

TO: Carol Rasco
FROM: Bruce Reed
SUBJECT: Personal Responsibility and Health Care
DATE: May 21, 1993

File:
① Health Care
② WR - Child Support Enforcement

I hope you have a chance to bring up the idea we discussed last week, of using the Health Security Card to inspire personal responsibility.

I believe that linking opportunity and responsibility -- as the Clintons have always done -- will help a great deal to broaden support for universal health care. Most Americans would feel more comfortable about extending the right to health care to all if they knew that nobody will get something for nothing.

I can envision at least three ways to apply this concept:

1. You lose your Health Security Card if you don't pay your child support. In Arkansas and in the campaign, the President said that delinquent parents shouldn't be able to get credit cards. The same principle ought to apply here, where the government has even greater leverage. Why should the government provide health care for deadbeat fathers who refuse to provide for their children? Moreover, absent parents shouldn't have health insurance unless the children they brought into the world do, too. As you know, access to the absent parent's health insurance is often as important to custodial parents as the support payments themselves.

2. If childbirth is covered under the minimum benefit package, hospitals should be required to ask the mother's cooperation in establishing paternity. Over the long term, the key to improving child support enforcement is establishing paternity -- and the best place to do so is in the hospital, where the father is present 80% of the time. Assuming that HPICs are going to help pay the cost of childbirth, they should at least require hospitals to ask the name and Social Security number of the father. Voluntary experiments in hospitals around the country have proved quite successful.

3. No Health Security Card if you drop out of high school for no good reason. This approach might be too controversial to mandate nationwide, but perhaps we could allow states to consider it as an option (or on an experimental basis). Remember: During the campaign, Stan Greenberg found that denying drivers licenses for dropouts was one of the most popular aspects of the Clinton record, even though it wasn't a Presidential issue.

file: Health - stem cell research P. 2

cc: Bruce, Chris

February 11, 1999

The Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

Last month, the General Counsel at HHS, Harriet Rabb, issued a memorandum to Dr. Harold Varmus, Director of the National Institutes of Health, supporting the legality of using taxpayer funds for research on stem cells taken from living human embryos. Shortly thereafter, and using the Rabb memo as a basis, Dr. Varmus announced that NIH will reverse current federal policy and begin funding research which relies on the mutilation and destruction of human embryos.

We wish to express to you, in the strongest possible terms, our objection to Ms. Rabb's memo and to Dr. Varmus's decision. Any NIH action to initiate funding of such research would violate both the letter and spirit of the Federal law banning federal support for research in which human embryos are harmed or destroyed.¹ Rather than providing guidance on how best to implement the law that Congress enacted and the President signed, the memorandum appears to be a carefully worded effort to justify transgressing that law.

In her memorandum Ms. Rabb makes significant errors on the way to her conclusion that it would be permissible for NIH to fund research using stem cells harvested from human embryos. We call upon you to correct the General Counsel's interpretation and to reverse Dr. Varmus's decision.

¹ Since January 1996, Congress has included in the annual Labor, Health and Human Services, Education Appropriations Act a section prohibiting funding for this type of research. Section 511 of the most recently enacted research funding bill, Public Law 105-277, provides (in part) that--

- (a) None of the funds made available in this Act may be used for--
 - (1) the creation of a human embryo or embryos for research purposes; or
 - (2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under CFR 46.208(a)(2) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

The Honorable Donna E. Shalala

At the start of her analysis, the General Counsel unilaterally narrows the meaning of "research in which a human embryo or embryos are destroyed" and states that it prohibits only direct federal funding of the specific act of destroying the embryo. In this way she limits the scope of the law passed by Congress and signed by the President. While the *act* of destroying or injuring an embryo would certainly be ineligible for Federal funding, the law has a broader application. It also bars the use of tax dollars to fund research which follows or depends upon the destruction of or injury to a human embryo.

Congress could have structured paragraph (2) of subsection (a) of the law like paragraph (1) and simply prohibited the use of funds for the destruction or discarding of human embryos. We did not do that, and by established rules of statutory construction, HHS may not construe the law's provision on "research in which" embryos are destroyed as narrowly as its provision on the creation of embryos.² Instead, we prohibited the funding of research projects in which the lethal dissection or harmful manipulation of living human embryos is a necessary prerequisite, including projects where the material used in the experiments is obtained by destruction of an embryo that would not otherwise be done (or not otherwise done in the same way). In congressional testimony, Dr. Varmus has confirmed that it is impossible to obtain stem cells from embryos for these experiments without destroying the embryos.

The Rabb memo also ignores the policy reflected in current law on fetal tissue transplantation research using tissue from intentionally aborted children. While that law is itself open to criticism, it at least bans the use of fetal tissue in federally funded research if abortion was induced for the purpose of providing the tissue. Under current law, federal funds may not be used for fetal tissue transplantation experiments following an abortion if the timing and method of the abortion were altered solely for the purpose of providing usable tissue for research. Yet, in the embryonic stem cell research which NIH proposes to fund, the timing, method and procedures for destroying the embryonic child would be determined solely by the federally funded researcher's need for usable stem cells.

Finally, both Ms. Rabb's memorandum and Dr. Varmus's testimony before a Senate subcommittee present a new definition of "human embryo" that would undermine both the congressional rider on embryo research, and the President's own 1994 directive against using federal funds to create human embryos for research purposes. They now say that an entity is an "embryo" only if one can show that it is capable, if implanted in the womb, of becoming a born "human being." This narrow definition has no support whatsoever in federal law.

²When a law has two parallel clauses, one of which is deliberately written in broader terms than the other, it may not be interpreted to have the same meaning as the narrower clause. See *Russello v. United States*, 464 U.S. 16, 23 (1983), and cases cited therein.

The Honorable Donna E. Shalala

Nevertheless, researchers are already offering to use damaged human embryos in their destructive research, or even to engineer lethal defects in advance into the embryos they create for such research, in order to take advantage of this Administration cover and ignore the congressional and presidential directives altogether.

For more than 20 years, Federal laws and regulations have protected the human embryo and fetus from harmful experimentation at the hands of the Federal government -- regardless of whether the embryo is "perfect" or damaged, wanted or unwanted, intended for abortion or intended for live birth. This area of law has provided a bulwark against government's misuse and exploitation of human beings in the name of medical progress. It would be a travesty for this Administration to attempt to unravel this accepted ethical standard.

We urge you to review this issue carefully, and to put a stop to a proceeding which so clearly does violence to the meaning and intent of Federal law.

Sincerely,

October 5, 1998

MEMORANDUM FOR ERSKINE BOWLES

FROM: Chris Jennings 

SUBJECT: HMO disenrollment from Medicare and Response by Administration

cc: John Podesta, Rahm Emanuel, Jack Lew, Bruce Reed, Gene Sperling,
Ron Klain, Larry Stein, Sylvia Mathews, Elena Kagan, David Beier,
Janet Murguia, Dan Mendelson

We are attempting to schedule a meeting later this morning with you, Secretary Shalala and her staff to go over a range of options that could respond to Health Maintenance Organizations (HMOs) that chose to selectively terminate some of their plans from participation in the Medicare program. Because of the growing news coverage of this issue, Rahm and Bruce believe it is advisable for us to move quickly to determine our strategy and public positioning on this issue. They asked me to draft this memo in preparation for such a meeting.

Background

As of late last night, HHS had not completed its analysis of the impact of the roughly 25 (mostly large) HMOs that chose to selectively terminate some of their plans from participation in the Medicare program. Preliminary data and projections appear to indicate that the decisions by these HMOs will affect between 325,000 to 400,000 beneficiaries in about 375 counties. Because the Medicare program has about 6.5 million of its over 38 million beneficiaries in HMOs, about 5 percent of Medicare HMO enrollees and about 1 percent of the entire Medicare population seem likely to be impacted in any way at all. Having said this, because most of the beneficiaries affected will have another Medicare HMO option in their county, there appears to be a much smaller number of beneficiaries enrolled in HMOs (between 30,000 and 80,000 -- about 1 percent of the Medicare HMO population) who will no longer have any such option. (They will, however, always have access to their traditional fee-for-service plan, as well as to at least some supplementary "Medigap" coverage.)

Congressional reaction. The Congress, so far on a bipartisan basis, has been critical of the decision by some within the HMO industry to selectively withdraw from Medicare. On Friday, the Republican Leadership left the Commerce Committee in the hands of the Democrats and some of their party's most vociferous critics of HMOs (such as Dr. Ganske) to excoriate the industry's representative. Mr. Thomas, the Chair of the Ways and Means Subcommittee on Health, has also indicated at least his initial support of our decision not to allow plans to charge more and/or reduce benefits. Having said this, members of states that will be disproportionately affected can be counted on to pressure us to take more actions. Senator Dodd has already weighed in, and we can be sure others will follow.

Reaction from the AARP. The American Association of Retired Persons (AARP) support last week's decision by the Administration to reject the industry's request for changes in their coverage and cost sharing. They have indicated that they want to work with us to make sure that beneficiaries know all of their options and rights (discussed below) relating to the plan terminations from the program. Although they acknowledged that their sentiments may change as more beneficiaries complain, AARP indicated that they now see no reason to move quickly to respond to initial "scare" articles by taking any position that appears to reward "bad apple" HMOs. Having said this, they also do not believe we need to take a strong and public position that appears we have drawn lines in the sand on against doing something on this issue. They are of the mind that we should wait to see how big the problem is and how the public responds to it before taking any formal, final position. They think a quick tough position may unconstructively unify the HMO industry against us.

Options to Respond to HMO Industry's Actions.

Before briefly outlining some options, it is important that you are aware of actions we can and should take regardless of our broader strategy on the Medicare HMO issue. Clearly, we must be quick to ensure that HCFA collaborates with the aging advocates (like AARP), the aging network (like the Area Agencies on Aging), state-based insurance counselors, and others in and outside the Administration to ensure that beneficiaries in impacted areas know that they can always return to the program's fee-for-service plan. Beneficiaries also need to know that the law requires Medicare supplemental insurers to offer beneficiaries access to certain "Medigap" coverage without being underwritten in any fashion. As a result, insurance that fills in the voids that Medicare does not cover is truly accessible for this population. Finally, to illustrate our commitment to find ways to assure this never happens again, we may also want to indicate our intention to introduce legislation that would help ensure that this never happens again. (For example, we might want to contemplate provisions that penalize plans for "cherry-picking" the high reimbursement areas or disallow HMOs to enter any new market if they have withdrawn in others.) Being proactive could help immunize us against any suggestions that we are insensitive to the needs of the beneficiaries.

Options for responding to last week's decision by many HMOs to pull out of Medicare:

1. **Explicitly announce a "no action is merited" position.** In short, draw a line in the sand quite publicly and reject any proposal to allow HMOs to shift costs back onto beneficiaries. Blame any subsequent mess on HMOs who signed a contract in May and who now want to renege on their commitment. Highlight all the "selfish" reasons why some HMOs are dropping out and underscore our commitment to never be "black-mailed" into changing the contracts we signed on behalf of the beneficiaries.

Pros: Strong and decisive action; Puts industry on the defensive and initiates a much more public war with one of the nation's most unpopular industries -- HMOs.

Cons: Republicans, some Democrats, and AARP may feel we are acting too politically and too abruptly; Charges of callousness to harmed beneficiaries may ensue; If we don't stay tough throughout inevitable "horror" stories, we will look much weaker.

2. **Tacit "do nothing" position, but leave door (quietly) open option.** Under this scenario, we would continue to say we are looking into impact to determine severity, but would say we continue to be skeptical that there is a valid argument to do anything. We would background the press on the weaknesses of the HMOs' arguments, but would hint that we might not reject out of hand any future intervention if our review turns up major problems for beneficiaries.

Pros: Appears that we are standing up to the industry, but also gives us time and flexibility in case we want to alter our current course; would likely be supported by the Republicans and AARP for now, might be safest -- but certainly not boldest --option for the moment.

Cons: Could appear weak and indecisive; In the alternative, could appear we are insensitive to beneficiaries' woes; Opens door to HMOs to come in to cut a deal that may viewed by the validators as setting very bad precedent for the Medicare program.

3. **Expedite approval of new plans coming into counties now not served.** This option would highlight our commitment to work with and give expedited approval to HMOs that were not in a service area when another HMO dropped its coverage. These so-called "good-guy" plans could give a less comprehensive benefit or cost-sharing protection package than the one that it would replace.

Pros: Rewards good players and punishes "bad apple" HMOs; Supports our contention that we are taking reasonable actions to help beneficiaries keep access to an HMO option; In combination with base administrative and legislative package (outlined above), would illustrate that our "first and foremost" commitment is to beneficiaries -- not HMOs.

Cons: Very few new plans can be expected to come into these marginal markets; Will not significantly reduce the number of "victim" stories that will be reported; Makes us potentially more vulnerable to criticism that we did not do everything we could to help beneficiaries; If we pursue this option but eventually cave to HMOs' desires for other plans to get a similar offering, we would be perceived as very weak.

4. **Expedite approval of new plans, but allow selected old plans to apply to come back in if no other option is available.** This approach would allow a plan that withdrew from a service area, which now has no HMO option, to downgrade its benefits package to a level the HMO believes is financially viable.

Pros: Would help more beneficiaries at least retain some of their current HMO coverage; Would be more responsive to the inevitable pressure from the Congress to do more to give hope that plans will come back; and if -- as is likely -- the old HMOs do not come back, it is easier to lay the blame on them. (In other words, we did everything the HMOs asked for and they still did not come back.)

Cons: Rewards bad actors; Makes us look somewhat weak -- as though we backed down from pressure of the HMOs, Sets bad precedence for Medicare for future similar disputes with the industry (unless our administrative/legislative package makes it appear certain that we cannot or would not be able to do this again.)

