eligible for FEHBP — including retirees and dependents — as any other non-federal employees when they leave the FEHBP plan.

- **Supplemental plans:** Allow current retirees to enroll in a government subsidized supplemental plans — such as dental or prescription drug plans — that would maintain or "reasonably reflect" their current level of health coverage even if Medicare coverage changes. Future retirees and current employees would not necessarily be offered subsidized supplemental plans.

- **Non-U.S. residents:** Require the Office of Personnel Management to establish a program that would replace health coverage for eligible federal workers living abroad once FEHBP is terminated.

- **Funding:** Require the government to pay for the premium contribution from the appropriation or fund that currently pays for the government's part of FEHBP.

- **Transition:** Maintain the Employee Health Benefits Fund, which supports the government portion of FEHBP, after the insurance program is terminated for as long as the Office of Personnel Management considers necessary to satisfy outstanding claims.

### Veterans Health Care

Under the legislation, the Department of Veterans Affairs (VA) health system would be integrated into the new health-care structure through a network of VA doctors and hospitals within each health alliance. In essence, the VA plan would become one of several health plans offered by each health alliance, while remaining a

separate government-run system.

The VA administers the largest government-run health-care system in the nation, with 171 hospitals, 128 nursing homes and hundreds of outpatient clinics. It serves more than 2 million veterans annually.

Health alliances would offer veterans a VA health plan as an option, in addition to the other plans available to the public. The secretary also could offer the plan to veterans' family members.

Those who receive free care from the VA — mostly poor veterans and those with service-connected disabilities — would retain free VA services. Others, who are currently required to pay some of the cost of VA treatment, would pay premiums, deductibles and other charges, as if the VA were a private health plan.

The secretary would have greater flexibility to restructure the VA's health system by, for example, closing a facility or reconfiguring it to meet different needs. In addition, the secretary could apply for outside grants and advertise for potential customers.

The bill would:

- **Enrollment:** Allow veterans and the dependents of those with service-connected disabilities to enroll in the VA health plan. The VA secretary could authorize the enrollment of spouses and children of veterans in the plan.

- **Benefits:** Require the VA to provide each enrollee with at least the same comprehensive benefits package offered under the national health-care plan. The VA also would provide eligible veterans with all health services currently authorized by the VA but not included in the comprehensive benefit package. Veterans not enrolled with the VA could still receive VA services, but only if the VA plan were reimbursed for costs by that veteran's health-care plan.

- **Costs:** Require the VA to offer free care to certain veterans, including former prisoners of war, the indigent and those with service-connected disabilities. All others would pay premiums, co-payments and deductibles based on rules established by the health alliance under which the VA plan operated.

- **Medicare reimbursement:** Require the Department of Health and Human Services to reimburse the VA for treatment of enrollees who are eligible for Medicare but are not eligible for free VA treatment. Veterans who fell into this group would pay any deductible or co-payment not covered by Medicare.

- **Supplemental insurance:** Allow the VA to be reimbursed for treating any enrollee in the VA plan who is covered by supplemental insurance plans to the extent of that person's coverage.

- **Health-care fund:** Establish a revolving VA health plan fund to receive payments from enrollees in VA health plans. The fund would be available to cover the plans' expenses. Payments from enrollees for VA health plan treatment in which the costs already were covered by appropriations would be transferred to the Treasury Department. This last provision is intended to reimburse the federal government for the start-up cost of new VA services that eventually would be paid for by the enrollees.

- **Organization:** Organize VA health facilities within the general structure of health plans established under the Health Security Act. VA facilities in each region would be organized to operate as one or more health plans.

- **State pre-emption:** Pre-empt state laws that impose any requirement on a VA plan that is inconsistent with federal laws. States could not deny certification of a VA health plan because of a conflict between state and federal laws.

- **Contracting:** Allow the secretary to contract with other health providers for services the VA cannot provide or cannot provide as cheaply.

- **Resource sharing:** Allow the secretary to enter into agreements with other health providers to share resources.

- **Administrative flexibility:** Allow the secretary to: reorganize the VA; contract for services previously provided by VA employees and establish procedures for VA health plan employees.

The secretary also could use non-appropriated funds, such as payments by enrollees, for promotion, advertising and marketing of the VA health plan.

- **New funding:** Authorize creation of a fund from fiscal 1995 to

to 1997 to aid in the operation of new VA health plans. The fund would receive \$1 billion in fiscal 1995, \$600 million in fiscal 1996 and \$1.7 billion in fiscal 1997 — but only if the appropriations for VA medical programs each year matches or exceeds the president's budget request.

Under the bill, VA health plans could accept outside grants and other funds not normally available to government-run health plans if the money were intended to meet the needs of special populations, such as veterans who are homeless or who have AIDS.

## Indian Health Care

To provide health care to the nation's Indian population, Clinton has proposed expanding and improving the Indian Health Service (IHS), the primary provider of health services to Indians. The IHS would operate outside Clinton's proposed system of regional health alliances, but eventually would offer the same benefits. Indians could elect to enroll with either the IHS or an alliance. The plan would include powerful financial incentives to encourage Indians to select an IHS health program.

Through a series of treaties and agreements, the federal government has been obligated to provide health services to Indians since the 1830s. That commitment manifests itself today as the IHS, a comprehensive health system of more than 40 regional hospitals serving 1.3 million of the approximately 2 million Indians. In fiscal 1994 Congress appropriated roughly \$1.9 billion for the IHS.

Last March, tribal leaders announced that they opposed joining the IHS into a national system of regional health alliances that would be subject to state oversight. They feared they would lose some authority over health programs.

The bill would:

- **Purchasing health insurance.** Provide Indians with the choice of enrolling in an IHS health program or a regional health alliance. Indians who chose an IHS plan would not pay any premiums or other health-care costs. Those who enrolled in an alliance would pay premiums and other health-care costs.

- **Tribal governments.** Exempt tribal governments and organizations from making employer premium payments to providers.

- **Indian Health Service improvements.** Provide for the renovation, improvement and construction of hospitals and other IHS health facilities using authorized appropriations and guaranteed loans offered by a revolving loan fund created under the plan.

- **Guaranteed benefits.** Guarantee that by 1999 the IHS would provide the same comprehensive benefits provided by regional health alliances. Indians also would continue to qualify for free supplemental benefits. The bill would authorize \$180 million for supplemental benefits in fiscal 1995, \$200 million in fiscal 1996 through 1999 and unspecified funds in fiscal 2000.

- **Contracting.** Allow IHS programs to provide services on behalf of other health plans, as long as the service did not affect IHS care of the Indian population.

- **Consultation.** Require the Health and Human Services secretary to consult with Indian representatives every year about health care initiatives.

- **Authorized appropriations.** Beyond supplemental benefits, the bill would authorize \$40 million in fiscal 1995, \$180 million in fiscal 1996 and \$200 million in fiscal years 1997 through 2000 to improve and expand IHS facilities and programs.

## Workers' Compensation, Auto Insurance

The bill would require that health plans provide care or arrange for care when individuals have a workers' compensation claim or an auto insurance medical claim. Initially, the financing for workers' compensation and auto insurance would not change; those carriers would pay the injured person's health plan to provide the care.

The bill also would:

- **Commission on Integration of Health Benefits.** Establish a 15-member commission that would study whether the responsibility for workers' compensation and the medical portion of automobile insurance should be transferred permanently to health plans. The commission would report to the president by July 1, 1995.

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## **Clinton Presidential Records Digital Records Marker**

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### **CEO Letters**

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**HUMAN RESOURCES DEPARTMENT**

**Bethlehem Steel Corporation**  
**1170 Eighth Avenue**  
**Bethlehem, Pennsylvania 18016**  
**Fax: (610) 694-3497**

8/3/94

**To:**

ALEXIS HERMAN

ASST. TO THE PRESIDENT

DIRECTOR OF OFFICE  
OF PUBLIC LIAISON

THE WHITE HOUSE

**From:**

BENJAMIN C. BOYLSTON

**Message:**

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We are transmitting 3 page(s), plus the cover page.

If you do not receive all the page(s), please call back as soon as possible.

Name: Sara Phillips

Phone: (610) 694-5195

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Cleveland, OhioBethlehem Steel Corporation  
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of America, AFL-CIO  
Pittsburgh, PennsylvaniaArmco Steel Co., L.P.  
Middletown, OhioACME Steel Company  
Akron, OhioWhiting Pittsburgh Steel Corporation  
Pittsburgh, Pennsylvania

July, 1994

Dear Employee,

Re: Health Care Reform

You have been reading in the press and hearing on radio and TV a great deal about the debate in Congress on Health Care Reform. We believe that it is important that you be well informed on this subject which means so much to all of us.

The need for comprehensive Health Care Reform -- reform that constrains spending, guarantees coverage to all Americans, and improves the quality of care -- is greater now than ever before.

Yes, we have a Health Care Crisis! For those who do not see the crisis, we would point to the following facts:

- 39 million Americans have no insurance -- the number of uninsured increased by over 2 million between 1991 and 1992.
- One out of four Americans will lose health insurance for some period during the next two years.
- Losing or changing a job often means losing health insurance.
- Health care costs are rising faster than other sectors of the economy. Costs are projected to exceed \$1 trillion in 1994, and Congressional Budget Office predicts national health expenditures totaling \$1.68 trillion by the year 2000.

The United Steelworkers of America and Bethlehem Steel support the basic principles of Health Care Reform outlined by President Clinton. The President's Plan and that which is evolving in Congress maintains the present employment-based health care system, but requires that all employers must share at least 80% of the cost for their employees. The employer mandate is essential for securing universal coverage, financing comprehensive benefits for the undercovered and the uncovered, and avoiding taxation of employee benefits.

We believe fundamental reform is necessary at the national level, and that it must address cost, access, and quality. Such reform must be consistent with the following key principles:

1. Universal coverage must be addressed. All Americans should have the security of a comprehensive health benefits package. We support the principle that working Americans should be covered for health insurance through the workplace -- with appropriate subsidies for small business -- and that nonworking Americans, regardless of their circumstances, should be covered through broad community programs.

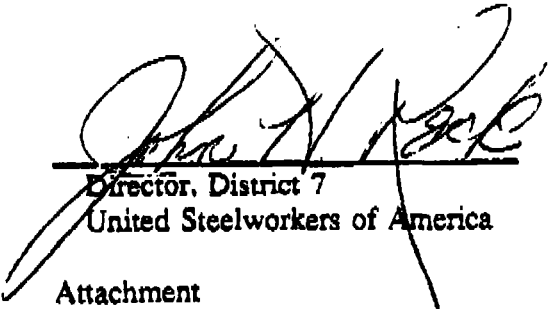
2. Costs control must be addressed. Aggregate growth in our Nation's Health Care System must be controlled. We support the use of national global budgets or spending targets to bring the annual escalation in health care costs down to an acceptable level (the CPI inflation rate).
3. Cost shifting must be eliminated. Legislation is needed to ensure that public and private payers pay the same for health care through all-payer regional rate-setting reimbursement schedules for provider fees.
4. We must ensure that we maintain the quality of health care with the use of appropriate tools such as practice protocols, technology assessment, quality measurement systems, and National Quality Data Bases.
5. Administrative waste must be eliminated through the use of standard identification cards and claim forms and electronic processing.
6. Malpractice reform is needed to reduce costs associated with medical malpractice suits and defensive medicine.
7. Medicare must remain as the primary payer for the elderly.

Committees in the U.S. Senate and U.S. House of Representatives are currently drafting Health Reform legislation. It is essential that the Congress successfully complete its work and pass comprehensive Health Reform in 1994 and not settle for minimal reforms. The Administration's Plan and legislation reported by three of the four Congressional Committees provide for improved coverage for early retirees between ages 55-64.

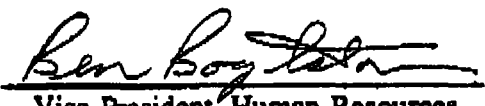
If you believe, as we do, that comprehensive reform is needed to ensure that all Americans have health care and that costs are controlled, we urge you to call or write your elected representatives in Washington, D.C. Your message to Congress is simple. Tell them that:

- All Americans should have health coverage.
- Costs must be brought under control.
- National spending targets must be set to lower costs.
- Rate controls are needed so everyone pays the same for care.

Time is short! And the stakes are important to you and to our industry. Please contact your Representatives and Senators and urge them to support comprehensive health reform to ensure health coverage for all Americans through shared responsibility and cost controls through meaningful restraints on premiums and rates.



Director, District 7  
United Steelworkers of America



Vice President, Human Resources  
Bethlehem Steel Corporation

Attachment

# Let Washington Know

## IF YOU BELIEVE THAT:

- Health care costs are out of control.
- Global budgets should be established at the federal level to curb health care cost increases and bring them in line with the nation's overall inflation rate. (Currently health care costs increase three times faster than inflation.)
- Rate controls should be established so that all payers—public and private—pay the same amount.
- Cost shifting must be stopped before it cripples America's businesses.

**THEN**, tell your elected representative in Washington, DC.  
Tell them that:

- All Americans should have health insurance.
- Costs must be brought under control.
- Global budgets must be set to lower costs.
- Rate controls are needed so everyone pays the same for care.
- Cost shifting must be eliminated.

*Tell them in a brief, handwritten letter mailed to the address listed below or call them.  
Call 1-800-9-CARE-94 and tell the operator the name of your elected representative.  
You will be connected directly to his/her office.*

### U.S. REPRESENTATIVES

Telephone 1-800-9-CARE-94

(Address for all is: U.S. House of Representatives,  
Washington, DC 20515)

The Honorable John P. Murtha (D-PA)  
2423 Rayburn House Office Building

The Honorable Paul F. McHale, Jr. (D-PA)  
511 Cannon House Office Building

The Honorable George W. Gekas (R-PA)  
2410 Rayburn House Office Building

The Honorable Helen D. Bentley (R-MD)  
1610 Longworth House Office Building

The Honorable Benjamin L. Cardin (D-MD)  
227 Cannon House Office Building

The Honorable Kweisi Mfume (D-MD)  
2419 Rayburn House Office Building

The Honorable L. William Paxon (R-NY)  
1314 Longworth House Office Building

The Honorable Jack Quinn (R-NY)  
331 Cannon House Office Building

The Honorable Peter J. Visclosky (D-IN)  
2464 Rayburn House Office Building

The Honorable Stephen E. Buyer (R-IN)  
1419 Longworth House Office Building

### U.S. SENATORS

Telephone 1-800-9-CARE-94

(Address for all is: U.S. Senate,  
Washington, DC 20510)

The Honorable Arlen Specter (R-PA)  
530 Hart Senate Office Building

The Honorable Harris Wofford (D-PA)  
521 Dirksen Senate Office Building

The Honorable Barbara A. Mikulski (D-MD)  
709 Hart Senate Office Building

The Honorable Paul S. Sarbanes (D-MD)  
309 Hart Senate Office Building

The Honorable Alfonse M. D'Amato (R-NY)  
520 Hart Senate Office Building

The Honorable Daniel P. Moynihan (D-NY)  
464 Russell Senate Office Building

The Honorable Daniel B. Coats (R-IN)  
404 Russell Senate Office Building

The Honorable Richard G. Lugar (R-IN)  
306 Hart Senate Office Building

*Illustration by Susan Powers*



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Rollins Environmental Services, Inc. and  
Rollins Truck Leasing Corp.  
Wilmington, Delaware

Mr. R. Randall Rollins  
Chairman of the Board  
Rollins, Inc.  
Atlanta, Georgia

Mr. Danny Edwards  
President and Chief Executive Officer  
Royal Grip, Inc.  
Scottsdale, Arizona

Mr. Ralph E. Schey  
Chairman and Chief Executive Officer  
Scott Fetzer Company  
Westlake, Ohio

Mr. Norman E. Alexander  
Chairman and Chief Executive Officer  
Sequa Corporation  
New York, New York

Mr. Richard W. (Dick) Snyder  
Chairman and Chief Executive Officer  
SnyderGeneral Corporation  
Dallas, Texas

Mr. J. Virgil Waggoner  
President and Chief Executive Officer  
Sterling Chemicals, Inc.  
Houston, Texas

Mr. Darryl F. Allen  
Chairman, President and Chief Executive Officer  
TRINOVA  
Maumee, Ohio

Mr. Daniel Valot  
Chairman and Chief Executive Officer  
Total Petroleum (North America) Ltd.  
Denver, Colorado

Mr. James B. "Jim" Skaggs  
President and Chief Executive Officer  
Tracor, Inc.  
Austin, Texas

Mr. John P. DesBarres  
Chairman, President and Chief Executive Officer  
Transco Energy Company  
Houston, Texas

Mr. Frank H. Bevevino  
Chairman and Chief Executive Officer  
U.S. Food Service, Inc.  
Wilkes-Barre, Pennsylvania

Mr. Robert P. Krass  
President and Chief Executive Officer  
UCAR Carbon Company Inc.  
Dabury, Connecticut

Mr. Richard A. Goldstein  
President and Chief Executive Officer  
Unilever United States, Inc.  
New York, New York

Mr. Jere D. Fluno  
Vice Chairman and Member of the Office of the  
Chairman  
W. W. Grainger, Inc.  
Skokie, Illinois

Mr. Richard L. Keyser  
Executive Vice President and  
Member of the Office of the Chairman  
W. W. Grainger, Inc.  
Lincolnshire, Illinois

Mr. Dean L. Buntrock  
Chairman of the Board and Chief Executive Officer  
WMX Technologies, Inc.  
Oak Brook, Illinois

Mr. Sheldon R. Erikson  
Chairman, President and Chief Executive Officer  
Western Company of North America  
Houston, Texas

Mr. David R. Whitwam  
Chairman of the Board and Chief Executive Officer  
Whirlpool Corporation  
Benton Harbor, Michigan

Mr. Richard A. (Dick) Abdoo  
Chairman of the Board  
Wisconsin Electric Power Company  
Milwaukee, Wisconsin

Mr. Robert N. Pokelwaldt  
Chairman and Chief Executive Officer  
York International Corporation  
York, Pennsylvania

THE WHITE HOUSE  
WASHINGTON

February 19, 1994

MEMORANDUM FOR ALEXIS HERMAN  
BOB RUBIN

FEB 22 1994

FROM: MACK McLARTY

SUBJECT: CLINTON BUSINESS SUPPORTERS -- STRATEGY

The President commented this past Friday before his CEO luncheon that he was concerned about Clinton supporters not being involved in our Public Liaison and National Economic Council strategy. He noted that several of the people invited to the luncheon had been to the White House several times and were not supporters.

While I think a large number of the Clinton business supporters have been invited to the White House, either to small dinner parties or to briefings held on various issues, I think the President has a good point. I would appreciate a one-page memorandum regarding our plan to make sure we include, on an orderly and regular basis, Clinton business supporters in our NEC and Public Liaison outreach. Included in that memorandum, I would like to know who is going to be responsible in your respective areas for the follow through on this. I would suggest that you include Political and Bruce Lindsey in the development of your thoughts.

Thanks.

*Macf*

cc: The President  
Joan Baggett  
Harold Ickes  
Bruce Lindsey

*✓*

THE WHITE HOUSE

WASHINGTON

December 23, 1993

MEMORANDUM FOR MRS. HILLARY RODHAM CLINTON

BOB RUBIN  
IRA MAGAZINER  
ROGER ALTMAN

FROM: Alexis Herman

RE: Health Care Meeting with CEOs 12/21/93

Joe Gorman reported that he had a positive conversation with John Ong of The Business Roundtable. Ong committed to getting back with Joe Gorman before any further actions would occur on the part of The Business Roundtable.

We have contacted the offices of all of the principals in the meeting and are receiving their names for the joint consultation team.

Attached is the list that has already been received from Proctor & Gamble Company.

I am requesting that the level of Executive Vice President of Human Resources as opposed to Benefit Managers be a part of the company's team designation. We should insure at a minimum a process meeting with the teams in the first week of January.

Attachment

cc: Maggie Williams  
cc: Melanne Verveer

bcc: Amy

Bus/C205

# Procter & Gamble

**RLES LEPPERT, JR.**

**Director  
National Government Relations**

**December 23, 1993**

**TO: Ms. Alexis Herman  
Assistant to the President  
Public Liaison  
The White House**

**FROM: Charles Leppert, Jr.  
Director National Government Relations  
Procter & Gamble Company**

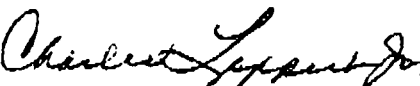
This follows up on our telephone conversation this morning as requested.

Mr. Edwin L. Artzt, Chairman of the Board and Chief Executive, The Procter & Gamble Company, has named the following P&G Executives to work with the White House Ad Hoc Working Group on Health Care Reform:

- Ben L. Bethell, Senior Vice President, Human Resources
- M. J. "Mac" Gowin, Vice President, Human Resources
- Jerry L. Lafferty, Manager, Health Care Planning
- R. Marvin Womack, Vice President, National Government Relations

Messrs. Bethell, Gowin and Lafferty are located at P&G World Headquarters, Cincinnati, Ohio. Marvin Womack is located in the Washington, DC office. Additional information on each P&G Executive is attached.

I understand per our conversation that you are planning a meeting of the Ad Hoc Group sometime during the first week of January, 1994. Please let Marvin or me know the exact date and we will notify our P&G executives.

  
Charles Leppert, Jr.

CL/jr

cc: E. L. Artzt  
B. L. Bethell  
M. J. Gowin  
J. S. Lafferty  
R. M. Womack

12/22/93

Dear Paul,

Thanks for your time on 12/24/93  
Mrs. Clinton especially found the meeting  
helpful. We are proceeding as discussed,  
and I expect the joint team to meet  
the first week in January  
All the best in the New Year -  
Will stay in touch Alexis

12/22/93

Dear Paul,

Thanks for your time on 12/24/93  
Mrs. Clinton especially found the meeting  
helpful. We are proceeding as discussed,  
and I expect the joint team to meet  
the first week in January.

All the best in the New Year -  
Will stay in touch. Alex

THE WHITE HOUSE

12/ 22/ 93

Dear Joe,

Thanks for your time on 12/21/93.  
Mrs. Clinton especially found the  
meeting helpful. We are proceeding as  
discussed and I expect the joint  
consultation team to meet the final  
week in January.

All the best - the New Year -  
will stay - thank Alice

THE WHITE HOUSE

12/22/93

Dear Joe,

Thanks for your time on 12/21/93.  
Mrs. Clinton especially found the  
meeting helpful. We are proceeding as  
discussed and I expect the joint  
consultation team to meet the first  
week in January.

All the best in the New Year -  
will stay in touch. Always

THE WHITE HOUSE

12/22/93

Dear Ed,

Thanks for your time on 12/2/93  
Mrs. Clinton especially found the  
meeting helpful. We are proceeding  
as discussed and I expect the  
joint consultation team to meet the  
first week in January.

