Withdrawal/Redaction Sheet
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001. paper	Phone No. (Partial) (1 page)	1/20/1994	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Speechwriting
OA/Box Number: 8169

FOLDER TITLE:
HRC [Hillary Rodham Clinton]/Stump 1/94

2012-1004-S
ms492

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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FIRST LADY HILLARY RODHAM CLINTON
REMARKS TO XXX
PHILADELPHIA, PENNSYLVANIA
JANUARY 20, 1994

[Acknowledgments]

It is a privilege to be back in Philadelphia today, a day that is an anniversary of sorts. It was a year ago that the President was inaugurated -- and it was just a year ago that his Administration began the important journey to revitalize our economy, restore our sense of security and renew America's can-do spirit.

And what a year it has been.

Thanks to the dedication of millions of Americans -- from everyday citizens concerned about their country to politicians debating issues in the corridors of power -- we have made considerable strides over these last 12 months in fulfilling a very ambitious agenda.

The Family and Medical Leave Act. Earned income tax credits. National service. Deficit reduction. NAFTA. These measures -- which the President submitted and Congress approved during the past year -- all reflect a fundamental belief that Americans deserve security in return for their hard work and good citizenship.

And that philosophy remains the guiding principle as we move forward in this new year -- a year that holds the hope and promise of achieving the most important legislation of a generation: health security for every American.

Nearly 46 years ago [July 1948], Harry Truman accepted the Democratic nomination for President here in Philadelphia in this very convention center [are we sure it's the same exact one]? And in his acceptance speech, Truman minced no words about the problems facing the country, chief among them health care.

"The nation suffers from lack of medical care," he said. [But] "that situation can be remedied any time the Congress wants to act upon it."

Harry Truman never got the health care reform he wanted. Despite his repeated pleas to Congress, there was always some shallow excuse, always some petty grievance, some selfish argument working against him.

That was a missed opportunity. It was a missed opportunity followed by more missed opportunities. And all of those missed opportunities have added up to a crisis in our health care system today that threatens to bankrupt our nation. Nearly 40 million

shallow excuse, always some selfish argument working against him.

That was a missed opportunity. It was a missed opportunity followed by more missed opportunities. And all of those missed opportunities have added up to a crisis in our health care system that today threatens to bankrupt our nation and erode our precious sense of personal security.

At each pt a chance to help ppl but special interests stop us + continue to dirge -More specific assertion -vs. insur. companies

Nearly 40 million Americans don't have adequate health coverage. Millions are locked in jobs because they fear that switching companies or relocating to another city will mean sacrificing their benefits. Another 100,000 have been forced to declare personal bankruptcy due to astronomical medical bills -- a situation unimaginable in any other developed nation.

Yet even in the face of these troubling statistics, even when confronted with report after report about hard-working families who can't get adequate health care for themselves or their children or their aging parents, there are some who still believe that health care reform isn't really necessary.

In fact, some insist there is no health care crisis at all, that it's all just fantasy or fiction.

That theory may sound plausible to people living in an ivory tower, but it certainly isn't plausible to millions of Americans whose everyday existence is the real world.

If you think there's no crisis, try telling that to the 700,000 people who wrote letters to the White House last year with stories about our health care system.

Try telling it to parents who can't get an immunization for a child because their insurance won't cover it. Try telling it to senior citizens who can't get prescription drugs because their coverage won't pay for them. Try telling it to the hard-working employee who can't get coverage after switching jobs and moving to a new city. Try telling it to the cancer patient who is denied coverage because of a so-called "pre-existing condition." Try telling it to doctors and nurses who spend more hours filling out forms than tending to patients.

BC the present can't

A year ago, I met a doctor at St. Agnes Hospital in Philadelphia who summed up the problem so simply. He said: "You know, there's an old saying: If it ain't broke, don't fix it. Well it is 'broke' and I'm begging you to make sure that it gets fixed.'"

The past year has not only confirmed for me the great strengths of our health care system -- but also the magnitude of the crisis we're in. As you know, I've just come back from

overseas and I can assure you that our doctors, hospitals, nurses and technology are still the finest anywhere in the world.

We must stay that way. But we can only stay that way if we listen to the pleas of millions of our own citizens -- health care professionals, business owners, employees, seniors, students and others -- who say the health care system is broken and needs to be fixed.

I know our system needs fixing because I've heard stories from hundreds and hundreds of Americans I've met traveling around the country during the past year. I've heard of the hardships endured by a [worker] whose benefits were cut off because he switched jobs. I've heard from a single mother who realized it was more economical to stay on welfare and receive Medicaid than to keep a good job that offered no health insurance. From a [senior citizen example] who had to choose each month whether to use his savings to pay the rent or pay for medicine. From a woman who was billed $2,400 for a pair of crutches.

These people are not mere statistics. They're not just faceless numbers tossed around by economists. They're not pawns to be bargained and traded in a political power game.

They are real people with real problems. And their problems are our problems. Because we all end up paying more -- and getting less -- when millions and millions of our fellow citizens lack adequate medical care.

How do we the rest of us end up paying more? Hospitals and physicians charge more to cover the costs of treating the uninsured, and our insurance premiums get higher and higher. Aging parents and relatives require more costly care and treatments because they aren't covered for the drugs they need to prevent illness. Children are put at risk of getting serious diseases because their parents can't afford simple immunizations. Family after family is devastated by exorbitant medical bills.

It doesn't have to be this way.

Fortunately, we have a fresh chance to achieve real health care reform -- now.

After a year of listening to the concerns of Americans from every walk of life, after listening to a year of healthy dialogue and debate among ordinary Americans, health care professionals and economists and political leaders across the country, the President submitted legislation to Congress that promises the kind of real reform that has eluded us for more than a half century.

Our solution sounds too big
Sense of caution, phase-in —
but here is a bottom line ——

The President's approach is not just for the good of those without insurance, but for the good of all of us.

c.b. is covered

For the good of all of us, it will guarantee health insurance for everyone. For the good of all of us, it will make it illegal for insurance companies to decide who gets coverage and who doesn't. For the good of all of us, it will prohibit lifetime limits on your coverage. And for the good of all of us, it will guarantee a comprehensive benefits package, including coverage for preventive care and prescription drugs.

More holistic solution - if c.b covered, you can choose doctor, plan, etc.

In sum, it will help make our nation, our society, our families, stronger overall. It will make life better for children, and parents, and aging relatives. It will make life better for the healthy and the sick. It will make life better for doctors and nurses -- and of course, for their patients. It will give us all greater emotional and financial security.

More on preventive care - v. necessary to apply.

No other approach offers the same protection, the same compassion, the same security.

No other approach guarantees coverage for everyone. No other approach prevents insurance companies from picking and choosing whom they will cover and how much they will pay. No other approach ensures lifetime benefits. No other approach offers a comprehensive package of benefits. No other approach meets the special needs of senior citizens.

No other approach makes sure that every American has health coverage that can never be taken away.

For the past year, our nation has engaged in a wonderful and historic discussion of health care. Now it's time to move beyond questions about whether we need health care reform to when we will achieve it. Now it's time to act.

In the past few days, our nation has witnessed the terrible tragedy of a severe earthquake in southern California. As we have seen over and over on the television news, families and communities have been ravaged by the devastation, left without homes, left without clothes and, in some cases, left without loved ones.

That's what happens when a disaster strikes with no warning.

Like an earthquake, a serious illness can wreak havoc on a family with no insurance. Even if it doesn't claim a life, it can leave relatives in financial ruin. ← and emotional

As we think about health care reform over the coming months, we must think not only about ourselves, but about our friends and neighbors and communities. Like the residents of Los Angeles, who

responded to the earthquake with acts of heroism, courage, compassion, and generosity, we must do the same in the face of a national health care crisis.

Health care reform is about all of us. That's why we must act now -- not recklessly, not impulsively, but with care and thought and foresight. If we have the courage, the compassion -- and the wisdom -- to achieve real health care reform now, we will be better for it in the years and decades ahead. Most important, we will have helped stave off a disaster in the making.

Thank you.

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[001]

TO: Melanne, Kim

1/20/94

FROM: Lissa P6/b(6)

RE: Stump speech for HRC

Here's a draft of what might pass for a stump speech. It could use some more specifics -- anecdotes and statistics -- but I wasn't able to get much from Lynn yet.

Given the new polling data, the tone may be a bit too tough and we may want to soften it. In general, I've tried to recast the usual health care stuff to emphasize that there is a crisis, that the president's approach is the most comprehensive and most compassionate, and that it will be good for everybody, not just the uninsured.

I also tried to put in language that will appeal to senior citizens, but you may want more of that.

Cheers.

J.

First of all, we cannot go on the way we have been going. We do not have a system of health care in America. We have a patchwork, broken-down system. As a gentleman said to me this morning at St. Agnes -- a medical doctor -- he said, "You know, there's that old saying: If it ain't broke, don't fix it." He said, "This system is broken and desperately needs to be fixed." He said, "If I were talking about it as a patient, I would say that it is in intensive care and we're not seeing the kind of vital signs that would lead us to believe it will recover." And I think that that is a fair assessment from those who are on the front lines, either as patients or as providers.

And the second thing we know is that we are already spending more money than any nation on earth in both absolute and relative terms, but we are not doing a good job in providing the kind of health care that that money should provide. We have to face up to the costs in this system, and we have to have the courage to talk about that openly, as all of you are prepared to do this afternoon. And we have to recognize that there will need to be changes in our health care delivery and financing systems if we are going to control costs. And that controlling costs is a necessary first step in not only providing universal access to health care for all Americans, but in beginning to eliminate that sense of vulnerability and personal insecurity that affects all Americans, even those currently with insurance.

So I want to salute those of you who have put this conference together, to thank Senator Wofford and Governor Casey. And to pledge, on behalf of the President and the Vice President and all those in the Clinton-Gore administration, their absolute commitment to doing what is necessary, despite how tough it will be, to present legislation in May that will hold out the promise of a new health care system for all Americans, and then get about the business of trying to implement it so that we can see it in action sometime by the end of this year.

Thank you very much. (Applause.)

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FIRST LADY HILLARY RODHAM CLINTON
STUMP SPEECH
JANUARY 1994

DRAFT

[Acknowledgments]

[This opening can be used for Philadelphia and revised for other speeches]

It is a privilege to be back in Philadelphia during a time that is an anniversary of sorts. It was just a year ago that the President was inaugurated -- and it was just a year ago that his Administration began an important journey to revitalize our economy, restore our sense of security and renew America's can-do spirit.

And what a year it has been.

Thanks to the dedication of millions of Americans -- from everyday citizens concerned about their country to politicians debating issues in the corridors of power -- we have made considerable strides over these last 12 months in fulfilling a very ambitious agenda.

The Family and Medical Leave Act. Earned income tax credits. National service. Deficit reduction. NAFTA. These measures -- which the President submitted and Congress approved during the past year -- all reflect a fundamental belief that Americans deserve security in return for their hard work and good citizenship.

- we can break gridlock
- don't have to drift

And that philosophy remains the guiding principle as we move forward in this new year -- a year that holds the hope and promise of achieving the most important legislation of a generation: health security for every American.

- laissez faire

Nearly 46 years ago [July 1948], Harry Truman accepted the Democratic nomination for President here in Philadelphia in this very convention center [are we sure it's the same exact one]? And in his acceptance speech, Truman minced no words about the problems facing the country, chief among them health care.

"The nation suffers from lack of medical care," he said. [But] "that situation can be remedied any time the Congress wants to act upon it."

Harry Truman never got the health care reform he wanted. Despite his repeated pleas to Congress, there was always some

Americans don't have adequate health coverage. Millions are locked in jobs because they fear that switching companies or relocating to another city will mean sacrificing their benefits. Another 100,000 have been forced to declare personal bankruptcy due to astronomical, unpaid medical bills.

Despite these statistics, despite report after report about hard-working families who can't get adequate health care, there are some skeptics who remain unwilling to embrace health care reform.

Frankly, I find it remarkable that it's now fashionable in some quarters to suggest that there is no health care crisis at all, that it's somehow fantasy or fiction.

That theory may hold water in the ivory tower, but it certainly has no likeness to the real world.

Try telling the 700,000 people who wrote letters to the White House last year with stories about our health care system that there is no health care crisis.

Try telling the doctors and nurses who are drowning in paperwork that there's no health care crisis. Try telling the young parents who wind up using the emergency room as their family doctor that there's no health care crisis. Try telling senior citizens who can't afford prescription drugs that there is no health care crisis. Try telling the cancer patient who can't get coverage because of a so-called "pre-existing condition" that there is no health care crisis.

A year ago, I met a doctor at St. Agnes Hospital in Philadelphia who summed up the problem so simply. He said: "You know, there's an old saying: If it ain't broke, don't fix it. Well it is 'broke' and I'm begging you to make sure that it gets fixed.'"

The past year has only confirmed for me the magnitude of the crisis we're in. As you know, I spent a good deal of time on the road last year listening to health care professionals, business people, ordinary citizens, seniors, students and working people about our health care system.

I heard hundreds and hundreds of stories -- stories from a xxx whose benefits were cut off because he switched jobs. From a single mother who realized it was more economical to stay on welfare and receive Medicaid than to keep a good job that offered no health insurance. From a xxx who was denied coverage because xxxx had a pre-existing condition. From parents who couldn't get an immunization for an infant because their health plan wouldn't pay for it.

