CATO

MEMORANDUM

MICHAEL D. TANNER
Director of Health and Welfare Studies

TO: Ed Crane

FROM: Mike Tanner

RE: Politics of Health Care Reform

DATE: February 14, 1993

In follow-up to our earlier conversation, I want to bring to your attention some serious concerns that I have with the strategy that some "conservatives" are pursuing on health care reform.

Although the Clinton plan has taken some serious hits in the past couple of weeks, I think it is far too early to pronounce it dead. Right now the Cooper bill is being cast as the alternative, but I don't think that is likely to last. Cooper has some big flaws (note my *Wall Street Journal* piece this week). Once they come out in the media, I think Cooper will fade quickly.

Once Cooper begins to fade, the question will return to the Clinton plan itself. The Clinton plan should be defeatable. It certainly offers a lot of areas to attack. But, I am deeply concerned that the Clinton plan's opponents are about to make a serious strategic mistake.

There appears to be a concerted effort among some opponents of the Clinton plan to rally opposition behind the Consumer Choice Health Security Act (S 1743, HR 3698), sponsored by Senator Don Nickles (R-Ok) and Representative Cliff Stearns

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(R-FL). Certainly the Heritage Foundation, which essentially wrote the plan, is attempting to portray it as the "official" alternative.

As we have frequently discussed, this proposal is gravely flawed as a matter of principle. However, given that the bill has virtually no real prospects for passage, I am far more concerned at this time that Nickles-Stearns frames the issues, vis-a-vis the Clinton plan, in a way that may actually help the President's plan.

Most seriously, the Nickles-Stearns bill completely concedes the question of "universal coverage." There is now strong opposition to Clinton's mandate that businesses pay 80% of their employees health care costs. Indeed, opposition to the employer mandate is one reason for the popularity of the Cooper bill. But, instead of simple opposition to a mandate, Nickles-Stearns sets the issue up as a contest between an "employer mandate" and an "individual mandate."

This almost certainly snatches defeat from the jaws of victory. Instead of opposition to the President's unpopular job-destroying mandate, the question becomes a debate over who pays. Imagine "Joe Sixpack" watching the debate on TV. "Let's see," he says, "the President says my boss should pay for insurance and his opponents say I should pay for it. Which one of these plans am I for?"

The mandate is analogous to a tax. The President wants to impose a new tax on business. We are not likely to defeat it by arguing that the tax should be imposed on workers instead. Only

a principled opposition to the tax itself is likely to be successful. Likewise, only principled opposition to a mandate is likely to defeat the Clinton mandate.

Second, the Nickles-Stearns bill concedes the government's right to develop a minimum standard benefits package. Its sponsors apparently take comfort from the fact that their package is less generous and, therefore, less expensive than the President's. But once the idea of a minimum benefits package designed and imposed by the government is accepted, there is an open invitation for a bidding war on what benefits should be included. The only question becomes what is in the plan. Trying to defeat Clinton's "generous" plan with a "parsimonious" plan, does not strike me as a winnable proposition. Moreover, Clinton will have a wonderful opportunity to buy off various special interest groups by offering them inclusion in the package. Once again, the only position likely to defeat Clinton is the principled one -- allowing consumers to choose the benefits they want to buy.

Third, the Nickles-Stearns bill concedes the concept of "community rating." This strips Clinton opponents of a very potent weapon. During my trips around the country, I have found that people are very upset by the unfairness of community rating. They understand that community rating means that individuals with healthy lifestyles will see their premiums rise to subsidize those who have unhealthy habits, such as smoking, overeating, abusing drugs and alcohol, and engaging in unsafe sexual practices. While Nickles-Stearns does not have the pure

community-rating of the President's bill, it does prohibit basing premiums on health risk. Among other things, this cuts the "pro-family" groups out of the debate. Why should they spend their resources opposing the Clinton plan, if the opposition contains the same "anti-family" provisions.

Finally, Nickles-Stearns undermines the most viable alternative to Clinton -- medical savings accounts. We have been making progress recently in convincing the public, media, and Congress that one of the major problems with America's health care system is the third-party payment system, which divorces health care consumers from the costs of their decisions. However, Nickles-Stearns continues to rely on third-party payment for most health care expenses. Moreover, by capping individual insurance deductibles at $1,000 ($2,000 for a family), the plan cuts the legs out from under any attempt to move toward self-insurance and eviscerates the idea of medical savings accounts. How can we rally support behind medical savings accounts when the "official" alternative plan treats them so cavalierly. Medical savings accounts should be the centerpiece of any alternative to the Clinton plan, not a tag-on.

The discussion over the last couple of weeks has been about a Clinton-Cooper compromise. However, a Clinton-Nickles compromise would not be much better. I know that in the aftermath of the New Republic article, the Heritage foundation has been complaining that our opposition to Nickles-Stearns is "divisive." Still, I think it is important to let the anti-Clinton forces know about the potential dangers of the Nickles-

Stearns approach. I don't want to see us split the anti-Clinton forces. But, I don't want to march off a cliff with them either.

What do you think?

Bob -

There are a whole series of existing Federal programs not being discussed here:

Indian Health
Veterans
Champus
D.O.D military Medical
Federal Employees Health Benefit Plan

Thats one hell of a series of health problems!

Ted's

IN ATTENDANCE

36 SENATORS

6 HOUSE MEMBERS

3 GOVERNORS

SENATORS WHO DID NOT ATTEND

COHEN
KASSEBAUM
FAIRCLOTH
HELMS
PACKWOOD
D'AMATO
CRAIG
HATFIELD

Bob —

I agreed to take your place at Homebuilders speech on Monday —

SENATE REPUBLICAN
HEALTH CARE TASK FORCE RETREAT
PRIVATE SECTOR DISCUSSION GROUP PARTICIPANTS

March 4, 1994

Paul ~~Heard~~ Hard
Senior Vice President
Policy & Communications
National Association of Manufacturers

Richard Davidson
President
American Hospital Association

Charles L. Fry
Corporate Vice President, Public Affairs
G. D. Searle & Company

The Honorable Willis D. Gradison
President
Health Insurance Association of America

Alan M. Krandwitz
Senior Vice President, Government Relations
National Association of Wholesaler-Distributors

David Jones
Chairman & CEO
Humana, Inc.
(Chairman, Healthcare Leadership Council)

Ralph Larson
Chairman & CEO
Johnson & Johnson

John J. Motley
Vice President Federal Government Affairs
National Federation of Independent Businesses

Robert E. Patricelli
Chairman, CEO
Value Health Inc.
(Chairman, Health Committee, Chamber of Commerce of the United States)

Michael O. Roush
Director, Federal Government Relations (Senate)
National Federation of Independent businesses

Austin Sullivan
Vice President, Public Affairs
General Mills

Dr. James Todd
Executive Vice President
American Medical Association

Robert Winters
Chairman & CEO
Prudential Insurance Company of America
(Chairman, The Business Roundtable)

HEALTH CARE RETREAT
ATTENDANCE LIST
As Of March 2, 1994

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Robert Bennett
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Conrad Burns
Dan & Marcia Coats
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Phil Gramm
Charles Grassley
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James Jeffords
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Trent Lott
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Mitch McConnell
Frank & Nancy Murkowski
Don Nickles
William Roth
Alan Simpson
Arlen Specter
Ted Stevens

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Malcolm Wallop
Kay Bailey Hutchison
Robert Smith
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Hank Brown
Strom Thurmond

(35)

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William Thomas
Thomas Bliley
Nancy Johnson
Newt Gingrich
Dennis Hastert
Cliff Sterns

(6)

GOVERNORS

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Mike Leavitt, UT
Stephen Merrill, NH

(3)

RNC

Haley Barbour

(1)

Republican
National
Committee

Haley Barbour
Chairman

March 3, 1994

MEMORANDUM FOR SENATOR JOHN CHAFEE

FROM: HALEY BARBOUR

RE: RECENT NATIONAL SURVEY RESEARCH BY REPUBLICAN POLLSTERS

Since I will not arrive in Annapolis until 10:00 or so tonight (the RNC telecasts a weekly, one-hour show at 8:00 p.m. EST every Thursday), I will miss the session with the pollsters; therefore, I am forwarding in writing the results of some health care reform questions asked by Republican pollsters in private surveys over the last couple of weeks.

Support for the Clintons' plan has declined in every public survey, and that holds true in the private surveys as well. This is obvious from the Fabrizio, McLaughlin mid-February survey (hereinafter FM), Public Opinion Surveys (POS) early February poll, and the American Viewpoint (AV) poll that came out of the field last week. (See Appendix A)

The movement against the Clintons' plan seems based on the increasing public perception of its negative effects on the quality and cost of care. This is evident from every survey, as shown in Appendix B. The Tarrance Group survey of late February is shown as TG.

Generally, people expect to pay more under the Clintons' plan and to receive fewer benefits. They not only think the Clintons' plan would drive up costs, but quality issues are beginning to have more significance in the public debate. A number of questions in the various surveys make clear that respondents think the quality of care would decline and that they might lose their choice of doctors and health plans. (Appendix B)

Increasingly, the Clintons' plan is seen as a government-run health care system, although that view has not fully ripened. It is clear, however, that most people think a government-run health care system would hurt the quality of care. (Appendix C)

That line of reasoning probably accounts for the opposition to mandatory health alliances like those in the Clinton and Cooper bills. By large margins respondents think quality would go down and costs would go up if most people were required to buy their health insurance through government purchasing agencies. (Appendix D)

Using a thermometer scale of 0 to 100 for intensity of feeling, one survey showed the highest rating (and therefore the most intense feeling) was 89 to maintain the quality of health care in this country and the second highest was 87 to maintain the ability to choose your own doctor. I think quality issues could soon surpass cost issues and become the most important consideration to most voters. (Appendix E)

While support for the Clintons' plan is diminishing, there is a strong desire for health care reform, and most people are not yet aware that the Republicans are advocating our own alternatives. Just over a third said they thought the Republicans had an alternative health care plan, and a plurality said Republican opposition to the Clintons' proposal was on political grounds. More than one-third said they would vote against their current Member of Congress if health care legislation did not pass this year. I cannot assess that in full, as I have not seen the cross tabs, but that is an unusually high number. (Appendix F)

Several surveys tested competing approaches to health care reform. There is support for a comprehensive package of specific reforms as opposed to the Clintons' solutions of total reform or creating a new system. You will notice two surveys show heavy majority support for this approach, while one shows mixed support. (Appendix G)

The attached appendices give the actual questions and responses referred to in the foregoing summary.

Attachments
cc: Senator Dole
Representative Gingrich
Governor Campbell
Attendees

APPENDIX A

FM6 From what you've read or heard, do you favor or oppose President Clinton's Health Care Plan?

1. Favor 36.0
2. Oppose 46.1
3. DK/Refused 17.9

POS4 Based on what you know, do you (ROTATE) ____favor or ____oppose President Clinton's health care plan, or do you not yet have an opinion? (IF FAVOR/OPPOSE ASK:) And do you STRONGLY (favor/oppose) the plan or just SOMEWHAT (favor/oppose) the plan?

13%	STRONGLY FAVOR
19%	SOMEWHAT FAVOR
10%	SOMEWHAT OPPOSE
19%	STRONGLY OPPOSE
40%	DON'T HAVE AN OPINION
*	REFUSED (DO NOT READ)

AV1 1. In general, do you favor or oppose President Clinton's health care reform plan?

Favor	42%
Oppose	42%
Don't Know	14%
Refused/NA	1%

APPENDIX B

AV2 Which of the following statements comes closest to your own view of the effect of the Clinton health care plan on you?

I will probably pay more for health care coverage but get less in benefits	35%
I will probably pay more for health care coverage but get more in benefits	8%
I will probably pay less for health care coverage but get less in benefits	7%
I will probably pay less for health care coverage but get more in benefits	5%
My health care costs and benefits probably won't change much	39%
None of the Above [VOLUNTEERED]	3%
Don't Know [VOLUNTEERED]	3%
Refused/NA [VOLUNTEERED]	*%

Now, I would like to read you a list of the different aspects of the health care system that will be affected by President Clinton's health care reform package. For each one, please tell me whether you think this aspect of the health care system for you and your family will -- 1) get better, 2) stay the same, or 3) get worse -- as a result of Clinton's health care reforms? **(READ AND ROTATE)** IF BETTER OR WORSE, THEN ASK: And is that much (better/worse) or somewhat (better/worse)?

		BETTER MUCH	BETTER SMWHT	UNSURE (DNR)	STAY SAME	WORSE SMWHT	WORSE MUCH
TG19	Your health care costs in the first year	4%	12%	15%	27%	26%	16%
TG20	Your health care costs over the next five years	6%	17%	12%	16%	25%	25%
TG16	The quality of care you receive **(DO YOU THINK THAT THE QUALITY OF CARE YOU RECEIVE WILL GET BETTER OR WORSE AS A RESULT OF CLINTON'S HEALTH CARE REFORMS?)**	5%	11%	10%	34%	21%	20%
TG17	Your choice of doctors	4%	10%	11%	32%	21%	23%
TG18	Your access to health care	8%	14%	9%	34%	18%	18%

APPENDIX B (Con't)

The following are some details about President Clinton's health care reform plan. If each of the following were true, please tell me whether you would favor or oppose the Clinton Plan.

		Favor	Oppose	DK/Ref
FM9	President Clinton's Health Care Plan would create 79 new government agencies and commissions to administer his plan.	21.9	71.6	6.5
FM10	President Clinton's Health Care Plan would impose a 1.9% payroll tax on all workers to help pay for this plan.	35.6	58.4	6.0
FM11	President Clinton's Health Care Plan would establish state-by-state health care budgets and if a state exceeded its budget, medical services could be rationed in that state.	20.9	71.5	7.6
FM12	Under President Clinton's Health Care Plan you are not guaranteed the right to choose your own doctor.	9.6	86.5	3.9
FM13	President Clinton's Health Care Plan would limit your choice of health coverage to government designed plans.	14.1	80.3	5.6
FM14	President Clinton's Health Care Plan would cost taxpayers $ 1.7 Trillion in new spending, which amounts to $6,800 per American over the next 5 years.	14.5	79.1	6.4

APPENDIX C

Now, thinking specifically about the Clinton health care reform plan --

TG26 From what you have seen read or heard about the Clinton Administration's health care reform package, how much control do you think the federal government would have under the Clinton plan over the U.S. health care system? Would you say it will have -- complete control, a great deal of control, moderate control, very little control or no control at all -- over the health care system?

Complete	22%
Great deal	34%
Moderate control	30%
Very little	6%
No control at all	2%
DON'T KNOW ENOUGH ABOUT THE PLAN (DNR)	3%
UNSURE (DNR)	2%

Thinking about a government-run system of health care --

TG27 Do you think that you and your family's health care would get better, stay about the same, or get worse under a government-run system?

Get better	13%
Stay the same	29%
Get worse	51%
UNSURE (DNR)	7%

Changing topics again...

(½ SAMPLE A ONLY ASK:)

POS9A How good a job do you think the federal government would do if given the responsibility of implementing and actually running the health care system? Would you say it would do an excellent, very good, only fair, or poor job?

(n=400)

3%	EXCELLENT
14%	VERY GOOD
35%	ONLY FAIR
42%	POOR
5%	DON'T KNOW/NOT SURE (DO NOT READ)
*	REFUSED (DO NOT READ)

FM8 How comfortable would <u>you</u> <u>personally</u> be in entrusting your family's medical care to a health care plan run by the Federal Government? Would you be very comfortable, somewhat comfortable or not comfortable at all?

1. Very comfortable 9.5	2. Somewhat comfortable 35.8
3. Not comfortable 51.8	4. DK/Refused 3.0

Now, if today's health care system is going to be changed, and thinking about goals in any bill passed by Congress, I am going to read you a list of possible reforms and I would like you to rate how important you feel that reform is. Please rate each reform on a 1 to 100 scale where 1 means NOT TOO IMPORTANT and 100 means VERY IMPORTANT. Although ALL of these may be important, most, of course, would be rated somewhere in between those two extremes. The FIRST/NEXT one is...**(ROTATE Qs. 10-16)**

RATING

POS12 Do NOT allow the federal or state government to run the health care system — Mean = 65

APPENDIX D

Still thinking about President Clinton's health care reforms -- As you may already know, President Clinton's health care reform package requires that most companies and individuals must buy their health insurance through a government purchasing agency.

TG21 Do you believe that the "quality" of health care for you and your family would -- 1) get better, 2) stay the same, or 3) get worse -- if you had to buy your health care insurance through a government purchasing agency? IF BETTER OR WORSE, THEN ASK: And is that much (better/worse) or somewhat (better/worse)?

Better/much	5%
Better/somewhat	9%
UNSURE (DNR)	12%
Stay the same	21%
Worse/somewhat	21%
Worse/much	32%

Again, knowing that Clinton's health care plan will require most companies and individuals to buy their health care through a government purchasing agency --

TG22 Do you believe that the "cost" of health care for you and your family would -- 1) decrease, 2) stay the same, or 3) increase -- if you had to buy your health care insurance through a government purchasing agency? IF DECREASE OR INCREASE, THEN ASK: And is that (decrease/increase) a lot or (decrease/increase) somewhat?

Decrease/a lot	5%
Decrease/somewhat	15%
UNSURE (DNR)	15%
Stay the same	16%
Increase/somewhat	25%
Increase/a lot	24%

AV3 That most businesses and individuals would be required to buy their health insurance through a government-controlled agency, choosing only from a group of government-approved plans.

Much More Likely	11%
Somewhat More Likely	15%
Somewhat Less Likely	25%
Much Less Likely	44%
Neither [VOLUNTEERED]	1%
Don't Know [VOL]	3%
Refused/NA [VOL]	1%
TOTAL MORE LIKELY	26%
TOTAL LESS LIKELY	69%

APPENDIX E

Now, if today's health care system is going to be changed, and thinking about goals in any bill passed by Congress, I am going to read you a list of possible reforms and I would like you to rate how important you feel that reform is. Please rate each reform on a 1 to 100 scale where 1 means NOT TOO IMPORTANT and 100 means VERY IMPORTANT. Although ALL of these may be important, most, of course, would be rated somewhere in between those two extremes. The FIRST/NEXT one is...**(ROTATE Qs. 10-16)**

		RATING
POS11	Make sure that people can select any doctor or hospital of their choice	Mean = 87
POS16B	**Maintain America's high quality health care**	**Mean = 89**

APPENDIX F

AV9 Please tell me whether you agree or disagree with the following statement? I believe that health reform is so important that if Congress does not pass health care reform this year, I will vote against my current Member of Congress in the 1994 election.

Agree	36%
Disagree	58%
Neither [VOL]	0%
Don't Know [VOL]	5%
Refused/NA [VOL]	1%

Still thinking about efforts to reform health care --

TG23A Do you think that the Republicans have a plan to reform our national health care system or not?

Yes/have plan	36%
No/no plan	46%
UNSURE (DNR)	18%

TG23B Do you think that the Republicans or Democrats in Congress have any plans to reform our national health care system other than the one proposed by President Clinton?

Yes/have plan	56%
No/no plan	27%
UNSURE (DNR)	17%

As you may know, a number of Democrats and Republicans in the U.S. Congress have introduced a variety of health care reform packages as alternatives to President Clinton's plan. Thinking about this --

TG24 Do you believe that the Republicans are offering these alternative plans because they are supportive of health care reform but disagree with the specifics of the Clinton plan, OR are they just playing politics and trying to kill the Clinton plan?

Supportive of reform	33%
Kill Clinton plan	48%
BOTH (DNR)	9%
NEITHER (DNR)	1%
UNSURE (DNR)	10%

APPENDIX G

Still thinking about reforming health care --

TG25

Some people say that we need a health care reform plan like the President's which will replace the current health care system. They say unless we have total reform, any changes will be piecemeal and not enough, and we will fail to ensure that all Americans have universal health care coverage, or that costs will go down in the long term.

Other people say that we should have specific reforms of the things that are wrong with the existing health care system -- such as requiring insurance companies to provide for pre-existing conditions, ability to keep your health insurance if you lose or change your job, reduction of paperwork, and malpractice reforms to bring down costs -- rather than creating a totally new and untested government-run health care system.

Which viewpoint comes closer to your own?

Total reform	24%
Specific reform of current system	63%
NEITHER/LEAVE ALONE (DNR)	4%
UNSURE (DNR)	9%

AV7

We should fix the things that are wrong with the existing health care system through specific reforms such as requiring insurance companies to provide for pre-existing conditions, allowing people to keep their insurance if they transfer jobs, reducing paperwork, malpractice reform, and other insurance reforms - rather than creating an untested system that forces most Americans to switch their health care plans.

Agree	78%
Disagree	19%
Neither [VOL]	1%
Don't Know [VOL]	2%
Refused/NA [VOL]	*%

POS18 Now, let me tell you about one specific health care proposal in Congress. This proposal does THREE things:

First, the plan prevents insurance companies from denying coverage to people with a pre-existing medical condition when they change jobs;

Second, it makes it tougher for lawyers to sue doctors which would help reduce costs.

Finally, the plan would expand access to health care for the working poor who can not afford health insurance but still make too much money to currently qualify for federal assistance.

BUT this proposal does NOT guarantee EVERY American would have health insurance coverage. Having heard about this proposal, if it was passed by Congress ... which phrase best describes what you would think... would this proposal be ...**(ROTATE TOP TO BOTTOM, BOTTOM TO TOP)**

11% a failure
49% a good first step, with more to be done
17% a dramatic change that would immediately help millions of people
15% all we should do until we are sure the country can afford universal coverage

7% DON'T KNOW/NOT SURE (DO NOT READ)
1% REFUSED (DO NOT READ)

POS19 Now, thinking again about this proposal that would assure that people with pre-existing conditions would not lose coverage by changing jobs, reforms medical malpractice laws, and expands access to health care for the working poor... if this law were passed, how concerned would you be that it did NOT also guarantee universal health coverage to ALL Americans? Would you be...**(ROTATE TOP TO BOTTOM, BOTTOM TO TOP)**

41% VERY CONCERNED
40% SOMEWHAT CONCERNED
12% NOT TOO CONCERNED
5% NOT AT ALL CONCERNED

2% DON'T KNOW/NOT SURE (DO NOT READ)
1% REFUSED (DO NOT READ)

**A MEMORANDUM TO REPUBLICAN SENATORS
ATTENDING THE HEALTH CARE TASK FORCE
CHAIRED BY U.S. SENATOR JOHN CHAFEE (R-RI)**

FROM: **NEW MEMBERS**
Robert F. Bennett
Paul D. Coverdell
Lauch Faircloth
Judd Gregg
Kay Bailey Hutchison
Dirk Kempthorne

SUBJECT: **THE FOUNDATION FOR BUILDING REPUBLICAN CONSENSUS ON HEALTH CARE REFORM**

As we discuss reform alternatives to our health care delivery system, we believe that a consensus should be reached, to the full extent possible, among Republican Senators prior to any attempts to reach consensus with the President and the Senate Democrats.

This forum can serve as the beginning of building such a consensus because it comes at a critical time in the debate on reform of our health care delivery system. The American people have heard the Presidential rhetoric and listened to the sound bite politics on health care reform. Now we are beginning to hear what the American people -- the customers of our current health care system -- are saying about the rush toward reform.

The results are startling when Presidential rhetoric meets voter reality. The Washington Post reported on Wednesday, March 2, 1994, that 80% of the public is concerned that the quality of their medical care will decline if the President's plan is enacted.

This figure directly parallels earlier reports by CNN/USAToday/Gallup showing that 81% of the public is satisfied, or very satisfied, with the current health care system.

Eight out of ten people are served well and satisfied by our current system. Of the two out of ten not served well, some have serious problems, some have concerns less urgent.

These results urge us to ask, is it necessary to overhaul our entire health care system, disrupting and

destabilizing the quality of health care of 80% of our families and businesses, in order to reach the 20% currently not served well? Furthermore, must we look toward turning 100% of our health care system, a system approaching 15% of our economy, over to the government, to reach the 20% of the public currently not served well?

We believe the answer to both questions is no. And, as the President rushes to push his reform package through Congress we strongly believe any reform efforts must be done correctly before they are done quickly. The public agrees. The Washington Post poll mentioned earlier shows that under the Clinton government-run health care plan:

- Three out of four Americans are concerned the cost of their medical care will increase;
- Three out of five Americans are concerned the plan will create another large and inefficient government bureaucracy; and
- Three out of five are concerned that taxes will have to be increased to pay for the plan.

There is an alternative to a massive government-overhaul of the health care delivery system. This alternative seeks to implement "necessary reforms" to preserve the best elements of our existing system while working to improve problem areas.

As new members, we endorse the concept of targeted health care reform because, through an improvement on specific targets in health care delivery, we can produce major and significant improvements in the system immediately without destabilizing health care for all Americans.

We believe targeted reform should serve as the foundation upon which we build Republican consensus. Market reforms, administrative reforms, anti-trust revisions, and medical malpractice reforms are targets we can address now, not four years from now, and bring results. Furthermore, we can utilize the strengths and resources of our states as laboratories for innovation in health care delivery.

For some reform targets, finding consensus may take more time, such as: medicare and its reimbursement system; a modified

community rating concept; catastrophic health care plans; the deductability for the self-employed; coverage for the uninsured; and other tax incentives. Each of these areas, however, does merit considerable discussion.

In the meantime, we can target our efforts towards those two out of ten individuals not served well without creating a new government entitlement that encompasses all Americans.

A consensus will yield results. United we can defeat any government-run plan. We can preserve 15% of our economy. And we can promote a market-based reform approach that strengthens the health care delivery system in our country.

TARGETED REFORM
A REPUBLICAN FOUNDATION

1. **Institute Insurance Market Reforms to increase availability of insurance coverage**

   - Portability
   - Small Market Reforms
   - Adjusted elimination of pre-existing condition clauses

2. **Enact Administrative Reforms to reduce medical costs**

3. **Eliminate Anti-Trust Burdens to promote efficiency in the delivery of health care**

4. **Reform Medical Malpractice Laws to reduce legal burdens on providers**

5. **Utilize States as "Health Care Reform Laboratories" to guide the Congressional debate**

   - Broad flexibility to States over Medicaid
   - State Innovations in the delivery of medical care to the uninsured
   - Pilot projects and special recognition of rural health care needs

BUILDING BLOCKS

GOALS

1. Defeat Administration Proposal
   * Offer Republican alternatives
   * Filibuster
   * Offer amendments
   * Negotiate bi-partisan Congressional Compromise

2. Increase health security and access to health insurance
   * Tax code changes/equity
   * Subsidies/vouchers/credits
   * Mandate employers to offer (not Pay)
   * Insurance market reforms
     * guarantee issue
     * limit pre-existing conditions exclusion
     * guarantee renewability
   * Incentives for rural and community care
   * Require individuals to be covered or to pay penalty.

3. Maintain Quality
   * Report Cards
   * Outcomes research
   * No price controls or global budgets

4. Guarantee choice of providers/insurance

   * IRA's/MSA options
   * Mandate on employers to offer multiple plans
   * Preemption of state mandates
   * Point of service requirement
   * Status quo

5. Restrain Health Care Costs

   * Government regulations: price controls/global budgets/ premium caps/Clinton alliances/national board
   * All Payor (monopoly)
   * Competition
   * Antitrust Reform
   * Malpractice Reform
   * Paperwork Simplification
   * Increase Individual Responsibility
     * Cost Sharing
     * Life Style
     * Tax Disincentives
   * Insurance Reforms
   * Medical Savings Accounts
   * Consumer Value Information
   * Voluntary Purchasing Groups/Co-ops

6. Full Financing
   * DSH
   * Limitation on tax deductibility and exclusion
   * Medicare/Medicaid cuts
   * Cigarette tax
   * Other sin taxes
   * Require employers to contribute to costs of insurance.
7. Universal Coverage
   * As goal or requirement
   * Individual Mandate
   * Employer Mandate
   * No mandates/marketforces
   * Timing
   * Single payer
8. State Flexibility
   * ERISA waivers
   * Preemption of mandated benefits
   * Opt out of Federal system
9. Reform Medicaid
   * Swap
   * Buy-in Medicaid to private insurance (of low income to Medicaid)
   * Caps
   * Managed Care

10. Reform Medicare

* Means test A/B
* Opt to retain private coverage at time of eligibility
* Raise risk contract participation
* Require managed care participation
* Prescription drugs

76 AP 03-04-94 08:07 EST 98 Lines. Copyright 1994. All rights reserved.
PM-Health Care-Slowdown, 1st Ld-Writethru, a0415,780<
Dole Gives Any Health Reform 50-50 Chance of Passage This Year<
By NITA LELYVELD Associated Press Writer

WASHINGTON (AP) Major health plans now before Congress are hobbled by fundamental problems, and health reform legislation has just a 50-50 chance of passage this year, Senate Minority Leader Bob Dole said today.

