JACKSON HOLE GROUP

Paul M. Ellwood, M.D.
President

September 27, 1993

Ms. Hillary Rodham Clinton
Health Care Reform Task Force
The White House
1600 Pennsylvania Ave.
Washington, D.C. 20500

Dear Ms. Rodham Clinton,

Since our September 15 meeting, I have spoken with a number of people to see whether we might accelerate the health reform negotiating process by developing a set of consensus principles. I now believe it will be more productive to bypass the preparation of general principles and focus instead on specific barriers to prompt passage and successful implementation of your health reforms.

Each of the crucial participants in the negotiations share the President's objectives of mandatory, universal, comprehensive health insurance, with the costs of such coverage increasing no more rapidly than the general economy by a specified date. All agree that such cost containment must occur without jeopardizing the health of the public -- indeed, while making gains in important public health indices. Most of those I deal with would prefer to allow the health care market an opportunity to achieve these objectives through vigorous, carefully structured price and quality competition among organized delivery systems.

I have one overriding concern: time. Though we chronic reformers have never had the level of attention and support that you and President Clinton have generated, my experience in trying to change the health system suggests that more time and stronger incentives will be needed to achieve your goals. Five areas of the proposal could be modified in order to enlist the support of other managed competition advocates and to speed the rate at which competing health plans will contain costs:

(1) Extend the timetable for achieving universal coverage and full cost containment to the year 2000
(2) Enhance consumers', providers', and payers' responsibility in containing costs
(3) Clarify the definition of an accountable health plan
(4) Defer a decision on the method of budget enforcement
(5) Consider combining individual and employer mandates.

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In addressing these five areas, I will outline the central policy problem in each and suggest the broad outlines of a politically plausible negotiation. Our common challenge is to identify a framework in which compromise is possible between the Administration and managed competition advocates, particularly among conservative moderate Democrats and Senate Republicans. My suggestions here are not offered as "best policy" but as reasonable accommodations among people of differing views.

Implementation schedule

Health Alliances can perhaps be formed and operating within two years following passage. This will be an instrumental step in reform, and will have no direct, measurable impact upon cost or quality without the participation of experienced accountable health plans. The managed competition model requires structural reform of the delivery and finance systems. Such structural change will require time, but will be durable, dynamic and could exceed your goals if done properly. The process of organizing providers into new structures, altering their compensation and motivation, simplifying administrative systems, measuring and feeding back results, and shifting their emphasis to primary care and prevention will take several years. Even with these structures in place, health plans -- and consumers -- will certainly need two or three competitive cycles to find their place in the market and show significant cost reductions.

In some parts of the United States -- perhaps California, Portland, the Twin Cities, or Boston -- we will see very rapid results. These communities have had large organized, competing delivery systems for twenty to fifty years. Elsewhere, we know that fewer than 15% of consumers now enroll in efficient managed care organizations, and much more time will be required before dramatic savings are evident.

The schedule for universal coverage and attainment of budget goals may have to be extended to the year 2000, rather than attempting to enforce budgets in 1996.

Consumer, provider and payer responsibility

Moderate and conservative advocates of managed competition will advocate greater reliance on individual responsibility and less on government controls. To address their orientation, the policy should employ every conceivable tool that will encourage consumers, providers, and payers to assume more responsibility for the cost of care. It is particularly important to strengthen four elements of the current proposal:

(1) Include labor-management health care contracts under reform requirements: All Americans should experience similar pressures to seek out less costly sources of care as soon as possible. Any exceptions will be regarded as inherently unfair and will slow cost containment. The length of time for

which existing contractual exceptions to the overall policy are maintained should be as brief as politically feasible;

(2) Specify a limit on tax deductability of health benefits: The tax cap both reduces net Federal tax losses and motivates consumers to make prudent purchasing decisions. Conservative Democrats and moderate Republicans continue to favor its use. The health policy will need some device to further heighten consumer sensitivity to premium prices, and any such tool should also give preference to the most cost-effective health plans;

(3) Encourage Medicare beneficiaries to make cost-conscious health decisions: Medicare beneficiaries include the largest single payer bloc and a pool of disproportionately high health care users. Overall system reform will be more quickly realized if Medicare eligibles are responding to similar incentives as the rest of the population. Increasing pharmacy and long-term care benefits for Medicare without subjecting beneficiaries to similar incentives as the under-65 population will perpetuate excesses in both consumer and provider behavior.

(4) Maintain a pluralistic purchaser environment: Payers representing over 100 employees have been the driving force for health care reform since 1970. Many of them have convinced their employees to select the most cost-effective plans, have organized themselves into effective buyer coalitions, have benefits managers who understand the health system, and can skillfully work with labor to achieve cost savings. These larger employers must remain active, independent purchasers. They should be kept out of the Alliances under all circumstances, and encouraged -- in fact rewarded -- when they help their employees receive the most cost-effective care.

Accountable Health Plans

AHPs will need further definition -- not antitrust exemptions -- if we are to accelerate the formation of strong provider-based health plans. Federal standards should stipulate that the plans be capitated, that they have contracts or arrangements with the necessary providers in order to provide the uniform benefits, that they adhere to insurance reforms, and that they be held accountable for their impact on their enrollees' health status.

Provider choice can best be assured through point-of-service options such as that advocated by the Mayo Clinic Foundation and the American Society of Internal Medicine. The "all willing provider" arrangements proposed by the AMA, and the mandatory offering of pure fee-for-service indemnity insurance, will necessitate immediate government price controls and

will keep factor prices high. Such mandated indemnity plans will carry an increased likelihood of financial collapse and risk leaving both providers and consumers feeling betrayed.

While choice of provider is a strongly held value, it can also be used by some providers to defend the status quo. We should be attentive to the risk of sending regressive signals to those health providers already moving rapidly towards integration and efficiency and potentially reversing the progress already made in many communities.

Enforcement of budgets

While I recognize that government controls will be called for if market forces fail to curtail costs, premature specification of those controls, and the development of a regulatory superstructure to implement them, will sabotage the chances of private sector success. For this reason, the policy should not spell out the form of intervention that might ultimately be employed in the event these reforms should fail. If a government-sponsored Health Alliance is very large, and designed to execute premium control authority, it may well be regarded by health plans as their principal customer, and in fact become less effective in stimulating competition and consumer responsibility.

Calculation of weighted average premiums will offer a convenient means of monitoring the progress of cost containment efforts, but will prove to be an unwieldy tool for budget enforcement by politicians and government staff. Such measures will punish good plans with low initial premium prices, and induce regulators to attempt to impose restrictions on consumers' free choice among qualified plans.

The Employers' role in financing

I think we will find wide support for a comprehensive benefit package which emphasizes prevention and primary care, financed through a combination of employer and individual mandates -- much as is advocated in the President's plan. I do not believe it wise, however, to place ceilings on the employer contribution, since such limits will reduce their interest in containing costs and impose further risk on the Federal Treasury.

Though we have not completed our analysis, a reasonable line of compromise might cover employees of small firms (e.g., under 50 or 100 employees) with an individual mandate supplemented by tax credits or premium subsidies, and require them to purchase coverage through the Alliance. Firms of more than 100 would be kept out of the Alliance, be mandated to finance employee coverage, be permitted to exert some influence over where their employees receive care, and retain some financial benefit if their employees seek out the least costly providers.

Whether or not this framework proves acceptable, both parties will need to acknowledge that the eventual financing scheme may involve increases in taxes or open-ended mandates, and they should enter into negotiations intending to reach agreement. No meaningful consideration of alternative financing strategies can occur without access to a common data base, assumptions, and computer models all of which are controlled by the Executive branch.

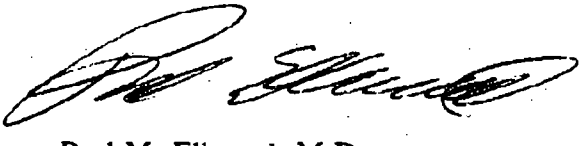
Next steps

My review of these issues and suggestions for compromise reflect my knowledge of the views of conservative and moderate Democrats, and the key Senate Republicans. I have been keeping out of the public debate in the media since our last discussion. I intend to quietly pursue these ideas with the various groups that need to come together on a common plan, unless you regard this framework as patently unacceptable. If there is some basis for proceeding, it would be helpful to understand which elements within my outline are most problematic.

I regard this as a confidential communication, and I will not share it with others except David Gergen. I am involved in many discussions with legislators, the health sector, and payers, however. If I am persuasive, some of these suggestions may well resurface in one form or another during the coming hearings and in other settings.

I thank you again for allowing me to participate in these discussions, and look forward to assisting you and the President in any way I can.

Sincerely,



Paul M. Ellwood, M.D.

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James J. Mongan, M.D.

Executive Director, TMC
Dean, UMKC
School of Medicine

October 29, 1993

First Lady Hillary Rodham Clinton
The White House
Washington, D.C.

Dear Mrs. Clinton:

Thank you for your visit to our hospital. We are honored.

I wanted to take this opportunity to share the most important lesson I learned handling the health insurance issue for President Carter 14 years ago.

As you know very well, there is one moral test of success or failure at the end of this debate — and that is, did we achieve Universal Coverage? That is also the test history will judge your efforts by. You and the President have been rock-solid on this point -- and have indicated it is not negotiable. I applaud you for that.

But, the lesson I learned 14 years ago is that Universal Coverage is not an on/off switch. In fact, by its nature, it becomes a highly negotiable and dangerous gradient. The attached chart describes my view of that gradient.

The key lesson in my mind, is that some delay is probably OK -- some dilution is probably OK — but, making Universal Coverage contingent upon other economic circumstances — such as inflation or unemployment rates, or achievement of health spending targets is deadly --contingencies strike at the heart of achieving Universal Coverage.

And, of course, the Republicans are claiming they are for Universal Coverage, but clearly subordinate that goal to the goal of avoiding taxes and mandates which moves you even farther down the gradient away from Universal Coverage.

I hope you will continue working on building the political and substantive case necessary to serve as a bulwark to protect against sliding away from Universality.