5. **"Third way" option: try to split the difference between option 3 and 4 to attempt to get the best and avoid the worst of both options.** It might be possible (although we are still trying to develop a way to rationally apply this option) to allow only new plans in, but to give the HHS Secretary emergency authority to approve -- in selected cases -- applications from HMOs from the old service area to come back into the county. Under this approach, no such plan could even be considered unless it was clear that no new plan was a contender. There would have to be additional criteria as well to ensure that there is a substantive difference between option 4 and 5.

Pros: Could argue that we showed how we could respond to beneficiaries' concerns without backing down to the "bad apple" HMOs; See #4 above for similar pros.

Cons: Could be vulnerable to charges that it is "too cute by half;" Might not be able to develop criteria that provided enough direction/cover to the Secretary to differentiate.

Conclusion. There may be other options, but the above outlines what is most likely to be discussed later today. The White House staff (DPC, NEC, OMB, OVP, Rahm, etc.) has not made any final recommendations. In general, however, the White House tends to want to be a bit more aggressive than HHS. Consistent with this, HHS had indicated an interest in option 4 on Friday. However, some of Donna's staff seemed to be cooling to the idea over the weekend. Regardless, it is clear that all views on this issue will be influenced by the degree to which we receive troubling reports about beneficiaries.

HHS' staff will be meeting early this morning to go over their preliminary analysis and options. We will advise you if anything unusual comes back to us prior to your meeting.

Health care

Ann M. Catalini
06/02/97 04:22:48 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: Congressional Meeting Tomorrow at 11:45 am

Hello everyone. Just wanted to make sure that your boss had the congressional meeting tomorrow at 11:45 am in the Cabinet Room on his/her schedule. The meeting is to discuss the health components in reconciliation and the following Members are expected to attend:

- Rep. Bill Archer (R-TX)
- Rep. Charles Rangel (D-NY)
- Rep. Pete Stark (D-CA)
- Rep. Bill Thomas (R-CA)
- Rep. Tom Bliley (R-VA)
- Rep. John Dingell (D-MI)
- Rep. Michael Bilirakis (R-FL)
- Rep. Sherrod Brown (D-OH)

Thanks,
Ann

Message Sent To:

- Carole A. Parmelee/WHO/EOP
- Sara M. Latham/WHO/EOP
- June G. Turner/WHO/EOP
- Michelle Crisci/WHO/EOP
- Bessie M. Weaver/OMB/EOP
- Melissa Green/OPD/EOP
- Virginia N. Rustique/WHO/EOP
- Elisa Millsap/WHO/EOP
- Alice H. Williams/CEA/EOP
- Debbie B Bengtson/OVP @ OVP
- Cathy R. Mays/OPD/EOP
- Sarah A. Bianchi/OMB/EOP
- Jason S. Goldberg/WHO/EOP

TALKING POINTS FOR CONGRESSIONAL HEALTH BUDGET MEETING

June 3, 1997

- **HISTORICAL OPPORTUNITY.** This budget offers an unprecedented opportunity to pass the most significant health care reforms since Medicare and Medicaid were enacted over 30 years ago. If we succeed, we will:
 - Modernize and reform Medicare, extending the life of the Medicare Trust Fund for well over a decade, and lay the foundation for addressing the long-term financing challenges facing the program;
 - Offer states unprecedented flexibility to efficiently administer Medicaid; and
 - Extend health care coverage to millions of uninsured American children.
- **BIPARTISAN PROCESS.** We are at this point because of your cooperation and diligence in putting the interests of good policy ahead of partisan politics. This occurred both in the negotiations leading up to the budget agreement, and in the preparation for the upcoming mark-ups.
- In particular, Chairman Archer, Chairman Bliley, Subcommittee Chairman Thomas, and Subcommittee Chairman Bilirakis deserve great praise for how you have integrated our Democratic colleagues in the drafting of the respective mark-ups. I believe the final budget and the country will be all the better for the process you have established.
- **COMMON GROUND.** The result of this bipartisan work is a foundation of policies that we all agree will help reform the entitlement programs. These include:
 - Modernizing the program by offering more plan choices to Medicare beneficiaries. Mr. Thomas, you have been a leader in this area.
 - Reforming the fee-for-service program through prospective payment systems for home health, skilled nursing facilities, outpatient departments, and other fee-for-service providers. Mr. Thomas and Mr. Stark, you have been working on these issues for years.
 - Assuring that beneficiaries have adequate consumer and quality protections in both Medicare and Medicaid. Mr. Stark and Mr. Dingell, you have led the way here; and
 - Providing new Medicare preventive benefits, such as screening for cancer and diabetes self-management. Mr. Thomas, Mr. Bilirakis and Mr. Stark have worked diligently on these issues.

PRIORITIES. At the beginning of the Congressional mark-up process, I would like to emphasize several of my priorities.

MEDICARE

- **Prudent purchasing reform.** I share your belief that Medicare will survive only if we take from the private sector its best lessons in competition and negotiation. That is why I hope you give serious consideration to proposals that give the Secretary the authority to negotiate lower prices through competitive bidding and other similar market-oriented mechanisms.
- **Immediate home health reallocation.** I support the immediate reallocation of long-term home health care to Part B because it is good policy. There is no reason to phase it in over time. Doing so will reduce how much we extend the life of the Trust Fund by at least two years.
- **Carving out academic health center payments from managed care.** I believe we should make it a priority for medical schools and other teaching facilities to be directly compensated for their unique additional costs -- and not dependent on whether managed care plans pass on the payment we give them for this purpose.
- **Medical Savings Accounts (MSAs).** Everyone in this room knows I have major concerns about a new Medicare Medical Savings Account. Such an approach will -- according to CBO -- cost the Trust Fund money and has great potential to adversely select healthy populations away from the traditional program. I don't believe we should move in this area.

MEDICAID

- **Disproportionate Share Hospital (DSH) reductions.** After major objections from Governors, among others, we agreed to drop the per capita cap proposal from our savings package. Now the Governors want to reduce the DSH reductions. We believe that our savings are achievable if DSH funds can be better targeted.
- **Medicaid investments.** Our investments were explicitly referenced in the budget agreement. If we can maintain our DSH savings -- as I believe we can, we should honor the agreement on the investments.

CHILDREN'S HEALTH INITIATIVE

- **Efficient investment for children's coverage.** One issue that I feel the most strongly about is the opportunity to expand children's coverage. I look forward to working with you on the most efficient way to provide meaningful coverage for up to 5 million children.

However, I have concluded that tax incentive approaches are not the best mechanisms to most efficiently target our limited \$16 billion children's health budget investment. I have become convinced that these approaches are administratively burdensome, costly and would not most efficiently pick up uninsured children. Therefore, I believe that the \$16 billion should be used through Medicaid or a capped mandatory grant option. If, however, you propose tax incentive options in the context of your tax cut proposals, I am open to reviewing them to determine their priority relative to other tax cut proposals.

- **CLOSING.** While we will not agree on everything at the beginning of this process, I am confident that we can build upon the strong bipartisan working relationship that we have developed, and finalize this historic agreement in a way that is acceptable to all.

HEALTH CARE: BUDGET STRATEGY

MEDICARE

Issues in Disagreement	Mark-Up Status	Policy Options and Process	Final Policy Goal
Medical Savings Accounts (MSAs)	House Republicans will include program-wide MSA option, similar to what was included in the BBA. Rules governing MSA are currently unclear -- as is CBO scoring. House Dems will likely try to strike/alter provision.	Since Senate Finance may not have MSAs, taking an immediate position on a demo may be premature. NEC/DPC policy process reviewing acceptable demonstration options. Options will be available for Principal's sign-off as early as June 6th. In the interim, POTUS should raise major concerns with Members.	Eliminate the provision altogether or, if necessary to finalize an agreement on Medicare, develop an acceptable demo.
Medical Malpractice	Republicans will include a BBA-like provision in House mark-up. It will likely cap punitive and non-economic damages at \$250,000.	No policy development options underway or likely necessary, since Senate will not include in their version and will strongly oppose in conference.	Eliminate provision through a strategy designed to ensure that conferees recede to Senate.
Academic Health Center "Carve-Out"	The House Mark will not include our proposal to "carve out" the portion of managed care payments being credited to plans for their costs of contracting out with teaching and DSH facilities.	Not many policy options other than to either keep or eliminate the "carve-out." The Senate Mark will likely retain the President's provision. (High priority for Moynihan.) POTUS may want to stress as priority with Members.	Work to get conferees to recede to likely Senate provision.
Home Health Reallocation	House and Senate Republicans (with exception of Commerce Committee) will change our policy to phase in not only the premium increase, but also the actual transfer of home health expenditures. Change will reduce the life of the Trust Fund by about 2 years and undermine our policy rationale for the transfer.	Should continue to argue for our original policy and clear (through OMB and normal NEC/DPC process) strong position for HHS to take during Mark-Ups. NOTE: It certainly could be argued that Republican position is explicitly inconsistent with balanced budget agreement addendum.	Strongly push the Republicans to accept our current policy. If unsuccessful, use this as leverage for other issues. (The Republican approach will still probably extend the life of the trust fund until at least 2007).

Issues in Disagreement	Mark-Up Status	Policy Options and Process	Final Policy Goal
Prudent Purchasing Reforms	Republicans (and probably a number of Democrats) will likely reject the President's proposals to enhance Administration's ability to utilize market-oriented purchasing techniques (e.g., competitive bidding).	These provisions are a high priority to OMB, HHS, and have Administration-wide support. They illustrate our commitment to business-oriented mechanisms to purchase medical devices, lab services, etc. HHS should be empowered to continue to advocate for them, even though it will be very difficult to get Congress to respond. The meeting with the Members might be a good opportunity for the POTUS to push this initiative.	Although will be difficult to achieve, attempt to integrate all or most of the Administration's prudent purchasing provisions in the final bill. In so doing, secure "elite" validation that the Administration is committed to true structural reforms.
Medicare Commission	Republicans or Democrats may include language in the Mark or in subsequent amendments for the establishment of a bipartisan Commission to address long-term Medicare financing challenges.	NEC process that had been discussing these issues is being reconvened by Gene to consider options for both Medicare and Social Security, as well as how best to respond to Hill pressures.	Get out in front of the issue so that the President -- not the Congress -- has greater influence over the structure of any Commission. Ensure nothing gets passed on this issue that we cannot fully support. Preferably work out an agreement on the handling of this issue outside of the budget agreement.

HEALTH CARE: BUDGET STRATEGY

MEDICAID

Issues in Disagreement	Mark-Up Status	Policy Options	Final Policy Goal
<p>Disproportionate Share Hospital (DSH) Payment Reductions</p>	<p>\$15 billion in scorable DSH savings (roughly the amount we assumed) will require \$20 billion in dedicated cuts b/c of CBO 25% leakage assumption. Committees -- responding to heavy lobbying from the Governors and hospitals -- are reducing DSH cut to about \$9 billion by downsizing (non-kid) investments (see below) and increasing savings from flexibility provisions. Reportedly, allocation of remaining savings hits high DSH states quite hard.</p>	<p>NEC/DPC process reviewing all possible ways to reduce DSH cut without reducing any investments. This means we are focusing on additional flexibility options that CBO would score. Beyond the flexibility options we already assumed, our only other real option is to save \$5 billion by allowing states to use Medicaid rates (rather than Medicare rates) for dual eligibles. Problems include (1) Negative impacts on providers (and possibly beneficiaries) AND (2) A \$4.4 billion offset from Medicare.</p>	<p>Point out that the states won a big victory with the elimination of the per capita cap and push for all or most of the \$15-16 billion in DSH savings assumed in the budget agreement. Link these savings to need for better DSH targeting (outlined below) and the need to protect investments (also outlined below.)</p>
<p>DSH Targeting</p>	<p>Our rationale for relatively significant DSH savings was linked directly to our ability to better target the state spending of these dollars on those institutions that really did disproportionately serve the uninsured. Last night, we learned that the House Commerce Mark may have a modest targeting provision. (This is news, since we thought they would have none as a result of opposition from the Governors.)</p>	<p>HHS, OMB, DPC and NEC will review House targeting language as soon as available to determine adequacy. (Their provisions will likely be insufficient to respond to the concerns raised by the public hospitals, the children's hospitals, and the unions). We are in the process of developing alternatives. More likely, though, we will build off whatever the Hill starts with -- this is a major provider/union/state issue that is extremely complicated and formula driven.</p>	<p>To achieve the best possible agreement on targeting, most likely by pursuing a conference strategy. Final policy will likely not emerge until the very end.</p>

Issues in Disagreement	Mark-Up Status	Policy Options and Process	Final Policy Goal
<p>Medicaid investments</p>	<p>In order to reduce the size of the DSH cut, the House Republicans are reportedly planning on dropping \$2.7 billion in Medicaid investments for:</p> <ul style="list-style-type: none"> -- D.C.(\$900 million), -- Puerto Rico (\$300 million), and -- Low income Medicare beneficiary protections (\$1.5 billion) <p>that were called for in the budget agreement.</p> <p>So far, the Republicans have not reduced the dollars allocated for children's health (or other "below the line investments") to take care of their DSH problem. The House Republicans are planning to show the Governors budget tables that illustrate that with a new block granted children's program (with virtually no strings attached) they will have the same or more resources than they would have had with their DSH payments.</p>	<p>If the weekend reports are true, the House Republican Medicaid budget would be in clear violation of the budget agreement. Until the NEC/DPC process can meet to review the implications of these provisions (not until later this week), we of course would maintain our budget agreement position. The question is what, if anything, should the President say in his meeting with the Members on this subject?</p> <p>It is worth noting that both the Democratic and Republican staff on the Commerce Committee are asking us to consider using Medicare savings to offset the \$1.5 billion low income beneficiary protections cost. (This illustrates how difficult everyone is finding it to get savings from DSH.) If the Republicans include an MSA in their Mark-Up, one idea might be to use the savings from the elimination of the MSA to pay for this investment.</p>	<p>Protect most if not all the investments we won in the balanced budget agreement discussions.</p>