All the best in the New Year -  
Will stay in touch - Always

THE WHITE HOUSE

12/22/93

Dear Ed,

Thanks for your time on 12/4/93  
Mrs. Clinton especially found the  
meeting helpful. We are proceeding  
as discussed and I expect the  
joint consultation team to meet the  
first week in January.

All the best in the New Year -  
Will stay in touch - Always

THE WHITE HOUSE

12/22/93

Dear George,

Thanks for your time on 12/24/93.  
Mrs. Clinton especially found the meeting  
helpful. We are proceeding as discussed,  
and I expect the joint team to meet  
the first week in January.

All the best in the New Year -  
Will stay in touch Alexis

12/22/93

Dear George,

Thanks for your time on 12/21/93.  
Mrs. Clinton especially found the meeting  
helpful. We are proceeding as discussed,  
and I expect the joint team to meet  
the first week in January.

All the best in the New Year -  
Will stay in touch Alfie

12/22/83

Dear Red,

Thanks for your time on 12/4/83.  
Mrs Clinton especially found the meeting  
helpful. We are proceeding as discussed,  
and I expect the joint teams to meet  
the first week in Jan.

All the best for the New Year -  
Will stay in touch. G. Alfia

12/22/83

Dear Red,

Thanks for your time on 12/4/83.  
Mrs Clinton especially found the meeting  
helpful. We are proceeding as discussed,  
and I expect the joint teams to meet  
the first week in Jan.

All the best for the New Year -  
Will stay in touch Gilpin

*Marilyn*

THE WHITE HOUSE

WASHINGTON

December 7, 1993

MEMORANDUM FOR SECRETARY LLOYD BENTSEN  
SECRETARY RON BROWN  
MACK MCLARTY  
ROGER ALTMAN  
ERSKINE BOWLES  
BOB RUBIN  
ANN JORDAN

FROM: *AMH* ALEXIS HERMAN

SUBJECT: CEO OUTREACH CALLS - HEALTH CARE REFORM

As we discussed, attached is the initial list of CEOs that will represent the administration's call list on health care. As you can see, each section is assigned to one of you.

As we agreed, you should communicate with these CEOs on a regular basis (a minimum of once a month is recommended) to: educate them on changes in the plan; receive their input on recommended changes; and to take the general pulse of the business community.

It is extremely important that you feedback this information to my office regularly (I hope that you will complete your first round of calls by Friday, December 17). My office will then process your reports for use in fine-tuning both the legislation and our outreach efforts.

Attached are response sheets for your use.

cc: Maggie Williams  
Ira Magaziner  
Christine Varney

December 10, 1993

MEMORANDUM FOR

FROM: ALEXIS HERMAN

SUBJECT: UPDATE ON BUSINESS OUTREACH ON HEALTH CARE REFORM

**I. The Pulse of the Business Community**

Over the past three months the Office of Public Liaison has met with and facilitated policy meetings on health care with a cross-section of the business community in an effort to educate the community on the details of the Health Security Act, as well as to assess how individual companies feel about the plan.

Particularly in the past six weeks, we have met with 300 Washington representatives of Fortune 500 companies through our industry-by-industry series, 25-30 Presidents and/or Executive Directors of small business associations, and we have conducted telephone conferences with 20 key CEOs. We have arranged opportunities for the POTUS and Hillary Rodham Clinton to communicate with key CEOs during their travels, and utilized the assistance of key policy officials such as Ira Magaziner, Bob Rubin, and Erskine Bowles to help communicate our message to business representatives.

Most recently, we conducted a meeting of 15 key Washington representatives who exhibited support during our previous industry-by-industry meetings. We have created this group of friendly Washington representatives of prominent companies to provide to us, on an ongoing basis, an honest assessment of how our plan is viewed by the business community. These meetings are not designed to debate the policy issues, but instead, to provide intelligence and to give recommendations on how the Administration should proceed on its outreach efforts. This replicates a successful model used during consideration of the economic package.

As a result of our educational business meetings we have gained substantial information about which sectors of the business community are willing to outwardly support the Health Security Act, those who are supportive of the principles of the plan and are willing to work with the White House, and gotten a better sense of our overall strengths and weaknesses in the business community in regard

to health care reform.

In recent meetings, we have gained recommendations from trusted members of the business community in the following two areas:

1. Communication

- A. Communicate one or two key concepts on behalf of health reform which:
  - (1) are important to business, ie: cost savings.
  - (2) differentiate between the Clinton plan and the Cooper plan.
- B. Better articulate the cost of cost shifting and how our plan saves on that.
- C. Better articulate that universal coverage is cost control.
- D. Focus the debate on health care reform as improving the economy, ie: deficit reduction, jobs.

2. Revisions to the plan

- A. Treat corporate alliances as equals to regional alliances.
- B. Clarify strong ERISA protection.
- C. Give greater rewards for good wellness programs.

**II. How to Respond**

In light of the candid assessment described above, the following represents our recommended actions in the short term.

- A. Recruit business surrogates of national prominence who are willing to say positive things about the plan, as well as respond to criticisms. They provide needed business credibility to the plan's benefits in reducing the deficit and controlling business health care costs. These business surrogates can also recruit support from their peers.

Two individuals that come quickly to mind are retired CEOs Red Poling and Arnold Hoatt. We should also consider asking Democratic luminaries with business credentials to assist, for example, Bob Strauss who was so helpful during the NAFTA fight.

B. Close on business support for the following two areas.

1. 300 businesses educated through the industry-by-industry series of meetings. Determine where they are, recruit these supporters, and determine the concerns of those who are leaning toward support.
2. Redlining/other Insurance Discrimination meetings. We are meeting with those companies and small business associations who have been affected by redlining practices which have excluded them from health care insurance in the past. We will use supportive small business owners in the same way we will use prominent CEOs to express support for the plan.

C. Specific actions over the next four weeks.

1. Plan a business event, utilizing the types of individuals described above, before the Christmas holidays to exhibit business support for the President's efforts during this news vacuum.
2. Plan several additional business events with the POTUS and Hillary Rodham Clinton in early January, prior to the return of Congress.
3. Continue to take the business pulse through Administration CEO calls.
4. Reinstate CEO lunches. This is a proven vehicle for garnering business support and positive media about the President's initiatives.

### III. Process

Implement the following over the next two weeks:

- o Monthly meeting of the larger administration group.
- o Weekly meeting of the coordinating team.
- o We should pick the coordinator and initiate meeting with the OPL team.

**OFFICE OF PUBLIC LIAISON: HEALTH CARE BUSINESS OUTREACH  
TIMETABLE FOR THE REMAINDER OF 1993**

| <b>Week</b> | <b>Listing of Goals and Tasks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Nov. 15-20  | <ul style="list-style-type: none"><li>o Conduct 3 industry briefings</li><li>o Coordinate a meeting for OPL/NEC to work through what is needed in the Benefit/detriment analysis</li><li>o Begin research of redlined Industries</li><li>o Follow-up work on industry meetings, and HRC meetings held on 11/8 and 11/12</li><li>o Conduct an OPL/SBA coordination meeting</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                               |
| Nov. 22-27  | <ul style="list-style-type: none"><li>o Conduct 1 industry briefing</li><li>o Coordinate a meeting for the OPL/NEC/Delivery Room group to task out the development of written materials</li><li>o Develop questionnaire</li><li>o Continue research of business events for the coming year for the master calendar: major associations; trade associations; state and big city chambers</li><li>o Complete research of redlined Industries</li><li>o Plan CEO conference call for following week</li><li>o Meet with Charlotte Hayes to work out a formal method for coordination on business events</li><li>o Follow-up work on industry briefings</li><li>o Cabinet Affairs to assign a business liaison staff person from each department and agency to work on health care outreach</li></ul> |

**Week****Listing of Goals and Tasks (continued)**

---

Nov. 29  
- Dec. 4

- o Conduct 4 industry briefings
- o Conduct 1 redlined industry briefing
- o Conduct CEO conference call
- o Conduct first inter-agency business liaison meeting on Health Care Reform
- o Proposed POTUS lunch with CEOs
- o Continue research of business events for the coming year for the master calendar: major associations; trade associations; state and big city chambers
- o Continue work on development of written materials, and questionnaire
- o Follow-up work on industry briefings
- o Address surrogate problem with Cabinet Affairs, Health Care Delivery Room and DNC Health Care Campaign

Dec. 6-11

- o Conduct 3 industry briefings
- o Conduct 1 redlined industry briefing
- o Proposed POTUS lunch with CEOs
- o Plan CEO conference call for following week
- o Finalize questionnaire
- o Continue research of business events for the coming year for the master calendar: major associations; trade associations; state and big city chambers
- o Continue work on development of written materials, and questionnaire
- o Follow-up work on industry and redlined briefings

**Week****Listing of Goals and Tasks (continued)**

---

Dec. 13-18

- o Conduct 4 industry briefings
- o Conduct 1 redlined industry briefing
- o Conduct CEO conference call
- o Proposed POTUS lunch with CEOs
- o Follow-up work on industry and redlined briefings
- o Reconnect with NEC for results of benefit/detriment analysis
- o Begin planning health care business outreach calendar for January 1994
- o Develop a facsimile list of business supporters to send health care talking points.

Dec. 20-24

- o Conduct 1 industry briefing
- o Follow-up work on industry and redlined briefings
- o Continue work on health care business outreach calendar for January 1994

# October 1993

## OFFICE OF PUBLIC LIAISON: BUSINESS OUTREACH ON HEALTH CARE

SUNDAY

MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY

SATURDAY

|                                                                 |                                          |                                  |                          |                                                |                                            |    |
|-----------------------------------------------------------------|------------------------------------------|----------------------------------|--------------------------|------------------------------------------------|--------------------------------------------|----|
|                                                                 |                                          |                                  |                          |                                                | 1                                          | 2  |
| 3                                                               | 4                                        | 5                                | 6                        | 7                                              | 8                                          | 9  |
| 10                                                              | 11<br><i>Columbus Day<br/>(Observed)</i> | 12                               | 13<br>Auto Industry (RA) | 14<br>Metals Industry (IM)                     | 15<br>Rubber/Plastic<br>Manufacturers (BR) | 16 |
| 17                                                              | 18                                       | 19<br>Food Manufacturers<br>(IM) | 20                       | 21<br>Retailers (IM)<br>Distilled Spirits (BR) | 22<br>Energy Producers (RA)                | 23 |
| 24                                                              | 25                                       | 26<br>CEO CONFERENCE<br>CALL     | 27                       | 28                                             | 29                                         | 30 |
| 31<br><i>Daylight Savings—set<br/>back 1 hour<br/>Halloween</i> |                                          |                                  |                          |                                                |                                            |    |

# November 1993

## OFFICE OF PUBLIC LIAISON: BUSINESS OUTREACH ON HEALTH CARE

| SUNDAY    | MONDAY                                 | TUESDAY                                                                    | WEDNESDAY | THURSDAY                          | FRIDAY                                                                                           | SATURDAY  |
|-----------|----------------------------------------|----------------------------------------------------------------------------|-----------|-----------------------------------|--------------------------------------------------------------------------------------------------|-----------|
|           | <b>1</b><br>Aerospace Industry<br>(IM) | <b>2</b><br><i>Election Day</i>                                            | <b>3</b>  | <b>4</b><br>Accounting Firms (RA) | <b>5</b><br>Agri-Business (IM)                                                                   | <b>6</b>  |
| <b>7</b>  | <b>8</b><br>HRC/CEO NEW<br>YORK MTG.   | <b>9</b>                                                                   | <b>10</b> | <b>11</b><br><i>Veterans Day</i>  | <b>12</b><br>Computers, Scientific,<br>and Office Equipment<br>(IM)<br>HRC/CEO<br>CLEVELAND MTG. | <b>13</b> |
| <b>14</b> | <b>15</b><br>Food Retailers (IM)       | <b>16</b><br>Gen. Man. - Bldg<br>Mtrls, Mining,<br>Cosmetics (BR)          | <b>17</b> | <b>18</b>                         | <b>19</b><br>Chemical Manufacturers<br>(IM)                                                      | <b>20</b> |
| <b>21</b> | <b>22</b>                              | <b>23</b><br>Telecommunications/<br>Utilities (IM)                         | <b>24</b> | <b>25</b><br><i>Thanksgiving</i>  | <b>26</b>                                                                                        | <b>27</b> |
| <b>28</b> | <b>29</b>                              | <b>30</b><br>CEO CONFERENCE<br>CALL<br>Diversified Service/<br>Electronics |           |                                   |                                                                                                  |           |

# December 1993

## OFFICE OF PUBLIC LIAISON: BUSINESS OUTREACH ON HEALTH CARE

SUNDAY

MONDAY

TUESDAY

WEDNESDAY

THURSDAY

FRIDAY

SATURDAY

|    |                                           |                                                                               |                                                                                              |                      |                                                                           |                 |
|----|-------------------------------------------|-------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------|-----------------|
|    |                                           |                                                                               | 1<br>POTUS/CEO LUNCH<br>(proposed)                                                           | 2<br>Forest Products | 3<br>Commercial Banking<br>Amusement Parks/<br>Parking Lots<br>(Redlined) | 4               |
| 5  | 6                                         | 7<br>Industrial/Farm/<br>Transportation<br>Equipment<br>Diversified Financial | 8<br>POTUS/CEO LUNCH<br>(proposed)<br>Hair Salons/Flower<br>Shops/Health Clubs<br>(Redlined) | 9<br>Hanukkah        | 10<br>Petroleum Refining                                                  | 11              |
| 12 | 13<br>Construction/Trucking<br>(Redlined) | 14<br>CEO CONFERENCE<br>CALL                                                  | 15<br>Savings Institutions<br>Assorted Manufacturers<br>POTUS/CEO LUNCH<br>(proposed)        | 16                   | 17<br>Transportation Service<br>Companies                                 | 18              |
| 19 | 20<br>Publishing/Printing                 | 21<br>Winter begins                                                           | 22                                                                                           | 23                   | 24                                                                        | 25<br>Christmas |
| 26 | 27                                        | 28                                                                            | 29                                                                                           | 30                   | 31<br>New Year's Eve                                                      |                 |

SAMPLING OF RETIRED CEOs

Mr. Walter Haas  
Retired Chairman  
Levi Strauss

Mr. Arnold ~~Haas~~ Hyatt  
Retired Chairman  
Stride Rite

Mr. Harold "Red" Poling ✓  
Retired Chairman & CEO  
Ford Motor Company  
Dearborn MI

Mr. John Young ✓  
Retired Chairman  
Hewlett-Packard Company  
Palo Alto CA

- *Link B...*  
- *Paul All...*  
- *Joe G...*  
- *Kodak - J...*

*Walter*

*ready / Propon*  
*at*  
*4:00*  
*Luther*

*Part Time - / water*

- *Amemi Open*  
- *NY NEX*

**SAMPLING OF CEOs ENGAGED IN A DIALOGUE ON HEALTH CARE**

Mr. Paul Allaire  
Chairman & CEO  
Xerox Corporation  
Stamford, CT

Mr. Dwayne Andreas  
Chairman & CEO  
Archer Daniels Midland Company  
Decatur, IL

Mr. Curtis H. Barnette  
Chairman & CEO  
Bethlehem Steel Corporation  
Bethlehem, PA

Mr. August A. Busch  
Chairman of the Board & President  
Anheuser-Busch Companies, Inc.  
St. Louis, MO

Mr. Jim Crowe  
Chairman & CEO  
MFS Communications Company Inc.  
Omaha, NE

Mr. Garry Drummond  
Chairman and CEO  
Drummond Company  
Birmingham, AL

Mr. Robert J. Eaton  
Chairman & CEO  
Chrysler Corporation  
Highland Park, MI

Mr. Donald Fisher  
CEO  
The Gap, Inc.  
San Francisco, CA

Mr. Robert Haas  
Chairman and CEO  
Levi Strauss and Co.  
San Francisco, CA

Mr. John W. Hechinger, Sr.  
Chairman of the Board  
Hechinger Company  
Landover, MD

Mr. David H. Hoag  
Chairman & CEO  
LTV Corporation  
Cleveland, OH

Ms. Marian Ilitch  
Little Caesar Enterprises  
Detroit, MI

Dr. Ray R. Irani  
Chairman of the Board, President and CEO  
Occidental Petroleum Corporation  
Los Angeles, CA

Mr. Kenneth A. Macke  
Chairman & CEO  
Dayton Hudson Corporation  
Minneapolis, MN

Mr. Paul Montrone  
Fisher Scientific  
Hampton, NH

Mr. Southwood Morcott  
Chairman  
Dana Corporation  
Toledo, OH

Mr. John F. Smith, Jr.  
President & CEO  
General Motors Corporation  
Detroit, MI

Mr. Stewart Turley  
Chairman and CEO  
Eckerd Corporation  
Clearwater, FL

Mr. Alan L. Wurtzel  
Chairman of the Board  
Circuit City Stores, Inc.  
Richmond, VA

- Jimmie Haratz
- Jerry Frank
- Sydney
- Bob Crabb - Allen
- Allen - Peter

# HEALTH CARE INDUSTRY- BY- INDUSTRY MEETINGS

participants as of 11/19/93

| COMPANY                          | INDUSTRY                         |
|----------------------------------|----------------------------------|
| Adolph Coors Company             | Alcoholic Bev                    |
| Agwa,                            | Food Manufacturer                |
| Air Products and Chemicals       | Chemicals                        |
| Albertson's                      | Food Retail                      |
| Alcoa                            | Metals                           |
| Allegheny Ludlum                 | Metals                           |
| Allied-Signal, Inc.              | Aerospace                        |
| American Cyanamid Company        | Chemicals                        |
| American Express Co.             | Accounting                       |
| American Gas Association         | Energy                           |
| American-Standard                | Building Materials               |
| Ametek, Inc.                     | Sci. & Photo Equip.              |
| Anchor Glass Container Company   | Building Materials               |
| Anheuser-Busch Companies, Inc.   | Food Manufacturer; Alcoholic Bev |
| APCO                             | Food Manufacturer                |
| Archer Daniels Midland Company   | Food Manufacturer                |
| Arkansas Power and Light         | Energy                           |
| Armstrong World Industries, Inc. | Building Materials               |
| Arthur Anderson                  | Accounting                       |
| Arvin industries, Inc.           | Auto                             |
| AST Research Inc.                | Computers                        |
| Avon Products, Inc.              | Cosmetics/Soaps                  |
| Baker Hughes                     | Energy                           |
| Ball Corporation                 | Rubber                           |
| Baxter International, Inc.       | Sci. & Photo Equip.              |
| Becton Dickinson & Company       | Sci. & Photo Equip.              |

| COMPANY                                        | INDUSTRY                |
|------------------------------------------------|-------------------------|
| Beech Aircraft Corporation                     | Aerospace               |
| Bethlehem Steel Corporation                    | Metals                  |
| BF Goodrich Company                            | Rubber;Chemicals        |
| BM Industries                                  | Energy                  |
| Boeing Company                                 | Aerospace               |
| Bond Beebe Barton and Muckelbauer              | Accounting              |
| Burpee Seed Company                            | Agri-business           |
| C.R. Bard Inc.                                 | Computers               |
| Campbell Soup                                  | Food Manufacturer       |
| Cargill, Inc.                                  | Agri-business           |
| Carter Hawley Hale Stores, Inc.                | Retail                  |
| Caterpillar, Inc.                              | Agri-business           |
| Chrysler Corporation                           | Auto                    |
| Circle K Corporation                           | Food Retail             |
| Cleveland-Cliffs Inc.                          | Aerospace               |
| Coca-Cola Company                              | Food Manufacturer       |
| ConAgra, Inc.                                  | Food Manufacturer       |
| Continental Grain Company                      | Agri-business           |
| Dana Corporation                               | Auto                    |
| Dean Witter Financial Services Group           | Accounting              |
| Deere and Company                              | Agri-business           |
| Deloitte and Touche                            | Accounting              |
| Digital Equipment Corporation                  | Computers               |
| Distilled Spirits Council of the United States | Alcoholic Bev           |
| Dow Chemical Company                           | Agri-business;Chemicals |
| Edison Electric Institute                      | Energy                  |
| EG & G                                         | Sci. & Photo Equip.     |
| El Du Pont De Nemours and Company              | Agri-business           |
| El Paso Natural Gas Company                    | Energy                  |
| Electronic Data Systems                        | Computers               |

| COMPANY                                      | INDUSTRY                       |
|----------------------------------------------|--------------------------------|
| ENRON                                        | Energy                         |
| ENSERCH Corporation                          | Energy                         |
| Ernst and Young                              | Accounting                     |
| Ethyl Corporation                            | Chemicals                      |
| Federated Department Stores, Inc.            | Retail                         |
| Ferro Corporation                            | Chemicals                      |
| FMC Corporation                              | Agri-business; Chemicals       |
| Food Lion Inc.                               | Food Retail                    |
| Food Marketing Institute                     | Food Retail                    |
| Ford Motor Company                           | Auto                           |
| Freeport McMoran, Inc.                       | Mining/Crude Oil               |
| Gencorp Inc.                                 | Aerospace                      |
| General Dynamics                             | Aerospace                      |
| General Mills Inc.                           | Food Manufacturer              |
| General Motors Corporation                   | Auto                           |
| Georgia-Pacific Corporation                  | Agri-business; Forest Products |
| Goodyear Tire and Rubber Company             | Rubber                         |
| Great Atlantic and Pacific Tea Company (A&P) | Food Retail                    |
| Hariton, Mancuso and Jones                   | Accounting                     |
| Hechinger Company                            | Retail                         |
| Helene Curtis Industries, Inc.               | Cosmetics/Soaps                |
| Heublein International                       | Alcoholic Bev                  |
| Hewlett-Packard Company                      | Computers                      |
| Hiram Walker Group                           | Alcoholic Bev                  |
| Hoechst Celanese Corporation                 | Chemicals                      |
| Honeywell, Inc.                              | Computers                      |
| Hughes Space and Communications Group        | Aerospace                      |
| IBM Corporation                              | Computers                      |
| ICI Americas                                 | Agri-business                  |