STUMP SPEECH

Remarks for the Maine Health Care Forum
Hillary Rodham Clinton
Philadelphia, PA
February 7, 1994

[Acknowledgments]

It is wonderful to be back in the great albeit cold state of Maine. And a pleasure to be here at the University of Maine, which in addition to being a beautiful and distinguished academic institution is the home of the 1992-93 NCAA National Hockey Champions--The Black Bears. It is so great to see the members of your team again and I look forward to watching your athletes lead the US Hockey team to victory in Norway. I will tell the President to wear his number 93 Black Bear jersey for good luck.

The President and I have now been in Washington for just over a year, and I cannot help but think about how far we have all come. During this past year, we have worked to move our economy in the right direction, restore our sense of security and renew America's spirit.

And thanks to the dedication of millions of Americans, we have made real progress over these last 12 months.

Passing the Family and Medical Leave Act so good workers can be good parents. Expanding the earned income tax credit to reward work over welfare. Launching a new national service initiative that helps more young people go to college. Reducing the deficit. Expanding trade with NAFTA.

These measures -- which the President submitted and Congress approved during the past year -- all reflect a fundamental change that has taken place in our nation. The days of drift and gridlock are over. We have all taken responsibility for the future of this country. We have shown that when the American people set their minds and their hearts to doing something, it gets done.

And I know that our resolve will grow stronger still as we move forward in this new year -- a year that holds the hope and promise of achieving the most important legislation of a generation: health security for every American.

A year ago, as I began working on this problem, I met a doctor at St. Agnes Hospital, right here in Philadelphia, who summed up the problem so simply. He said: "You know, there's an old saying: If it ain't broke, don't fix it. Well, Mrs Clinton, our health care system is 'broke' and I'm begging you to make sure that it gets fixed.'"

In the past year, I have learned we have the best health care professionals and research institutions in the world. I have seen doctors in inner city emergency rooms battling to save lives hour after hour, day after day. I have seen talented young doctors donate their services to people in rural areas who cannot afford to pay for them.

But in speaking to and reading letters from people all across America -- farm families, small business owners, older Americans, and, yes, medical professionals, I have heard one

benefits package with low deductibles that is spelled out in law; others provide just a basic package with high deductibles, or leave it to a government board to decide after the law is passed.

We outlaw insurance company discrimination completely; others may say they prevent insurance companies from dropping people, but they still let them double or triple your premiums when you get sick.

We believe that the proposal we put forth best achieves the goal of guaranteed private insurance for every American that can never be taken away. However, as we've said from the beginning, we are ready to listen to serious proponents of health reform who think they have a better way of achieving that goal.

Our commitment to achieving the kind of health care reform that I have been talking about today must be stronger and stronger still. Because however optimistic I am, I cannot help but remember that our nation's past is full of other years and other promises of health care reform that could not be fulfilled. When President Roosevelt introduced social security he tried to pass health security as well. He could not. Neither could President Truman or President Eisenhower. Twenty years ago, President Richard Nixon proposed employer-based, private insurance for every American with shared responsibility among employers and employees. It was a proposal that closely resembles ours. But he also did not succeed. Every President since the 1930's has tried. Health care reform has been introduced in every Congress.

So why hasn't it happened? Why has the history of health care reform in this country been a history of missed opportunities? The answer is fairly simple: Health care reform has not happened because special interest groups have been too powerful, and special interest groups have way too much invested in keeping things as they are.

But this time, if we work together, I am convinced things will be different.

This time, we will make history and guarantee private insurance to every American. I ask you to join with me and do what is right for America. Thank you.

message loud and clear: our health care system is broken and it needs to be fixed.

And to those in Washington who still deny that we have a crisis in our health care system today, I say: Tell that to the single mother who wants to work but has to stay on welfare to get health benefits for her child. Try telling it to Carol Weil of Rockport, ME whose family is uninsured and ineligible for aid. Try telling her how she and her husband should pay for their son's enormous hospital bills, and what they should do with their four children now that their home has been foreclosed on. Tell it to the older American who has to choose each month between food and medicine. Tell it to the family that hit the 'lifetime limit' on their insurance coverage and was forced into bankruptcy. Tell it to the nurse who is forced to spend more of her time on paperwork than on patient care.

Tell them there's no crisis. Because I won't -- and neither will the President. We're going to take on this challenge, we're not going to just tinker at the edges, and we're going to bring about real reform for the American people.

This crisis didn't happen overnight. And it didn't happen by accident. It is the direct result of the insurance company control over the system.

Let's face it -- today's health care system is rigged against families and small businesses, and the insurance companies are in charge. They pick and choose whom they cover -- and they've decided that 81 million Americans under the age of 65 have medical problems for which they should pay higher premiums or be denied coverage. They use

"lifetime limits" to cut off your benefits -- and although people may not know it, three out of four insurance policies have these things hidden in the fine print.

And they drop you when you get sick -- leading to 58 million Americans without insurance at some point during the year.

If someone with a lifetime limit or worse yet, no coverage at all, becomes seriously ill, their entire family's savings could be wiped out. In fact, every year over 100,000 middle-class families declare bankruptcy because of a serious illness or injury.

Where I come from we call facts like these a crisis. We call them a very big and potentially debilitating problem. But the truth is, it doesn't matter what we call our health care situation-- it matters that we fix it. And that we fix it now.

For almost twenty years Maine legislators (like Senator Mitchell), providers, consumers, and businesses have been and continue to be active in improving this state's health care system. You have strived to improved access to higher-quality health care while lowering costs.

We in the Federal Government want to follow your example.

We must return our health care system to the people who should be in the driver's seat -- patients and their doctors. And our approach does that by outlawing the insurance company discrimination that is so common today. It makes it illegal for the insurance companies to

decide who gets coverage. Illegal to charge people more if they're older or sick. Illegal to put lifetime limits on coverage.

We want to phase in reform over a few years to make sure it's done right. But when we're done, insurance ought to mean what it used to mean. You pay a fair price for security, and when you get sick, health care's always there, no matter what.

The President's goal is this: guaranteed private insurance to every American. And I want to be clear about what that means because there's a lot of misinformation out there. Most people will get insurance the same way they do today, through their employer. Each consumer -- not their employer, not a bureaucrat -- will have a choice of health plans and doctors --and plans will enroll everyone who applies.

Once someone's picked a plan, if they need to go to the doctor for a check-up or get sick, they'll simply take their Health Security card, show it at the doctor's office or the hospital, and get the care they need. Then they'll fill out one standard form, and they're done. That way, we can go back to using doctor's offices as places of healing, not monuments to paperwork and bureaucracy.

The President's approach would guarantee a comprehensive benefits package that includes coverage for preventive care and prescription drugs. Immunizations, well-baby care, and check-ups for children -- all covered free of charge.

And the President's approach will be good for physicians. It puts power and choice back in the hands of individuals and physicians -- so they will be able to choose what plans to join, and their patients will have their choice of plan and provider. A single claims form and standard, comprehensive benefit package will make all our lives simpler. And guaranteed private insurance will mean that doctors won't have to worry about whether the insurance company will decide to reimburse them, or whether their patients have insurance at all.

We also agree that local community care networks must be the centerpiece of a reformed system -- groups of providers who see their mission as keeping people well and have the right incentives to do exactly that. With our approach, doctors will play an especially vital role in providing the primary and preventive care needed to keep people healthy.

The President's approach also protects older Americans -- something that's very important personally to the President and myself -- by preserving Medicare and by adding new coverage for prescription drugs and some long-term care.

As this debate on reform moves forward, you will start to hear a lot about other approaches. I ask you to think carefully about those alternatives. And ask their proponents the same tough questions you're about to ask me.

Because there are some key differences between our approach and the alternatives. We use savings in the growth of Medicare for better health coverage for older Americans; others use it to pay other bills unrelated to health care. Our approach provides a comprehensive

CONFERENCE CALL 1/26/94

STAN/ Is there a crisis } 2 main themes
Univ. coverage or not

CHRISTINE Chart ↑ ins. companies
to rebut Dole

MANDY Alternative that will screw sr. citizens + leave millions vulnerable
HRC also worried abt AIDS speech
Make sure includes basic msg

KIM/ Acceptance speech for AIDS awards — 5 mins.
comments i LA

DHIC -
FLA - FRI

MG/ AIDS = perfect example of crisis
Some deny AIDS is a problem
Some deny health crisis

Focus more on ins. company control
Always have a letter from each state

Re crisis: It's a gift that they have raised this?
b/c not a disc of structure; focus re
whether a crisis is a total no-brainer
Those vs it same as Bush There is no recession
A whole richness to this b/c not
abt alliance

CONF CALL (2)

STAN/ Sense of drift; Probs; how a sense of possibility > State of Union

we need eventually
Get beyond the word "crisis"
It is not just crisis, no crisis
big crisis, not small crisis; big probs; small probs

Our solution is not radical; a conservative solution to big problem
Our way = build on what is good

M&J Ppl believe the probs
Need reassurances abt what the solution

Guaranteed Private insurance
Use Nixon example - he gave up w/ idea
Extend outpatient benefits for Medicare

We're trying to build on what works - a private sector solution

Other huge area:
Senior citizens
Meanest users of health care & they're spooked
All other approaches reduce Medicare - we are protecting Medicare

Medicare is endangered by not doing reform -

CONF CALL (3)

Keep going to Mcare to cut the deficit
This is a Mcare profession plan
Needs a personal example that she cares abt + cherishes older Americans
"If this is not right for older Americans I wouldn't do it"

food for children, good for seniors

STAN/ 1st page of accomplishments →
don't want to use
Historical assertion — important (Nixon)

MANDY/ Have to be careful abt her tone re: insurance co.
Her job = reassurance not conflict
Fundamental choice we're trying to lay out —
ins co = in charge
Leaving ppl w/a sense of powerlessness + fear
We're trying to empower ppl — "put the card in yr. hand"
Choice of plan, choice of doctor;
not change once if you're older etc.

Security in terms not so much of cost but a litany abt ins. industry
Lifetime limits
Question of control
Now choices are ltd

CONF CALL (4)

Prevention care –
Ins. co. doesn't pay to keep you well
Don't want u to go for X up in case
Sly is wrong that will cost to treat

More on caution ; phase in

long term care – not warehousing sr citizens

Fairly emotional stump speech – lays out by Rs
but reassures
That she gets it in terms of ppl's lives

SPAN/ Ppl are making v. personal judgments
insurance you can depend on
She shld ask that ppl are talking abt
Dinner table conversations
– whether to discuss other approaches
Legislative alternatives – has to discuss Congl
debate

BOB/ End/you're gonna hear a lot –
Does this approach protect sr. citizens?
Make her the educator
Questions are by debated in Congress
at dinner table

On ? of coverage – we think c.b. shld be viewed
plans – but has to be comprehensive

- other people don't think that's important

Contrasts
- univ. coverage?
- are benefits comprch. or bare bones
- Do you max them up front
- good for seniors?

NEVADA

Don't use the word veto
Pres has said no univ cov ≠ real health care

Needs to put Pres. into speech more

People have that contradiction in their heads —
big problems; ~~good~~ but Amer. health care really good

Preserving what's good
What's good is at risk

HRC / Philadelphia 1/19/94 NOTES

No health crisis

Reinhardt Mortality rates worse for uninsured ...

Medical bills → bankruptcy (personal)

(unlike in any other developed country)

Mobile, A society -- insurance is not adequate

if it is only tied to your job

→ # of working mothers, children who are

among the uninsured

TRUMAN 10/6/48

Address at Conv. Hall in Philly

HRC/Philadelphia

Civilization/civility

Time to go from "me" to "we"

Natural disasters → selflessness, humanity, compassion to help others

MANDY - questions

→ Msg to unions

→ still emphasize what's good?

Eller

- Seniors nervous about pace; govt involvement
- Don't use "plan" -- use approach
- Pres insists on certain key elements
- Pres will veto any bill w/o univ. coverage.
  ↳ don't use that word

Health security for all Americans

Health benefits that c

Mrs. companies —

Hillary Rodham Clinton
Talking Points
Health Leadership Council
21 January, 1994

Acknowledgements.

It is my great pleasure to be here today. Since its inception in 1990, The Health Care Leadership Council has always shown a great willingness to confront the problems in American health care. Your organization has worked hard to find solutions.

The President and I applaud your commitment and we share it. While we may advocate different approaches, I believe that all of us share a common goal. Every single one of us wants to provide secure, high-quality, affordable health care to all Americans.

You are all well aware of the problems we face in our current system. You all know the statistics-- 39. 5 million Americans are uninsured; ___ Americans will lose their insurance every month. And you know that despite (these awesome statistics) we are spending 14% of our national income on health care.

Clearly, this is unacceptable. So it is very puzzling to me that there are some who say that there is no problem with our current system, that we should just do nothing, and allow things to continue unchecked. There are some who point to the fact that medical cost growth is as low as it's been since 1973 as evidence that things are fixing themselves.

Well, 1973 was the year that President Nixon's health care reform bill was also before Congress. Leading health economists, such as Uwe Reinhardt of Princeton agree that the prospect of reform always causes (the industry) to tighten its belts somewhat. But without reform costs will continue to accelerate.

(The fact is that if we do nothing, we can look forward to paying 20 percent of our national income on health care in the future. If we fail to act, every American can expect to pay higher premiums nearly every year, with no guarantee of security, no guaranteed benefits and no guarantee that insurance will be there when they need it. Almost one dollar out of every five dollars Americans spend will be on health care. Millions of Americans will find that rising costs will force their firms to cut back on benefits and limit choices of doctors and health plans. And by the end of the decade, just to keep their benefits, American workers will sacrifice almost 600 dollars in wages every year).