``I think it's going to be a much smaller package'' than the one proposed by President Clinton, said Dole, a Kansas Republican.

Rep. Jim Cooper, D-Tenn., has offered a plan he calls ``Clinton Lite,'' which aims for universal coverage but without a government role as large as proposed by the administration.

But Dole, appearing on CBS, said, ``I don't think the Cooper plan will survive, either.''

Speaking from Annapolis, Md., where Republican lawmakers have gone on a retreat to talk about health reform, Dole said he and his GOP colleagues were making progress toward assembling yet another plan, but he estimated it wouldn't be ready for 60 days.

``We've got so many plans, what were hoping to do is put together strong package with bipartisan support,'' Dole said on NBC.

When asked whether any package could get through Congress this year, Dole replied: ``I think there's a possibility, I'd say 50-50.''

Dole said any plan that requires participation by employers or individuals would be hard to get passed. ``The word 'mandates' scares off a lot of people ... mandates are going to be hard to sustain in all these plans,'' Dole said.

On Capitol Hill, gradual, less comprehensive approaches are increasingly winning favor.

On Thursday, 30 members of Congress 15 from each party backed a new, no-frills health bill they said would make it easier for sick workers to obtain health insurance and harder for them to lose it. It wouldn't do all that much else.

Rep. J. Roy Rowland, D-Ga., who wrote the bill with Rep. Michael Bilirakis, R-Fla., acknowledged the approach wouldn't meet President Clinton's bottom line: universal coverage. But he wondered ``why we have to do it all at once.''

Rep. Thomas E. Petri, R-Wis., may have summed up the mood in Congress at a hearing Thursday before the House Education and Labor Committee.

``I hope by the time we finish in this Congress, we'll have something ... that moves this forward at least a bit,'' he said. ``Let's not make the perfect, because we can't agree on the perfect, an enemy of the good.''

Petri's remarks might not make the White House squirm. Sen. Daniel Patrick Moynihan's might.

The chairman of the Senate Finance Committee suddenly halted discussion of health care basic benefits at a hearing Thursday to tell a lengthy, perhaps apocryphal, story about the effects

of government on health care. He called it ``just a cautionary tale.''

It was about the failed efforts some 30 years ago to help the mentally ill by getting them out of hospitals.

``The last public bill signing of John F. Kennedy on Oct. 23, 1963, he signed the Community Mental Health Center Construction Act of 1963 and he gave me a pen,'' said the New York Democrat. one per 100,000 and continue on that pattern. We were going to empty out our institutions and treat people locally.''

``We emptied out our institutions. ... But we didn't build the community health centers,'' he said. ``And 30 years later we have a problem of homelessness.''

``It's been absolutely catastrophic, a tribute to ignorance and all that is wrong and it would never have happened if we hadn't set out to improve things.''

Will the government help when it gets its hands on health care? Americans remain sharply divided.

In an ABC News-Washington Post poll released Tuesday, 47 percent of those polled said the Clinton plan made too many unnecessary changes; 46 percent said the changes were the right ones. As for whether the Clinton administration was moving too fast on health care, 36 percent said yes, while another 36 percent said the administration was moving too slow.

Overall the poll showed 48 percent of those asked disapproving of the Clinton plan and 44 percent approving the first time disapproval edged approval since the bill was introduced.

On Thursday afternoon, 33 Republican senators headed to Annapolis, Md., for an overnight retreat to discuss health care. House Republican leaders and the governors of South Carolina, New Hampshire and Utah were to join them.

Dole said as they departed that the change in mood about health care was no surprise.

``I think the country's moving. I think the American people are moving. And it's not because of Harry and Louise,'' he said, referring to characters in ads paid for by the Health Insurance Association of America.

``It's finding out about the plan and that it's so complicated, and they're talking to doctors and others.''

81 AP 03-04-94 09:03 EST 109 Lines. Copyright 1994. All rights reserved.
PM-Clinton-Whitewater, 2nd Ld-Writethru, a0486,890<
White House Moves To Distance Administration From Whitewater Probe<
By RON FOURNIER Associated Press Writer

WASHINGTON (AP) Accused by Republicans of meddling in a federal inquiry, the White House is moving quickly to distance the administration from an investigation of an Arkansas thrift with ties to the Clintons.

``All these investigations, they should go forward unimpeded,'' President Clinton said Thursday, capping a day of damage control.

At issue were revelations that the White House received three private briefings on a confidential investigation into Madison Guaranty Savings and Loan Association and the Whitewater land venture that was partly owned by the president and Hillary Rodham Clinton.

Clinton was said to be upset that his aides, particularly White House Counsel Bernard Nussbaum, did not realize the meetings would cause a flap.

The Washington Post, quoting unidentified officials, said today that Nussbaum was considering resigning.

Asked about the report, an administration official, speaking on condition of anonymity, said it was ``appearing more likely that he won't be around much longer.'' Another adviser commented: ``While I don't know of any solid timetable, I think Bernie wants to move on. I think if he does it would be largely his own doing, and the cumulative results of a long time thinking about this, not the events of the past days or weeks.''

``I don't think he's serving the president very well,'' Senate Republican Leader Bob Dole said of Nussbaum today. ``And there are others who are not serving the president very well,'' Dole said on NBC. ``I think it's about time that some of them pack it in.''

Meanwhile, The New York Times reported today that a courier for the Rose Law Firm in Little Rock, Ark., told a federal grand jury on Feb. 16 that he shredded a box of documents from the files of White House lawyer Vincent W. Foster Jr., who committed suicide last year.

The courier said he did not know precisely what he had shredded but that the papers were separated by binders marked with the initials ``VWF,'' the firm's typical abbreviation for Foster, the Times said.

The law firm denied any of Foster's papers had been shredded. artner Ron Clark said.

Clark said the law firm had discussed shredding documents with Hedges. ``He told us he didn't see any Whitewater documents. We think he told us the truth,'' Clark said.

Clark said the documents Hedges referred to were internal documents unrelated to Whitewater matters. He said they were shredded in connection with one lawyer moving from one office to another and weren't Foster's records.

Foster was a co-partner of Mrs. Clinton in the Rose firm before Clinton was elected in November 1992 and brought him to Washington as deputy White House counsel. Foster was found shot to death outside the capital in July.

Authorities ruled the death a suicide, but special counsel Robert Fiske is reviewing the case as part of a broader probe of Arkansas financial dealings by the Clintons and others, including the Whitewater real estate development.

Republicans pounced on Thursday's disclosure of private briefings related to the Madison affair, suggesting that the White House was trying to influence the inquiry through political appointees familiar with the complicated investigation. Senate Minority Leader Bob Dole accused the White House of ``mixing politics with law enforcement.''

White House Chief of Staff Mack McLarty issued a memo Thursday instructing staff to restrict contact with agency officials and federal regulators, clearing all discussions about Whitewater and the thrift through the White House legal team.

And Treasury Secretary Lloyd Bentsen ordered his staff to have no further contact with the White House about the case and referred the matter to the Office of Government Ethics ``to ensure that all ethical guidelines were followed.''

The White House said nothing improper was done, but conceded that holding the private meetings opened Clinton to charges of a cover-up.

``I have every confidence in what the facts will reveal,'' Clinton told reporters. ``So I think that it's very, very important that while all this is going on that the activity around it should be handled in such a way as to avoid even the appearance of a conflict.''

In a letter to Senate leaders, 43 Republican senators promised to block the administration's nomination of Ricki R. Tigert to head the Federal Deposit Insurance Corp. until a congressional hearing is conducted on a White House briefing by Deputy Treasury Secretary Roger Altman.

Altman, a Clinton appointee and interim head of the S&L watchdog Resolution Trust Corp., surprised lawmakers last week with confirmation of the briefing.

Details of two other briefings were released Thursday.

In late September, the Treasury Department's top attorney told Nussbaum that criminal referrals against Madison had been prepared by the RTC. Spokesman Mark Gearan said the fact that the Clintons were named in the referrals might have been mentioned. An official familiar with the inquiry has said the referral says the Clintons may have benefited from questionable Madison transactions but does not accuse them of wrongdoing.

A month later, Treasury officials met with Nussbaum, Gearan and top Clinton aide Bruce Lindsey about the referrals sent to the U.S. attorney's office in Little Rock.

TAX CAP / BENEFITS PACKAGE DISPUTE

IF YOU CREATE TAX CREDIT OR PUT SOME LIMIT ON DEDUCTIBILITY ALL THE BILLS ASSUME SOMETHING ABOUT WHAT THE BENEFITS LOOK LIKE.

BOTH NICKLES AND GRAMM PLANS REQUIRE THAT DIFFERENT KINDS OF BENEFIT PACKAGES BE OFFERED. SOMEONE HAS TO DEFINE WHAT THEY ARE.

**A MEMORANDUM TO REPUBLICAN SENATORS
ATTENDING THE HEALTH CARE TASK FORCE
CHAIRED BY U.S. SENATOR JOHN CHAFEE (R-RI)**

FROM: **NEW MEMBERS**
Robert F. Bennett
Paul D. Coverdell
Lauch Faircloth
Judd Gregg
Kay Bailey Hutchison
Dirk Kempthorne

SUBJECT: **THE FOUNDATION FOR BUILDING REPUBLICAN CONSENSUS ON HEALTH CARE REFORM**

As we discuss reform alternatives to our health care delivery system, we believe that a consensus should be reached, to the full extent possible, among Republican Senators prior to any attempts to reach consensus with the President and the Senate Democrats.

This forum can serve as the beginning of building such a consensus because it comes at a critical time in the debate on reform of our health care delivery system. The American people have heard the Presidential rhetoric and listened to the sound bite politics on health care reform. Now we are beginning to hear what the American people -- the customers of our current health care system -- are saying about the rush toward reform.

The results are startling when Presidential rhetoric meets voter reality. The Washington Post reported on Wednesday, March 2, 1994, that 80% of the public is concerned that the quality of their medical care will decline if the President's plan is enacted.

This figure directly parallels earlier reports by CNN/USAToday/Gallup showing that 81% of the public is satisfied, or very satisfied, with the current health care system.

Eight out of ten people are served well and satisfied by our current system. Of the two out of ten not served well, some have serious problems, some have concerns less urgent.

These results urge us to ask, is it necessary to overhaul our entire health care system, disrupting and

destabilizing the quality of health care of 80% of our families and businesses, in order to reach the 20% currently not served well? Furthermore, must we look toward turning 100% of our health care system, a system approaching 15% of our economy, over to the government, to reach the 20% of the public currently not served well?

We believe the answer to both questions is no. And, as the President rushes to push his reform package through Congress we strongly believe any reform efforts must be done correctly before they are done quickly. The public agrees. The Washington Post poll mentioned earlier shows that under the Clinton government-run health care plan:

- Three out of four Americans are concerned the cost of their medical care will increase;
- Three out of five Americans are concerned the plan will create another large and inefficient government bureaucracy; and
- Three out of five are concerned that taxes will have to be increased to pay for the plan.

There is an alternative to a massive government-overhaul of the health care delivery system. This alternative seeks to implement "necessary reforms" to preserve the best elements of our existing system while working to improve problem areas.

As new members, we endorse the concept of targeted health care reform because, through an improvement on specific targets in health care delivery, we can produce major and significant improvements in the system immediately without destabilizing health care for all Americans.

We believe targeted reform should serve as the foundation upon which we build Republican consensus. Market reforms, administrative reforms, anti-trust revisions, and medical malpractice reforms are targets we can address now, not four years from now, and bring results. Furthermore, we can utilize the strengths and resources of our states as laboratories for innovation in health care delivery.

For some reform targets, finding consensus may take more time, such as: medicare and its reimbursement system; a modified

community rating concept; catastrophic health care plans; the deductability for the self-employed; coverage for the uninsured; and other tax incentives. Each of these areas, however, does merit considerable discussion.

In the meantime, we can target our efforts towards those two out of ten individuals not served well without creating a new government entitlement that encompasses all Americans.

A consensus will yield results. United we can defeat any government-run plan. We can preserve 15% of our economy. And we can promote a market-based reform approach that strengthens the health care delivery system in our country.

TARGETED REFORM
A REPUBLICAN FOUNDATION

1. **Institute Insurance Market Reforms to increase availability of insurance coverage**

   - Portability
   - Small Market Reforms
   - Adjusted elimination of pre-existing condition clauses

2. **Enact Administrative Reforms to reduce medical costs**

3. **Eliminate Anti-Trust Burdens to promote efficiency in the delivery of health care**

4. **Reform Medical Malpractice Laws to reduce legal burdens on providers**

5. **Utilize States as "Health Care Reform Laboratories" to guide the Congressional debate**

   - Broad flexibility to States over Medicaid
   - State Innovations in the delivery of medical care to the uninsured
   - Pilot projects and special recognition of rural health care needs

The Polling Spotlight

From the Office of the GOP Conference Secretary, Trent Lott, Secretary
Dave Hoppe, Staff Director 202•224•3496

released 3/3/94

1) FROM WHAT YOU KNOW OF IT, DO YOU APPROVE OR DISAPPROVE OF CLINTON'S HEALTH CARE PLAN? (Washington Post/ABC Poll; 1,531 adults surveyed; conducted 2/24-27; margin of error +/- 3%)

APPROVE	44%
DISAPPROVE	48
NO OPINION	8

2) HOW COMFORTABLE WOULD YOU PERSONALLY BE IN ENTRUSTING YOUR FAMILY'S MEDICAL CARE TO A HEALTH CARE PLAN RUN BY THE FEDERAL GOVERNMENT? (Fabrizio, McLaughlin and Associates; conducted in Jan. and/or Feb. 1994; 800 or 1,000 adults surveyed; margin of error +/- 3.4% for the 800 sample, and +/- 3/1% for the 1000 sample)

VERY COMFORTABLE	9.5%
SOMEWHAT COMFORTABLE	35.8
NOT COMFORTABLE AT ALL	51.8

3) WOULD YOU FAVOR OR OPPOSE CLINTON HEALTH PLAN IF YOU KNEW THAT THE...

PLAN WOULD NOT GUARANTEE YOU THE RIGHT TO CHOOSE YOUR OWN DOCTOR?	FAVOR	9.6%
	OPPOSE	86.5
PLAN WOULD CREATE 79 NEW GOVERNMENT AGENCIES AND COMMISSIONS TO ADMINISTER THE PLAN?	FAVOR	21.9%
	OPPOSE	71.6
PLAN WOULD LIMIT YOUR CHOICE OF HEALTH COVERAGE TO GOVERNMENT DESIGNED PLAN?	FAVOR	14.1%
	OPPOSE	80.3
PLAN WOULD REDUCE THE LEVEL OF COVERAGE THAT MANY AMERICANS NOW RECEIVE?	FAVOR	14.6%
	OPPOSE	80.5

4) DO YOU FAVOR OR OPPOSE REPUBLICANS BLOCKING PRESIDENT CLINTON'S HEALTH CARE REFORM PLAN IF IT...

DOESN'T GUARANTEE THE RIGHT TO CHOOSE YOUR OWN DOCTOR?	FAVOR	62.5%
	OPPOSE	33.7
WOULD FORCE THOSE WITH COVERAGE ONTO A GOVERNMENT PLAN WITH FEWER BENEFITS?	FAVOR	59.4%
	OPPOSE	32.9
WOULD LIMIT/RATION THE AMOUNT OF SERVICES AN INDIVIDUAL COULD RECEIVE?	FAVOR	58.9%
	OPPOSE	33.9

5) THE FOLLOWING MIGHT CONCERN SOME PEOPLE, BUT NOT OTHERS ABOUT THE CLINTON HEALTH CARE PLAN. PLEASE INDICATE WHETHER IT'S A BIG CONCERN, A SMALL CONCERN, OR NOT AT ALL A CONCERN OF YOURS. (Washington Post/ABC Poll; 1,531 adults surveyed; conducted 2/24-27; margin of error +/- 3%)

	PERCENT SAYING "BIG CONCERN"	
	10/10/93	2/27/94
THE QUALITY OF YOUR MEDICAL CARE WILL DECLINE	64%	80%
YOU MIGHT NOT HAVE GOOD CHOICES OF DOCTORS OR HOSPITALS	72	75
THE COST OF YOU MEDICAL CARE WILL INCREASE	70	74
PEOPLE WHO NEED IT MOST WON'T GET ADEQUATE MEDICAL CARE	56	72

6) CLINTON HEALTH PLAN IS... (CBS Poll; conducted 2/15-17; 1,193 adults surveyed; margin of error +/- 3%)

FAIR TO PEOPLE LIKE ME	38%
NOT FAIR	44

7) IF THE CLINTON PLAN IS PASSED...

	NOW	12/93
IT WILL MAKE HEALTH CARE BETTER	35%	42%
IT WILL MAKE HEALTH CARE WORSE	33	23
IT WON'T HAVE MUCH IMPACT EITHER WAY	22	28

Bob Dole

NEWS U.S. SENATOR FOR KANSAS

FROM: SENATE REPUBLICAN LEADER

OFFICE OF THE SENATE REPUBLICAN LEADER
PRESS OFFICE
FACSIMILE COVER SHEET

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FROM: Dennis Shea

RE: _____

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70 REU 03-03-94 16:48 EST 16 Lines.
BC-CLINTON-WHITEWATER-TREASURY (REPEATING)
TREASURY ORDERS ETHICS REVIEW IN FAILED THRIFT CASE
(Eds: Repeating to fix slug)
WASHINGTON, March 3 (Reuter) - Treasury Secretary Lloyd Bentsen said Thursday he has asked the independent Office of Government Ethics to investigate contacts between Treasury officials and the White House about a failed Arkansas thrift.
``I did not attend any of these meetings, nor was I informed about these meetings,'' Bentsen said, referring to reports that Treasury officials twice informed the White House about a government investigation into the collapse of Madison Guaranty Savings and Loan, which had ties to President Clinton and first lady Hillary Rodham Clinton.
MORE
MORE

Bob Dole

NEWS FROM: U.S. SENATOR FOR KANSAS
SENATE REPUBLICAN LEADER

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8 AP 03-03-94 15:26 EST 86 Lines.
AM-Clinton-Whitewater,770<
Clinton to Staff: 'Bend Over Backward' to Avoid Probe Meddling<
With AM-S&L Contracts-Rose, Bjt<
By FOURNIER Associated Press Writer

WASHINGTON (AP) Embarrassed anew by White House handling of the Whitewater affair, President Clinton ordered aides Thursday to ``bend over backward'' to avoid meddling in a federal investigation involving him.

Insisting that ``no one has actually done anything wrong,'' Clinton nonetheless expressed regret that his advisers received private briefings on a government investigation into a failed Arkansas thrift.

``I'm concerned about that,'' Clinton said. ``I think it would be better if the meetings and conversations hadn't occurred.''

Critics have wondered aloud if the White House were trying to influence the investigation into Madison Guaranty Savings and Loan Association and the related Whitewater land venture formerly co-owned by the president and Mrs. Clinton.

``You're asking for big, big trouble and showing some stunningly bad judgment when you start mixing politics with the law enforcement,'' Senate Minority Leader Bob Dole said.

In a letter to Senate leaders, 43 Republican senators promised to block the administration's nomination of Ricki R. Tigert to head the Federal Deposit Insurance Corp., until a congressional hearing is conducted on a White House briefing by Roger Altman. Altman is a Clinton appointee and interim head of the Resolution Trust Corp., the S&L cleanup agency.

Clinton's comments mark the second time in a week his administration confirmed private meetings about the inquiry with government officials. All told, there were three such meetings, the White House said.

To dampen the fire, Clinton ordered a memo from Chief of Staff Mack McLarty outlining procedures for staff contacts with other government officials. He urged his staff to be even more cautious than the memo requires.

``We will bend over backward to avoid not only the fact but any appearance of impropriety,'' Clinton told reporters.

Confirming a Washington Post story, the White House on Thursday described two meetings:

In late September, the Treasury Department's top attorney told White House Counsel Bernard Nussbaum that criminal referrals against Madison had been prepared by the RTC. Spokesman Mark Gearan said the fact that the Clintons were named in the referrals might have been mentioned. An official familiar with the inquiry has said the referral says the Clintons may have benefited from questionable Madison transactions but does not accuse them of wrongdoing.

A month later, Treasury officials met with Nussbaum, Gearan and top Clinton aide Bruce Lindsey about the referrals sent to the U.S. attorney's office in Little Rock.

The latest report comes on the heels of criticism of Altman

for meeting with White House officials about the Madison case. After Republicans criticized his actions, Altman issued a statement admitting ``bad judgment'' and said he would stop dealing with the Madison case.

The letter from GOP senators says, ``Needless to say, such a meeting is highly improper and raises very real questions about Mr. Altman's impartiality and the alleged independence of the investigation.''

Explaining the latest revelation, the White House said Treasury attorney Jean Hanson offered the information to Nussbaum in a brief encounter after an unrelated meeting.

Criminal referrals are documents in which federal regulators who carry out only civil investigations pass on suspected evidence of criminal wrongdoing to prosecutors.

It is not customary to discuss the contents of such a document with anyone named in it, or their associates.

The October conversation between Treasury officials and several White House aides was held to figure out how to respond to press inquiries, the White House said. Lindsey said Treasury officials did not describe the contents of the RTC filings.

``In retrospect I guess the meeting probably shouldn't have occurred but you have to understand in October 1993 none of this was an issue at the time,'' Lindsey said.

Said Clinton: ``Nearly as I can determine, nobody has done anything wrong or attempted to improperly influence any government action.''

Expressing confidence that he will be cleared by the special prosecutor overseeing the investigation, Clinton said, ``All these investigations ... should go forward unimpeded.''

In the future, his staff ``will be much more sensitive,'' Clinton said. ``I don't think there will be further problems on this.''

76 REU 03-03-94 16:52 EST 87 Lines.
BC-HEALTH-REPUBLICANS 1STLD (SCHEDULED)
REPUBLICANS SEARCH FOR ELUSIVE CONSENSUS ON HEALTH
(Eds: Updates with news conference, recasts throughout)
By Sue Kirchhoff
WASHINGTON, March 3 (Reuter) - Buoyed by Democratic wrangling and polls showing waning public support for President Clinton's health care plan, Senate Republicans begin meeting Thursday to craft their own strategy.

Republican lawmakers say they do not expect to write a separate reform plan during their two-day retreat in nearby Annapolis, Maryland, but hope to set out principles to guide their own fractured party during debate in coming months.

``I believe the president's plan is dead, and with the collapse of the president's plan I think it is more important than ever that there be a unified Republican alternative,'' said Texas Republican Senator Phil Gramm.

While the Republicans have ranged from conciliatory to combative on health care reform, they generally have taken a more cautious approach than the White House, calling for more gradual change and less government intervention.

Insurance industry advertisements criticising Clinton's plan, opposition by business groups and Democratic infighting have weakened support for the Clinton bill in recent weeks, which Republicans say bolsters their case.

But GOP lawmakers say they don't expect to bridge the gap between Rhode Island Republican Senator John Chafee's bill requiring individuals to buy insurance and providing universal coverage, and less ambitious plans by conservatives like Gramm. agreement because that's not what we're trying to do,'' Chafee said, adding he thought he was capable of ``not being rolled'' by conservatives at the retreat.

``What I'm seeing from the polls is Americans want a second opinion,'' said Senate Minority Leader Bob Dole.

Dole has been a prime example of the conflicting pressures buffeting the Republican party, sometimes stating there is no health crisis and other times calling for bipartisan efforts.

Despite falling polls for Clinton and gridlock in the two main House committees charged with voting on a bill, Democratic leaders say Congress will pass major reforms.

``I believe we will pass comprehensive health care reform this year that includes the most important provision -- that is, guaranteed private health insurance for all Americans,'' said Senate Majority Leader George Mitchell, a Maine Democrat. retreat, along with a contingent of House members, some governors and Republican Party Chairman Haley Barbour.

Republicans have long held weekly meetings on the health issue. But there are fissures between party conservatives and moderates, as well as between the House and Senate on just what the Republican position should be.

Questions include whether individuals should be required to buy insurance -- most have already ruled out Clinton's proposal that employers be required to buy workers' insurance -- and whether universal coverage should be a goal.

There are also divisions between moderates who see health reform as vital and more conservative Republicans who do not.

``I think that we have a great opportunity to pass incremental legislation this year. Beyond that, I don't think there is a consensus,'' said Representative Thomas Bliley of Virginia, who will attend the retreat.

Senate Republicans are in a stronger position to influence the debate, due to a close 11-9 Democratic majority on the key Senate Finance Committee and the fact that Democrats lack the votes to prevent a Republican filibuster -- a debating tactic that can block a measure even if it has majority support.

Congressional and industry sources had assumed that House Democrats, with their large majority, could push a bill through without Republican votes. But House efforts have stalled and Democrats say they want, and may need, the GOP.

However, most House Republicans, led by Minority Whip Newt Gingrich of Georgia, have signed onto a bill that would not guarantee universal coverage -- Clinton's botom line -- or make other major reforms that Democrats say are necessary.

``It is a difficult thing for the country to have the Democratic leadership, instead of sitting down and working with us, having them write phony bills'' that will not pass, Gingrich said, adding that he saw room for bipartisan compromise.

``There are going to be Republicans in the end. They're just taking a hard line on it now,'' said a senior House Democratic aide, pointing to Gingrich's reputation for attempting to block Democratic legislation.

REUTER

74 AP 03-03-94 16:46 EST 87 Lines.

AM-Health Reform,720<

30 Congressmen Offer Bare-Bones Health Reform Bill

By CHRISTOPHER CONNELL Associated Press Writer

WASHINGTON (AP) Thirty lawmakers proposed a bipartisan, bare-bones health reform bill Thursday to help workers with serious illnesses keep their insurance and to help Congress avoid a stalemate.

The 15 Democrats and 15 Republicans said they had plucked the common elements from the Clinton proposal and rival plans and repackaged them in a consensus bill that would not add a single dollar to federal spending or the deficit.

It would come nowhere near President Clinton's goal of guaranteed coverage for all Americans.

``I don't know why we have to do it all at once,'' said Rep. J. Roy Rowland, D-Ga.

His coauthor, Rep. Michael Bilirakis, R-Fla., said no more than a third of the Congress had backed any single reform bill, but 297 House members separately had backed the proposals grafted onto the consensus plan.

``The bottom line is ... to (get) a bill through the Congress this year,'' Bilirakis said. ``The way it is right now, everything is so splintered, we're just going to look like fools up here.''

``Let's get started with the foundation. We can build the house later on,'' said Rep. William H. Zeliff Jr., R-N.H., a cosponsor.

Thirty-three Republican senators, meanwhile, left on an overnight retreat to Annapolis, Md., to hash out their differences on health reform behind closed doors. House GOP leaders and the governors of South Carolina, New Hampshire and Utah were joining them.

Senate Minority Leader Bob Dole, R-Kan., said it wasn't a bill-drafting session and Sen. John Chafee of Rhode Island, the retreat organizer, said, ``I can tell you now, having taken a few soundings, that there won't be unanimity.''

Dole said, ``We'll get closer than the Democrats,'' and added, ``I think we can do better'' that the stripped-down reform plan that Rowland and Bilirakis have advanced.

Rowland, a former family physician, said their bill had ``not one new dollar'' in it. He called it a ``cut-and-paste'' job.

It would limit pre-existing condition exclusions in employer health benefit plans and allow workers to keep coverage when they changed jobs. But it would not outlaw pre-existing condition clauses in policies sold to individuals.

The bill would discourage malpractice lawsuits, require patients with a grievance to try alternative dispute resolution first, strictly limit lawyers' fees and put a $250,000 cap on awards for pain and suffering. It would also cut red tape and encourage the spread of community health centers to help the uninsured.

It would allow the self-employed to deduct 100 percent of their health insurance expenses from their taxes instead of 25 percent.

That would cost $8 billion over three years, but in a bookkeeping move the bill would pay for that by forcing the Postal Service, the Tennessee Valley Authority and other agencies to put aside more money for future retiree health benefits.