| COMPANY                                      | INDUSTRY                       |
|----------------------------------------------|--------------------------------|
| Independent Petroleum Association of America | Energy                         |
| Inland Steel Industries, Inc.                | Metals                         |
| International Paper Company                  | Agri-business; Forest Products |
| J.C. Penney Company                          | Retail                         |
| Joseph Seagrams and Sons, Inc.               | Alcoholic Bev                  |
| Kaman                                        | Aerospace                      |
| Kellogg Corporation                          | Food Manufacturer              |
| KPMG Peat Marwick                            | Accounting                     |
| Legg Mason Wood Walker Inc.                  | Accounting                     |
| Lockheed Corporation                         | Aerospace                      |
| Loral Corporation                            | Aerospace                      |
| Lowe's                                       | Retail                         |
| LTV Corporation                              | Metals                         |
| Lukens Inc.                                  | Metals                         |
| Marathon Oil Company                         | Energy                         |
| Masco Corp.                                  | Metal Products                 |
| May Department Stores Company                | Retail                         |
| McDermott, Inc.                              | Metal Products                 |
| McDonnell Douglas                            | Aerospace                      |
| Medtronic                                    | Computers                      |
| Mentor Graphics Corporation                  | Computers                      |
| Merrill Lynch Pierce Fenner and Smith Inc.   | Accounting                     |
| NALCO Chemical Company                       | Chemicals                      |
| National Coal Association                    | Energy                         |
| National Steel Corporation                   | Metals                         |
| Navistar International                       | Auto                           |
| Newmont Mining Corporation                   | Mining/Crude Oil               |
| Noll Pharmaceuticals                         | Chemicals                      |
| Northrop Corporation                         | Aerospace                      |

| COMPANY                             | INDUSTRY                           |
|-------------------------------------|------------------------------------|
| Occidental Petroleum Corporation    | Mining/Crude Oil                   |
| Oryx Energy                         | Mining/Crude Oil                   |
| Owens-Corning Fiberglas Corporation | Building Materials                 |
| Owens-Illinois                      | Building Materials                 |
| PACCAR                              | Auto                               |
| Payless Drugstores                  | Retail                             |
| Pennzoil Company                    | Energy                             |
| Pepsico Inc.                        | Food Manufacturer                  |
| Perkin-Elmer Corporation            | Computers                          |
| Pioneer Hi-Bred International       | Agri-business                      |
| Polaroid Corporation                | Sci. & Photo Equip.                |
| PPG Industries, Inc.                | Building Materials                 |
| Price Waterhouse                    | Accounting                         |
| Procter & Gamble                    | Cosmetics/Soaps                    |
| Publix Super Markets                | Food Retail                        |
| Quaker Oats Company                 | Food Manufacturer                  |
| Ralston-Purina                      | Food Manufacturer                  |
| Reynolds Metals Company             | Metals                             |
| RJO Enterprises                     | Computers                          |
| RJR Nabisco, Inc.                   | Agri-business;Food<br>Manufacturer |
| Rockwell International Corporation  | Aerospace                          |
| Salomon, Inc.                       | Accounting                         |
| Scott and Stringfellow              | Accounting                         |
| Sears, Roebuck and Company          | Retail                             |
| Southland Corporation               | Food Retail                        |
| SPX                                 | Auto                               |
| Standard Products                   | Plastic                            |
| Sundstrand                          | Aerospace                          |
| Sunkist Growers Inc.                | Agri-business                      |

| COMPANY                          | INDUSTRY            |
|----------------------------------|---------------------|
| Supermarkets General Corporation | Food Retail         |
| Tandy Corporation                | Computers           |
| Texas Instruments Inc.           | Computers           |
| Textron Inc.                     | Aerospace           |
| The Gap, Inc.                    | Retail              |
| The Limited, Inc.                | Retail              |
| Toy's 'R' Us, Inc.               | Retail              |
| TRW Space and Electronics Group  | Aerospace           |
| Tyco Labs, Inc.                  | Plastic             |
| Unilever United States, Inc.     | Cosmetics/Soaps     |
| United States Shoe               | Retail              |
| United Technologies              | Aerospace           |
| Visa                             | Accounting          |
| W.R. Grace & Co.                 | Chemicals           |
| Wal-Mart Stores                  | Retail              |
| Wine Institute                   | Alcoholic Bev       |
| Xerox Corporation                | Sci. & Photo Equip. |

THE WHITE HOUSE

WASHINGTON

December 10, 1993

MEMORANDUM FOR SELECTED DISTRIBUTION

FROM: Alexis Herman

RE: Update on Business Outreach on Health Care Reform

Over the past three months the Office of Public Liaison has met with and facilitated policy meetings on health care with a cross-section of the business community in an effort to educate the community on the details of the Health Security Act, as well as to assess how individual companies feel about the plan.

Specifically, in the past six weeks, we have met with 300 Washington representatives of Fortune 500 companies in industry-by-industry briefings, small meetings with 25-30 Presidents and/or Executive Directors of small business associations, and through conducted telephone conferences with 20 key CEOs.

On December 11, we conducted a meeting of 15 key Washington representatives who had been a part of previous briefings. This group is an ongoing group of friendly Washington representatives of prominent companies who provide us, on a consistent basis, an honest assessment of how our plan is viewed in the business community as well as our other initiatives. These meetings are not designed to debate the policy issues, but instead to provide intelligence and to give recommendations on how the Administration should proceed on its outreach efforts.

The net result of these meetings have generally yielded overall concern regarding the Health Care Security Act in the business community. The concerns can best be described as a sense of movement away from the President's plan due to either a preceived philosophical difference with the Administration on the size of the plan, and the belief that we may be creating a new entitlement program, or simply a fundamental disbelief of our numbers.

The specific recommendations that have flowed from these meetings can be captured in two areas: Strategic Communications and Revisions to the Plan.

1. Communication

- A. Communications are now viewed as too technical in the public domain. Communicate one or two key concepts on behalf of health reform.
  - (a) Are important to business, i.e., cost savings.
  - (b) Differentiate between the Clinton Plan and the Cooper Plan.
- B. Better articulate the cost of cost shifting and how our plan saves on that.
- C. Better articulate that universal coverage is cost control.
- D. Focus the debate on health care reform as improving the economy. Stress job creation.

2. Revisions to the Plan

- A. Treat corporate alliances as equals to regional alliances.
- B. Clarify strong ERISA protection.
- C. Give greater rewards for good wellness programs.

The following active steps are proposed to launch an aggressive, effort to harness and maintain business support for the Health Security Act.

- A. Recruit business surrogates of national prominence who are willing to say positive things about the plan, as well as respond to criticisms. They provide needed business credibility to the plan's benefits in reducing the deficit and controlling business health care costs. These business surrogates can also recruit support from their peers. Red Poling has agreed to help lead this effort. We must balance with other individuals such as Arnold Hyatt and Bob Strauss.
- B. Close on business support for the following two areas:

Industry-by-industry, 300 businesses have been educated

through the industry-by-industry series of meetings. We must determine where they are, recruit supporters, and determine the concerns of those who are not there.

Business impacted by redlining. We are meeting with those companies and small business associations who have been affected by redlining practices--Those who have been excluded them from health care insurance in the past. We will use supportive companies in the same way we will use prominent CEOs to express support for the plan.

- C. Plan a business event, utilizing the types of individuals described above, before the Christmas holidays to exhibit business support for the President's efforts during this news vacuum.
- D. Plan several additional business events with the POTUS and Hillary Rodham Clinton in early January, prior to the return of Congress.
- E. Continue to take the business pulse.
- F. Reinstate CEO lunches. This is a proven vehicle for garnering business support and positive media about health care reform.
- . Implement the following over the next two weeks:
  - A. Monthly meeting of the larger administration group to facilitate coordination.
  - B. Weekly meeting of the coordinating team to stay abreast of the issue in tactics.
  - C. Identify a coordinator to tracking information and assist in the execution of the overall strategy.

## SUMMARY OF CONCERNS FROM FRIDAY'S STRATEGY MEETING

### IDEOLOGICAL SKEPTISM:

- o They're not convinced it will curtail health care costs, and more specifically, they are not convinced their own health costs will be curtailed. Most companies believe they will pay more for health care under our plan, both short term and long term. On top of this concern, is the belief that will have little to no control for the health care that they will be paying for.
- o The regional alliances and the subsidy pool are viewed as a new government program, essentially an entitlement, which even with the most credible cost estimates is likely to spin out of control in future. Even when our numbers seem to add up, the business community tends to believe that it is too good to be true and therefore can not be sustained.
- o Business's instinctive conservatism feels they must oppose any new government program, no matter how well intended.

### ISSUE CONCERN:

- o The provision which allows single payer states to include large companies which would otherwise qualify for ERISA protection is a major concern and will continue to be a significant stumbling block.
- o The Act makes changes to ERISA, which although not extensive, are strongly viewed as the beginning of eroding ERISA protection for multi-state employers. This perception can only be reversed by a strong statement of commitment from the Administration regarding ERISA.
- o The one percent corporate assessment is an easy bottomline provision for companies to calculate and to calculate a significant loss. The savings provisions are harder to translate and calculate, therefore difficult to view as offsetting the loss from the corporate assessment. In addition, there is great skepticism that the assessment will remain at 1%.

- o The Act changes the ability of companies to directly benefit from the wellness programs they have worked so hard to initiate in recent years. In addition, companies that have invested in flexible benefit programs will no longer be able to continue these efforts.
- o Due to the size of regional alliances, the corporate alliances fear they will not be able to compete, nor negotiate on behalf of their employees in individual communities. They want to be able to band together with other corporate alliances; they want to be able to put smaller groups of employees into regional alliances; and they want to have the option to reverse a decision to either go into or stay out of a regional alliance.

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MEMORANDUM FOR THE PRESIDENT

FROM: ANTHONY LAKE/ROBERT E. RUBIN

SUBJECT: Overview of Uruguay Round

DECLASSIFIED

E.O. 13526

White House Guidelines, September 11, 2006

By *M* NARA, Date *7/12/14*

*2012-0741-6*

As the Uruguay Round heads toward conclusion, we wanted to provide you with a memorandum outlining the coalition likely to support the package as well as potential opponents. These blocks will not be fully known, of course, until an agreement is reached and there has been a chance to study the details. Even then, some will withhold support to gain concessions in the implementing legislation - as in the NAFTA fight. But the outlines of the eventual coalition are becoming clear.

Overview

The coalition supporting the agreement is likely to consist of a broad range of manufacturing industries (e.g., construction equipment, paper, computers) benefitting from the tariff reductions. Most of agriculture (e.g., wheat, feed grains, beef, rice) will support the package as well as industries benefitting from greater intellectual property protection (e.g., pharmaceuticals, biotechnology) and from freer services trade (e.g., computer-related services, construction). The opposing coalition will consist of textiles and apparel, organized labor, some agricultural interests (e.g., cotton, sugar, peanuts), at least some environmental groups and those concerned with U.S. sovereignty.

In the middle is a swing block consisting of some powerful interests, including the entertainment industry, financial services, and industries concerned with preserving U.S. dumping laws (e.g., semiconductors, steel, autos). All of these industries could support a good agreement; their support would probably make the difference between a relatively easy versus a very tough Congressional fight. That is why we have focused on these issues so intensely in the closing days.

Several differences with the NAFTA fight are likely to emerge. Union opposition probably will be less intense, but still active. The business coalition will be less comprehensive, since not every industry will benefit. Textiles and apparel will be more intensely opposed. Overall, though, the debate should have less

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cc: Vice President  
Chief of Staff

intensity and less resonance nationally than NAFTA (although the sovereignty issue could provide some of this). Whereas the free trade, editorial press split over NAFTA in some instances, early indications are that it will be firmly united behind the Uruguay Round.

Below is a more detailed description of the various Uruguay Round coalitions, with summaries of the benefits for key interests.

### Likely Allies

Four large interests are likely to support the Round, as described below:

1. Manufacturers Benefitting From Tariff Cuts: The vanguard of support is likely to come from a broad collection of manufacturing industries benefitting from tariff cuts in over 8000 areas as well as other provisions. The agreement is expected to cut global tariffs by an average of [37] percent, with tariffs in some key areas reduced to zero. [Note: figures in brackets are still preliminary, pending final agreement.] Preliminary USTR/CEA estimates project that the tariff cuts alone would, over ten years, create as many as [1.4 million] U.S. jobs (gross figure) and yield efficiency gains for the U.S. economy of around \$60-65 billion per year within 10 years.

Industries benefitting will include construction equipment, electronics, pharmaceuticals, medical equipment, furniture, paper, beer, and agricultural equipment. A few examples illustrate:

- o In electronics, average tariffs abroad will drop by 27% - a solid benefit to the 1.1 million workers in this industry.
- o In pharmaceuticals, of which we export over \$5 billion a year, tariffs will drop [85%].
- o In furniture, where we import more than twice what we export, tariffs will fall by [67%].

Many of these industries will also benefit from expanded access to foreign government procurement markets. For example, U.S. companies will be able to sell to many foreign government-owned electrical utilities for the first time. EC and Japanese government procurement markets could be \$300 billion annually. New countries probably will sign onto the agreement, including Korea, Taiwan, Australia and China - opening more opportunities.

The coalition benefitting from all these changes is also important because it represents bread-and-butter manufacturing interests. The Round has at times been criticized for focusing on "new" industries, like services, and not on manufacturing. This coalition undermines that claim. (Parenthetically, the civilian aircraft terms are not yet fully resolved, but it

appears the industry may be, at the very least, no worse off (i.e., the former Airbus deal is preserved)).

2. **Agriculture:** By and large, most of agriculture should support this agreement. The final agricultural package provides three types of benefits:

**Export Subsidies:** Countries must cut subsidies by 21 percent over 6 years. The EC uses subsidies much more heavily than the U.S.; in 1991, \$12.8 billion for the EC versus \$0.9 billion for the U.S. These provisions are important to U.S. wheat, corn, soybean and feed grain farmers, who are hurt by subsidized sales. These crops are more heavily concentrated in the Midwest and West.

**Domestic Supports:** These are the programs most countries maintain to support prices in their own markets (e.g., U.S. price support programs). Most U.S. farm groups can support the proposed 20 percent reductions in these programs, because they will, in effect, get credit for the \$13 billion cut made in U.S. programs in the 1990 budget bill.

**Market Access:** This area covers farm tariffs and quotas. The U.S. secured fairly good benefits in these negotiations (e.g., first-time access to Japanese/Korean rice markets; average tariff cuts of 36% for high-value products like beef, fruits and vegetables in the growing markets of the Far East).

As noted below, not all farm interests will support the agreement, but the weight of the community will be supportive.

3. **Intellectual Property-Based Industries:** One of the Uruguay Round's chief achievements is to provide, for the first time, multilateral rules protecting intellectual property. For example, the software and entertainment industry will secure 50 year protection for their products, while the pharmaceutical industry will be guaranteed 20 years of patent protection. Foreign pirating today denies the U.S. \$60 billion in sales each year. The new rules should be supported by a coalition of information-based industries, including pharmaceuticals, software, and at least some semiconductor manufacturers.

This coalition may not be entirely united; some companies, like Pfizer and Intel, believe the transition periods are too long and have other problems with the text. We are working hard to secure their support. We believe most of this coalition will be supportive eventually.

4. **Services:** Today, over \$700 billion worth of services are traded each year, but no multilateral rules govern this growing area. Again, the Uruguay Round provides such rules for the first time. The agreement provides better access for U.S. insurance, telecommunications, construction, accounting and other professional service providers (e.g., lawyers). One outstanding

sector is banking. This industry is important economically and because it has provided much of the financial support for past Congressional trade campaigns. As discussed below, the steps we take in the final days will determine whether they are an ally.

### Likely Opponents

The opposition overall is not likely to be as intense as in the NAFTA fight, but it cannot be underestimated.

1. Textiles and Apparel: They are likely to lead the opposition. The agreement would phase out U.S. textile and apparel quotas over 10 years and significantly reduce our highest (or "peak") tariffs. Note that the textile companies supported NAFTA, but will oppose the Uruguay Round. (They felt NAFTA would bring apparel production from the Far East to Mexico, with the textiles being sourced out of the U.S.) Textile workers and the entire apparel industry will remain opposed. Kantor secured an agreement that offers less than the Bush Administration offered. This may mollify some opposition (and possible gain a few supporters) but the industry essentially will be opposed. (Retailing interests will be supportive, but they are far weaker politically.)

2. Organized Labor: Labor is likely to oppose the GATT agreement, but not as strongly as NAFTA. Labor may be smarting after the NAFTA fight and may not be willing to lay its prestige on the line to fight another trade agreement. (Also, it will be even more preoccupied next year with health care.) Early efforts to soften their opposition will be important.

3. Some Agricultural Interests: Although most farm interests will support the agreement, cotton, peanuts and sugar probably will oppose. These crops are now protected by quotas, which will need to be converted to tariffs under the agreement - and each crop will need to permit a certain percentage of import penetration (usually growing to 5 percent over 10 years). (Of course, these same provisions helped gain us market access into Japan and Korea's rice markets, for example.) In addition, cotton opposes opening our textile market, fearing foreign cotton will be used. Dairy is concerned about provisions requiring it to open its market, but U.S. dairy exports also benefit from EC subsidy reductions. Dairy's likely position is less certain.

4. Environmentalists: Environmentalists are concerned that more powerful GATT dispute settlement will allow GATT to second-guess U.S. health and safety laws. U.S. exporters seek such review to stop other countries from using these laws as disguised forms of protectionism (e.g., EC banned imported beef containing hormones, even though there was no evidence such beef was harmful). The agreement strikes a balance by saying GATT cannot overrule domestic laws unless there is no scientific basis for the law. We also have secured a working group in the GATT to address trade and environmental concerns, something environmental groups wanted. Our hope is to win over (or at least keep silent)

those groups that supported us on NAFTA. Those who opposed are likely to remain in opposition.

5. **Sovereignty Interests:** The opposition also may attract Ralph Nader, Jerry Brown and others united by concerns about loss of U.S. sovereignty and other populist themes. (It is unclear whether Perot will make this a major effort - or be diverted by other issues, like health care.) These issues will resonate less strongly than the NAFTA issue, but still need watching.

### **Swing Blocks**

This group likely will determine whether the Congressional Uruguay Round campaign is very tough or easier than the NAFTA fight. Each of these interests is politically powerful and could undermine the perception that you brought home a good agreement.

1. **Antidumping Interests:** The industries concerned with preservation of our antidumping laws (e.g., semiconductors, steel and autos) are not only politically powerful, but resonate in Congress as bedrock American manufacturing industries, giving their concerns special weight. Key legislators - like Gephardt, Danforth, Baucus and Dole - put great importance on the dumping code. The latest word from Geneva is that we have attained our objectives in this area. But it will take at least a short while to assess industry reaction.

Note that many of these companies probably would support the Round if the dumping rules are not weakened. The EC's semiconductor tariffs were cut, depending on the particular product, from 14 percent to [0-10] percent. EC steel tariffs also will be cut. We should act quickly to solidify support from these key companies.

2. **Entertainment Industry:** At this writing, the audio-visual issue had not been settled. Valenti and others threaten to oppose the final package if sufficient progress is not made. Note that past Presidents have secured virtually nothing on this subject in past negotiations (i.e., NAFTA, U.S.-Canada free trade agreement). Anything you secure will be a success by comparison.

3. **Banking/Financial Services:** At this writing, Japan, Korea and other key countries are still balking at opening their financial services markets. As you recall, our position has been that we will not grant them Most Favored Nation (MFN) benefits, unless they provide reciprocal concessions. If concessions from these countries are achieved, the financial services industry would be strongly with us. If benefits are not forthcoming and we refuse to grant MFN (and continue our freedom to use Section 301 to open markets), the industry probably will not oppose us. One approach we should avoid: not gaining concessions, but giving full MFN. This would spark opposition from this powerful industry.

American Airlines

Amc #

Bus. H/C

EDWARD P. FABERMAN  
VICE PRESIDENT  
GOVERNMENT AFFAIRS

March 16, 1994

Ms. Alexis Herman  
Assistant to the President and  
Director of Public Liaison  
The White House  
Washington, DC

Dear Alexis:

I wanted to keep you advised of a new health care initiative that came about as a result of the February 18 luncheon that Bob Crandall attended at the White House with the President. We have been working with a number of organizations to put together another coalition (we are already working with the Health Care Reform Project and Pre-Medicaid Health Security Coalition) to focus on the need for universal coverage and employer mandates.

As a follow-up to the discussions with the President at the February 18 luncheon, Bob Crandall sent the attached letter to the other CEO's attending the lunch (list is attached). In addition, we are trying to bring in other corporations and unions to work with us on this most important effort. We hope to begin the coalition's activities within the next few days.

Please call me if you have any questions.

Very truly yours,



Attachments

cc: Anne Wexler

August A. Busch III  
Chairman & President  
Anheuser-Busch Companies, Inc.

Joseph T. Gorman  
Chairman & CEO  
TRW Inc.

Dwayne Andreas  
Chairman & CEO  
Archer-Daniels-Midland Company

Kent C. Nelson  
Chairman & CEO  
United Parcel Service of America

Donald V. Fites  
Chairman & CEO  
Caterpillar, Inc.

Michael H. Jordan  
Chairman & CEO  
Westinghouse Electric Corp.

Garry Drummond  
Chairman & CEO  
Drummond Company

~~Garry Drummond~~  
~~Chairman & CEO~~  
~~Drummond Company~~

George Fisher  
Chairman & CEO  
Eastman Kodak Company

John F. Smith, Jr.  
President & CEO  
General Motors Corp.

Sanford Weill  
Chairman  
The Travelers Inc.

Robert W. Hannan  
President & CEO  
Thrift Drug Inc.

Calvin Anthony  
President  
Tiger Drug Company

# American Airlines

March 10, 1994

R. L. CRANDALL  
CHAIRMAN AND PRESIDENT

Dear .

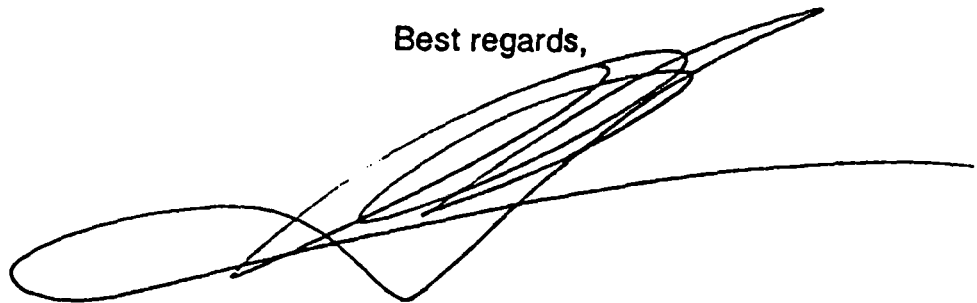
At the White House luncheon we both attended on February 18, the President urged us to do what we can to promote universal health care coverage and an employer mandate. During the meeting, I said that American Airlines was exploring the formation of a coalition focused on those two objectives.

Since that meeting, we have met with hospital, insurance and corporate benefit leaders to explore their interest in such a coalition and have found substantial enthusiasm. Thus, The Wexler Group, a highly regarded government relations firm, has begun coordination of preliminary activities, including identification of other organizations which may be interested in participating.

I am writing to ask you to join the coalition -- for which I am attaching a draft statement of purpose -- which will need substantial corporate participation to be successful. Organization meetings -- which we hope to be holding in the next few weeks -- will be at the offices of The Wexler Group, 1317 F Street, NW, Suite 600, Washington, DC. I hope you will be able to assign someone from your staff to help us get this effort underway.