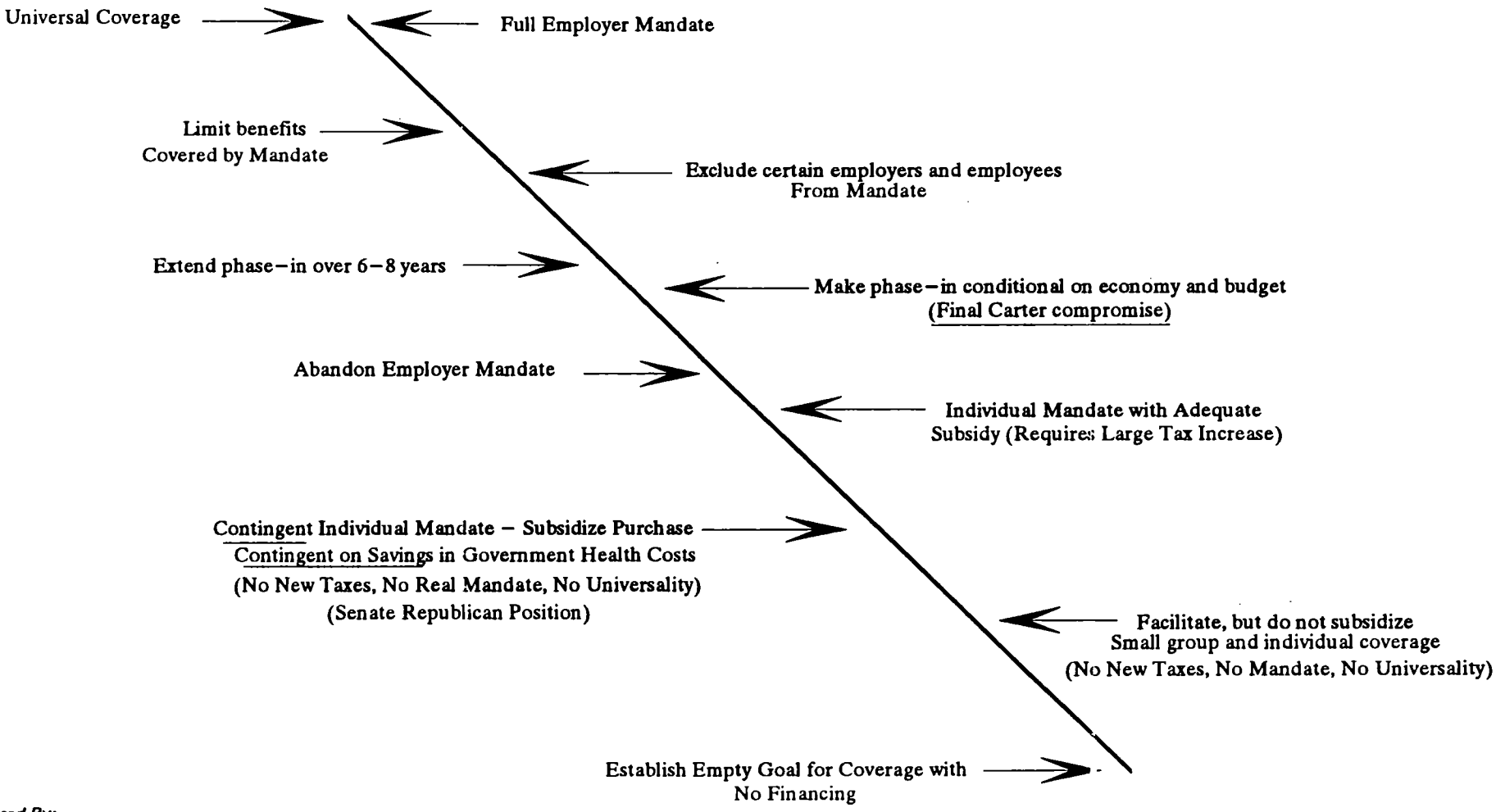
If I can help in any way as you work with this, please give me a call.

Sincerely,

James J. Mongan, M.D.
Executive Director, TMC
Dean, UMKC School of Medicine

SLIPPERY SLOPE FROM UNIVERSALITY

Begin With Universal Coverage Through Employer Mandate and Expanded Public Program



Prepared By:

Dr. James J. Mongan — *Executive Director, Truman Medical Center*
— *Dean, University of Missouri-Kansas City, School of Medicine*

MRS. CLINTON
from N.

11/16/93

Notes from Labor/Management Health Care Seminar

November 13, 1993

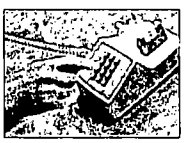
Jamestown Community College, Olean Campus

Most important points:

- Universal coverage is most important to this group.
- Cost containment is second, government should provide incentives for cost containment
- Mandates vs. incentives for individuals and businesses, Should we tell businesses what plan to use, or let them choose what's best for them?
- Simplicity, efficiency -- insurance costs are far too high for the confusion and redundancy caused by insurance companies.
- Wellness programs and reflections on insurance premiums, people who smoke, drink excessively, or who are grossly overweight should have to pay more of the burden for those who take care of themselves. They will be the ones who jack up costs and abuse the health care system more. Wellness programs are needed.
- Individual vs. corporate responsibility for insurance, plus the issue of deductibility
- Role of government - should government play a huge role, of should they stay out as much as possible? Most agreed that they don't want to create a new bureaucracy.
- General practitioners vs. specialists -- Too many specialists in the U.S. now, not enough general practitioners or family doctors in the rural areas of the Southern Tier.
- Malpractice suits are way out of control. Doctors must now take every possible test on a patient so he can cover himself in the court room if anything goes wrong. Can we limit the amount an individual can sue for.
- Are we keeping people alive too long, sinking more money into machines, when there's absolutely no hope for recovery? The last 2 weeks of life are the most expensive. Is there an alternative?
- People want the right to choose their own doctor.
- What about temporary employees and young kids? Do businesses have to provide benefits to them as well?

BOB VAN WICKLIN - RECORDER

Americans Are Calling For Health Care Reform.



Each day thousands of Americans call our 800 number looking for a better way to reform the health care system. They are getting a sweeping proposal developed by America's best insurance companies.

It will provide cradle to grave coverage for all Americans. Coverage you are sure to get even if you have an existing illness. Coverage you can afford and coverage you can keep even if you change jobs or lose your job. Best of all, you can choose to keep your present plan. This is the reform America wants.

A Better Way To Reform

We are committed to the health care reform America wants. Call toll free for information on the visionary proposal developed by the Health Insurance Association of America (HIAA) and endorsed by thousands of farmers, seniors, businesses and individual consumers. Read the plan that will help make the President's plan better.

For A Better Way To Reform
1-800-285-HEALTH

Coalition for Health Insurance Choices

Sponsored by a coalition of thousands of businesses, individuals, consumers, farmers, seniors and insurers. Major funding by Health Insurance Assoc. of America.

Political Surveyor

By Charles E. Cook

Campaign Finance Reform Plans Seek Common Ground

Perhaps the most frustrating aspect of the campaign finance reform debate has been the extent to which zealots and partisans have been driving the process.

Common Cause and the editorial pages of national newspapers have appointed themselves the judges of what constitutes reform, and any Member advocating anything less than a total overhaul of the system is branded a threat to the democratic process.

House Democrats will mark up their campaign reform bill next week and bring it to the floor soon thereafter. Republicans unveiled their proposal last week.

The plan promoted by House Republicans and developed by a task force headed up by **Rep. Bob Livingston** (R-La) bans all PACs, soft money, and bundling by PACs and lobbyists; requires that a majority of a campaign's contributions come from individuals residing inside the district; increases the contribution limit from individuals to state parties to $20,000; and curtails the use of union dues for political purposes.

Democrats are focusing on a much more complicated plan designed by **Rep. Sam Gejdenson** (D-Conn) that would create a voluntary spending limit of $600,000; cap PAC and high-dollar (over $200) receipts at $200,000 each; limit a candidate's personal contributions to $50,000; codify lowest-unit rates for non-preemptable broadcast advertising; and make adjacent broadcast time available free to targets of independent expenditure campaigns.

Candidates who agree to abide by these limitations would receive voter communications vouchers redeemable for up to one-fourth the spending limit for use in purchasing TV, radio, and print advertising or postage. Opponents of candidates who decline to participate in this system will have their own spending limits lifted but will remain eligible for the benefits.

Under discussion for the public financing component of this bill are a $5 checkoff on federal income tax returns; a PAC "registration fee," with amounts ranging from $5,000 to $30,000; and a tax on all campaign receipts at a rate of 5 percent or less.

The GOP proposal reflects the feeling among many Republicans that there's nothing to lose by throwing out the status quo completely, but its provisions virtually eliminate the possibility of support from Democrats. In fact, it almost seems tailored to do that.

Conversely, even though the outlines currently being discussed by Democrats are far short of the total public financing plan advocated by many Democrats earlier, the new plan retains some public financing.

Two compromise plans have emerged, however — one from **Rep. Glen Browder** (D-Ala) and the other a bipartisan effort headed by **Reps. Fred Upton** (R-Mich) and **Mike Synar** (D-Okla). Both feature the "minimalist" approach, seeking common ground while avoiding the pitfalls of public financing, which is anathema to most Republicans and many moderate-to-conservative Democrats. They also avoid the PAC-abolition approach that is unacceptable to many senior Members as well as members of the Black Caucus.

Browder's Fair Campaign Finance Reform Act would cut in half existing PAC and individual contribution limits and tax all contributions at 35 percent. But it would allow those candidates who agree to voluntary spending limits ($600,000, with no more than $300,000 from PACs and no more than $300,000 in maximum-level individual contributions) to have a tax exemption on all contributions and to raise money under the current limits ($5,000 for PACs; $1,000 for individuals).

Both plans feature the 'minimalist' approach and avoid the pitfalls of public financing.

Those participating would also be eligible for reduced rates for television and radio advertising and postage costs.

As an even simpler fallback position, Browder is offering a "Big Spenders Sin Tax Act," which would remove the current exemption in the tax code for all House campaign receipts over $600,000 and all PAC receipts over $300,000. And it would give third-class mailing and lowest-unit broadcast rates to campaigns staying within those two limits.