That would raise $11 billion over five years money the government could spend immediately, but it could require a two-cent increase in stamp prices. ``We're not happy with that,'' said Bilirakis, indicating the sponsors would look for other ways to raise the money.

Rowland and Bilirakis got 100 colleagues to sign a letter to President Clinton in October urging him to abandon his all-or-nothing approach to health reform and try some interim steps first.

Clinton, on CBS-TV, said he will keep fighting for universal coverage ``as long as I'm president.''

He indicated flexibility on his troubled proposal for mandatory insurance purchasing alliances, but said, ``You're going to have to have some way to protect the little guy.''

Rowland said it would be ``tragic'' for Clinton to veto the consensus bill, if it is approved by Congress, and expressed doubt the president would make good on his threat.

``The more the president sees he's losing some steam, the more they may be amenable to working things out,'' Bilirakis said.

Rowland, Bilirakis and four cosponsors sit on the House Energy and Commerce Committee, which announced Wednesday it would bypass its divided health subcommittee and try to draft a bill in the full committee in April.

House Minority Whip Newt Gingrich, R-Ga., at a news conference with Dole and Chafee, said the Democrats are ``within one vote of losing control of (that) committee.''

	S 1807 Gramm Comprehensive Family Health Access and Savings Act	S Durenber Comp
How does the bill seek to control rising health care costs?	By letting individuals create medical savings accounts and keep what is saved, the spending incentive in private health care is broken. Further, through reforms to Medicare and Medicaid, and by allowing individuals greater choice, all consumers will become more cost conscious thereby saving the system money.	The bill relies kets to control Government po as a tax cap, tion, insurance chasing alliance ing markets. Therefore, the bi petition to dri People will hav choose low-cos federal subsidies they will be able quality plans be sary information to enable people
FEDERAL ENTITLEMENTS		
What changes does the bill make in Medicare?	Elderly would be permitted to opt out of traditional program to seek private coverage, including the establishment of a medical savings account. retiree would keep half of any savings realized by purchasing private coverage.	The bill does not i care beneficiaries fied accountabl however, must p Medicare risk-con if they are eligible Social Security A The bill reduc inpatient hospital s
What changes does the bill make in Medicaid?	Payments to states would be capitated, allowing for annual growth equal to the medical inflation nindex. States would be given greater flexibility in establishing innovative Medicaid programs.	The bill would r program and eral subsidies beneficiaries t able health pla families with percent of po to join the lowe at no cos copayments higher-priced the cost of the Individuals a comes betwe cent of poverty scale subsidi olds for eligib sistance will future on a pa

and reduces pice services.

Coverdell

TEAM GOP

A PRO-ACTIVE PLAN FOR HEALTH CARE REFORM

It is anticipated that the U.S. House of Representatives could begin debate on the Clinton health care plan as early as May. May 1, 1994 is approximately 70 days away. Senator Mitchell has marked the month of June for debate in the Senate on the Clinton health care plan. June 1, 1994 is less than 100 days away. We must capitalize on each day to spread our message against the Clinton plan and any government-run alternative proposed in Congress.

MISSION:

To protect 15% of our national economy from a government take-over;

To promote market-oriented solutions for health care reform;

To defeat any government-run health care proposal.

OBJECTIVE:

Maximize media coverage and general visibility on the egregious aspects of the Clinton and government-run plans in each state represented by a GOP Senator, thereby reaching more than 2/3 of the country, 32 states and 3/4 of the U.S. population.

The White House may have the pulpit, but we have the people.

ACTION PLAN:

These 70 days must be viewed as a campaign -- Bill Clinton and the White House will certainly view it as one.

The battle over health care reform must not be decided inside the beltway. We must take the battle over this issue to the people -- in communities throughout the country. If the people decide, we win. If the beltway decides, Clinton wins.

Health care reform involves many issues; however, at its core is one simple decision -- does the government control the choices involved in our health care system or do our families, businesses and communities control health care? Is it government over people, or government for the people?

This is the fundamental decision we must take to the people. More government, more taxes, less choice, less quality -- no prescription for reform.

The discussion is no longer whether the health care delivery system is in crisis or not. Although debatable about the crisis status, we lose in this argument. We must discuss the results of

the Clinton plan. The real crisis will be the results of a government-run system on our economy and nation if enacted.

This is where team GOP can make a difference. United, we can defeat any government-run plan. We can preserve 15% of our economy. And, we can promote a market-based reform approach that strengthens the health care delivery system in this country.

RESOURCES:

The Steering Committee
The Policy Committee
The Republican Conference
Conference Secretary
Command Center
Ideas Center
Broadcast Center
Polling Data

In addition we have access to the Republican National Committee, the National Republican Senatorial Committee and House Leadership Support Offices.

I. COORDINATE GOP LEADERSHIP IN THE CAMPAIGN

Speaking with a unified voice will require the support of the Republican leadership. We must move Senate leadership in the direction of market-based reforms.

II. BEGIN DAILY ASSAULTS ON PROBLEMS WITH GOVERNMENT-RUN PLAN

On a daily basis, the White House faxes to certain Hill members a one-page sheet entitled "Health Care Reform Today". Its purpose is to promote the Clinton plan by providing quick "facts" to members. We must respond. Why allow them this sole outlet?

We should begin a daily assault on these fax sheets discrediting the Clinton plan.

We can utilize the Republican Policy Committee and other research-oriented outlets to prepare quick responses to their "facts."

III. BEGIN REGIONAL TOWN HALL SERIES WITH SENATORS

Coordinate a campaign of regional town hall meetings to discuss health care reform. Hold a midwest town hall meeting bringing together Wisconsin Governor Thompson, Illinois Governor Edgar, Senators Grassley, Lugar and Coats. In the South, bring together South Carolina Governor Campbell, Senators Thurmond, Coverdell, Mack, Cochran, Lott, and/or former Governor Alexander. In geographic regions where there are strong numbers of GOP officials, the region could be subdivided for increased coverage.

IV. FOCUS ATTENTIONS ON REGIONAL MEDIA OUTLETS

Utilize resources of the Republican Conference to reach regional "friendly" media outlets.

RADIO

Talk Radio. Schedule regular participation on Conservative radio talk shows -- i.e. Bob Grant in New York City, Sean Hannity in Atlanta, Bob Lee in Salt Lake City, Jim French in Seattle, KFYI in Phoenix, or KTSA in San Antonio.

Schedule weekly, bi-weekly radio news conference calls with selected radio news reporters in each state.

Utilize the Senate Republican Conference (SRC) audio mailbox services to tape a message allowing access to all radio stations in the state and nationwide. Messages can be updated on an "as-needed" basis.

Prepare audio actualities on key egregious aspects of the Clinton plan for dissemination to news stations.

Schedule live or taped radio interviews at each stop during travel in the state.

TELEVISION

Organize weekly, bi-weekly satellite feeds for live or taped news interviews.

Prepare short, 60 to 90 second taped messages on health care issues for transmittal to state television stations on a daily or weekly basis.

Notify C-SPAN of health care forums in the region or state for possible coverage.

Develop an individual cable access show around health care issues.

Develop video news clips from health care forums for distribution statewide.

Participate in local TV public affairs shows.

Notify the RNC and the SRC of key events for additional coverage and assistance in dissemination of materials. Submit material for SRC and RNC Video News Releases.

PRINT

Prepare a core health care reform op-ed for dissemination to state daily and weekly newspapers and national outlets. This core op-ed can be updated to focus on key egregious aspects of the Clinton or alternative government-run plans.

Prepare a weekly mailing of statements and press releases to all state newspapers.

Prepare a joint op-ed or statement with Caucus members to maximize potential placement in national media and to broaden regional coverage.

Coordinate regional editorial board meetings with "friendly" newspaper outlets to disseminate information.

V. ACCESS ALTERNATIVE MEDIA OUTLETS

Computer On-Line Services

With each day, more Americans are gaining access to information through computer on-line services such as Internet and Prodigy. Senators can provide these services with news releases and opinion articles so that users can access our views on health care.

Newsletters

Senators can reach members of organizations and businesses by submitting materials to company newsletters. Industry associations representing clusters of small businesses would be a natural ally in disseminating our materials. The Associated Builders and Contractors (ABC) or the Food Marketing Institute (FMI), for example, represent key groups that are opposed to the Clinton plan. Articles in their publications can help energize their constituencies against the Clinton or government-run alternatives.

Expanded Satellite Coverage

Although touched upon under television media opportunities, Senators can reach a core audience through satellite television coverage of Town Hall meetings, cable-access coverage of forums in the state, and prepared, taped interviews sent to cable access stations for broadcast.

A second option is to expand our coverage on corporate or association cable shows. Many corporations and associations produce local cable shows for their employees or constituencies. As with industry-specific newsletter coverage mentioned above, Senators should seek access to these cable show opportunities.

Corporate Audio Mail Messages

In addition to computer on-line services, corporations and business entities are communicating through national audio mailbox services. Employees of Amway, for example, can leave messages for employees throughout the country by accessing the Amway audio mailbox system. Senators can leave messages on this mailbox system reaching tens of thousands of employees.

VI. COORDINATE CONSERVATIVE COLUMNISTS AGAINST THE GOVERNMENT-RUN PLAN.

Steering Committee members shall begin regular meetings and coffee-sessions with favorable columnists to solicit articles to get the message out.

VII. COORDINATE SYNDICATED CABLE TV ASSAULTS.

Utilize the resources of favorable cable television outlets such as:

RESN
NET
GOPTV
RTV
CBN

VIII. ALLY WITH NATIONAL BUSINESS ORGANIZATIONS (BUILDING COALITIONS)

The chorus of organizations in opposition to the Clinton plan is growing louder. It is time to unite with these organizations to keep them moving away from what they see as "alternatives" to the Clinton plan that are in reality "Clinton-lite" models.

Steering Committee members shall meet with leadership of organizations such as the Chamber of Commerce, the National Federation of Independent Business, American Business Conference, or The Business Roundtable. Utilize their resources to keep the momentum moving away from Clinton and government-run plans.

Members shall begin outreach efforts to additional groups, who have been our natural allies -- i.e. the Hispanic Chamber of Commerce, the Christian Coalition.

Activities to consider:

Joint press conferences
Series of roundtable discussions
Op-eds, co-authored
Joint national and regional health care tours

IX. CO-OPT NATURAL GOP ALLIES

Utilize the media resources of natural GOP allies such as the Christian Coalition, families associations, and anti-tax organizations. Much of these activities can be coordinated through the RNC similar to coalition building in an election.

X. COORDINATE A NATIONAL SERIES OF SMALL BUSINESS COMMITTEE FIELD HEARINGS.

An untapped and natural ally we have in this fight is the small business community. We must develop a massive small business frontal assault on the egregious parts of the Clinton health care plan.

Establish a series of small business committee hearings throughout the country on egregious aspects of the Clinton plan.

XI. COORDINATE FLOOR ACTIVITIES

Organize weekly strikes on the floor to raise issues in the Clinton and government-run health care plans.

XII. USE AMENDMENT STRIKES TO RAISE ISSUES IN A CLINTON OR GOVERNMENT-RUN PLAN.

This application was effective in raising the awareness of the "off-budget" implications of the Clinton plan. The same tactics can be used to take issue with selective egregious parts of the Clinton plan or the alternative government-run plans.

XIII. REVIVE HEALTH CARE TASK FORCE UNDER STEERING COMMITTEE.

Coordinate GOP press secretary task force on health care and a legislative staff task force to keep the focus unified among offices.

XIV. COORDINATE ACTIVITIES WITH STATE GOP OFFICES, GOP GOVERNORS AND THE RGA.

Highlight the egregious points of the Clinton plan on state's rights and the state's ability to develop a plan tailored to their state's needs. The "One size fits all model" greatly hinders our states.

SENATE REPUBLICAN HEALTH CARE TASK FORCE RETREAT
March 3 and 4, 1994

SENATE REPUBLICAN
HEALTH CARE TASK FORCE RETREAT
MARCH 3 - 4, 1994
AT THE INNS OF ANNAPOLIS

THURSDAY, MARCH 3

3:00pm	Bus departs from Hart Horseshoe for Annapolis
4:00pm	Bus arrives at Calvert Inn
4:00-4:30pm	Registration and Room Assignment
4:30-4:40pm	Chairman Welcome Outline of program Distribution and overview of questions that will help guide substantive and strategy discussions
4:40-6:30pm	Analysis/Comparison of Republican Reform proposals Presentation of side-by-side and Member discussion: Led by Stan Jones and Rod DeArment
6:30-6:45pm	Break
6:45-7:45pm	Working Dinner What the public is saying about health care reform Presentation: Bob Blendon Response: Bob Teeter
7:45-9:40pm	Member discussion

FRIDAY, MARCH 4

6:30 am	Continental Breakfast available
8:15-9:30am	Private Sector Discussion
9:30-9:45am	Break
9:45-12:00pm	Building Blocks of Reform
12:00-12:15pm	Break
12:15-2:00pm	Working Lunch Final Discussion
2:10pm	Bus Departs from Calvert Inn

DIRECTIONS TO CALVERT HOUSE
ANNAPOLIS, MARYLAND

From the Hart Senate Office Building take East Capitol Street across the Whitney Young bridge, which is on the east side of RFK Stadium. Stay in the middle lane on the bridge; bear right at the end of the bridge , and take 295 North (signs will be posted).

Follow 295 North approximately 2 1/2 miles to the Route 50 East exit towards Annapolis. Take Route 50 East approximately 26 miles to the Rowe Boulevard exit toward Historic Downtown Annapolis. After the second traffic light, get in the left lane and continue straight to Church Circle.

Once in Church Circle, follow the circle around to School Street. Take a right onto School Street which puts you into State Circle.

The Governor Calvert House is about 1/2 the way around the circle, just past Maryland Avenue and before North Street.

HEALTH CARE RETREAT
ATTENDANCE LIST
As Of March 2, 1994

SENATORS

John H. Chafee
Robert Dole
Pete Domenici
Dave Durenberger
Orrin & Elaine Hatch
Robert Bennett
Christopher Bond
Conrad Burns
Dan & Marcia Coats
Thad Cochran
William Cohen
Paul Coverdell
Slade Gorton
Phil Gramm
Charles Grassley
Judd Gregg
James Jeffords
Dirk Kempthorne
Trent Lott
Richard Lugar
Connie Mack
John McCain
Mitch McConnell
Frank & Nancy Murkowski
Don Nickles
William Roth
Alan Simpson
Arlen Specter
Ted Stevens

SENATORS (CONT.)

Malcolm Wallop
Kay Bailey Hutchison
Robert Smith
John Warner
Hank Brown
Strom Thurmond

(35)

REPRESENTATIVES

William Thomas
Thomas Bliley
Nancy Johnson
Newt Gingrich
Dennis Hastert
Cliff Sterns

(6)

GOVERNORS

Carroll Campbell, SC
Mike Leavitt, UT
Stephen Merrill, NH

(3)

RNC

Haley Barbour

(1)

SENATE REPUBLICAN
HEALTH CARE TASK FORCE RETREAT
EXPERT/RESOURCE PARTICIPANTS

C. Eugene Steuerle, Ph.D.
Senior Fellow
Urban Institute

Stuart M. Butler, Ph.D.
Vice President & Director of
Domestic Policy
The Heritage Foundation

Frank McArdle, Ph.D.
Manager
Washington Research Office
Hewitt Associates LLC

Mark V. Pauly, Ph.D.
Health Care Systems Department
The Wharton School

John Sheils
Vice President
Lewin-VHI

Robert B. Helms, Ph.D.
Director of Health Policies
Studies
American Enterprise Institute

Grace-Marie Arnett
President
Arnett & Company

Richard E. Curtis
President
Institute for Health Policy
Solutions

William Kristol
Chairman
Project for the Republican
Future

Robert Teeter
President
Coldwater Corporation

Dan Crippen
Senior Vice President for
Research
The Duberstein Group

R. Glenn Hubbard
Professor of Economics & Finance
Columbia University

Michael Tanner
Director of Health and Welfare
Studies
CATO

Roderick A. DeArment, Partner
Covington & Burling

Stan Jones
Director
George Washington Health
Insurance Reform Project

Lynn Etherege
Private Consultant

Robert Blendon
Professor & Chairman
Department of Health Policy
& Management
Harvard University
School of Public Health

John Goodman
President and CEO
National Center for Policy
Analysis

January 1994

C. EUGENE STEUERLE
Senior Fellow
The Urban Institute

CAREER BRIEF

Eugene Steuerle is a Senior Fellow at The Urban Institute and author of a weekly column, "Economic Perspective," for Tax Notes Magazine. At the Institute he has conducted extensive research on budget and tax policy, social security, health care and welfare reform. As a member of the International Monetary Fund Fiscal Affairs Advisory Committee, Dr. Steuerle also has undertaken tax assistance missions to China, while the government of Barbados recently undertook a tax reform effort modelled after a report that he co-authored as head of another mission.

Earlier in his career he served in various positions in the Treasury Department under four different Presidents and was eventually appointed Deputy Assistant Secretary of the Treasury for Tax Analysis. Between 1984 and 1986 he served as Economic Coordinator and original organizer of the Treasury's tax reform effort, for which Treasury and White House officials have written that tax reform "would not have moved forward without your early leadership" and the "Presidential decision to double the personal exemption...[is] due to your insightful analysis." A former IRS Commissioner has written "During the past decade, few people have had greater impact on major changes in the tax law and the principal improvements in tax compliance and administration."

Dr. Steuerle's publications include four books, and more than 90 reports and articles, 250 columns and 20 Congressional testimonies or reports. One book, The Tax Decade, was recommended by one historian as "required reading for all who study the development of public policy in the twentieth century." His most recent book (co-authored with Jon Bakija) Retooling Social Security for the Twenty-First Century, was cited by the former Executive Director of the National Commission on Social Security Reform as "undoubtedly the most comprehensive analysis of the very long-range financing problems confronting the Social Security program."

Dr. Steuerle serves or has recently served as an advisor, consultant, or board member to the American Tax Policy Institute, the IRS, the Ways and Means Committee of the U.S. House of Representatives, the International Monetary Fund, the National Commission on Children, and as a member of the Capital Formation Subcouncil of the Competitiveness Policy Council. Previous positions also include Federal Executive Fellow at the Brookings Institution, Resident Fellow at the American Enterprise Institute, and President of the National Economists' Club Education Foundation. He is cited frequently in newspapers and news magazines such as The New York Times, The Washington Post, The Economist, Newsweek, Business Week, The Wall Street Journal, USA Today, The Financial Times, and The Philadelphia Inquirer; and has appeared on TV and radio shows or stations such as CNN, ABC, and NPR.

EDUCATION

1975 Ph.D., University of Wisconsin
1973 M.S., University of Wisconsin
1972 M.A., University of Wisconsin
1968 B.A., University of Dayton

PROFESSIONAL BACKGROUND

1989-present Senior Fellow, The Urban Institute, and author of a weekly column, "Economic Perspective," for Tax Notes Magazine.

1987-1989 Deputy Assistant Secretary for Tax Analysis, Department of the Treasury. As the nation's highest tax economic official, the DAS directs the Office of Tax Analysis, an office of approximately 50 Ph.D.-level economists whose responsibilities include design and economic analysis of tax proposals, major studies of tax and budget issues, development of elaborate and sophisticated economic models and data files, and estimation of the receipts side of the Budget of the United States Government.

1986-1987 Director of Finance and Taxation Projects and Resident Fellow, American Enterprise Institute for Public Policy Research. Research included studies of the effects of tax reform on the economy, on charitable giving patterns, and on the IRS.

1984-1986 Economic Staff Coordinator, Project for Fundamental Tax Reform (1984-6). Duties here included service as the principal organizer and designer of the Treasury Department's 1984 Report to the President on Tax Reform for Fairness, Simplicity, and Economic Growth, commonly known as the Treasury I study that led to the Tax Reform Act of 1986.

1983-1984 Federal Executive Fellow, The Brookings Institution. Research here included studies of stagflation, tax shelters, tax arbitrage, and the taxation of financial institutions.

1974-1983 Several previous positions were held within the Department of the Treasury's Office of Tax Policy, including Senior Executive Service positions as Deputy Director for Domestic Taxation and Assistant Director. As head of the Domestic Taxation staff, the Deputy Director serves as the U.S. Government's principal economic officer directing studies on matters of domestic taxation.

STUART M. BUTLER

British-born economist Stuart M. Butler is a Vice-President and the Director of Domestic and Economic Policy Studies at The Heritage Foundation in Washington D.C. He plans and oversees the Foundation's research and publications on all domestic issues. He is an expert on health, urban and welfare policy, the theory and practice of "privatizing" government services, and the politics of the environment.

Butler has authored books and articles on a wide range of issues, from health care to the future of South Africa. In 1981, he wrote Enterprise Zones: Greenlining the Inner Cities (New York, Universe Books), and in 1985, his book Privatizing Federal Spending (Universe) developed a political strategy for reducing the size of government. His book, Out of the Poverty Trap (New York, Free Press, 1987), co-authored with Anna Kondratas, lays out a comprehensive conservative "war on poverty." Most recently, A National Health System for America, co-authored with Edmund Haislmaier and published in 1989 by the Heritage Foundation, lays out a blueprint for a national health system based on free market principles.

In 1981, Butler received the George Washington Honor Medal for his work on urban policy and the Valley Forge Honor Certificate for his book on privatization. In addition, Butler was included in the National Journal's list of the 150 individuals outside government who have the greatest influence on decisions in Washington. The Washington Post says "Butler epitomizes a large segment of the new conservative movement that has become vocal in pursuing its new economic policies at a time when the country seems to be turning away from the old solutions to persistent problems." and The New York Times says he "provided the intellectual underpinnings for the [Reagan] administration's efforts to move [government services] into private control..."

In March 1990 he was appointed a Commissioner on Housing Secretary Jack Kemp's Advisory Commission on Regulatory Barriers to Affordable Housing. He is a frequent guest on television and radio talk shows and is a popular conference and dinner speaker.

Butler was educated at St. Andrew's University in Scotland, where he received a bachelor of science degree in physics and mathematics in 1968, a master's degree in economics in 1971, and a Ph.D. in American economic history in 1978. He was born July 21, 1947 in Shrewsbury, England. He is a British citizen, and married with two daughters.

(6/92)

BIOGRAPHICAL SKETCH

Mark V. Pauly, Ph.D.

Mark V. Pauly is the Bendheim Professor, Chairman and Professor of Health Care Systems Department, and Professor of Insurance and Public Policy and Management, at the Wharton School, and Professor of Economics, in the School of Arts and Sciences at the University of Pennsylvania. He served as Executive Director of the Leonard Davis Institute of Health Economics (LDI) from 1984-89 and currently is LDI's Director of Research.

One of the nation's leading health economists, Dr. Pauly has made significant contributions to the fields of medical economics and health insurance. His 1968 article on the economics of moral hazard continues to serve as a benchmark in the medical insurance field concerning the effect of insurance coverage on the use of medical care services. He has analyzed Medicare and Medicaid financing, the impact of methods of paying health care providers on their behavior, and the role of employment-related group insurance.

Dr. Pauly is an active member of the Institute of Medicine, an adjunct scholar of the American Enterprise Institute, and a member of the advisory board of the Washington-based Capital Economics. He has been, in addition, a member of the technical advisory panels to the National Institute of Drug Abuse, the Health Care Financing Administration's Division of National Cost Estimates, and the Advisory Council on Social Security. He sits on the editorial boards of Public Finance Quarterly, Health Services Research, the Journal of Risk and Uncertainty, and the Journal of Health Economics. Dr. Pauly is extensively published, with over 100 journal articles and books in the fields of health economics, public finance, and health insurance. Prior to joining Pennsylvania's faculty, he was a visiting research fellow at the International Institute of Management in Berlin, West Germany where he studied Germany's health care system, and professor of economics at Northwestern University.

He is the author (with others) of a tax credit approach to health reform called "Responsible National Health Insurance" (described in Pauly, et al., "A Plan for 'Responsible National Health Insurance'," Health Affairs, Spring, 1991).

Dr. Pauly is a 1963 graduate of Xavier University. He received his M.A. in 1965 from the University of Delaware, and his Ph.D. in economics from the University of Virginia in 1967.

American Enterprise Institute for Public Policy Research

ROBERT B. HELMS, Ph.D.

Robert B. Helms is a Resident Scholar and Director of Health Policy Studies at the American Enterprise Institute. He has written and lectured extensively on health policy, health economics, and pharmaceutical economic issues.

He is the editor of three new AEI publications on health policy, *American Health Policy: Critical Issues for Reform*, *Health Policy Reform: Competition and Controls*, and *Health Care Policy and Politics: Lessons from Four Countries*.

From 1981 to 1989 Dr. Helms served as Assistant Secretary for Planning and Evaluation and Deputy Assistant Secretary for Health Policy in the Department of Health and Human Services. He holds a Ph.D. degree in economics from the University of California, Los Angeles.

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Grace-Marie Arnett
Health Policy Consulting
Arnett & Co.

Grace-Marie Arnett has operated her own consulting firm in the Washington, D.C., area for ten years. She specializes in health policy consulting and has written extensively on reform issues. She is a frequent guest on radio and television programs and speaks regularly to audiences throughout the U.S. She also assists businesses, agencies, and associations in analyzing health care reform, developing position statements, and planning communications programs.

She has advised a presidential commission studying health policy issues and currently is working with other policy experts in developing alternative health care reform proposals based upon a market approach.

She has had articles published in the *Washington Post*, *The Wall Street Journal*, and in a number of daily newspapers throughout the country as well as in the *National Review* and other periodicals.

Before starting her own consulting firm, Ms. Arnett served as **executive director** of the **Washington Psychiatric Society**, a professional association of psychiatrists in the Washington, D.C. area. The early part of her career was spent in **journalism and politics.** During this time, she wrote news and analytical articles focusing on tax policy, politics, and other domestic issues, and covering Congress, the White House, and the administrative agencies. She won numerous **awards** for her work as Washington correspondent for the Copley News Service and as a feature writer for the Albuquerque Journal. She also served as **Washington correspondent** for CBS radio affiliate KMOX and for the Fort Worth Star-Telegram.

She has been **press secretary** to **Sen. Pete V. Domenici**, deputy press secretary to the **President Ford Campaign** in 1976, and a media consultant to the **Republican National Committee.**

Ms. Arnett received the Marion Chase Memorial **Award** for public service presented by the **D.C. Mental Health Association** in 1989. She received the award for continuing service to the patients and professionals of the nation's capital from the **District of Columbia Chapter of the Washington Psychiatric Society and the Medical Society of the District of Columbia** in 1986. And she received the outstanding achievement award from the **Washington Psychiatric Society** in 1984.

Post-it™ Fax Note 7671	Date 2/28/94	# of pages ▶ 1
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Co./Dept.	Co. Arnett & Co.	
Phone # 224-3608	Phone # 296-5431	
Fax # 228-2853	Fax # 291-4543	

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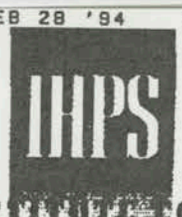

INSTITUTE FOR HEALTH POLICY SOLUTIONS

Richard E. Curtis

Mr. Curtis is the president of the Institute for Health Policy Solutions, a not-for-profit, nonpartisan organization established in April 1992 to identify, analyze, and develop policies to solve health system problems. He has an extensive background in both public and private health care financing issues as well as in a broad range of policy development, analysis, and technical assistance activities. Areas of expertise include alternative strategies to cover uninsured populations, restructuring the health insurance market, health care financing policy for low-income populations, and health care cost containment. He has spent much of the past two years developing and analyzing alternative strategies for federal, state, and private coalition development of health purchasing cooperatives for small employers. Mr. Curtis has substantial experience in working with the insights and perspectives of individuals from a variety of disciplines to develop alternative policy solutions. Other positions he has held include: working group chairperson for the White House health system reform task force; Director of the Department of Policy Development and Research, Health Insurance Association of America; founding Director, National Academy for State Health Policy; and Director of Health Policy Studies, National Governors' Association (NGA). While at NGA, he also served as Director of the Project on the Medically Indigent for the Academy for State and Local Government, and was a contributing editor to *Business and Health* magazine.