HEALTH CARE: BUDGET STRATEGY

CHILDREN'S HEALTH

Issues in Disagreement	Mark-Up Status	Policy Options and Process	Final Policy Goal
<p>Tax Deductions as Use for Some of the \$16 Billion Investment for Children</p>	<p>Despite the fact that CBO and other outside, independent validators have concluded that tax incentives are clearly not the most efficient policy option to insure children, the House Ways and Means Committee (Mr. Thomas) and the Finance Subcommittee on Health Chairman (Senator Gramm) seem intent on allocating between \$3-6 billion on tax deductions (including MSAs, under the Gramm approach) aimed at providing insurance for children.</p>	<p>The Thomas/Gramm approach is inconsistent with the budget agreement unless we explicitly alter our current NEC/DPC-cleared position against it. Our first priority is to ensure that we push the Committees back to the Medicaid and/or Capped-Mandatory approach that was outlined in the budget agreement. Tuesday's meeting would be a good time for the POTUS to say that tax approaches should be taken from the tax cut allotment (if used at all), rather than from the \$16 billion set-aside for kids.</p>	<p>Limit investment to either/or Medicaid or a new capped mandatory program, unless the funding for the tax incentive alternatives does not come from the \$16 billion children's health investment (and the alternatives are policy defensible).</p>
<p>Allocation of Investment and Optimal Children's Health Policy</p>	<p>Because Mark-Up is not until next week, we do not know exactly how the Committees of jurisdiction will allocate their dollars between Medicaid and a new grant program. It seems clear that Finance Committee will spend much more on Medicaid than on grants, and the Commerce Committee will do just the opposite.</p> <p>It also looks likely that the Finance Committee will place much greater accountability on the Governors to assure that dollars are used to pay for uninsured children (and not current state liabilities) and that they are spent on a "meaningful" benefit.</p>	<p>The NEC/DPC process is developing policy options for consideration by the Principals. We believe a policy that expands Medicaid to a certain, relatively low percentage of poverty, supplemented by a new capped grant program for children in higher incomes, seems to represent the most advisable policy.</p> <p>The NEC/DPC Deputy's policy team is reviewing options on targeting, state accountability, protection against state or employer substitution, benefits, etc. that could be ready for the Principals early next week.</p>	<p>To pass legislation that most efficiently and successfully provides a "meaningful" insurance benefit to the largest number of uninsured children.</p>

File:
Health Care

**TALKING POINTS ON HEALTH CARE TASK FORCE
AND THE "TOLLGATE" POLICY DEVELOPMENT PROCESS**

WHAT THE TASK FORCE IS . . .

President Clinton established the Task Force on National Health Care Reform to develop a proposal that would bring spiralling health care costs under control and give American families the peace of mind and security they deserve. The President gave his Task Force a clear charge: by building on the work of the campaign and the transition, and incorporating suggestions and advice from all corners, prepare health care reform legislation that he can submit to Congress within 100 days. President Clinton's Joint Address to Congress emphasized that Washington can delay no longer: the American people demand health care reform now.

Demonstrating his level of commitment to solving this complex problem, the President appointed First Lady Hillary Rodham Clinton to chair the Task Force. As President Clinton said, the First Lady is not only experienced but is capable and effective at bringing people together around complex and difficult issues to hammer out consensus (and get things done).

The Task Force also includes representation from the highest levels of the government -- including the Secretaries of Health and Human Services, Labor, Treasury, Commerce, Defense, and Veterans Affairs -- as well as senior White House officials.

POLICY DEVELOPMENT: THE "TOLLGATE" PROCESS . . .

The overall policy evaluation effort of the Task Force is being coordinated by the President's Senior Adviser for Policy Development, Ira Magaziner, and is based on the "Tollgate" system -- a research and evaluation process commonly used in the business world for large-scale projects that need to be completed quickly. To advise the Task Force, Mr. Magaziner has formed over 25 working groups. These working groups, which are divided into health policy subject areas, will guide their research efforts through a series of tests, or "tollgates", before a comprehensive set of options is presented to the Task Force for consideration.

The first series of tollgates -- the broadening phase -- require the working groups to put all serious options "on the table" -- ensuring that all issues are considered, all questions are discussed, and that the correct methodology is being used. The next phase of the tollgate process narrows this broad group of options and makes draft recommendations, which will later be synthesized into a comprehensive set of proposals. At that point, auditors will check to ensure that all cost and savings projections are sound, and that all legal concerns are addressed.

AN INCLUSIVE PROCESS . . .

The President feels strongly that this be an open and inclusive process, and has structured the system to encourage participation from all levels of government, all segments of the health care industry and the business community, and the American people.

Hundreds of people -- including officials from various agencies, Congressional staff, health care experts, and White House personnel -- are directly involved in developing policy within the working groups.

In an attempt to make health care reform respond to the concerns of both those who receive health care and those who provide health care, there are doctors, nurses, social workers, and hospital administrators working on and contributing to many of the working groups. In addition, diverse panels of consumers and health care professionals will be brought in regularly from around the country to advise the working groups as they develop their recommendations.

Representatives from several White House departments -- including Congressional Relations, Inter-Governmental Affairs, and the Public Liaison's Office -- are actively reaching out for advice from members of Congress, state and local governments, organized health care interest groups, representatives from small and large businesses, and the American people. All groups have been encouraged to submit written proposals and many are being brought into the White House to meet personally with Ira Magaziner and other working group members.

In addition, the Task Force operates a round-the-clock "War Room" -- which receives the thousands of speaking requests, policy papers, letters and phone calls from Americans concerned about solving our health care problems. And whether it be a hospital administrator's treatise on malpractice reforms or a widow's handwritten letter expressing outrage at her skyrocketing prescription drug costs, each inquiry is taken seriously, channeled to the appropriate working group, and given immediate consideration.

The First Lady has been travelling throughout the nation talking to the American people about their health care concerns and their suggestions on how to reform the system. She has accepted several invitations to participate in roundtable discussions that will be held throughout the country in the next month -- where she can listen to the recommendations of all the people -- consumers, providers, and special interests -- who are eager to contribute to the Task Force as it develops its proposal for comprehensive health care reform.

THE WHITE HOUSE
WASHINGTON

June 16, 1994

MEMORANDUM FOR WHITE HOUSE STAFF:

Over the next few weeks, the health care reform debate will essentially turn to one key issue: Universal Coverage.

The fight for Universal Coverage is the fight for hard working middle-class Americans. Without Universal Coverage, millions of middle-class Americans will be left uninsured, and millions more will live in constant fear of losing their insurance.

Attached is our argument for Universal Coverage, and the impact of a non-Universal Coverage plan on middle-class Americans.

Please take some time to review this material. With your help, we can win this debate.

The staff in the Health Care Delivery Room is available to answer your questions: 456-2566. Thank you for your continued efforts.

Sincerely,

Harold Ickes

Harold Ickes
Deputy Chief Of Staff

***WHY UNIVERSAL
COVERAGE:***

**Fighting For The
Health Security Of
America's Middle Class**

- I. Why We're Fighting For UNIVERSAL COVERAGE
- II. Personal Stories
- III. The Pivotal Point is UNIVERSAL COVERAGE
- IV. Progress That Won't Be Stopped
- V. The Bottom Line
- VI. Speech Text

I. WHY WE'RE FIGHTING FOR UNIVERSAL COVERAGE

- **The UNIVERSAL COVERAGE debate is not about the wealthy: They'll be able to afford care under any plan.**

The UNIVERSAL COVERAGE debate is not about low income Americans: They'll get care through Medicaid and other programs.

UNIVERSAL COVERAGE IS ABOUT HEALTH SECURITY FOR HARD WORKING MIDDLE-CLASS AMERICANS

- This Administration was founded on the principle of Putting People First. From the beginning, President Clinton has made a strong commitment to hard working middle-class Americans. In the Clinton Presidency, the concerns of hard working Americans -- not the special interests -- guide public policy.
- Why is UNIVERSAL COVERAGE so important? Because, without Universal coverage, the middle class is hit hardest. The fight for UNIVERSAL COVERAGE is truly the fight for health security for hard working, middle-class Americans. The President is deeply committed to this battle.
- *Some people say, "Why does the President insist on UNIVERSAL COVERAGE?"*

The President's bottom line remains UNIVERSAL COVERAGE, because the middle class is hit hardest if every American isn't covered.

- *Some people say, "91%, 92%, 99%: what's the difference?"*

The difference is dramatic, especially for hard working middle class Americans. Without UNIVERSAL COVERAGE, 24-40 million Americans, 83% of them in working families, would remain uninsured. Millions more would go through each day with the fear of losing their insurance. Lower income Americans will get more help, the rich remain secure and the middle class will pay the price.

- **If we fail to cover every American, we don't fail the wealthy, who will get covered anyway; we don't fail people with lower incomes, who will receive more help; we fail the hard working middle-class who will either remain uninsured, or have to live in fear of losing thier insurance-- and that is wrong.**

REAL Health Care Reform will include hard working middle-class Americans, and not exclude them.

II. PERSONAL STORIES

- I'll tell you why we're fighting so hard for UNIVERSAL COVERAGE. Every day, the President, the First Lady, and people in our Administration -- we all hear about hard working Americans whose lives are being torn apart by uncertainties about their health care -- Americans like 37 year old Susan Millard who lives in Milwaukee, Wisconsin. Susan works for a living, and earns a middle-class income, but she still can't afford health care insurance. On the other side, she earns too much to get assistance through welfare. Recently, Susan suffered neck injuries, and her medical bills skyrocketed. Now, she lives day to day in fear of having to have surgery that she can't pay for. It angers her to think that she may have to quit her job and go on welfare in order to get coverage. In her own words, "you have to either be too rich or too poor, but you can't be that middle person -- no, the system shuts out the common folks." The fight for UNIVERSAL COVERAGE is the fight for health security of working middle-class Americans like Susan.
- Americans like Jim Bryant, who told the *Boston Globe* that he works 70 hours a week but has no health insurance for his family. He wonders if it's fair that he misses his son's soccer games on Saturdays to go to his second job while people who are on welfare have health benefits he and his middle-class family don't have. In a moment of frustration, he pointed out to his wife that if they broke up she and their sons could get benefits that working families like theirs can't afford.
- It's middle-class families like the Bryants and the Millards who will get no help at all from half-measures, quick fixes, and band-aid style reforms. They represent the 8-10% of Americans that will have to go on welfare to get health coverage. That's not real reform! In many states, more than 400,000 middle-class workers will not be insured under a non-UNIVERSAL COVERAGE plan. For the sake of these hard working families, let's do it right. Let's not leave anyone out. Let's cover everyone. Let's get the job done this year.

III. THE PIVOTAL POINT IS UNIVERSAL COVERAGE

- This isn't just about the uninsured, although their numbers are growing and nearing 40 million. This debate is about the tens of millions of hard working middle-class Americans who live with the uncertainty of never knowing whether their health care will be there when they need it. After all, they could have a member of their family get sick, or they could lose their jobs, or they could change jobs and not be able to get insurance at the new one. The only way all of our people will be secure is when every American knows that whether they lose their job, change jobs, move, get sick, get insured, or just grow old, their health care will be there.

"Health Care Reform just isn't the real thing unless middle-class working people are guaranteed coverage, and after 60 years of delay, the American people deserve the real thing."

IV. PROGRESS THAT WON'T BE STOPPED

- The American people want and need health care reform. They want the security of health benefits that can't be taken away. For the sake of America's middle class, we can't allow the partisan naysayers to stand in the way of change. We simply cannot afford to play politics with the lives of hard working Americans.
- Momentum in Congress demonstrates that we are well on the way to guaranteeing private insurance for every American that can never be taken away. Most Members of Congress have heard the urgent call from the American people who want health care reform. **There should be no turning back, we must finish the job.**

V. THE BOTTOM LINE

- The President's bottom line remains UNIVERSAL COVERAGE. This is not a time to give up on the health security of America's hard working middle-class.
- Today, an historic window of opportunity for health care reform remains open. But, without action, this window will slam shut on the health security of hard working middle-class Americans. All over America, there are millions of middle-class families who work hard, but can't afford insurance. Leaving behind these parents and children is unacceptable.

Why Universal Coverage: Fighting For The Health Security Of America's Middle Class

This Administration was founded on the principle of Putting People First. From the beginning, President Clinton has made a strong commitment to hard working middle class Americans. Under the Clinton Presidency, the concerns of hard working Americans -- not the special interests -- guide public policy.

Part of the Administration's commitment to America's middle-class is manifested in President Clinton's fight for health care reform. In the past year, we have made enormous progress towards real health care reform. And now, we're almost there.

After 60 years of fits and starts, roadblocks and dead ends, we are finally making progress towards real health care reform. For the first time in United States history, the relevant Committees in both houses of Congress are seriously moving forward on health care reform. There have been twists and turns along the way -- and no doubt more ahead -- but we are steadily moving closer to our goal: passage of major health care reform this year.

On June 9, the Senate Labor and Human Resources Committee became the first full Congressional Committee, to report out a health care reform bill. With bi-partisan support, the Committee adopted a bill which preserves all the fundamental principles of the President's plan.

And now, as the four remaining Congressional Committees finish their deliberations -- as we get down to crunch time in the health care reform debate -- one issue has risen to the forefront: **UNIVERSAL COVERAGE**.

On one side, there are those, like the President, who support guaranteed private insurance for every American. On the other side, there are those who support private insurance with no guarantee.

The President's bottom line remains: Only a health care reform bill that contains **UNIVERSAL COVERAGE** will make it past his desk.

Why is **UNIVERSAL COVERAGE** so important? Because, without **UNIVERSAL COVERAGE**, 24-40 million Americans, 83% of them in working families, would remain uninsured. Millions more would go through each day with the fear of losing their insurance. Lower income Americans will get more help, the rich remain secure and the middle class will pay the price.