The second middle-ground approach, the Congressional Campaign and Election Reform Act offered by Synar and Upton, is a far tougher approach.

It would drop the PAC contribution limit from $5,000 per election to $1,000; cut the limits for individuals in half; ban bundling by PACs, lobbyists, foreign agents, and limited partners; cut back drastically on soft money; give targets of independent-expenditure campaigns free adjacent air time for response; ban leadership PACs; and force connected PACs to use PAC funds to cover administrative costs.

While Browder's attack focuses mostly on spending and overdependence on PAC and large-donor contributions, Synar and Upton attack PACs more directly. Neither is outrageously partisan or unduly complicated, and neither uses public financing or is overly intrusive of the political process.

Both represent honest attempts to pass some meaningful legislation rather than the posturing and stalemates that have so dominated the process up to now.

JOHN D. ROCKEFELLER IV
WEST VIRGINIA

United States Senate

WASHINGTON, DC 20510

October 22, 1993

Dear Jerry,

We are writing to express our deep disappointment in your remarks at the NAM press conference held Wednesday morning. We are incredulous that you presented such a dim assessment of the President's proposal for health care reform, especially considering what is at stake for the manufacturing industry. We never thought that being too ambitious was a fatal flaw, or even undesirable.

We would have thought you would have welcomed the President's plan -- not to mention his total commitment to health care reform -- as the best thing that could happen to this country. Your member companies know full well how much of their resources are being squandered on a plainly broken health care system. Health care reform will have a major impact on the bottom lines of your member companies -- more than most other legislation in recent years. We would have thought you would want to build a climate of support for health reform and the pillars of the President's plan, rather than doing nothing but magnifying what you see as the plan's shortfalls.

The NAM's resolution on health care reform and the President's plan are only inches -- not miles -- apart on what are probably two of the most fundamental issues: access and cost containment. You mentioned, almost in passing, the NAM's "openness to mandates," and you also said that the door was not closed on premium controls.

We would have hoped that you would have chosen to focus on these important <u>similarities</u>, which are fundamental to actually achieving the crucial goals of universal coverage and cost containment, rather then dwelling exclusively on a few differences.

We would have thought that because 98 percent of large firms and 87 percent of small firms provide prescription drug coverage, and because almost 100 percent of large firms and 82 percent of small firms currently provide mental health coverage, NAM would have concluded that the President was recommending a level of benefits consistent with what a majority of private sector companies have already determined to be essential for adequate coverage. Instead, your remarks implied that the Clinton plan is over-reaching in trying to extend the same basic level of health security to <u>all</u> Americans that your companies already recognize as being so fundamental.

Frankly, we are puzzled why the same NAM that supported an entitlement cap proposal earlier this year -- a cap that would have reduced Medicare and Medicaid spending by the same amount as the Clinton plan, but with all the savings applied to deficit reduction -- now questions the integrity and ambition of those savings goals.

And we certainly would have thought that the NAM would have appreciated the savings and streamlining that would result from having a regional alliance manage, negotiate prices, and monitor the quality of health benefits on behalf of thousands of small- and medium-size employers. Right now, as you know, each and every one of these companies has to devote time, employees, and other scarce resources to wrangling with insurance companies. Depending on their size, as much as 20 to 40 percent of the dollars they spend on health care is going to administrative costs alone.

The President and the First Lady are close to concluding one of the most impressive and unprecedented chapters in American history when they submit a health reform bill to Congress next week.

The day after the President's inauguration, he immediately turned to health care, and set in motion a process that was more rigorous in sum and substance that anything we have ever witnessed. The NAM was part of that process. Certainly the NAM was not so naive to think it would not disagree with some elements of the President's plan, especially considering the complexity of health care reform and the tensions that exist in trying to produce a plan that meets the moral test of making sure all Americans have health coverage, and meets the fiscal test of affordability.

Many of your own member companies have already come forward individually and proclaimed their belief that we need strong leadership -- and strong medicine -- to reform our nation's health care system. Our country is now fortunate enough to have both. We have a President who has staked his reputation on health care reform. And we have a plan that is comprehensive and, at long last, ambitious enough to hold real promise in getting our country back on a strong economic footing. Until health care costs are reined in, as NAM recently testified before Congress, you and your members can be assured that less will continue to be spent on "upgrading plants and facilities, R&D, training/retraining and other critical business investments."

We are just beginning the legislative process. Each and every one of the issues you raised will be hotly debated -- and ultimately resolved. We had hoped that you would have decided to begin that legislative process with an open mind and with good will.

We must reiterate our profound disappointment. We hope that you and your members reconsider, and reach the conclusion that the President's plan and commitment provide an opportunity for the manufacturing sector that may not return. We are anxious to learn of the next steps that NAM plans, and restate our own commitment to ensuring the enactment of a health reform plan that is in America's best interest.

Sincerely,

Thomas A. Daschle

John D. Rockefeller IV

Mr. Jerry J. Jasinowski
President
National Association of Manufacturers
1331 Pennsylvania Avenue, NW
Suite 1500 N
Washington, DC 20004-1703

Fall 1991 Volume 1, Number 1

What are the Barriers to a Comprehensive Child Health Policy in the United States?

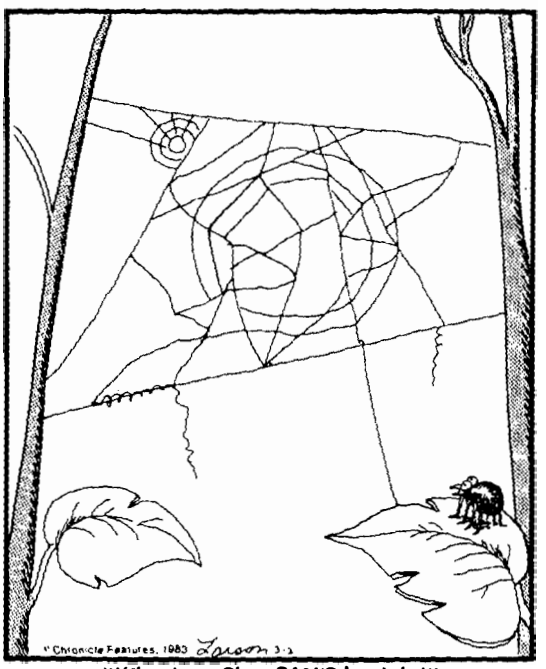
Welcome to Think!

— Steve Freedman
Director, Institute for Child Health Policy

— John Reiss
Director, National Center for Policy Coordination
in Maternal and Child Health

Welcome to the premiere issue of *Think! A Forum for Ideas on Child Health Policy. Think!* is a new, pilot publication from the Institute for Child Health Policy (ICHP). ICHP's mission is to help coordinate and generate ideas and resources within the maternal and child health community; in order to help meet these goals we developed the idea for this new type of newsletter.

What's new about *Think!*? *Think!* is an opinion letter. The ideas, opinions and solutions expressed in this publication will come directly from you, our readers! Each issue will feature a new panel of contributors who will express their perspective on a specific topic related to child health policy. Readers will also contribute reactions to those perspectives in subsequent issues. We envision that this open forum format will stimulate our readers to think in new ways about the issues in child health policy and will challenge them to formulate new and innovative solutions to children's health care problems.



"Whoa! . . . That CAN'T be right!"

The Far Side cartoon by Gary Larson is reprinted by permission of Chronicle Features, San Francisco, CA.

For our first issue we decided to ask a broad question, "What are the barriers to a comprehensive child health policy in the United States?" In subsequent issues we plan to address different questions relating to aspects of health care financing,

See Welcome, Page 16

Clinton Presidential Records
Digital Records Marker

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No. of Pages Today's Date 11/8 Time

Comments Here's our Reform Position I left a message with Jo Goldstein regarding your visit with the Clinton's Please let me know if I can do anything else.

Original Disposition: ☐ Destroy ☐ Return ☐ Call for pickup

HEALTH POLICY

AAO-HNS Position Statement on Health Care Reform

The Academy is developing an evolving position statement on health care reform. During the Academy's 97th annual meeting last month in Minneapolis, the Board of Directors endorsed 12 health care reform positions.

1. Support universal access

2. Support eliminating pre existing condition clauses

3. Support ear, nose and throat physicians as a point of entry into the health care system; and support history or symptom patient self-referral

4. Support tort reform for professional liability including the use of practice guidelines within such reform

5. Support increased taxes on tobacco and alcohol

6. Support infant hearing screening for *high risk* newborns

7. Support coverage of hearing aids for children including cochlear implants and auditory rehabilitation

8. Support the potential distribution of health care based upon clinical indicators and cost/benefit studies

9. Support legislation that would allow physicians to join any managed care entity for which they meet the credentials (any willing provider laws)

10. Support legal protection under the law for physicians to bargain collectively

11. Support administrative simplification through use of electronic billing, a universal billing form and a universal explanation of benefits form

12. Oppose global budgets including premium caps

This beginning framework is the direct result of a member survey distributed at the annual meeting. The survey and responses follow on the next page. For more information please contact Christopher Gallagher at (703)519-1536.

A PROPOSAL FOR :

I. MAJOR COST CONTAINMENT OF MEDICAL CARE

II. ENHANCING QUALITY OF MEDICAL CARE

Charles W. Cummings, MD
Mansfield F. W. Smith, MD
James Y. Suen, MD

A PROPOSAL FOR:

I. MAJOR COST CONTAINMENT OF MEDICAL CARE

II. ENHANCED QUALITY OF MEDICAL CARE

Essential Elements

1) *A partnership agreement with the major national scientific medical societies to develop medical practice opinions using a standard process and format.*

2) *Mandates for government program administrators and incentives for private pay insurers to conform to published opinions of accepted medical practice.*

3) *Establishment of Scientific Councils within each of the national medical professional societies to adjudicate questions of what is and isn't acceptable practice.*

4) *Legislation to grant limited immunity from anti-trust litigation for medical opinion programs which meet federal standards.*

MEDICAL DECISION MAKING:
HOW TO ENHANCE QUALITY AND REDUCE COST

*Billions of health care dollars are wasted on inappropriate, outmoded, and/or unproven procedures. Money also is wasted when cost effective procedures are denied, resulting in worsening problems. There are enormous potential cost savings--both long and short term--to be gained from eliminating the unwarranted.