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PROJECT FOR THE
REPUBLICAN FUTURE

WILLIAM KRISTOL
CHAIRMAN

WILLIAM KRISTOL

William Kristol is Chairman of the Project for the Republican Future, an independent organization based in Washington, D.C., committed to articulating and advancing a principled Republican governing agenda. From January through October, 1993, he was Director of the Bradley Project on the 90's, a survey of America's social, economic and cultural landscape for the Lynde and Harry Bradley Foundation of Milwaukee, Wisconsin.

From 1989 to 1993, Mr. Kristol served as Chief of Staff to the Vice President of the United States. From 1985 to 1988, Mr. Kristol was Chief of Staff to Education Secretary William Bennett, leaving that position to run Alan Keyes' U.S. Senate campaign in Maryland. Before moving to Washington, Mr. Kristol taught at the John F. Kennedy School of Government, Harvard University, and at the University of Pennsylvania. He received his A.B. and Ph.D. degrees in government from Harvard.

Mr. Kristol's teaching and writing in the fields of political philosophy, American political thought and public policy have appeared in journals such as the Chicago Law Review, the Harvard Journal of Law and Public Policy, Commentary and the Public Interest.

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February, 1993

Robert M. Teeter

Mr. Teeter is president of Coldwater Corporation, a consulting and research firm that provides services in the areas of strategic business planning, marketing, public affairs and policy analysis. He served as chairman of the Bush-Quayle '92 Committee and in 1988, was senior advisor to the Bush for President Committee.

Prior to establishing Coldwater Corporation, Mr. Teeter was with Market Opinion Research for over twenty years, during which time he held several management positions. He was president of the company from 1979 through 1987.

His clients include a variety of businesses, public organizations and trade associations. In addition, he serves on the Board of Directors for Browning-Ferris Industries, Detroit and Canada Tunnel Corporation, Durakon Industries and United Parcel Service.

***

Mr. Teeter participates in numerous civic activities and has been particularly active in the field of education. In 1989, he was appointed to the President's Education Advisory Committee. He is a member of the Board of Trustees for Albion College, a Director of the Gerald R. Ford Library and serves on the National Advisory Committee to the College of Engineering at the University of Michigan.

Mr. Teeter received his Masters degree from Michigan State University and his Bachelor of Arts Degree from Albion College.

Mr. Teeter and his wife Elizabeth have two children and live in Ann Arbor, Michigan.

RODERICK A. DeARMENT

In September 1991 Roderick A. DeArment rejoined Covington & Burling as a Partner after serving more than 2 years as United States Deputy Secretary of Labor.

As Deputy Secretary of Labor, Mr. DeArment was responsible for the day-to-day operation of the U.S. Department of Labor and was involved in all major policy issues handled by the Department including pensions, worker safety and health enforcement, wage and child labor enforcement, international trade and aid programs for Eastern Europe. Mr. DeArment served as the Acting Secretary of Labor from November 1990 to February 1991.

Prior to his appointment to his position at the Department of Labor in 1989, Mr. DeArment was a Partner at Covington & Burling specializing in tax, trade, and legislative matters.

From 1985 to 1986 Mr. DeArment served as Chief of Staff to United States Senate Majority Leader Bob Dole. Prior to that appointment Mr. DeArment served as Chief Counsel and Staff Director of the Senate Committee on Finance. During his six years with the Senate Finance Committee, Mr. DeArment helped shape the Crude Oil Windfall Profits Tax, the Economic Recovery Tax Act of 1981, the Tax Equity and Fiscal Responsibility Tax Act, the Social Security Amendments of 1983, and the Deficit Reduction Act of 1984.

Mr. DeArment first joined Covington & Burling as an Associate in 1973. He received a J.D. degree from the University of Virginia Law School, where he served as an editor of the Virginia Law Review. Mr. DeArment received his undergraduate education at Trinity College in Hartford, Connecticut, from which he graduated with honors.

STANLEY B. JONES

Born: July 27, 1938

Education: B.A. Dartmouth College, 1960, Magna Cum Laude with high distinction in Philosophy, Phi Beta Kappa.

Danforth Graduate Fellowship to Yale for graduate study in Philosophy and Religion, 1960-63

Current Position:

Consultant in Health Policy

Advise insurers, employers, and providers on competitive private health insurance markets, and the potential roles of health insurance in containing costs and improving the accessibility and quality of health care.

Previous Positions:

1986 to 1989

Founder and President, Consolidated Consulting Group and Vice President, Consolidated Healthcare, Inc.

Recruited and directed staff in analytic studies of costs and market requirements of multiple choice health insurance systems, long term care insurance, and other aspects of private health insurance product design, marketing and rating.

1978 to 1980 & 1983 to 1986

Founding partner in consulting firm of Fullerton, Jones & Wolkstein - Health Policy Alternatives

Analyzed impact on private clients of federal legislative and regulatory proposals, and prepared alternative proposals regarding private health insurance, Medicare and Medicaid, and health services and health professions education.

1980 to 1983

Vice President for Washington Representation, Blue Cross and Blue Shield Associations

Coordinated policy studies and advocacy activities of the Blue Cross and Blue Shield system regarding

proposals for federal legislation and regulation.

1977 to 1978

Program Development Officer, Institute of Medicine, National Academy of Sciences

Developed studies, conferences and other projects relevant to current public policy issues in health insurance, health professions education, disease prevention and health promotion, health science policy, and health services.

1971 to 1977

Member of professional staff and then Staff Director, Subcommittee on Health, Committee on Labor and Public Welfare, United States Senate

As Staff Director, planned and coordinated subcommittee legislative activity on national health insurance proposals, and programs of the Public Health Service Act, Community Mental Health Centers Act,and the Food, Drug and Cosmetic Act.

1969 to 1971

Chief, Planning Systems Branch and then Director, Office of Management Policy, Health Services and Mental Health Administration, Department of Health, Education and Welfare

Directed staff in studies of federal grant programs and development of regulations authorized by portions of the Public Health Services Act.

1964 to 1969

Coordinated data processing and computer systems conversion activities of the Division of Research Grants and served as staff to the Associate Director of Division of Computer Research and Technology, National Institutes of Health, Department of Health, Education and Welfare.

1963 to 1964

Participated in National Institutes of Health "Management Intern Program".

Other Recent Professional Activities

Member, Institute of Medicine, National Academy of Sciences, 1980 to present, serving as:

Chairman, National Academy of Sciences Panel on Long Range Planning For Disability Research, 1989
Chairman, Invitational Workshop on Utilization Management, 1987
Chairman, Ad Hoc Committee on Education of Health Professionals, 1987
Member, Board on Mental Health and Behavioral Medicine, 1980-86
Member, Robert Wood Johnson Fellowship Board, 1980-86

Member, District of Columbia General Hospital Commission, 1985-87

Member, Robert Wood Johnson Review Committee for Program to Promote Long-Term Care Insurance for the Elderly, 1988

Fellow of Institute of Society, Ethics and the Life Sciences, The Hastings Center, 1978 to 1989.

Frequent public speaking and teaching engagements on health insurance and health legislation.

Papers:

"Multiple Choice Health Insurance: The Lessons and ?Challenge to Private Insurance," Inquiry, Summer, 1990.

"Outcomes Measurement: A Report From The Front," Ron Geigle & Stanley B. Jones, Inquiry, Spring, 1990.

"Many Will Be Hurt: Another View of Mandating," Bulletin of the New York Academy of Medicine, Jan. - Feb., 1990.

"Perspective: Can Multiple Choice Be Managed?," Health Affairs, Fall, 1989.

" What Distinguishes The Voluntary Hospital in An Increasingly Commercial Health Care Environment?" Stanley B. Jones, Merlin K. DuVal, Chapter 8 of In Sickness And In Health, Edited by J. David Seay and Bruce C. Vladeck, McGraw-Hill, 1988.

"Competition or Conscience? Mixed-Mission Dilemmas of the Voluntary Hospital," Stanley B. Jones, Merlin K. DuVal, Michael Lesparre, Inquiry, Summer 1987.

"Moglichkeiten und Grenzen Einer Markwirtschlichen Steuerung des

Gesundbeits - und Krankenhauswesens," ("Possibilities and Limitations of a Marketplace Mechanism for Health and Hospital Systems"), Arzt und Kranken, August 1982.

"Existing Federal Programs as Models for Compensation of Human Subjects," Compensating for Research Injuries, V.2, Report of President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, June, 1982.

"Labor's New Approach to National Health Insurance," National Health Policy, What Role for Government, Proceedings of a Conference on National Health Policy at Stanford University, March 28 and 29, 1980, Hoover Press Publication 265.

"Improving the Financing of Health Care for Children and Pregnant Women," Report of Select Panel on the Promotion of Child Health, Department of Health, Education and Welfare, 1981.

"The Consumer Choice Approach to National Health Insurance," NCHSR Research Proceedings Series, Effects of the Payment Mechanism on the Delivery of Health Care, October, 1977.

"Publicly Funded Plan: The Most Equitable and Cost-Effective," Journal of the American Hospital Association, March, 1976.

Community Activities

Member of Vestry & Candidate for Holy Orders in the Episcopal Church - Ministry in health and health policy.

Organizer and Board Chairman of Good Shepherd Interfaith Volunteer Caregivers, a program providing services for the frail elderly in Shepherdstown, W. Va.

MENU
CALVERT HOUSE
MARCH 3 AND 4, 1994

BUFFET DINNER, MARCH 3

Carved Roast Beef
Or Baked Chicken Cacciatore with Linguini
Steamed New Potatoes
Fresh String Beans/Honey Glazed Carrots
Garden Salad Bar
Antipasto Platter
Tortellini Salad
Assorted Pastry Desserts

CASH BAR

BUFFET BREAKFAST, MARCH 4

Muffins/Bagels/Pastries
Assorted Cereals
Fresh Fruit

Coffee, Tea, Milk, and Juice

BUFFET LUNCH, MARCH 4

Sandwich Bar with assorted meats, cheeses, breads
Hearty Vegetable Soup
Garden Salad Bar
Cookies and Brownies

*** Coffee, Tea, Sodas will be available continuously both days. ***

BACKGROUND MATERIALS

I. American Enterprise Institute Side-By-Side of Legislative Proposals

II. EBRI Special Report: Sources of Health Insurance and Characteristics of the Uninsured

III. Health Care Fact Sheet on Miscellaneous Issues

IV. Project for the Republican Future: Four Memoranda

V. Senator Durenberger: Two Dear Colleague Letters

VI. Elizabeth McCaughey: Two New Republic Articles

VII. Letter from Governor Thompson

VII. Congressional Research Service Side-By-Side

PREPARED BY AEI

HEALTH CARE REFORM: A SIDE–BY–SIDE ANALYSIS

Plan Feature	The Health Security Act President Clinton	The Managed Competition Act Reps. Cooper, Grandy, et al.	Health Equity and Access Reform Today Act Sen. Chafee, Rep. Thomas, et al.	The Affordable Health Care Now Act Rep. Michel, Sen. Lott, et al.
Mandate/ Universality	Mandates employers to pay 80% of average insurance premium within purchasing cooperative, up to 7.9% of payroll, or from 3.5% to 7.9% for small businesses (<50). Large employers (>5,000) can operate their own plans or join alliances. Self–employed and un–employed pay entire premium. Means–tested assistance is provided.	No business or individual mandate to pay for coverage. All businesses with fewer than 100 employees will join a purchasing cooperative. Large employers not joining the cooperative must offer insurance on their own.	Individual mandate. Small businesses (<100 emp.) must *offer* insurance, either through cooperative or individually. Large employers must also offer insurance. Vouchers will be provided to individuals with incomes below 240% of poverty level.	Mandates business to offer at least one health plan meeting minimum standards. Employers are not required to pay for coverage. Encourages employees to enroll in purchasing cooperatives.
Purchasing Cooperatives	States must establish (by 1997) at least one cooperative to control regional insurance purchasing, marketing, cost, and regulation.	States must charter at least one non–profit cooperative with exclusive territories. Cooperative will offer a menu of accountable health plans (AHPs), collect premiums, disseminate information, and risk–adjust payments to AHPs.	States must establish boundaries for voluntary regional cooperatives to enroll individuals and small businesses. Cooperatives will collect premiums, establish open seasons, collect administrative fees, and risk–adjust health plans in accordance with federal guidelines.	Facilitates the establishment of purchasing cooperatives by eliminating state regulations and mandates, and eliminating IRS restrictions on geographic and business commonality tests restricting 501(c)(9) tax–exempt trusts.
Benefits Package	Establishes minimum package that includes: mental health, substance abuse, dental, and clinical preventive services. Cooperatives must initially allow fee for service (FFS) plans which will have higher copayments, deductibles, and will have controls on fees. No plan costing more than 20% of weighted average will be allowed.	AHPs must offer a minumum benefits package that will be federally defined (and passed by Congress). Will be based on treatable diagnosis, not types or amounts of care.	Establishes a commission to set a minimum benefits package and an alternate catastrophic package (for establishment of an MSA) which must be approved by Congress. Minimum package includes preventive services, some mental health, and limited prescription drugs.	Insurers in the small group market (2–50 emp.) required to offer three plans: a standard plan, a catastrophic plan, and an MSA plan. The NAIC will establish target actuarial values for the standard and catastrophic plans.
Global Budgets	National Health Board (NHB) sets budget based on average premium costs in alliances and the demographic and socioeconomic characteristics of alliance populations. NHB will limit premium growth to CPI plus 1.5% in first year, equaling CPI in 1998. If alliance exceeds budget, an assessment is placed on each plan above average cost. Alliances can limit enrollment in high–cost plans. Corporations must also meet inflation targets or be forced into an alliance. Medicare/aid will also have strict global budgets.	No provision.	No provision	No provision.
Prescription Drugs	HHS will review drug launch prices by comparison to 7 other industrialized countries and by review of company records. "Unreasonably" priced drugs will be reported, but not controlled. Establishes new Medicare drug benefit which can refuse coverage for "unreasonably" priced drugs.	No provision. Does call for the consideration of an expanded Medicare drug benefit financed on a PAYGO basis.	Included in the minimum benefits package	No provision
Preexisting Conditions	No plan can deny coverage to any applicant based on health or financial status.	No AHP can deny coverage for preexisting conditions.	Guarantees eligibility and renewal. Those that let insurance lapse will be subject to 6 month exclusion.	Limits preexisting exclusions on all employer offered plans, including self–funded plans. Guarantees renewability.
Community Rating	No variations in premiums due to health, age, gender, or other matters related to risk are allowed.	AHPs will not be allowed to experience rate, but will be allowed to offer an "adjusted community rate" (allowing adj. for geography and, to limited degree, age).	Small business plans will not experience rate, but will be subject to a rate band in the first year, transitioning to an "adjusted community rate" (allowing adj. for geography and age)	Limits premium rate variations charged to small businesses based on factors other than geography, age, gender, and plan design

HEALTH CARE REFORM: A SIDE–BY–SIDE ANALYSIS

Plan Feature	The Health Security Act President Clinton	The Managed Competition Act Reps. Cooper, Grandy, et al.	Health Equity and Access Reform Today Act Sen. Chafee, Rep. Thomas, et al.	The Affordable Health Care Now Act Rep. Michel, Sen. Lott, et al.
Tax Treatment	Tax deduction will be limited to the weighted average premium cost in regional alliance after 10 years of enactment of this plan. After year 2000, benefits above minimum can be deducted as business expense, but will not be excluded from income.	Employer tax deduction limited to cost of the lowest priced AHP meeting minimum standards. Self–employed deduction increased to 100%, and individuals may deduct their portion of premium paid. Insurance not qualified as an AHP is not deductible.	Caps health insurance deduction and exclusion. Allows for tax–free contributions into a Medical Savings Account up to the tax cap. Cost of catastrophic plan is deducted from calculation of the cap.	Gradually increases tax deduction for the self–employed from 25% to 100%. Gradually increases tax deduction for health insurance for those not receiving employer–provided coverage. Contributions to MSAs are fully tax–deductible.
Admin. Changes (claims proc. & reporting)	Establishes standard forms, uniform health data sets, and electronic networks and standards, as well as issuance of Health Security Cards.	A national board would assist in standardizing forms and electronic transfer of data. Each cooperative will collect and disseminate outcome data for AHPs within its area.	Establishes a federal panel to oversee the development of a standard electronic reporting system. Establishes a nationally–linked health information database.	Mandates HHS to develop a standard claims form and electronic coverage and billing data set, requires SS# as identifier on all medical claims, requires magnetized medical cards, and provides privacy protections.
Program Financing	6 year revenue from: Medicare/aid savings ($238B), sin tax revenue ($105B), other fed. health prog. savings ($47B), revenue gains ($51B), shift of Medicare/aid recipients to employers ($259B).	$25B cost financed by capping employer health deduction ($16B), reducing increase in Medicare provider fees ($6.5B), means testing Medicare part B subsidy ($1.5B), and prefunding federal retiree health benefits ($1B).	Caps growth of Medicaid at 7%, slows Medicare growth to 7%, ends government payment for unpaid hospital services and revenue from limiting tax exclusion.	Increases Medicare part B premium to 75% , alters federal retirement rules, and increases federal retirement age to 62 (total savings $17 bil.).
Medicaid	Medicaid patients enroll in cooperatives with 95% of cost paid by Medicaid (state/fed portions stay the same). Employed Medicaid recipients covered by employer.	New federal program replaces Medicaid with premiums paid for individuals below 100% of poverty level. Individuals and families between 100% and 200% of poverty level receive subsidies. State responsibility is removed, but they are encouraged to establish LTC programs.	States will receive a per capita federal payment, and will be allowed to provide coverage through cooperatives. Rate of growth of payment will be limited.	Allows states to enroll Medicaid patients in managed care plans without receipt of waivers.
Medicare	Individual can stay in cooperative after age 65 with fixed payment (based on estimated per capita cost) provided from HI trust fund. Establishes a prescription drug benefit.	Expands subsidies for low–income beneficiaries. Expands Medicare SELECT program.	Improves Medicare risk contracts to encourage HMO enrollment. Study will be conducted on how to integrate Medicare enrollees into cooperatives.	Consolidates parts A & B over 5 years. Eliminates requirement that HMOs serving Medicare patients have less than 50% Medicare enrollment. Expands law to allow managed care networks to provide Medigap benefits.
Malpractice	Establishes Alternative Dispute Resolution (ADR) system, ends collateral source payments, allows periodic award payments, limits contingency fees to 33.3% of award (states may establish lower limits), and establishes a repeat offender list. Lawsuits will also be reviewed for merit by a professional board. Also includes establishment of "enterprise liability" rules.	Establishes ADR system, restricts punitive damages on products approved by FDA, places $250,000 cap on noneconomic losses, directs punitive damages to be paid to the states. Allows periodic award payments, controls contingency fees to attorneys, sets negligence standards, requires plaintiffs to pay defendants' legal fees for "frivolous" actions. Includes other minor reforms.	Establishes ADR system, caps noneconomic damages at $250,000, ends collateral source payments, allows periodic award payments. 50% of punitive damages will be paid to state to improve state monitoring.	Establishes ADR system, restricts punitive damages on products approved by FDA, places $250,000 cap on noneconomic losses, directs punitive damages to be paid to the states. Allows periodic award payments, controls contingency fees to attorneys, sets negligence standards, requires plaintiffs to pay defendant's legal fees for "frivolous" actions. Includes other minor reforms.
Long–Term Care (LTC)	New LTC program will cover all individuals needing assistance with three activities of daily living, regardless of income or age. Financing will be met with a means–tested copayment and new federal/state match.	No provision. Does call for congressional consideration of extending tax preference to LTC insurance, federal subsidies, and expanded Medicare coverage of LTC. Any benefit must be financed on a PAYGO basis.	LTC costs will receive same tax treatment as health care. Requires LTC insurance to meet certain federal standards.	Provides tax–favored treatment of LTC policies. Permits permanent life insurance, 401(k), & IRA savings to pay for longer care and to be excluded from taxable income. Allows states to develop asset protection plans.
Retiree Benefit	Retired workers entitled to health insurance through the cooperative with the government paying 80% of average premium cost.	No provision.	No provision.	No provision.
Medical Savings Account (MSA)	No provision.	No provision.	An MSA will be available to those electing the catastrophic plan. Contributions to MSAs are tax–deductible and excludable up to the cap. Cost of catastrophic will be deducted from the cap.	Allows tax–free deposits to MSAs for medical expenses, LTC, Medigap, and Medicare premiums. Must purchase catastrophic plan with deductible of at least $1,800 ($3,600 for families).

HEALTH CARE REFORM: A SIDE–BY–SIDE ANALYSIS

Plan Feature	Comp. Family Health Access & Sav. Act Sen. Phil Gramm et al.	Consumer Choice Health Security Act Sen. Don Nickles et al.	American Health Security Act Rep. Jim McDermott et al.	Responsible National Health Insurance AEI Press, 1992
Mandate/ Universality	No mandate. Individuals choosing not to be insured will (after 1 year) lose eligibility for preexisting conditions subsidy explained below. Individual will be payer of first resort for moneys owed. All applicable federal and state laws concerning the collection of unpaid debt will apply.	Mandates individuals to purchase minimal medical coverage for medically necessary "acute medical care." Individuals failing to purchase coverage would be ineligible for the tax credit explained below and would lose personal exemption for health insurance.	Establishes a single–payer system covering all U.S. citizens and lawfully admitted aliens. Others may be covered at discretion of the newly established national board or under a state program.	Mandates individuals to purchase coverage against catastrophic medical expenses. Required coverage varies with income. Coverage could be purchased individually, through an employer, or through another social institution. Tax credits or vouchers will be provided based on income.
Purchasing Cooperatives	Removes antitrust barriers to ease joint ventures in the provision of services and removes other regulatory restrictions on the formation of voluntary purchasing cooperatives.	No provision.	No provision.	No provision. However, does encourage states to solicit bids for fallback insurance that would provide the required coverage for those who do not obtain other insurance.
Benefits Package	For employers to continue the tax deduction on health insurance they must offer three plans: a continuation of current insurance, an HMO or PPO, and a catastrophic plan with a deductible of $3,000 with the establishment of an MSA.	Minimum requirement for "acute medical care" including: physician services, inpatient, outpatient, and emergency services, appropriate alternatives to hospitalization, and prescription drugs. Deductible limits do apply for standard coverage and for establishment of an MSA.	Complete coverage (no deductible, copayment, or other charge) of inpatient, outpatient, primary and preventative services, nursing, home health, LTC, vision, dental, prescription drug, mental health, and most other noncosmetic "frill" services.	Mandatory core level of benefits will be determined by Congress. Suggested beginning point is services covered by a low–cost, managed care plan with significant market share. Permitted copayments rise with income, but the core package is mandatory for all.
Global Budgets	No provision.	No provision.	National budget established annually, based on prior year expenditures plus growth in GDP. Board will allocate funds to states based on per capita average, adjusted for cost and health status in the state. Adjustments must be budget neutral. States must submit budgets to board, allocate funds, and spend less than 3% on admin. charges. State programs will receive federal funds equal to 86% of their weighted average pop. based share of national budget. The states are responsible for the balance.	No provision.
Prescription Drugs	No provision.	Included in the minimum benefits package.	Board will establish list of approved drugs based on advice of committee, and will negotiate maximum prices with manufacturers. States will pay for drugs based on these prices and will set separate dispensing fees for pharmacies.	See benefits package.
Preexisting Conditions	Individuals with preexisting conditions will be expected to pay 150% of average catastrophic premium for persons in same age and area. Gov. will pay excess (above 150%) if entire cost exceeds 7.5% of income. Insurers will bid to cover high risk pool.	Guarantees issue, renewal, and limits exclusions based on preexisting conditions. Also limits underwriting.	All current U.S. citizens and legal immigrants will be covered. Coverage will be provided as of birth or date of legal immigration.	Initial purchase is mandatory. Fallback insurance is offered to high risks, with credits given to individuals above 150% of average rate. Renewability is guaranteed for 3 years with adjustments allowed only for increases in average risk.
Community Rating	No provision.	Insurance plans will not be allowed to experience rate, and will be limited to an "adjusted community rate" (allowing adj. for geography, age, and gender).	Not applicable.	No provision. However, does suggest modified community rating as one option to avoid adverse selection.

HEALTH CARE REFORM: A SIDE–BY–SIDE ANALYSIS

Plan Feature	Comp. Family Health Access & Sav. Act Sen. Phil Gramm et al.	Consumer Choice Health Security Act Sen. Don Nickles et al.	American Health Security Act Rep. Jim McDermott et al.	Responsible National Health Insurance AEI Press, 1992
Tax Treatment	Converts tax deduction for the self–employed into a tax exclusion, gradually equaling the national average employer contribution. A similar exclusion will be provided for those not receiving employer provided coverage. Contributions to MSAs are fully tax deductible.	Replaces current tax exclusion with a refundable tax credit. Credit is based on a sliding scale determined by an individual's ratio of health expenses to income. Credit ranges from 25% to 75% percent of cost.	Will expand withholding tax and employer match. Employers will be required to pay an 8.4% payroll tax, while employees will pay a 2.1% payroll tax (ratio set at 4/1). Small business (<75 employees with avg. wage <$24,000) tax capped at 4%.	Would convert tax exclusion into tax credit to assist the poor and those with high–risk ratings. Tax system would be used to enforce mandate by taxing those failing to purchase insurance at a rate equal to their premium rate, net any credit.
Admin. Changes (claims proc. & reporting)	All federal and state agencies involved in the funding and delivery of care will use standard forms, and must reduce paperwork by 75% in 5 yrs. Standard form will be developed for private concerns that receive public money.	The Secretary of HHS would be authorized to require all health care providers to submit claims in accordance with national standards. Secretary will also study electronic claims processing and other administrative savings.	Development of uniform electronic database, establishment of national ID, and uniform claim and payment forms.	No provision.
Program Financing	Medicare savings ($61.5B), Medicaid savings ($112.5B), and other offsets ($15.7B).	Primary financing will be provided by the conversion of the tax exclusion and caps on Medicare and Medicaid. Other savings will come from eliminations and reductions in Medicare programs.	Will be financed through withholding tax and employer match, cigarette tax, and a tax on handguns and ammunition.	Will be financed through the conversion of the tax exclusion.
Medicaid	Makes per capita payment to the states to allow them to enroll patients in HMOs or MSAs. Creates a sliding credit for families ineligible for Medicaid with incomes between 100% and 200% of poverty level for purchase of catastrophic insurance.	Medicaid would continue, but disproportionate share program would be converted into state grants to promote health insurance, disease prevention, and health promotion for population just above Medicaid eligibility.	Medicaid is superseded upon enactment, but must pay for services completed before enactment (Jan. 1, 1995).	Would replace Medicaid with the system of credits and vouchers listed above.
Medicare	Individual can continue current policy or receive capitated payment as long as individual enrolls in private insurance. 50% of savings can be taken as cash. Increased MSA deposits will reduce role of Medicare.	No provision.	Medicare is superseded upon enactment, but must pay for services completed before enactment (Jan. 1, 1995).	Medicare could be folded into RNHI, with low income elderly recieving credits, or it could be left as is, or elderly could be given the choice between the two systems. RNHI could also be phased in as current workers retire.
Malpractice	Plaintiff pays "frivolous" court costs. Liability limited to actual damages. Contracts can be used to limit liability in return for lower fees. Noneconomic damages limited to $250,000. Contingency fees limited to 25%. Limits collateral source payments and allows for periodic payment. Statute of limitations reduced to 2 years from discovery and 4 years from occurrence. No punitive damages against FDA–approved drugs or technology.	Provides guidelines for federal and state arbitration, limits noneconomic damages to $250,000, provides periodic payments for rewards over $100,000, and limits the liability of defendants for noneconomic and punitive damages to their percentage of fault (as determined by trier of fact). Also limits collateral source payments.	No provision. However, a quality council will collect data from outcomes research and will develop practice guidelines and adopt guidelines to identify outliers whose practice suggests quality deficiencies. Each state will develop independent quality reviews.	No provision.
Long–Term Care (LTC)	Allows individuals opting for capitated payment under Medicare to use other 50% of savings toward LTC costs.	Permits permanent life insurance, 401(k), and IRA savings to pay for longer care and be excluded from taxable income.	Nursing and home health services, home and community–based LTC services, hospice care, and prescription drugs are covered. LTC services provided to anyone needing assistance with 2 activities of daily living.	No provision.
Retiree Benefit	No provision.	No provision.	Individuals will be covered for entire life.	No provision.
Medical Savings Account (MSA)	MSAs will be available to those electing the catastrophic plan with a $3,000 deductible. Contributions to MSAs receive same tax treatment as premium payments. Unspent funds can be withdrawn and treated as income.	Allows for the establishement of MSAs and provides same tax credits listed above for deposit. One MSA per household with annual deposits limited to $3,000 plus $500 per dependent.	No provision.	No provision.