Please call Ed Faberman at American's Washington office, 202/857-4221, or Bruce Fried of The Wexler Group at 202/662-3744, to indicate your support and with whatever questions you have.

Best regards,

A large, stylized handwritten signature in black ink, likely belonging to R. L. Crandall, written over a horizontal line.

Attachment

## **FairShare HealthCare**

### **The Partnership for Employment Based HealthCare**

#### **STATEMENT OF PURPOSE**

All members of the coalition agree that universal coverage is critical to the efficient and optimal performance of the health care system and the broader economy. Among the methods of achieving universal coverage, an employment based system in which there is both employer and employee financial participation, offers the most practical approach. An employment based system is preferred by most Americans and advances a public-private approach to the human and economic needs for universal health care coverage.

- Universal coverage is critical to successful health care reform:
  - As a matter of equity, humanity and economy, every American should be covered for appropriate health care. The costs in terms of lost productivity and wasted human resources are untenable.
  - The current problems in our health delivery and financing systems cannot be effectively remedied when one in six Americans lack health care coverage at any one time.
  - There can be no effective means to control the growth of health care costs - either through market or regulatory mechanisms -- when significant portions of the population remain outside the health care system.
- A prudently designed employment based system offers the most effective means of achieving universal health care coverage by:
  - addressing an important element of the current cost shifting crisis in which the costs of caring for the uninsured are borne by the insured;
  - extending coverage to the majority of the uninsured -- 84 percent of the 39 million uninsured live in families headed by workers;
  - providing the simplicity of using the current mechanism by which Americans receive coverage -- a mechanism preferred by most Americans.

All coalition members agree that an employment based system of universal coverage is a essential component of health care reform.

**American Airlines**

10/1/94

EDWARD P. FABERMAN  
VICE PRESIDENT  
GOVERNMENT AFFAIRS

February 15, 1994

FEB 15 1994

Ms. Alexis Herman  
Director of Public Liaison  
Office of Public Liaison  
The White House  
Washington, DC

Dear Alexis:

I thought you'd be interested in the attached letter to Ira which sets out American's overall health care priorities and concerns.

We are continuing our efforts to generate additional support -- business and Congressional -- for the Health Security Act. As you know, we believe that the basic goals of that Act, most particularly universal coverage, are important for this country. We stand ready to work with you and the Administration to obtain passage of the bill.

Very truly yours,



Attachment

# American Airlines®

February 15, 1994

Mr. Ira Magaziner  
Health Care Advisor  
The White House  
Washington, DC.

Dear Ira:

I am pleased that we have had several opportunities over the last several months to discuss health care proposals. American Airlines shares President and Mrs. Clinton's belief that effective health care reform is of critical importance to our economy and to the nation as a whole. As you may know, AA has been an advocate of health care reform for some time. Bob Crandall has testified twice before Senator Kennedy's Committee on Labor and Human Resources (the first time in 1987) on the need for health care reform and employer mandated coverage. As a follow-up to our discussions, I thought that I would forward to you a summary of our health care priorities and concerns.

AA's interest in health care reform stems from our role both as an employer and as a large consumer of health care. Through our benefit plans, AA currently provides health coverage to nearly a quarter of a million employees, dependents, and retirees at an annual cost of over \$350 million.

The intense competition of the airline industry and the record losses we have experienced since the beginning of 1990 have made controlling our health care costs especially important. Through aggressive and innovative programs, we have been able to keep our medical inflation rate below the national average, but it is still unacceptably high.

The Health Security Act contains many of the elements we feel are essential to effective health care reform. First and foremost, we think employer mandated coverage is essential. Like many employers, AA is forced to pay for health care twice -- for our own employees, and again, via taxes and inflated prices, for the employees of businesses who provide no or lesser health care benefits. We believe mandated, universal coverage provided by employers, individuals, or governments, as applicable, will eliminate this inequity.

We also agree with the tax treatment of medical benefits under the Health Security Act. Employers, particularly those with self-funded medical plans, have built-in incentives to limit their health care spending. Limits on the deductibility of employer health care costs and failure to pass employer mandates, would exacerbate the competitive advantage of companies who do not provide benefits for their employees by worsening the cost burden of those who do.

Since one objective of reform is to sharpen the consumer's focus on the cost of health care, it makes sense to limit the tax exclusion of health benefits to employees. This will promote cost-conscious behavior by giving employers and employees a shared stake in containing health care costs.

There are a number of provisions in the Administration's proposal that should be modified to maximize existing cost cutting initiatives. Health care savings, as well as increased access and quality, will come from more efficient delivery systems resulting from increased competition among providers. An increased emphasis on the creation of an efficient and competitive health care market -- not a larger role by federal and state governments -- will reduce the cost of health care.

An efficient health care market requires that large consumers of health care -- like AA -- who have been at the forefront of the managed care movement, are able to negotiate independently with vendors and aggressively manage their own costs. The following items, which impact employers forming corporate alliances will discourage participation in the health care system by those parties with the most ability, expertise, and incentive to improve it:

- Weakening of ERISA preemption of state laws for self-insured employers,
- payroll taxes on employers establishing corporate alliances,
- financial reserve requirements,
- forced contributions to "essential community providers," and
- complex coverage and administrative responsibilities.

These disincentives, to operating independent, self-funded medical plans would significantly impact companies like American which operate in all fifty states, and should not remain in a final bill. In particular, the absolute preemption of state regulations of our plans should be maintained. The private sector has made significant progress in recent years controlling health care costs. An employer mandate will help provide universal coverage and ensure that all employers have a stake in an efficient health care system. Given that stake, employers should be given a viable option to control their own spending, without undue government regulation.

We are also concerned about proposals for global budgets and premium caps. Clearly, a fundamental goal of reform must be to bring the medical inflation rate in line with overall inflation. However, restraints on spending are at odds with the functioning of competitive markets. While global budgets and premium caps may produce some savings in the short-term, the price, we believe, will be long-term inefficiency and a greater administrative burden on both government and business.

It is also essential that alternatives be considered for the proposed 1% payroll tax on corporations which choose to provide coverage through a corporate alliance. Such a tax is inconsistent with the need to generate quality, high paying jobs. A payroll tax rewards companies that offer lower paid jobs. Clearly, salary is no reflection of an individual's health care usage. A worker who makes one-fourth of what an AA pilot makes may have identical health care needs as an American Airlines' pilot, thus the tax is punitive to American and the airline industry as a whole. Considering the financial health of the our industry, a payroll tax would further weaken its global competitive position.

We believe that these issues can be addressed without diminishing the Administration's overall objective -- reasonable health care for all Americans. We share that goal and applaud the Administration's willingness to address this urgent and complex national problem. We are eager to see meaningful health care reform passed in 1994, and look forward to working with you to achieve that end. I hope that we can continue a constructive dialogue with you as the debate unfolds.

I look forward to working with you and others in the Administration on this most important issue.

Very truly yours,

A handwritten signature in black ink, appearing to be 'Ed'.

Edward P. Faberman  
Vice President  
Government Affairs

*MLK  
Amy  
Jager*

**American Airlines**

*Am H*

EDWARD P. FABERMAN  
VICE PRESIDENT  
GOVERNMENT AFFAIRS

March 16, 1994

*Bus & H/C*

Ms. Alexis Herman  
Assistant to the President and  
Director of Public Liaison  
The White House  
Washington, DC

*C*

Dear Alexis:

I wanted to keep you advised of a new health care initiative that came about as a result of the February 18 luncheon that Bob Crandall attended at the White House with the President. We have been working with a number of organizations to put together another coalition (we are already working with the Health Care Reform Project and Pre-Medicaid Health Security Coalition) to focus on the need for universal coverage and employer mandates.

As a follow-up to the discussions with the President at the February 18 luncheon, Bob Crandall sent the attached letter to the other CEO's attending the lunch (list is attached). In addition, we are trying to bring in other corporations and unions to work with us on this most important effort. We hope to begin the coalition's activities within the next few days.

Please call me if you have any questions.

Very truly yours,



Attachments

cc: Anne Wexler

*Mr. L...  
Amy  
Yager*

American Airlines

*Am F*

EDWARD P. FABERMAN  
VICE PRESIDENT  
GOVERNMENT AFFAIRS

March 16, 1994

Ms. Alexis Herman  
Assistant to the President and  
Director of Public Liaison  
The White House  
Washington, DC

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Please call me if you have any questions.

Very truly yours,



Attachments

cc: Anne Wexler

August A. Busch III  
Chairman & President  
Anheuser-Busch Companies, Inc.

Joseph T. Gorman  
Chairman & CEO  
TRW Inc.

Dwayne Andreas  
Chairman & CEO  
Archer-Daniels-Midland Company

Kent C. Nelson  
Chairman & CEO  
United Parcel Service of America

Donald V. Fites  
Chairman & CEO  
Caterpillar, Inc.

Michael H. Jordan  
Chairman & CEO  
Westinghouse Electric Corp.

Garry Drummond  
Chairman & CEO  
Drummond Company

Garry Drummond  
Chairman & CEO  
Drummond Company

George Fisher  
Chairman & CEO  
Eastman Kodak Company

John F. Smith, Jr.  
President & CEO  
General Motors Corp.

Sanford Weill  
Chairman  
The Travelers Inc.

Robert W. Hannan  
President & CEO  
Thrift Drug Inc.

Calvin Anthony  
President  
Tiger Drug Company

# American Airlines

March 10, 1994

R. L. GRANDALL  
CHAIRMAN AND PRESIDENT

Dear .

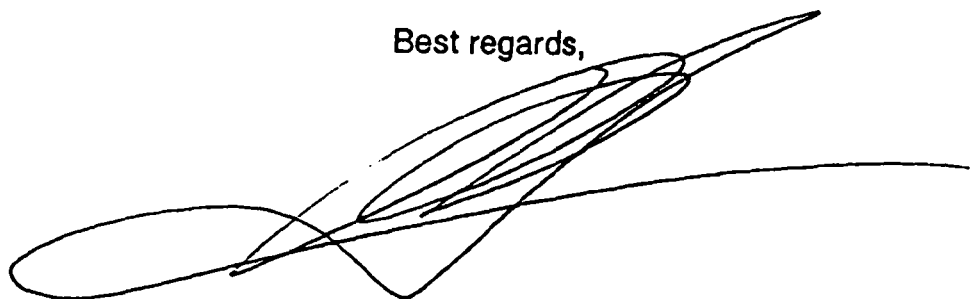
At the White House luncheon we both attended on February 18, the President urged us to do what we can to promote universal health care coverage and an employer mandate. During the meeting, I said that American Airlines was exploring the formation of a coalition focused on those two objectives.

Since that meeting, we have met with hospital, insurance and corporate benefit leaders to explore their interest in such a coalition and have found substantial enthusiasm. Thus, The Wexler Group, a highly regarded government relations firm, has begun coordination of preliminary activities, including identification of other organizations which may be interested in participating.

I am writing to ask you to join the coalition -- for which I am attaching a draft statement of purpose -- which will need substantial corporate participation to be successful. Organization meetings -- which we hope to be holding in the next few weeks -- will be at the offices of The Wexler Group, 1317 F Street, NW, Suite 600, Washington, DC. I hope you will be able to assign someone from your staff to help us get this effort underway.

Please call Ed Faberman at American's Washington office, 202/857-4221, or Bruce Fried of The Wexler Group at 202/662-3744, to indicate your support and with whatever questions you have.

Best regards,

A large, stylized handwritten signature in black ink, likely belonging to R. L. Grandall, written over a horizontal line.

Attachment

## **FairShare HealthCare**

### **The Partnership for Employment Based HealthCare**

#### **STATEMENT OF PURPOSE**

All members of the coalition agree that universal coverage is critical to the efficient and optimal performance of the health care system and the broader economy. Among the methods of achieving universal coverage, an employment based system in which there is both employer and employee financial participation, offers the most practical approach. An employment based system is preferred by most Americans and advances a public-private approach to the human and economic needs for universal health care coverage.

- Universal coverage is critical to successful health care reform:
  - As a matter of equity, humanity and economy, every American should be covered for appropriate health care. The costs in terms of lost productivity and wasted human resources are untenable.
  - The current problems in our health delivery and financing systems cannot be effectively remedied when one in six Americans lack health care coverage at any one time.
  - There can be no effective means to control the growth of health care costs - either through market or regulatory mechanisms -- when significant portions of the population remain outside the health care system.
- A prudently designed employment based system offers the most effective means of achieving universal health care coverage by:
  - addressing an important element of the current cost shifting crisis in which the costs of caring for the uninsured are borne by the insured;
  - extending coverage to the majority of the uninsured -- 84 percent of the 39 million uninsured live in families headed by workers;
  - providing the simplicity of using the current mechanism by which Americans receive coverage -- a mechanism preferred by most Americans.

All coalition members agree that an employment based system of universal coverage is a essential component of health care reform.



AlliedSignal Inc.  
1001 Pennsylvania Avenue, N.W.  
Suite 700  
Washington, DC 20004

202 662 2650

ATL 67

**Ken W. Cole**  
Vice President  
Government Relations

*Amy  
M. Herman*

March 16, 1994

MAR 16 1994

Alexis M. Herman  
Assistant to the President and  
Director of Public Liaison  
The White House  
Washington, DC 20500

*Buss & K*

Dear Alexis:

I enjoyed my lunch in the White House Mess with you today. As I promised, enclosed is a copy of the Chamber of Commerce survey on health care.

The meeting of the Joint Automotive Supplier Council will be held on April 28 in Washington. Among the issues that will be discussed at that meeting is a position on National Health Care Reform. I am enclosing a list of the supplier members of the Council; Jack Smith of General Motors and Stan Gault of Goodyear are the current co-chairmen.

Once again, thanks for the lunch; I look forward to seeing you again soon.

Best regards,

*KWC*

KWC/pd  
Enclosures



recycled paper

**U.S. CHAMBER OF COMMERCE  
HEALTH CARE QUESTIONNAIRE**  
©U.S. Chamber of Commerce

\_\_\_\_\_ Number of full-time employees

As indicated in the accompanying Background Information, a number of common elements to reforming the U.S. health care system are included in most of the proposals being considered by Congress. These common elements do not include mandates for either the providing of or paying for health insurance. They do, however, include such elements as a standard minimum benefit package to permit comparison shopping among all insurers; price-and-quality report cards on health plans; insurance market reform to assure availability and portability; consumer choice; purchasing pools for small employers and individuals; simplified administrative procedures; medical malpractice reforms; and 100 percent tax deductibility for the self-employed.

Do you generally support these types of reforms?

Yes \_\_\_\_\_

No \_\_\_\_\_

No opinion \_\_\_\_\_

Should the United States seek, over time, universal coverage for all Americans?

Yes \_\_\_\_\_

No \_\_\_\_\_

No opinion \_\_\_\_\_

**Health Care Reform Options**

Turning to the issue of how health insurance should be provided and paid for, please indicate your opinion of the following six options. For each option, please indicate if this is an unacceptable or acceptable option by putting a check-mark (✓) in the appropriate space. Then, please select only one of the six options as your most preferred option.

**1. Enhance the current system**

Health insurance should be a voluntary employee benefit but should include common reform elements described above. The decision as to whether health insurance should be made available to employees or if any or all of it should be paid for by the employer should be voluntary, not mandated by government.

Unacceptable \_\_\_\_\_

Acceptable \_\_\_\_\_

No opinion \_\_\_\_\_

-over-

**2. Expand coverage for low income individuals and families**

Government should provide expanded financial assistance to help buy private insurance for low-income individuals and families, thereby improving health care coverage and lessening cost-shifting.

Unacceptable \_\_\_\_\_

Acceptable \_\_\_\_\_

No opinion \_\_\_\_\_

**3. Employer-required access**

Government should mandate that all employers offer health insurance to their employees, but whether the employer pays for any or all of that insurance should be a voluntary decision. This incorporates making medical savings accounts (similar to a medical IRA) available to employees.

Unacceptable \_\_\_\_\_

Acceptable \_\_\_\_\_

No opinion \_\_\_\_\_

**4. Employer mandate**

Government should mandate all employers to make health insurance available to employees and also mandate employers to pay for some portion of that insurance, and individuals to take that insurance. This option assumes government will provide some financial assistance to qualifying small businesses, generally for those with low-wage employees, and to low-income individuals and families.

Unacceptable \_\_\_\_\_

Acceptable \_\_\_\_\_

No opinion \_\_\_\_\_

If you select this option as acceptable, indicate below what portion of health insurance costs an employer should be required to pay.

1% to 20% \_\_\_\_\_ 21% to 40% \_\_\_\_\_ 41% to 60% \_\_\_\_\_ 61% to 80% \_\_\_\_\_ 81% to 100% \_\_\_\_\_

**5. Individual mandate**

Government should mandate every individual to have health insurance but should not mandate employers to pay for it. If the employer did not voluntarily pay for it, the individual would then be required to pay for it. Government financial assistance for low-income individuals and families would be available.

Unacceptable \_\_\_\_\_

Acceptable \_\_\_\_\_

No opinion \_\_\_\_\_

**6. Government-run health care system**

Government should provide health insurance coverage for all citizens and should pay for it through taxes on individuals and businesses.

Unacceptable \_\_\_\_\_

Acceptable \_\_\_\_\_

No opinion \_\_\_\_\_

**Most preferred option**

Which of the six options above would you find most preferable? Place a check mark (✓) by only one option.

- \_\_\_\_ 1. Enhance the current system.  
 \_\_\_\_ 2. Expand coverage for low-income individuals and families.  
 \_\_\_\_ 3. Employer-required access

- \_\_\_\_ 4. Employer mandate  
 \_\_\_\_ 5. Individual mandate  
 \_\_\_\_ 6. Government-run health care system

Thank you for completing this survey. We appreciate your concerns and opinions. Please return it in the enclosed envelope by March 31, 1994.

# **Joint Automotive Supplier Governmental Action Council**

## **Council Members**

AlliedSignal Inc.  
ASC Inc.  
Bethlehem Steel Corporation  
Borg-Warner  
BTR Sealing Systems Group  
Chrysler Corporation  
Dana Corporation  
The Dow Chemical Company  
E.I. duPont de Nemours & Company  
Eagle-Picher Industries, Inc.  
Eaton Corporation  
Equion Corporation  
Ford Motor Company  
General Electric Corporation  
General Motors Corporation  
The Goodyear Tire & Rubber Company  
Ingersoll-Rand Company  
ITT Corporation  
Johnson Controls, Inc.  
Mascotech, Inc.  
Milliken & Company  
Motorola, Inc.  
Norfolk Southern Corporation  
PPG Industries, Inc.  
Rockwell International Corporation  
Southern Pacific Transportation Company  
Tenneco Automotive  
Textron Inc.  
The Timken Company  
TRW Inc.  
United Technologies Corporation  
USX Corporation

**NAM** National Association  
of ManufacturersAmy  
Myager  
12/12  
T/C 1/12

ASAP

|        |                                                                   |                 |                 |
|--------|-------------------------------------------------------------------|-----------------|-----------------|
| TO:    | <u>Alexis Herman</u>                                              |                 |                 |
| FIRM:  | <u>The White House</u>                                            |                 |                 |
| PHONE: |                                                                   | FAX:            | <u>456-2983</u> |
| FROM:  | SHARON CANNER<br>ASSISTANT VICE PRESIDENT<br>INDUSTRIAL RELATIONS |                 |                 |
| DATE:  | <u>1/12/94</u>                                                    |                 |                 |
| PAGES: | <u>10</u>                                                         | INCLUDING COVER |                 |

IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CALL MARJORIE WEAVER AT  
(202) 637-3126.

COMMENTS:

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Manufacturing Makes America Strong

1331 Pennsylvania Avenue, NW, Suite 1500 - North Tower, Washington, DC 20004 • 1790 • (202) 637-3124 • Fax: (202) 637-3450



# **NAM** National Association of Manufacturers

*Sharon F. Canner*

*Assistant Vice President*

*Industrial Relations*

January 12, 1994

Alexis Herman  
Assistant to the President  
and Director for Public Liaison  
The White House  
Washington, DC 20500

Dear Alexis:

Per Jerry Jasinowski's request, I am attaching copies of letters sent to Ira and the President in 1993. As he mentioned, we are preparing a letter to the President outlining the 5 or 6 priority issues for NAM. Our intent is to deliver this letter on Friday. Should you have questions, please give me a call at 202/637-3124.

Sincerely,

Enclosures

**Manufacturing Makes America Strong**

11331 Pennsylvania Avenue, NW, Suite 1500 - North Tower, Washington, DC 20004 • 1790 • (202) 637-3124 • Fax: (202) 637-3182



Jerry J. Jasinowski

President

October 18, 1993

The President  
The White House  
Washington, DC 20510

Dear Mr. President:

On behalf of the NAM's more than 12,000 members, I commend you, Mrs. Clinton and your Administration's entire health care team for setting out a comprehensive plan to improve the nation's health care system. As legislative consideration of this difficult challenge begins, you have done the country a great service by laying a solid foundation for both the informed debate and the bipartisan compromise that will be essential to reaching final agreement on a plan that can pass the Congress and be signed by you.

Let me first emphasize what the NAM sees as three major strengths of the Administration's proposal:

- It would establish the principle of shared employer and individual financial responsibility for moving towards universal access within an employment-based health care system.
- It would assure Americans they will not lose health coverage due to changes in health or employment status and would improve the availability and affordability of health coverage to small businesses.
- It identifies, and attempts to address, the need both for containment of spiraling health care costs as well as for reductions in the excessive administrative burdens that permeate the entire system.

Having noted these, I must honestly tell you that, from the perspective of U.S. manufacturers, the Administration's health care plan also has some major weaknesses:

- First and foremost, the plan is too large and ambitious by half. Nowhere is this more evident than in the proposed scope of the benefit package that would be guaranteed to be available to all. This guarantee must be reduced to a basic and affordable package of core health benefits. Expensive additional coverages, such as prescription drugs, mental health and long-term home care, should be added only when and if it becomes clear that we can pay for them.

The President  
October 18, 1993  
Page Two

- Another area where the plan clearly overreaches is its proposed establishment of a sprawling bureaucratic structure of huge regional alliances coupled with a national board and a vast array of special purpose oversight committees. This kind of excessive government regulation will strangle the competition that is absolutely essential to containing the cost of health care services and reducing administrative expenses. What's needed is much less bureaucracy and much more emphasis on market-oriented approaches.
- Yet another example of the plan simply going too far is that it would force all firms with fewer than 5,000 workers--in other words, about 70% of the workforce--into regional purchasing alliances. We feel strongly that the threshold should be considerably lower, perhaps around 500, so that more large and medium-sized employers would be able to pursue innovative benefit design and cost control techniques by self-insuring. Many such creative efforts have already resulted in the provision of benefits as good as or better than those your plan would guarantee, at costs lower than your plan projects.
- Our last major difficulty is that the Administration plan would grant states too much latitude to impose differing health care systems and requirements, unreasonably burdening multi-state employers. These employers should be allowed to operate under a uniform federal framework that precludes state benefit mandates, forced participation in state single payer systems, and imposition of special state health taxes or data requirements.