The UNIVERSAL COVERAGE debate is not about the wealthy: They'll be able to afford care under any plan. The UNIVERSAL COVERAGE debate is not about low income Americans: They'll get care through Medicaid and other programs. UNIVERSAL COVERAGE IS ABOUT HEALTH SECURITY FOR HARD WORKING MIDDLE-CLASS AMERICANS.

This isn't just about the uninsured, although their numbers are growing and nearing 40 million. More-so, the debate is about the tens of millions of hard working middle-class Americans who live with the uncertainty of never knowing whether their health care will be there when they need it. After all, they could have a member of their family get sick, or they could lose their jobs, or they could change jobs and be unable to get insurance at the new one. The only way all of our people will be secure is when every American knows that whether they lose their job, change jobs, move, get sick, get insured, or just grow old, their health care will be there.

Every day, the President, the First Lady, the Vice President, and people in our Administration -- we all hear about hard-working Americans whose lives are being torn apart by uncertainties about their health care. People like Jim Bryant, who told the *Boston Globe* that he works 70 hours a week but has no health insurance for his family. He wonders if it's fair that he misses his son's soccer games on Saturdays to go to his second job while people who are on welfare have health benefits he and his middle-class family don't have. In a moment of frustration, he pointed out to his wife that if they broke up she and their sons could get benefits that working families like theirs can't afford.

That's just not right! No one who works should have to go on welfare to get health insurance. It's middle-class families like the Bryants who will get no help at all from half-measures, quick fixes, and band-aid style reforms. In many states, more than 400,000 middle-class workers will not be insured under a non-UNIVERSAL COVERAGE plan. For the sake of these hard working families, let's do it right. Let's not leave anyone out. Let's cover everyone. Let's get the job done this year.

Health care reform just isn't the *real* thing unless middle-class working people are guaranteed coverage, and after 60 years of delay, the American people deserve the *real* thing.

Today, an historic window of opportunity for health care reform remains open. But, without action, this window will slam shut on the health security of hard working middle-class Americans. All over America, there are millions of middle-class families who work hard, but can't afford insurance. Leaving behind these parents and children is unacceptable.

The fight for UNIVERSAL COVERAGE is truly the fight for health security for hard working, middle-class Americans. It is fight we cannot afford to lose. We just can't let these people down. The President is deeply committed to this battle.

CBO TALKING POINTS

Administration

February 8, 1994

- This debate should be about providing all Americans with guaranteed private insurance that can never be taken away. The CBO accounting decision is ultimately a technical, score-keeping issue that will not affect the outcome of health reform.
- Private sector health care premiums should not be counted as part of the federal budget. It doesn't make sense. Under the current system, employers pay premiums to health insurers to purchase insurance for their employees. These transactions have never been considered part of the federal budget. The President's approach builds on the current system with employers continuing to pay insurance premiums to private sector health providers. These private sector premiums are not part of the federal budget now and there's no legitimate reason why they should be considered part of the federal budget under reform.
- Why would a payment from one private party to another private party be part of the federal budget? The government will neither collect nor spend this money. This transaction is similar to the requirement in many states today that residents must purchase auto insurance. The resulting payments -- between these people and their insurance companies for a car insurance policy -- are *not* counted as taxes on state budgets nor would anyone expect them to be. The argument that any payment required by the government should be part of the budget ignores the many cases today where the government sets a minimum standard to provide security to its citizens (i.e., minimum wage). It would be unprecedented to begin to count these now as part of the federal budget.
- We specifically rejected a government-run, government-financed system in favor of a system that is rooted in the private sector and builds on the employer-based system to guarantee every American private comprehensive health insurance.
- While private premiums should not be used to calculate the federal budget, information on premium payments -- including estimated total premium contributions by employers and consumers -- *will* be clearly displayed in the budget. We want to ensure that this information is readily available and accessible to the American public.

- In addition, any funds being collected or spent by the federal government -- such as new Medicare benefits, veteran's health, or discounts on the price of insurance to small businesses and low income families -- have always been and will continue to be clearly counted as part of the budget.
- If there are technical budget issues that need to be worked out, they will be resolved as the Congressional committees move forward, in consultation with the Congressional Budget Office. The bottom line for the President has always been providing all Americans with guaranteed comprehensive private insurance that can never be taken away.

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EXECUTIVE OFFICE OF THE PRESIDE
EXECUTIVE OFFICE OF THE PRESIDE

18-Jan-1994 03:33pm

TO: (See Below)
FROM: Jeffrey L. Eller
Office of Media Affairs
SUBJECT: For Internal Use Only

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1/18/94

IS THERE A HEALTH CARE CRISIS IN AMERICA?

Q: Some Republicans, and even Senator Moynihan, say there is no health care crisis in America. Do you agree?

A: We disagree, but if they seriously believe that there's no problem, let's have a real debate. Unfortunately, this is apparently just a political strategy of some Republicans. And it's very sad because there are many Republicans who are very committed to a real, bipartisan solution to this health care issue, and health care is not an issue that anyone should be using to play politics with.

[Background:

Republican strategist William Kristol has written a widely-circulated memo saying the only way to defeat the President's plan is to flat-out oppose it. And the only way to justify that opposition is to deny that a health care "crisis" exists in America. Dick Cheney and others have picked up this line in the last few weeks, and Sen. Moynihan repeated it on Sunday's "Meet the Press." And a recent Wall Street Journal item said that Kristol's "follow-up strategy" is to get Gingrich and Dole to introduce a "limited set of insurance and malpractice reforms and tax incentives."]

Now, you can argue over whether or not the current health care system is in a state of "crisis" per se. But we do know this: our health care system is seriously broken, and the President is committed to fixing it. And those who deny there are serious problems don't understand the lives of middle-class Americans who live in fear that their health care won't be there when they need it.

The Health Security Act proposes a system of guaranteed private

insurance. It builds on the current system of private

insurance with two critical changes: first, the guarantee of

comprehensive health benefits that can never be taken away; and second, greater power for individuals and small businesses to choose affordable, quality health insurance.

Q: What about the fact that medical cost growth is as low as it's been since 1973?

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

America's Health Care Crisis

The Statistics

- ? Last year, 2 million Americans lost their health coverage permanently.
- ? Every month, 2 million Americans lose their insurance for some period of time. If someone in the family comes down with a serious illness during that time, the family's savings could be wiped out.
- ? In 1980, Americans were being charged \$2,600 per family for health care. This year, between prescription drug costs, what you pay for premiums, Medicare taxes and other health costs, we're being charged \$8,000 per family.
- ? The US ranks 19th in the world in combatting fatal heart disease among adults, 20th in infant mortality, and 16th in life expectancy.
- ? Drug companies charge American consumers three or four times as much as they charge foreigners for the very same drugs.
- ? Small businesses are charged an average of 35% more than big businesses for the same insurance.

The Stories

Tell the following people that nothing's wrong with our health care system:

Gayle S. of Baton Rouge, Louisiana -- who was dropped by her insurance company when illness struck.

Tom M. of Kingston, Tennessee or Patricia G. of Simi Valley, California -- whose cancer treatment was delayed by insurance company "fine print."

Rick and Sandy R. of Waldorf, Maryland -- whose family was driven into bankruptcy when a child's illness slipped

through an insurance company loophole.

Kerry K. of Titusville, Florida -- a small business owner whose insurance company told him he'd have to fire two elderly employees if he wanted health coverage for his company. The two elderly employees were his own parents.

If We Do Nothing...

- ? Every American can expect to pay more every year with no guarantee that their health care will be there when they need it.
- ? One of every four Americans will lose their insurance at some point in the next two years.
- ? Almost \$1 out of every \$5 Americans spend will go to health care, and American families will be charged \$14,000 a year for 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.
- ? By the year 2000, workers will lose over \$600 in real wages to rising health costs.
- ? Over the next five years, health spending will rise to consume 20 percent of the Federal budget.
- ? 30% of small businesses will be forced to drop coverage for their employees because of the high cost.

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12-Jan-1994 08:23pm

TO: (See Below)
FROM: Jeffrey L. Eller
 Office of Media Affairs
SUBJECT: Health Care Talking Points 1/13

The White House
Health Care Reform Today
January 13, 1994

* Today, William Niskanen, former member of Reagan's Council of Economic Advisers, now at the Cato Institute, and John Lott of Wharton released a letter signed by economists criticizing "price controls" in the Health Security Act. The misleading and inaccurate letter does not criticize universal coverage, employer mandates, or nearly all of the substantive aspects of the plan. Contrary to the letter's false claims, the President's plan relies on premium caps -- not price controls -- to be the back-stop mechanism which controls how fast business and individual premiums can go up each year.

* Price controls call for government micro-management of every health care service, drug technology, and product. The President considered, but 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.

* The premium caps are a reinforcement measure to build discipline and certainty into our health care system. If employers are to be told they have the responsibility to contribute to coverage, they deserve the guarantee that their premiums won't rise unchecked and that the federal government will not spend without accountability.

* The Congressional Budget Office (CBO) released a report in September of this year which stated a

number of necessary ingredients to increase the effectiveness of premium caps in controlling health care costs without adverse effects, such as instituting a standardized benefits package and mandating guaranteed renewal of insurance policies. The Health Security Act includes every one of CBO's suggestions for improving the effectiveness of limits on premium increases. [CBO "Controlling the Rate of Growth of Private Health Insurance Premiums" September, 1993]

* There have been concerns raised about what the Health Security Act will do to public employees in New York. Public employees have traditionally enjoyed good health care coverage. Nowhere is that

more true than in New York. Under the leadership of Governor Cuomo and others, New York State has recognized that its employees need protection against the high cost of health care through a comprehensive package of health care benefits. Estimates by Governor Cuomo's own advisory committee indicate that New York and New York State will come out winners when Congress enacts the President's health reform proposal which is based on universal coverage and cost containment. Having said that, the Administration respects the views of Governor Cuomo, and we will continue to work closely with him, Senator Moynihan and the entire New York Congressional delegation to make sure the final version of the Health Security Act not only protects existing benefits but also improves them while adding the vital element of security.

Health Care Reform Today * The White House *
202-456-2566 * Fax: 202-456-2362

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EXECUTIVE OFFICE OF THE PRESIDE
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13-Jan-1994 08:33am

TO: (See Below)
FROM: Jeffrey L. Eller
Office of Media Affairs
SUBJECT: Internal Talking points

TALKING POINTS ON ECONOMIST LETTER ON PRICE
CONTROLS
For Internal Use Only
Not for Distribution
January 13, 1994

In an effort reminiscent of the scare tactics used in the health insurance industry's television campaign, William Niskanen, a member of Reagan's Council of Economic Advisers now at the Cato Institute, and John Lott of Wharton released a letter signed by economists criticizing "price controls" in the Health Security Act. The misleading and inaccurate letter does not criticize universal coverage, employer mandates, or nearly all of the substantive aspects of the President's plan. It instead attacks the plan for price controls, which the President considered but specifically rejected. Contrary to the letter's false claims, the President's plan relies on premium caps -- the back-stop mechanism which controls how fast business and individual premiums can rise each year. As leading health economists will attest, the letter does not accurately reflect the content or effects of the spending restraints in the Health Security Act.

PREMIUM CAPS ARE NOT PRICE CONTROLS

* The President considered, and specifically rejected, a plan imposing price controls on health care. The letter is misleading because it fails to distinguish between price controls and premium caps. Price controls call for government micro-management of every health care service, drug technology, and product. 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.

* The premium caps are a reinforcement measure to build discipline and certainty into our health care system. If employers are to be told they have the responsibility to contribute to coverage and if the federal government is going to provide discounts to small businesses and individuals, then they deserve the guarantee that their premiums won't rise unchecked and government won't spend without accountability.

* The Congressional Budget Office (CBO) released a report in September outlining a number of necessary ingredients to increase the

effectiveness of premium caps in controlling health care costs without adverse effects, such as instituting a standardized benefits package and mandating guaranteed renewal of insurance policies. The Health Security Act includes every one of CBO's suggestions for improving the effectiveness of limits on premium increases. [CBO "Controlling the Rate of Growth of Private Health Insurance Premiums" September, 1993]

* The federal government won't make market decisions on specific prices; health plans will have to decide themselves how to become more efficient in a way that won't drive consumers to another plan. As Stephen Zuckerman and Jack Hadley, two leading health policy analysts wrote in support of the plan's premium limits, "it seems far preferable that insurance companies that are responsible to their subscribers make these decisions than having the federal government involved in detailed price negotiations and review procedures with individual hospitals and physicians." [Washington Post "Clinton's Cost Controls Can Work" 11/7/93]

PROMINENT HEALTH ECONOMISTS DISPUTE LETTER'S CONTENTS

* The following nationally renowned health economists, some of whom have been publicly critical of our plan, recognize the letter as misleading and distorted.

Henry Aaron
Director of Economic Studies, The Brookings
Institution
Charles Schulze
Brookings Institution, former member of the
Council of Economic Advisers
Uwe Reinhardt
Princeton University
Lawrence Klein
University of Pennsylvania (Nobel laureate, 1980).
Stuart Altman
Brandeis University
Joe Newhouse
Harvard University
Laura Tyson
Chair, Council of Economic Advisers
Alan Blinder
Member, Council of Economic Advisers
Joseph Stiglitz
Member, Council of Economic Advisers

OTHER REFORM PLANS CONTAIN SIMILAR MEASURES

* Most health reform plans that are serious about controlling skyrocketing health care spending -- ranging from those introduced in the last few years by conservative Republicans such as Senator Kassebaum and Representative Michel to plans by centrist Democrats such as Senator Kerrey and Representative McCurdy to single payer advocates such as Senator Wellstone and Representative Stark -- contain measures to restrain the growth of national health care spending and protect consumers and business from skyrocketing costs.