Sources of Health Insurance and Characteristics of the Uninsured

Analysis of the March 1993 Current Population Survey

EBRI
EMPLOYEE BENEFIT RESEARCH INSTITUTE

Special Report

- This *Issue Brief / Special Report* examines the extent of health insurance coverage in the United States, the characteristics of the uninsured population by employment status, firm size, industry, income, location, family type, gender and age, race and origin, and education, as well as how the uninsured population has changed over the last several years.

- Eighty-three percent of nonelderly Americans and 99 percent of elderly Americans (aged 65 and over) were covered by either public or private health insurance in 1992, according to EBRI tabulations of the March 1993 Current Population Survey (CPS). The March 1993 CPS is the most recent data available on the number and characteristics of uninsured Americans.

- In 1992, 17.4 percent of the nonelderly population—or 38.5 million people—were not covered by private health insurance and did not receive publicly financed health assistance. This compares with 36.3 million in 1991 (16.6 percent), 35.7 million in 1990 (16.5 percent), 34.4 million in 1989 (16.1 percent), and 33.6 million in 1988 (15.9 percent).

- The most important determinant of health insurance coverage is employment. Nearly two-thirds of the nonelderly (62.5 percent) have employment-based coverage. Workers were much more likely to be covered by employment-based health plans than nonworkers (71 percent, compared with 40 percent).

- A primary reason for the increase in the number of uninsured between 1991 and 1992 is a decline in employment-based coverage among individuals (and their families) working for small firms. Forty-two percent of the additional 2.2 million individuals without coverage between 1991 and 1992 were in families in which the family head worked for an employer with fewer than 25 employees.

- The number of children who were uninsured in 1992 was 9.8 million, or 14.8 percent of all children. This compares with 9.5 million and 14.7 percent in 1991. The increase in the number and proportion of uninsured children was partially offset by an increase in the proportion of children with Medicaid.

- In 12 states and the District of Columbia, more than 20 percent of the population was uninsured in 1992 (table 3). These states and their uninsured rates were Nevada (26.6 percent), Oklahoma (25.8 percent), Louisiana (25.7 percent), Texas (25.7 percent), the District of Columbia (25.5 percent), Florida (24.2 percent), Arkansas (23.5 percent), Mississippi (22.7 percent), New Mexico (22.5 percent), Georgia (22.4 percent), California (22.2 percent), South Carolina (20.8 percent) and Alabama (20.1 percent).

SELECTED FIGURES OF CHARACTERISTICS OF THE UNINSURED

(From EBRI Analysis of March 1993 Current Population Survey)

Non-Elderly - 83% have health insurance - of that, 15% had public health insurance

Elderly - 96% are covered by Medicare - of that, 35% have individually purchased Medigap supplemental insurance and another 33% have employer provided Medigap insurance.

- In 1991 - 16.6% of the non-elderly (or 36.3 million people) were not covered by insurance

- In 1992 - 17.4% of the non-elderly (or 38.5 million people) were not covered by insurance

(A primary reason for the increase in the number of the uninsured is a decline in coverage by small firms)

- 92% in families with income over $50,000 have health insurance
- 52% in families with income below poverty line have public insurance
  - 50% Medicaid
  - 2% Medicare, CHAMPUS or CHAMPVA

- Of the 4.2 million increase of uninsured between 1989 and 1992
  - 19% were in families headed by worker in firm of less than 25
  - 21% were in families headed by worker in firm between 25 to 99
  - 14% were in families headed by worker in firm between 100 to 499
  - 21% were in families headed by worker in firm over 500
  - 25% were in families headed by non-worker

- Of the Uninsured
  - 56.7% are working adults
  - 17.8% are non-working adults
  - 25.4% are children

- Of the Uninsured
  60% are families headed by full-year workers with no unemployment
  52% are families headed by full-time workers
  8% are families headed by full-year, part-time workers

- Only 13% of individuals in families headed by a full-time, full-year worker are not covered by insurance. - But they represent the largest segment (52%) of the uninsured.

- 1/2 of all uninsured workers were either self-employed or working in firms with fewer than 25 employees.

- In 1992 - 88% of the uninsured were in families with an AGI of less than $20,000
  - 53% of the uninsured were in families with income under $20,000
  - 35% of the uninsured were in families with income under $5,000
  - 6% of the uninsured were in families with income over $50,000

Health Care Fact Sheet on Miscellaneous Issues

[Excerpts from Ernst & Young, EBRI and CBO Data]

EXPENDITURES	**1980**	**1993***	**2000***
National Total ($B)	$ 250	$ 903	$ 1,613u
Percent of GDP u	9.2	14.6	18.9
Per Capita Amount ('91$) u	$1,761	$3,217	$4,503
National Total (AAC%)	---	10.4	9.8

Expenditure Distribution	**1980**	**1993***	**2000***
Hospital	41%	40%	40%
Physician	17	19	20
Nursing Home	8	8	7
Drugs	9	8	7
Other	25	25	25

Payor Distribution	**1980**	**1993***	**2000***
Private Health Insurance	29%	30%	28%
Patient Out-of-pocket	24	19	17
Federal Government	29	32	36
Other Government/Private	18	19	19

PROVIDERS

Physicians

Active Physicians (1995*)	634,600
Group Practices (GPs) (1991)	16,576
Physicians in GPs (1991)	184,358
Physician Income AAC (1982-91)	6.4%
Malpractice Premiums (1982/1991)	$5,800/$14,900

Hospitals	**1980**	**1993***	**2000***
Total Average Margin	3.8%	4.3%	–
% with (-) Margins	26.2%	24.5%	–
Comm. Hosp. Closures	50	45	39
Comm. Hospitals/Beds (1992)	5,292 / 920,043		
Multi-hospital Systems (1992)	53% of all hospitals, 59% of all beds		

Managed Care	**1988**	**1992**	**AAC**
No. HMOs	643	556	(3.6%)
HMO Enrollment (M)	31	37	4.4%
No. PPOs	691	1,036	10.7%
PPO Enrollment (M)	18	58	33.4

(M)=Millions (B)=Billions (T)=Trillions
u=CBO Data ; *Projected Data; AAC=Average Annual Change
s=Employee Benefits Research Institute Data, 1993 CPS

INTERNATIONAL	US.	Can.	Ger.	Jap.	U.K.
%Health GDP (1991)	13.4	10.0	8.5	6.6	6.6
%Growth GDP (1991)	2.7	0.9	8.1	6.4	4.7
Per Capita (1991) (US$)	2,867	2,149	2,088	1,800	1,162
Life Expectancy (F)	78.8	80.4	79.0	82.1	78.8
Life Expectancy (M)	72.0	73.8	72.6	76.1	73.2
Infant Mortality (/100)	0.89	0.68	0.71	0.46	0.74
Length of Stay (days)	6.4	11.4	15.2	44.9	20.0
Beds per 1,000	4.7	6.7	10.4	15.8	6.4
Physicians per 1,000	2.5	2.2	3.2	1.6	1.4

INSURANCE COVERAGE

Insured s	1991
Total (M)	251.7
Employment-based	55.6%
Public Program	37.0%
Other Private	7.3%

Uninsured <65 y/o s	1991
Total (M)	38.5
Full-time Emp (Full-year)	52.4%
Part-time Emp (Full-year)	7.8%
Full Year, Some Unemp.	17.4%
Part Year	6.9%
Non-worker	15.6%

% Uninsured by Income, Workers aged 18-64 s	
>$10,000	32%
$10,000-19,999	23%
$20,000-29,999	10%
$30,000-39,999	6%
$40,000-49,999	3%
$50,000 or more	3%

% Uninsured by Family Type Nonelderly Population s	
Total	17%
Married with Children	13%
Married without Children	15%
Single with Children	20%
Single without Children	29%

Expenditures	1987	1991	1992	AAC
Employer Total	$ 128	$ 238	–	16.8%
Per Employee	$ 1,985	$ 3,605	$ 3,968	14.9%

MEDICAID (POOR)

	1990	1993*	1995*	AAC 1990-93
Expenditures (B)	$ 71	$ 145	$ 196	26.9%
Recipients (M)	25	33	36	9.7%

MEDICARE (ELDERLY)

	1993*	1995*	AAC 1995*	1989-93
Expenditures (B)	$ 152.9	$ 191.0	10.6%	

(M)=Millions (B)=Billions (T)=Trillions
u=CBO Data ; *Projected Data; AAC=Average Annual Change
s=Employee Benefits Research Institute Data, 1993 CPS

FEDERAL DEFICIT	Actual 1993	1994*	1995*	1996*	1997*	1998*
Estimated Annual (B) u	$ 255	$ 223	$ 171	$ 166	$ 182	$180
Gross Federal Debt (T) u	4.4	4.7	5.0	5.3	5.7	6.0
Gross Fed Debt Interest (B) u	293	298	311	330	346	263

INFLATION INDEX	1993	1994*	1995*	1996*
CPI-U u	3.0%	2.7%	3.0%	3.1%
Real GDP % Chg u	2.8	2.9	2.7	2.7
Nominal GDP (B) u	6,370	6,730	7,099	7,483

DEMOGRAPHICS	1990	2000*
Total U.S. Population (M)	249.924	274.815
Rhode Island	1,003,000	

	1993	1995*	1999*
Unemployment: u	6.8%	6.1%	5.7%

	1980-89	1990-99*
Population Increase:	22.9%	24.9%

Aged Population	1990	2000*	Increase 1990-2000*
Under 65 (M)	218.4	239.9	9.9%
% Total Pop.	87.3%	87.0%	
65 & Over (M)	31.5	34.9	10.6%
% Total Pop.	12.6%	12.7%	
% RI Pop.	15.1%		
85 & Over (M)	3.1	4.3	39.3%
% Total Pop.	1.2%	1.6%	
% MO Pop.	1.5%		

AIDS	1993*	1994*	1995*
Cumm. HIV Cost (B)	$ 11.8	$ 13.4	$ 15.2
People with AIDS	203,191	231,469	260,846

(M)=Millions (B)=Billions (T)=Trillions
u=CBO Data ; *Projected Data; AAC=Average Annual Change
s=Employee Benefits Research Institute Data, 1993 CPS

PROJECT FOR THE

REPUBLICAN FUTURE

December 2, 1993

MEMORANDUM TO: REPUBLICAN LEADERS

FROM: WILLIAM KRISTOL

SUBJECT: Defeating President Clinton's Health Care Proposal

What follows is the first in what will be a series of political strategy memos prepared by The Project for the Republican Future. The topic of this memo is President Clinton's health care reform proposal, the single most ambitious item on the Administration's domestic policy agenda.

These four pages are an attempt to describe a common political strategy for Republicans in response to the Clinton health care plan. By examining the president's own strategy and tactics, this memo suggests how Republicans might reframe the current health care debate, offer a serious alternative, and, in the process, defeat the president's plan outright.

Nothing in these pages is intended to supplant the many thoughtful analyses of the Clinton health care plan already produced by Republicans and others, analyses which have done much to expose both its glaring weaknesses and immediate dangers. In fact, this memo borrows heavily from articles and papers prepared by conservative public policy think tanks, the Republican National Committee, House and Senate Republicans, and the dozens of superb critiques that have appeared in newspapers and magazines. Nor is this an attempt to prescribe legislative tactics for defeating the Clinton bill; for that we defer to our Republican leaders in the Congress. Instead, it is an effort to assess the current political climate surrounding the health care debate and to provide a winning Republican strategy that will serve the best interests of the country.

The Project for the Republican Future was founded last month to help shape a Republican vision and advance an agenda for governing. It seeks to frame a new Republicanism by challenging not just the particulars of big-government policies, but their very premises and purposes. In the coming months, we will prepare and circulate other memos on critical issues of politics and policy. We welcome your reactions to this memo so that we can further refine a Republican strategy, and we encourage your thoughts on future subjects for consideration.

PROJECT FOR THE REPUBLICAN FUTURE: A POLITICAL STRATEGY FOR HEALTH CARE

I. THE CURRENT SITUATION

Just after President Clinton introduced his health care plan in September, opinion polling reflected strong public support for it. That support has now sharply eroded. A late September *Washington Post*/ABC News poll, for example, had national respondents approving the plan by a 56 to 24 percent margin; the same poll in October had approval down to a 51 to 39 percent margin; and a mid-November *Post*/ABC poll now shows bare plurality support for the plan of 46 to 43 percent.

To some extent, these results follow a predictable pattern of Clinton Administration policy initiatives, which have tended to open well on the strength of the president's personal advocacy, and then to falter as revealed details make plain his attachment to traditional, big government, tax-and-spend liberalism. Faced with forceful objections in the past, the Administration has generally preferred to bargain and compromise with Congress so as to achieve any victory it can. But health care is not, in fact, just another Clinton domestic policy initiative. And the conventional political strategies Republicans have used in the past are inadequate to the task of defeating the Clinton plan outright. That must be our goal.

Simple Criticism is Insufficient. Simple, green-eyeshades criticism of the plan -- on the grounds that its numbers don't add up (they don't), or that it costs too much (it does), or that it will kill jobs and disrupt the economy (it will) -- is fine so far as it goes. But in the current climate, such opposition only wins concessions, not surrender. The president will lobby intensively for his plan. It will surely be the central theme of his State of the Union Address in January. Health care reform remains popular in principle. And the Democratic Party has the votes. After all, the president's "tax fairness" budget, despite unanimous Republican opposition and rising public disapproval, did pass the Congress.

Any Republican urge to negotiate a "least bad" compromise with the Democrats, and thereby gain momentary public credit for helping the president "do something" about health care, should also be resisted. Passage of the Clinton health care plan, in any form, would guarantee and likely make permanent an unprecedented federal intrusion into and disruption of the American economy -- and the establishment of the largest federal entitlement program since Social Security. Its success would signal a rebirth of centralized welfare-state policy at the very moment we have begun rolling back that idea in other areas. And, not least, it would destroy the present breadth and quality of the American health care system, still the world's finest. On grounds of national policy alone, the plan should not be amended; it should be erased.

But the Clinton proposal is also a serious *political* threat to the Republican Party. Republicans must therefore clearly understand the political strategy implicit in the Clinton plan -- and then adopt an aggressive and uncompromising counterstrategy designed to delegitimize the proposal and defeat its partisan purpose.

II. THE CLINTON STRATEGY

"Health care will prove to be an enormously healthy project for Clinton ... and for the Democratic Party." So predicts Stanley Greenberg, the president's strategist and pollster. If a Clinton health care plan succeeds without principled Republican opposition, Mr. Greenberg will be right. Because the initiative's inevitably destructive effect on American medical services will not be practically apparent for several years -- no Carter-like gas lines, in other words -- its passage in the short run will do nothing to hurt (and everything to help) Democratic electoral prospects in 1996. But the long-term political effects of a successful Clinton health care bill will be even worse -- much worse. It will relegitimize middle-class dependence for "security" on government spending and regulation. It will revive the reputation of the party that spends and regulates, the Democrats, as the generous protector of middle-class interests. And it will at the same time strike a punishing blow against Republican claims to defend the middle class by restraining government.

The 80-80 Split. The president intends to convince the American middle class to buy into this new government dependency by overcoming their skepticism with fear. Poll numbers explain his tactics. A large majority of Americans consistently reports that it believes our country's health care system, writ large, to be dysfunctional; 79 percent of respondents to a Princeton Survey Research Associates/*Newsweek* poll in late September, for example, said the American health care system needed fundamental change or a complete rebuilding. Popular discomfort with American medicine as a "system" is Clinton's opportunity. But the same polls contain the key to Clinton's vulnerability, as well. The vast majority of Americans are pleased with the care this system now provides them personally; 80 percent of respondents to a late September Yankelovich/*Time*/CNN poll said they were "somewhat" or "very" satisfied with their own medical services.

So the president advances a promise of "universal" health care coverage as a solution to the problem of the uninsured, but his plan must win the approval of a middle class most members of which are generally happy with the health care they have. He cannot plausibly claim that his plan will make the middle class even happier with their present care. That argument, at least, is already lost. Respondents to a mid-November CBS/*New York Times* poll say, by a two-to-one margin, that the Clinton plan is more likely to degrade than enhance the quality of their own medical care, and by an almost six-to-one margin that their personal medical expenses are more likely to go up under Clinton than down.

The Administration's only option, then, is singlemindedly to focus on the fears many middle-class Americans have about health care as an abstract "system" that might someday threaten them. The Administration's public pronouncements ignore all basic, practical questions about how their health plan will actually affect the quality and flexibility of American medical care. And its spokesmen encourage the notion that radical change involving a sacrifice of quality and free choice is necessary for health "security."

III. A REPUBLICAN COUNTERSTRATEGY

The president makes his pitch to the 79 percent of Americans who are inclined to agree that "the system" isn't working, hoping to freeze health care debate on the level of grand generalization about structural defects. He is on the side of the angels rhetorically -- denunciations of the status quo, easy moralism about his own alternative, rosy predictions of a utopian future in which security is absolutely guaranteed. Republicans can defeat him by shifting that debate toward specific, commonsense questions about the effect of Clinton's proposed reforms on individual American citizens and their families, the vast majority of whom, again, are content with the medical services they already enjoy.

Republicans should ask: what will Bill Clinton's health care plan do to the relationship most Americans now have with their family doctor or pediatrician? What will it do to the quality of care they now receive? Such questions are the beginning of a *genuine* moral-political argument, based on human rather than bureaucratic needs. And they allow Republicans to trump Clinton's security strategy with an appeal to the enlightened self-interest of middle-class America.

The Republican counterstrategy involves pursuing three distinct tasks: 1) deflating the exaggerated fears of systemic health care collapse that Democrats have encouraged; 2) clarifying and publicizing how the Clinton reform plan would alter and damage the quality and choice of medical treatment most Americans now take for granted; and 3) pointing out that incremental and meaningful solutions to problems of health security -- solutions that do not require scrapping the current structure of American medicine and experimenting with something invented in Washington -- are already available and politically within reach.

Deflating Fear. Genuine, yet remediable problems do exist in the American system of medicine, but the rhetoric surrounding the president's health plan deliberately makes those problems sound apocalyptic. "Fear itself" does not trouble the new New Dealers; indeed, they welcome it as a powerful tool of political persuasion. Mrs. Clinton, in particular, routinely describes a nation of individual lives teetering on the brink, each only an illness or job switch away from financial ruin. The text of the president's Health Security Plan and vir-

tually all the public remarks on heath care made by his advisors are filled with images of a health care system spawning little else but frustration and tragedy. It is a brazen political strategy of fear-mongering, conducted on a scale not seen since the Chicken Little energy crisis speeches of President Carter.

Fanning the flames of public unease is a purely political tactic for the Democrats, and it deserves to be exposed as such. For while public concern about health care is undoubtedly real, the president's deliberate campaign of fright seems designed less as a response to the public and more as a justification for his own far-reaching, grand reforms. Republicans should scrupulously avoid endorsing the president's depiction of a nation beset by fear over health care, which provides him cover for the war-time, centrally-planned, emergency-style measures that characterize his alarmist overhaul of our medical system. Republicans should instead painstakingly debunk that account, and remind the nation, point by point, that it currently enjoys the finest, most comprehensive, and most generous system of medical care in world history.

Raising Questions About Medical Quality and Choice. The most devastating indictment of the president's proposal is that it threatens to destroy virtually everything about American health care that's worth preserving. Under the plan's layers of regulation and oversight, even seeing a doctor whenever you like will be no easy matter: access to physicians will be carefully regulated by gatekeepers; referrals to specialists will be strongly discouraged; second opinions will be almost unheard of; and the availability of new drugs will be limited.

So while there are now countless valid criticisms of the Clinton plan's various aspects, the most politically effective ones focus on how the proposal would fundamentally change the quality and kind of medical service that Americans cherish and expect. This means an assault on the Clinton plan's two central tenets: mandatory, monopolistic health alliances and government price controls. Hand in hand, these two cornerstones of the president's plan will establish a system of rationed medical care.

Under Clinton's plan, the alliances will submit annual budgets to a national health board, thereby creating pressure to save money and trim service wherever possible. That means tightly regulated managed health care for most people, with an emphasis on efficiency over quality. Those who can afford huge premiums may be able to see a private fee-for-service doctor, though fee schedules will make it difficult for most independent physicians to stay in business. In time, the family doctor tradition will disappear. And avoiding this result by purchasing health insurance outside the alliances will be either impossible or criminal. The chief effect of price controls -- the linchpin of the president's cost-containment theory -- will be a rigid national system of pre-set budgets and medicine by accountants. There is no reason to believe that such a system won't follow the pattern that price controls have established in every other area: rationing, queuing, diminished innovation, black markets, and the creation of a government "health police" to enforce the rules.

Though the president and his surrogates deny all this, the basic building blocks of his proposal permit no other result. Republicans should insistently convey the message that mandatory health alliances and government price controls will destroy the character, quality, and inventiveness of American health care.

Advocating Security Without Upheaval. The initial appeal of the president's proposal is its promise of lifelong, universal security, defined in standard Democratic terms as a federal entitlement benefit. But this promise can also be restated as the plan's most glaring weakness: it mistakes federal spending and regulation for individual security. In exchange for his government-program security, Americans must accept a massive uprooting of the entire U.S. health care system, with disruptive and deleterious consequences.

As both a political and policy matter, the best counter-strategy to Clinton's offer of security requires resisting the temptation to compete with the president in a contest of radical reforms. Allaying public concern about health security can be achieved by addressing a few basic problems directly -- and without unravelling the current system. The easiest way to do that is by pursuing the short list of reforms for which there is already a

national consensus. Relatively simple changes to insurance regulation, for example, can eliminate the barriers to health insurance for people with pre-existing medical conditions. The unemployed or people whose employers do not provide health insurance should be able to deduct the full cost of their premiums. The federal government could target its health spending to provide clinics in rural areas and inner cities where access to health care remains a problem. Long-overdue reforms to medical malpractice law would help lower insurance rates across the board. And a simplified, uniform insurance form would reduce paperwork, another unnecessary irritant of the current system. All these small steps would make health insurance less costly and health care easier to obtain.

Even where national health budgeting is concerned, there exist opportunities for significant reform that do not involve Great Society-scale upheaval. States might be permitted to operate Medicare and Medicaid programs through managed care, for example, rather than through now-mandated fee-for-service plans -- and thereby realize huge cost savings in their own budgets. (The Democratic governor of Tennessee recently applied for, and received, the necessary waiver of federal regulations to pursue just such a reform.) In fact, there are all sorts of cumbersome and costly health care mandates and regulations now imposed on states; they should be lifted to allow governors to allocate their federal programs in the most efficient way. The potential savings from Medicare and Medicaid -- the engine of our escalating federal deficit -- are enormous.

These are hardly revolutionary or even visionary proposals. In fact, variations of these reforms have been floating around the Congress for some time. Their simplicity and their lack of big-government "sophistication" stand in stark contrast to the extensive controls, reorganizing, standardization, and rationing that are at the heart of president's Health Security Plan.

IV. LAYING GROUNDWORK FOR THE FUTURE

These may only be intermediate measures. A more ambitious agenda of free-market reforms remains open for the future: medical IRAs, tax credits and vouchers for insurance, and the like. But Republicans must recognize the policy and tactical risks involved in near-term advocacy of sweeping change, however "right" it might be in principle. The Clinton plan's radicalism depends almost entirely for its success on persuading the nation that American medicine is so broken that it must not just be fixed, but replaced -- wholesale and immediately. And it would be a pity if the advancement of otherwise worthy Republican proposals gave unintended support to the Democrats' sky-is-falling rationale.

The more modest Republican reforms discussed earlier would have the virtue of cooling the feverish atmosphere -- fostered largely and deliberately by the Administration -- in which health care is currently discussed. And they offer a potentially much larger benefit to the Republican Party as a model of future conservative public policy: a practical vision of principled incrementalism. The character of Republican opposition to the president's health care plan, properly pursued, has broad implications. The party's goal, in health care and in other policy areas, should be to make the case for limited government while avoiding either simple-minded bean-counting, on the one hand, or Democrat-like utopian overreach on the other. The target of Republican policy prescriptions must be the individual citizen, not some abstract "system" in need of ham-fisted government repair. If we can, in this way, provide a principled alternative to the paternalistic experimentalism that consistently underlies Democratic ideas of governance, Republicans will be poised to claim the moral high ground in this and future debates.

The first step in that process must be the unqualified political defeat of the Clinton health care proposal. Its rejection by Congress and the public would be a monumental setback for the president, and an incontestable piece of evidence that Democratic welfare-state liberalism remains firmly in retreat. Subsequent replacement of the Clinton scheme by a set of ever-more ambitious, free-market initiatives would make the coming year's health policy debate a watershed in the resurgence of a newly bold and principled Republican politics.

PROJECT FOR THE
REPUBLICAN FUTURE

January 10, 1994

MEMORANDUM TO: REPUBLICAN LEADERS

FROM: WILLIAM KRISTOL

SUBJECT: Health Care Reform: The Next 100 Days

Attached is a second political strategy memorandum on the debate over health care reform. We continue to believe that any version of President Clinton's proposal can and must be defeated, and that attempting to negotiate over aspects of his plan would be an ill-advised strategy for Republicans. It is increasingly evident that Clinton's plan is at once fundamentally unnecessary, since there is no systemic health care "crisis," and radically dangerous, because it threatens the quality of American health care. Republicans must not be embarassed to oppose the president's plan wholeheartedly.

In this memo, we argue that Republicans need to adopt an aggressive political and legislative strategy over the next three months to advance a counter-agenda of incremental reforms targeted at the real problems in our health care system. These reforms, which enjoy broad bipartisan support, could be implemented now, and would not preclude the possibility of more fundamental changes along free market lines in the future. Advancing these reforms now would enable Republicans to point out that we want to fix what needs to be fixed, and that it is the president's plan that stands in the way of sensible reform of the health care system.

We appreciate your helpful comments and reactions to our first memo, and look forward to continuing to work with you on this and other important issues.

Attachment

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HEALTH CARE REFORM: THE NEXT 100 DAYS

"It seems to me we shouldn't wait all year, or two years. When we've got some areas we agree on, why not just go ahead and pass those early next year and get them behind us? Pre-existing condition, portability, let companies get together, get better deals from health insurance companies by pooling -- there are a lot of things we can agree on. Senator Bentsen has had the bill around here -- it's been around here for three or four years and we haven't passed it."

Senator Robert Dole, news conference, December 16, 1993

"[M]y view is that I think there isn't a [health care] crisis.... There are problems. We ought to address those problems, and we ought to do it as quickly as we can.... [T]here are a lot of good provisions that we could take care of, small business reforms, take care of pre-existing conditions, things of that kind that we'd have almost unanimous approval on."

Senator Dole, *Meet the Press*, January 2, 1994

With these words, Senator Dole has articulated a substantively honorable and strategically sound Republican position on health care. Republicans believe that the Clinton Administration's proposal for mandatory regulatory alliances and price controls would, if enacted, constitute a devastating blow to the quality of American health care and to doctor-patient relationships. And Senator Dole argues, correctly, that the Administration's rigid insistence on a full-scale overthrow of the American medical system is actually delaying and damaging prospects for genuine and serious health care reforms, reforms that already enjoy wide bipartisan support.

The Minority Leader is right to urge swift Congressional action on a package of targeted, incremental health care reforms. Republicans should advance those reforms, perhaps as amendments to other bills, as soon as the Congress reconvenes. Such a strategy would make obvious to the nation that the Clinton proposal is both radically dangerous and fundamentally unnecessary. For if these reforms are opposed by the Administration and the Democratic leadership in Congress, it will be clear that the Clinton health care plan is motivated not by concern over the real problems of ordinary Americans, but by the ideological and political designs of the White House.

Republicans have an opportunity in the coming weeks and months to redirect and seize control of the health care debate -- to our and the nation's benefit. That opportunity must not be missed.