We know that we must make changes. Our health care system is seriously broken, and we are committed to fixing it. Not just because of the moral imperative, but because of the financial one (expand?)

As you know, the President has presented his approach to health care reform to the Congress. We firmly believe in his plan, but we also believe in the importance of process. It is only through working together-- through debate and thoughtful discussion that we will arrive at the best solution for this nation. We hope that you will continue to play an integral role in the national dialogue on this issue.

We are flexible on the details of our proposal, but the Health Security Act is based on certain principles. And on these we will not compromise.
The bottom line is that there must be universal coverage. Every American must be guaranteed a package of comprehensive benefits that can never be taken away. There can be no limit on benefits over your lifetime. No refusal of insurance if you have a pre-existing condition. No losing your insurance if you get sick or lose your job. And no indiscriminate rate increases.

It is imperative that we slow down the rate of growth of health care costs. Unlike other proposals, the Administration has provided data detailing exactly how much the program will cost, where the funds come from, and how they will be spent. We have documented how premiums and discounts were estimated and exactly where we expect to get savings.

The President considered, and specifically rejected, a plan imposing price controls on health care. The President's primary strategy for cost containment is private sector competition-- creating the right economic incentives to bring costs in line and encourage health plans to compete on price and quality.

We believe that the marketplace is the best mechanism to serve consumers. It will provide real choice, real quality and real competition. We believe that it is competition, NOT regulation, and certainly not discrimination (or cherry picking) that will contain costs.

You have heard our principles--security, simplicity, choice, quality, savings, responsibility. You know what the bottom line is-- we must achieve universal coverage. Every American must have a choice of affordable, high-quality health care. We must contain costs and end discrimination in the marketplace.

These are our goals and we believe that our approach will achieve them. If there are alternative approaches that also secure these objectives we welcome them. The challenge before you--the leaders of the health care industry-- and before us all is to find the best way to achieve these goals. I look forward to working with you all.

ââââââââââââââââââââââââ â â

HRC. Children's Hospital Event
20 January, 1994.

Draft, TAR, 18 January

Acknowledgements.

I am so happy to be back in Philadelphia on this special day. As you know, today marks the one year anniversary of the President's inaugural.
And what a year it has been.
Sometimes I think it has flown by and other times I think I am ten years older than I was last year on this day, but one thing I know is that this has been an extraordinary year for our nation. We have seen the impossible become possible. We have achieved what we could once only dream about. We have confronted some difficult problems. And we have made very real changes to ensure that our country stays strong and that the future of every single American is bright.
In this past year the President has done something truly remarkable--he has changed the agenda of our nation. The question is no longer whether we will have health care reform, but what type of health care reform should we enact.

It was about a year ago that I made my first trip to Philadelphia as First Lady. I took a tour of St. Agnes Hospital, and I met a physician (details) We talked for awhile and he said to me "Mrs Clinton, there's an old saying: 'if it ain't broke don't fix it' Well, Mrs Clinton, this system is 'broke' and I am begging you to make sure that it gets fixed."

If I did not understand the full scope and magnitude of the doctor's statement then, I certainly do now. In the past year, I have learned a tremendous amount about our current health care system. I have had the privilege to speak to thousands of Americans from all walks of life about their experiences. I have received hundreds of thousands of letters from concerned citizens. And I will not forget what I have heard and seen.

I will not forget... **insert examples here of stories moving toward examples like 'if there were no lifetime limits X would be fine...' etc.**

a soul of why we are all here today. AND

We cannot forget. These stories are the heart of the matter. The men, women and children who told them are the heart of this country. We cannot forget because when you cut through all the rhetoric, all the politics, and all the sound bytes, what remains is that 39.5 million Americans are uninsured. The fact remains that every month ___ Americans lose their insurance. Since the President spoke to Congress about health care reform in September ___ Americans have lost their insurance. None of us is truly secure. Even those of us who are currently insured cannot with any certainty know whether we will be insured to the same

degree at the same cost next year. We cannot because it is impossible to know what will happen to us, whether we will remain employed, whether we will suffer some illness or accident that will totally change our insurance situation.

What I have learned in the past year makes it very clear to me that any health care reform bill we enact must provide health security to all Americans. Every American citizen, regardless of where they live, where they work, or whether they have ever been sick before, must be guaranteed high-quality, affordable health care. The President believes that this is absolutely essential. (And) he will not sign any bill that does not provide universal coverage.

And the Bottom line

(This coverage) must include a comprehensive package of benefits.
--primary/ preventive care.
--long term care, prescription drugs for seniors.

(where is best current language for these?)

Any plan that is enacted must also control costs. As you all know, we are currently spending 14 percent of our national income on health care. If we do nothing we can look forward to spending 20 percent of our national income on health care in the future.

If we fail to act, every American can expect to pay higher premiums nearly every year, with no guarantee of security, no guaranteed benefits and no guarantee that insurance will be there when they need it. Almost one dollar out of every five dollars Americans spend will be on health care. Millions of Americans will find that rising costs will force their firms to cut back on benefits and limit choices of doctors and health plans. And by the end of the decade, just to keep their benefits, American workers will sacrifice almost 600 dollars in wages every year.

Given everything I have been talking about today (and everything I have witnessed in the past year), I find it extremely puzzling that there are some people who believe that there is no problem with our current health care system. That there are people who say that we can just do nothing and allow things to continue unchecked. I can only assume that these people have not had the opportunities I have had-- they have not been able to talk to the American people, to hear about their experiences, to listen to their concerns and their fears.

That 39.5 million Americans are uninsured is an awesome statistic, but it runs the danger of being <u>just a statistic</u>. One that can be filed away and conveniently forgotten. But when you think about the fact that for every one of those 39.5 million Americans there is a child who will not be immunized or a family whose doctor is the emergency room, then you know that there is a problem with our current system, and you know that we must have reform.

KEY MESSAGES: REASSURANCE AND CONTRAST

CLINTON PLAN	COMPARISON
The health care crisis is real.	Some say there is no health care crisis. They don't understand the American people.
The Clinton Plan guarantees health insurance to everyone.	The other plans do not guarantee insurance coverage to everyone.
The Clinton Plan makes it illegal for the insurance companies to decide who gets coverage and how much they pay.	The other plans still allow insurance companies to pick and choose whom they will cover and set how much they will pay.
The Clinton Plan ends lifetime limits on coverage, ensuring that health care will be there when you need it.	The other plans would still allow insurance companies to cut off benefits.
The Clinton plan will provide real health security.	The other plans do not provide the American people with the security of health care that will be there when they need it.
The Clinton Plan provides a good benefit package you can depend on.	The other plans don't provide any guarantees about what will be covered.
The Clinton Plan provides a comprehensive benefit package, including coverage for preventive care and prescription drugs.	The other plans provide bare-bones benefits.
The Clinton Plan specifies what's in the benefit package.	The other plans leave the specifics of the benefit package to be determined later by a government board.
The Clinton Plan provides a choice of health care plans and a choice of doctors.	The other plans mean fewer choices.

Lissa -

Here are some articles you may want to build into the response to "there's no health care crisis" argument. I've highlighted the relevant passages.

Also - I was told that the Philadelphia civic center was where Truman was nominated. I'm not positive about this. You may want to build that into her opening comments. I also think this would provide a good segue into the "there's no health care crisis" rebuttal.

- We're embarking on a long, arduous path to getting health reform passed. Many presidents have tried - - the first president to talk about comprehensive health reform. Then Truman (who received his nomination in this very place - need to check this out) introduced this, but it never got out of committee. Richard Nixon and Jimmy Carter...all have talked about comprehensive health reform. But, each time, something has gotten in the way to squelch these reforms.

- Health reform will be a complicated, difficult process. We don't have any illusions about that. But, it needs to be done. The opponents of health reform have said that there is no health care crisis in America.

It's a crime that all industrial countries provide health insurance for their people. In the U.S., 39.5 million Americans lack health insurance, and this number continues to grow.

It's a crime that we spend 14% of our GDP on health care, yet we have so many uninsured. How is it that other countries can cover everyone, yet only spend 8-10% of GDP on health insurance?

It's a crime that over 100,000 families declare personal bankruptcy due to medical problems.

LYNN

[redacted]

We have been on defense long enough. It's time for offense. We must regain control of the dialogue. We have been largely engaged in arguments about our weakness' instead of fighting on our strengths and in that fight, revealing the weakness' of our opponents. We must aggressively move the health care debate to the central principles of the President's plan that we know the American people strongly support.

We must put our opponents on the defensive. Their plans are deeply vulnerable. This does not mean we should engage in personal attacks. It does mean that we should move to contrasts in which we focus attention on areas of our strengths and our opponents weakness'. It's time that our opponents started explaining to reporters, to Congress, to their constituents, why they don't want every American to have guaranteed heath insurance, why they won't tell the American people what benefits are covered in their plans etc.

We must characterize the President's plan, provide reassurance and establish defining contrasts. It is essential that we present a simple characterization of the President's approach, provide reassurance, and present clear facts that differentiate the plan and, that we do this in a reinforcing way. We are more likely to succeed if each of these is pursued in ways that reinforce the other.

The fights we choose will help reassure the American people about the President's plan. Taking on the forces of the status quo [the insurance industry, right wing Republicans etc.] on key principles will do more than put our opponents on the defensive, it will reassure the American people about the content of the President's plan and what it will mean for them.

We must also begin to define our own plan instead of allowing it to be defined by our opponents. People are still confused about our plan and what it will mean for them and their families. Is government taking over? Will they lose the benefits they have? By defining our plan as "guaranteed private insurance" we can help reduce the uncertainty and provide reassurance. The biggest questions still center on whether the President's plan will help or hurt their families and those questions are explained by worries about personal cost, quality of care, scope of coverage, and choice of doctor.

We must recognize that many battles our opponents want can be fought to a draw, but never completely won. There are issues where our goal must be to neutralize attacks and minimize their role in the debate. Issues such as job loss or bureaucracy/government control can have a damaging effect on overall support of the plan if they are not challenged. We should determine the most serious of these issues and continue the team approach within and outside the Administration to deal with them. These are not battles where the President and First Lady should be engaged.

The President and First Lady should focus on the big picture and the fundamental choices, not draw lines in the sand on details or get caught in legislative minutiae. The President and First Lady should focus on the moral imperative behind the plan and its fundamental principles. They should take on the status quo -- those who say there is no health care crisis -- and pose the fundamental choices between the Clinton Plan and the alternatives. But surrogates should be assigned the more detailed critiques of the other plans, the discussion of the legislative 'play by play' and the case for important aspects of the plan.

We must target our resources to ensure that we hit specific legislative targets as well as demographic targets, seniors and union members. That means every resource we have -- from the President's and the First Lady's schedules to the phone time of surrogates -- must be carefully focused on and organized around specific legislative targets and toward seniors and union members whose support is critical but who now need reassurance that their benefits will be protected by the President's plan. Further, this means that the President must provide that reassurance; his schedule must include events with seniors and we must organize surrogates, particularly union leaders, to help reassure their members.

HOW TO CHARACTERIZE THE CLINTON PLAN

There are several important points to convey to the American people about the President's approach to health care reform and about the definition of that reform. These are not principles to fight for or battles to engage in with our opponents. Rather, these are reassuring descriptions of the approach and process embodied in the Clinton Plan.

* The Clinton Plan offers a system of guaranteed private insurance. It builds on the current system with two critical changes:

  First, the guarantee of comprehensive health insurance that you can never lose

  Second, greater consumer power for people and small businesses to choose quality health insurance at lower cost

* The Clinton Plan preserves what works in America's health care system, and fixes what's broken.

* The Clinton Plan will be phased in over a few years to make sure the reforms are done right.

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CLINTON PLAN	COMPARISON
The President's plan is good for seniors.	The other plans threaten seniors with less coverage and higher bills. They raid Medicare to use the money to pay other bills unrelated to health care.
The President's plan maintains Medicare.	The other plans threaten to raise Medicare premiums and reduce coverage.
The President's plan provides new coverage for prescription drugs and some long term care.	The other plans don't provide any prescription drug or long term care benefit.
The President's plan ensures that insurance companies won't be able to charge older people more than younger people.	Because they don't cover everyone, the other plans allow insurance companies to continue to charge older people more than younger people.
The President's plan invests savings in Medicare to improve benefits for seniors.	The other plans cut Medicare without investing the savings in new benefits.

The most powerful positioning for the Clinton Health Care plan combines insurance for everyone with a critique of the insurance companies. It is important for the President, the First Lady and our supporters in the Congress to set out what is at stake: with Clinton, insurance companies will no longer be allowed to drop or refuse you, jack-up your rates because of your medical history or just because you got older; the other plans still allow insurance companies to pick and choose whom they will cover. That is the choice.

(NOTE: This full positioning only describes the contrast with the Republican plan but the lack of lifetime limits, and the continued ability of insurance companies to charge older people more than younger people accurately describes the contrast with all of the other plans.)