*Medical reimbursement decisions are not always made rationally. Doctors, insurance companies and government agencies all are driven by different assumptions and frequently arrive at different conclusions. Patient expectations, legal liability fears, and cost containment imperatives are some of the factors.

*There are medical opinion programs which have produced outstanding reports. The Consensus Development Conferences of the NIH, the AMA's Diagnostic and Therapeutic Technology Assessment Program, and the Medical Practice Opinion Program of the California Medical Association are examples. There are two problems with such reports: 1) They are developed so cautiously to avoid lawsuits that they are time-consuming to produce and thus limited in number; and 2) there is no enforcement component once the opinions are issued.

*Once the medical opinion programs have been developed, program guidelines could be entered on computer. Floppy disks of those guidelines could be provided to all physicians so that the guidelines could be accessed immediately for recommendations regarding acceptable evaluations, treatment, and follow-up visits. Deviations from the guidelines would not be reimburseable unless justified and approved by the national Scientific Council.

The above method should eliminate unnecessary tests and unproven treatments with the potential for billions of dollars in savings and enhancement of quality of medical care.

The Council would review the question, gather background from the medical literature and from interested parties both pro and con, and issue an opinion. Ideally, the review process would take no more than 60 days. Timeliness is important when an inquirer needs to make a reimbursement decision. Questions which involve multiple specialties, such as heart-lung transplantation or breast cancer screening, would go the the Scientific Councils of all the related specialty organizations. The organization to receive the question would coordinate the multi-specialty response.

Legal Issues

Due process would guide the reviews. Affected parties would have the opportunity to comment, potential conflicts of interest would be disclosed, and there would be a mechanism for appeal or rereview. The biggest obstacle at present to an effective review system is fear of liability. To free the scientific review process from the constraints of legal intimidation, it will be necessary to enact a protective statute for properly constituted scientific review. Without tort reform in this area, a single abberent individual could stalemate the scientific review process.

Cost

Cost of the process is minimal if the existing national scientific specialty societies are used. Most reviews are done by mail for maximum objectivity. Computers, FAX and modems all make rapid and low cost reviews possible. Members of each Scientific Board would serve without compensation and the national scientific societies would contribute staff.

Precedent

There is precedent for this concept in the AMA's Diagnostic & Therapeutic Technology Assessment Program. This program has produced over 1500 well researched opinions since its inception. An example is attached.

Benefit

Medical reimbursement decisions now are made in a chaotic environment of conflicting interests. Insurers and the government differ over the legitimacy of various treatments. There is no agreement on what constitutes basic or essential medical care. We need a mechanism to which groups can turn for definitive and unbiased scientific information. The public needs the protection which a Scientific Council can provide.

REFERENCES

1) LUNG TRANSPLANTATION. From Questions and Answers: Diagnostic and Therapeutic Technology Assessment (DATTA). JAMA 269:7 Feb 17, 1993

2) THE PERILS OF PROVIDING MEDICAL OPINION: A State Medical Association's Experience. Williams HE, Ramsey LL: WEST J MED 155:183-199, Aug 1991

3) ACOUSTIC NEUROMA. Consensus Statement. NIH Consensus Development Conference 9:4, Dec 11-13, 1991

RESULTS OF AARP HEALTH CARE REFORM SURVEY
(National Adult Sample, Age 18+, N = 1,208, Oct. 28 - Nov. 8, 1993)

- There is thus far little understanding of the Clinton plan (38% say they understand it "fairly well" or "very well"), and little knowledge of key health-care reform terms (except HMO).

- There is a substantial edge in those favoring the Clinton plan over those opposing it (51% to 36% with 13% "Don't Know"). Support for the Clinton plan is higher among those age 65 and older (53%) and those age 18-34 (54%)

- Most respondents think they will not be better off under the Clinton plan in terms of benefits (15% say they would be better off) and quality of care (13% say they would be better off), and a majority (55%) think they will pay more in the way of insurance premiums and out-of-pocket costs under the Clinton plan.

- A majority (56%) say they would be willing to pay more to choose any doctor than to select a doctor from a list and pay less. When offered a choice among three types of plans (HMO, PPO, fee-for-service -- although these terms were not used in the question)-- a majority (51%) picked the PPO plan over HMO (23%) and fee-for-service (23%) plans.

- When offered a choice among three basic types of health-care reform plans (single-payer system like Canada's, comprehensive reform like the Clinton plan, and incremental reform), 40% chose Clinton-style comprehensive reform, 27% chose single-payer, and 26% opted for incremental reform.

- Most respondents are either "strongly satisfied" (47%) or "somewhat satisfied" (30%) with their present health insurance coverage. Most are either very confident" (37%) or "somewhat confident" (40%) that they would be able to maintain their present level of coverage at an acceptable cost to them over the next two years, even if nothing is done about health-care reform. A majority (52%) of those who are employed think they will have to pay more for their company plan over the next two years, but only 26% expect their employers to reduce their benefits over that time period.

- Most (68%) respondents who are employed either full-time or part-time are in favor of the employer mandate and 78% are not concerned that they would lose their jobs if this were imposed. Slightly more than a quarter (27%) said they would be more likely to change jobs under the guaranteed coverage provision. Nearly three in ten (28%) of those age 50-64 who are presently employed full or part-time age 50-64 said they would be more likely to consider retiring early under the provision that the federal government would pay 80% of their health insurance premium; and more than a third (35%) are either "very concerned" (9%) or "somewhat concerned" (26%) that their employer would use this provision to force employees to retire early.

- There is strong sentiment for imposing budget limits and caps -- on both public and private health care systems (54%).

- Likewise, there is substantial support (at the 61%-66% level) for Clinton's health-care reform financing means (cigarette tax of 75 cents a pack; requiring employers to pay most of the cost of health insurance premiums for their employees; imposing a one percent tax on large corporations that choose to offer their own health plans; and restraining increases in Medicare costs by imposing limits on payments to doctors and hospitals).

- **Long-Term Care.** The respondents do not know how long-term care is treated in the Clinton plan. They divide roughly into thirds as to whether the Clinton plan includes any kind of long-term care coverage (30%), does not include it (37%), or do not know whether it does or not (37%). Two-fifths (38%) do not know what kind of long-term care coverage is included, and most of the rest (48%) think it includes both home and community-based care and nursing-home care. Nearly three-fifths (57%) say that coverage of home and community-based long-term care would make them more supportive of the Clinton plan. When offered a choice, more than three-fifths (62%) chose home and community-based care over nursing-home care with a six-month deductible (30%). The largest number (42%) say that the 5-8 year phase-in of long-term care coverage would make no difference in their support of the Clinton plan. Nearly a third (31%) think it is either "certain" or "very likely" that they or a member of their extended family will need long-term care within the next five years.

- **Future of Medicare (asked of those 50 and older).** Nearly four in ten (38%) think that Medicare benefits will not be as good as those of people under the age of 65 and only 15% think Medicare benefits will be better. Three-fifths of those who think Medicare benefits will be worse say that the addition of prescription drug and home and community-based long-term care coverage would make them more supportive of the Clinton plan. Three-fifths would be willing to pay at least $12 a month in additional Medicare premium for drug coverage; one-third would be willing to pay $20 a month. Among those age 50-64, 72% say they would choose to stay in their present health plan rather than enter the Medicare system as it exists today; although a plurality (43%) oppose the idea of states folding Medicare into their health plans, two-thirds (64%) of those who do not strongly favor this idea would favor it if they would get substantially better benefits under the state plan.

- **Views of AARP's Role in Health-Care Reform.** Two-fifths of the respondents said they were familiar with AARP's role in health-care reform, and they generally (77%) approve of AARP's role thus far. They divide about evenly over whether AARP should do the same (41%) or more (46%) to promote health-care reform.

THE ALLIANCE FOR MANAGED COMPETITION

News Release

For Immediate Release:
November 3, 1993

Contact: **John Gibbons**
202/ 835-0538

Washington, D.C. -- The Alliance for Managed Competition today rebuffed critics who have recently charged that managed competition would narrow consumer choice of health care providers.

We feel that charge is way off the mark.

Under the model of managed competition we support, Americans will have a choice of many health plans, be able to switch plans, and be able to change providers within their plan.

Under the model of managed competition we support, Americans will no longer have to shop for health care out of a phone book. Under managed competition they will have up-to-date information about costs, the success of medical treatments and patient satisfaction.

The current firestorm of controversy concerning consumer choice under managed competition has been initiated by those who either fear change or are genuinely opposed to managed competition.

On the issue of choice: case closed. Let's move on in a bipartisan effort to achieve health care reform.

The Alliance for Managed Competition is composed of five major managed health care companies who provide coverage for over 60 million Americans. They are: Aetna, CIGNA, MetLife, The Prudential, and The Travelers.

(Attached is a copy of an ad that will be placed in major publications starting tomorrow.)

###

TOP 10 REASONS...

WHY AMERICANS WILL HAVE MORE CHOICE OF HEALTH CARE PROVIDERS UNDER MARKET BASED MANAGED COMPETITION

10. Americans ***will*** be able to change providers within their plan.

9. Americans ***will*** be able to switch plans.

8. Americans ***will*** be able to seek providers outside their plan.

7. Americans ***will*** be able to choose from a menu of plans.

6. Americans ***will*** be able to have a "primary care physician" who will advise them about the selection of other providers within their plan.

5. Americans will have ***real information*** -- a report card -- about "patient satisfaction" concerning providers within their plan.

4. Americans will have ***real information*** -- a report card -- about costs when they choose a plan.

3. Americans will have ***real information*** -- a report card -- about the success of medical treatments when they choose a plan.

2. Americans will ***no longer*** have to choose health care providers out of a phone book.

1. The essence of managed competition is ***informed consumer choice***.

CASE CLOSED. LET'S MOVE ON.