THE POLITICS OF HEALTH CARE: THE LAST THREE MONTHS

Three months after President Clinton formally introduced his health care plan to a joint session of Congress, public enthusiasm for the proposal continues to dwindle. In a *Time*/CNN poll released last month, fewer than one in ten respondents said Congress should pass the president's health care bill in its present form; almost half of all respondents, by contrast, said the Clinton plan should either undergo major changes or be rejected completely. What's more, evidence continues to emerge that the financing "crisis" the president uses as his proposal's central justification has in fact been receding without his help. The U.S. Labor Department's "price inflation for consumer medical goods and services" statistic -- which the Administration routinely cites for its "frightening rate of increase" -- continues to decline, down from 9.6 percent in 1990 to 5.5 percent in November 1993: the lowest level in 20 years. The U.S. Chamber of Commerce reports that business payroll costs devoted to health and dental insurance are similarly down for the first time in years. And the consulting firm Foster Higgins reports that private health insurance premium growth was cut almost in half between 1988 and 1992.

Missed Opportunities. Given the evident weaknesses of the president's plan, it must be conceded in retrospect that those Republicans who initially counselled a gracious and "bipartisan" GOP response were shortsighted. As Congressman Newt Gingrich pointed out in a mid-December speech, Republicans failed, in the period immediately after the president's health care speech, to "go to the core of the debate": to make an unambiguous case against the president's politically inspired plan and to warn of the harm that would come from his attempt to bring our health care system under massive federal control. But Rep. Gingrich's remarks, among others, indicate that Republicans have begun to focus on the core issue: the president's plan would degrade the quality of American medical care. This argument needs to be the first bullet in any set of Republican talking points.

It must also be conceded that existing Republican "positive alternatives" to the Clinton plan have failed to have sufficient impact on the basic character of public debate. Whatever the merits of various Republican plans introduced thus far, the unhappy fact remains that none of them has achieved the momentum necessary to undermine support for the president's plan. And hard headed vote-counting suggests that, at least in this session of Congress, these Republican alternatives cannot pass.

The Next Three Months

So at the beginning of 1994, health care politics are at a virtual stalemate; public enthusiasm for the president's plan has precipitously declined, but Republicans have failed to capitalize on its obvious flaws and kill it outright. This situation is just a temporary lull, however, and it would be a mistake for Republicans to imagine that time is on our side. The president's plan is due for resuscitation -- unless Republicans mount a counter-offensive.

Committee hearings controlled by Democrats begin on Capitol Hill later this month. The president is likely soon thereafter to start his now ritual process of offering federal bounty in exchange for votes. To get bipartisan backing and lure wayward Republicans, he will make concessions. And knowing that lawmakers are anxious to pass health care reform before the fall elections, he will, if necessary, convene a "summit" where his plan would still be the basis of negotiation. Most important, two weeks from now the president will give a nationally televised State of the Union address that will be in large measure devoted to advertising his plan's glories -- and reminding his audience how perilous their own "health security" remains. Indeed, ever-more fear-mongering should be expected. A White House official was quoted last week saying: "We need to return to the crisis atmosphere."

This full slate of Administration activity will provide a formidable boost for the Clinton plan. That's why the next 100 days are a critical window of both risk and opportunity for Republicans. The risk is that the president will be poised to recapture the public policy high ground on health care, leaving his opponents merely to complain about his plan's flawed financing and cumbersome bureaucracy. The Republican opportunity, on the other hand, is to wrench the debate from the president now, by redefining both what is at stake and how genuine reform can and should proceed.

How Republicans Can Redefine the Debate

First, Republicans must consistently and aggressively debunk the Administration's "crisis" rhetoric, and just as insistently lay out the case against the Clinton plan as damaging to the quality of American medicine and to the relationship between patient and doctor. But Republicans must also act with dispatch to advance a meaningful reform alternative: not a "plan," but a set of proposals targeted at the specific and limited problems that are of greatest concern to Americans. Such proposals would constitute real health care reform. They would move the debate in the opposite direction of the president's proposal. And they would also be embraced by the public. In a survey conducted by Public Opinion Strategies in late October, 62 percent of respondents favored a set of critical but limited improvements to the health care system.

The chief virtue of small-scale, focused reforms is that many of them already enjoy stated support from large numbers of Republican and Democratic lawmakers. Indeed, an incremental approach to health care reform was advocated as recently as 1992 by now-Treasury Secretary Bentsen, whose Senate Finance Committee reported out one set of proposals. At the time, George Mitchell, recognizing that such a plan would rob the Democratic Party of a key election year issue, stopped it from coming to a floor vote. That suggests a second advantage of Republican-proposed incremental reforms in 1994: the Administration and its closest allies will likely block measures that would be welcomed by most Americans because such reforms will undermine the already thin rationale for the president's elaborate network of government regulation and price controls.

In sum: Republicans should immediately propose simple federal legislation that fixes the most serious problems in American health care -- and force the president to explain why he says no.

Targeted Reforms

Below we list a number of discrete, focused health care reform measures that could be offered in Congress over the next few months. This list is not intended to be definitive or exhaustive, nor should it be read as a set of detailed legislative proposals. Instead, advanced either piece-by-piece as amendments or as a single package, these provisions can help Republicans reframe the political debate while making meaningful repairs to our health care system.

Reforming Insurance Markets to Make Health Insurance Stable and Portable. Minor changes to existing COBRA legislation would allow currently insured workers, regardless of the number of employees at their company, to continue their health coverage even after they leave their jobs by paying premiums directly to the insurer. This reform would guarantee access to uninterrupted health coverage to all Americans who are now dependent on their employer for insurance. Additional small reforms could extend the same guarantee to individuals once covered as dependents -- a woman who separates from her spouse, for example.

Limiting Preexisting Condition Restrictions Under Employer Health Plans. If Congress adopts measures to assure everyone already in the health insurance system that their coverage cannot be denied in the future -- even if they change jobs or move -- the widespread fear of being dropped or turned down by an insurance plan because of a severe illness will evaporate. These provisions could also guarantee that individuals with a pre-existing condition who have health insurance, but have to change insurance carriers, would be charged no more for their new plan than the normal premium rate charged to all new customers. Since 1991, several legislative proposals to rectify the problem of pre-existing conditions have won bipartisan support.

Eliminating Barriers to Small Business Insurance Pools. According to a study by the Employee Benefit Research Institute, 20-30 percent of employees at firms that employ fewer than 100 people are without health insurance. If existing regulatory barriers involving geographical proximity and common business practice requirements were eliminated, more small business groups could purchase health insurance collectively through pools or tax-exempt trusts, increasing their bargaining power and dramatically reducing their costs. A further legislative change could allow non-business organizations -- churches, unions, farm bureaus -- to form similar insurance pools for their members.

Lowering Insurance Premiums for Individuals by Making Them Tax Deductible. Today, people who receive health coverage through their employers are not subject to taxation on those benefits. By contrast, the self-employed who purchase their own insurance are given only a 25 percent tax deduction. Correcting this tax anomaly by allowing all individuals who buy their own health plans to deduct their

PROJECT FOR THE

REPUBLICAN FUTURE

February 10, 1994

MEMORANDUM TO REPUBLICAN LEADERS

FROM: WILLIAM KRISTOL WK

SUBJECT: Defeating the Coming Clinton-Cooper Compromise

Attached is a third political strategy memorandum on the debate over health care reform. The good news is that the president's plan has been further wounded in recent weeks. The bad news is that the logic of the current situation points toward eventual Clinton-Cooper compromise legislation -- legislation that would be bad for health care and for the nation.

We argue in this memo that Republicans can help avert this outcome. We can do this, first, by intensifying our assault on the Clinton plan and its underlying premises, which are shared by the Cooper proposal. This assault will require a mobilization of public opinion across the country. All polls tell us that the more people learn about the president's plan, the more likely they are to reject it. It is therefore essential that Republicans, business groups, and conservative organizations engage in media, direct mail, and other "voter contact" efforts now in order to expose the perils of the president's plan. The course of public opinion over the next several weeks is crucial to shaping a desirable legislative outcome.

Second, the Republican leadership on Capitol Hill needs to complement these grassroots efforts to discredit both Clinton and Cooper by moving more aggressively to advance a set of proposals that address America's health care problems. This set of principled, targeted reforms should not be simply another "Republican alternative"; rather it should be put forward explicitly as the basis for future bipartisan compromise -- a "Moynihan-Dole" bill, say -- that serves as the fundamental alternative to Clinton-Cooper. Such a bill would build on past bipartisan efforts while forging a new path toward greater choice and control for individuals and the doctors who treat them. And it would have the added virtue of appealing to all who are increasingly doubtful about the president's bill, including those who, while retreating from Clinton, may have taken temporary refuge with Cooper.

As in the past, we would be grateful for your thoughts about this assessment of the health care debate and the recommendations that accompany it.

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full cost will substantially lower the price of health care insurance, and make it more accessible for those whose employers do not provide it.

Permitting the Establishment of Medical Savings Accounts. Current tax law permits employees to set aside income in a tax-exempt account to be used for medical expenses. A slight change to the tax code allowing such accounts to roll over, would effectively permit the establishment of medical savings accounts. Further small changes would permit the self-employed to have their own "medical IRAs." If such accounts were used in conjunction with catastrophic insurance plans, individuals would have more control over their health care spending and costs would come down. Dominion Resources, Inc., in Richmond,Virginia, has implemented a version of medical savings accounts for its employees; its total health costs have increased by less than 1 percent annually since 1989.

Reducing Costs Through Malpractice Reform. Medical malpractice insurance is among the fastest growing components of a physician's business costs. Proposals to alter this perverse aspect of tort law are a common component of several current and past health care reform plans. Given the broad consensus on this issue, further delay in reforming medical malpractice law seems unwarranted.

Simplifying Health Care Paperwork Through Administrative Reforms. The burden of health care administrative requirements is widely recognized as a fundamental but straightforward problem. It can be ameliorated by the creation of a standard claims form and data set that could take advantage of a health care industry that has long been computerized in other areas. A host of other steps to reduce health care fraud and improve information collection have already been proposed in Congress. The cost savings of all these measures would be substantial.

Reducing Medicaid and Medicare Expenses By Lifting the Regulatory Burden on States. Republican governors in California, Michigan, Wisconsin, Montana, Massachusetts, and elsewhere have already begun to reform health care by enacting some of the measures listed above at the state level. But as long as Medicare and Medicaid comprise the bulk of health care spending in any state, the heaviest burden of state-level cost-containment rests with the federal government. Federal regulations on state Medicaid and Medicare programs should be steeply rolled back to give governors the flexibility to supervise them as they see fit.

Providing Health Insurance Tax Credits or Vouchers to Low Income Families. For those working heads of households who are not poor enough to qualify for Medicaid but still find the cost of an insurance plan beyond their reach, a government voucher or tax credit system could help defray the cost of adequate coverage. This proposal is not without some expense. But much of it could be financed by redirecting federal payments already made to states for hospital costs incurred through the treatment of low-income individuals; existing proposals to cut federal health care programs are another obvious funding source. Whatever form or financing method is used, a tax credit or voucher system of this sort would increase access to health insurance for low-income Americans -- without a vast system of employer mandates, price controls, government rationing, and mandatory alliances.

To repeat: the president's plan would have a seriously detrimental effect on the quality of American medical care. And the president's plan is unnecessary; there is no health care crisis, and the reforms suggested above show how acknowledged problems can be directly addressed. That is the most effective Republican message in the opening months of 1994.

HEALTH CARE: DEFEATING THE COMING CLINTON-COOPER COMPROMISE

"[Y]ou should realize our bills are very similar. The White House bill and my bill have a lot in common, and we're very proud of that.... I want the White House to win." Rep. Jim Cooper (February 4, 1994)

"[I]n some ways I think that Jim Cooper is being extremely helpful to the process, extremely helpful to the process." Sen. Jay Rockefeller (February 4, 1994)

"[I]n broad outline the Clinton and Cooper proposals are more alike than either side at times finds it convenient to acknowledge." The Washington Post (February 7, 1994)

Jim Cooper, Jay Rockefeller, and the *Washington Post* know something that many people in Washington (including, we fear, many Republicans) do not: that while the Clinton Administration's health care legislation may be in trouble, its project of reform by sweeping government dictat is, unfortunately, still alive.

The new conventional Washington wisdom about health care has it that the Clinton plan is in trouble, its current momentum stalled and its future prospects threatened by the emergence of Representative Jim Cooper's "moderate alternative." This week's *Time* goes so far as to suggest that Clinton's plan might be "DOA." Evidence for this theory is deceptively obvious. The president has been on the defensive since before his State of the Union message, which included a veto threat he apparently deemed necessary to protect legislation he had introduced just two months earlier. That speech failed to move poll numbers as intended; public support for the plan remains below levels recorded early last fall. And there have been signs of White House fear and weakness ever since.

Concerned about potential political support for less radical reform than his, the President has offered surprising (if ultimately unsuccessful) concessions in a bid for support by the National Governors Association. His aides have responded somewhat hysterically to a series of critical television ads -- and to an article in *The New Republic* that convincingly detailed their plan's likely ill effect on American medical services. Tuesday's Congressional Budget Office pronouncement raises further serious questions about the plan's financing and budget effect. And last week saw a new rush of business objections to the Administration's health care proposal: tough Congressional testimony by the Chamber of Commerce, a declaration of opposition by the National Association of Manufacturers, and an outright endorsement of Cooper by the Business Roundtable.

THE CLINTON-COOPER PHONY WAR. It's true that the Clinton health care legislation, as written, is made weaker by the fresh strength of the Cooper bill. And the harsh reaction to this development by the White House and its allies seems at first glance to support the notion that large ideas are at issue in a Clinton/Cooper tug of war. But large ideas are not in fact at issue; Clinton and Cooper are instead, as the Congressman correctly claims, "first cousins in this debate and ... hoping for a family reunion this year." Both Democratic proposals involve a radical federal regulatory rearrangement of the financing and delivery of American medical services. In this respect they constitute not two political positions on health care, but only one. Clinton's health plan is by no means "dead on arrival."

The fact that Clinton and Cooper now thoroughly dominate the Washington health care debate, and thus threaten permanently to circumscribe its acceptable parameters, should alarm Republicans. Neither bill is compatible with conservative principle, and Republicans therefore have no business cheering for either side of the Clinton/Cooper controversy -- much less "participating constructively" in its resolution, despite the disingenuous advice we now receive from editorialists. Any conceivable

Clinton-Cooper compromise legislation would represent an unprecedented government encroachment on the authority of individual citizens to make basic decisions about their daily lives, in this case about their very health. Republicans ought not be reluctant to defend such individual rights and oppose a Clinton-Cooper compromise that threatens them.

The health care debate is at a watershed. The Cooper bill is currently ascendant not because "managed competition" has any broad-based, intrinsic appeal, but rather, we suspect, because its Congressional and business supporters see no other politically realistic vehicle with which to register their opposition to Clinton. Republicans must now make clear that Cooper is not a meaningful departure from the Clinton vision, and must make a principled case for the real alternative solution to America's health care problems: sensible, straightforward reforms that would make insurance more stable and affordable. Those reforms have enjoyed bipartisan support in the past; they can earn such support again this year.

Unless we are prepared to oppose Clinton-Cooper vigorously and propose our own reforms intelligently, the ultimate success of Clintonism, broadly understood, will be virtually certain. The White House can meet Jim Cooper well more than half way in the public and private compromise negotiations now underway, and the president will still be able to sign the terrible result into law.

UNDERSTANDING THE COOPER BILL. Managed competition, the core of the Cooper bill, shares with the president's proposal the vision of a government-directed remaking of American health care delivery and financing. Though it comes in free-market guise, the Cooper bill would undo the medical system we now take for granted -- just as radically and completely as would the Clinton plan.

True, Cooper avoids a mandate that employers pay for their employees' health care. That has been its central attraction for business groups. But a closer examination of the bill reveals other ways in which employers would be drawn into a web of state-administered health care machinery. Firms with fewer than 100 employees (about 93 percent of all businesses), for example, would be required to register with regional Health Plan Purchasing Cooperatives, forward information about all their full- and part-time employees, and deduct from paychecks the cost of health care premiums, whether or not the firms were providing health care coverage.

Each of these purchasing cooperatives would be required to make available "accountable health plans" that offer a standard set of benefits determined by a vote of Congress. Proponents of the Cooper bill point out, correctly, that under their plan consumers might still choose plans whose benefits exceed the government's established standards. But the Cooper bill is essentially designed to limit individual choice by pushing consumers into the lowest-priced health plan in their region. Through the introduction of a tax deduction cap, both individuals and employers would be permitted to deduct only the cost of the lowest priced plan in their region. Anything beyond that would be subject to the top corporate rate. Businesses that today offer their employees generous health plans would effectively be forced either to accept the government's more austere benefit limits or face stiff economic penalties.

This is a remarkably coercive use of the tax code. The federal government would first decide what type of health insurance should be in a employee's benefit package, and then, in effect, penalize all those who choose what the Cooper bill deems "excess" health coverage. Cost savings would presumably emerge from the competition among these minimum benefit plans to become the lowest bidder in any given region. The Cooper bill advances these measures in the name of cost containment. But they are tantamount to an arbitrary government restriction on how much money goes into the health system. To retain the tax deductible status of the health plan under which they work, doctors, nurses, and hospital administrators would be driven primarily by budget priorities. The ability of patients to obtain high quality service and a full range of treatment options would invariably be compromised.

In most regions, the only plans able to meet government-set standards for certification as "accountable health plans" would be health maintenance organizations (HMOs). Representative Cooper's candor on this point has been widely overlooked. "My guess," he has said, "is that fee-for-service medicine will be discouraged and mostly die out." Alain Enthoven, one of the authors of the managed competition model, has made the same prediction: "We doubt that [private-practice doctors] would generally be compatible with economic efficiency." Seeing a specialist when you like, seeking a second opinion, choosing your own family physician -- all these things would be as rare under Cooper as under Clinton.

Surviving health plans would be further hampered by the Cooper requirement that no plan charge enrollees different rates for any reason other than age. While ostensibly designed to guarantee access to health insurance, this Cooper version of "community rating" would effectively prevent a plan from offering different premiums based on health status or medical history. Under Cooper's system, in other words, the individual who quits smoking or takes preventive health measures would be treated the same, for insurance purposes, as a smoker or someone with a debilitating disease. And both would likely wind up in the same "lowest price" accountable health plan.

For the health consumer in America, life under the Cooper plan would look very much as it would under the president's: standardized medicine, impersonal systems of care, and hospitals and doctors judged by economic efficiency standards. "Cost containment" would become the mantra of American medicine, and all incentives in the system would be geared toward cutting corners and trimming service. Doctors operating in an accountable health plan would be required to report on procedures, treatments, outcomes, patient background, expenses and other "necessary" medical information; health plans would withhold payment to any doctor who does not provide such requested data. The number of specialists trained each year would be decided and alloted by a panel of government experts.

Above everything, the Cooper system shares the president's fixation with a complex architecture of national health care bureaucracy that regulates, monitors, and coordinates virtually every aspect of the doctor-patient relationship. Like the president, Cooper would establish Health Cooperative Boards in each region. He would also create a Health Plan Standards Board to establish standards for every health plan; an Agency for Clinical Evaluations to oversee federal medical research; and a Benefits, Evaluation, and Data Standards Board to manage a national health data system. The entire structure would be governed by a Health Care Standards Commission of five presidential appointees -- an independent agency that would function as a Supreme Court of Health. While steps may be taken to shield them, all these organizations would be subject to immense pressure from politicians, interests groups, and professional health industry lobbyists. Vital decisions about experimental drugs or even routine medical procedures would become political questions. The quality of treatment patients receive, the options available to them, and the advancement of medical practice would all become tertiary concerns.

THE REPUBLICAN RESPONSIBILITY. The Clinton health care plan and its Cooper "cousin" are together a gigantic leftward social policy gamble by the Democrats, one that should be impossible to win given everything the United States has learned over the past 25 years about the failures of big-government liberalism. The White House had no right to expect anything but fierce opposition to the proposal -- from American business, which has a legitimate and necessary interest in protecting itself from government, and from Republicans, who have a comparable but even more important interest in defending both private American relationships (like that between patient and doctor) and those non-governmental institutions that remain basically sound and successful (our health care system most definitely among them). But such an opposition has not emerged, not so far at least. And if it doesn't, soon, the Clinton gamble may well pay off -- despite the fact that it pursues a misguided answer to a misconceived problem, and does so from premises a justly skeptical America has long since rejected.

For its part, the Republican Party in Congress has limited options. It can remain fractured, with various Members attached to various proposals, and hope for the best. But the best won't happen; Clinton-Cooper will pass, and the Republican Party will have been passively complicit in its passage. The Party might instead decide to play the inside legislative game of Clinton-Cooper-Chafee, working the subcommittee hearings and the committee markups, and trying somehow to influence the final bill on the margins. Clinton-Cooper passes that way, too, and Republicans will be actively implicated.

There are those Republicans prepared to argue that such a result involves no compromise of conviction. DavidDurenberger, for example, Cooper's only Republican cosponsor in the Senate and a cosponsor also of the very similar Chafee bill, says that "Republicans already have a winning strategy and that strategy is managed competition," which he calls a "comprehensive vision" consistent with "Republican principles." Senator Durenberger is wrong. Managed competition is not a Republican principle. It is massive social regulation, precisely the kind of thing the Republican Party should exist to oppose, and for Republicans to acquiesce or participate in its enactment would bring us no credit, and much shame.

The only honorable and realistically successful path for Republicans, then, is that outlined by Senator Dole in his calm and intelligent State of the Union response, and restated last Wednesday in a speech by RNC chairman Haley Barbour: advancing specific solutions to the problems of health care coverage, affordability, and cost that most Americans agree exist while at the same time defending our medical system's unparalleled benefits -- and making clear that those benefits are under attack by the White House. Republicans should not be deterred from this position, as some appear to have been in recent days, by press criticism and isolated polling statistics. The criticism comes from advocates of the Clinton-Cooper position. And public opinion, which political parties are formed to help shape and change, is already overwhelmingly hostile to any health care reform that would, as Clinton-Cooper will, limit the availability of medical services. Senator Dole and Chairman Barbour are making a correct argument in principle. And a winnable one.

A STARK CHOICE. There is already widespread public nervousness over the Clinton-Cooper program. New York Representative Charles Schumer, for example, reflecting on his trip home during the last Hill recess, expressed this fear quite starkly to *The New York Times*: "How are we going to explain to a majority of my constituents, who have worked hard and invested in a [health] plan that they're not terribly unhappy with, that they should jump into the abyss of the unknown?" He was talking about the Administration's legislation, of course, but the same question can and should be asked of Cooper. And when it is, Cooper's supporters -- many of whom have joined his bill for purely tactical, anti-Clinton purposes -- will be eager for an alternative to the coming Clinton-Cooper compromise.

It is the Republican Party's duty to speak for Charles Schumer's Brooklyn constituents and the silent majority of Americans who want reform but whose medical care would be badly damaged by the radical experimentation of the Clinton-Cooper health care proposals. Republicans must reframe the health care debate and offer these Americans a clear choice: a crisis-driven Clinton-Cooper "jump into the abyss," on the one hand, or real solutions to existing problems that give individual citizens, not government, more control over their health care. What is needed is not yet another "Republican plan"; instead, the Republican Hill leadership should put forward a proposal that can be the basis of effective bipartisan legislation.

The political damage recently sustained by the Clinton health care plan suggests that a Clinton-Cooper compromise will be forced on the White House sooner rather than later. It would be useful to get the principled alternative -- a proposal that might eventually become the "Moynihan-Dole" bill, for example -- on the table just as fast. This is a sound strategy for Republicans, and for the country.

PLEASE DELIVER TO: John H. Chafee 03/02/94

PROJECT FOR THE
REPUBLICAN FUTURE

March 2, 1994

MEMORANDUM TO REPUBLICAN LEADERS

FROM: WILLIAM KRISTOL

SUBJECT: HEALTH CARE: THE PRINCIPLES OF CONSERVATIVE REFORM

Tomorrow in Annapolis, Senator Chafee will convene a retreat designed to bring clarity and unity to the Republican position on health care reform. We wish him well. But before his conferees get too absorbed in the details of compromise among provisions of competing larger "plans," we think they should keep in mind two overarching substantive and political truths.

First, notwithstanding the inevitable insider's fixation on the shifting fortunes of Clinton-Cooper-Chafee-Michel-Nickles-Gramm-and-so-on, there are now -- and always have been -- only two meaningful positions on health care. One holds that the American health care system is fundamentally crippled and defective, and must be replaced by something newly designed and administered in Washington. The other holds that problems in the health care system can be solved directly, without undoing American medicine's basic delivery structures, and without threatening the incalculable benefits those structures now provide. Radical overhaul on the one hand, or conservative reform (in the best and broadest sense of that phrase) on the other. The choice is that simple and that stark. And the proper and principled Republican option is obvious.

How the Tide is Turning. The second truth about health care is this: public opinion and the momentum of the current political situation increasingly favor conservative reform. Popular support for the Clinton health care scheme is evaporating; everyone knows that. Last week's CBS News poll showed a 46-39 percent plurality of respondents disapproving of the president's handling of health care; a similar plurality said the Clinton plan is "not fair" to "people like me." Indeed, most strikingly, the CBS poll now ranks health care as the president's worst issue. In short, health care, a centerpiece of the Administration's political strategy, is fast becoming an albatross for the president -- and an opportunity for Republicans.

It's important that Republicans understand why this is so. The answer is not that the Clinton plan's legislative details have alarmed certain business and interest groups, or that the plan's

budget numbers don't add up. The answer is that the American people are not persuaded -- and, indeed, are increasingly doubtful -- that any radical overhaul of the health care system is either safe or necessary. A *Time*/CNN/Yankelovich poll of two weeks ago asked whether the state of our health care system was a "crisis," or a "problem, but not a crisis." By a clear majority, 51 to 43 percent, their choice was "problem." (And 5 percent said there was "not a health care problem" at all!) Even universal coverage, the question that has made some Republicans particularly nervous, turns out to be something less than an unambigous popular favorite. True, 49 percent of Time respondents say government should guarantee it. But a full 41 percent already say only access should be guaranteed -- which insurance reform and a low-income voucher would go far to provide -- and this result comes before Americans have been offered any clear explanation of the federal regulation, monitoring, and administration that mandated universal coverage would require.

Radicalism in Retreat. Read carefully, the health care news out of Washington these days is a picture of radical overhaul in retreat. A long series of Democrats told the *Washington Post* last week that their constituents were nervous to the point of opposition about sweeping government redirection of health care. Freshman Rep. Tom Barlow of Kentucky told the Post that his voters "know we've got to do something, but they don't want to take a giant leap into a national program." Senator David Boren reported much the same thing from Oklahoma: "They're not saying it's not a problem. They're not saying: Don't do anything. But they're saying: Be cautious. Be real cautious." Rep. Jim Slattery of Kansas told *Congress Daily* this week that "there isn't overwhelming political support for Clinton" -- or for Cooper. And Dan Rostenkowski, acknowledging that he is viewed by some Democrats as "the skunk at the party" for his realism, told *USA Today* last week that he would advise the President to sign a package of meaningful conservative reforms this year -- and declare victory.

Clinton-Cooper Plan stalwarts hate such talk. But there is now more and more of it, and it means that there is an opportunity to advance a serious legislative alternative to a radical, government-planned overhaul of health care. Now is the time to lay out a set of bipartisan, consensus proposals to address the real problems of health insurance and financing. Republicans have nothing to gain from any further delay in developing the basis for a principled bipartisan compromise.

If it is hope for winning with a purely "Republican" health care bill that's holding things up, it is time that hope yielded to reality. As long as Democrats control Congress, no strictly Republican bill will pass, and Republicans should not begrudge the president his signing ceremony -- so long as the legislation he signs is not pernicious. If it is fear of public reaction against conservative reform that gives Hill Republicans pause, that fear is misguided and unnecessary; the public supports such reform and opposes the radical alternative, as many (if not most) Congressional Democrats have already concluded in private. And if some Republicans (in Annapolis or elsewhere) are inclined to pursue bipartisan compromise along radical rather than conservative lines, they should be strongly discouraged. Health care is not an issue on which Republicans should snatch defeat from the jaws of victory.

For the use of Senator Chafee's Annapolis conferees, we provide an outline below of bipartisan legislation to achieve principled conservative health care reform.