Michel (H.R. 3080) Under the Michel proposal, premium rates would be regulated by limits on the variation of rates charged to small businesses. Kassebaum-Glickman (S. 325/H.R. 834 (Danforth, McCurdy co-sponsors) Costs would be controlled by placing binding annual limits on the maximum allowable rate of increase in "BasicCare" premiums. McDermott-Wellstone (S. 491/H.R. 1200) An "American Health Security Board" would specify the total spending by the Federal government and states for covered services. Kerrey (S. 1446) A Commission would control costs through a global budget set state by state, based on a national per capita cost calculation. Jeffords (S. 3331) A national board would establish "MediCORE" budgets which would estimate and enforce total annual national expenditures.

LETTER FLAWED AND MISLEADING

The letter contains numerous flaws and distortions, including:

Rhetoric: "Your plan...caps annual spending on health care."

Reality: This statement is simply inaccurate. While the plan caps premium increases, it doesn't contain any provision to determine or enforce the nation's total amount of spending for health care. Consumers and employers can purchase additional coverage, with no limits on spending. Consumers pay for these costs out-of-pocket with no limits. Premium caps merely protect them from unreasonable increases on what they pay for the comprehensive benefits package.

Rhetoric: "Price controls produce shortages, black markets, and reduced quality. This has been the universal experience in the four thousand years that governments have tried to artificially hold

down prices using regulations."

Reality: We agree. That's why our plan does not rely on price controls. Caps on premium increases are more analogous to rate regulation of public utilities, such as electricity and water, which have been hailed by economists as a major advance in regulation that incorporates many market elements. You don't see electric and gas companies running out of money or indiscriminately cutting off service to consumers.

Rhetoric: "Your plan...imposes price limitations on new and existing drugs."

Reality: The President's plan does not set limits on all new and existing drugs. What limits are in the plan apply largely to the Medicare program -- limits proposed, supported and implemented by past Republican and Democratic administrations alike.

Rhetoric: "Caps, fee schedules, and other regulations may appear to reduce medical spending, but such gains are illusory."

Reality: The Reagan and Bush Administrations proposed numerous limits in the Medicare and Medicaid programs without adverse effects. Would Msrs. Lott and Niskanen eliminate all of these controls? If so, would they have the American taxpayer pay the higher prices?

Rhetoric: "Your plan sets the fees charged by doctors."

Reality: Wrong. Most doctors will be paid by health plans under arrangements negotiated by those doctors and health plans -- not by the government.

Rhetoric: "The result [of government regulation of gasoline]...forced people to waste hours waiting in lines..."

Reality: The analogy to oil regulation is absurd. Oil is a limited good, most of which is imported. Unlike oil, medical services are virtually unlimited. The more we're willing to pay for, the more of it can be produced. Unfortunately, while wasteful, inappropriate hospital admissions and other services costs lots of dollars, they often don't result in better health -- just higher costs.

Rhetoric: "We will end up with...expensive new bureaucracies."

Reality: The last thing the President wants is big government bureaucracies, and that is exactly

why he rejected a government-run plan. The Health Security Act calls for the minimal amount of new government needed to ensure that the market is operating to guarantee real choice, real quality and real competition.

Rhetoric: "Threat of price controls on medicines has already decreased research and development at drug companies, which will lead to reduced discoveries..."

Reality: The threat of comprehensive reform may have caused some insurance companies and drug manufacturers to limit their prices and may have caused hospitals to become more efficient, but there is no evidence of decreased research and development since the President's plan was proposed.

PRICE CONTROLS PROPOSED UNDER REPUBLICAN ADMINISTRATIONS

* It is ironic that Mr. Niskanen would lead an attack on the Clinton plan for price controls on health care since Republican administrations have a long tradition of wage and price controls dating back to the Nixon administration. Under Reagan and Bush alone, at least 63 specific limits or freezes in the Medicare and Medicaid programs were enacted for hospital fees, physician and other health provider services, and state expenditures. In the absence of comprehensive reform, however, these cuts were simply shifted to businesses and consumers, causing Medicare and Medicaid spending to skyrocket. [Department of Health and Human Services]

Do the premium caps work too well or not well enough?

* Many critics of the plan, including a number of the economists who signed the Lott-Niskanen letter, have criticized the Clinton plan's financing in recent months, saying that the numbers don't add up. But if they are attacking the premium caps, they must believe these cost controls work and the plan's numbers do, in fact, add up. However, this letter claims that our cost controls will work only too well. Which is it going to be? These critics need to get their stories straight.

INTERNATIONAL COMPARISONS

* Other industrial countries such as Germany, Japan and France, have adopted some form of cost control mechanism for health care spending -- without resulting in rationed care or decreased quality. According to the General Accounting Office, "other industrialized countries have had more success than the United States in controlling the growth of health care spending without adversely affecting coverage or broad measures of health status." [GAO "Health Care Spending Control : The Experience of France, Germany and Japan" November, 1991]

1/13/94

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The White House
Health Care Reform Today
January 12, 1994

* In effort oddly reminiscent of the health insurance industry's scare tactic campaign, the ultra-conservative Cato Institute is planning to release a misleading letter from economists criticizing the Health Security Act for relying on cost controls. First, remember that the letter only criticizes one part of the plan. Second, remember that premium caps are not price controls; in fact, a number of alternative proposals in Congress, and several industrial countries, use similar constraints to put some check on spiraling costs. Third, many similar cost control mechanisms were proposed and implemented in Medicare and Medicaid under Reagan and Bush.

* Again, we have considered -- but specifically rejected -- a policy imposing price controls on health care. Our 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 strongly believe that, regardless of how quickly or how firmly competitive reforms take hold, we need to build some discipline and certainty into our system -- so that businesses and consumers know that their health insurance premiums will not be allowed to suddenly spiral out of control one year, and that the federal government will not spend without accountability. That is why we reinforce the competitive system with a limit on health care premium increases.

* In contrast to our plan, price controls call for government micro-management of every health care service, drug, technology and product. Price controls would have the government substitute its views for the markets in hundreds -- maybe thousands -- of decisions. We reject that type of micro-management in favor of letting a market that truly competes work.

* Lane Kirkland, President of the AFL-CIO said yesterday the feeling among working class Americans is that there is a health care crisis and those who say there isn't aren't in touch. He said: "They may not have a health care crisis, but we do and we see it." He pledged to commit "...whatever it takes" to fight for the President's health reforms."

DPC Program Staff

The White House
Health Care Reform Today
January 11, 1994

* As we head into this week, it's important to keep in mind the distinction between price controls and premium caps. The President's plan uses premium caps -- limits on how fast your health care premiums can go up each month -- to control costs.

* We have considered -- but specifically rejected -- a policy imposing price controls on health care. Our 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 strongly believe that, regardless of how quickly or how firmly competitive reforms take hold, we need to build some discipline and certainty into our system -- so that businesses and consumers know that their health insurance premiums will not be allowed to suddenly spiral out of control one year, and that the federal government will not spend without accountability. That is why we reinforce the competitive system with a limit on health care premium increases.

* This is the most sensible approach to ensuring cost control. As Stephen Zuckerman and Jack Hadley, two leading health policy analysts wrote, "...it seems far preferable that insurance companies that are responsible to their subscribers make these decisions than having the federal government involved in detailed price negotiations and review procedures with individual hospitals and physicians."

* In contrast to our plan, price controls call for government micro-management of every health care service, drug, technology and product. Price controls would have the government substitute its views for the markets in hundreds -- maybe thousands -- of decisions. We reject that type of micro-management in favor of letting a market that truly competes work.

* Last week, New York Newsday reported that many NYC-area small companies "...feel the high cost of health care is their most serious problem but surprisingly many business owners expect Clinton's health plan to provide help by

CONTROLLING COSTS. CHEMICAL BANK SURVEYED 532
small businesses with annual revenues ranging
\$1-million - \$10-million and found over 80%
described health care costs for employees as a
serious or somewhat serious problem and rated it
higher than other problems including government
regulation and taxes. (Source: Healthline)

Health Care Reform Today * The White House *
202-456-2566 * Fax: 202-456-2362

The White House
Health Care Reform Today
January 7, 1994

* American workers continue to bear the burden of rising health care costs, according to a new U.S. Chamber of Commerce survey. Reuters reported that "the value of employee benefits rose faster than wages and salaries, and that companies shifted most of the increased cost of health care onto their employees."

The survey -- of more than 1,100 companies employing more than 2.6 million workers -- found that while company health costs rose only one percent, employees paid 9 percent more in 1992 than they did in 1991.

Meaningful health care reform must help bring health care spending under control so that workers can finally begin to see wage increases again. The Health Security Act includes strong measures for controlling health care costs and insuring that health care remains affordable for both businesses and workers.

* Yesterday the Chicago Tribune reported that health care would "likely remain a robust source of jobs." John Cabral, a planner at the University of Illinois at Chicago's Center for Urban Economic Development predicted that if health reform results in health insurance becoming available to those who now lack it -- thereby increasing their access to medical care -- "we will have a boom in the industry." This latest report confirms the findings of previous studies-- health reform will result in more jobs in health care, not fewer.

* The AARP on Wednesday urged Illinois Governor Jim Edgar to support the President's plan to bring greater security and health care coverage to older Americans. AARP Illinois director said "Health care reform should be the number one priority on the state's legislative agenda. There's no question that Congress will approve some sort of national health reform legislation this year." We agree, and welcome the AARP's continued call for health security for all Americans.

* On a final note, we welcome Representative Bill Thomas and his co-sponsors to the health care debate: we applaud their bill as recognizing that universal coverage is an absolute must for meaningful reform, and look forward to working together to decide on the best way to get there.

HEALTH SECURITY ACT

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THE HEALTH SECURITY ACT OF 1993 Health Care That's Always There

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

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

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

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

What's Wrong With the Current System

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

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

The Health Security Plan

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

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

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

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

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

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

- **Security for you and your family.**
- **A comprehensive package of benefits.**
- **Health care costs that are under control.**
- **Improved quality of care.**
- **Increased choices for consumers.**
- **Less paperwork and a simpler system.**

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

Principle #1:

Security: Giving you health care that's always there.

Over the next two years, one of every four of us will lose health coverage for some time. The Clinton plan guarantees that you will never lose your insurance -- no matter what. Here's how the plan guarantees security:

- **Makes it illegal for insurance companies to deny you coverage because of "pre-existing conditions."** The Health Security Act also makes it illegal for insurers to raise your premiums or drop you because you get sick. All health plans will be required to accept anyone who applies -- healthy or sick, young or old.
- **Guarantees coverage if you lose your job.** The proposal guarantees that you will keep your health coverage even if you lose your job, with the employer portion picked up by Federal revenues and savings. Under the current system, if you lose your job, you lose your health insurance.
- **Guarantees coverage if you switch jobs, move or start a small business.** You will always be protected -- no matter what. Today, if you switch jobs, move or start a small business, you can find yourself without health insurance -- and risk bankruptcy.
- **Provides coverage for early retirees.** The health security plan guarantees coverage for early retirees, so they don't have to worry about being without coverage after they retire and before they are covered by Medicare. Today many early retirees are losing their health benefits.

Principle #2:

Comprehensive benefits: Keeping you healthy.

All Americans will receive a Health Security card that guarantees you a benefits package that is as comprehensive as those offered by most Fortune 500 companies...and then some.

Emphasizes preventive care. The comprehensive benefits package goes beyond virtually all current insurance plans by covering a wide range of preventive services, including mammograms, Pap smears, and immunizations, **at no charge to you.** It puts a new emphasis on helping you stay healthy, rather than waiting until they get sick. Prevention saves money and improves people's health.

Includes prescription drugs. Many insurance companies and Medicare have failed to cover prescription drugs. But drug costs are breaking family budgets, forcing many older Americans to choose between food and medicine. Health insurance should cover prescription drugs. The Health Security plan does.

All Americans will be guaranteed coverage of :

- Preventive Care (i.e., screenings, physicals, immunizations, mammograms, prenatal Care; at no cost)
- Doctor Visits
- Prescription Drugs
- Hospital Services
- Emergency/Ambulance Services
- Laboratory and Diagnostic Services
- Mental Health and Substance Abuse Treatment
- Expanded Home Health Care
- Hospice Care/Outpatient Rehabilitation
- Vision and Hearing Care
- Children's Preventive Dental Care

Principle #3:

Savings: Controlling health care costs.

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

Limits how much insurance companies can raise your premium. Insurance companies will no longer be able to raise your premiums as they please. Today, insurance companies hike your premiums – sometimes at several times the rate of inflation – if you get sick, if someone in your family gets sick, and for any other reason.

Introduces competition to the health care marketplace. The Health Security plan will release the chokehold that in today's system, insurance companies have on all of us – consumers, nurses, doctors, and businesses. Reform will encourage competition – forcing costs down as health plans compete by offering high-quality care at an affordable price.

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

Asks the drug companies to hold down prescription drug prices. The Health Security plan asks drug companies to take responsibility for keeping prices down, without setting prices. In today's system, overcharging runs rampant – certain prescription drugs cost Americans three times more than people pay in other industrialized countries.

Reduces paperwork. All health plans will adopt a single, standard claims form by Jan. 1, 1995. Along with other measures to streamline the system and free nurses and doctors from excess bureaucracy, this will reduce paperwork, cut red tape, and save money.

Squeezes the waste out of Medicare and Medicaid. By slowing the growth of these government programs, the proposal uses funds that have been wasted on excessive charges and funnels them into comprehensive benefits. Under reform, Medicare will be expanded to

cover prescription drugs, and there will be a new long-term care program to help cover home- and community-based care. Today, Medicare and Medicaid spending keeps going up and up. But the elderly and poor aren't getting any extra benefits. Health security will change that.

Principle #4:

Quality: Making the world's best care better.

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

Gives consumers the power to judge the quality of care. Consumers will receive quality "report cards" that provide information on the performance of health care plans and patient satisfaction. These report cards will hold health plans accountable for meeting high standards. The National Quality Program will help states share information on health plan performance.

Reforms malpractice. The President's proposal will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to use alternative forms of dispute resolution before they end up in court. This will help eliminate the "defensive medicine" that drives up costs and hurts quality -- doctors ordering extra tests because they fear lawyers looking over their shoulders.