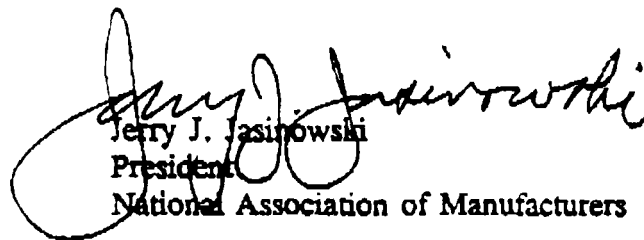
The strengths and weaknesses summarized above were discussed at length at a recent meeting of the NAM's board of directors. At that meeting, our directors adopted the enclosed resolution on health care reform, setting forth the points already mentioned and raising additional important issues as well. I hope you and the members of your health care team will read this resolution and give it some serious thought.

Before closing, however, I want to highlight one other concern that is pervasive in the comments I hear from our members. There is, to be candid, profound skepticism that your plan will successfully reduce the growth of health care costs. This takes many forms, ranging from worries that the proposed Medicare/Medicaid savings will not materialize--or, if they do, that this will exacerbate cost-shifting to the private sector--to concerns that the plan's proposed subsidies for small businesses and early retirees will swell the federal deficit. It is a problem you will have to deal with convincingly in the months ahead.

The President  
October 18, 1993  
Page Three

Let me now say in closing that the NAM wants very much to play a constructive role in the process of putting together a truly bipartisan health care plan, one that builds upon your landmark first effort by drawing on its best features and combining them with what is best in the various alternative plans being offered by members of Congress. We look forward to cooperating with you, your Administration and the Congress in that critical process. In this regard, we are greatly encouraged by the frank and helpful attitude displayed to date by your health care team, and especially by Mr. Ira Magaziner, who has been unfailingly responsive to our many inquiries and requests.

Sincerely,



Jerry J. Jasinowski  
President  
National Association of Manufacturers

Enclosure

cc: The Hon. Roger Altman  
The Hon. Lloyd Bentsen  
The Hon. Mack McLarty  
The Hon. Leon Panetta  
The Hon. Alice Rivlin  
The Hon. Donna Shalala  
Mr. Ira Magaziner



National Association  
of Manufacturers

Jerry J. Jasinowski  
President

July 22, 1993

Mr. Ira Magaziner  
Senior Advisor for Policy Development  
Room 216 OEOB  
Washington, DC 20050

Dear Ira:

The NAM Executive Committee greatly appreciated your patience in responding to their many questions at our recent meeting. The more details we learn about the Administration's health care reform proposal, the more impressed we are with the careful review you have made of this issue. But, as we learn more, additional questions do arise.

We therefore are quite eager to see the full proposal in final form, so that we may move it expeditiously through our policy-making process. As you know, we want to be as fair as possible, and thus will neither support nor reject individual components of the plan until we have studied it in its entirety. I would nevertheless like to summarize what, at this point, are a number of key concerns our members have:

Cost/Financing. Of prime concern will be the overall cost of the plan. I cannot overemphasize the critical importance of designing the basic plan that is to be available to all so that its cost is on the low side. If the basic plan is too "pricey" then your overall proposal may well be "dead on arrival," which is exactly what you want to avoid. We are particularly concerned to hear reports about a broad mental health component in the basic benefits package.

You mentioned that new financing for the plan was not expected to exceed \$50 billion, with about two-thirds of that coming from savings in the Medicaid area and the remaining third from increased tobacco taxes. On the first source, it is essential that you be very sure these savings will actually materialize. On the second, we remain extremely troubled by the dangerous potential for both the application and expansion of a rationale that justifies excise tax increases by linking certain societal costs with the products being taxed.

Two other cost-related issues are crucial: your proposal must contain effective measures to end cost-shifting to the manufacturing sector; and, employers already providing adequate health care benefits to employees should not experience any significant cost increase under your proposal. Can we be assured that this will be the case?



National Association  
of Manufacturers

Jerry J. Jasinowski  
President

May 13, 1993

Ira Magaziner  
Senior Advisor for Policy Development  
The White House  
Room 216 OEOB  
Washington, DC 20050

Dear Ira:

The response to your remarks on Wednesday morning at the NAM Issue Breakfast, I believe, was quite positive. Many questions, of course, remain about the final cost and technically how NAM members will be affected. To summarize some of the points made and to raise other issues of concern to us, I call your attention to the following:

**Cost.** The goal of expanding coverage to approximately 37 million uninsured presents a major challenge. With no firm figures yet public, we are, of course, quite concerned about the net added cost that employers will be asked to bear. We have serious reservations about the scope of the benefit package, the employer/employee cost share, whether prescription drug and long term care are included, etc. Will employers now providing health benefits fare better under the new plan than they do now?

On the cost issue we have a settled conviction: the one sure way to sink health care reform is to propose a program that's simply too expensive. It is essential in our view that the net additional cost of the program be at the lower end of the ranges being discussed.

Further, cost will also depend on the time frame for phasing in universal coverage. A longer phase-in would not only make good economic sense, but the infrastructure is not in place now to deliver care to everyone. A long transition time will be essential. Children and pregnant women should be a priority, bringing in other groups gradually.

In addressing the cost of the plan, it is important to be cognizant of the role of cost-shifting. Currently, employers pay for the uninsured through cost-shifting. Of the 1991 bill for health care paid by manufacturers, \$11.5 billion (Lewin/ICF, Inc.) was due to cost-shifting. Underpayments to doctors and hospitals by Medicare and Medicaid contribute heavily to cost-shifting as well as to manufacturers' costs of providing health coverage for workers' dependents employed by non-providing employers. If it can be demonstrated that the cost-shift will be eliminated or at least significantly reduced, that would do much to alleviate many of our members' concerns.

**Cost Controls.** Voluntary targets for providers are worth a try, we believe. A regulatory system with legally enforceable targets is not the answer. Over the long term providers will game the system and consumers and payers will be the losers. Instead, we should try to obtain the cooperation of providers and aim to create incentives for providers to deliver quality care at reasonable cost.

Ira Magaziner  
May 13, 1993  
Page Two

**Financing.** The financing of a reformed system should be spread as broadly and uniformly as possible throughout all sectors of the economy, rather than targeted on specific businesses, and should be shared by both employers and employees. It appears that, to cover the uninsured, employers not providing benefits would be subject to a payroll tax or premium contribution under the Administration's plan. While NAM is not yet prepared to endorse a mandated system, we certainly believe that under any such system all employees should be required to make contributions to the cost of their health coverage.

Employers already providing their employees with adequate health benefits should incur a commensurately smaller tax, or premium increase if any, than those employers providing fewer or no benefits. It is crucial that a careful analysis be made of the basis for levying premiums or taxes, so that high-wage employers do not bear a disproportionate burden in the financing of a reformed system. Finally, efforts should be made to minimize job losses among employers adversely impacted by the reformed system.

**Quality and Administrative Reforms.** These elements are key to an improved system. The Administration's attention to addressing the unnecessary tests, excessive paperwork burden of hospitals and physicians and incentives that now result in more care than needed is welcome news to NAM members. On the data side, we strongly support uniform data collection both within states and across the nation. U.S. computer sophistication is such that we can do this now. There is no need to reinvent the wheel. The working group on electric data interchange (WEDI), which reported out last year with participation from insurers and the federal government, laid out a plan for doing this.

Health plans must compete on cost as well as on quality in seeking consumer business. We recommend a stand alone quality organization in each state that would be separate from the health alliance. This would prevent conflict of interest in having an alliance judge the quality of care it purchases. This organization would deal with the current fragmented system of utilization and quality oversight among purchasers of care. A single organization responsible for monitoring system-wide quality can embrace the entire continuum of care and can create a patient-centered global database on medical practice patterns and patient outcomes.

**Medical Liability Tort Reform.** Practice guidelines and alternative dispute resolution (ADR) mechanisms, while important, are not sufficient. Enterprise liability (institution rather than doctor is sued) has some merit, but there is little experience with the concept. Demonstration projects would be welcomed.

NAM strongly supports the California reforms which lay out uniform standards for medical liability claims, e.g., periodic payments for damages over \$100,000; \$250,000 limit on non-economic damages; mandatory offsets for collateral sources and plaintiff lawyer fees limited by sliding scale.

Defensive medicine--the extra tests and treatments ordered by physicians to protect against lawsuits--adds to the cost of medical care. A 1993 study reported that \$36 billion could be saved over five years if we were to enact medical liability tort reform. This sum of money would go a long way to help finance coverage for the 37 million uninsured.

Ira Magaziner  
May 13, 1993  
Page Three

**State Flexibility and Employer Plans.** Allowing states maximum flexibility in enacting their own reform plans will result in a patchwork of state systems. Businesses, particularly small firms, would move from place to place depending on the state health reform law, causing economic disruptions. Multi-state employers, which have provided benefits to a large segment of American workers and their families for many years, will find it both financially and administratively difficult and expensive to continue this important commitment.

Further, allowing state ERISA waivers (Hawaii, New York and Minnesota are pending) will discourage the development of a federal framework for reform so necessary to assure uniform coverage regardless of residence. Should a critical mass of states come to Washington requesting waivers, which are subsequently granted, the reality of a federal uniform system will die. We must discourage a state-by-state approach which is both bad economic and health policy.

**Medicare.** Including Medicare beneficiaries in the new health system is essential in tackling private sector cost-shifting. We applaud the Administration's intent to do so. Having beneficiaries receive care through managed care arrangements, rather than fee-for-service, is important to bringing down program costs which are projected to bankrupt the Medicare trust fund by the end of the century.

**Structure of the Health Alliance.** Large self-insured employers should have the option to remain outside the Alliance for several reasons. In general, large firms have made great strides in managing their costs, developing relationships with providers, buying on quality--in short have made a significant investment in providing cost-effective benefits for their employees. Further, including enormous numbers of employees now covered by private employer plans would place great a burden on the new Health Alliances which already must handle numerous small businesses and individuals.

A private nonprofit agency, not government, should operate a single or multiple purchasing alliances as appropriate within the states. A new government bureaucracy should be discouraged from dominating a reformed system. Government entities tend to become politicized as witness what happened to health planning in the 1970s.

Small employers whose employees receive benefits through the Alliance as well as large employers who may also have some relationship to the Alliance, should be asked to serve on the Alliance's governing board. For purposes of participating in the Alliance, we support an aggregate national count of employees for each company, rather than by individual plant site.

**Tax Status of Health Benefits.** Limiting employer deductibility for health care will do nothing to change consumer behavior, which is essential to managing health costs. We therefore oppose limiting the employer deduction and would urge instead that consideration be given to exploring changes to the employee tax exclusion.

Ira Magaziner  
May 13, 1993  
Page Four

**Workers' Compensation.** If the Administration's proposal includes the medical portion of workers' compensation, it is critical that nothing in the proposal jeopardize the right of the employer to contest a decision on the cause of injury. This means that a doctor in an accountable health plan (AHP) should not have the final say on whether an injury is occupationally or non-occupationally related. Additionally, the new system cannot be a vehicle to expand workers' compensation indemnity benefits.

Other points you are urged to consider: methods for maintaining experience rating and for reducing litigation, the development of treatment standards, employer choice of providers, and laws that would provide for criminal and civil penalties for workers' compensation fraud. In the near future, we will forward to you a separate letter expanding on these and other considerations regarding workers' compensation.

The manufacturing community is supportive of the general thrust of the administration's thinking on reform. We look forward to seeing the details of the proposal, which we will judge as a whole as it addresses the cost, quality and access problems of the system and the potential financial impact on manufacturing. In closing, however, I want to stress again how critically important it is that the reform plan be perceived not just as improving the efficiency of the system, but also as being something the nation can afford.

Sincerely,

Jerry J. Jasinowski  
President

# NAM National Association of Manufacturers

Jerry Jasinowski

President

January 21, 1994

Mrs. Hillary Rodham Clinton  
The White House  
Washington, DC 20500

Dear Mrs. Clinton:

As you know, I have been working with Alexis Herman of the President's staff to see if we could arrange for you to make a presentation on the Administration's health care reform plan to our Board of Directors when it next meets on February 4-5 in Naples, Florida. Specifically, we are hoping you could address our board on Saturday morning, February 5.

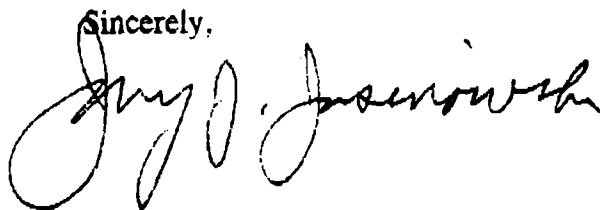
This meeting will be attended by over 100 senior corporate executives who serve on the NAM's board, most of them chief executive officers of American manufacturing firms. These executives, virtually all representing companies that provide excellent health benefits to their employees, have an abiding interest in the outcome of the current legislative debate over reform of the nation's health care system.

For your further information, I am enclosing a copy of a letter I sent the President today, including an attached resolution adopted at our last board meeting in October 1993. These documents summarize our major concerns with the Administration's proposed Health Security Act.

As I have said in prior communications, the President and you have done the country a great service by laying a comprehensive foundation for the bipartisan compromise that must now occur if a plan that can pass the Congress is to be fashioned. Addressing our directors next month is, I feel, an excellent opportunity for the Administration to indicate what initial actions it might be willing to consider to reach such a bipartisan compromise.

I very much hope you will accept our invitation.

Sincerely,



Enclosure

cc: Alexis Herman

|                                          |                        |                |
|------------------------------------------|------------------------|----------------|
| Post-It™ brand fax transmittal memo 7671 |                        | # of pages > 6 |
| To: Alexis Herman                        | From: Jerry Jasinowski |                |
| Co.                                      | Co. NAM                |                |
| Dept.                                    | Phone # 637-3113       |                |
| Fax #                                    | Fax #                  |                |

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**NAM National Association  
of Manufacturers**

Jerry Jasnowski

President

January 21, 1994

The President  
The White House  
Washington, DC 20500

Dear Mr. President:

With this year's Congressional session soon to begin, I want to make sure you are fully apprised of the Association's views and intentions regarding the upcoming legislative debate on health care reform. The NAM shares your desire to reform the nation's health care system to provide access to those not now covered, to assure Americans they will not lose the coverage they now have due to changes in health or employment status, and to improve the quality and reduce the cost of the care being delivered.

We have, admittedly, some major differences over how best to achieve these goals. During 1993, we devoted much time and effort to formulating what we believe to be thoughtful and constructive criticism of the Administration's health care reform plan--the proposed Health Security Act. This process culminated in a resolution adopted last fall by our Board of Directors after hours of lengthy debate over several days. A copy of that resolution is enclosed.

The views synthesized in the enclosed resolution were communicated by us on repeated occasions to members of your health care team, who were most cooperative in making themselves available to discuss them with me and members of the NAM. Notwithstanding this, the end result has been most unsatisfactory, since to date none of our suggestions appear to have been heeded.

The NAM nevertheless would like to make yet another effort to work with the Administration to improve the proposed Health Security Act and make it acceptable to a much broader range of U.S. employers. At a minimum, we believe major changes are essential in the following areas:

Cost of the Plan. The proposed guaranteed benefits package must be dramatically scaled back to a basic and affordable package of core health benefits. Beyond this basic core, benefits should be extended strictly on a pay-as-you-go basis. The goal cannot be the best package of benefits that can be designed, but rather must be the best package that the nation, its employers and its employees can afford.

Financing. On the financing side, it is critical that you avoid Medicare/Medicaid cutbacks which either are politically unrealistic or which, if adopted, would further exacerbate the cost-shifting problem. Similarly, any subsidies included in the plan must be reasonable in the context of the overall federal deficit. Of course, one of the best ways to reduce the cost of those subsidies deemed necessary is to reduce the overall cost of the guaranteed benefit.

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The President  
January 21, 1994  
Page Two

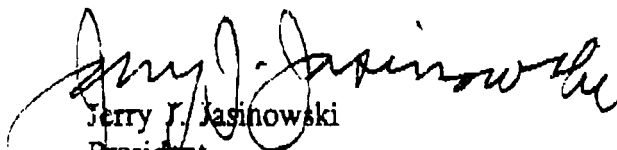
Regional Health Alliances. The 5,000 employee threshold, below which all employers would be forced into state-run regional health alliances, is simply much too high. It would force over 70% of the workforce into these bureaucratic monoliths, whose sheer size would threaten to overwhelm the self-insured employer plans remaining outside this system, thus stifling private health care innovation and leading in effect to an aggregation of single-payer systems. This threshold should be reduced from 5,000 to 100. Moreover, employers with fewer than 100 employees who are already obtaining adequate and affordable coverage through multiple-employer associations should be permitted to continue such arrangements.

Corporate Alliances. To foster increased private sector competition, corporate health alliances should be encouraged, not discouraged. This would allow continued innovation in benefit design and cost containment and be more consistent with the Administration's announced goal of maintaining a private employer-based system. Accordingly, the plan's excessive regulation of corporate alliances must be moderated, and excessive taxes and reserve requirements must be avoided. Moreover, since nearly all employers electing to maintain corporate alliances would have operations in multiple states, the existing ERISA protections against having to comply with widely varying state requirements must be continued in full force and effect.

Price Controls. Premium caps and global budgets are essentially price controls and price controls have never worked in the long run. If benchmarks are needed, expenditure targets are preferable to enforceable caps and budgets. In addition, more emphasis needs to be placed on market-oriented approaches, such as offering incentives to Medicare recipients to switch to managed care networks and permitting competing health alliances in the same geographic region.

Our major concerns are summarized above. Additional concerns are outlined in the enclosed resolution, and include the need for stronger medical liability tort reform and for much less reliance on powerful and potentially overreaching bureaucracies. We would appreciate an early opportunity to meet with your health care team to see if these concerns can be dealt with in the context of the Administration's plan. We feel quite strongly that the Administration must demonstrate a willingness to make large changes in its plan that meaningfully address the major concerns or else risk losing the support of most of the business community. Unless such changes are forthcoming, I can see no other option for us but to focus our future efforts on working within the context of other reform plans now before the Congress.

Sincerely,

  
Jerry J. Jasinowski  
President  
National Association of Manufacturers

**NATIONAL ASSOCIATION OF MANUFACTURERS  
BOARD OF DIRECTORS MEETING  
Los Angeles, California  
Approved October 9, 1993**

**Resolution on Health Care Reform**

American manufacturers have consistently demonstrated a broad commitment to providing employees and their families with good health care benefits. We therefore have a vested interest in the current debate over how best to reform the U.S. health care system. The Administration has presented a comprehensive plan for addressing this challenge, and a number of other constructive proposals for major systemic reform have been developed by members of Congress. The National Association of Manufacturers is working with the Administration and the Congress to shape a bipartisan reform plan that is right for the United States and that has, as major goals, reducing health care costs as a percentage of Gross Domestic Product and making U.S. firms more competitive in world markets. To guide this process, we offer--subject to the caution that these are preliminary views that may change as more specific details become known--the NAM's assessment of the Administration plan:

**Positive Aspects**

- Establishes the principle of shared employer and individual financial responsibility for moving towards universal access within an employment-based health care system.
- Proposes insurance market reforms that would assure Americans they will not lose health coverage due to changes in health or employment status, and that would improve the availability and affordability of health coverage to small businesses.
- Provides for regional purchasing alliances as a means to assist small firms and individuals in obtaining affordable coverage.
- Attempts to address the need for cost containment as well as for reductions in the excessive administrative costs that pervade the health care system.
- Focuses on the need to improve the quality of health care through enhanced consumer access to information on provider performance, which should help reduce unnecessary and inappropriate care.
- Recognizes that the cost of coverage for early retirees negatively affects many U.S. companies and their ability to compete in international markets.

**Negative Aspects**

- Advocates an overly generous package of guaranteed benefits far beyond what the nation can afford.

- 2 -

- Relies on a narrow, probably diminishing tax base and on very ambitious Medicare/Medicaid savings goals that could perpetuate cost-shifting to the private sector. Moreover, the plan fails to deal comprehensively and evenly with the multifaceted cost-shifting problem.
- Undermines, for multi-state employers, the existing federal framework (ERISA) that precludes state mandates, participation in single-payer systems and the imposition of state taxes and state data requirements.
- Sets an inappropriate 5,000 employee threshold below which employers would be forced to join regional health alliances, placing nearly 71% of U.S. workers into such publicly-sponsored entities and forcing many smaller employers, who individually or through groups have initiated cost-effective quality health care arrangements, to join these regional alliances at substantially higher cost.
- Provides excessive restrictions on those employers who would be allowed to operate their own corporate alliances, imposing potentially unjustified cost increases and unreasonable limits on innovative benefit designs and cost containment techniques.
- Creates cost controls and overreaching regulatory structures that conflict with the goal of reducing administrative costs and of making health care markets more competitive, while putting insufficient emphasis on the need to make consumers of health care services more cost-conscious.
- Does not adequately address medical liability tort reform.

We appreciate the Administration's recognition that its health care reform plan will undergo a series of revisions as it moves through the legislative process. As Congress considers the Administration plan together with competing Congressional plans, the NAM urges that its deliberations be guided by the following recommendations:

1. **Guaranteed Benefits Package.** The guaranteed benefit package must be significantly trimmed. The plain fact is that we cannot afford to provide, over and above a basic package of core benefits, a long list of expensive additional coverages. Such coverages should be added, if at all, only later after it is clear they are affordable. Benefits and costs should be tied together.

2. **Cost-Shifting.** Any approach to ending cost-shifting must simultaneously address all the different types of cost-shifting that occur, which includes cost shifts to the private sector from government, to the manufacturing sector from non-manufacturing sectors and, within the manufacturing sector itself, to firms whose health plans are cost-effectively managed from inefficient plans.

3. **Multi-State Employers/ERISA.** Any reformed system should continue to permit multi-state employers to operate under a uniform federal framework (i.e., ERISA) that precludes

- 3 -

state benefit mandates, mandatory participation in state single-payer systems, and the imposition of special state data requirements or state taxes to fund health reform.

4. **Regional Alliances.** The general concept of regional alliances as purchasing cooperatives that enable small firms and individuals to obtain affordable health coverage is a sound one. The 5,000 employee threshold, below which joining an alliance would be mandatory, is much too high and should be dramatically reduced. Consideration should also be given to allowing employers with fewer than the threshold number of employees the option of acquiring health coverage through group plans sponsored by unions, employer associations and other non-profit organizations.