ROLES IN THE DEBATE

o **THE PRESIDENT AND FIRST LADY**

The President and the First Lady, better than anyone else, can convey a real understanding and recognition of the health care crisis and reinforce the principles of the plan. They can provide reassurance and clarity to the American people about what is in the plan: coverage for every American, the guarantee of comprehensive benefits they can never lose, etc. They can take on the status quo as those who won't be straight with the American people about the plan, the insurance companies or the extreme right wing. In fact, they should not be shy about this challenge because it helps define what we stand for. Events and speeches must reinforce these broad themes without involving the President and the First Lady in the daily exchanges or the details of the negotiations -- public and private. It is critical that the President and the First Lady be directly involved in a series of events to reassure seniors and union workers.

o **SURROGATES**

Surrogates must be responsible for carrying more specific messages and sharper attacks. They can do the detail work. That means being more specific about the contrasts between the President's plan and the other plans. This is an enormous task. Specific assignments must be given that include surrogates at every level -- Cabinet, sub-Cabinet, and supportive Members of Congress, Governors, Mayors, and outside groups. In this specific time frame -- between the State of the Union and when Congressional Committee are expected to begin marking up bills -- there are specific messages where surrogates must be focused.

> **Without an employer mandate, universal coverage is impossible to achieve.**
(Surrogates: labor, doctors, nurses, emergency room physicians, religious leaders, single payor advocates, business leaders such as car companies; Lloyd Bensten, Ron Brown, Bob Rubin, Erskine Bowles, Roger Altman; as well as Members of Congress and state and local leaders TBD.)

> **The President's plan protects Medicare and provides seniors with new benefits for prescription drugs and long term care. And, because it includes universal coverage and real controls to prevent health insurance costs from rising faster than inflation, it protects seniors from paying more or losing coverage.**
(Surrogates: senior groups, disability groups, dread diseases groups, home health care industry, pharmacy groups; Donna Shalala, Ron Brown, Dick Riley, Henry Cisneros, Phil Lee, Fernando Torres Gill; as well as Members of Congress and state and local leaders TBD.)

NEUTRALIZERS

For those issues that we must "fight to a draw," we must identify those people who will be responsible for "neutralizing" our opponents. These are issues that should not define the debate but on which we must challenge. Gene Sperling already has worked effectively to assemble a team with Bob Rubin, Laura Tyson, and others. This effort should be reinforced and focused on those issues where the President's plan already has been and will be under attack.

> Too much bureaucracy/mandated alliances

> Rations care

> Job loss

> Higher health insurance costs

This is an extremely important area, because it is an area of greatest doubt for the American people. We can answer these doubts by talking about how the plan limits insurance premiums to the rate of inflation -- health care costs can no longer rise faster than wages; and, by taking up the attack on fraud and the new penalities in the plan for fraud. The issue of fraud also is very powerful on its own and has great potential because of what it says about our approach to health care costs -- the attack on fraud says we're conservative because we're attacking fraud in the system.

ELITES AND OUTSIDE GROUPS STRATEGY

We have allowed elite opinion, national media, business CEOs and academic economists, many of whom should support comprehensive health reform, to conclude that our plan is too bureaucratic and radical and that a "Cooper" type "Clinton-lite". If the flaws of the Copper and Chafee bills become apparent, this could lead them to favor incremental over comprehensive reform.

The Media:

We alienated the Washington media early on by not being more open to them last year. Many of them are intimidated by the complexity of the subject.

With the media, there is no substitute for direct, frequent outreach. WE have compiled a list of key national media figures and have assigned people to "adopt" them for the duration of the health care battle. (exhibit)

In addition, we will schedule regional briefings (monthly) with the editorial boards of the networks, The New York Times, The Washington Post, Newsweek, Time, U.S. News, Business Week, and Fortune.

Through media affairs, we should also reach out on a regional basis directly to t.v., radio talk and newspaper reporters in targeted states and districts.

Business:

The small business community will be divided on health reform with the very powerful forces -- the NFIB, the Restaurant Association and the insurance agents --- unilaterally opposed.

We should continue to develop lists of supportive small businesses from around the country and schedule periodic events to partially neutralize the opposition.

we should make significant efforts to keep the Chamber in a constructive mode, particularly on the employer mandate, though their leadership will be under pressure to oppose us. We should also create some public events for supportive small business associations and should consider some easy and supportable policy changes early to increase the number of small business groups who will actively support us --- truckers, movers, realtors, homebuilders, beauticians, florists, etc.; we should try to create some media interest in what would be counterintuitive support of small business for our plan.

The large business community has been our most disappointing group. While some CEOs have legitimate concerns where we failed to make changes they proposed which are justified, an even greater number appear to be reacting to ideologically to oppose what they perceive as a big social program.

Large companies who have an interest in continuing high-tech research cost growth -- insurance, pharmaceutical and medical device companies --- are combining with companies such as PEPSICO,

I am sure that this is not news to any of you. Every person in this room--whether you are a first year intern or a doctor with thirty years of service-- is all too familiar with the defects of our current health care system.

Lynn- insert specific concerns here.

All of you know that change is necessary, and that it is inevitable. We cannot stop change from occuring, but we must work together to make sure that it works for all Americans. This is the challenge we now face, and I believe that the American people will rise to meet it.

(This Administration has always understood the importance of change)
The President's approach to health care reform builds on a very simple principle--as the doctor at St Agnes said, "if it ain't broke, don't fix it". We are committed to building on what works in our system. And there can be no doubt-- we have the best health care system in the world for those who can afford to access it. My recent visits to health care facilities in other countries made me more proud than ever of the health care we provide in the United States. **(Twinning program)**

But as the rest of the world looks to our example, we must make sure our actions remain exemplary. We must fix what is wrong with our current system before it undermines even further what is right.

The President believes that his approach will do this. His approach builds on our current system with two critical changes: First, it offers the guarantee of comprehensive health insurance that can never be taken away. It will provide <u>real</u> health security. (Unlike other proposals) the President's approach makes it illegal for the insurance companies to decide who gets coverage and how much they pay. It ends lifetime limits on coverage, ensuring that health care will bethere when you need it.

Second, it offers greater consumer power for people and small businesses to choose quality health insurance at lower cost.
(do we need to expand here?
specific gains for the medical community?

Is there any discussion of alternative plans?

D. LEGISLATIVE STRATEGY

Ideally, the strategy we are outlining is premised on the belief that it is in our interest to postpone for as long as possible in the legislative process the hard negotiations on specific elements of the reform proposal.

In the House, we hope that major substantive decisions can be made after the three major committees have marked up their competing versions of the bill.

We can at that point work with the leadership and Rules Committee to pull together a bill for floor consideration which has the best chances to gather majority support on the House floor.

Although it is unlikely that we will be able to escape all serious negotiations at the committee level, it is our goal to minimize these accommodations early in the process to preserve our negotiating strength. It is our intention to confirm this strategy in meetings between the President, Speaker, and Majority Leader before the State of the Union.

The most significant implication of this strategy is that there will be major legislative battles and accommodations reached in each committee which may be construed as substantial setbacks for the Administration unless we devise a communications strategy which anticipates and deflects it.

Assuming this is taken into account, we are recommending that the committee hearings be used to emphasize particular thematic principles and favorable plan comparisons where possible.

House Energy and Commerce:
Comparison of administrative complexity among plans
Insurance reforms: lifetime limits, community rating, et al

House Ways and Means:
Explore cost control options/comparison between price controls and premium caps
Comprehensive benefits which can never be taken away

House Education and Labor
Security/Employer mandate
Retiree health benefits

Senate Finance:
Employer mandate
Cost Controls
Insurance reform

Senate Education and Labor:
Comprehensive benefits
Seniors

DEMOCRATIC NATIONAL COMMITTEE STRATEGY

TO BE DETERMINED

These people are not just statistics. They are not just pawns in a political game. They're not faceless numbers tossed around by economists. They are real people with real problems. And their problems will become our problems if we don't have the courage to accept this crisis and deal with it once and for all.

Fortunately, history has been forgiving enough to give us yet another fresh chance to achieve real health care reform. Real reform that will guarantee health insurance for everyone. Real reform that will make it illegal for insurance companies to decides who gets coverage and how much they pay. Real reform that will not allow insurers to place lifetime limits on your coverage. Real reform that will provide a comprehensive benefits package, including coverage for preventive care and prescription drugs. Real reform that will ensure that patients retain their choice of health pla

Try telling

General Mills, K-Mart, etc., who have large uninsured populations and who are receiving support from companies with conservative CEOs like GE, to create a strong push against us at the BRT, NAM and elsewhere.

We must move quickly to counter these developments.

- We should bring together a group of former junior CEOs who will support our plan for a visible event with the President of First Lady. we could probably assemble 25 CEOs at this point from among administration friends, early retiree beneficiaries and other corporate supporters. The meeting of supportive CEOs with the First Lady on Wednesday is a good starting point for this effort.

- We should continue our work with an expanded group of influential companies to determine potential changes in the bill which might bring a broader group of supporters. The "Atkins" group, ERIC and the ad hoc group we have assembled are the best potential groups for us to engage.

- We should continue efforts to get NAM and BRT to 'keep their powder dry" over the next 6 to 8 weeks. We need a better coordinated effort with friendly congressional leaders over the next three weeks with BRT board members. We should investigate further whether a First Lady speech to the NAM board can forestall any action on their part.

Academic Economists:

We have gained considerable ground with academic economists since our leaked report in early September. We now have an active cadre who support us and will characterize our plan as "not flawless but far better than any other."

We will coordinate more frequent op eds and a supportive economists letter and the development of a more active surrogate speaker schedule.

I couldn't sign it. And 30 days after that, they sent me one just as bad. I had to sign it, because they quit and went home.

They said, when OPA died, that prices would adjust themselves for the benefit of the country. They have been adjusting themselves all right! They have gone all the way off the chart in adjusting themselves, at the expense of the consumer and for the benefit of the people that hold the goods.

I called a special session of the Congress in November 1947—November 17, 1947—and I set out a 10-point program for the welfare and benefit of this country, among other things standby controls. I got nothing. Congress has still done nothing.

Way back 4½ years ago, while I was in the Senate, we passed a housing bill in the Senate known as the Wagner-Ellender-Taft bill. It was a bill to clear the slums in the big cities and to help to erect low-rent housing. That bill, as I said, passed the Senate 4 years ago. It died in the House. That bill was reintroduced in the 80th Congress as the Taft-Ellender-Wagner bill. The name was slightly changed, but it is practically the same bill. And it passed the Senate, but it was allowed to die in the House of Representatives; and they sat on that bill, and finally forced it out of the Banking and Currency Committee, and the Rules Committee took charge, and it still is in the Rules Committee.

But desperate pleas from Philadelphia in that convention that met here 3 weeks ago couldn't get that housing bill passed. They passed a bill they called a housing bill, which isn't worth the paper it's written on.

In the field of labor we needed moderate legislation to promote labor-management harmony, but Congress passed instead that so-called Taft-Hartley Act, which has disrupted labor-management relations and will cause strife and bitterness for years to come if it is not repealed, as the Democratic platform says it ought to be repealed.

On the Labor Department, the Republican platform of 1944 said, if they were in power, that they would build up a strong Labor Department. They have simply torn it up. Only one bureau is left that is functioning, and they cut the appropriation of that so it can hardly function.

I recommended an increase in the minimum wage. What did I get? Nothing. Absolutely nothing.

I suggested that the schools in this country are crowded, teachers underpaid, and that there is a shortage of teachers. One of our greatest national needs is more and better schools. I urged the Congress to provide $300 million to aid the States in the present educational crisis. Congress did nothing about it. Time and again I have recommended improvements in the social security law, including extending protection to those not now covered, and increasing the amount of benefits, to reduce the eligibility age of women from 65 to 60 years. Congress studied the matter for 2 years, but couldn't find the time to extend or increase the benefits. But they did find time to take social security benefits away from 750,000 people, and they passed that over my veto.

I have repeatedly asked the Congress to pass a health program. The Nation suffers from lack of medical care. That situation can be remedied any time the Congress wants to act upon it.

Everybody knows that I recommended to the Congress the civil rights program. I did that because I believed it to be my duty under the Constitution. Some of the members of my own party disagree with me violently on this matter. But they stand up and do it openly! People can tell where they stand. But the Republicans all professed to be for these measures. But Con-

gress failed to act. They had enough men to do it, they could have had cloture, they didn't have to have a filibuster. They had enough people in that Congress that would vote for cloture.

Now everybody likes to have low taxes, but we must reduce the national debt in times of prosperity. And when tax relief can be given, it ought to go to those who need it most, and not those who need it least, as this Republican rich man's tax bill did when they passed it over my veto on the third try.

The first one of these was so rotten that they couldn't even stomach it themselves. They finally did send one that was somewhat improved, but it still helps the rich and sticks a knife into the back of the poor.

Now the Republicans came here a few weeks ago, and they wrote a platform. I hope you have all read that platform. They adopted the platform, and that platform had a lot of promises and statements of what the Republican Party is for, and what they would do if they were in power. They promised to do in that platform a lot of things I have been asking them to do that they have refused to do when they had the power.

The Republican platform cries about cruelly high prices. I have been trying to get them to do something about high prices ever since they met the first time.

Now listen! This is equally as bad, and as cynical. The Republican platform comes out for slum clearance and low-rental housing. I have been trying to get them to pass that housing bill ever since they met the first time, and it is still resting in the Rules Committee, that bill.

The Republican platform favors educational opportunity and promotion of education. I have been trying to get Congress to do something about that ever since they came there, and that bill is at rest in the House of Representatives.

The Republican platform is for extending and increasing social security benefits. Think of that! Increasing social security benefits! Yet when they had the opportunity, they took 750,000 off the social security rolls!