Encourages cooperation in rural and urban areas. Rural residents will have access to the latest technology and emergency services through telecommunications links set up between local doctors and advanced networks of specialists and hospitals. In urban areas, the plan will increase investment in public hospitals and community health centers.

Provides incentives for more family doctors to practice in rural and urban areas. The health security plan will give financial breaks to doctors and nurses who work in underserved rural and urban areas. It will expand the National Health Service Corps. Two of three rural counties today do not have enough doctors and 111 rural counties have no physician at all.

Increases funding for prevention research. The National Institutes of Health (NIH) will expand research in areas like children's health, and health and wellness promotion. Preventive care keeps people healthier and saves money at the same time.

Promotes research on the effectiveness of treatments. Today, a lack of information about the most cost-effective methods of treatment often leads to expensive defensive medicine and wide variation in treatments and costs. The plan's investments in research into what treatments really work will help improve the quality of care.

Principle #5:

Choice: Preserving and increasing what you have today .

Preserves your right to choose your doctor. The proposal ensures that you can follow your doctor and his or her team to any plan they might join. Today, more and more employers are forcing their employees into plans that restrict your choice of doctor. After reform, your boss or insurance company won't choose your doctor or health plan -- you will.

Increases your choice of health plan. You will be able to choose from among all the health plans offered in your area -- no matter where you work. Only one of every three companies with fewer than 500 employees offer any choice of health plan. After reform, every employee will be able to choose a health plan.

Puts consumers in the driver's seat. The Health Security Act brings competition to health care -- unleashing the market forces that will lower costs and improve quality. Giving small businesses and consumers the power to band together in alliances will level the playing field and give them the same bargaining strength as big businesses.

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

Principle #6:

Simplicity: Reducing paperwork and cutting red tape.

Gives everyone a Health Security Card. The card -- with full protection for privacy and confidentiality -- will allow for electronic billing and the creation of health care information networks. This will reduce paperwork and simplify the system.

Requires insurance companies to use a single claim form. The Health Security Act will reduce the insurance company red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. All health plans will adopt a single, standard claims form by Jan. 1, 1995. It will enable doctors and nurses to spend more time taking care of you -- and less time wrestling with paper.

Eliminates fine print. Everyone will get a comprehensive benefits package -- and what you get will be spelled out in easy-to-understand language. If you get sick, insurance companies won't be able to point to fine print and deny you the coverage you've paid for.

Streamlines billing reimbursement for doctors, nurses and hospitals. The comprehensive benefits package, a standard rules and codes for payment, and elimination of excessive government regulations will reduce confusion. Doctors, nurses, and hospitals will have more time to care for patients; and all of us will benefit.

Removes the burden on business of negotiating insurance. Groups of businesses and consumers – regional health alliances -- will negotiate for high-quality care at affordable prices. This will simplify today's system, where hundreds of thousands of businesses negotiate with more than 1500 insurance companies. The burden of finding insurance will be lifted -- and so will administrative costs -- which can run as high as 40% of total health costs for small business.

HOW THE SYSTEM IS FINANCED

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

The system is financed from five major sources:

- 1) Employer and employee contributions -- Everyone will pay a portion of health insurance premiums, even if your contribution is small, because everyone must assume responsibility. Today, the overwhelming majority of employers cover their employees, and they'll continue to do so. But the businesses that provide insurance are paying for those who don't. No one should get a free ride.
- 2) Medicare and Medicaid savings -- Specific savings can be achieved by slowing the rate of growth of these programs. Every penny of these savings will be channeled back into benefits -- prescription drugs and long-term care -- for the people which these programs serve.
- 3) "Uncompensated care." -- Savings can be achieved from money now paid to hospitals and doctors who care for people who can't afford care but receive it anyway and the uninsured.
- 4) Sin taxes and other federal revenues -- There will be some new "sin taxes," and other revenues will be added as health care costs slow, less money is spent, and the difference is no longer tax-deductible.
- 5) Other savings -- Reducing paperwork and administration -- estimated to cost \$100 billion or more a year -- will cut bureaucracy and save money. Cracking down on health care fraud - - estimated to be at least \$80 billion annually -- and imposing new stiff penalties will also yield savings.

PAYMENT SCENARIOS

As a rule, most individuals and families in which at least one person works will pay a maximum of 20% of the average health plan premium in their area. Those who choose a lower cost plan -- from among those offered in the area -- will pay a little less than the

20% average. Those who choose a more expensive plan will pay a little more, as they do today. Employers who currently pay 100% of health benefits may continue to do so.

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

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

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

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

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

EXCEPTIONS

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

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

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

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

Families with incomes below 150% of the poverty level: Families at this level are eligible for discounted premiums and pay a maximum of 20% of the employee's share of

the average plan premium. This applies to individuals making \$10,455 annually; couples with incomes of \$14,145; families of three earning \$17,835; and families of four with incomes of \$21,525.

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

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

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

The Children's Health Fund

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MEMORANDUM

TO: Carol Rasco

FROM: Irwin Redlener, M.D. 

DATE: September 24, 1993

RE: Health Reform and Job Creation

Bruce
FYL

Greetings. I wanted to chat with you after the physicians' event at the White House on Monday, but did not get a chance. I am very interested in the notion of job creation around health reform. I had an opportunity to mention this briefly to the President, and later to Bruce Reed.

The point is that there is significant potential job creation that might reasonably be projected around health reform (and possibly welfare reform as well). I think this is an important area of consideration about which we should have data that could be used for the Congressional process. Part of this analysis might require outside assistance, but I think it is worth looking at.

The issue of job creation should probably not be seen as a primary selling point for health reform. It would, however, work in terms of countering some of the arguments that major job loss would follow employer mandated coverage.

An analysis of the situation would likely begin with the types and numbers of professional and non-professional jobs that would be required to provide primary health care to 37 million people currently not covered. This would be done by understanding ratios to population for all levels within the health care delivery system. It should also focus on non-professional workers from billers to ancillary services. It could be extended to manufacturers and suppliers of medical supplies and other secondary and tertiary consequences of bringing new services to a large group of people.

9707

EXECUTIVE OFFICE OF THE PRESIDENT

08-Sep-1993 09:29pm

TO: (See Below)
FROM: Jeffrey L. Eller
Office of Media Affairs
SUBJECT: Health Care Talking Points 9/9

The White House
Health Care Reform Today
September 9, 1993

* As we said yesterday, you'll continue to hear mis-information concerning Medicaid and Medicare. We'll continue to set the record straight.

* Today many working Americans receive coverage through Medicare and Medicaid, even though they have jobs. Under reform, employers and employees together will contribute for their health care, saving the Medicaid and Medicare programs money.

* Today, some people end up on Medicaid simply because their health care costs outstrip their ability to pay for it. Once everyone has coverage, these people will never show up at a Medicaid office-- more savings for the Medicaid program. The new money for subsidies in the program come from several sources: primarily from additional savings in Medicaid spending. Today, Medicaid makes large payments to hospitals and other providers who take care of uninsured people. Since the uninsured will all be covered in the new plan, these payments can be reduced. Comprehensive health reform also leads to savings in other federal programs, such as the Defense Department, Veterans' Administration, and federal employee health programs..

* The consultation process continues. As a result, many people are looking over drafts of the plan - and naturally numbers are flying all over the place. Remember, those numbers are not being leaked by the White House nor are we floating trial balloons. These numbers are subject to the consultation process and very likely will change. But the principles of health

care will remain the same, security, simplicity and savings.

* President Clinton himself said it best about the challenges of the coming months and whether or not we can succeed: "Absolutely. I don't think we have an option because I think the country can't walk away from this problem. But I think we should begin with this because this is something that will unify Americans and will unify the Congress and will prove that we can spend the money we have in appropriate ways and stop wasting so much of it."

Health Care Reform Today * The White House *
202-456-2566 * Fax: 202-456-2362

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EXECUTIVE OFFICE OF THE PRESIDENT

08-Sep-1993 01:17pm

TO: (See Below)
FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: HIAA Talking Points 9/8

FOR INTERNAL USES ONLY -- DRAFT -- FOR INTERNAL USES ONLY --
DRAFT

Coalition for Health Insurance Choices Ad Campaign
"Protecting Profits or Preserving Choice?": The Facts

RHETORIC:

"Having choices we don't like is like no choice at all. If we let the government choose, we lose." [Text from CHIC Ad, USA Today, 9/7/93]

REALITY -- THE CLINTON PLAN WILL INCREASE CHOICES:

Today, many Americans are denied their right to choose their doctor when their companies force all employees into one single plan. A recent survey indicated that only 28% of employers with fewer than 500 employees offer any choice of health plan. [Foster Higgins 1992 Survey]

Under the National Health Security Act, 100% of Americans will have their choice of health plans. Americans will have more choices than they do now. All Americans must be offered a choice of health plans -- one of which has to be a traditional fee-for-service plan.

{SYMBOL 183 \f "Symbol" \s 10 \h} The National Health Security Act will let everyone choose their own doctors and keep the doctors they have now if they want. President Clinton wants to preserve this crucial element of the American health care system: -- the right to decide who will take care of you.

\$5.7 Million Campaign to Protect Their Profits:

The Coalition for Health Insurance Choices launched a \$1.7 million ad campaign. [Newsday, 9/8/93]

Since April, the Coalition has already spent \$4 million dollars on similar ads. [National Underwriter--Life and Health, 4/26/93]

Coalition is front for Health Insurance companies:

Coalition for Health Insurance Choices is "a group put together and funded by the Health Insurance Association of America." [Atlanta Journal, 5/12/93]

The Coalition's \$4 million ad campaign "was entirely financed by the coalition's principal member, the Health Insurance Association of America. That group represents Prudential Insurance Co. of America and other health insurance providers" [Advertising Age, 4/26/93]

HIAA IS MADE UP OF INSURANCE PROFITEERS:

The Coalition also includes many organizations representing health insurance underwriters -- the people who profit by deciding who not to insure. Members include: The National Association of Life Underwriters and the National Association of

EXECUTIVE OFFICE OF THE PRESIDENT

09-Sep-1993 10:03am

TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: Health Care Questions and Answers 9/9

FOR INTERNAL USE ONLY
HEALTH CARE Q AND A
Thursday, September 9, 1993

Q: Is the plan final or not? What's going on?

A: In the most thorough policy making process in American history, the Clinton administration has been consulting with members of Congress and interested groups since January. Over 260 meetings have taken place with over 250 members of Congress. In addition, more than 1,600 meetings have taken place with more than 1,200 special interest groups.

We are taking our draft health security proposal to Congress and interested groups and will continue to consult closely with them and work with them to incorporate their suggestions.

Q: What's with these Medicaid/Medicare cutbacks?

A: Contrary to the misleading headlines appearing today, we must restate: There are no Medicare or Medicaid cutbacks. All we are proposing is to slow the rate of growth in future Medicaid and Medicare spending. We will also put a limit on private sector premiums so that savings from Medicare and Medicaid are no longer just shifted to the private sector.

And again, savings from Medicare will be used for additional benefits for Medicare beneficiaries -- long term care and prescription

drugs -- and savings from Medicaid will be used to protect people from ever losing their insurance. In addition, doctors and hospitals must remember that the savings in Medicare and Medicaid will come alongside new revenues from the millions of new patients now covered by the private sector.

Q: What about the accusation that you are using "soft" numbers?

A: For the first time in history we have brought together all federal agencies that deal with health care numbers and asked them to agree on a unified set of numbers. There has been unprecedented sharing and scrutiny of modeling techniques as well as rare cooperation and agreement among experts among federal agencies --

including HCFA, AHCPR, Labor, and Census. In addition, the numbers have been double and triple checked by teams of outside independent actuaries, health economists, and auditors.

Q: Why is your proposal so complex?

A: No one doubts that this is a massive undertaking. Any proposal that affects 1/7 of the nation's economy -- reaching \$1 trillion dollars as of next year -- is bound to seem complicated. I can guarantee you that it is not nearly as complicated as trying to describe today's "crazy quilt" health care system.

Q: Was the LA Times piece on malpractice reform accurate?

A: The issue of limits on non-economic damages in malpractice suits, contrary to the article, is one of a few issues the President chose not to sign off on until after the consultation process. The President has said from the beginning that we will have serious tort reform that will cut down on frivolous lawsuits, control costs, and promote the settlement of disputes outside of the courtroom. That's exactly what the provisions now in the plan do.

Q: Are you taxing big businesses who choose to run their own health plans?

A: That's another option the President will decide after consultations.

Q: What about the WSJ and Boston Globe stories that say that the savings goes mostly to deficit reduction?

A: Some of the savings will be used to protect people from ever losing their insurance, and some will be used for deficit reduction. We'll have the exact numbers when the President announces his plan.

"Let's put this in context: For the past twelve years, skyrocketing health costs have been a major factor in exploding federal deficits. Without health reform, the declines in annual deficits produced by the President's economic package wears off by 1997, and the deficit will continue to grow. The health reform proposal will continue to close the deficit. And any deficit reduction that results from controlling the growth of health costs would be a major change from the status quo. The Wall Street Journal story today said it best: This will "mark a sea change in the effect of health costs on federal spending."

[Solomon, Prunty, 9/9/93]

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File:
Health Care

July 26, 1993

Dear Friend:

Health care is a \$900 billion dollar industry, one-seventh of America's annual G.N.P. and larger than the entire economy of Italy. For that reason alone, health-care reform should be fashioned and evaluated according to economic as well as medical criteria.

In this policy briefing, Robert Shapiro, vice president of the Progressive Policy Institute, demonstrates why President Clinton and the Administration must take the laws of economics seriously as it moves deliberately on health care. In short, Shapiro asserts that health-care reform will fail if it does not accommodate the way economic markets actually work. This means that we cannot simply expand vastly the demand for medical care and try to use government regulation and controls to hold down price increases.