5. **Corporate Alliances.** The rules for corporate alliances should be less regulatory and bureaucratic, so as not to stifle innovation in both benefit design and cost containment, and neither excessive reserve requirements nor unjustified surcharges should be imposed.

6. **Consumer Education and Participation.** Any reform plan must include a major focus on giving consumers of health care services sufficient incentives to be more cost-conscious in their selection and utilization of such services and, just as importantly, to reduce the need for such services through healthier lifestyles and greater emphasis on preventive care.

7. **Market Forces vs. Regulation.** Since it is unclear that premium controls will work, increased emphasis should be placed on market-oriented approaches, such as incentives for Medicare beneficiaries to switch to managed care networks. As a general rule for approaching cost containment, targets are preferred to direct controls.

8. **Excessive Bureaucratic Structures.** Any reform plan should avoid establishing powerful and potentially overreaching national or regional bureaucracies such as the Administration's plan for a network of huge regional alliances, coupled with a national board and accompanied by special purpose oversight committees.

9. **Required Employer Participation.** This may well be considered if the final package emerging from Congress makes overall sense in terms of affordable benefits, sound financing, adequate employer flexibility, reasonable limits on government intrusiveness, effective cost and quality controls, and an end to cost-shifting to business.

10. **Medical Liability Tort Reform.** Strong medical liability tort reforms are needed, and should include limits on non-economic damages in jury awards, stricter statutes of limitations and limits on attorneys' fees. The scope of such reforms should include liability for medical products.

11. **Integration of Workers' Compensation.** Any changes including workers' compensation medical services in a reformed health care system must lead to overall financial savings for employers that presently provide both.

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**DNC - Outreach**

Divider Title: \_\_\_\_\_

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**DEMOCRATIC \* NATIONAL \* COMMITTEE**

David Wilhelm, Chairman

**POLITICAL DEPARTMENT**

PH 202-863-8000

FAX 202-863-8140

**FAX COVER SHEET**DATE: DEC 20 TIME: 6 PMTO: ALEXIS HERMANFAX: 456-2983 # OF PAGES (incl. cover): 3FROM: CAREN WILCOXSUBJECT: HEALTHCARE

IF YOU HAVE TROUBLE WITH THIS TRANSMISSION.

PLEASE CALL \_\_\_\_ AT 202-863-\_\_\_\_.

COMMENTS: \_\_\_\_\_

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## MEMO

TO: Alexis Herman, Assistant to the President

FROM: Caren Wilcox, *CU* Director, Business Outreach, DNC

RE: Healthcare Business Outreach

DATE: December 20, 1993

## GENERAL ISSUES IN THE BUSINESS COMMUNITY RE HEALTHCARE

While the primary outreach to the business community remains in The White House via your OPL efforts and those of the First Lady and her direct advisers, I have been in contact with various colleagues, some trustees, and have been speaking to some business groups. Via these efforts and some new direct efforts, I have learned about some issues of concern.

I understand that you have prepared a memorandum as a result of the meeting you had with Washington reps regarding their advice on issues of concern to the business community. From what I have been told they raised the "philosophical" issues, the finance credibility issue, ERISA, flexible compensation, wellness programs, the 1% to be paid by corporate alliances and the alliances.

As you know I have talked to the flex people at some length. The only issue on which I would place major emphasis is the confusion about the structure of the regional alliances. The Republicans have really done a job on this issue in trying to portray them as governmental bodies. I try to describe them as state authorized corporations to be governed by purchasers and users, (just as every corporation has to be authorized by some state or Delaware, or a federal corporation.) We need to gain a much clearer view of these as structures to reassure many people.

## SPECIFIC MEETING WITH XEROX

I met with Mike Farren, Vice President of Xerox and Liz Smith, their Washington executive (who comes out of the Clothing and Textile Workers Union.) We discussed the potential role Paul Allaire can play, given the layoffs being experienced by Xerox, and also the potential for a visit to Rochester to visibly display how the "alliance" there works even though it is single payer.

Mike and Liz believe that Allaire can be most effective helping to meet with small groups of other CEOs and discussing the concepts and the issue of corporate responsibility with them. (His PR department will urge a low public appearance schedule due to the Xerox layoffs.) They say that Allaire reports that the BRT CEOs are relatively open minded when they are alone, but close up when they get with corporate staffs who attack the plan, and then they back off. In the BRT there is the problem that Prudential heads

the health committee (and Prudential is a big insurance provider to Xerox.)

We discussed an appearance in Rochester by the First Lady and/or the President during January to highlight the operation of an alliance. Not only is it a great site due to Moynihan, Slaughter and LaFalce, but it is good because Fischer is now there at Kodak, and Al Dugan, a senior executive at Xerox is also on the NAM Board.

The only other issue we discussed relative to the plan was the problem of benefits managers at Xerox claiming that our benefits package was "richer" than that of Xerox. I asked them to be sure that what they were citing was not immunizations, well baby care, and mental health, rather than other benefits. Farren said they would get a rundown on that.

Farren also reported on Newt Gingrich's appearance at the BGRC, in which he made it clear he plans to depend on the Cooper bill to act as a pivot for his criticism. I'll try to get a clearer view of the speech from some others there.

cc: Steve Hilton  
Amy Zisook  
Marilyn Yager  
Mike Lux

Craig Smith  
Minyon Moore  
Heather Booth

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January 11, 1994

MEMORANDUM FOR DISTRIBUTION

FROM: LYNN MARGHERIO  
SUBJECT: PHYSICIAN OUTREACH STRATEGY

OVERVIEW:

**Physicians by and large neither understand nor support the Health Security Act.**

Most physicians tend to be schizophrenic in their views on health reform. They dislike the status quo because of the increasing power of the insurance companies and the growing prevalence of managed care. These trends limit the autonomy of physicians, they limit choice for both physicians and their patients, and they interfere in the doctor-patient relationship.

On the other hand, physicians, whose political views tend to be conservative, distrust the government and its ability to fix the problems in the health care sector without adding new layers of bureaucracy and regulation.

When asked in recent polls this fall (See Appendix 1 for results of the AMA and CNN/USA Today polls) what they thought about the Health Security Act:

- Physicians were much less likely than the general population to feel that the health care system needed major changes or needed to be completely rebuilt (41% versus 73%).
- The majority of physicians opposed it.
- They felt that, under the Act, their incomes would decline, costs would increase, quality would decrease, rationing of health care would occur, and government would play a larger role. In addition, they felt that the proposed malpractice reforms would be inadequate.

## **Removed from the politics, most physicians support the main elements of the Health Security Act**

At the same time they oppose what they understand to be the package of reforms under the Health Security Act, the AMA poll indicates that most physicians support its main elements.

- 70% support an employer mandate to achieve universal coverage
- 78% support a comprehensive benefits package
- 91% support insurance reforms that include no denial or loss of coverage for any reason
- 55% support strict limits on premium growth
- 70% support choice of plans and providers

## **Physicians have some substantive reasons for not supporting the Health Security Act**

The Health Security Act is viewed by physicians as threatening their incomes and their positions as the key decisionmakers in the delivery of health care. At the same time, it does not go far enough in reforming the medical malpractice system.

- Physicians' net incomes grew 24% from 1982–1989. The average income for physicians in 1991 was \$170,600. Without reform, physician income is projected to grow at 5.5% per year. Capping the rate of premium increases as recommended by the Health Security Act is almost certain to reduce the rate of increase in the average physician's income.
- Most state licensure laws do not allow non-physician providers prescribe medications or perform certain procedures without being under the supervision of a physician. With an increased emphasis on cost effectiveness and managed care networks under reform, advance-practice nurses, physician assistants and technicians will play a greater role in patient care and medical decisionmaking.
- There are misconceptions about the cost of malpractice. Most physicians think the costs are higher than they are. Nonetheless, the perception that malpractice threats leads to defensive medicine is real. Physicians universally view national limits on noneconomic damages as a critical element to successful malpractice reform. They think we gave in to the trial lawyers.

Despite these concerns, on balance, physicians do much better under the Health Security Act than under any other proposal being considered by the Congress. It's mainly a communications battle we've been losing with them.

### MISCONCEPTIONS ABOUT THE HEALTH SECURITY ACT PERSIST

Negative press stories, combined with negative campaigning by the AMA, the insurance industry and small business groups have left strong misconceptions in physicians' minds about the impact the Health Security Act will have on their practices and the doctor-patient relationship:

- The Health Security Act will limit choice for patients and for physicians. Everyone will be forced into a few managed care plans. Independent, unfettered practice will disappear along with the remnants of physician autonomy.
- The regional alliances are a new layer of unnecessary bureaucracy and regulation – – through the alliances, the government will play a larger role in medical decisionmaking. They now have to jump through the hoops put in place by the insurance companies and the federal and state governments.
- The cap on premium growth is just another form of price controls. In addition to regulating their payment rates through the Medicare and Medicaid programs, the federal government will now micromanage their payment rates in the private insurance market.
- Premium caps threaten quality and will lead to rationing of health care.

Our challenge is to get a communications strategy underway to reverse these misconceptions.

## WHERE THE GROUPS ARE

While the President's proposal is by far the most favorable to physicians of any of the proposals currently being considered on the Hill, the physician community's involvement in the debate ranges from lukewarm support to public confrontation.

### **AMA:**

The American Medical Association (AMA), the largest physician organization with 296,000 members, has advocated health reform in the past, pushing for universal coverage, an employer mandate and a comprehensive set of benefits. Although these recommendations are consistent with the core principles of the President's proposals, the AMA has been less than a supportive or constructive player in the year's health care debate.

Because the AMA represents a cross-section of physicians -- from general practitioners to subspecialists making well above six figures -- they are internally divided over health reform. The AMA leadership continues to support comprehensive health reform. The subspecialists are driven to opposition by their ideology (they do not support the Clinton Administration) and preserving their incomes.

With a base that's hard to hold together, the AMA has been sending mixed signals about health reform. To White House officials, they privately express support and a willingness to work together. The recent press and the pressure they are exerting on our supportive groups to back off suggests otherwise.

- In early December, their House of Delegates (the primary policymaking body) met in New Orleans to vote on policy priorities. Although they had supported an employer mandate as the primary means of financing health reform since 1988, the House voted to explore other means of reaching universal coverage as well as continuing to support the employer mandate. The press reported this as the AMA rejecting the employer mandate. The press also reported that the White House had been invited to address the conference but did not show up. (In reality, they had invited the President who had a scheduling conflict. They did not want Mrs. Clinton to address the conference, as she had addressed a delegation several months prior. Ira Magaziner had expressed a willingness to speak to the conference if invited; an invitation was not extended.)
- In response to the negative press the President's proposal had received, we held a validation event with ten physician groups at the White House. When the AMA heard about it, they started a full-court press on the other groups not to participate. Then, the day of the event, the AMA released a letter to the President stating that the vote did not signify a "retreat" from the employer mandate. Rather, they still supported an employer mandate, but would consider other financing options. In the same letter (which they released to the press),

they pointed out that while other physician groups might be "generally supportive", physicians still had major concerns with the President's proposal – they found it too bureaucratic and regulatory, they oppose premium caps and the malpractice reforms do not go far enough.

The AMA's grass roots campaign will be engaged in the next week. Given their past performance, it is highly unlikely that their characterizations of the Health Security Act will be favorable.

#### **Supportive physician groups:**

Ten physician groups, representing over 300,000 physicians have issued statements of support and stood with the President at the White House in a validation event on December 16. These groups include:

The American Academy of Pediatrics: 47,000 members  
The American Academy of Family Physicians: 74,000 members  
American College of Obstetricians and Gynecologists: 33,000 members  
American College of Physicians: 77,000 members  
American College of Preventive Medicine: 2,000 members  
American Medical Women's Association: 13,000 members  
American Society of Internal Medicine: 26,500 members  
American Thoracic Society: 11,000 members  
National Medical Association: 17,000 members  
National Hispanic Medical Association: 30,000 members

Each of these groups supports the core elements of the Health Security Act:

- Universal coverage
- Comprehensive benefits
- Employer mandate
- Focus on primary care and prevention

The majority of the groups also support some kind of budgeting and support the fee-for-service provisions in the Act. Most of the groups do not believe we have gone far enough in malpractice reform and many feel that the alliance structure is too bureaucratic.

The groups vary considerably in their degree of support and their capacity to mobilize their grass roots. The smallest of the organizations have very little, if any, infrastructure at the state and local levels. Their state and local chapters range from none to very little representation in some states to moderate representation in other states. There is considerable overlap in the organizations at the state and local level with the state and county medical societies, which are the most visible medical organizations at the local level.

Two of the three largest physician groups have been our most supportive allies -- the AAP and the AAFP. The third group, the ACP, while supportive, has become increasingly skittish as the AMA has turned up the heat.

### **The American Academy of Family Physicians**

As recently as December 1, 1993, the Board of Directors of the AAFP voted unanimously to support the Health Security Act as the starting point for health care reform..."the best of the plans offered so far." In their press release, they praised the plan for its focus on health security, primary care and prevention, fee-for-service options and cost containment features. They contrasted these positive features with areas of concern -- minimal malpractice reforms, research initiatives that do not specifically address primary care, minimal regulatory relief for physicians, and including obstetricians/gynecologists in the definition of primary care.

The AAFP has been a constructive supporter throughout, but particularly went to bat for the Health Security Act in December in its statements of support for the employer mandate when the AMA was perceived as backing away from it, and by its strong and visible participation in the validation event on the 16th.

We expect the AAFP to continue to be supportive, using its publications to educate its membership, continuing to participate in validation events, helping to identify and build the network of surrogate physician speakers, etc.

(The AAFP is a member of the Health Care Reform Project. Although they have changed their position, they had been considering breaking away from the Project following a press conference on the employer mandate they felt went too far in characterizing their views.)

### **The American Academy of Pediatrics**

Perhaps the most supportive of the physician groups, the AAP can be most helpful in a strategy to reach American families. Mothers and families trust their pediatricians -- often, families choose their health plan based on the one their pediatrician recommends -- and will trust their views on health reform.

On the policy front, the AAP feels strongly that the Health Security Act is the best plan for children. At the heart of their support is universal coverage (9 million children currently lack insurance) and a focus on continuous care for children, from preventive services through rehabilitation. We worked with them extensively to come to a preventive services schedule they could be happy with. The outstanding major policy concern they have (the children's hospital group and Rep. Slattery share these concerns) is the lack of rehabilitation services for chronically ill children.

*At least 1 million children in the United States suffer from a severe, debilitating and ongoing chronic illness such as severe cerebral palsy, cystic fibrosis, or chronic lung disease of infancy... Over 10 million additional children have incurred a less serious but longstanding illness such as severe asthma, seizure disorders, juvenile rheumatoid arthritis, or juvenile diabetes.*

Under the Health Security Act, some of these children will be covered for rehabilitation services through the Medicaid program or through the new home and community-based long term care program. While many will be protected, others will continue to fall through the cracks as they do today. The Administration is committed to working with the Congress to devise a benefit that best meets the needs of these children.

In spite of their concerns, the AAP intends to continue to be publicly supportive of the Health Security Act. They will reach out to families through a brochure that will be available in their doctors' offices, through op-eds and local press and magazines, and through events and education sponsored with the Children's Coalition (comprised of the AAP, the PTA, and the Washington Business Group on Health).

On the legislative side, the AAP will bolster its own commitment as a national organization to work with Members on the specific elements of the legislation, by having at least one member pediatrician visit with each Member of Congress.

### **The American College of Physicians**

The American College of Physicians, with 77,000 practitioners of internal medicine, is the nation's largest medical specialty society.

From a pure policy point of view, the ACP and the Health Security Act are very similar. The primary common elements include:

- Universal coverage with a comprehensive benefits package
- Mixed public and private financing
- Insurance reform, including community rating
- Employer mandate
- Expenditure limits
- Primary care and prevention

While generally positive, the ACP's public statements of support verge on equivocation. Also, this week they indicated that they are having difficulties keeping their membership on board as they have been so publicly associated in support of the Health Security Act. They will pursue a legislative strategy consistent with their principles, but are wary of any further public validation events. For example, they rejected an invitation to cosponsor the HRC/Koop forum in Philadelphia on January 20.

This tentative public posture is driven primarily by politics, but they do have policy concerns.

- As a member group of the AMA, the ACP has been, and will continue to be, at best, cautious in its support. They are wary of stepping too far out of line with the general AMA position.
- The ACP also has concerns about the TennCare waiver the Administration granted. Basically the waiver grants Tennessee the authority to develop a basic benefit package that would replace Medicaid and the state employee benefits plans and would also be available for purchase by low-income Tennesseans. The ACP objects to the arrangements for physician payments under the waiver: physicians receive a fixed payment for their services and balance billing would be prohibited. The ACP believes that the payment rates are way too low.

## ACTION PLAN

The physician community poses a difficult challenge to educate on health care. On the one hand, they respond negatively to rhetoric and quick overviews of the proposal. They view this as an insult to their intelligence. On the other hand, their knowledge of the President's proposal is essentially what they read in the newspaper.

To overcome the misconceptions and to increase awareness about the positives of the Health Security Act for physicians, we plan to focus on: 1) state and local opinion leaders, 2) the HRC/Koop forums with physicians; 3) getting out the message about other proposals; 4) continuing to shore up support from our core supportive physician groups, 5) reaching out to new groups; 6) print strategy.

### **1) State and local opinion leaders**

Our strategy has been to counterbalance the conservative voices of the six-figure subspecialists with the more moderate physician groups at a national level. As we move forward through the legislative debate, we need to maintain this effort, yet it's clear that the national leadership and the membership are not in the same place with respect to health reform. Our communications strategy going forward needs to target the key physician leaders at the state and local levels.

### **A) Briefings of state and local societies**

Toward the end of 1993, we held White House briefings for the medical specialty societies and the state medical societies, as well as an all-day briefing for supportive physicians. Ira Magaziner has presented at all of the briefings. At the all-day briefing, we brought together a team of Administration physicians, ranging from Phil Lee, MD and Jo Ivy-Bufford, MD to Arnie Epstein, MD, Risa Lavizzo-Mourey, MD and others.

We received mostly positive feedback from both types of events -- the medical specialty societies entered the briefing skeptical if not hostile. They left the briefing with many of their concerns addressed and feeling much more positive about the dialogue they felt had been established with the Administration. The one Saturday briefing was generally well received although we had some negative feedback from presentations the physicians felt were too hard a sell.

We plan to bring in key state and local physician leaders from the medical societies and the state and local chapters of our supportive groups for a series of weekly briefings at the White House. A handful of state medical societies can be cultivated to be generally supportive (for example, WA State, CA, WI). At the other extreme, medical societies in states like Georgia will not likely change their tune no matter how hard we try. Because these briefings require a significant investment of resources, I recommend directing our efforts to groups in the target states and in those states likely to be supportive.

### **B) Building a network of surrogate speakers**

We cannot expect physicians who are not Administration staff to be 100% "on message" when they speak about the Health Security Act. Physicians need to include both pros and cons in their presentations in order to be credible to their peers. This is the phenomenon we have been experiencing with our core supportive groups and the physician surrogates who are currently speaking on behalf of the proposal. Unfortunately, the criticisms are often selectively highlighted by the press.

For those physicians who speak regularly to their peers and to other audiences, we have been working with the National Health Policy Council (a 501c3) to establish an external speakers bureau. We will channel requests the Administration cannot fulfill to the NHPC and will create a feedback loop to monitor the speaker's reception as well as address particular questions or concerns the speakers get from the field.

Additionally, we are holding a series of all-day briefings for generally to very supportive physicians who are opinion leaders in their own communities and nationwide. At these briefings, physicians have an opportunity to ask questions in small group sessions, learn about other proposals on the Hill, and learn about the details of the Health Security Act.

The next all-day Saturday briefing will be on January 20, followed by two in February and two in March (if demand continues).

We hope to use these briefings to identify surrogate speakers and to build a network of people who would disseminate information, write op-eds, and help with grass roots education in their home communities. Also, as many in the audience will be individuals recommended by the cosponsors, these briefings will hopefully result in a larger pool of speakers to attend field hearings who will be supportive of the Health Security Act and who will serve as validators in cosponsors' home states.

## 2) **HRC/Koop Forums**

The President asked C. Everett Koop to moderate a series of forums with the First Lady for physician education and to facilitate the input of physicians throughout the national discussion on health reform. These forums, which include an hour-long question and answer period, have received good feedback by the individuals who have actually attended the briefings. (The HRC/Koop forums have had mixed reviews in the press; because of Dr. Koop's desire to include more conservative physicians in the audience, the Q&A period has included some hostile questions.)

These format of these forums has been tightly controlled by Dr. Koop (The Presidents of the sponsoring organizations introduce Dr. Koop. He introduces HRC. She addresses the audience for about 20 minutes and then opens it to questions and answers. The audience is 99% physicians. All have been open to the press except for the first one at the Institute of Medicine.)

Mrs. Clinton and C. Everett Koop have held four physician forums thus far across the country.

- Institute of Medicine in Washington, D.C.

The Institute of Medicine is the medical arm of the National Academy of Sciences. Its members include the academic and research communities. The first and perhaps best received of the forums to date unfortunately was closed to the press.

- The Association of American Medical Colleges - Washington, D.C.

The Association of American Medical Colleges represents academic medicine. The audience at this forum was generally supportive, although the question and answer period was dominated by medical students rather than the medical school leadership.

- The Georgia Baptist Hospital/Georgia Medical Society in Atlanta, GA

Because it is a target state, we chose to do a forum here and built it from the ground up with tight directives from Dr. Koop to work with the state medical society. The local African-American physician organization also cosponsored the event, although they are nowhere near as well organized as the medical society.

Because we had little control over the audience, many of the questions were hostile. (Georgia physicians tend to be some of the most conservative physicians in the country.) Local press described the physicians as critical of the proposal.

- The Dartmouth-Hitchcock Medical Center in Dartmouth, NH

This forum had a tri-state audience of physicians from New Hampshire, Maine and Vermont. Dr. Koop organized the entire event, down to the audience. Just prior to Mrs. Clinton's arrival, there had been stories about the inadequacies of the mental health benefit. As a result, the majority of the questions were on mental health.

The next forum will be on January 20 in Philadelphia at the Children's Hospital. We are working out at least one additional date.

### 3) **Contrasting to other plans**

The Health Security Act is drawing the most fire from the physician community, even though it is the most positive for this constituency. The other proposals -- from the Chafee bill and the Cooper bill to the IRA proposals -- would be opposed by the physician groups if they really analyzed them:

- They do not achieve universal coverage
- The benefits package is undefined -- most physician groups support a comprehensive set of benefits
- They restrict choice for doctors and their patients with their policies to increase the marketshare of managed care plans
- They favor national insurance companies, further removing the physician community from decisionmaking

Because the Health Security Act is at the center of the debate, the physicians' groups have not been focused on the other proposals. We need to work with these groups to educate their membership about the other plans.