Let's move on in a bipartisan effort to achieve health care reform.

THE ALLIANCE FOR MANAGED COMPETITION

Providing Health Coverage for 60 Million Americans

AETNA CIGNA METLIFE THE PRUDENTIAL THE TRAVELERS

October 23, 1993

MEMORANDUM TO THE FIRST LADY

From: Gene Sperling

Subject: Economist Outreach

I. OVERALL STRATEGY: We should have an inclusion project to reach out to major economists who have expressed reservations about our plan, but are generally supportive of universal health care. It is critical that this not seem just like a one time outreach, or just a call for support. This must be a serious two-way dialogue, in which we recognize their reservations, give these people a context to contribute substantively, and ask them to consider what is necessary to move toward universal health care.

Some of the ways that we can establish ongoing relationships are:

1) To make it clear that we want to hear their substantive views directly, and make it clear that their memos will go directly to Mrs. Clinton, Ira and other top members of the health and economic teams. Many people are well aware that there will be compromises before this is over, and are anxious to contribute to that discussion.

2) We should look for opportunities to get drafts, ideas and comments when we are doing speeches, op-eds and testimony.

3) We should look for advice on how to handle specific problems -- how to explain the alliances etc. Many people who criticize us may still be with us on key elements of our plan;

4) We can invite experts to come to brief economic principals who will be speaking on health care, such as Rubin, Altman

2. ACTION PLAN:

1. Mrs. Clinton will call eight to ten experts between Sunday and Tuesday. Calls will be more efficient than meetings and will be just as effective in opening the dialogue. Each call should ensure that there is a context for further contact.

2. Over 12 key economists will be briefed in the 24 hours before the plan is released. Most of the briefings will be by Cutler and Thorpe over the phone, though some others like Blinder may also do these briefings. (Henry Aaron is coming over to the White House Tuesday morning for a briefing with Cutler, Thorpe and myself).

3. Group Briefings: We are still considering have a group briefing to go through the details of the plan. They key is that this group briefing should not be our main or first

contact with many of these economists. We need to establish a personal contact first. Other briefings include think-tanks. We will be doing a special Friday briefing on the 29th for Brookings Institution that Henry Aaron will host. We will also do perhaps an Urban Institute and AEI briefing.

4. Budget Briefings: I have asked Alice Rivlin to help me in trying to brief some of the major budget experts who are often asked to comment. Examples are people like John White, Susan Tanaka, Rudy Penner, and Martha Phillips (Exec. Director at Concord Coalition). The Brookings Briefings will certainly reach some of the general budget validators, such as Charlie Schultze and Barry Bosworth.

5. Letters From Mrs. Clinton: We will draft letters from Mrs. Clinton to those who have written positive op-eds for us -- whether or not they have been published. It is critical in general that we

CALLS FOR MRS. CLINTON: (With all of these calls tell them that someone will be calling them in the next few days to go over the numbers with them.)

1. MARILYN MOON: She is critical that we need to be careful about not over-promising.

10/25
Lft message

She was involved in the transition, and may feel that she has not been included enough sense then.

She is friends with Judy Feder.

Action: Mrs. Clinton should call. She should say that she understands her concerns and would like to be able to show her drafts of some speeches in the future to get her thoughts. Understand your concern about shooting straight and that is what we want to do. On other hand, we need to have a constructive dialogue and not let our internal disagreements become ammunition for those who oppose health care reform.

Phone # (w) (202)857-8691
(h) (202)951-4385

10/26 toughest thing to criticize + not be used by media
☆ Calls to brief

★ will be here in D.C. - answer ?
re paper for Princeton

2. STUART ALTMAN: He was highly involved with the transition, and may feel that he was not given the proper role or thanks. He was brought over to the White House on the speech night and appreciated it. He was supportive on McNeil-Lehr. Rosty may be asking him to be an advisor

Action: Mrs. Clinton should call him. She should say that she feels we are not doing a good enough job discussing the premium caps, and that as she knows that he was one of the key people who first called for this, she wanted to know if he could think of writing something for us that would be helpful in talking about this -- as well as substantive discussions.

10/25
left message

tough concept + easy to distort

Phone # (w) (617)736-3803
(h)

Will be at Princeton - on board 90%
? growth rate
? savings rebate from the well-insured

3. UWE REINHARDT: Ira has done a good job with him lately, as seen by his New York Times Op-ed. He may not appreciate all the attention Paul Starr has gotten. He also helped us by describing to the Wall Street Journal that one of the reasons for lower health care inflation was the "Hilary Factor" -- companies embarrassed to raise costs too much right now.

Action: Even though you have spoken with him a couple of weeks ago it would still be good to call him and

1) thank him for the New York Times op-ed.

2) thank him for being willing to include us so much in his conference (Alice Rivlin and others will open and Ira will speak at the end) and;

3) say that you want him to feel free to write us with ideas and comments as the process goes on.

4) Anything positive things he can say about how people who had doubts should feel better about this plan right now would be helpful.

Phone: # (w) (609)258-4781
(h) (609)924-5394

4. HENRY AARON: His main problem with the Clinton plan is that he does not believe savings can get as low as we assume and that costs are often technology driven -- not all due to waste and perverse incentives. While he has been quoted often against our plan, he has also given us some of our most positive quotes and very much believes in universal health care, and that our plan is essentially correct.

He was publicly supportive of Putting People First when it was put out, which was a major boost in light of criticism from others at Brookings. Gene Sperling consulted with him often during the campaign and putting together the budget, and he co-authored an excellent New York Times op-ed in the final days of the budget urging Congress to pass the plan. So while he has been critical he has been a friend as well. He is a big fan of David Cutler.

Action: Mrs. Clinton should call and say thanks for all the help she has given Gene Sperling and others during the campaign and on the overall economic plan. Tell him that you know that he has had some differences on health care and that she understands he must speak his mind, but that she wants to be able to consult with him and for him to feel free to write to her directly. Tell him that he should feel free to give materials to Gene or David Cutler and have them get things to her. Also he is one person -- if you are interested -- that it might be worth suggesting a meeting with at some point.

You might mention that you know a team is going over to Brookings next Friday for a briefing.

- A wmed like to be as much help possible -
- need to work for real reform
- now that plan is settled, no plan will command a majority -

10/25 Phone #: (w) 797-6128
(h) (202) 829-7149

5. TED MARMOR: Seems to want to help. Feels that he has the credibility to broker support with the single payer groups. He doesn't like all the articles on the degree of cost savings, as he feels it distracts from the real health care issues.

10/25 Lyt mem. Action: Mrs. Clinton should call and thank for the op-ed he wrote with Yale Law Professor Jerry Mashaw. Let him know that we are interested in hearing his views on where he thought there could be common ground with single payers, and that you would like to be able to consult with him as time goes by.

Phone: # (w) (203)432-8988/3238
(h) (203)777-8931

6. JOE NEWHOUSE: He does not give a lot of political comments and tends to think technically, but is well respected economist/medical expert at Harvard. He is writing for the Princeton Conference on risk adjustment and why it is inherently difficult to do. His concerns are largely similar to Baumol in that our growth estimates must be stressed as reflecting one-time savings, and like Aaron, thinks that much of the cost increases are technology driven, not due to waste and inefficiency. Cutler has spoken with him about how we are responding to the Baumol concerns, and he is feeling better about things -- especially if we have the National Board review the longterm growth rates. We feel he is coming along, and that you might want to ask him for advice on how best to do risk-adjustment. notion

Phone: # (617)432-1325

7. RASHI FEIN: Economist at Harvard Medical School. Has some concerns on the structure and speed of cost containment. Ken Thorpe should call to brief on numbers, and Gene Sperling will call and invite him to the White House to talk to Bob Rubin and others on health care economics.

Phone: # (w) (617) 732-2112

8. JACK HADLEY: He wrote a good op-ed with Steve Zuckerman. We should send a personalized letter from Mrs. Clinton and Ira should call and thank and let him know that we want to brief him on the numbers.

Phone: # (w) (202)342-0107
(h) (202)362-0731

9. STEVE ZUCKERMAN: Urban Institute (same as above)

Phone: # (w) (202)857-8679

Additional Phone Calls to Come: We will get you information on Monday about calls to Victor Fuchs, Alan Enthoven, Paul Ellwood, Joshua Weiner, and another call to Baumol.

Gephardt:

- recruit by chairs
- labor

Southerners good in understanding universal coverage

Waxman?

Stark?

PERSONAL AND ~~CONFIDENTIAL~~ MEMORANDUM

TO: Hillary Rodham Clinton October 24, 1993
FR: Chris Jennings
RE: House Cosponsorship Update and Requested Call List
cc: Maggie, Melanne, Steve, Jack, Ira, Distribution

Since our conversation today, Steve R. has talked with you, George, Howard and myself on the subject of House cosponsorships. George advised us NOT to call up Congressman Gephardt tonight, but rather to arrange a conference call with his Chief of Staff, George and Steve tomorrow morning. At that time, they will discuss House cosponsorship status and strategy for the upcoming days. (We also have a meeting scheduled tomorrow with Senator Daschle and Congressman Gephardt's office to finalize plans for the Wednesday event.)

During our Hill discussions tomorrow, we will -- once again -- adamantly stress the importance of a large number of cosponsors. We will discuss the concern about the public not being able to distinguish between the bill transmittal and the bill introduction. We will also state our disappointment about the lack of visible movement on the House cosponsorship front.

In response, Congressman Gephardt, his staff, and other Leadership Members may raise their concern that the lack of time (and insufficient amount of information about the bill) has made it extremely difficult to get the minimally acceptable 100 cosponsors on the bill by the scheduled Wednesday transmittal date. They can be expected to also raise their fear about the riskiness of a very ambitious and widely reported (but unsuccessful) attempt to attract cosponsors. In addition, the Leadership may suggest that we not underestimate the newsworthiness of a health reform initiative cosponsored by virtually every Member of the Congressional Leadership and every Committee Chairman (of primary jurisdiction). They will say that the unprecedented nature of that outcome would be a very attractive story in and of itself. (Although we would much prefer numerous cosponsors, both Steve and I believe that the White House -- if need be -- could spin this outcome fairly well.) Lastly, they will also stress that they still remain confident that, by introduction day, we will have well over 100 cosponsors.