Shapiro argues that these challenges do not constitute an excuse for inaction. The way the current medical system works, he writes, endangers not only the health of millions of Americans but the entire economy as well. Thus, the Administration must propose market-based incentives to both discipline demand and encourage providers to increase the supply, along with reforms to gradually provide universal health-care security.

Sincerely,

Chuck Alston
Communications Director



POLICY BRIEFING

July 26, 1993

Health-Care Reform and the Laws of Economics

Robert J. Shapiro

President Clinton's plans to reform America's health-care system can succeed, but only if he does not try to accomplish everything at once and only if the plan's economic logic is sound. To ensure universal coverage and reduce medical-care inflation without damaging the economy, the reforms will have to be implemented gradually, foster more economic competition among providers, and demand more economic responsibility from every patient.

At the heart of the issue is one of the oldest problems in economic policy: What should government do when people want more of some good than the economy will produce at prices they are willing or able to pay? Presidents facing this problem can look for ways to balance the people's desires with the laws of supply and demand, or try to satisfy them and risk injuring the economy. The test of leadership for this President, elected to cure both the economy and the health-care system, will be his ability to shape a package that provides everyone a measure of security while respecting the manner and pace of economic change.

Facing the Problem

So far, both health-care reformers and skeptics have demonstrated that it is easier to identify problems than to find sound solutions. The most ambitious reformers are clearly correct that fundamental change has to come soon. In no other advanced country does one of every seven persons have to manage without routine care -- one of the reasons why life expectancy in the U.S. now ranks 15th in the world. Furthermore, the enormous costs of the medical system producing these dismal results injure the American economy. For nearly a decade, health-care costs have been the principal factor driving both federal borrowing and federal spending. Rising insurance costs have cut the wage gains of most workers. Moreover, the doubling of the share of the nation's resources claimed for medical services, from barely seven percent of GNP in 1970 to roughly 14 percent today, has dampened investment and growth elsewhere in the economy by reducing the profits of nearly all firms and bidding-up the price of capital and skilled labor. Put another way, so long as health care grows much faster than the rest of the economy, the rising bill can't be paid without sacrificing investment, productivity and income growth for most Americans.

Reform is imperative; but the skeptics are also correct that no government or group of experts have the knowledge or means to reform, all at once, an extraordinarily complex, \$900 billion-a-year sector that accounts for one-seventh of the largest economy in the world. In such an industry -- with billions of annual transactions carried out at tens of thousands of facilities, using millions of workers and hundreds of thousands of different goods to produce tens of thousands of services -- sensible reforms must proceed incrementally and in ways that do not conflict with the normal operations of the economy. Further, they must take into account differences among regions and states.

Two of the basic laws of economics are at issue here. The first is that prices rise when demand increases and supply does not expand as quickly. Simply extending or mandating insurance coverage for the 35 million people who lack it today will inevitably spark faster-rising medical prices and costs. If this coverage includes long-term care, prescription medicines, mental-health, dental treatments and more -- as many reformers want -- medical-care inflation will rise even faster.

The second law confronting health-care reform is that economic demand for most things responds to prices. So long as conventional insurance and the current health-care system let most Americans use medical services without paying directly for them -- with little practical recognition of the costs -- demand for health care will never be disciplined and prices will continue to rise. These arrangements not only encourage the demand for routine medical treatment, they also guarantee a broad market for expensive new medical technologies. Once developed, costly new technologies quickly become generally available and broadly applied, greatly intensifying cost pressures.

If these economic forces *did not* matter, the President and Congress could simply tell business and government to cover everyone for every condition right away. But they *do* matter, as our current problems with medical care demonstrate. Public and private insurance for elderly and poor people, and for most workers and their families, has vastly expanded demand for health-care services, pushing up the costs for those paying the bills. As a result, insurers and businesses have been forced to exclude more workers and more conditions from basic coverage, especially small firms expanding their payrolls and mature companies obliged to cover large numbers of older employees. The paradox for health-care reform is that in our current "cost-unconscious" medical marketplace, universal coverage tends to price itself out of the reach of those guaranteed it.

The principles of economic competition can begin to resolve this paradox by creating powerful economic inducements to discipline the demand for medical treatment and increase the supply of efficiently-delivered care. Managed

competition, the most prominent policy strategy based on these principles, would try to restructure our health-care markets by creating new incentives that (1) force insurers to compete more on the basis of value and price; (2) require everyone to assume more personal economic responsibility for their health-care choices; and (3) constrain providers to meet people's basic needs more efficiently, principally through health maintenance organizations (HMOs).

Pointing a Way

Over several years, we can provide basic coverage for everyone without injuring the economy. No one should doubt that we must do so. It will require that we extend coverage gradually, and even then the additional demand will raise health-care prices for everyone. It also will require that the President and Congress resist appeals to add new benefits to basic insurance. By most estimates, adding benefits for mental-health and dental services, medicines and long-term care could increase the nation's health-care bills by as much as \$100 billion a year. Ensuring basic coverage for everyone will mean reforming the basic ground rules of our health-care markets so that there, as everywhere else in the economy, consumers bear more of the costs of their own choices, forcing health-care businesses to become more efficient in order to survive. In short, it requires a new medical-care marketplace that satisfactorily can balance supply and demand.

If we choose this path, its incentives should reorganize the practice of medicine. Most of us will have to accept treatment less often from doctors and more often from nurses and other non-physicians. All but the truly poor will have to pay more for insurance and more for every service; everyone will have to forgo any prospect of a huge malpractice award. Most physicians will have to practice through HMOs; but, if high-quality medicine is part of the equation, they will still retain control over their own professional decisions.

This asks a lot of the vast majority of Americans who *already are insured*. Yet it is this majority, *not* the uninsured minority, driving the demand for universal coverage covering virtually any medical condition. According to surveys, most of us want a guarantee that we *always* will have the services we need, now and when we are older. We want to be certain that whatever our medical condition or job status, we and our families can get all the medical care we need.

Among the legions of health-care reformers, the proponents of market competition are challenged by those who see government mandates and price regulation as the only practical means of extending coverage and controlling costs. This alternative, however politically expedient it may seem, can only defer the remorseless logic of supply and demand at great economic cost.

The Shape of Tough-Minded Managed Competition

The strategy for managed competition has two basic parts, addressing in turn patients and providers. First, discipline demand for medical services by compelling people to pay more for them. For years, the standard proposal has been to limit the deduction that businesses can claim for insurance premiums they pay for their workers in order to raise the pressure on firms to search for more efficient coverage. But raising the cost of insurance coverage for business will not be enough to restrain demand, judging from the fact that a decade of determined insurance-shopping by most companies has not slowed health-care inflation.

This approach should be taken two steps further. First, limit the amount that companies can deduct for providing health insurance to the cost of the least-expensive package of basic benefits on the market, thereby providing a direct incentive for firms to select the most lean and competitive health plan. Second, heighten the pressure on everyone by counting as part of a person's taxable income any premiums exceeding this minimum amount paid in his or her name by an employer.

The object is not to increase anyone's financial burdens, but to use tax policy to promote an insurance marketplace where consumers weigh the purchase of economical coverage against other plans and insurers have stronger incentives to compete for their business on the basis of price and value. This can happen by maintaining the current taxpayer subsidies, both the deduction for business and the income-exclusion for their employees, but only up to the cost of the lowest-priced package of basic benefits. At first, these incentives could attract more business for the most-efficient insurers and providers than they could handle; but, this tax reform can be phased-in over several years.

Building competitive health-care markets requires reforms affecting demand for particular medical services as well as insurance. Under managed competition, everyone but the poor pays part of the cost of nearly every service they choose so that people have to assess the value of every health-care choice. To be sure, choice means nothing when your life is at stake, and people will always look to medical insurance for the security that life-saving treatment will always be available. But if people accept more economic responsibility for the rest of their care -- if copayments for most routine medical treatments are more like auto-insurance deductibles for collision damage -- prices for these routine services should rise at rates more like those for other goods and services.

Mandating Coverage

The principle challenge to this view comes from some reformers who want

to piggyback an employer mandate requiring every company to insure every worker onto reforms requiring that most people pay more of the costs of insurance but not most treatments. The leading proposal would require that all employers contribute either 7 percent of their annual payroll costs to cover most of the cost of basic insurance for every employee (80 percent of the basic premium). In addition, to cover the rest of the cost of basic coverage, workers would pay either about 2 percent of wages or the remaining 20 percent of the premium.

The economics of a mandate are equivocal, at best. With more than three-fourths of U.S. companies now voluntarily including insurance coverage in their employees' market compensation, evidence that an employer mandate would devastate business is not strong. Why doesn't normal market competition for workers compel the rest to offer coverage? From the worker's perspective, the pool of low-skilled people seeking jobs is large enough so they usually cannot bargain effectively for health-care benefits. By most employers' calculations, the productivity of most low-wage workers cannot justify health-care coverage that would, in effect, substantially raise their total compensation. Far from guaranteeing benefits to all low-skilled workers, therefore, the economics of a rigid employer mandate would probably cost many of them their jobs. Forced to make the choice, many companies would replace many, newly-expensive low-skilled workers with equipment or contracts to foreign facilities.

Until a stronger economy and managed competition make coverage more economical for these firms, reform should move cautiously on any employer mandate. On both economic and equity grounds, there is a strong case for making the federal government the financier of last resort for universal coverage, using revenues from a progressive income tax, rather than forcing companies to trade off health-care costs against job creation and using the regressive payroll tax. This could be achieved by providing either a substantial subsidy for small firms employing low-wage workers or a refundable tax credit for uncovered individuals to purchase their insurance.

The problem with a direct public subsidy for universal coverage -- whether the mandate falls on the firm or the individual, and whether the government subsidizes small employers or their low-paid workers -- is the incentive it would create for some firms to eliminate their current benefits. Until a more competitive health-care marketplace lessens the problem, it should help if both the subsidy and any mandate are phased in over several years, beginning with families with small children, and the subsidy phased out as a family's income rises. As labor conditions vary greatly across the country, each state could be allowed to choose which form of subsidy is best suited for its economy. With these limits, the costs could be covered by the revenues derived from limiting the business deduction and employee exclusion for employer-paid premiums.

Reforming the Health-Care Industry

The second part of a market-based strategy involves reforms of the health-care industry itself, driven principally by powerful statewide or regional insurance-purchasing pools called health alliances. These organizations would operate something like the New York Stock Exchange, bringing together buyers and sellers and setting rules of trade that, in effect, compel insurers to compete more on the basis of price and value.

To begin, the health alliances would collect most people's insurance premiums and help consumers choose among competing insurers and plans by publishing simple, standard information about the benefits and outcomes of every plan. (It is vital that consumers be able to genuinely evaluate the benefits and performance of every plan since the powerful tax incentives for purchasing the lowest-priced coverage will encourage some insurers and providers to try to compete by cutting-back on basic benefits and reducing quality.

In addition, the alliances' new rules of trade for insurance would end the price discrimination that today can deny people coverage or set their premiums on the basis of their pre-existing conditions. Instead, the alliances would define a standard package of basic benefits that all insurers would have to offer everyone at prices unaffected by a person's health status. Insurers would have to agree to these terms or lose the right to sell coverage through the alliances - a serious threat when nearly everyone is paying their premiums through them. By agreeing, an insurer will have to compete with rivals offering the standard package at less cost or with better outcomes, or face the commercial consequences.

The health alliances must have the authority to maintain a transparent and non-discriminatory marketplace for insurance without broader regulatory powers that could stifle competition or even evolve to a government-managed, single-payer system. Like a stock exchange, the alliances would be chartered not to regulate insurance prices or micro-manage the operations of medical providers, but only to oversee the terms of trade for the health-insurance market.

These reforms, however, would quickly bring about a major shakeout in the insurance industry. To compete and survive, insurers would have to contract with providers that find ways of delivering basic services more efficiently. There is no mystery about where these cost-saving efficiencies would be found. Managed competition will produce a fierce rush to HMOs, which offer blanket coverage for a per-person price by staffs of doctors, nurses and other assistants paid by salary or on a per-patient basis, instead of fee-for-service medicine by physicians and specialists of patients' own choosing. (It may also

spur the growth of preferred provider organizations, or PPOs, a variant on the HMO in which groups of doctors combine for a collective practice. Thus far, PPOs have not demonstrated the HMO's potential for efficiency gains and cost restraint.)

In theory, this strategy packs real economic power; by one reasonable estimate, a doctor in an HMO can cover two to three times the patient-load of private, fee-for-service physicians. Yet to date HMOs have *not* spread quickly. Most Americans prefer choosing all of their own doctors, and most doctors prefer conducting their own practices -- and for most people, the incentive to change has been modest since most HMOs still price their services only a whisker under fee-for-service. In short, so far HMOs have not achieved (or perhaps not passed on) the cost savings required to make universal coverage work without injuring the economy.

There is some evidence, drawn from recent experience with health coverage for California public workers and for Minnesota state employees, that HMOs can deliver medical care more efficiently and cheaply when they are part of a managed-competition system. More intense competition *will* help. In addition, economics can help identify incentives not only for HMOs to contain costs, but also for HMO doctors and nurses to recommend fewer and less costly services.

To achieve this, reform has to confront the high level of uncertainty characteristic of the practice of modern medicine. Doctors and nurses often cannot be certain how much testing and treatment a patient needs or, more precisely, what services a patient positively *does not* need. Many physicians over-prescribe expensive procedures whether or not they practice in HMOs to avoid being sued for *not* ordering more services that *might* prove helpful. They also bear no cost for ordering services that prove unnecessary. To drive-up the average HMO's cost-effectiveness, health-care reform has to include broad malpractice protection for physicians practicing standard but not extraordinary medicine, and perhaps incentives for employee ownership or profit-sharing by HMO physicians and nurses.