ESSENTIAL COMPONENTS OF SENSIBLE HEALTH REFORM

HEALTH INSURANCE SHOULD BE RENEWABLE AND PORTABLE

- Individual and group health plans should be made renewable without premium increases due to pre-existing conditions of those already covered by a policy.
- Individuals who already have health insurance should, if they change jobs or move, be permitted to enroll in similar plans without facing premium increases due to health status.
- Individuals who work at small companies should be allowed to continue their insurance coverage for a transitional period after they leave their job; existing COBRA legislation should be extended to cover businesses with fewer than 50 employees.

HEALTH INSURANCE SHOULD BE MORE AFFORDABLE AND ACCESSIBLE

- Individuals and the self-employed should be able to deduct the full cost of their health insurance from their personal income tax -- the same tax advantage enjoyed by those who now get health coverage from their employer.
- Employers should be able to offer medical savings accounts -- essentially tax-free medical IRAs -- in conjunction with a catastrophic health care plan.
- Small businesses should be allowed to pool together to buy group insurance for their employees without facing cumbersome federal and state regulations and mandates.
- Individuals should be able to obtain health insurance through nonbusiness organizations such as churches, unions, or fraternal organizations.

LOW-INCOME FAMILIES SHOULD RECEIVE ASSISTANCE TO PURCHASE HEALTH CARE INSURANCE

- Working heads of households who do not earn enough to afford a family insurance plan should receive a government voucher to help defray the costs. The voucher could be made available on a sliding scale up to a family of four earning, say, $23,000 a year -- approximately 160 percent of the poverty line. Similar results could be obtained by designing a tax-credit for this group of Americans. Funding for this proposal could be found in currently proposed Medicare cuts and by redirecting federal payments already made to states for hospitals treating low-income individuals.

THE HEALTH CARE SYSTEM SHOULD BE SIMPLER AND LESS LITIGIOUS

- Federal and state health care programs should standardize their forms and set a timetable for reducing the amount of paperwork they generate.
- The first steps of medical malpractice reform should be instituted: for example, effectively eliminating pain and suffering awards if an early offer is made to have the defendant assume the full economic cost of malpractice claims. The bipartisan Gephardt-Moore bill of the 1980s proposed a similar reform.

STATES SHOULD BE ABLE TO REFORM THEIR MEDICAID PROGRAMS

- The federal government should create a fast-track regulation waiver process for states that wish to administer their Medicaid programs in different ways. Priority should be given to states that intend to use voucher systems to give Medicaid patients greater access to private health care or create cost-saving managed care systems such as those in Massachusetts or Wisconsin.

Conservative Reform vs. Radical Reorganization

Republicans must be aware that the sensible and eminently achievable reforms described above are always at risk of being hijacked and transformed into intrusive government plans to control the nation's health care. That result must be avoided. The merit of these ideas is that they respond, in a measured way, to genuine concerns about the current system. But equally important, they attempt to make our health care system simpler, giving Americans more control over their insurance and greater flexibility over the treatment decisions they make about their own health care.

Of course, even President Clinton has tried to disguise his plan as a set of six simple principles, rarely acknowledging the vast and intricate regulatory regime it would establish. That's why we believe that any serious attempt at basic health care reform should meet two straightforward tests:

> First, no reform should undo our present system or force Americans to abandon the way they now purchase health insurance and receive medical services.
> Second, whatever changes are introduced, they should not establish any new government function or use government authority to limit the amount of medical care available to individuals.

If Republicans hew to these two principles while pursuing straightforward, targeted health care reform, they will quickly see how many of the most important current Congressional enthusiams lead in the wrong direction.

Employer mandates and price controls -- the pillars of the Clinton plan -- would establish an assortment of new governmental powers to control the most basic features of our health care system. Mandatory health alliances, central to both the Clinton and Cooper plans, would prevent small employers from making their own insurance arrangements and would install a centralized, monopolistic, and bureaucratic regime to allocate health care. A standard benefits package, common to Clinton, Cooper, and some Republican plans, would give political appointees (and the interest groups that lobby them) control over what kind of health care benefits Americans are entitled to receive. The individual mandate to purchase health care, found in both the Nickles and Chafee bills, is an expansion of federal authority over private decisionmaking. The community rating system proposed in several plans, which prevents insurers from discriminating among clients on the basis of their medical history, would destroy the essential character of insurance and prevent a company from offering price incentives to policy holders who take positive steps to maintain their health. Federal government control over the number of medical students trained in various specialties, central to the Clinton and Cooper visions, would involve an unacceptable level of government management in our health care system.

Such proposals have no place in sensible health care legislation.

A Word About Tax Caps and Tax Exclusions

There also exist other proposals that, while appealing in principle, raise questions of politics and prudence. Limiting tax-exempt health benefits is the most prominent example. Proposals to end the tax-exempt status of employer-provided health benefits or cap the amount employers can deduct from their taxes have been around for decades. Such measures would sensitize consumers to the true cost of their health care, creating more efficiency and generating cost-savings in the system.

But the practical consequences of such policies cannot be ignored. Both the Cooper and Chafee plans would ultimately force employers to seek the lowest cost health plan in a region in an effort to avoid the tax penalty or, in the case of Senator Chafee's plan, would impose a significant tax increase on large numbers of Americans who decided to stick with the insurance plans they now rely on. Whatever public policy rationale could be offered for such measures, it is beyond dispute that they would have a tumultuous effect on the health insurance arrangements Americans have made for themselves. We believe that advocates of changing the tax exclusion rules governing health care benefits might instead consider proposing a tax cap on only the most extravagant employer health plans -- perhaps those costing 150 percent of the national average health package. This step, though small, would nevertheless introduce a degree of price sensitivity to the system and, at one end of the spectrum, encourage some employers and their employees to make health insurance decisions based on real costs.

THE TRUE NATIONAL CONSENSUS

Despite all the editorials, speechmaking, and political posturing, the current debate is not about "universal coverage," "cost containment," "managed competition," or "the third-party payer system." Health care reform, to most Americans, means adding security, flexibility, and affordability to an insurance system that is now too often a source of anxiety. The best way to address that anxiety is through insurance portability, pre-existing conditions, tax equity, small business pooling, medical savings accounts, paperwork reduction, medical malpractice reform, and assistance for low-income families. The consensus on these issues is so broad that it defies reason that Congress has not yet agreed on a basic package of reforms.

The greatest current obstacle to passage of such a package is the Administration's insistence on establishing a national health care entitlement, replete with government regulations, controls, and penalties. Republicans should recognize the leadership opportunity that exists for those willing to challenge the premise of the White House's proposal with an alternative vision of principled reform. Such measured steps will be criticized by more liberal Democrats as inadequate, of course. So what? The vast majority of Americans (and, we suspect, most Congressional Democrats) would enthusiastically welcome such reform. All that remains now is for Republicans to embrace and make the case for it.

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United States Senate

DAVE DURENBERGER

January 19, 1994

Dear Colleague:

Last month you received a memorandum from William Kristol from the Project for the Republican Future on the subject of "defeating President Clinton's Health Care Proposal."

Kristol proposes an unqualified political defeat of the Clinton proposal -- a "monumental setback for the president."

After the fall, Republicans would offer a short list of "more modest" reforms of insurance, malpractice and paperwork. A more ambitious Republican agenda (tax credits, medical IRAs, etc.) would be saved for the future. He dubs this "principled incrementalism."

I don't doubt the sincerity of his effort. However, Kristol offers neither a winning political strategy nor a policy position that serves the best interests of the United States.

We do have a crisis in health care in this country. The Clinton Administration has wrongly characterized the problem as a crisis of access. It is NOT an access problem, it is a COST problem. If costs continue to escalate at current rates, health care expenditures will break the bank and our own best efforts at access.

It is essential that we accomplish reform of the health care delivery system in order to control costs. The ONLY way to do that is to change the incentives for the delivery of care. The market-based reforms embodied in the Managed Competition Act (S. 1579) and the Republican HEART proposal (S. 1770) will accomplish the necessary system reform.

Kristol perpetuates the unfortunate tendency to polarize the health reform debate around terms like comprehensive VERSUS incremental. It is a false dichotomy.

The Clinton proposal is fatally flawed, NOT because it is so-called comprehensive. It is flawed because it buries markets in a tangle of regulation and bureaucracy.

What Kristol offers is also flawed, but not because it is incremental. His modest recommendations are necessary and are embodied in the managed competition proposals. They are flawed because they offer no vision for the future. Managed competition doesn't do it all, but it gives us a sense of direction--a comprehensive vision that includes ALL the necessary first steps to get us there.

Kristol cautions Republicans not to compete with the President in a contest for radical reforms. By this, I assume he is warning us away from the middle ground embodied in S. 1770 and S. 1579. I would remind him that Senate Republicans are not neophytes on this issue:

- Many of the Senate authors have devoted much of their careers to health policy.

- John Chafee has led the Republican Task on Health through years of meetings to increase our knowledge of these complicated issues.

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LABOR AND HUMAN RESOURCES
SPECIAL COMMITTEE ON AGING

- I introduced a market-based reform bill in 1979. So did then Senator Dick Schweiker and then Congressman Dave Stockman.

- Republicans labored hard during the 1980s to reform Medicare, including Prospective Payment legislation, TEFRA risk contracts, and the Catastrophic bill.

- Republicans invented small group insurance reform. Republicans built bi-partisan leadership for Medicare Catastrophic.

- We led the defeat of President Clinton's Hospital Budget regulation.

We must keep in mind that ALL our efforts at health reform in the last decade have been bipartisan. Republican principles are not sacrificed by working collaboratively with Democrats. My cosponsors on S. 1579--Senators Breaux and Lieberman--share our commitment to market-based reforms. The efforts of John Chafee, Jim Cooper (D-TN) and Fred Grandy (R-IA) in the House to build a mainstream coalition that is bipartisan and bicameral exemplifies our commonalities.

I urge you NOT to fall into the trap of negativity and denial. That approach has failed Republicans politically in the past and will fail us again in the future. As a party, we do not need health care as an unresolved issue in 1996.

I am not suggesting that we must embrace the seriously flawed Clinton bill. I am strongly opposed to it in its present form. But, I believe that if we stand firm on the market-based principles of managed competition, and stand side-by-side with Democrats who share those principles, we can prevail.

President Clinton can't do reform with the liberal left. He can't do it with Democrats only. He can't do it without a significant group of Republicans. We can't do reform - incremental or comprehensive - without the President. Let's persuade him the MCA/HEART is the reform.

I believe that these reforms are in the best interests of the country. I also believe they are in the best interests of the Republican party because they are grounded in limited government and sound markets.

To Mr. Kristol, I simply say that Republicans already have a winning strategy and that strategy is managed competition. To my Republican colleagues who have signed onto the HEART bill, I say lets stick to our principles. There is too much to lose if we do not.

Sincerely,

David Durenberger
United States Senator

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DAVE DURENBERGER

February 28, 1994

Dear Republican colleague:

I look forward to our retreat this week to discuss the Republican role in health reform.

After 3 1/2 years of Thursday breakfast meetings, a substantial majority (19) of our Senate Republican task force has agreed on a direction for health reform which is also setting an example for others.

This letter expresses concern about those Republican political strategists who call our work "the kind of thing the Republican Party should exist to oppose."

By linking managed competition to the Clinton plan, William Kristol implies that the 26 Republicans supporting the Cooper-Grandy bill in the House and the 19 Republican Senate cosponsors of the Chafee bill bring "shame" to the Republican party.

We Republicans are not novices on these issues. Many of us have been working together on health reform since we defeated Carter's hospital cost containment bill in 1979. Senators Chafee, Dole, Packwood, Danforth, and Roth among others have a long track record of health legislation.

Conservatives like Kristol are correct on several points.

They are right in observing that we need catastrophic coverage and better risk pooling mechanisms. Like everyone else, they recognize that we need basic insurance reform so that policies can be more equitably priced and available to working people.

They are also right to say that in a number of local markets, experiments in voluntary pooling and greater efficiency in delivery systems have ameliorated price increases.

However, in the Senate Republican task force we concluded that we can't wait for episodic and fragmentary reform at the state level while ignoring more comprehensive reform at the national level.

Over 3 1/2 years, the task force has addressed the problems in the system and, most of all, the issues involved in change. For pragmatic, strategic, and policy reasons, we've chosen the principles embodied in HEART (Chafee-Dole).

To Mr. Kristol's chagrin, that puts us in league with Cooper (Breaux-Durenberger) and with the system reform elements buried in the Clintons' 1300 page bill.

Pragmatic Reasons for Reform Now:

State-by-state reform is occurring and Democrats in every state are rising to the regulatory bait in their health care markets. From Lawton Chiles in Florida, to a host of candidates from Oregon to Minnesota to Vermont, state governments are plowing forward with government controls over health care systems.

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Bob Dole's comments at the Finance Committee hearing last week illustrated the perverse effect of state-by-state regulation over local medical markets.

If we do nothing at the national level, we risk a patchwork of conflicting and highly regulatory health systems with significant adverse effects on multistate businesses, interstate health care networks, and local markets such as Utah and Minnesota that are impeded by profligate spenders in other states. ERISA preemption WILL NOT survive state pressures in the absence of federal reform.

Strategic Reasons for Reform Now:

President Clinton will compromise anything to get universal coverage. Why not take advantage of his singleminded goal?

Republicans know that our federal entitlement programs and our tax policy are the real sources of medical inflation. Pete Domenici's leadership on the Budget Committee has brought this issue to the forefront of the debate. We also know employer mandates won't achieve universal coverage.

We have a rare opportunity to change the federal reimbursement systems that are threatening to break the federal treasury and penalize every effort at efficiency in local markets. Republicans believe in making markets work--not replacing markets with government control. We must not bow to Clinton's call for universal coverage without ensuring coverage policy reform.

Policy Reasons for Reform Now:

From a policy perspective, we have an opportunity to reset the rules to make the medical markets work. That is where real long-lasting cost containment can be accomplished.

For 40 years, national policy paid for anything and everything and sheltered private citizens from the economic consequences of their medical spending. We have created a monster of consumption. We need to change the signals for both the public programs and the private market to pay for results not services.

When we do, it is imperative that the savings accrue to the consumers who are buying more wisely and to the efficient providers of care. Savings should not absorbed through taxes and transferred to less efficient markets. Good behavior must be rewarded not taxed.

The problem for conservatives is that they can't seem to see the dysfunction in medical markets. Its true that we have the best health care services and technology in the world. But we don't have the best health care system.

The problems extend beyond the small group market, although we agree these reforms will alleviate some of the inequities for small business buyers.

A closer look at Kristol's analysis in his most recent memo, "Defeating the Coming Clinton-Cooper Compromise" illustrates my point.

Purchasing Groups

By attacking alliances (also known as purchasing groups or cooperatives) as a "web of state administered health care machinery," he misses a central tenet of functioning markets. Buyers must have information on which to make informed choices and sufficient market power to exercise those choices. Group buying can also result in administrative efficiency.

EFFICIENCY, CHOICE, INFORMATION, and POWER conferred by member-controlled buying groups will make the medical market work better. That's the goal of purchasing cooperatives. Those goals will not be achieved by the Clinton alliances, but will be under the structures proposed in the Chafee and Cooper bills.

Accountable Health Plans

An accountable health plan fully integrates financial, managerial, and clinical aspects of health care. They must be accountable to their members for their cost and effectiveness as well as patient satisfaction.

Insurance reform changes the way that insurance plans are priced and sold. An accountable health plan changes the insurance "product."

Conservatives have used scare tactics to imply that our intention is to drive out fee-for-service medicine. That decision will be made by consumers in the marketplace--not by politicians.

Once people are able to select a health plan on the basis of price and quality, they MAY choose a fee-for-service plan or they may not. If fee-for-service cannot compete, it will be because people believe they get more value for their health care dollar in other systems of care. That is the essence of CHOICE not the elimination of it.

Tax Policy

Kristol also implies that choice will be limited by the imposition of a cap on the tax exclusion for health care expenditures. Such a limit, he argues, is a "remarkably coercive use of the tax code." After 16 years of service on the Finance Committee, I find that characterization laughable.

ALL tax policy is designed to create incentives for certain kinds of behavior BY taxpayers. As we all know, the mortgage interest deduction is designed to encourage and reward home ownership. This is one of thousands of such examples in the code.

Our present tax policy fuels consumption by insulating people from the economic consequences of their medical spending. It rewards overspending and penalizes constraint.

All the proposed tax caps do is limit the amount of spending consumers can do with tax free dollars. Nothing in this approach inhibits an individual from buying more health care than the tax cap shelters. You just can't do it with pretax dollars.

Kristol calls the tax cap an arbitrary restriction. Its no more arbitrary than the limits on the deductibility of business lunches. Businessmen can still eat (and presumably eat well). They just can't do it at our expense!

Information

Finally a word about the role of information in a functioning health care system. Markets don't always produce information, yet they cannot function without it. That is basic economics.

Information is the tool of accountability. We cannot hold doctors, hospitals, health plans, or government accountable without information. When we have better information on medical outcomes, we will get better health care and make better choices.

Government's role in reporting requirements and uniform data systems is not new nor does it presage government control. Air travelers can rely on safety and on-time data to use their personal dollars to choose an airline. This assists the private market rather than replaces it.

Kristol counts up the institutional arrangements in Cooper and Chafee, then bemoans them as too bureaucratic. If he looked more closely at our present HHS infrastructure, he would see that these bills streamline what we already have and facilitate the orderly analysis of information necessary for quality improvement. We can't support a 1990s health care system on a 1960s infrastructure.

Choice:

We all use the same vocabulary, but speak different languages. Nowhere is that more apparent than in the use of the word "choice." Thematically, the conservatives have hammered home the point that managed competition deprives consumers of choice. Choice implies that we know what we're doing, getting and paying for. That simply is NOT the case in our present system.

The purpose of system reform is to guarantee consumers that they can choose a health plan based on accurate information about its price and its quality -- that is real choice.

And, that is why it is not accurate to say that Americans have the best health care system in the world. Because it's only potentially the best.

Republican Reform

A recent New York Times poll found that people trust Democrats not Republicans to improve health care by a margin of 59 to 20. Clinton has squandered his political advantage because his plan is a complex tangle that the American people cannot understand.

As Republicans we can take advantage of the desire for reform among Americans to reshape the debate and to work with like-minded colleagues on both sides of the aisle.

But, Republicans can't do it by "assaulting" Clinton, Cooper, and, by implication, Chafee-Dole. Republicans cannot do it by blocking comprehensive reform, riding a limited insurance reform horse, and expecting the President and the people to embrace it. Without the support of the public and the support of the President, Republicans cannot win anything.

The goal of our retreat is unity. Accusing some of us of bringing shame and dishonor on the party because we propose solutions based on a long tradition of Republican health reform activity is counterproductive.

I prefer that we invest in the debate on reform, arm ourselves with a good understanding of the present system and a vision of where we want the system to go in the future.

Republicans must assure Americans that they understand the problem and are committed to genuine and meaningful reform.

So far, we're losing 59-20.

Chafee-Dole tries to get us back in the game.

I look forward to getting the job done in this session of Congress.

Sincerely,

Dave Durenberger
United States Senator

NO EXIT

By Elizabeth McCaughey

If you're not worried about the Clinton health bill, keep reading. If the bill passes, you will have to settle for one of the low-budget health plans selected by the government. The law will prevent you from going outside the system to buy basic health coverage you think is better, even after you pay the mandatory premium (see the bill, page 244). The bill guarantees you a package of medical services, but you can't have them unless they are deemed "necessary" and "appropriate" (pages 90-91). That decision will be made by the government, not by you and your doctor. Escaping the system and paying out-of-pocket to see a specialist for the tests and treatment you think you need will be almost impossible. If you walk into a doctor's office and ask for treatment for an illness, you must show proof that you are enrolled in one of the health plans offered by the government (pages 139, 143). The doctor can be paid only by the plan, not by you (page 236). To keep controls tight, the bill requires the doctor to report your visit to a national data bank containing the medical histories of all Americans (page 236).

If these facts surprise you, it's because you haven't been given a straight story about the Clinton health bill. Take two examples: on November 4, Leon Panetta, the director of the Office of Management and Budget, testified to senators that the bill does not "set prices" and "draw up rules for allocating care"; a month later Hillary Rodham Clinton assured a Boston audience that the government will not limit what you can pay your doctor. The text of the bill proves these statements are untrue.

The administration also says that the bill will not lower the quality of your medical care or take away personal choices you now make. This statement goes right to the issues that matter most. How true is it? To help you decide, here is a guide to the 1,364-page Health Security Act.

No effort is made here to compare the Clinton bill with the many alternatives offered by Republicans and other Democrats or to assess the nature and extent of the health care "crisis." The purpose is to answer one question: Under the Clinton bill, if you become ill, will you be able to get the treatment you need and make choices about your own health care?

The Law Will Make You Get Health Care Through Your "Alliance." Under the bill, unless you get Medicare, military benefits or veteran's benefits, or you or your spouse work for a company with more than 5,000 employees, you must enroll in one of the limited number of health plans offered by the "regional alliance" where you live (page 15). Regional alliances are government-run monopolies that select health plans, collect premiums from residents and their employers and pay most of the money to HMOs and insurers. If you fail to enroll, or the plan you choose is oversubscribed, alliance officials will assign you to one (pages 144, 146). The goal is to curb health care spending by limiting what *every* American is allowed to pay for health insurance. Restricting how much people can pay for insurance limits how much money is in the pot to take care of them when they're sick.

The Health Care You Can Get Will Be Limited. Under the bill, a National Health Board—seven people appointed by the president—will decide how much the nation can spend on health care beginning in 1996 (the baseline year). Based on that national budget, the board will set a budget for each region and a ceiling on what the average health plan in the region can cost. The bill outlaws plans that would cause a region to exceed its budget or that cost over 20 percent more than the average plan. After 1996, increases in health plan premiums will be strictly limited by an "inflation factor" based on the consumer price index (pages 256, 984-987, 990, 995).

Putting price controls on premiums to limit the amount of money in the health care system might wring out waste during the first year or two, but there is no doubt it will cause hardship later on. Seventy-seven million baby boomers will be reaching the age when they need more medical care. Increasing numbers of teen pregnancies and low-birth-weight babies also will require more health care dollars—$158,000 on average for each severely underweight newborn. Even the bill's authors anticipate that restricting the dollars available for health care in the teeth of these trends will produce grave shortages: the bill provides that when medical needs outpace the budget and premium money runs low, state governments

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and insurers must make "automatic, mandatory, nondiscretionary reductions in payments" to doctors, nurses and hospitals to "assure that expenditures will not exceed budget" (pages 113, 137).

Above a threshold level of quality, alliance officials will approve health plans based on lowest cost, not highest quality, to stay under the premium ceiling set by the National Health Board, explains Cara Walinsky of the Health Care Advisory Board and Governance Committee, which advises 800 hospitals worldwide. That is why Anthony L. Watson, chief executive of the Health Insurance Plan (HIP) of Greater New York, is optimistic. If the Clinton bill passes, "New York is mine," he told *The New York Times*. "I'm going to be the lowest-cost plan." HIP, with a physician staff that is 57 percent foreign-trained, already has what that newspaper calls "the image of being the least desirable health care option for city workers and others who cannot afford anything more."

Staying With the Doctors You Use Now Will Be Hard. Deciding for yourself when to see a specialist or get a second opinion and selecting the hospital you think is best will be even harder. The bill is designed to push people into HMOs, which restrict your choice of physicians and hospitals, and use gatekeepers to curb the use of specialists, expensive tests and costly high-tech treatments. What most of us call fee-for-service (choose-your-own-doctor) insurance will be difficult to buy. The ceiling on premiums and the 20 percent rule will eliminate most fee-for-service plans, which tend to be more expensive than their pre-paid counterparts. Although the Clinton administration insists that Americans always will be able to choose fee-for-service insurance, experts such as Dr. John Ludden, medical director of the Harvard Community Health Plan, say that option will "vanish quickly."

Even where it is possible to buy fee-for-service insurance, it will be hard to find doctors practicing on that basis. According to Walinsky, the Clinton proposal contains "very strong incentives" against fee-for-service "on the consumer side but also on the provider side." Price controls on doctors' fees and other regulations will push doctors to give up independent practice and sign on with HMOs. We've been told that the government won't be putting price controls on doctors, but the bill limits what health plans can pay physicians and prohibits patients from paying their doctors directly. Alliance officials post a schedule of fees, and it is illegal for doctors to take more (pages 134, 236).

In addition, alliance officials set yearly limits on payments to fee-for-service doctors in each field of medicine, like cardiology or pulmonology. What if a flu epidemic causes pulmonologists to see more patients with breathing problems than the region's budget allows? The bill compels insurance plans to slash doctors' fees or cut off their payments entirely until the next year "to assure that expenditures will not exceed the budget" (page 137).

HMOs Do the Job of Rationing. Under the Clinton bi federal government uses price controls on premiu curb dollars paid into the health care system. Lin how those dollars are spent is a job shared by all officials, who budget payments to doctors in the dling fee-for-service sector, and HMO administrators are expected to do the lion's share of health rationing. Is "rationing" too strong a word? Not ac ing to Ludden, whose HMO serves 570,000 people predicts that "price controls on premiums will driv straight to rationing at bedside." Princeton Profe Paul Starr, a key designer of the Clinton plan, prefe say that premium caps will induce "a different fram mind" in both doctors and health care administra "They will have to manage under constraint."

HMOs already have a track record of tightly c trolling a patient's access to physicians. Kaiser Permanente, the first person a patient sees is the "advice nurse," who ma the decision whether a doctor is needed. In HMOs, ratio of physicians to members averages 1 to 800, ab half the ratio of physicians to the general populati Specialists are particularly hard to see.

Current HMO cost-cutting methods already are dra ing criticism from Congress, government investigat and worried doctors. The Clinton bill's premium ca will compel HMOs to use even more stringent metho of limiting care, but the bill omits any safeguards protect patients from abusive practices.

For example, missing from the bill is any effort put a stop to "the withhold," the pervasive HMO pra tice of punishing doctors financially for providing ca they believe their patients need. Almost all large, fo profit HMOs, including those operated by Aetna Metlife, Oxford and Prudential (but not Cigna) with hold between 10 percent and 25 percent of a doctor compensation until year's end, and return it only i the doctor has met HMO targets for limiting patien tests, referrals to specialists and hospitalizations. Doctors report that targets are so stringent that HMOs almost always keep part of the withhold, which means that what a doctor orders for a patient comes out of the doctor's own pocket at the end of the year.

The withhold has caused a surge in dangerous "hallway consultations," according to Dr. Alan Jasper, a pulmonologist and critical care specialist at St. Vincent's Medical Center in Los Angeles. Other doctors stop Jasper in the hospital corridors, describe their patient's breathing problem and seek a diagnosis, in order to avoid referring the patient for a specialty consultation and incurring points against the withhold. The danger, says Jasper, is that the other doctor might fail to mention a critically important aspect of the patient's condition.

The withhold motivates primary care doctors to take a "we'll see how you feel next week" or "let's try this first" approach, even if it means additional worry and needless suffering for the patient. At a Humana-owned HMO in San Antonio, for example, a 40-year-old woman

with back pain was told by the orthopedist that she needed an MRI. But her primary care doctor rejected the specialist's request for the test, saying the patient would have to try something less expensive, and sent her for acupuncture, followed by months of hot packs and physiotherapy. When nothing worked, the gatekeeper authorized the MRI, which revealed that the woman needed a lumbar dischetomy (disc removal), as the orthopedist had suspected. The story was related by the woman's surgeon, Dr. William V. Healey, a clinical professor at the University of Texas, who said the lesson was that HMO cost-cutting incentives, such as the withhold, fail to account for the graver cost—the months a patient is home from work, worried and in pain.

Another HMO cost-cutting strategy that makes doctors and patients worry is the utilization review—a sick patient must wait while the doctor telephones a utilization review company, describes the symptoms and medical history to a nurse or clerk seated at a computer terminal and hopes for an O.K. to proceed with tests and treatment.

Three hundred and fifty utilization review companies that claim to slash health care costs sell their services to HMOs, hospitals and others at a rate of $1 to $3 per patient reviewed. It's a $7 billion industry. Such "cookbook medicine" ignores the non-average, abnormally sick patient who may need more intense treatment than the computer program recommends. It also discounts the value of examining a patient, and ignores the physician's judgment and expertise. Dr. Jerome Groopman, head of oncology and hematology at the New England Deaconess Hospital in Boston, says, "It's an 800 number. They don't know me from Adam!"