I wonder if they think they can fool the people of the United States with such poppycock as that!

There is a long list of these promises in that Republican platform. If it weren't so late, I would tell you all about them. I have discussed a number of these failures of the Republican 80th Congress. Every one of them is important. Two of them are of major concern to nearly every American family. They failed to do anything about high prices, they failed to do anything about housing.

My duty as President requires that I use every means within my power to get the laws the people need on matters of such importance and urgency.

I am therefore calling this Congress back into session July 26th.

On the 26th day of July, which out in Missouri we call "Turnip Day," I am going to call Congress back and ask them to pass laws to halt rising prices, to meet the housing crisis—which they are saying they are for in their platform.

At the same time I shall ask them to act upon other vitally needed measures such as aid to education, which they say they are for; a national health program; civil rights legislation, which they say they are for; an increase in the minimum wage, which I doubt very much they are for; extension of the social security coverage and increased benefits, which they say they are for; funds for projects needed in our program to provide public power and cheap electricity. By

indirection, this 80th Congress has tried to sabotage the power policies the United States has pursued for 14 years. That power lobby is as bad as the real estate lobby, which is sitting on the housing bill.

I shall ask for adequate and decent laws for displaced persons in place of this anti-Semitic, anti-Catholic law which this 80th Congress passed.

Now, my friends, if there is any reality behind that Republican platform, we ought to get some action from a short session of the 80th Congress. They can do this job in 15 days, if they want to do it. They will still have time to go out and run for office.

They are going to try to dodge their responsibility. They are going to drag all the red herrings they can across this campaign, but I am here to say that Senator Barkley and I are not going to let them get away with it.

Now, what that worst 80th Congress does in this special session will be the test. The American people will not decide by listening to mere words, or by reading a mere platform. They will decide on the record, the record as it has been written. And in the record is the stark truth, that the battle lines of 1948 are the same as they were in 1932, when the Nation lay prostrate and helpless as a result of Republican misrule and inaction.

In 1932 we were attacking the citadel of special privilege and greed. We were fighting to drive the money changers from the temple. Today, in 1948, we are now the defenders of the stronghold of democracy and of equal opportunity, the haven of the ordinary people of this land and not of the favored classes or the powerful few. The battle cry is just the same now as it was in 1932, and I paraphrase the words of Franklin D. Roosevelt as he issued the challenge, in accepting nomination in Chicago: "This is more than a political call to arms. Give me your help, not to win votes alone, but to win in this new crusade to keep America secure and safe for its own people."

Now my friends, with the help of God and the wholehearted push which you can put behind this campaign, we can save this country from a continuation of the 80th Congress, and from misrule from now on.

I must have your help. You must get in and push, and win this election. The country can't afford another Republican Congress.

NOTE: The President spoke at 2 a.m. in Convention Hall in Philadelphia. The address was carried on a nationwide radio broadcast.

161 Statement by the President Upon the Death of General Pershing. *July 15, 1948*

IT BECOMES my sad duty to announce that John J. Pershing, General of the Armies of the United States, a great American, died this morning at Walter Reed General Hospital in Washington.

Embodied in General Pershing's character were all those soldierly qualities that are essential to a great captain: brilliant leadership, steadfast courage, tireless energy, unswerving loyalty, and constant devotion to duty. He had a genius for organization, as everyone who served under him will bear witness. In World War I, he led the greatest army this country had, up to that time, been called upon to assemble.

The sorrow at his passing will not be confined to his own country. Friend and foe alike have publicly paid tribute to his loyalty to duty, his ability to lead and inspire, his wisdom and courage under extreme

159 Remarks Commending Management and Labor Leaders on the Railroad Settlement. *July* 8, 1948

I WANT to congratulate you gentlemen on this settlement. It is great for our country. I wanted to see this thing settled as it should be done, by bargaining and not in any other way. You did this on your own hook, and I feel very good about it. I congratulate all of you on it. I am satisfied that you would like to have this publicly known as a settlement on your own hook, and I am going to ask you gentlemen to go out of here and tell the press exactly what happened and what the agreement is.

Again I want to congratulate you.

NOTE: The dispute was settled when the unions agreed to accept a wage increase of 15½ cents an hour for firemen and engineers and the railroads agreed to revise certain rules to the advantage of the employees. The agreement ended the 61-day period of operation and control of the railroads by the Army under Executive Order 9957 (3 CFR, 1943–1948 Comp., p. 701).

160 Address in Philadelphia Upon Accepting the Nomination of the Democratic National Convention. *July* 15, 1948

I AM SORRY that the microphones are in the way, but I must leave them the way they are because I have got to be able to see what I am doing—as I am always able to see what I am doing.

I can't tell you how very much I appreciate the honor which you have just conferred upon me. I shall continue to try to deserve it.

I accept the nomination.

And I want to thank this convention for its unanimous nomination of my good friend and colleague, Senator Barkley of Kentucky. He is a great man, and a great public servant. Senator Barkley and I will win this election and make these Republicans like it—don't you forget that!

We will do that because they are wrong and we are right, and I will prove it to you in just a few minutes.

This convention met to express the will and reaffirm the beliefs of the Democratic Party. There have been differences of opinion, and that is the democratic way. Those differences have been settled by a majority vote, as they should be.

Now it is time for us to get together and beat the common enemy. And that is up to you.

We have been working together for victory in a great cause. Victory has become a habit of our party. It has been elected four times in succession, and I am convinced it will be elected a fifth time next November.

The reason is that the people know that the Democratic Party is the people's party, and the Republican Party is the party of special interest, and it always has been and always will be.

The record of the Democratic Party is written in the accomplishments of the last 16 years. I don't need to repeat them. They have been very ably placed before this convention by the keynote speaker, the candidate for Vice President, and by the permanent chairman.

Confidence and security have been brought to the people by the Democratic Party. Farm income has increased from less than $2½ billion in 1932 to more than $18 billion in 1947. Never in the world were the farmers of any republic or any kingdom or

any other country as prosperous as the farmers of the United States; and if they don't do their duty by the Democratic Party, they are the most ungrateful people in the world!

Wages and salaries in this country have increased from 29 billion in 1933 to more than $128 billion in 1947. That's labor, and labor never had but one friend in politics, and that is the Democratic Party and Franklin D. Roosevelt.

And I say to labor what I have said to the farmers: they are the most ungrateful people in the world if they pass the Democratic Party by this year.

The total national income has increased from less than $40 billion in 1933 to $203 billion in 1947, the greatest in all the history of the world. These benefits have been spread to all the people, because it is the business of the Democratic Party to see that the people get a fair share of these things.

This last, worst 80th Congress proved just the opposite for the Republicans.

The record on foreign policy of the Democratic Party is that the United States has been turned away permanently from isolationism, and we have converted the greatest and best of the Republicans to our viewpoint on that subject.

The United States has to accept its full responsibility for leadership in international affairs. We have been the backers and the people who organized and started the United Nations, first started under that great Democratic President, Woodrow Wilson, as the League of Nations. The League was sabotaged by the Republicans in 1920. And we must see that the United Nations continues a strong and growing body, so we can have everlasting peace in the world.

We removed trade barriers in the world, which is the best asset we can have for peace. Those trade barriers must not be put back into operation again.

We have started the foreign aid program, which means the recovery of Europe and China, and the Far East. We instituted the program for Greece and Turkey, and I will say to you that all these things were done in a cooperative and bipartisan manner. The Foreign Relations Committees of the Senate and House were taken into the full confidence of the President in every one of these moves, and don't let anybody tell you anything else.

As I have said time and time again, foreign policy should be the policy of the whole Nation and not the policy of one party or the other. Partisanship should stop at the water's edge; and I shall continue to preach that through this whole campaign.

I would like to say a word or two now on what I think the Republican philosophy is; and I will speak from actions and from history and from experience.

The situation in 1932 was due to the policies of the Republican Party control of the Government of the United States. The Republican Party, as I said a while ago, favors the privileged few and not the common everyday man. Ever since its inception, that party has been under the control of special privilege; and they have completely proved it in the 80th Congress. They proved it by the things they did *to* the people, and not *for* them. They proved it by the things they failed to do.

Now, let's look at some of them—just a few.

Time and time again I recommended extension of price control before it expired June 30, 1946. I asked for that extension in September 1945, in November 1945, in a Message on the State of the Union in 1946; and that price control legislation did not come to my desk until June 30, 1946, on the day on which it was supposed to expire. And it was such a rotten bill that

MEMORANDUM

To: Chris Jennings, The White House
From: Uwe E. Reinhardt, Princeton University
Subject: Intro piece by the First Lady
Date: January 12, 1993

Dear Chris:

The truly important message the First Lady might convey in a foreword or intro piece would be to drive home, once more, the following points which seem to get lost, from time to time, in our nitpicking over technical points.

First, the notion that there is "no health crisis" now being marketed by some would be news to the many Americans who either not have access to proper health care or, if they do, who find themselves near or in bankruptcy after a bout of serious illness.

- In an article published by Jack Hadley, Jude Feder et al. in JAMA, they showed pretty clearly that, after adjustment for all other factors that impact on morbidity, uninsured Americans die at up to three times the rate from identical illnesses than do similarly situated but insured Americans. Recently, another study of this sort was published in JAMA. I attach a write up. In the face of such statistics, it is cruel and irresponsible to argue that lack of health insurance does not imply lack of health care. Americans must recognize that our health system does ration life years and quality life on the basis of income and price for many low-income Americans. If we want to do this fine; let's acknowledge it. People who deny it, however, we are fit for damnation.

- Even if the uninsured did have access to proper health care, there remains the problem that they would be hounded by medical bills. It may not be well known that medical bills are one of the most prominent sources of personal bankruptcy in the United States. We are truly unique in that respect in the developed world.

Second, the argument that most Americans are well insured by the private sector is bogus. It, too, will be news to people who have recently been laid off. Americans not on government programs such as Medicare or Medicaid are are not "well insured;" they are "unsured" in the sense that they lose that insurance when they lose their jobs. The notion that COBRA 89 takes care of the problem, because an unemployed can purchase his/her private coverage from the old company at the old group rate *but with the unemployed's own money* is as cruel as it is ridiculous. It is Marie-Antoinetteism at its finest, for it reminds one of Marie Antoinette cute remark "Let them eat cake!" As more and more Americans are being restructured out of their jobs, they need truly portable insurance that is also affordable to them during spells of unemployment.

The First Lady should remind us economists (and others like us) that it is honorable and good to debate the many technical details of the proposal, but that we must never lose sight of the central thrust of the President's endeavor: to give every Americans the peace of mind that proper health care will be available in the hour of need and that the family will not go broke as a result of illness. Technical changes that will deflect us from this goal--e.g., a shift to a form of financing that does not guarantee portable universal coverage--is simply not acceptable and should not be acceptable to economists either. That is tinkering, not health reform. The fundamental question Americans should ask themselves is one I raised at Annapolis: who should bear the risk for our possible failure to control health-care costs: Americans in general, or the uninsured, among them working mothers? It is astounding how many well paid, well insured men would elect the working mother to assume that risk taking. And that in John Wayne country! It is time we move from celluloid decency to real life decency.

To: Hillary Rodham Clinton
Fr: Bob Boorstin and Jason Solomon
Date: January 12, 1994

Re: Health Affairs Introduction

Uwe Reinhardt, who contributed to and helped put together the next issue of Health Affairs, asked Chris Jennings if you might be able to write an introduction to the issue, which contains articles almost all about the Clinton plan. Reinhardt suggested that your introduction remind the academics who tend to read this stuff that people -- not theories and statistics -- are at the center of this debate. He sent along ideas about what your introduction might say. (see attached) And we have attached a draft.

Reinhardt also co-authored an introduction with the editor of the journal. (see attached) As you know, Reinhardt has been very supportive recently, and an introduction by you is not only a way to reach "opinion leaders" on health policy but also to thank him for his continued support.

Included in the issue will be articles from Administration officials such as Walter Zelman, Alice Rivlin, Rick Kronick and Bernie Arons about our proposal. The Table of Contents is attached.

If you could review this draft and give us your comments, that would be great. Thanks.

Comparison of Uninsured and Privately Insured Hospital Patients

Condition on Admission, Resource Use, and Outcome

Jack Hadley, PhD; Earl P. Steinberg, MD, MPP; Judith Feder, PhD

To investigate the association between insurance status and condition on admission, resource use, and in-hospital mortality, we analyzed discharge abstracts for 592 598 patients hospitalized in 1987 in a national sample of hospitals. In 13 of 16 age-sex-race–specific cohorts, the uninsured had a 44% to 124% higher risk of in-hospital mortality at the time of admission than did the privately insured. After controlling for this difference, the actual in-hospital death rate was 1.2 to 3.2 times higher among uninsured patients in 11 of 16 cohorts. The uninsured also were 29% to 75% less likely to undergo each of five high-cost or high-discretion procedures and 50% less likely to have normal results on tissue pathology reports for biopsies performed during five of seven different endoscopic procedures. Our results suggest that insurance status is associated with a broad spectrum of aspects of hospital care.