Uncertainty for patients takes a different form: How will the quality of their care be protected as its quantity and costs are reduced? The only answer is to rely on the independent judgment of highly-trained and well-paid physicians, nurses and other health professionals. Insurance premiums and co-payments have to be set sufficiently high to maintain ample incomes for medical professionals, and doctors and nurses have to retain the independent decision-making that all professionals expect -- or American medicine will have to settle for people less equipped or inclined to ensure high-quality care.

The Regulatory Alternatives

The laws of economics apparently demand a great deal of everyone -- too much for those urging the President to simply mandate universal coverage and then contain health-care costs by federal regulation. By all the evidence and theory we know, this political fix would injure both the economy and the health-care system.

The two chief regulatory options are a "global budget" and price and wage controls. With the first, the government would determine what share of the nation's income could go to health care by controlling the price of all insurance premiums. If businesses and workers are required to pay government-set fees to the health alliances to cover all insurance, and these fees are allowed to rise year by year according to a set measure such as payroll costs or the consumer price index, medical providers would have to make do with the resources allowed them by government. Everyone involved -- doctors and nurses, HMOs and hospitals, insurers and suppliers -- would negotiate or contend for their shares.

By itself, a global budget would not contain health-care inflation for long, because it does not address the market pressures driving up prices. If government tried to limit the resources, in effect, by decree, people would continue to demand levels of costly services that could not be covered by the revenues allowed by government. When these resources run out in the eleventh or twelfth month of the global budget -- when the government guesses wrong about the revenues required to cover quality treatment at a particular hospital or HMO, in a particular year, for a particular city -- something important would have to give. People would go untreated so that universal coverage contracts, or premiums would increase by more than promised and so bust the global budget, or reimbursements would fall the following year and the squeeze on revenues and treatment would recur in more virulent form.

In contrast to a global cap, a more plausible case can be made for a very limited version to discourage price increases during the transition to managed competition and universal coverage. As with a global budget, a limited budget cap would depend on the government determining by some measure how much insurance premiums should increase. The crucial difference is that the cap would apply only to premiums for basic coverage and only while the mandate for universal coverage was being phased in -- and the cost pressures on the cap would be eased by the economic incentives of a more competitive health-care system.

Still, the economics for even a limited cap remain dubious. Government experts cannot know in advance what markets can determine only in practice -- namely, the cost over the coming year for the most efficient insurers and

channel labor and other resources to industries paying higher, uncontrolled prices and wages, producing shortages of medical services when more are needed.

To work, price and wage controls need fixed targets to regulate, but health-care reform, if it is to work, will drive continuous changes in medical services and the practices of medical personnel.

If we are serious about providing universal coverage and slowing the growth of health-care costs -- and without injuring the economy -- government controls cannot be part of the solution. Instead, we will have to change the ways we consume and provide medical care -- once again, reorganizing the practice of medicine, receiving treatment less often from doctors and more often from nurses and other non-physicians, paying more of the cost of insurance and of nearly every procedure and foregoing the ability to win large judgments for malpractice.

Even so, health-care costs will continue to rise faster than other goods and services for some time -- and not only because insurance will always be there. In addition, the numbers of Americans who are elderly and so require costly routine care will continue to increase. The extraordinarily costly AIDS epidemic will continue to spread. And technological advances in medicine will continue to be phenomenally expensive and, under almost any imaginable reform, every costly advance will continue to be available under standard insurance and at nearly every large facility.

The President's clear task is to teach Americans that it is not the government's duty to preserve the current system nor is it right to replace it with controls. Rather, we must reform the system's basic ground rules so that, over some years, we *can* achieve universal coverage while satisfactorily balancing health-care supply and demand. Even with market-based reforms, most Americans will pay more than they do today, for years to come. But if the President and Congress will respect the laws of economics as they carry out these reforms, the additional burden could help keep everyone's coverage secure and the economy sound.

* * *

Dr. Robert J. Shapiro is the Vice President of the Progressive Policy Institute.

providers to deliver their basic services. Health-care reform itself will make such determinations truly impossible, since it will quickly bring about countless changes in medical practices and treatment protocols, and upheavals in the insurance and provider markets themselves. When the government's health-care accountants guess wrong and the rates they allow cannot cover basic costs, the resulting pent-up price pressures will reignite medical inflation once the temporary cap is lifted. If the cap mechanisms were to become permanent, it would amount to government price controls for basic insurance, limiting the power of economic competition to drive down insurance prices.

Price and Wage Controls, versus Quality Health Care

The second regulatory alternative is broad price and wage controls. There is no sound economic theory or evidence to support the hope that these controls could work in health care. To begin, price and wage controls are virtually impossible to enforce in a industry like medical care, with tens of thousands of separate facilities where billions of annual transactions are carried out, providing thousands of different services and using tens of thousands of different goods. Already, health-care businesses have demonstrated a protean capacity to preserve their revenues and profits in the face of such controls. When the government froze Medicare Part-B doctors' charges in the mid-1980s, physicians reported visiting their patients more frequently, shifting to more highly-reimbursed treatments, and ordering more tests that required little of their own time -- and total costs continued to rise rapidly.

The current Medicare cost controls -- the Prospective Payment System, which reimburses hospitals at set rates for each illness rather than each procedure -- have not been much more effective. Over several years, this system has modestly slowed the growth in Medicare costs, but *total* medical costs have not been restrained because hospitals offset their losses by raising charges on everyone else. Today, hospitals recover about 90 percent of the costs of treating Medicare patients -- and charge privately insured people 128 percent for the same treatments. If government tried to control the entire system in this way, total costs would still depend on diagnosis -- over which hospitals, doctors and HMOs will always retain control.

Moreover, price and wage controls would virtually cripple the effectiveness of managed competition. The conflict comes from the squeeze they would impose on an HMO's operating margins. As the forces of managed competition enable HMOs to provide more, efficiently delivered health care, controls would prevent the most efficient ones from negotiating with their suppliers and doctors for favorable terms. This would reduce their savings and undercut their competitive edge, and so inhibit their growth just when the system requires their expansion. More generally, by targeting controls only to health care, the "reform" would

Bruce
File:
Health Care

EXECUTIVE OFFICE OF THE PRESIDENT

26-May-1993 07:37pm

TO: (See Below)
FROM: S. Collier Andress
Office of Communications
SUBJECT: talking points

THE CLINTON HEALTH CARE PLAN

THE STATUS QUO

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

THE CLINTON PLAN

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

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

The proposal will be based on the following principles:

- 1) Security: The Clinton plan will provide Americans with the security of knowing that they will have health coverage even if

they switch jobs, lose their job or have a preexisting condition.

- 2) Choice: The Clinton plan will allow you to choose your doctor. And most Americans will have more choice of health plans. Under the Clinton proposal, your employer or insurance company won't pick your health plan -- you will.
- 3) Quality: The Clinton plan will increase the quality of care. And it will hold doctors and hospitals accountable with a simple consumer "report card" for each health plan.
- 4) Controlling Costs: The Clinton plan will make health care affordable again. And it will control the spiralling costs that are strangling American businesses.
- 5) Comprehensiveness: The Clinton plan will guarantee all Americans a comprehensive benefits package.
- 6) Simplicity: The Clinton plan will reduce paperwork for both doctors and patients, and it will eliminate fraud and abuse. The health care bureaucracy will shrink under the Clinton plan.

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Security for Every American

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

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

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

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

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

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

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between jobs. No matter what disease hits or when it hits or who it hits.

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

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

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

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

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

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

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

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

Every day, every hour, exploding health care costs are picking

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all our pockets and handbags. Right now, as you sit here, you're
paying for someone who's been forced to go

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

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

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

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

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

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matter where you live or where you work.

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

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

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

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

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

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

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their loved ones.

That will be gone.

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

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

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

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

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

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

Now let me say to the small business owners in this room that, if you're covering your employees right now, we're going to bring your costs under control. We're going to protect you. We're going to stop the insurance schemes that discriminate against you and drive

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your premiums through the roof. We're going to let you team up with other small businesses and negotiate for the same rates that insurance companies give the big guys.

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And if you're not able now to cover your employees, we're going to help make insurance affordable for you, your family and your workers! We're going to ask everybody -- workers and employers alike -- to chip in for health care. We're going to give you the assistance you need but we're going to stop asking the folks who are now paying for insurance to pay for those who don't. Because it's not fair when the dry cleaner who covers his workers has to pay a whole lot more because the owner of the car wash down the street can't pay the price.

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

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

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

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

Now there are a lot of people out there who are going to tell you that we don't need to change. They're going to try to scare you by making up all sorts of stories about terrible things. Then

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they'll tell you that they agree we need some reform -- but only on their terms.

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

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

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

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

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

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or Democrats. There are just Americans.

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

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

HEALTH CARE REFORM:
QUESTION AND ANSWERS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q: How are you going to control costs?

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

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

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

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

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

The Clinton plan will improve the quality of American health care. Under the Clinton plan, the best technologies in the world will be put to work for you. There will be more primary care doctors and nurses to give care. And there will be a simple consumer report card -- so that doctors and hospitals are held accountable based on results, not on how many forms they fill out.

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Most important, the Clinton plan will give American families the security that they will never lose their insurance.

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Q: Won't this plan kill small business?

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

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

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

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

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

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

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

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

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

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

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employees -- giving them the security that they will never lose their insurance.

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

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

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

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

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

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

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

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

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

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

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

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be less paperwork -- and better health care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q: Will I be able to stay on Medicare?

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

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

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

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

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

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

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

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

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

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

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

Q: Will the plan cover undocumented immigrants?

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

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to do so.

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

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

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

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

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

DPC - Jul staff - fyi

EXECUTIVE OFFICE OF THE PRESIDENT

29-Jun-1993 07:35pm

TO: (See Below)
FROM: Jeffrey L. Eller
Office of Media Affairs
SUBJECT: Health Care Talking Points 6/30

The White House
Health Care Reform Today
June 30, 1993

* "I invite you to join the debate." That's what President Clinton said directly to the National Federation of Independent Business yesterday as he spoke to them about the economy and health care. Saying they would not always agree, the President told the NFIB that he would meet with representatives of small business on a regular basis...just as he now meets with corporate CEO's.

* But the President made it clear...reforming health care is a priority and it will be done.
"...I assure you that we're all going to be better off if we enter into an honest debate and try to work through this, and we try to resolve it. The worst thing we can do is to leave it alone; and especially, the worst thing we can do for the small business sector, because bigger employers will figure out how to get managed care and they'll just go around this whole health insurance system we have today. Everybody else is going to be out there just strung up. So we must face it. And we've got to provide some means of covering people, letting them change jobs, and having people have this without going bankrupt. And that is something that I am deeply dedicated to."

* Writing for Knight-Ridder newspapers, R.A. Zaldivar reported that several members of the NFIB were not necessarily opposed to a plan that asks all employers to contribute to the costs of their employees health care. Bill Blackburn of Ramco Tools in Kent, Washington was quoted: "I believe the mandate would be OK with me in my thinking. We are paying for these costs anyway." Byron Green of Indianapolis said: "We don't like to be told what we're supposed to do, but if employees have to pay a portion, I'd feel a little bit more free to do it." Even an NFIB field representative was quoted: "Small-business owners are going to have to accept responsibility for paying."

* Here at the White House, we've centralized information for health care reform into room 160 of the OEOB. This nerve center will quickly respond to questions and concerns regarding the President's health care plan. Representatives from key White House departments will be available and can be reached at 202-456-2566. This means you won't have to call all over the White House to get health care information. The fax number is 202-456-2362.

* We want to hear from you. Feel free to give us a call or fax information, including newspaper clips. Those who oppose health care reform are sparing no expense to frame their message early. If you see clips or direct mail, please fax it over to us.

Health Care Reform TodayThe White Houseu202-456-2566uFax: 202-456-2362

Distribution:

TO: Barry J. Toiv
TO: Marsha Scott

EXECUTIVE OFFICE OF THE PRESIDENT

30-Jun-1993 07:46pm

TO: (See Below)

FROM: Jeffrey L. Eller
Office of Media Affairs

SUBJECT: Health Care Talking Points 7/1

The White House
Health Care Reform Today
July 1, 1993

*More evidence of the health care problem. During hearings in Scottsbluff, Nebraska yesterday, the AP reports that Dr. Vince Bjorling said cost-shifting is a major health care problem. "If my patient needs Tylenol, and I order him two Tylenol, the hospital may charge him \$15." We all know that is too much to pay for Tylenol. Today, people who have insurance pay for those who don't. Yesterday's hearings, sponsored by two Nebraska Committees appointed by Governor Ben Nelson, heard a steady stream of concerns as to why health care reform is needed.

*Yesterday, at the joint House-Senate message meeting, the First Lady received valuable suggestions and advice about the importance of a multi-faceted communications strategy. The Administration's communication effort will provide quick information to Members of Congress, elected officials, the media, health care constituencies and consumers. The White House communications center in room 160 of the OEOB is central to this goal. For more information, you can contact us at 202-456-2566.

*Good news on health care from Cong. Newt Gingrich. Talking to reporters following the weekly bi-partisan leadership meeting with President Clinton, Congressman Gingrich indicated to the AP that dealing with health care this year may be easier than he thought. He said: "...my guess is there is a lot of ground for commonality." He's right...that's why White House staff will continue to consult with both Democrats and Republicans on health care.

*Today, First Lady Hillary Rodham Clinton will participate, via satellite, in a ceremony marking the signing of the

Missouri Health Care Access Bill. The bill recognizes that to improve America's health care system, high quality, cost-effective care must focus on keeping people healthy, not just treating them once they're sick.

*A common question is what will the national health care reform effort have on the reform movement that is ongoing in the states. States who are tackling health care should be applauded... but everyone seems to agree that this cannot be done by the states alone. Controlling costs, providing security and guaranteeing all Americans a comprehensive package of benefits are challenges for our entire nation to solve. Under the President's proposal, the federal government will provide a broad framework for providing security and controlling costs. States will continue to play an essential role in making those guarantees a reality for all citizens.

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