We are currently developing analyses of the other proposals from the physician perspective. These analyses will be ready by the end of next week. We will ask our supportive groups to make these documents their own and disseminate them widely. We will ask some of our more politically minded physician supporters to write op eds showing the benefits of the Health Security Act versus the other plans being considered.

### 4) **Supportive physician groups**

We will continue to be in regular contact with the ten physician groups to discuss policy concerns as well as political/outreach considerations. In addition, we have been notified of all of their major upcoming meetings and will send an Administration representative to keynote events as resources allow. Where we cannot fulfill requests, we will refer the organization to the National Health Policy Council who can provide an "expert" speaker who is both knowledgeable and supportive of the President's proposal.

Once the master schedule of events and themes is developed in the Delivery Room, we will work with these groups to organize events and press around the themes.

On January 20, the American Academy of Pediatrics and the American College of Physicians will cosponsor an HRC/Koop physician forum in Philadelphia.

On February 12, we will invite others of our supportive groups to cosponsor the next HRC/Koop forum in San Francisco.

#### 5) **Other groups**

Beyond the ten groups that have shown the most support, we have worked with other groups that have been constructive players as well. These include academic physicians (the Association of American Medical Colleges (AAMC), the Association of Academic Health Centers (AAHC)), osteopathic physicians, physician members of the disease groups (like the American Lung Association and the American Heart Association).

##### Academic Physician Groups

The Association of American Medical Colleges (AAMC) and the Association of Academic Health Centers (AAHC) have been constructive players in the health reform discussion and are mostly supportive of the key elements of the Health Security Act. More than the practicing physicians, however, these groups do not tend to be "event-oriented" or vocal about their support of one proposal over another.

The First Lady has addressed the deans on several occasions, and Ira Magaziner has had small group meetings with several of the leading deans (as well as the AAMC and AAHC) over the past months. We will continue to send Administration representatives to their large group meetings and will work with them on policy concerns.

##### Disease Groups

The disease groups (such as the American Lung Association, American Heart Association, etc.) have been generally supportive of the President's proposal. While they do not represent physicians exclusively, they do have many physicians and other professionals in their membership who may be sympathetic.

Ira Magaziner recently spoke to this coalition and was very well received. We will engage in more proactive discussions with the disease groups to encourage their involvement and support.

##### Osteopaths

Representing 7-10% of the physicians in the United States, over half of whom practice in primary care specialties, doctors of osteopathy have issued a statement of support for the President's proposal and should be able to be more actively engaged in the push for reform.

Steve Gleason is arranging a meeting between these doctors and White House and DHHS officials for the end of January/beginning of February to reengage them.

## 6) Print strategy

Our original strategy for print media was to get published in the premier medical journals and then to focus on the second tier journals through external authors. Initially, we tended to choose academics and people that tend to write on these areas anyway. However, the timeframe that most of these people work on is so different from the political timeframe. For a print strategy to work, we need to develop a cadre of people who are more politically driven. They are more likely to understand the time sensitivity and would be more likely to write something on message and not be offended when we suggest ideas of strategic importance.

While we will continue to work with physicians as resources allow to get articles into the medical journals, we will place increased emphasis on op-eds in local newspapers and non-medical journals that have syndicated columns on health care. For these, we will recruit more politically-oriented physicians.

### Medical Journals

The two premier medical journals are the Journal of the American Medical Association (JAMA) and the New England Journal of Medicine (NEJM). NEJM printed an article by Arnold Epstein, MD, in November, discussing the impact of the Health Security Act on physicians. Risa Lavizzo-Mourey, MD, has submitted an article on prevention to JAMA.

We have requested articles from a group of mid-level academic physicians to submit to second-tier journals like the Southern Medical Journal and the Western Medical Journal.

### Op-eds and Monthly magazines

Some of our surrogates appear on local radio or in local newspapers on a weekly basis. As we develop the network of surrogates, we will work with them to create columns and stories around the themes developed by the Delivery Room. (For example, we might work with T. Berry Brazelton in his columns in Parenting and Good Housekeeping.)

# APPENDIX

December 8, 1993

## MEMORANDUM FOR DISTRIBUTION

FROM: LYNN MARGHERIO

SUBJECT: AMA POLL AND EARLIER CNN/USA TODAY POLL

The AMA had a telephone poll of 400 physicians conducted from October 27 through November 10, 1993. The questions asked physicians to compare the President's proposal against the current system, a single payer system and the AMA's own plan. There were no questions asked about other plans in the Congress.

The poll's findings were the following:

- 22% are positive about the President's proposal; 44% are negative.
- 75% of those physicians polled view the Clinton proposal as a way to ensure access. They overwhelming majority don't think it will control costs, maintain quality or preserve freedom of choice. Further, they believe that they and their patients will be worse off.
- 67% feel that, under reform, the government will have the most influence on the kind of health care services patients receive, compared to a view held by only 7% today. This is at the expense of physician influence over health care delivery.

In the framing of the survey questions, the AMA portrays government involvement as extreme:

Re: Alliances: "A government-run system of alliances through which almost everyone except Medicare beneficiaries will purchase insurance."

Re: National Board: "A National Health Board established by the federal government to oversee the new system."

A majority of physicians support the following elements of the President's proposal:

- Employer mandate - 70%
- Comprehensive benefits package - 78%
- No denial or loss of coverage for any reason - 91%
- Strict limits on premium growth - 55%

Note: the AMA believes that we are both imposing caps on health insurance premiums and imposing a national health care budget.

- Alternative dispute resolution - 87%
- Access to a wide choice of health plans and providers - 70%

While the physicians polled support freedom of choice, 77% of them do not believe that the Clinton plan will be effective in preserving choice for patients.

#### CNN/USA TODAY POLL

Over October 1-18, 1993, CNN/USA Today conducted a poll of 502 practicing physicians. This poll compared physician response to responses of adults overall.

- Physicians on average tend to be more conservative than the general populace.

While 73% of adults polled felt that the health care system needed major changes or needed to be completely rebuilt, only 41% of physicians felt the same.

- 58% oppose the President's proposal.
- 59% believe that their income will go down under the President's proposal.
- 63% believe that health care costs will increase under the President's proposal.
- 67% feel that the quality of health care will decrease and 76% feel that patient satisfaction will health care will decrease.
- 86% feel that this will lead to rationing of health care services.
- 87% feel that bureaucracy will increase.
- 87% feel that physician control over medical decisions will decrease.

## REPORT OF THE BOARD OF TRUSTEES

B of T Report I-93-59

Subject: Physician Survey on Health System Reform

Presented by: Lonnie R. Bristow, MD, Chair

1 As part of its ongoing activities to assess physician opinions and attitudes on a wide range of  
2 issues, the American Medical Association (AMA) has recently conducted a survey assessing  
3 physician attitudes toward health system reform, the Clinton proposal, and the AMA's health  
4 system reform activities. This report is presented for information as the House of Delegates  
5 considers various health system reform issues.

6  
7 METHODOLOGY OF THE STUDY

8  
9 This survey was conducted by telephone from October 27 through November 10, 1993 by the  
10 Gordon S. Black Corporation. A total of 2,080 randomly selected records from the AMA  
11 Physician Masterfile were selected for use during this survey. A total of 400 physicians were  
12 randomly selected and interviewed in this survey. The margin of error for this sample size is  
13  $\pm 1.5\%$  for the sample as a whole, at the 95% confidence level.

14  
15 HIGHLIGHTS

16  
17 Listed below are several highlights of the study. A complete tabulation is presented in  
18 Attachment A.

- 19
- 20 • Overall reaction to the Clinton Administration's reform plan is negative among a 44%  
21 plurality of physicians, while one-third are neutral, and just over one in five react  
22 positively.
  - 23
  - 24 • However, a majority of physicians support specific elements of the Clinton plan that  
25 ensure access to care. These include no denial or loss of coverage for any reason, a  
26 comprehensive benefit package, access to a wide choice of health plans and access, with  
27 extra fees, to a wider choice of physicians and hospitals. They also support an employer  
28 mandate, limits on the growth of health insurance premiums, and liability reform  
29 requiring the use of alternative forms of dispute resolution.
  - 30
  - 31 • Physicians show little support for plan elements that place further controls on  
32 themselves or for the plan's approach to funding. They do not support cuts in Medicare  
33 and Medicaid payments to physicians and hospitals, nor do they support liability reform  
34 that does not include caps on non-economic damages.
  - 35
  - 36 • Three-fourths think the Clinton plan would be effective in ensuring access, but  
37 majorities rate it ineffective in controlling costs, maintaining quality, and preserving  
38 freedom of choice for patients.

## B of T Report I-93-59--page 2

- 1 • Compared to the current situation, a slight majority say their patients would fare worse  
2 under the Clinton plan, and a larger majority say physicians would fare worse.  
3
- 4 • A majority of physicians believe insurance companies now have the most influence on  
5 the kind of health care services Americans receive, and an even larger majority think  
6 the government will have the greatest influence under the Clinton plan.  
7
- 8 • Most physicians say they understand the Clinton Administration's plan "fairly well."  
9
- 10 • Two-thirds say they received the AMA's all-physician mailing. A majority read at least  
11 some parts of it, and most of the others scanned it. Large majorities found it helpful in  
12 understanding the plan and the AMA's position.  
13
- 14 • Three-fourths of physicians have heard or read AMA officials' comments about the  
15 plan. Half of them found those comments to be equally positive and negative; most  
16 others thought the comments were mostly negative. Two-thirds agreed with the AMA's  
17 comments.  
18
- 19 • A majority of physicians think the AMA opposes the plan, and a majority of both  
20 members and non-members say the AMA should oppose it.  
21
- 22 • Three-fourths think a policy of flexible federal goals for the total amount of health care  
23 expenditures would be best for the country, rather than strict federal limits or no  
24 spending goals at all.  
25
- 26 • On a number of the survey's measures, AMA members tend to evaluate the Clinton  
27 plan more harshly than non-member physicians. Primary care physicians tend to rate  
28 the plan more positively than do specialists.  
29
- 30 • Multivariate analysis of the results indicates that physicians' views of the potential  
31 effectiveness of the plan and the impact it would have on patients are the two attitudes  
32 most closely correlated with overall reaction to the plan. The better that physicians feel  
33 their patients would fare under the plan and the more physicians feel that the plan  
34 would be effective, the more positive they are, overall, toward the plan.  
35

36 COMPARABLE FINDINGS

37  
38 The findings of the AMA survey, conducted by Gordon S. Black Corporation, are similar to  
39 those reported by a USA Today/CNN poll conducted by The Gallup Organization in early  
40 October. The Gallup Organization reports that despite their specific concerns, physicians are in  
41 agreement with several of the principles behind Clinton's proposed reforms. Nearly nine of 10  
42 physicians favor the ideas of guaranteeing equal access to health care and providing federal  
43 health insurance subsidies for low-income and unemployed Americans. A majority of physicians  
44 also favor the plan's approach to insurance, which would allow Americans to choose among  
45 plans based on HMOs, fee-for-service, or a combination of the two. Physicians also favor  
46 placing caps on insurance premiums.

## B of T Report I-93-59--page 3

1 On the other hand, less than half of physicians support the plan's push for health alliances and  
2 only one-third want mandated caps on Medicare and Medicaid spending increases. Gallup also  
3 reported that one of the most controversial elements to physicians is the establishment of a  
4 national health board which would be appointed by the President to monitor health care  
5 spending. Overall 42% of doctors support his board; it is opposed by 54%.

6  
7 CONCLUSION

8  
9 The Board of Trustees will continue to monitor physician attitudes toward health system reform  
10 throughout 1994 in the belief that this type of information can be of assistance when evaluating  
11 the various health system reform proposals that will be debated by the 103rd Congress.  
12 Additional informational reports will be made available to the House of Delegates as needed.

## B of T Report 1-93-59--page 4

## Physician Responses to the Clinton Health System Reform Plan

October 27 - November 10 (N=400)

Note: All percentages are rounded to the nearest whole percent. As a result, subtotal responses may not add to totals, and total responses may not add to 100%.

1. Did you watch or listen to President Clinton's initial announcement of his health system reform plan on September 23?

69% Yes  
31% No

2. From what you know now about the Clinton Administration's health system reform plan, is your overall reaction positive, neutral, or negative?

22% Positive32% Neutral44% Negative2% Don't Know

6% Very  
10% Somewhat  
7% Slightly

26% Very  
14% Somewhat  
5% Slightly

3. If implemented completely, how effective or ineffective do you think the Clinton Administration's plan will be in ...?

|                                              | <u>Effective</u> |                 | <u>Ineffective</u> |             |
|----------------------------------------------|------------------|-----------------|--------------------|-------------|
|                                              | <u>Very</u>      | <u>Somewhat</u> | <u>Somewhat</u>    | <u>Very</u> |
| a. Ensuring access to care for all Americans | 29%              | 46%             | 18%                | 7%          |
| b. Controlling health care costs             | 4%               | 26%             | 28%                | 43%         |
| c. Maintaining quality of care               | 1%               | 28%             | 28%                | 43%         |
| d. Preserving freedom of choice for patients | 3%               | 20%             | 36%                | 41%         |

4. Compared to the way things are now, do you think your patients would fare better, the same, or worse under the Clinton Administration plan?

19% Better24% The Same52% Worse2% Don't Know

5% A Lot  
11% Somewhat  
4% Slightly

19% A Lot  
23% Somewhat  
8% Slightly

5. Compared to the way things are now, do you think physicians in your specialty and type of practice would fare better, the same or worse under the Clinton Administration plan?

11% Better22% The Same61% Worse2% Don't Know

3% A Lot  
6% Somewhat  
3% Slightly

26% A Lot  
28% Somewhat  
8% Slightly

## B of T Report I-93-59--page 5

6. Now I'd like to ask you how you think the Clinton plan compares to other health system reform proposals in terms of impact on patients and physicians.
- First, compared to the Clinton plan, do you think your patients would fare better, the same, or worse under . . . ?
- 6a. the AMA's plan, Health Access America
- |            |              |           |                |
|------------|--------------|-----------|----------------|
| 38% Better | 16% The Same | 12% Worse | 34% Don't Know |
|------------|--------------|-----------|----------------|
- 6b. a government-financed single-payer plan
- |            |              |           |                |
|------------|--------------|-----------|----------------|
| 27% Better | 19% The Same | 43% Worse | 11% Don't Know |
|------------|--------------|-----------|----------------|
7. Now, compared to the Clinton plan, do you think physicians in your specialty and type of practice would fare better, the same, or worse under . . . ?
- 7a. the AMA's plan, Health Access America
- |            |              |          |                |
|------------|--------------|----------|----------------|
| 39% Better | 22% The Same | 9% Worse | 30% Don't Know |
|------------|--------------|----------|----------------|
- 7b. a government-financed single-payer plan
- |            |              |           |                |
|------------|--------------|-----------|----------------|
| 17% Better | 24% The Same | 48% Worse | 11% Don't Know |
|------------|--------------|-----------|----------------|
8. Under our health system now, who do you think has the most influence on the kind of health care services Americans receive: Doctors, Hospitals, Insurance Companies, Employers, or the Government?
- |                         |
|-------------------------|
| 26% Doctors             |
| 1% Hospitals            |
| 53% Insurance Companies |
| 8% Employers            |
| 7% Government           |
| 3% Other                |
9. Under the Clinton plan, who do you think will have the most influence on the kind of health care services Americans receive: Doctors, Hospitals, Insurance Companies, Employers, or the Government?
- |                         |
|-------------------------|
| 8% Doctors              |
| 3% Hospitals            |
| 17% Insurance Companies |
| 4% Employers            |
| 67% Government          |
| 2% Other                |
10. At this point in time, would you say you understand the Clinton Administration's health system reform plan very well, fairly well, not too well, or not well at all?
- |                    |
|--------------------|
| 14% Very Well      |
| 62% Fairly Well    |
| 20% Not Too Well   |
| 3% Not Well At All |
11. Did you receive from the AMA a special mailing of information about the Clinton Administration's plan, or not?
- |                |
|----------------|
| 67% Yes        |
| 19% No         |
| 14% Don't Know |

## B of T Report I-93-59--page 6

- 11a. (IF YES:) Did you read the information thoroughly, read some parts but not others, scan the information, or not look at the information at all? (N=267)
- 19% Read Thoroughly
  - 38% Read Some Parts
  - 37% Scanned Information
  - 7% Did Not Look At
- 11b. (IF YES TO Q11:) Did you find the information in the mailing very helpful, somewhat helpful, not too helpful, or not at all helpful . . . ?
- A. In understanding the Clinton Administration's plan (N= 248)
- 24% Very Helpful
  - 66% Somewhat Helpful
  - 9% Not Too Helpful
  - 1% Not At All Helpful
- B. In understanding the AMA's position with regard to the Clinton Administration's plan (N= 248)
- 39% Very Helpful
  - 54% Somewhat Helpful
  - 7% Not Too Helpful
  - 0% Not At All Helpful
12. Since President Clinton announced his health system reform plan September 22, which of the following have been your most useful sources of information on health system reform issues? (Multiple answers accepted)
- 12% Other physicians.
  - 23% The AMA.
  - 27% Your medical specialty society.
  - 15% Your county or state medical society.
  - 40% Media commentaries by columnists, politicians or health care experts.
  - 39% Or News reports?
13. Since President Clinton announced his health system reform plan, have you read or heard comments about the plan by AMA officials?
- 73% Yes
  - 27% No
- 13a. (IF YES:) Did comments by AMA officials about the plan seem to be completely positive, mostly positive, equally positive and negative, mostly negative, or completely negative? (N= 288)
- 0% Completely Positive
  - 10% Mostly Positive
  - 52% Equally Positive and Negative
  - 38% Mostly Negative
  - 1% Completely Negative
- 13b. (IF YES:) And did you generally agree or disagree with the AMA official's comments? (N=288)
- 67% Agree
  - 25% Disagree
  - 7% Don't Know

## B of T Report I-93-59--page 7

14. Overall, do you think the AMA supports or opposes the Clinton Administration's plan?

19% Supports  
59% Opposes  
14% Supports some parts/Opposes others  
2% Neither supports nor opposes  
7% Don't Know

15. In your opinion, should the AMA support or oppose the Clinton Administration's health system reform plan?

|            | <u>Support</u> | <u>Oppose</u> | <u>Support Some/<br/>Oppose Other</u> | <u>Not Enough<br/>Information</u> | <u>Other</u> |
|------------|----------------|---------------|---------------------------------------|-----------------------------------|--------------|
| Members    | 24             | 61            | 13                                    | 1                                 | 2            |
| Nonmembers | 33             | 51            | 8                                     | 3                                 | 5            |
| Total      | 30             | 55            | 10                                    | 2                                 | 4            |

16. What one element of the Clinton Administration's health system reform plan do you like the most?

83% Universal Coverage/Access  
12% Other  
6% None

17. What one element of the Clinton Administration's health system reform plan do you dislike the most?

27% Government Control/Bureaucracy  
14% Loss of Freedom of Choice  
13% Cost/Co-Payments/Reimbursement/Financing  
10% Managed Care  
36% Other

18. Does the Clinton Administration's reform plan seem complete, or is something important left out?

20% Complete  
71% Incomplete  
8% Don't Know

18a. (IF SOMETHING LEFT OUT:) What important elements are left out? (N=283) (Multiple answers accepted)

47% Cost/Financing/How to Fund  
23% Malpractice/Liability/Tort Reform  
15% Services/Benefits  
14% Freedom of Choice  
10% Input by Physicians  
7% Implementation  
35% Other

## B of T Report I-93-59--page 8

19. Now, I'd like to ask you about several parts of the Administration's plan. As I read each one, please tell me whether you support it strongly, somewhat or slightly, are neutral toward it, or oppose it strongly, somewhat or slightly.

|                                                                                                                                            | Support  |          |          | Neutral | Oppose   |          |          | Don't Know |
|--------------------------------------------------------------------------------------------------------------------------------------------|----------|----------|----------|---------|----------|----------|----------|------------|
|                                                                                                                                            | Strongly | Somewhat | Slightly |         | Slightly | Somewhat | Strongly |            |
| a. Cuts in Medicare and Medicaid payments to physicians and hospitals to help finance the new system.                                      | 2        | 4        | 3        | 5       | 5        | 15       | 61       | 4          |
| b. Strict limits on the growth of health insurance premiums.                                                                               | 27       | 20       | 8        | 13      | 4        | 14       | 9        | 4          |
| c. A comprehensive benefit package for all Americans.                                                                                      | 30       | 19       | 9        | 7       | 3        | 3        | 6        | 3          |
| d. A new liability system where everyone must first make use of alternative forms of dispute resolution before going to court.             | 69       | 13       | 3        | 3       | 1        | 2        | 1        | 4          |
| e. No denial or loss of coverage because of a pre-existing illness, unemployment, a move or a switch in jobs.                              | 76       | 13       | 2        | 2       | 1        | 1        | 1        | 4          |
| f. Health alliances or purchasing groups through which nearly everyone must purchase their insurance.                                      | 8        | 14       | 7        | 18      | 4        | 18       | 28       | 4          |
| g. All employers and employees required to contribute to the cost of their health insurance.                                               | 34       | 27       | 7        | 8       | 2        | 8        | 7        | 4          |
| h. A choice of health plans ranging from HMO's to limited fee-for-service, with extra fees for a wider choice of physicians and hospitals. | 29       | 33       | 8        | 9       | 3        | 7        | 8        | 1          |
| i. Liability reform that does not include a cap on non-economic damages.                                                                   | 4        | 8        | 3        | 7       | 5        | 17       | 49       | 3          |
| j. A national health care budget that limits the growth of expenditures on health and medical care.                                        | 11       | 13       | 7        | 13      | 5        | 17       | 18       | 1          |
| k. A National Health Board established by the federal government to oversee the new system.                                                | 7        | 12       | 9        | 12      | 3        | 14       | 28       | 4          |

-- Less than 1/2 of 1%

## B of T Report I-93-59--page 9

|                                                                                                                               | Strongly | Support   |          | Neutral | Oppose   |           | Strongly | Don't Know |
|-------------------------------------------------------------------------------------------------------------------------------|----------|-----------|----------|---------|----------|-----------|----------|------------|
|                                                                                                                               |          | Extensive | Slightly |         | Slightly | Extensive |          |            |
| L. A government-run system of allocation through which almost everyone except Medicare beneficiaries will purchase insurance. | 7        | 14        | 6        | 10      | 7        | 14        | 34       | 3          |
| M. Allocation of residency training positions by the U.S. Department of Health and Human Services.                            | 8        | 11        | 5        | 9       | 3        | 11        | 46       | 3          |
| N. For physicians in fee-for-service systems, fees established through negotiations with alliances.                           | 8        | 19        | 9        | 18      | 6        | 19        | 17       | 3          |

20. Which of the following do you think would be the best policy for the United States: strict federal limitations on the total amount of health care expenditures in the U.S., flexible federal goals for the total amount of health care expenditures, or federal goals or limits on the total amount of health care expenditures in the U.S.?