In the interim, we all agree with you that we should not let valuable time slip by without doing all we can to attract cosponsors. We will strongly emphasize this point in our meetings with the House Leadership and staff. In that vein, we will again offer any and all available Administration representatives to immediately pitch in to sign up cosponsors. (E.G., we will suggest the option of arranging for Cabinet Secretaries, their Legislation Undersecretaries and staff, and White House officials to use their contacts with the House to help out with cosponsors.)

And finally and most importantly, a number of very influential House Chairmen and other key Members are worth your calling to seek their cosponsorship. Most of these Members are people with whom you have worked and developed relationships with during the past several months. Some will ask to see more specifics, but most of these Members understand the politics of needing Democrats to stand with the President on this important initiative and know we aren't expecting them to endorse every line. During your conversations, (besides always asking for their advice) you should also seriously consider asking them if they would be willing to try to sign up their Committee Members (or bill sponsors, in the case of McDermott). The list:

Chairman Rostenkowski:

yes

will still issue statement

If we do not have Chairman Rostenkowski on as an original sponsor of the bill, the press will read more into his absence than there really is. Unfortunately, that is just the point. By all reports (from his staff), he is not going to go on the bill without a request from you or the President. In the conversation, you may want to offer an Economic Team (Ira, Bentsen, Rivlin, etc.) briefing on the financing components of the bill. We would like to do this for him late afternoon on Tuesday. (His staff will be briefed in the morning of that day.)

Congressman McDermott:

Gephardt call - he did think about it & hasn't made up his mind; doesn't want to confuse citizen groups who don't understand politics; will work w/us to make something happen

☆ will meet w/ single payer sponsors

Congressman Gephardt has asked that you call McDermott to see if he would be willing to cosponsor. Again, there is no way he will do it without a call from you (or the President). Like all the calls, you can and should -- of course -- say that a cosponsorship does not convey with it total agreement, etc. You may want to tell him, however, that it could signal support of the attached stronger single-payer state opt out provisions. (I will have faxed it over to Barbara Smith by time of your call).

Chairman Dingell:

yes

We believe that Chairman Dingell will be happy to add his name as an original cosponsor, but he would appreciate (and we would recommend) a call from you.

Chairman Ford:

yes

Next to Chairman Dingell, we believe that Chairman Ford will your strongest House Chairman ally. As far as we know, his staff remains fairly happy with everything they know about our bill to date. To the extent possible, we have tried to treat the Ed and Labor Committee on equal terms with the other two Committees. He would love to have a call from you requesting cosponsorship.

Chairman Moakley (Rules):

- you're going in right direction
- worried about abortion
- yes + as long as we don't expect him to do any work

No bill will make it to the floor without a rule from Chairman Moakley. Although he is a single payer advocate, your visit with him earlier this year seems to have assured his desire to be helpful. I doubt any policy will need to be raised, but if so you may want to discuss the new single-payer opt out language.

Chairman Jack Brooks, Judiciary: 225-6565

yes

We have worked hard with his staff over the last several months to draft some language that we believe achieves the appropriate balance on the malpractice and anti trust issues. You may want to thank him and his General Counsel, Jonathan Yarowski, for his help. (Although they may not like everything in the bill, you can say we will continue to appreciate and significantly defer to their counsel.)

* Brady Bill: have to give reason of not going to sell gun; correct identification; instant check like via "Sicko Brady's"

Chairman Sonny Montgomery, Veterans Affairs:

NO

- already on the Cooper bill
- pos. tive about Veterans
- will not be original sponsor but won't be roadblock

Chairman Montgomery has been saying some very positive things about the President's health care plan. Most recently, he published an article in Roll Call, the Capitol Hill paper that was very favorable. You may want to mention it and say you appreciated it. Ask him how the veterans organizations are doing and seek his original cosponsorship, and his help with the rest of the Committee.

✓ (yes) Pete Stark: in budget discussions
make tough decisions + get trashed away
to Senators; need period of time for no deals

✓ **Chairman Bill Clay,** 225-2406
Post Office & Civil Service: Chairman Clay just wrote an angry letter about the FEHB issue; he had heard that we were going to allow the FEHB employees to be integrated on a state by state basis into the new system, rather than wait until everyone was in (at the end of 1997). He felt Ira had turned his back on a commitment he thought Ira had made to the Chairman. You can say the policy will be as he wishes, i.e., to wait until everyone is in. You should extract a high price for this, i.e., his cosponsorship and his strong push for Committee Member cosponsorships. (By the way, we should also -- out of courtesy on this issue -- tell the Senate Chairman counterpart about this decision -- John Glenn, as well as his Subcommittee Chairman, David Pryor).

yes

✓ **Chairman Martin Sabo,** 225-4755
Budget: Despite all the problems, Congressman Sabo is still pleased with your event with him in Minnesota. The cosponsorship of the House Budget Committee could give us some needed numbers credibility and is worth strongly pursuing. He also could be very helpful with his Members.

yes

agree w/ basic objectives

✓ **Chairman John LeFalce,**
Small Business: Since dinner yesterday evening, John LeFalce feels like he has made it to heaven. It was a great event and he was most pleased with his role in it. He has also been very happy with the attention you have given him and his Committee and has indicated his willingness to do all he can for us on health reform. He can start with cosponsoring the bill and getting as many as his Members as possible. (Every Small Business Committee Member helps us out just a little bit more on one of the thorniest issues of all.)

yes

Rochester - overblown
6-1070
Used to have caps
Company town
Pushed people into HMOs

NFIB clips

★ Visit to Buffalo

☆ Public event: and fundraiser

1/22-23, 29

215-6, 12, 13, 19, 20, 26, 27
315-6 12, 13 19 20, 26, 27

Chairman Dave Obey, Jt. Economic Committee: Chairman Obey held the first health care reform hearing after the August recess. In it, he asked for and got Paul Starr. He was very pleased with his testimony. Despite his past gruff reaction to the long term care and workers comp. provisions, he has recently been one of our staunchest defenders. (He wants nursing home coverage offered on a voluntary basis and he doesn't want us to touch workers comp provisions because he thinks his state is doing just fine with their program). You may want to thank him for his very protective behavior toward Paul Starr during the Health Care University, (when he scolded the Members for not being so rude to Paul). Bottom line: he is a fierce advocate, someone you would like to have on your side, and a Member Chairs a Committee that can be critical to helping build up credibility on our numbers/economic assumptions/etc.

- States should have option
- = haven't changed state legis. action required?
yes - so long as no changes
- Will vote for any tax to cover everybody

Chairman Ron Dellums, Armed Services: 225-2661 Chairman Dellums does not have much jurisdiction beyond that of DoD. So far, we believe the DoD folks are happy with us; he should largely mirror their feelings. At any rate, a call seems worthwhile.

Chairman Kweisi Mfume, Cngrsnl. Black Caucus: 225-4741 Chairman Mfume has not always been the easiest Member to deal with, but he is a dealer. He may be looking for an issue, however, that -- from the beginning -- he is more closely and positively associated with the Administration. Let's hope that health care is one of them. He may well say he can't commit without seeing the language, but I still think it is worth pursuing him from the beginning.

- I want to be very supportive - party needs to be unified -
- Will try to move Caucus to position of support

Candess Collins 225-5006

Congressman Lou Stokes: Congressman Stokes is probably the key to the Congressional Black Caucus on health care issues. We need to talk to him and even invite him in after the bill is transmitted to make him feel more invested. His staff, Leslie Atkinson, has been extremely helpful and he may appreciate your recognizing his help through her. In addition, he still should be somewhat pleased with your appearance at his Congressional Black Caucus Health "Brain Trust" meeting.

Chairman Pat Schroeder, Congressional Caucus for Women's Issues: Congresswoman Schroeder wants to be as helpful as possible and we believe she can if she cosponsors and asks her colleagues to do same. You know the issues she cares about...

Chairman Jose Serrano Congressional Hispanic Caucus: 225-4361

Chairman Serrano may not be open to cosponsoring the President's plan before he sees the exact undocumented alien, the privacy protection, and other provisions of the legislation. However, out of Congressional courtesy, I believe it is worth extending a hand.

Chairwoman Jill Long, Cngrsnl. Rural Caucus: 225-4436

She and Charlie Stenholm are most closely associated with the Rural Caucus. Both would be advisable to call, make the rural pitch, in particular, and ask them to be cosponsors (particularly Jill Long, because she has indicated she would probably be willing to do so even though I believe she also went on the Cooper bill) and also ask them to pitch it to their rural caucus colleagues.

*** I have some more in mind, but this is quite a list already. These Members have great potential to help us out a great deal in attracting credibility and cosponsors. We will keep you informed of our Leadership meetings and progress on our end.**

Chief needs copy

Single-Payer Opt-out Agreement

- - Any state may implement a single-payer system, under which:

  - o All individuals and employers in the state could be required to participate in the system pursuant to rules of the state, except for Medicare.

  - o Medicare will participate if state is granted waiver assuring no reduction in benefits.

- - A single-payer State may use any equitable financing source, so long as it does not allow employers in the state to avoid paying the same payroll assessments as apply in other states.

- - Federal funds that would have been available to the state under the President's plan will be available to the state to implement the single-payer program.

- - To implement a single-payer system, state must provide benefits at least as good as otherwise required under the Health Security Act.

If is not the means used but the intent of the heart —
(morphine example from euthanasia statement)
↳ gradual

Questions for First Lady - AAMC - 11/7/93

1. In reference to the funding of academic health centers, there were to be two pools of 6 B dollars, one for indirect costs of med. education and one for grad. med. education.

Now the total pool seems to be reduced by 25%, the greater reduction in the IME.

Many academics were concerned originally that the 12 B would not cover the costs without sacrificing quality and more.

How would you respond to their concerns?