(*JAMA*. 1991;265:374-379)

INCREASING evidence suggests that the amount and content of medical care that an individual receives in the United States is related to whether the individual has health insurance.[1] Previous studies, for example, although uncontrolled for differences between groups in clinical status and need for services on admission, have shown that the uninsured have fewer physician visits per year, are less likely to have a hospital stay, and, if hospitalized, have a shorter length of stay than insured individuals.[2-4] Other studies have shown that, even after controlling for differences in admission diagnosis, the services that uninsured individuals receive are different from those that insured individuals receive.[5,6] In a recent analysis of 1983 hospital discharge data for 65 032 uninsured, Blue Cross, and Medicare patients hospitalized in the Boston area, for example, Weissman and Epstein[5] found, after adjusting for case mix, that insured patients had 7% shorter stays and underwent 7% fewer procedures than Blue Cross patients. More recently, Wenneker et al[6] found, after controlling for clinical and demographic factors, that insurance status was strongly associated with utilization of three expensive cardiac procedures among 28 000 patients admitted to Massachusetts hospitals in 1986 with circulatory disorders or chest pain. Very few data are available regarding differences in health outcomes among insured vs uninsured patients.[4]

The goal of this study is to identify whether there are statistically significant differences between uninsured and privately insured patients in three sets of factors related to hospital care: condition on admission, resources used in the hospital, and outcome. Specifically, we ask whether the uninsured are sicker when admitted to the hospital; whether fewer resources are expended on their care in the hospital, given their condition on admission; and whether they have a poorer outcome, given their condition on admission.

The research reported herein extends prior work in four important ways. First, we used a large national sample of 592 598 hospital discharges to compare the characteristics of hospital care received by uninsured and privately insured patients. Thus, our findings should be more generalizable to the nation's uninsured than those of studies based on a single, relatively small geographic area, such as Boston or Massachusetts. Second, the only previous study that has examined insured vs uninsured patients' use of high-cost procedures focused exclusively on three cardiac procedures.[6] In contrast, while controlling for diagnosis, we analyzed the frequency with which a broad spectrum of high-cost invasive and noninvasive procedures are provided to insured vs uninsured hospitalized patients. Third, we used multiple measures of condition on admission and resource use, which allow us to explore these factors in greater depth. Finally, we examined differences between the uninsured and privately insured in in-hospital death rates, an important measure of outcome.

DATA, VARIABLES, AND STATISTICAL METHODS

Data

The data set was derived from discharge abstracts submitted to the Commission on Professional and Hospital Activities, which is a research and data abstracting service for hospitals, by its member hospitals in 1987. The entire Commission on Professional and Hospital Activities 1987 database includes over 10 million discharge abstracts from approximately 1200 hospitals. For this study, we examined only discharges for people between the ages of 1 and 64 years whose primary source of payment was no charge, self-pay, Blue Cross, insurance company, or Medicaid and whose race was white, black, or Hispanic. Discharges for which any of this in-

From the Center for Health Policy Studies, Georgetown University School of Medicine, Washington, DC (Drs Hadley and Feder), and The Johns Hopkins Program for Medical Technology and Practice Assessment, The Johns Hopkins University, Baltimore, Md (Dr Steinberg).

Reprint requests to Center for Health Policy Studies, 2233 Wisconsin Ave NW, Suite 525, Washington, DC 20007 (Dr Hadley).

formation was unrecorded were deleted from our data set. We excluded newborns, infants under the age of 1 year, and women with a pregnancy-related diagnosis because these discharges account for a much higher proportion of uninsured cases than of privately insured cases.[9] We believed that without such exclusions, aggregate measures of case severity might be misleading.

The data file used in our statistical analyses consisted of all no charge and self-pay discharges plus a 5% random sample of all other discharges. (The sampled records were weighted by the inverse of their sampling probability in all analyses.) There were 592 598 discharges in this file. For some parts of our study, attention was limited to discharges with particular diagnoses or in which particular procedures were performed.

Variables

We defined "uninsured patients" as those having either no charge or self-pay listed as the primary source of payment and "privately insured patients" as those having either Blue Cross or an insurance company listed as the primary source of payment. Our database and statistical analyses also included Medicaid patients as another insured group. However, we only report results associated with uninsured and privately insured patients because it is very difficult to draw conclusions about the insurance effects of Medicaid without state-specific information on Medicaid coverage and payment policies, which vary substantially across states.[11,12]

The analysis consists of a series of comparisons of specific measures, constructed from the discharge abstract form, which can be interpreted as providing evidence regarding condition on admission, resource use, or outcome. The dependent variables, which we analyzed using multiple regression methods, are summarized in Table 1 and discussed below.

Risk-Adjusted Mortality Index.—The Risk-Adjusted Mortality Index (RAMI), developed by the Commission on Professional and Hospital Activities, is the *expected* in-hospital mortality rate based on actual in-hospital mortality rates for diagnoses, grouped by their diagnosis related group code, adjusted for patient age, race, sex, the presence of comorbidities (secondary diagnoses at time of admission), and the risk of death associated with comorbidities and the principal operative procedure (if any).[13] A higher RAMI value can be interpreted as representing a more severely ill patient.[13]

Probability of a Weekend Admission.—The choice of the second measure of condition on admission is based on the hypothesis that a weekend (Friday through Sunday) admission is likely to be more urgent than a weekday admission. In other words, we assumed that elective admissions are more likely to occur during a weekday because of private physicians' schedules, patient preferences, and hospital staffing patterns. Although many scheduled admissions are for serious conditions, we posited that, on average, they are less urgent or immediately life-threatening than the average weekend admission.

Average Length of Stay.—Length of stay is a common measure of resource use. However, even when controlling for diagnosis, length of stay can reflect the severity of a patient's condition as well as the level of resource use for a patient with a given level of severity. We attempted to control for the effects of severity by focusing the analysis of length of stay on diagnoses that have either a high or a low degree of physician discretion with regard to the need for a hospitalization. Using both prior literature[14-17] and clinical judgment, we initially selected 28 diagnoses thought to differ in the amount of discretion, from the physician's perspective, in the need for a hospital admission. Relatively high-discretion diagnoses may be thought of as being more elective, while relatively low-discretion diagnoses may be considered nonelective.

We then used linear regression models for each of the 28 diagnoses to estimate the RAMI for the uninsured, controlling for age, sex, race, hospital size, ownership, teaching status, and type of community. The 10 diagnoses reported in the analysis are the ones with the five lowest and five highest predicted RAMI scores derived from the regression models. Estimating length of stay equations separately for each diagnosis decreases the likelihood that differences in resource use will be obscured by differences in diagnostic mix between uninsured and privately insured patients.

Probability of a High-Cost and/or High-Discretion Procedure.—If insurance coverage affects resource use, we hypothesized that the uninsured would be less likely to be admitted for procedures that are very costly and/or somewhat discretionary in terms of their clinical necessity. Using these criteria, we selected five procedures—coronary artery bypass graft surgery, total knee replacement, total hip replacement, stapedectomy, and surgical correction of strabismus—and tested whether the probability of undergoing each of these procedures varies with insurance status. We used our entire sample of discharges, rather than those associated with a limited number of primary diagnoses, for these analyses because we wished to examine the probability that each of these procedures was performed for any reason.

Probability of a Specific Procedure Associated With a Particular Set of Diagnoses.—To better control for the effects on resource use of variations in the mix of diagnoses across groups of patients with different insurance status, we analyzed the probability of a patient's receiving a particular procedure or set of procedures after limiting the sample to discharges with a narrowly defined set of *International Classification of Diseases, Version 9*, codes as the primary discharge diagnosis. Five separate samples of discharges, each with a different set of limited diagnoses, were drawn. (The diagnoses in each group and the related procedure codes are shown in Table 4.) Each of these groups was analyzed separately to determine whether there was a significant difference in the use of the associated procedure between privately insured and uninsured patients.

We also examined two procedures that are often performed in conjunction with another procedure: biopsy, which often occurs with a bronchoscopy, and intraoperative cholangiogram, performed in conjunction with a cholecystectomy. All discharges involving patients who underwent either a bronchoscopy or a cholecystectomy, respectively, are the samples we employed for these two analyses.

Probability of a 'Not Abnormal' Biopsy Result.—The last resource use measure that we examined is the probability of a tissue pathology report of "not abnormal" during hospitalizations in which any of seven different endoscopy procedures (see Table 5) and an associated biopsy were performed. (The other possible findings on the pathology report are abnormal-other, mechanical abnormality, growth alteration, degeneration and necrosis, nonacute inflammation, acute inflammation, nonmalignant neoplasm, and malignant neoplasm.) We hypothesized that a relatively higher probability of a "not abnormal" finding in a tissue pathology report for one group of patients is suggestive of a more aggressive management strategy's being employed in the care of that group of patients compared with a reference group. This hypothesis assumes that the clinical threshold for performing the test and doing a biopsy is lower for the group of patients with the higher probability of "not abnormal" findings in tissue pathology reports than for the other group of patients.

Table 1.—Dependent Variables: Measures of Condition on Admission, Resource Use, and Outcome

Condition on Admission
Risk-Adjusted Mortality Index
Probability of a weekend admission
Resource Use
Average length of stay for each of 10 specific diagnoses
Incidence of selected high-cost or high-discretion procedures
Coronary artery bypass graft surgery
Total knee replacement
Total hip replacement
Stapedectomy
Surgical correction of strabismus
Incidence of selected procedures, controlling for diagnosis
Colonoscopy or proctosigmoidoscopy
Upper endoscopy procedures
Coronary arteriography
Contrast myelogram or CT* of spine
Head CT
Bronchoscopy with biopsy
Cholecystectomy with intraoperative cholangiogram
Tissue pathology of "not abnormal" for biopsy specimens obtained during selected endoscopic procedures
Outcomes
In-hospital death rate

*CT indicates computed tomography.

Table 2.—Measures of Condition on Admission: Regression-Adjusted Coefficients for Uninsured Relative to Privately Insured by Age-Sex-Race Cohort*

Sex, Age, and Race	Unweighted N	Relative Regression-Adjusted Coefficient: Risk-Adjusted Mortality Index	Relative Regression-Adjusted Coefficient: Probability of a Weekend Admission
Males			
Age 1-17 y			
White	36 527	1.57	1.18†
Black	6813	1.56‡	1.00
Age 18-34 y			
White	74 514	1.62†	1.22†
Black	17 614	2.06†	1.24†
Age 35-49 y			
White	46 428	1.80†	1.17†
Black	11 284	1.89†	1.27†
Age 50-64 y			
White	64 417	1.45†	1.14†
Black	9175	1.44†	1.23†
Females			
Age 1-17 y			
White	29 724	2.00†	1.12†
Black	7098	1.81	1.12‡
Age 18-34 y			
White	72 760	1.80†	1.21†
Black	15 828	1.04†	1.24†
Age 35-49 y			
White	52 371	1.62†	1.16†
Black	11 338	2.24	1.15†
Age 50-64 y			
White	61 611	1.52†	1.11†
Black	10 395	1.56†	1.07

*Null hypothesis is that relative rate or probability equals 1.00.
†$P \leq .01$.
‡$.01 < P \leq .05$.

Outcome.—We examined one outcome measure in our analysis, the probability of dying in the hospital. Although this measure has several limitations, it is one of the most frequently used indicators of the outcome of care. This variable was analyzed using the full set of discharges stratified into 16 age-sex-race-specific cohorts.

Statistical Methods

Multiple regression analysis was used to test for statistically significant differences between uninsured and privately insured patients in the various measures of condition on admission, resource use, and outcome. The regression models included as independent variables insurance status and controls for the effects of characteristics not held constant by stratification.

The results reported in Tables 2 through 6 are based on the regression estimates of the coefficients for uninsured and privately insured patients from equations of the following general form:

$$Y = \alpha U + \beta PI + \Sigma \mu_i X_i$$

where Y represents a measure of condition on admission, resource use, or outcome; α, the coefficient for uninsured patients; β, the coefficient for privately insured patients; U equals 1 if the patient is uninsured, 0 otherwise; PI equals 1 if the patient is privately insured, 0 otherwise; and X_i, other control variables.

The exact list of X_i variables depends on the particular dependent variable being analyzed and the extent of the stratification. In all analyses, the individual discharge was the unit of observation.

The coefficients α and β can be interpreted as mean values of Y for uninsured and privately insured patients, respectively, adjusting for differences in Y due to the X_i variables. The primary null hypothesis throughout the analysis is that there is no difference in Y between uninsured and privately insured patients, controlling for the effects of other factors, which is equivalent to the null hypothesis $\alpha = \beta$. This hypothesis can be evaluated using a t statistic calculated from the variance-covariance matrix of the regression parameters.[18] Note that because the regression model is linear in the parameters, the test of the null hypothesis is independent of the particular values of X_i chosen to standardize the values of α and β.

The tables of results report relative regression-adjusted coefficients, which are defined as the ratio of the adjusted mean of Y for the uninsured to the adjusted mean of Y for the privately insured, again standardized for a particular set of X_i values. Mathematically this is simply $(\alpha + \Sigma \mu_i X_i)/(\beta + \Sigma \mu_i X_i)$.

For example, if the value of the ratio is 1.10, one can then say, "The rate for the uninsured is 10% greater than for the privately insured, or the probability of the uninsured's receiving a particular service is 10% greater than for the privately insured."