6% Strict Federal Limitations  
74% Flexible Federal Goals  
21% No Federal Limitations

21. Does the AMA's performance so far on the health system reform issue have a positive, negative or no impact on your decision to join the AMA or renew your AMA membership?

23% Positive Impact  
11% Negative Impact  
64% No Impact

22. (IF NEGATIVE OR NO IMPACT:) What one action by the AMA on the health system reform issue would have a positive effect on your membership decision? (N=102)

15% Aggressive Involvement in Decision Making/Lobbying  
9% Support Physicians/Get Input from Physicians  
8% Present a Better Plan  
6% Address Liability Reform  
19% Other  
30% None  
13% Don't Know

- 22a. (IF POSITIVE IMPACT:) What action should the AMA take now in response to the health system reform issue? (Multiple answers accepted)

23% Aggressive Involvement in Decision Making/Lobbying  
24% Present a Better Plan  
16% Support Physicians/Get Input from Physicians  
11% Inform Physicians/Public  
46% Other  
3% None  
1% Don't Know

## American Medical Association

Physicians dedicated to the health of America



### News Release

#### FOR IMMEDIATE RELEASE

#### AMERICAN PHYSICIANS CONTINUE PUSH FOR REFORM

*In major new poll, doctors support Clinton plan on access to care*

NEW ORLEANS, Dec. 6—U.S. physicians remain strongly committed to health system reform, while both supporting and rejecting various aspects of the Clinton administration's plan to revamp the system, according to a new poll released here today by the American Medical Association.

In a poll conducted during October and November, 83% of physicians supported the Clinton plan on features that would extend coverage and access to Americans. A majority of physicians thought the plan would be either "very effective" (29%) or "somewhat effective" (46%) in ensuring care for all Americans.

Among the features supported by physicians: no denial or loss of coverage for any reason (91%), a comprehensive benefit package (78%), access to a wide choice of health plans, and -- with extra fees -- to a wider choice of physicians and hospitals (70%), an employer mandate (70%), limits on the growth of health insurance premiums (55%), and liability reform requiring the use of alternative forms of resolution dispute (87%).

On other aspects of the Administration's plan, physicians were more critical. Physicians' principal areas of opposition were: cuts in Medicare and Medicaid (81%), creation of a National Health Board (56%), allocation of residency training positions by the government (62%), a system of mandatory alliances (55%), and a national health care budget that limits the growth of expenditures (52%).

A plurality of 52% said patients would fare "worse" under the Administration plan while only 19% thought their patients would benefit, 24% expected patients to fare "the same," and 2% expressed no opinion. Additional analysis of the results indicates that the better physicians feel their patients will fare under the plan, and the more physicians feel the plan would be effective, the more positive they are overall toward the plan.

"The president has made enormous efforts to repair faults and inequities in our health care delivery system and American physicians are acknowledging those efforts," said AMA Chair Lonnie R. Bristow. "But as this poll demonstrates, more work needs to be done and physicians are ready to work with the Administration and the Congress towards a health system reform plan that puts patients first."

Details of the poll were released in New Orleans at the interim meeting of the AMA's House of Delegates. The study revealed skepticism about the likely success of the Administration's

(continued)

515 North State Street  
Chicago, Illinois 60610  
312 464 4430

## 2.

**(DOCTORS POLL)**

plan in controlling health care costs, with 4% of respondents predicting "very effective" results, while 43% said the plan would be "very ineffective" in clamping a lid on costs.

On the critical issue of quality of care, 4% of physicians thought the Administration plan would be "very effective" in maintaining quality, while 40% feared the plan would be "very ineffective" in upholding quality standards. Seventy-one percent of physicians interviewed thought the Administration plan did not go far enough on liability reform because it did not include a cap on non-economic damages.

Asked to give their overall reaction to the plan, 44% of physicians said their reaction was "negative," while 32% reported a "neutral" response. Twenty two percent reported a "positive" reaction to the plan.

"The AMA neither supports nor opposes the Clinton plan in its entirety," Dr. Hristow said. "We want the Administration and Congress to agree with us on a workable plan that will provide the greatest benefit to all Americans."

The poll was conducted by the Gordon S. Black Corporation of Rochester, N.Y. It covered AMA members and non-members, randomly selected but representative of the population of physicians nationwide. The margin of error is plus or minus 5%.

#

For more information, contact:

Craig May 312/464-4430  
Mark Stuart 312/697-2819  
Public Information Office

## REPORT OF THE BOARD OF TRUSTEES

B of T Report I-93-60

Subject: Health System Reform Action Plan

Presented by: Lonnie R. Bristow, MD, Chair

Referred to: Reference Committee A  
(J. William Cox, MD, Chair)

1 This interim meeting is a watershed meeting for the American Medical Association (AMA), the  
2 medical profession, and the patients we serve with respect to health system reform. The first  
3 session of the 103rd Congress has adjourned. Several legislative proposals, including the  
4 President's "Health Security Act" (HR 3600, S 1757), have been introduced. Health system  
5 reform will be the major legislative focus in 1994.

6  
7 The Board of Trustees believes that now that the debate has shifted to the Congress, concerted  
8 and increased efforts to influence reform legislation will be necessary. This report to the House  
9 of Delegates provides an update on the AMA's health system reform initiatives and action plan  
10 for the months ahead and includes recommendations for future AMA strategies.

11  
12 Since 1990, the AMA has fought for health system reform as set forth in *Health Access*  
13 *America*. It remains the broad unifying theme of our campaign, embodying both sound  
14 principles and goals for a better health care delivery system -- one in which all Americans will  
15 have access to quality health care at an affordable cost. The Board of Trustees has been  
16 steadfast and unyielding in seeking these goals as part of our patient/physician advocacy  
17 strategic plan and under the leadership authorized by the House of Delegates in Report 00  
18 (I-92).

19  
20 In late September, we sent a mailing analyzing the President's proposal and comparing it to  
21 AMA policy to all physicians and medical students. Over 31,000 physicians have indicated a  
22 willingness to be part of a leadership network of activist physicians in that call for action.

23  
24 AMA leaders have continued meeting with Congressional leaders and the Clinton Administration  
25 to ensure that the AMA's positions are included in legislation and to advocate changes in  
26 legislation that has been introduced.

27  
28 The AMA remains firmly committed to the principles of universal access and coverage. How to  
29 achieve these principles has become a key concern. We support an employment-based system  
30 as most productive of universal coverage. Recent history and current practice are that the vast  
31 majority of insurance is employer-based. While ease of implementation would lead one to look  
32 at continued reliance upon employer-based financing, we are willing to and must look at,  
33 explore, and advance all concepts that accomplish reasonable, non-tax funded guaranteed  
34 coverage for all Americans. It is possible that neither a strict employer mandate nor solely an  
35 individual mandate will accomplish the goals of reform. A separate report on individual health

## B of T Rep I-93-60 - page 2

1 insurance (B of T Report I-93-41) is before the House at this meeting. Our policy will  
2 necessitate new, innovative thinking, flexible, yet principle-based, to adhere to the best of  
3 system reform and to achieve the central goal of reform - access and coverage.

4  
5 Where is the AMA headed in this debate and what do we want out of it? In the months ahead,  
6 the AMA will continue working with all decision-makers to develop common ground in the  
7 legislative reform process. The AMA has not been working just with the Administration to  
8 modify its proposal. We have also been working closely with all key Congressional proponents  
9 of reform - achieving, for example, inclusion of major antitrust and liability provisions in their  
10 legislation.

11  
12 The AMA will continue as a constructive agent for change, advocating meaningful and effective  
13 reform legislation that incorporates the "best" (i.e. most consistent with AMA policy and goals)  
14 element of proposals advanced by both the Administration and the Congress. There are many  
15 aspects of all the proposals that would achieve specific AMA goals, but none of the proposals in  
16 its entirety meets all of the AMA's goals on universal coverage, cost containment, quality, and  
17 patient/physician freedom of choice. It is our job to make sure that the final legislation is  
18 fashioned in such a way so that our goals are achieved. The AMA is activating its grassroots  
19 network of physicians and will be in contact with you and your colleagues shortly to help foster  
20 a common ground in the legislative reform process.

21  
22 We commend to you the separate report before the House at this meeting, "Health System  
23 Reform Update" (B of T Report I-93-54) along with the review of the major Congressional  
24 reform proposals/bills offered to date that include details about what we must seek. That  
25 separate report describes numerous issues of concern with the Administration's proposal that the  
26 AMA will aggressively seek to modify in the months ahead.

27  
28 **RECOMMENDATIONS**

29  
30 The Board of Trustees recommends:

- 31  
32 1. That the AMA continue to pursue aggressively with all key proponents of health system  
33 reform major results such as: universal coverage, cost containment, quality, and  
34 patient/physician freedom of choice.  
35  
36 2. That the AMA continue to explore and advance all concepts that accomplish reasonable,  
37 non-tax funded guaranteed coverage.  
38  
39 3. That the remainder of this report be filed.

---

Fiscal Note: No significant impact

12/07/93 17:46 DNC POLITICAL + 202 456 7739  
OCT-21-1993 17:46 FROM TBS PR WASHINGTON, DC TO

NO. 413

0\*17 P.2

A CNN/ USA TODAY/ GALLUP POLL  
M.D. REACTION TO HEALTH CARE REFORM

-- TOP-LINE --

SEX: 1[ ]Male 2[ ]Female

TIME STARTED: \_\_\_\_\_

TIME FINISHED: \_\_\_\_\_

LENGTH: \_\_\_\_\_

INTERVIEWER'S NAME: \_\_\_\_\_

INTERVIEWER'S I.D.: \_\_\_\_\_

PAGE NUMBER: \_\_\_\_\_

REPLICATE NUMBER: \_\_\_\_\_

DATE: \_\_\_\_\_

REGION: 1 East  
2 Midwest  
3 South  
4 West

STRATUM: 1 Stratum One  
2 Stratum Two  
3 Remainder

DATE: \_\_\_\_\_

N=502 National Physicians  
422007

David Moore, Lydia S...  
October 1-18, 1993

INTRODUCTION: Hello. I am \_\_\_\_\_ calling from the Gallup Organization. We are conducting a brief survey today on behalf of CNN and USA Today concerning the Clinton health care plan. We recently sent Dr. \_\_\_\_\_ a letter explaining this survey and informing him/her that he/she has been chosen as a participant.

CONTINUE WITH STANDARD INTRODUCTION/ MAKE APPOINTMENT FOR INTERVIEW

RESULTS ARE BASED ON TELEPHONE INTERVIEWS WITH -- 502 -- PRACTICING, PATIENT CARE PHYSICIANS IN THE UNITED STATES CONDUCTED OCTOBER 1-18, 1993.

FOR RESULTS BASED ON SAMPLES OF THIS SIZE, ONE CAN SAY WITH 95% CONFIDENCE THAT THE MARGIN OF SAMPLING ERROR IS  $\pm 5$  PCT. PTS.

12/07/93 17:47 DNC POLITICAL + 202 456 7739  
OCT-21-1993 17:47 FROM TBS PR WASHINGTON, DC TO

NO. 413

0\*17 F.01

2. Which of the following statements best describes your opinion of the nation's health care system --

56 The health care system is fundamentally sound, or

41 The health care system is fundamentally unsound?

$\frac{3}{100}$  No opinion

IF SOUND:

3. Do you think the system requires some minor changes, or not?

99 Yes, minor changes

1 No, no changes

$\frac{0}{100}$  No opinion

IF UNSOUND:

4. Do you think the system needs to be completely rebuilt from scratch, or do we just need to make major changes in the system we now have?

14 Completely rebuilt

86 Major changes

$\frac{2}{100}$  No opinion

12/07/93 17:17 DNC POLITICAL - 202 456 7739  
 OCT 21 1993 17:47 FROM TES FR WASHINGTON, DC TO

NO. 113 DM1  
 0\*17 P.03

2/3/4 COMBINED:

| <u>M.D.s</u> | 9/24-26/93<br>National<br>Adults |                                |
|--------------|----------------------------------|--------------------------------|
| 1            | 3                                | Needs no changes               |
| 56           | 18                               | Needs minor changes            |
| 35           | 52                               | Needs major changes            |
| 6            | 21                               | Needs to be completely rebuilt |
| 2            | 6                                | No opinion                     |
| <u>100</u>   | <u>100</u>                       |                                |

5. From everything you have heard or read so far, do you favor or oppose President Clinton's plan to reform health care?

6. Do you [favor/ oppose] it strongly or moderately?

| <u>M.D.s</u> |                      | 9/24-26/93<br>National<br>Adults |
|--------------|----------------------|----------------------------------|
| 38           | Total Favor          | 59                               |
|              | 9 Strongly           |                                  |
|              | <u>29</u> Moderately |                                  |
| 58           | Total Oppose         | 33                               |
|              | 37 Strongly          |                                  |
|              | <u>21</u> Moderately |                                  |
| 4            | No opinion           | 8                                |
| <u>100</u>   |                      | <u>100</u>                       |

9. Do you expect your income as a doctor go up, go down, or stay about the same under the proposed plan?

4 Go up  
 59 Go down  
 34 Stay about the same  
3 No opinion  
 100

10. Under the Clinton health care plan, do you think each of the following things will increase, decrease or remain the same. First, will [INSERT ITEM, ROTATE START]. increase, decrease or remain the same? Next, [INSERT NEXT ITEM]?

|                                                   | <u>Increase</u> | <u>Decrease</u> | <u>Stay the same</u> | <u>No Opin</u> |
|---------------------------------------------------|-----------------|-----------------|----------------------|----------------|
| a. Health care costs for individual Americans     | 63              | 14              | 19                   | 4              |
| b. The Quality of health care                     | 8               | 67              | 25                   | *              |
| c. Access to health care                          | 53              | 31              | 16                   | *              |
| d. Patient satisfaction with health care          | 8               | 76              | 15                   | 1              |
| e. Rationing of health care services              | 86              | 6               | 7                    | 1              |
| f. Security of health care coverage for Americans | 67              | 18              | 13                   | 2              |
| g. Bureaucracy in the health care system          | 87              | 6               | 6                    | 1              |
| h. Physician control over medical decisions       | 2               | 87              | 11                   | *              |

12/07/93 17:48 DNC POLITICAL + 202 456 7739

DCT-21-1993 17:46 FROM TBS PR WASHINGTON, DC TO

NO. 413

0\*17 P.05

SENT BY: GALLUP ORG. World HQ. :10-21-93 :10:13AM :Intl./Media/Con. East-

1 202 515 1111

14. The Clinton plan includes a 238 billion dollar cut in the projected growth of Medicaid and Medicare spending. In your opinion, is it likely, or not likely that the federal government will achieve this cut?

7 Likely

91 Not likely

2  
100 No opinion

---

## **Clinton Presidential Records Digital Records Marker**

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This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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### **Energy and Commerce Committee**

Divider Title: \_\_\_\_\_

---

Energy and Commerce Committee- As of 3/7/94

[illegible]

---

## **Clinton Presidential Records Digital Records Marker**

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This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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### **Group Activities**

Divider Title: \_\_\_\_\_

---

August 19, 1994

MEMORANDUM TO HAROLD ICKES  
ALEXIS HERMAN

FROM: MARILYN YAGER  
BARBARA WOOLLEY

THROUGH: STEVE HILTON

RE: UPDATE ON PHYSICIAN AND HOSPITAL GROUPS ACTIVITY

We wanted to provide you with an update on our outreach to the provider groups. Highlighted are both organized events on behalf of health care reform and ongoing activities focusing on work with our supportive groups and amendments of importance.

Events:

- Organized conference call with Secretary Shalala and 17 of our supportive physician and hospital associations on August 17, 1994. The purpose of the conference call was to provide a quick overview on House and Senate action, give the groups the opportunity to give input, and make sure their message is positive and overall supportive.
- Facilitated Photo-Op with the First Lady and the Executive Board of the American Association of Nurse Anesthetists on Tuesday, August 16, 1994. On behalf of the President, the First Lady accepted a "Health Care Reform Honoree Award" and received a recording book of volunteer service hours. They followed with a pitch to their membership later that day at their annual meeting.
- Arranged meeting with POTUS, FLOTUS, and the Catholic Health Association (CHA) on Monday, August 15. The purpose of the meeting was to thank CHA for their continued support of health care reform and allow CHA the opportunity to discuss issues of concern to CHA.
- Facilitated press conference with Secretary Cisneros, Secretary Shalala and the National Association of Public Hospitals releasing a Lewin Study on Public Hospitals on Thursday, August 11, 1994. National and regional press coverage.
- Facilitated event with Secretary Riley and the Protestant Health Alliance member -- Baptist Health System, in Birmingham, Alabama. Local press coverage.
- Arranged meeting with physician groups and White House to discuss the "liability" issue in both the House and Senate.

Aug 19 1994

**Ongoing Activities:**

- **Track amendments of important to physicians and hospitals groups during Senate debate.**
- **Work phone calls to supportive groups.**
- **Get statements of concern/opposition/support on various proposals.**
- **Assist in getting participants to make up audience for events.**

**cc: Mike Lux  
Greg Lawler**

December 11, 1993

MEMORANDUM FOR MIKE LUX

FROM: Debbie Fine

SUBJECT: Tracking Group Activities

I plan to contact each of the groups in the attached list once a week, until activity picks up to the extent that this is no longer possible. At that point, depending on how useful the information has been, I can continue to track groups on a bi-weekly basis. I have tried to pick groups that represent a cross-section of constituencies: women, religious, older Americans, non-physician providers, consumers, disabilities and disease-specific groups.

The purposes of tracking these groups are:

- to compile weekly reports of activities on a national and a local level around health care reform,
- to gauge group and constituency specific support on an on-going basis,
- to reach out to these groups on a more consistent basis so that they not only feel that their activities are appreciated, but so that they feel more accountable for generating more activity.
- spinning our whatever the current message is, as well as reminding groups about the importance of overall reform (if they are overly focused on details).

These are mostly groups that are important, but that we haven't been able to communicate with regularly. Following up with them regularly makes a big difference to them -- demonstrating our knowledge and appreciation of their activities. I think it will strengthen relationships so that we are not only contacting them when we need them to do something.

The report can be used for:

- finding out what the rumors are on the hill so that we can better address concerns.
- by regularly receiving copies of materials distributed, we can both use groups'

materials to edit what we have -- and supplement them with information missing.

- tracking more closely which specific parts of the plan groups are focusing on or concerned about (i.e. employer mandate.)

Also, because we will have a much better sense of where groups are, we can:

- direct them to HCRP where appropriate, or to other groups that have similar goals as theirs.
- strengthen message and theme week activities -- by including groups that we may not always think of.
- have more effective rapid response because we will know better who can deliver of these groups, and who is stronger in certain areas of the country -- depending on the nature of the response needed,
- we will be able to get materials out through these groups more efficiently.

I would open the first conversation with an explanation of the project -- focusing on the keeping better up to speed with the groups, in conjunction with what they may be doing with the DNC or NHCC, etc. Many of these groups I already know, and therefore the weekly updates will be very natural. For those with which I have not had extensive contact, I will need to approach more carefully because they will not necessarily have any idea who I am.

In the first conversation, I think I would cover:

- depending on the group, I would check to see how much of a priority health care will be for them. Do they have state contacts on this issue, etc?
- Do they have a long or short term plan of action around health reform? If there is something in writing, can we have a copy?
- there may be some groups I'd like to check with on their contact here -- if I don't know them, I may see if they've worked extensively with anyone here, or when they were last in for a briefing. (I should obviously know this already.)
- I would ask them to send me the following information, if I don't already have it:
  - basic summary of organization
  - basic membership information: including a breakdown of membership in states if they have this anywhere (where they are strongest, etc.)
  - to put me on their mailing list
  - any statements they have issued on health care reform, or on any of the bills in the past couple of months

I will get them:

- Lewin talking points
- the section by section and new HSA on disc
- town hall schedule
- make sure they are on daily fax list.

Other points to cover on a weekly basis:

What notable regional or national events are going on this week (sponsored by the organization or within that constituency category) ?

What kinds of activities are you organizing -- either weekly, monthly, daily, etc. (phone banks, letter writing, mailings, etc.) -- both nationally and regionally?

1

Are you distributing materials? Get copies of all materials circulated.

How are you distributing materials (in churches, town hall meetings, through mailings, senior centers, etc.)?

Is there anything else we might be able to provide that would be genuinely helpful? What have you gotten from the White House so far? Get feedback on that lit.

Are there areas you think we need to better address in our literature? Are there aspects of the HSA that are not focused on in the public eye, that you think should get more attention.

Are there any questions that you have been hearing repeatedly from your members about the HSA? (Talk through some of them, but ask for them on paper on a regular basis.)

What are you doing in terms of a lobbying strategy?

What are you hearing on the hill?

I would also establish that I am available any time they have questions, concerns, etc. -- any time they read something in the paper that upsets, surprises, or pleases them on HSA that they want to double check. I would also establish that I would want them to call me if there's something going on they think I should know about.

## Potential List of Groups to Track on a Weekly Basis

### **Disease Groups**

AIDS Action Council  
Alzheimer's Association  
American Cancer Society  
American Heart Association  
American Lung Association  
National Multiple Sclerosis Society  
National Health Council

### **Seniors**

Long Term Care Campaign  
National Caucus and Center on the Black Aged  
National Hispanic Council on Aging

### **Women**

American Association of University Women  
Campaign for Women's Health  
League of Women Voters  
NARAL  
National Council of Jewish Women  
National Women's Health Network  
Planned Parenthood  
Women's Legal Defense Fund

### **Disabilities**

The Arc  
CCD  
National Council on Independent Living  
People First

### **Consumers**

Consumer Federation of America  
Consumers Union

## **Non-Physician Providers**

American Academy of Physicians Assistants  
NACHRI  
National Association of Social Workers  
National Black Nurses Association

## **Religious**

American Jewish Congress  
Catholic Charities USA  
Catholic Health Association  
Church Women United  
Interreligious Health Care Access Campaign  
NCC  
National Jewish Democratic Council  
Union of American Hebrew Congregations  
United Methodist Women's Division (Sonya Kim)

American Physical Therapy Association  
Iran Health Board???

Other constituencies not covered here that **need** to be:

**Rural:** I am hoping that the new USDA person who has been working with OPL can take this on. Rural Health Coalition and National Farmers Union are the two essential groups that he track -- but I'm sure there are several others with which he has relationships.

**Veterans:** Bob Jones has agreed to be in touch with the six key vso's (although he talked about maybe cutting that down depending on how active or inactive some of them are). He will at least get us an initial profile of the six at the beginning.

**Physicians:** Lynn will track the physician group activities.

**African American:** I don't know where this is at. I'll follow up with Minyon and others.

**Hispanic:** I will follow up with Suzanna on this.