2. One of the great things academic med centers have to offer is quality. Quality really has to be assured by a continuous process. Money aside, the GME pool is to be managed and distributed by a consortium, not by med schools. If the money goes to a consortium rather than directly to med schools, it does not assure the continuity of process.

Do you have some concern about this?

3. Under the plan sent to congress the average pay for residents in training will be less because of the reduction in overhead which ordinarily covered administration of programs and malpractice premiums. This is going to be viewed as a considerable hardship on these young people in training.

Do you have any suggestions how this might be adjusted?

4. There was to be a third pool of 3 B dollars designated for support of health care policy and basic and applied biomedical research. This seems to have been eliminated. Many scientists who are concerned about such research feel that the absence of such funding will be detrimental to outcomes research and prevention which are key points in the presidents plan.

Do you have any comment.

- Natl Cancer Institute Sam Broder
- LATAs artificial lines estab'd by consent decree: e.g. Ameritech
  - Wisconsin - SE Wis can't transmit directly to Madison
  - ↳ VP Gore said they'd to FCC designate
- you have choice but if you'd like to limit choice — discount + save money
- medical care as right & litigation [education + health = rights]

Panel Reports Genetic Screening Has Cost Some Their Health Plans

By PHILIP J. HILTS
Special to The New York Times

WASHINGTON, Nov. 4 — Some American workers have already lost their jobs and others their health insurance on the basis of information obtained through genetic screening, a panel of the National Academy of Sciences said today.

If laws are not passed soon to curb the problem, the panel warned, thousands more Americans will face such discrimination.

Tests can now detect genes for more than a dozen diseases, and for factors that contribute to dozens more. Tests are under development for detecting the gene for Huntington's disease and cystic fibrosis, and researchers say tests identifying those at high risk of heart disease and mental disorders will soon be available.

The number of such tests will skyrocket in the future, said Dr. Arno Motulsky, chairman of the panel at the Institute of Medicine at the National Academy of Sciences in Washington. Eventually, the Government's Human Genome Project should be able to identify most or all of the important genes that cause or contribute to disease.

Making Results Confidential

Noting that there will be commercial pressure to adopt such tests as soon as they become available, the panel said the tests should first be proved to be both safe and effective by the Food and Drug Administration. There are currently no such standards. In addition, laboratories that carry out the tests should be carefully monitored by the Department of Health and Human Services for their accuracy.

The panel added that people should not necessarily be tested for many of these ailments, even when tests become available, unless treatments also become available. And if testing is done, the information must be considered confidential and protected from employers and insurance companies.

"We recommend laws that forbid employers from collecting genetic information on prospective and current employees unless it is very clear that that genetic trait will directly affect job performance," said Dr. Motulsky, a professor of genetics at the University of Washington at Seattle. "We recommend the adoption of legislation that prohibits the consideration of genetic risk when making decisions on whether to issue or how to price health insurance."

The panel issued broad guidelines for handling information about genes, based on the principle that the person tested should have control over who gets the results.

Calling for Oversight

"All forms of genetic information should be considered confidential and should not be disclosed without the individual's consent," Dr. Motulsky said at a news conference in Washington. "All organizations that generate or maintain genetic information or samples should have procedures in place to protect confidentiality."

The report said, "As genetic screening becomes more widespread, these issues threaten to outrun current ethical and regulatory standards, as well as the training of health professionals." It added, "There will be a need for centralized oversight to insure that new genetic tests are accurate, and effective, that they are performed and interpreted with close to 'zero error' tolerance, and that the results of genetic testing are not used to discriminate against individuals."

The panel also urged that testing be accompanied by extensive information about the disease being tested for and the options a person would face if found to carry the gene. For example, finding that a fetus has a "neural tube defect," a defect of the nervous system that indicates severe brain damage, could lead to a decision to abort the fetus. But it could also lead to disputes between the family and doctors over whether to abort, and if the fetus is carried to term, about how to treat a newborn who has brain tissue missing and for how long.

Urging Federal oversight of genetic tests.

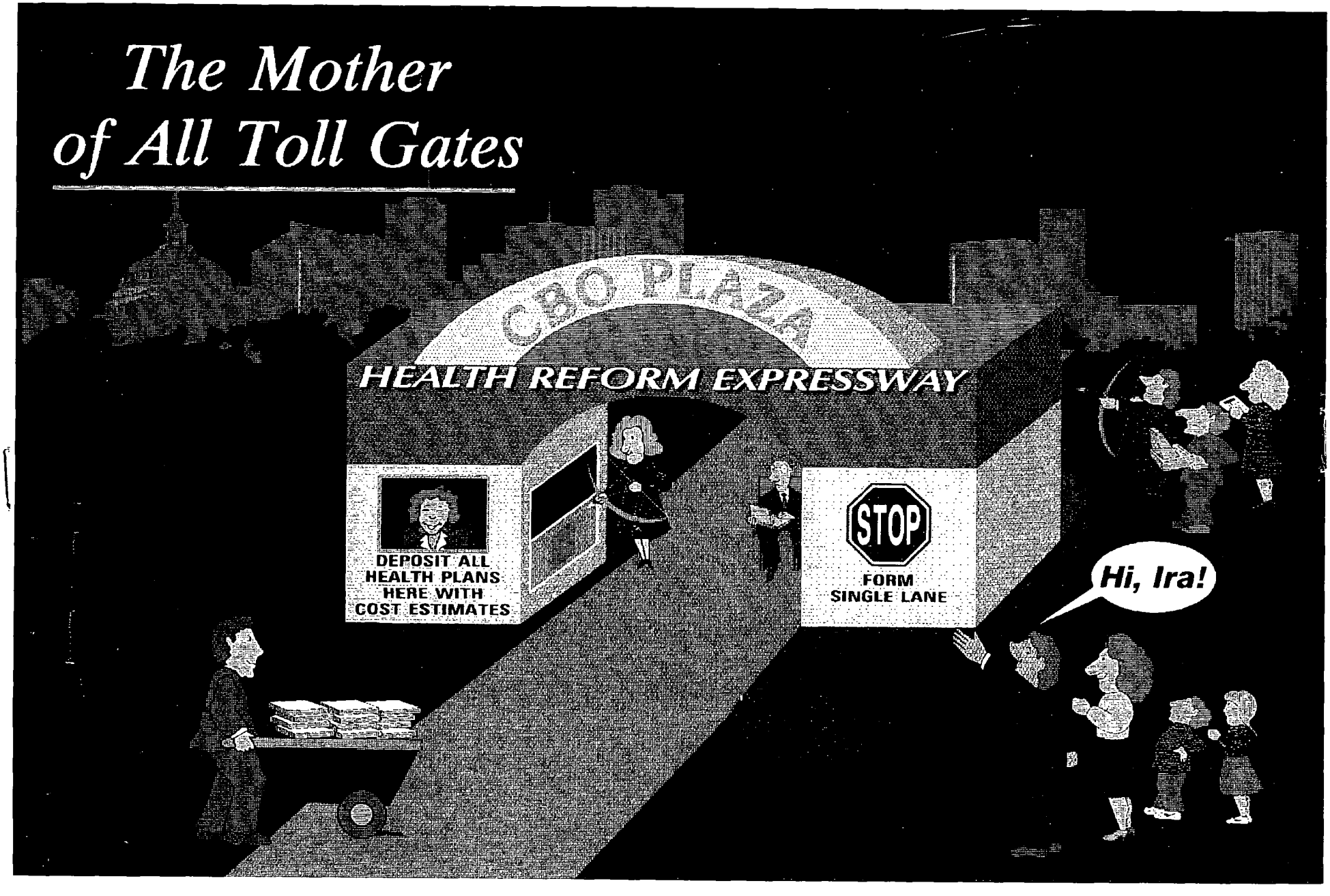
Workers must be aware that if a genetic test shows that they carry a gene for cystic fibrosis, which could mean they would have a child with the disease, an employer seeking to avoid health care costs and absenteeism might seek to dismiss them, whether they have an ill child or not.

Health insurers already prevent more than 160,000 people a year from getting insurance because of medical conditions they have, the report said, and this number could increase greatly if insurance companies are able to obtain information on the future health of not only workers but their families as well.

Under President Clinton's health plan, insurers would be forbidden from discriminating against people with preexisting conditions. But the plan is not specific on whether insurers could put limits on coverage for certain diseases, like AIDS.

The report referred to the "debacle of the 1970's with respect to sickle cell screening." After some states adopted laws requiring screening for sickle cell, the report said, trait carriers of the gene "were denied jobs and charged higher insurance rates without evidence that the trait placed a person at a higher risk of illness or death."

The Mother of All Toll Gates



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Uwe E. Reinhardt
James Madison Professor
of Political Economy

November 1, 1993

First Lady
Hillary Rodham Clinton
The White House
Washington, D.C.

Dear Mrs. Clinton:

Thanks so much for sending me a copy of that historical map now standing in the Map Room. You are right, the sight of that map was quite a moment for me. It brought to mind the war years, during which my mother, a veritable tigress, had to cope alone with her brood of unruly five. I shall carry the map over to her on my next visit to Germany. I am sure she will be deeply touched by your kind gesture.

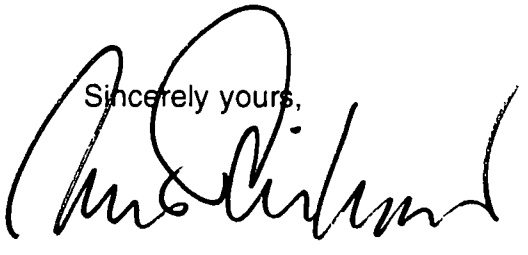
By all accounts, the health economists' workshop we held at Princeton University last weekend went well, thanks in no small part to the representatives from the White House. It was good of Ira and some of his staff to join us and to share with us the reasoning that begot the design parameters of the President's plan. Alice Rivlin, Len Nichols of her staff and David Cutler of the CEA made a first-rate and quite convincing presentation on the underpinnings of the cost estimates underlying the plan. I have served for years on the mortgage committee of a large pension fund and wish we had such careful cost and revenue estimates when we dispose of hundreds of millions of dollars of other peoples' money.