Controls for Factors Other Than Insurance Coverage

All analyses of differences between uninsured and privately insured patients were adjusted for age, sex, and race, either by stratification or by including age, sex, and race as control variables in the regression models. The RAMI score, the probability of a weekend admission, and the probability of an in-hospital death were analyzed separately for 16 age-sex-race-specific cohorts of discharges. The regression models for these cohort-specific analyses also included control variables for hospital size, ownership (public or private), teaching status (Council of Teaching Hospitals member), and type of community (100 largest cities, other metropolitan community, or nonmetropolitan). In addition, the analysis of the probability of a weekend admission included the RAMI score and the Medicare case-mix index as controls for possible differences in diagnostic mix and severity of illness. The analysis of in-hospital mortality included as additional control variables the RAMI score, the Medicare case-mix index, and an indicator of whether a surgical procedure was performed.

The regression model for average

Table 3.—Length of Stay: Regression-Adjusted Coefficients for Uninsured Relative to Privately Insured, by 10 Specific Diagnoses*

Diagnosis, by Degree of Physician Discretion and Estimated RAMI (ICD-9 Code)	Unweighted N	Estimated RAMI Value†	Relative Regression-Adjusted Average Length of Stay
High Physician Discretion			
Chronic tonsillitis (474.0)	3815	.001	0.88‡
Noninfectious gastroenteritis, NOS (558.9)	6460	.001	0.82‡
Acute bronchitis (466.0)	2884	.003	0.85§
Unilateral inguinal hernia (550.91)	4144	.004	0.92‡
Uterine leiomyoma, NOS (218.9)	3147	.005	0.77§
Low Physician Discretion			
Gastrointestinal hemorrhage, NOS (578.9)	1600	.028	0.89
Malignant neoplasm, bronchus/lung (162.9)	1548	.036	0.97
Congestive heart failure (428.0, 428.1, 428.9)	2788	.051	0.94
Acute myocardial infarction, inferior wall, NEC (410.4)	2512	.066	0.89‡
Acute myocardial infarction, anterior wall (410.0)	1788	.115	0.95

*Null hypothesis is that relative length of stay equals 1.00. RAMI indicates Risk-Adjusted Mortality Index; *ICD-9, International Classification of Diseases, Version 9*; NOS, not otherwise specified; and NEC, not elsewhere classified.
†Estimated values of the RAMI from a regression model that includes insurance status, age, sex, race, hospital size, ownership, teaching status, and type of community as control variables.
‡$P<.01$.
§$.01<P<.05$.

length of stay was estimated separately for each of 10 specific diagnoses. The control variables consisted of age, sex, race, hospital size, ownership, teaching status, and community type, as well as the RAMI, the Medicare case-mix index, and an indicator of whether any surgical procedure was performed. The purpose of the latter three variables is to control for differences in severity within the diagnoses analyzed. The regression model for the incidence of selected procedures and for tissue pathology outcomes included control variables for age, sex, race, hospital size, ownership, teaching status, and community type. The analyses related to the five high-cost or high-discretion procedures, as well as those related to condition on admission and in-hospital mortality, were estimated using the entire sample of 592 598 discharges. The analyses of the other procedures, length of stay, and tissue pathology outcomes were limited to discharges with selected diagnoses or procedures.

RESULTS

Condition on Admission

Table 2 reports the results from the analysis of the two measures of condition on admission, the RAMI and the probability of being admitted on a weekend. Regression-adjusted coefficients are reported for the uninsured relative to the privately insured for each of 16 age-sex-race–specific cohorts of discharges. The uninsured have a significantly higher RAMI for 13 of the 16 cohorts and a significantly higher probability of being admitted during the weekend for 14 of the cohorts. The relative coefficients thus strongly suggest differences between the uninsured patients and privately insured patients and may reflect more serious or urgent conditions among the uninsured.

Resource Use

Table 3 reports the relative lengths of stay for discharges from each of 10 selected high- and low-discretion diagnoses. The uninsured's length of stay is significantly shorter than the length of stay for the privately insured for each of the five high-physician discretion diagnoses, by 12% to 23%. Although the uninsured also have shorter stays than the privately insured for the low-discretion diagnoses, the differences are smaller, and only one is statistically significant.

In Table 4 we present further results pertinent to the question of differences in resource use between the uninsured and insured. Using the entire sample of discharges, we estimated regression models of the probability of undergoing each of five high-cost or high-discretion procedures among the privately insured and the uninsured. The results suggest highly significant and quantitatively large differences between uninsured and privately insured patients in the probability of undergoing these procedures. The uninsured are 29% less likely to have coronary artery bypass graft surgery and almost 75% less likely to have a total knee replacement. Rates for the other three procedures range from between 45% and 56% lower for the uninsured.

In Table 4, we also examine the relative use of other specific procedures, controlling for diagnosis by limiting each analysis to discharges with a specific diagnosis, group of diagnoses, or associated procedure. These analyses thus provide an opportunity to examine whether the clinical management of specific conditions varies with insurance status. In three of the 11 diagnosis-procedure combinations—colonoscopy or proctosigmoidoscopy, upper endoscopy, and coronary arteriography—there is a statistically significant difference ($P<.01$) in the probability of an uninsured person's undergoing the procedure relative to a privately insured person. In these instances, uninsured patients were from 20% to 44% less likely to have the procedure performed. We found no statistically significant difference ($P>.05$) between the uninsured and the privately insured in the use of myelography or computed tomography of the spine among patients with lumbar disk displacement, in the use of computed tomography of the head among patients with any of five diagnoses, in the incidence of biopsy among patients undergoing a bronchoscopy, or in the incidence of an intraoperative cholangiogram among patients undergoing a cholecystectomy.

In Table 5, we examine tissue pathology findings for biopsies performed during any of seven endoscopic procedures. The sample in each case consists of all discharges that had both a biopsy performed in association with the specific procedure and a tissue pathology report recorded on the discharge abstract. In each case, as well as for all the endoscopic procedures combined, we estimated the likelihood of a finding of "not abnormal," ie, the probability of a completely normal test result. As Table 5 shows, the uninsured are consistently less likely than privately insured patients to have a completely normal tissue pathology result. The differences are statistically significant in three cases. For five of the seven procedures, the relative probabilities are approximately .5 or less, ie, an uninsured person is less than half as likely as a privately insured person to have a biopsy pathology finding that is completely normal.

Outcome

In Table 6, we examine whether there are significant differences between privately insured and uninsured patients in the probability of an in-hospital death. The regression model includes as control variables the Medicare case-mix index, the RAMI, and whether the patient had a procedure, along with hospital characteristics and type of community. In this analysis we divided the full sample of discharges into 16 age-sex-race–specific groups, which were then analyzed separately.

Table 4.—Probability of Selected Procedures: Regression-Adjusted Coefficients for Uninsured Relative to Privately Insured*

Procedure (Procedure Code)	Unweighted N	Relative Regression-Adjusted Coefficient
High cost or high discretion	592 598	
Coronary artery bypass graft surgery (36.10-36.19)		0.71†
Total knee replacement (81.41)		0.25†
Total hip replacement (81.5, 81.51, 81.59)		0.55†
Stapedectomy (19.1-19.2)		0.80†
Surgical correction of strabismus (15.1-15.9)		0.44†
Colonoscopy (45.23-45.25) or proctosigmoidoscopy (48.23)	93 977	0.56†
Upper endoscopy procedures§ (42.23, 44.13, 45.13)	47 732	0.80†
Coronary arteriography‖ (88.55-88.57)	30 622	0.61†
Contrast myelogram or CT of spine¶ (87.21, 88.38)	2949	0.96
Head CT (87.03) by diagnosis		
Convulsions (DX code 780.3)	11 582	0.91#
Syncope and collapse (DX code 780.2)	4363	0.90
Concussion, NOS (DX code 850.9)	3280	0.88
Concussion without loss of consciousness (DX code 850.0)	2256	0.96
Concussion with brief loss of consciousness (DX code 850.1)	2584	1.02
Bronchoscopy (33.22, 33.23) procedures with a biopsy (33.24, 33.25)	3713	0.98
Cholecystectomies (51.22) with an intraoperative cholangiogram (87.53)	9500	0.84

*Null hypothesis is that relative coefficients equal 1.00. CT indicates computed tomography; DX, discharge diagnosis; and NOS, not otherwise specified.
†$P \leq .01$.
‡All discharges that had any of the following as the primary discharge diagnosis were considered: noninfectious gastroenteritis (DX558.9), abdominal pain (DX789.0), acute pancreatitis (DX577.0), viral enteritis (DX008.8), gastrointestinal hemorrhage (DX578.9).
§All discharges that had any of the following as the primary discharge diagnosis were considered: noninfectious gastroenteritis (DX558.9), abdominal pain (DX789.0), viral enteritis (DX008.8), acute pancreatitis (DX577.0), acute gastritis (DX535.0), gastrointestinal hemorrhage (DX578.9), esophagitis (DX530.1), atrophic gastritis (DX535.1), gastric mucosal hypertrophy (DX535.2), alcoholic gastritis (DX535.3), gastroduodenitis (DX535.5), other specified gastritis (DX535.4).
‖All discharges that had any of the following as the primary discharge diagnosis were considered: precordial pain (DX7865.1), chest pain (DX7865.0), angina pectoris (DX413.9), intermediate coronary syndrome (DX411.1), coronary atherosclerosis (DX414.0).
¶All discharges that had lumbar disk displacement (DX722.10) as the primary discharge diagnosis were considered.
#$.05 < P \leq .10$.

Table 5.—Tissue Pathology for Selected Procedures: Regression-Adjusted Coefficients for Uninsured Relative to Privately Insured*

Procedure (Procedure Code)	Unweighted N	Relative Regression-Adjusted Coefficient for Probability of "Not Abnormal" Tissue Pathology† Uninsured to Privately Insured
Esophagoscopy (42.23)	906	0.26‡
Gastroscopy (44.13)	2476	0.39‡
Proctosigmoidoscopy (48.23)	1120	0.87
Colonoscopy (45.23)	3761	0.82
Cystoscopy (57.32)	3320	0.84
Endoscopy of small intestine (45.13)	5408	0.51§
Bronchoscopy (33.22, 33.23)	2919	0.46
All above endoscopic procedures‖	19 934	0.64¶

*Null hypothesis is that relative coefficients equal 1.00.
†Possible outcomes are not abnormal, abnormal-other, mechanical abnormality, degeneration and necrosis, nonacute inflammation, acute inflammation, nonmalignant neoplasm, and malignant neoplasm.
‡$.01 < P \leq .05$.
§$.05 < P \leq .10$.
‖Includes a separate control variable for each endoscopic procedure.
¶$P \leq .01$.

Table 6.—In-Hospital Death: Regression-Adjusted Coefficients for Uninsured Relative to Privately Insured by Age-Sex-Race Cohort*

Age, Sex, Race	Unweighted N	Relative Regression-Adjusted Coefficient
Males		
Age 1-17 y		
White	38 527	1.45
Black	5813	1.25
Age 18-34 y		
White	75 514	1.34†
Black	17 614	1.92†
Age 35-49 y		
White	48 429	1.46†
Black	11 584	2.20†
Age 50-64 y		
White	64 417	1.23†
Black	9176	1.08‡
Females		
Age 1-17 y		
White	29 724	2.37‡
Black	7068	2.56†
Age 18-34 y		
White	72 760	1.48§
Black	15 826	1.80
Age 35-49 y		
White	53 571	0.92
Black	11 338	1.60‡
Age 50-64 y		
White	61 611	1.15‖
Black	10 396	1.36‡

*Null hypothesis is that relative coefficient equals 1.00.
†$P \leq .01$.
‡$.01 < P \leq .05$.
§$.05 < P \leq .10$.

In all cases but one (white women 35 to 49 years old), the uninsured have a higher relative probability of in-hospital death. Moreover, for 10 of the 16 age-sex-race-specific cohorts, the difference is statistically significant ($P \leq .05$), with the relative probabilities ranging from 1.20 to 8.20. The relative probability of in-hospital death for uninsured patients compared with privately insured patients is greater for blacks than for whites in seven of the eight age-sex cohorts.

COMMENT

Our analysis strongly suggests that an individual's condition on admission, use of resources during hospitalization, and likelihood of in-hospital death vary depending on whether the individual has health insurance. In the case of condition on admission, compared with the privately insured, the uninsured were more likely to be admitted for a condition that has a higher expected risk of death (based on the RAMI score) and appeared to be in more urgent need of care. The latter conclusion is suggested by our finding that, when differences in case mix between the uninsured and privately insured are controlled for with the Medicare case-mix index and the RAMI, the uninsured were significantly more likely to be admitted on a weekend.

Our findings regarding differences in resources expended on the hospitalized uninsured vs the hospitalized privately insured are more mixed, varying with the specific measure of resource use and the method of controlling for diagnostic mix that we employed. In our analysis of length of stay, which was based on hospitalizations for each of 10 diagnoses classified by the degree of physician discretion assumed to be involved in the decision to hospitalize, we found consistently shorter lengths of stay among the uninsured compared with the privately insured. These differences in length of stay were statistically significant for all five of the high-discretion/low-risk of death diagnoses, the category in which physicians' practices would be most likely to differ among insured vs uninsured patients, but for only one of the low-discretion/high-risk of death diagnoses.

We also found evidence of a difference

between the uninsured's and the privately insured's use of some, but not all, of the procedures we examined. For example, although we found a strikingly lower rate of performance of five high-cost and/or high-discretion therapeutic procedures (coronary artery bypass surgery, total knee replacement, total hip replacement, stapedectomy, and surgical correction of strabismus) among the uninsured compared with the privately insured in our entire sample of discharges, we found statistically significant evidence of a lower rate of use of only three (colonoscopy or proctosigmoidoscopy, upper gastrointestinal tract endoscopy, and coronary arteriography) of the seven diagnosis/diagnostic procedure pairs we examined. Our finding of a statistically significant difference in the uninsured's vs the privately insured's rate of use of some, but not all, procedures we examined and of a statistically significant difference in the uninsured's vs the privately insured's average length of stay for high- but not low-discretion hospitalizations suggests that if physicians are discriminating in the resources they expend on the uninsured and the privately insured, they may be doing so on a selective basis to minimize adverse effects on the health of the uninsured.