The effort of the White House representatives, and their sincerity, were much appreciated by the economists and by the staffers from the Hill. You can be proud of your people.

My wife, May, had prepared for Ira a colored hard-copy of a slide I had used in my presentation at Princeton. A copy of that display is enclosed herewith. You and the President may get a chuckle out of it. We hope Ira liked it.

With many thanks, again, for your kindness, and with my best personal regards and good wishes,

Sincerely yours,



Depicted below is an American mother who seeks to raise for this nation three American youngsters, presumably on the low income she can earn as a secretary. The picture was featured on the front page of *The New York Times* (October 5, 1992). In every industrialized society, save the United States, the last thing such a lady would have to worry about is obtaining access to health care or steep medical bills. She and her children would have comprehensive health insurance and, thereby, access to her nation's mainstream health care. Alas, in the United States this family probably represents the prototype of the uninsured. ***Journalists could play a major role re-focusing the debate about health policy on the probable fate of such families under the various proposals before us.***

Here's a third little one here

Terry Clark for The New York Times

Sunday 6 P.M.: Paula Brightbill, a divorced 36-year-old secretary, with her children, James, left, 12 years old, Michael, 6, and Dana, 14, as they prepare dinner in their home in Harrisburg, Pa.

Although I usually act just like an egg-head, I did draw the media's attention (last October to the unbelievably skimpy benefits in the Bush plan (pbar Health Letter). This is the picture I still use for my talks.

Although I am not sure whether or not she is insured, she and her family are a symbol of an uninsured family.

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Uwe E. Reinhardt
James Madison Professor
of Political Economy

October 14, 1992

Dear Friend and Fellow Communicator:

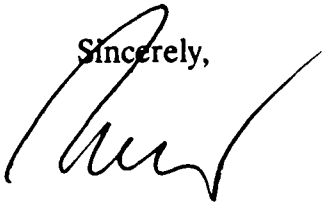
Enclosed herewith is a set of notes I recently used at a health-reporters' breakfast in Washington. I send them to you to bring to your attention to a peculiar and rather sad phenomenon: *the political process has somehow managed to style the debate on the issue simply as a set of financial flows and abstracted almost entirely from the human stories alternative health-reform proposals would beget. The media have gone along with that strategy.*

I am puzzled, for example, why so few, if any, of you have picked up on how quickly the tax-credits President Bush would offer American families would melt away with rising incomes. The general sense seems to be that the typical low-income family would receive around $ 3,750. But a family of 4 with an income of $ 23,000 would receive only the higher of $ 375 in tax credits or $ 562 in tax-savings by tax-deducting $ 3,750 in premiums. (These are CBO and CRS analyses). Under the President's proposal such a family, with a chronically ill member, could easily face an insurance premium of $ 6,000 per year. (Even large companies now pay close to $ 4,000 per family for group policies. Under the President's proposal, premiums in an area could vary by up to 50% per family because of health status.)

It seems to me that the public should be well aware of these fundamental parameters in evaluating alternative health proposals.

With my best wishes,

Sincerely,



INTRO TO THE PAPER

Imagine the following scenario: You and a group of colleagues are invited to a dinner at which the spirits—bourbon, gin, and chardonnay—flow like water. Eventually all of you are too impaired to drive home. Instead, you play a game called "Building America's Health Insurance System."

Would you, even in the most inebriated state, ever hit upon the idea to construct for our fine land a health insurance system that

- Ties the health insurance coverage of an entire American family to one particular job in one particular company in a way that causes the family to lose that coverage should the family's breadwinner lose that job
- Grants high-income families a higher tax subsidy toward the purchase of health insurance than it grants low-income families[1]
- Leads Americans to hold on to jobs they loathe, merely to have health insurance
- Tells families without employer-provided health insurance that their premiums will be sky high, should one or several members of the family be stricken with chronic illness
- Sometimes simply denies families or small business firms with chronically ill members any health insurance coverage
- Leaves some 35 million Americans completely without health insurance, among them many hard-working adults and some 10 million children
- Tells a family stricken with illness and without health insurance first to pauperize itself thoroughly before society will stretch out a helping hand in the form of Medicaid[2]
- Has members of uninsured families die at a much higher rate from given illnesses than similarly situated families that do have insurance coverage
- Allows private insurance carriers that cover individuals or small business firms to eat up over one-third of the premiums they collect in the form of commissions, administrative overhead, and profits
- Saddles doctors, hospitals, patients, and business firms with a claims process whose sheer waste of paper and time is unmatched anywhere in the world
- Costs some 40 percent more per capita than does Canada's health system, the second most expensive health system in the world
- Has the executives of even large American business firms now humble themselves in testimony before the U.S. Congress with their lament that they simply cannot control the cost of providing their employees with health in-

surance and that they therefore cannot compete effectively anymore in the international marketplace.

If this is the system you prefer, then you have your wish, for the preceding does describe well-known features of our nation's health insurance system. The system was cobbled together over the years by a partnership among America's business executives, labor leaders, and government officials who never thought very deeply about the long-term consequences of their design. Alas, the proverbial eggs they laid in the process now have become the proverbial chickens coming home to roost. The system is crumbling all around us.

Table 1 presents information taken from a ten-country survey on public attitudes toward health care undertaken in 1990 (Blendon et al. 1990) suggests that only Italy now matches the United States in the degree of popular dissatisfaction with the nation's health system. Respondents elsewhere in Europe and in Canada generally rated their health systems much more favorably than did Americans, who traditionally regarded their health system as the "best in the world."

Table 1. The Public's View of Their Health Care System in Ten Nations, 1990

	Minor Changes Needed (percent)*	Fundamental Changes Needed (percent)†	Completely Rebuild System (percent)‡	Per Capita Health Expenditure (U.S. Dollars)
Canada	56	38	5	$1,483
Netherlands	47	46	5	1,041
West Germany	41	35	13	1,093
France	41	42	10	1,105
Australia	34	43	17	939
Sweden	32	58	6	1,233
Japan	29	47	6	915
United Kingdom	27	52	17	758
Italy	12	46	40	841
United States	10	60	29	2,051

*On the survey, the question was worded as follows: "On the whole, the health care system works pretty well, and only minor changes are necessary to make it work better."

†"There are some good things in our health care system, but fundamental changes are needed to make it work better."

‡"Our health care system has so much wrong with it that we need to completely rebuild it."

Source: Harvard-Harris-ITF, 1990 Ten-Nation Survey.

Reprinted with permission from Robert J. Blendon, Robert Leitman, Ian Morrison, and Karen Donelan, "Satisfaction with Health Systems in Ten Nations," *Health Affairs* (Summer 1990).

REPLY

The commentators each add valuable *additional* perspectives to my remarks. We are not really at odds on any major points.

Carl Schramm and Marianne Miller extract from my article the impression that I portray "health insurers as the lone villains in the health care arena." To the extent that my article triggers this impression even in observers who are more detached and less besieged than are these two spokespersons of the Health Insurance Association of America, my article is flawed. A passage in an essay I recently penned for *Roll Call* may convey a more accurate portrayal of my views. In it I stated: "The problem with our current health insurance system, of course, is not that the people working within it are either malicious or slovenly; they work hard and mean well. Rather, the system is so poorly configured that it literally brings out the worst in a basically decent group of citizens. A productive reform of the system must be one that channels the efforts of these hard-working people toward socially more desirable ends."

Our health insurance system did not create itself, against the popular will. Its development was passively abetted by all of us, and very actively by the providers of health care, by the business community and by the U.S. Congress. Thus, I fully agree with Schramm and Miller's opening paragraph.

Furthermore, there is little point in pointing accusing fingers at the creators of our current insurance system. Let us reserve that exercise only for those who still defend this unseemly approach to financing American health care, even in the face of mounting evidence that the system is now morally bankrupt and not even economically efficient. There are still many of those defenders. We must debate them vigorously, and we must ultimately defeat them.

Richard Davidson calls for an end to the destructive non-price competition among hospitals that has saddled us with so much waste in the delivery of health care, and that is beginning to give the hospital industry a bad image in the media. Amen! Alas, he is not specific enough on just *how* this powerful industry is to be guided from mindless non-price competition to community-oriented cooperation, an exercise somewhat akin to making eagles fly in formation. Can we imagine the Board of, say, Holy Mercy unilaterally to withdraw from, say, cardiac surgery or other high-margin or high-prestige "product lines" just for the sake of the larger community, leaving the spoils to Methodist Hospital down the street? I wonder if a voluntary effort toward that end stands more of a chance than did the industry's "voluntary effort" at cost containment in the late 1970s. To my mind, the industry must be guided—goaded is the better word—by tough forces from the outside. These forces might be regulatory. My hunch is that they will come primarily in the form of harsh financial incentives.

William Dowling describes a vision of such a set of financial incentives. "All roads lead to Rome," the ancient Romans used to say. Nowadays, in health care, all roads seem to lead to one end point: capitation for comprehensive services coupled with the placing of doctors and hospitals into statistical fishbowls and ultimately, with global, top-down budgeting for all but a thin, upper-income-class elite. Arnold

UWE E. REINHARDT

Whither Private Health Insurance? Self-Destruction or Rebirth?

Summary

The American public increasingly finds itself disenchanted with the system for health care financing in this country. Three forms of reform proposal are examined: those that place the locus of primary responsibility for health insurance coverage on the individual, those that would rely on employer mandates with patients and government bearing the residual responsibility, and those that lodge chief financial responsibility with the government, and act as primary agent for cost control. The second approach, government-mandated employer-provided health insurance, appears to be the most politically viable at this time. However, that option is likely to be acceptable to the business community only if the mandate is coupled with additional regulation of private health insurance. Specifically, private health insurance in such a system likely would be based on mandatory open enrollment, community-rated premiums, and all-payer reimbursement, under which every payer pays a given provider the same fee for the same service.

UWE E. REINHARDT is James Madison Professor of Political Economy, Princeton University, New Jersey.

FRONTIERS

OF HEALTH SERVICES MANAGEMENT

This is a rework of the "Devil..." paper. It was written specifically for a group of insurance executives - before it was published.

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