A similar suggestion emerges from our findings that privately insured patients were consistently more likely than uninsured patients to have completely normal tissue pathology findings on biopsy specimens obtained during any of seven different endoscopic procedures (Table 5). This latter finding strongly suggests that physicians who perform these procedures have a "lower threshold of suspicion" for performing biopsies on privately insured patients than they do on uninsured patients. One cannot infer from our data, however, that physicians' thresholds for performing a biopsy on privately insured patients are too low, or that their thresholds for performing a biopsy on uninsured patients are too high.

Finally, our analysis demonstrates that the uninsured have a higher relative risk of in-hospital death than the privately insured in 15 of 16 age-sex-race-specific cohorts, even when the Medicare case-mix index, the expected risk of death, and whether a procedure was performed are controlled for. In 10 of these 15 cohorts, the difference is statistically significant ($P<.05$). Although it is possible that this observed difference in in-hospital mortality is due to underprovision of needed medical services to hospitalized uninsured patients, the difference also could be due to differences in severity of illness between the uninsured and privately insured that are not reflected fully in the Medicare case-mix index and the RAMI. It is also possible that privately insured patients are more likely than uninsured patients to be discharged to another facility, such as a nursing home or a hospice, where death might occur shortly after discharge from the hospital.

Our results extend the findings of other studies in several ways. First, we have provided evidence that insurance coverage has an effect on resource use for a broad spectrum of clinical problems in addition to lung cancer,[4] cardiovascular disease,[5] and the acquired immunodeficiency syndrome.[6] Second, we have found evidence for differences between the uninsured and the privately insured in resource use for some, but not all, conditions, and of differences in use of some, but not all, types of resources. Although our findings of differences in average length of stay for high- but not for low-discretion hospitalizations and of a consistently higher probability of completely normal tissue pathology in biopsy specimens obtained from the privately insured vs the uninsured do not clearly indicate whether differences in the care provided to the uninsured vs the privately insured reflect "the unmet needs of some of our citizens or the overmet needs of others,"[19] they do provide empirical support of the hypothesis that insurance coverage may have a bigger impact on the use of elective or more highly discretionary services than on medically necessary care."

Finally, we have found differences between the uninsured and the privately insured in a very important measure of outcome, namely, in-hospital mortality. Our finding of a higher in-hospital mortality rate among the uninsured, even after controlling for expected risk of death at the time of admission, suggests that we should not conclude that all differences between the care provided to the uninsured vs the privately insured are due to overuse of services by the privately insured.

Clearly, there is a need for further research comparing the care provided to the uninsured vs the privately insured that employs better measures of patients' condition at the time of admission and more refined measures of the process of care as well as measures of the outcomes of care other than simply in-hospital mortality. In addition, studies of the appropriateness of care should treat insurance coverage as an important covariate in assessing both cost and outcomes of the care of specific diagnoses.

The research for this study was supported by grant No. 11260 from The Robert Wood Johnson Foundation to Georgetown University.

We gratefully acknowledge the cooperation of the Commission on Professional and Hospital Activities (CPHA), which provided the data for the analysis, and the assistance of former CPHA staff members James Chesney, PhD, and Susan Des Harnais, PhD, who assisted us in specifying the analysis and commenting on the results, and Brenda Marshall, who conducted the computer analyses at the CPHA. The contents of the report, of course, are fully the responsibility of the authors.

Reference

1. *A Call For Action: Final Report*. Washington, DC: US Bipartisan Commission of Comprehensive Health Care; September 1990:39-67. S Prt 101-114.
2. Congressional Research Service. *Health Insurance and the Uninsured: Background Data and Analysis*. Washington, DC: US Library of Congress; May 1988:229-230. Publication 88-557, EPW.
3. Davis K, Rowland D. Uninsured and underserved: inequalities in health care in the United States. *Milbank Mem Fund Q*. 1983;61:160-183.
4. Freeman H, Blendon R, Aiken L, Sudman S, Mullinex C, Corey C. Americans report on their access to health care. *Health Aff*. 1987;6:13-14.
5. Health Care Financing Administration. *Health Services Utilization in the U.S. Population by Health Insurance Coverage*. Baltimore, Md: US Dept of Health and Human Services, Health Care Financing Administration; December 1985:15. DHHS publication 20218, Series B, Descriptive Report 13.
6. Greenberg E, Chute C, Stukel T, et al. Social and economic factors in the choice of lung cancer treatment. *N Engl J Med*. 1988;318:612-617.
7. Wennecker MB, Epstein AM. Racial inequalities in the use of procedures for patients with ischemic heart disease in Massachusetts. *JAMA*. 1989;261:253-257.
8. Wennecker MB, Weissman JS, Epstein AM. The association of payer with utilization of cardiac procedures in Massachusetts. *JAMA*. 1991;264:1255-1260.
9. Weissman JS, Epstein AM. Case-mix and resource utilization by uninsured hospital patients in the Boston metropolitan area. *JAMA*. 1989;261:2572-2576.
10. Sloan F, Valvona J, Mullner R. Identifying the issues: a statistical profile. In Sloan F, Blumstein J, Perrin J, eds. *Uncompensated Hospital Care*. Baltimore, Md: The Johns Hopkins University Press; 1986:31.
11. Green J, Arno PS. The 'Medicaidization' of AIDS: trends in the financing of HIV-related medical care. *JAMA*. 1990;264:1251-1256.
12. *Medicaid Source Book: Background Data and Analysis*. Washington, DC: US Congress, House Committee on Energy and Commerce, Subcommittee on Health and the Environment; 1988:450-452. Committee Print 100-AA.
13. DesHarnais S, Chesney D, Wroblewski R, Fleming S, McMahon L. The Risk-Adjusted Mortality Index: a new measure of hospital performance. *Med Care*. 1988;26:1129-1148.
14. Anderson G, Cantor J, Steinberg E, Holloway J. Capitation pricing: adjusting for prior utilization and physician discretion. *Health Care Financ Rev*. 1986;8:30.
15. Chassin M, Brook R, Park R, et al. Variations in the use of medical and surgical services by the Medicare population. *N Engl J Med*. 1986;314:287.
16. Roos N, Flowerdew G, Wajda R, Tate R. Variations in physicians' hospitalization practice: a population-based study in Manitoba, Canada. *Am J Public Health*. 1986;76:45-51.
17. Wennberg J. Dealing with medical practice variations: a proposal for action. *Health Aff*. 1984;3:14.
18. Kmenta J. *Elements of Econometrics*. New York, NY: Macmillan Publishing Co Inc; 1971:372.
19. Todd JR. Problems with incentives. *JAMA*. 1990;264:1994-1995.

Volume 13
Number 1
Spring (1) 1994

HEALTH AFFAIRS®

Published quarterly by
Project HOPE
Suite 600
7500 Old Georgetown Road
Bethesda, MD 20814

HA Spring 1994 SLUG: Editor's page
Pages — 5 January 1994

From the Editor

The Policymakers' Dilemma

One need look no further than America's previous failures to reform the health system to recognize that it is a complex undertaking. The challenge is daunting because it must attract broad political support in a nation that has never achieved consensus on an overriding social ethic (universal coverage) to which all other worthwhile goals in health care must take second place. Americans generally profess allegiance to the precept that the highly sophisticated health care of which this nation is justly proud should be available to all citizens, regardless of their ability to pay for it. At the same time, however, broad segments of the public are deeply suspicious of the only stakeholder that can force a truly egalitarian distribution of health care on our highly entrepreneurial delivery system: the government. The result of this ambivalence—open espousal of a very lofty goal, but open hostility to the only means of achieving that goal—has led to the perennial stalemate that is the hallmark of congressional wrangling over universal health insurance. President Bill Clinton's reform proposal can be seen as a bold attempt to shake this nation out of stalemate, literally by forcing us into a vigorous national debate. The plan itself is a highly complex architecture that seeks to bridge the divergent ideologies that drive this nation's debate on health policy. To that end, the plan seeks to enlist the power of market forces, but it attempts to channel these forces, by means of government regulation, toward the goal of portable, universal coverage. Coverage would be financed by a complicated mix of sources in as equitable a manner as the body politic is thought (by the plan's architects) to tolerate. In contemplating these regulations, one must keep in mind that any market system can flourish only within a regulatory and legal framework that makes competition for economic privilege civilized. After all, *competition* in this context is merely a polite word for *brawl*. Absent the supervision and regulatory powers of a governmental infrastructure, "free markets" almost always degenerate into the untoward and often violent free-for-all now unfolding in the disintegrating former Soviet empire. One of the common themes struck by many of the contributions in this volume is a salute to the Clintons for giving health policy, at long last,

the presidential priority that a sector that represents one-seventh of our economy deserves. As Congress works its will, the final product will likely resemble the president's initial vision only modestly. What might well be enacted is a version of the president's plan that slouches heavily toward its close cousin—namely, the plan recently introduced by two Republicans—Senator John Chafee of Rhode Island and Representative William Thomas of California. Like the president's plan, the Chafee-Thomas bill features as the chief workhorse for cost control the mechanism of "managed" (really regulated) competition among vertically integrated networks of health care providers. These providers would somehow divide among them a prepaid annual capitation payment per insured family and control their own costs internally through various means, all lumped together under the rubric of "managed" care. Just how such a system would be financed, however, remains the $64,000 question whose resolution will tax Congress's ingenuity and sorely test its commitment to the goal of universal coverage. The president has proposed a particular financing scheme, centered on an employer mandate and supplemented by a variety of sources, among them some modest sin tax increases and reductions in the growth of Medicare and Medicaid expenditures. While it is easy to question the employer mandate on the basis of pure economic principle, it is not clear whether the typical American voter would greet with equanimity the full implications to him or her of the alternative, the so-called individual mandate. It is surely a matter to which the proponents of the individual mandate must give more thought. Caught between the economic costs inherent in an employer mandate, on the one hand, and the political costs inherent in the individual mandate, on the other, Congress might, of course, retreat once more into its traditional corner of respite: further postponing universal coverage until that hypothetical better day when, it is hoped, health care costs will be under "better" control. For all intents and purposes, such a strategy at this time would spell abandonment of universal coverage as this nation's goal. Another failure in this regard would only serve to once again hold up the United States as the major outlier among civilized nations, all of which provide their citizens with insurance protection against the unpredictable financial consequences of illness. Not one author presenting at the Princeton workshop, nor one discussant who responded, appeared to favor a strategy of further delay.

Uwe E. Reinhardt, Princeton University
John K. Iglehart, Health Affairs

Introduction

By Hillary Rodham Clinton

Together, we stand at a unique moment in history. In the coming months, we have an opportunity to accomplish what our nation has never done before: provide health security to every American.

Countless experts and academics have thought through the issue of how to control health costs while guaranteeing security to every American. Some of this thinking is reflected in this issue. At the beginning of this Administration, I brought together a Task Force of over 500 policy experts, physicians and other health professionals to consider this challenge. The result of their work -- and our consultation with members of Congress, representatives of different groups with a stake in the debate, and many of you -- is the Health Security Act of 1993.

The articles that follow lay out the dimensions of the crisis that confronts our nation, explain our approach and competing approaches, and state the case for comprehensive reform as proposed in the Health Security Act.

I invite you to read the articles and continue to add meaningful contributions to the final debate. But as we go forward, we must remember that this debate is about more than competing policy options. It is, most fundamentally, about people -- hard-working people who deserve to know that their health care will never be taken away.

Over the past months, I have had the extraordinary opportunity of listening to thousands of Americans talk about health care. I've sat in living rooms talking to farm families. I've stood on loading docks talking to people who have worked for 10, 15, and even

20 years without insurance. I've visited hospitals, talking to doctors and nurses. I have been moved by stories of parents who cannot afford a prescription for a child who is sick and hurting, of families barely hanging on financially and emotionally because of a serious illness. These people would be surprised to learn that some think everything is just fine with our health care system.

I have carried their stories in my mind as we worked long and hard to devise solid answers to tough questions. The President's Health Security Act is a product of all the people who took the time to share their ideas, their research, and their personal experiences with us.

The concerns that were expressed again and again - from those who need care and those who give care - convinced me of one point: although America can still proudly boast the world's finest health professionals and astounding medical advances, our health care system is broken. And if we go on without change, the consequences will be devastating for millions of Americans and disastrous for the nation in human and economic terms.

As experts in health policy, I encourage you to stay involved in the debate and scrutinize the more technical details of the proposal. As you know, the American people need your help in understanding the complex issues and difficult choices that lie behind the design of any comprehensive reform effort.

But I also urge you not to lose sight of the central goal of reform: giving every American the peace of mind that their health care will be there when they need it. Watered-down legislation that does not guarantee comprehensive benefits that can never be taken away is mere tinkering, not real reform. (Note: The previous two paragraphs were adopted from Reinhardt's memo)

As an American concerned about the health of our nation, I stand with you as we confront this challenge that touches all of us. I am convinced that we can achieve lasting, meaningful change -- and with your help, we will.