"Horror stories abound" about utilization review, according to a 1993 report for the National Association of Attorneys General. Doctors' treatment plans are "rejected by inadequately trained personnel," according to the report, and utilization review companies refuse to give reasons for their decisions, even to doctors, because it is presumed doctors would figure out ways to get around the review guidelines once they were known.

Even when doctors' recommendations are ultimately approved, it can take weeks longer to diagnose and begin treating an HMO patient than a patient with fee-for-service insurance, Jasper explains, because of the successive delays in getting each test approved. One HMO patient with coughing trouble was given antibiotics by his primary care doctor, who thought the problem was pneumonia. The patient lost thirty-five pounds while waiting from October 27 to December 24 for an O.K. to see Dr. Jasper, then to have a CAT scan and lung biopsy, and finally to learn that the correct diagnosis was a lung fungal disease. Jasper said he could have had a fee-for-service patient on anti-fungal medicine within fourteen days, instead of nine weeks.

DRAWING BY VINT LAWRENCE FOR THE NEW REPUBLIC

The Attorneys General report urges state lawmakers to look into curbing utilization review in HMOs. In contrast, the Clinton bill calls utilization review a "reasonable restriction" on patient care and expressly includes it as a requirement for doctors treating patients with fee-for-service insurance as well (page 134).

The Government Won't Protect You From HMO Abuses. If most Americans are moved into HMOs, who will ensure that they get good health care? The Clinton bill establishes two national boards to develop quality standards and depends on alliance officials in each state to enforce them (pages 843-844). But history shows that federal and state officials have failed to protect patients from HMO abuses, even in small pilot programs.

In 1990 Florida newspapers printed lurid accounts of abuses by Humana Medical Plan, an HMO paid to care for the elderly under a small, experimental program to reduce Medicare costs. Congress ordered an investigation of Humana's performance, and Janet Shikles, in charge of the probe for the General

Accounting Office testified about the company's "failure to order appropriate diagnostic tests and failure to follow up on abnormal test results." *Consumer Reports* (August 1992) also investigated the shortcomings of the pilot Medicare-HMO program in Florida, and concluded that government oversight was "lackadaisical."

A nationwide investigation for Congress drew the same conclusion. Pointing out that only twenty-one of fifty-seven HMOs investigated received a passing grade, the late Senator John Heinz warned that the priority "has been to promote enrollment in HMOs and we have not given equal priority to monitoring what happens" to people "after they have enrolled."

Far from protecting patients in HMOs, the Clinton bill ties the hands of state lawmakers who want to pass protective legislation. Some states recently have enacted laws to safeguard choices patients want to make for themselves, such as which hospital or pharmacy to use. HMOs protest that these laws hobble cost containment, and the Clinton administration apparently agrees. The Clinton bill pre-empts state laws protecting patient choice (page 238).

You'll Get More Primary Care Than High-Tech Medicine, and That's Not Good News. Will patients get the care they need when gatekeepers limit their access to specialists and high-tech medicine, as the Clinton bill intends? The evidence strongly suggests that low-tech care will not be good enough. People with heart disease, for example, will suffer. HMOs already ration high-tech care to heart attack patients, according to a study in *The New England Journal of Medicine* (December 1993). HMO patients hospitalized with coronary disease (myocardial infarction, unstable angina, angina pectoris or ischemic heart disease) are 30 percent less likely to be given bypass surgery or a coronary angioplasty (declogging of the arteries) than similarly sick patients with fee-for-service insurance. Another recent study by Duke University points to the consequences of such low-tech care. In the study, American heart attack patients who tended to be treated with three costly, high-tech procedures—catheterization (inserting a thin tube into the heart for diagnosis), angioplasty and bypass surgery—recovered far better than Canadian heart attack patients, who had less access to the procedures. American patients, who were twice as likely to undergo the procedures, tended to have a better quality of life after a heart attack. Canadians suffered more recurring pain, felt more depressed and were less able to go back to work and pick up their old activities. Dr. Robert Califf says the Duke study may help people understand "the implications of reducing services in a health care system."

Is it true that we need less care by specialists? Not according to the National Institutes of Health, which recently issued a warning that patients with many common conditions should be treated routinely by a renal (kidney) specialist. According to the NIH panel, mary care doctors frequently are overlooking the e signs of kidney failure and are hanging on to patie too long. Patients should be referred to specia for dialysis sooner, said the NIH, before it is too late save their lives. Twenty-five percent of kidney patie who don't receive dialysis until it is an emergency Dr. C. Craig Tisher, chairman of the NIH pa warned that patients with high blood pressure, betes, weight problems and metabolism abnormali should be regularly cared for by a renal specialist, only a primary care doctor.

In the short run, the Clinton bill depends on HM to limit access to specialists and high-tech care. A longer-term strategy to limit such care, the Clinton b seizes control of medical education and requires th by 1998, no more than 45 percent of young docto be permitted to go on to advanced training in a sp cialty. Specialty programs at leading medical scho will be downsized. Doctors in training will be assign to the coveted specialty programs based partially race and ethnicity, depending on how "underrepr sented" each racial or ethnic group is "in the field medicine in general and in the various medical sp cialities" (pages 509, 514-515).

Restricting medical education by government fi undoubtedly will reduce the consumption of expe sive, cutting-edge care. Doctors who are not trained i sophisticated technology cannot use it. But preventin doctors from learning about the most advanced med cal procedures is a lethal way to curb health care co sumption. Keeping doctors uninformed could n possibly be an improvement.

Unwritten Rationing Rules. Under the Clinto bill, you are entitled to a package of basic ben efits, but you can have them only when the are "medically necessary" and "appropriate." That decision will be made by the National Quality Management Council, not by you and your doctor. The council (fifteen presidential appointees) will establish "practice guidelines" to control "utilization" of health services (pages 91, 836, 848). These guidelines will compel doctors to uniformly practice low-budget medicine. "There needs to be some point of reference for [health] plans to determine what is appropriate care," Starr said. "There is an enormous amount of excessive, inappropriate care." In Starr's view, the bill provides "high quality care." People who want access to more are asking for a "neurotic" level of care. What is most troubling about the practice guidelines is that they are not spelled out in the bill. Congress and the public are asked to approve the concept without knowing the content.

How rigorous will the standard of "medically necessary" and "appropriate" be? In other words, how much rationing based on cost-effectiveness will we have to endure? When a kidney transplant is needed, will the patient's age matter, as it does in Great Britain, where older patients are routinely denied high-tech treat-

ments? Will patients with advanced AIDS be entitled to intensive care? Oregon's standard of appropriate care for needy residents excludes high-tech, life-sustaining procedures for advanced AIDS cases, as well as for extremely premature babies and advanced cases of certain cancers. Groopman, who treats cancer and AIDS patients, worries that decisions now made by the patient, doctor and family will be made by a council of "omniscient bureaucrats" who "are looking at two things: dollars and ideology."

Many organizations, including the American Medical Association, specialty medical societies and insurers already devise what they call "practice guidelines" to help physicians keep abreast of the most effective treatments. Ludden explained that "doctors appreciate guidelines" when they are recommendations, "but not when they become matters of law."

Many physicians who treat the HIV-positive population are troubled that the Clinton plan's practice guidelines will prevent them from trying new strategies to help desperate patients. Jasper recalls that he learned quickly "through the grapevine" that other doctors were achieving some success with treating pneumocystis pneumonia, an AIDS-related illness, with adjunctive corticosteroids. Mandatory practice guidelines would have stifled such innovation and prevented Jasper from keeping his patient alive. Similarly, Ludden recalls that at Harvard "we were using aerosol pentamidine" to treat an AIDS-related condition "eighteen months before any practice guideline would have regarded it as appropriate." The Clinton bill would hold changes in medical treatments to a slow-moving government timetable, putting many patients' lives at risk while the National Quality Management Council deliberates.

If You're Over 65, Good Luck. Another cost-cutting measure in the Clinton bill deprives people over 65 of access to new cures. The secretary of health and human services has the power to set a controlled price for every new drug, and to require the drug manufacturer to pay a rebate to the federal government on each unit sold to Medicare patients at market price instead of the controlled price. If a producer balks at paying the rebate, the secretary can "blacklist" the drug, striking it from the list of medications eligible for Medicare reimbursement (pages 365-379). The proposed regulation threatens to keep a new drug such as Tacrine (a treatment for Alzheimer's) from older patients.

Under the bill, the secretary weighs the development costs and profit margin for the single drug, rather than the overall profitability of investing in new cures (page 373). Biotech investors point out that for every drug that reaches market, more than 1,000 others dead-end, with a 100 percent loss for investors. Limiting the price and profitability of the one drug in a thousand that succeeds will halt research into new cures, including drugs for ovarian and breast cancers now in the pipeline.

Before Signing On, You Should Know... The Clinton bill will prevent people from buying the medical care they need. Price controls on premiums will push most Americans into HMOs and pressure HMOs into sharply cutting access to specialists and effective, high-tech cures. Price controls on doctors' fees and regulations tying doctors' hands will curb the care physicians can give patients. Price controls on new drugs will keep people over 65 from getting the medications that can help them. Most important, government controls on medical education will limit what future doctors know, costing lives and suffering no one can calculate.

The administration often cites two statistics—America's relatively high infant mortality rate and its lower life expectancy—to support the need for the Clinton health bill. But these have almost nothing to do with the quality of American medical care. Both statistics reflect the epidemic of low-birth-weight babies born to teenage and drug-addicted mothers, as well as the large number of homicides in American cities and drug-related deaths.

In fact, if you are seriously ill, the best place to be is in the United States. Among all industrialized nations, the United States has the highest cure rates for stomach, cervical and uterine cancers, the second highest cure rate for breast cancer and is second to none in treating heart disease. In other countries that spend less, people who are sick get less care, are less likely to survive and have a poorer quality of life after major illness. Consider what happens in Canada, whose health care system often is held up as a model for the United States. In Canada medical technology is rationed to dangerously low levels. The United States has 3.26 open-heart surgery units per million people; Canada has only 1.23 units per million. Cardiovascular disease is Canada's number one health problem, yet open-heart surgery units and catheterization equipment are kept in such short supply that the average wait for urgent (not elective) surgery is eight weeks. The shocking result is that in Canada, a cardiac patient is ten times as likely to die waiting in line for surgery as on the operating table. In the United States, there is no wait.

The choice is not between the Clinton bill and the status quo. Members of Congress should read this bill, instead of relying on what they hear, and then turn their attention to alternatives sponsored by Democrats and Republicans. These alternatives provide urgently needed reform of the health insurance industry, outlawing its worst abuses, without taking important decisions away from patients and their doctors and without depriving Americans of effective, high-tech medical care when they are seriously ill. Congress also should consider ways to provide insurance for those who cannot afford it, and level with the public about what universal coverage will cost. Whatever the price, ultimately, it will be less expensive than the consequences of the Clinton bill. •

Clinton's plan on the ropes.

SHE'S BAAACK!

By Elizabeth McCaughey

On January 31 the White House press office released a statement questioning the accuracy of my recent article in TNR ("No Exit," February 7, 1993). I welcome this opportunity to engage in a dialogue with the White House about the content of its health bill. As I did in my original article, I will be documenting my description of the bill—and my point-by-point rebuttal of their arguments—with page numbers from the November 20, 1993, version. If White House representatives challenge the accuracy of my description again, I hope they will provide page numbers, too, so that TNR readers can compare the evidence and decide for themselves.

Most of the White House challenge focused on this paragraph from my article:

> If the bill passes, you will have to settle for one of the low-budget health plans selected by the government. The law will prevent you from going outside the system to buy basic health coverage you think is better, even after you pay the mandatory premium (see the bill, page 244). The bill guarantees you a package of medical services, but you can't have them unless they are deemed "necessary" and "appropriate" (pages 90-91). That decision will be made by the government, not by you and your doctor. Escaping the system and paying out-of-pocket to see a specialist for the tests and treatment you think you need will be almost impossible. If you walk into a doctor's office and ask for treatment for an illness, you must show proof that you are enrolled in one of the health plans offered by the government (pages 139, 143). The doctor can be paid only by the plan, not by you (page 236). To keep controls tight, the bill requires the doctor to report your visit to a national data bank containing the medical histories of all Americans (page 236).

The White House responded:

"There is nothing in this Act to prohibit any individual from going to any doctor and paying, with their own funds, for any service." "Under the Act, you can pay 'out-of-pocket[sic]' for anything you want at any time, to any physician or hospital willing to treat you." Price controls on doctors' fees? "That is wrong," according to the White House. "There are no price controls. . . ."

How accurate are these statements from the White House? The text of the bill proves they are untrue.

Can you pay any doctor any price for any service you want? Although it is possible to buy cosmetic surgery, psychotherapy or other uncovered services out-of-pocket, the bill prohibits doctors from accepting payments directly from you for the basic kinds of medical care listed in the Clinton benefit package. Below are the reg-

ulations barring doctors from taking your money. If you go to a doctor for treatment, the doctor will be paid by your health plan. That is true no matter what kind of health plan you are enrolled in. The doctor is prohibited from accepting payment from you (except fixed co-payments) for any basic medical services listed in the Clinton benefit package. That applies to doctors treating patients in HMOs and doctors outside HMO networks. Doctors outside HMOs must submit charges for your care to your health plan, accept reimbursement based on the government's schedule of price-controlled fees and report your visit according to the requirement of title V of the bill, which establishes the national electronic data bank:

> Sec. 1406(*d*)(2) DIRECT BILLING—A provider may not charge or collect from an enrollee amounts that are payable by the health plan ... and shall submit charges to such plan in accordance with any applicable requirements of part 1 of subtitle B of title V (relating to health information systems).

Are you allowed to pay a surgeon more, in hopes of getting the most expert, experienced care? No:

> Sec. 1406(*d*)(1) PROHIBITION ON BALANCE BILLING—A provider may not charge or collect from an enrollee a fee in excess of the applicable payment amount under the applicable fee schedule [page 236]....
>
> (3) AGREEMENTS WITH PLANS—The agreements ... between a health plan and the health care providers providing the comprehensive benefit package to individuals enrolled with the plan shall prohibit a provider from engaging in balance billing described in paragraph (1) [page 237].

The White House attacks the use of the phrase "price controls on doctors' fees" in my article. "Wrong," says the White House. "There are no price controls in the president's plan. Price controls—calling for government micromanagement of every health care service, doctor's fee, drug technology and product—were considered and specifically rejected."

But the text of the bill proves there are price controls on health plan premiums, new drugs and doctors' fees. Here are the price controls on doctors' fees:

> Sec. 1322(*c*) ESTABLISHMENT OF FEE-FOR-SERVICE SCHEDULE
>
> (1) IN GENERAL—each regional alliance shall establish a fee schedule setting forth the payment rates applicable to services furnished during a year to individuals enrolled in fee-for-service plans (or services furnished under the fee-for-service component of any regional alliance health plan) [page 134]....
>
> (4) ANNUAL REVISION—A regional alliance ... shall annually update the payment rates provided under the fee schedule [page 135].

The White House says "it is not clear why a patient would want to pay a doctor 'directly' for services that their [sic] insurance company is obligated to buy." One reason is privacy. Evading government regulations and paying the doctor directly would allow you to keep your personal medical problems out of the national data bank.

Will your personal medical history be stored in a national data bank? The White House says "not true" and "patently untrue" to my statement that "the bill requires the doctor to report your visit to a national data bank containing the medical histories of all Americans. The administration argues that although "physicians may be required to submit data ... for the purpose of improving quality and assessing treatments and outcomes," the bill "prevents against tying this data to specific individuals."

The text of the bill proves that the administration is mistaken. Information about your physical and mental health and any treatments or tests you have will be entered in a national data network and linked to you through your health security number. Here is what the bill says: the National Health Board will establish an "electronic data network" with regional centers to collect, compile and transmit information. The information expressly includes "clinical encounters," that is, when a physician treats a patient (page 861). A doctor who treats you (except for an uncovered service such as dental work or cosmetic surgery) and does not record your "clinical encounter" on the standardized form and submit it to your health plan will be fined up to "$10,000 for each such violation" (pages 236, 885-886). As the data about you travel from your doctor's office to the health plan, and then to the national electronic data network, this information continues to be tagged with your "unique identifier number."

The bill leaves no doubt that the network contains "individually identifiable health information," which is defined in the bill to include your "past, present or future physical or mental health" and health care provided to you (page 877). To protect your privacy, the bill offers this vagueness:

> All disclosures of individually identifiable health information shall be restricted to the minimum amount necessary to accomplish the purpose for which the information is being disclosed [page 873].

and this:

> [You] have the right to receive a written statement concerning ... the purposes for which individually identifiable information provided to a health care provider, a health plan, a regional alliance, a corporate alliance or the National Health Board may be used or disclosed by, or disclosed to, any individual or entity [page 874].

It would be unfair to suggest that the bill's authors are unconcerned about privacy. The bill mandates that the National Health Board will "promulgate standards respecting the privacy of individually identifiable health information that is in the health information system" within two years and propose privacy legislation within three years (pages 871, 876). But contrary to the White House statement, doctors must report their patients' personal medical information to a national data bank or risk harsh penalties, and the information in the bank remains individually identifiable.

Price controls on premiums will mean too little money to care for the sick. Limiting how much money people can choose to pay for basic health coverage limits how much money is in the pot to take care of them when they are sick. That was the point of the ad on television that the First Lady criticized. A couple are discussing what price controls on premiums will mean, and the woman asks, "But what if there's not enough money?"

The bill's authors anticipate that restricting dollars available for health care will produce shortages: when medical needs outpace the budget and premium money runs low, state governments and insurers must make "automatic, mandatory, nondiscretionary reductions in payments" to doctors, nurses and hospitals to "assure that expenditures will not exceed budget" (pages 113, 137).

In a charge echoed by Michael Weinstein of *The New York Times*, the White House accused me of misleading readers by "implying that such a mechanism exists in the main proposal." The White House stated emphatically that "it does not." The White House and Weinstein argue that only under a single-payer system would payments to doctors and others be cut off if needs outpace the budget and premium money runs low. They expressly charge me with quoting the single-payer regulations and misrepresenting them to be rules for the "main" Clinton health proposal.

The text of the bill proves that the White House and Weinstein are wrong. Cutting or delaying payments to doctors, other health care workers and hospitals to stay in budget is an integral mechanism in the administration's bill, and one of the two passages I quoted (page 137) is from the "main proposal." It provides that if needs exceed budget and premium money runs low:

> Sec. 1322(*c*)(2) PROSPECTIVE BUDGETING DESCRIBED ... the plan shall reduce the amount of payments otherwise made to providers (through a withhold or delay in payments or adjustments) in such a manner and by such amounts as necessary to assure that expenditures will not exceed budget.

The government will decide what is "necessary" and "appropriate" care. The White House attacks as "wrong" and "very misleading" my statement that "the bill guarantees you a package of medical services, but you can't have them unless they are deemed 'necessary' and 'appropriate.'" The administration also says it is "untrue" that that decision will be made by the government, not by you and your doctor.

Let's look at the actual bill:

> Sec. 1141. EXCLUSIONS
> (*a*) MEDICAL NECESSITY—The comprehensive benefit package does not include
> (1) an item or service that is not medically necessary or appropriate; or,
> (2) an item or service that the National Health Board may determine is not medically necessary or appropriate in a regulation promulgated under section 1154 [pages 90-91].
> Sec. 1154. ESTABLISHMENT OF STANDARDS REGARDING MEDICAL NECESSITY
> The National Health Board may promulgate such regulations as may be necessary to carry out section 1141(*a*)(2) (relating to the exclusion of certain services that are not medically necessary or appropriate).

The bill uses the word "regulations," not "recommendations," to describe the National Health Board's decisions. The bill also grants the National Health Board power to change the preventive treatments guaranteed in the benefit package and decide at what age and how often you are entitled to tests and screenings, immunizations and check-ups (page 94). Regarding practice guidelines, the bill makes it clear that the National Quality Management Council will develop measures of "appropriateness of health care services" (page 839) and "shall establish standards and procedures for evaluating the clinical appropriateness of protocols used to manage health service utilization" (page 848).

Racial quotas in medical training. The White House calls such a suggestion "ridiculous," but the bill shows it is true. Government will allocate graduate training positions at the nation's teaching hospitals based on race and ethnicity. In determining how many training positions teaching hospitals will have, the National Council on Graduate Medical Training will calculate the percentage of trainees at each teaching hospital "who are members of racial or ethnic minority groups" and which minority trainees are from groups "under-represented in the field of medicine generally and in the various medical specialties" (page 515).

Protecting consumers or HMOs? The White House calls it "deliberately inaccurate" to say that the bill pre-empts important state laws protecting the ability of patients to choose the hospital they think is best and make other choices about their health care. Here is what the bill provides:

> Sec. 1407. PRE-EMPTION OF CERTAIN STATE LAWS RELATING TO HEALTH PLANS
> (*a*) ... no state law shall apply ... if such law has the effect of prohibiting or otherwise restricting plans from—
> (1) ... limiting the number and type of health care providers who participate in the plan;
> (2) requiring enrollees to obtain health services (other than emergency services) from participating providers or from providers authorized by the plan;
> (3) requiring enrollees to obtain a referral for treatment by a specialized physician or health institution....
> (6) requiring the use of single-source suppliers for pharmacy, medical equipment and other health products and services.

Fee-for-service will be almost impossible to buy. The White House labels it wrong to predict that fee-for-service insurance will be extremely hard to buy. They point to the provision that "in general, each regional alliance shall include among its health plan offerings at least one fee-for-service plan." But many doctors, hospital administrators and health insurance experts say confidently that in practice, because of the broader provisions of the bill, fee-for-service will seldom be available. I cited these experts in my article. Here are their reasons:

(1) Regional alliances cannot permit the average premium paid in the region to exceed the ceiling imposed by the National Health Board (pages 1,000-1,005). Fee-for-service insurance, which allows patients to get a second opinion when they have doubts and see a specialist when they feel they need one, generally costs more than prepaid health plans that control patient access to medical care.

(2) Regional alliance officials are empowered to exclude any plan that costs 20 percent more than the average plan (page 132). They will have to apply the 20 percent rule virtually all the time, in order to keep total spending on health plans below the ceiling imposed by the National Health Board. In order to offer

a plan that costs more than 20 percent above the average plan and still stay under the ceiling, there would have to be other plans offered at well below the average-priced plan. That is unlikely. The bill limits the annual increase in premium prices to the Consumer Price Index, which is significantly below current annual increases in medical spending. Insurers will have a difficult time staying under the premium ceiling, and certainly will not offer plans well below it.

(3) Regional alliance officials are empowered to set the fees for doctors treating patients on a fee-for-service basis, and it is illegal for doctors to take more. In addition, prospective budgeting limits what fee-for-service doctors can earn yearly, even if they see more patients and work longer hours to make up for reduced fees. As Cara Walinsky of the Health Care Advisory Board and Governance Committee, which advises 800 hospitals, explains, the Clinton bill contains "very strong incentives" against doctors practicing on a fee-for-service basis. For all these reasons, Dr. John Ludden, medical director of the Harvard Community Health Plan, predicts that fee-for-service will "vanish quickly."

Does supplemental insurance provide an "exit"? The bill requires you to buy one of the low-budget health plans offered by your regional alliance. You can't go outside the system to buy basic coverage you prefer, even after you pay the mandatory premium. Is supplemental insurance the way out? The White House states "there are no restrictions on the purchase of supplemental insurance." The fact is the bill contains two important restrictions that will effectively close the door to better basic medical care: supplemental insurance cannot duplicate any of the coverage in the comprehensive benefit package, and it must be offered to "every individual who seeks" to buy it, regardless of health history or disability (page 244). Those two restrictions mean that the seriously ill will line up to buy it; insurers will not line up to sell it.

Finally, it is important to note one of the points the White House did not challenge: the Clinton bill is designed to push people into HMOs, which aim to limit patient access to specialized medicine and high-tech care. The premium price controls will pressure HMOs to use even more stringent methods of restricting care, yet the bill omits any safeguards to protect patients from abusive cost-cutting practices such as the withhold.

These facts, straight from the text of the bill, demonstrate the accuracy of my article "No Exit," and the appropriateness of its title. The White House would have you believe that its bill can stop rising health care spending and extend coverage to millions of uninsured Americans, without changing the quality and choice of the medical care you have now. Common sense suggests otherwise. A close reading of the bill proves it is untrue. Several alternatives by other Democrats and Republicans offer promising health insurance reform without limiting what you can buy and how much you can pay for it. It's time to give those bills a close look.

ELIZABETH MCCAUGHEY is John M. Olin Fellow at the Manhattan Institute.

TOMMY G. THOMPSON

Governor
State of Wisconsin

March 1, 1994

The Honorable John H. Chafee
United States Senate
567 Dirksen Senate Office Building
Washington, D.C. 20510

Dear John:

Thank you for inviting me to attend the Senate Republicans' retreat on the issue of health care reform. Unfortunately, my schedule makes it impossible for me to attend. I would like to take this opportunity however, to point out a number of my major concerns with the President's proposal.

*The employer mandates included in the bill will cost jobs.

*Mandatory alliances will restrict choice and impose an unnecessary layer of centralized bureaucracy.

*Global budgets with unrealistic targets will lead to rationing and to a complex bureaucracy to administer them.

*The maintenance of effort provisions in the bill penalize states that efficiently manage their health care costs. States like Wisconsin, whose costs are increasing at less than the national average, despite the broadest possible coverage, would have to pay an additional amount to subsidize those states who have been less efficient and less generous.

While your bill provides states with significant flexibility in some areas, I remain very concerned with the provision that caps federal Medicaid payments without a corresponding cap at the state level. This provision is a cost shift to states.

Room 115 East, State Capitol, P.O. Box 7863, Madison, Wisconsin 53707 • (608) 266-1212 • FAX (608) 267-8983

In Wisconsin, we have significant experience in using managed care for Medicaid participants and have proven that quality of care can be better in managed care than in a traditional fee-for-service setting. Wisconsin has successfully integrated Medicaid recipients into managed care delivery systems serving the general population.
The slow phase-in enrollment for the Medicaid population into the qualified health plans and the exemptions from managed care for special needs populations included in your bill are, therefore, not only unnecessary but could hinder state progress in this area.

The Cooper bill has also been receiving a great deal of attention lately. As you know, the bill would eliminate the acute care Medicaid program and replace it with a fedearally funded program. States would then have to assume responsibility for full funding of Medicaid long term care. This is unacceptable to Governors.

As you know, at the National Governors' Association Winter Meeting, Governors, in a bipartisan manner, adopted a health care reform policy, A Call to Action, which outlines those provisions which Governors would like to see enacted this year. I have attached a copy of our policy. Please feel free to consider it a framework for your discussion.

Again, I am sorry that I will not be able to join you, and I wish you great success in your efforts. I look forward to our continued work together.

Best regards,

Tommy

TOMMY G. THOMPSON
Governor

Enclosure

cc: Governor Campbell
Senator Dole
Congressman Gingrich

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Policy

EC-7. HEALTH CARE REFORM: A CALL TO ACTION

7.1 Preamble

The nation's Governors are committed to comprehensive health reform that calls for a federal framework with significant state flexibility, and they will work with Congress and the administration to develop such a system. At the same time, however, the growing demand for affordable quality health care, coupled with the immediate budgetary pressures caused by the Medicaid program, requires immediate action. Virtually every Governor has some health reform initiative in progress. These include comprehensive state-based reform initiatives, programs that assist small businesses in securing affordable health insurance, programs that expand health care coverage to a greater number of uninsured poor, and programs that implement managed care networks for Medicaid beneficiaries. None of these state initiatives are incompatible with national reform; instead, they continue to build a strong policy foundation for reform at the federal level.

7.2 Federal Barriers to State Health Reform

As states have moved ahead, their success has been limited by barriers resulting from current federal statutes. The nation's Governors call upon the administration and Congress to immediately remove those federal barriers.

7.2.1 Medicaid. By far, Medicaid represents the largest health care expenditure for states. On average, only spending for elementary and secondary education constitutes a larger portion of state budgets. Governors believe that irrespective of any national health reform strategy, Medicaid costs must be brought under control. Should Congress move to limit or cap the federal contribution to Medicaid, a move the Governors adamantly oppose, the Governors believe these changes and other relief will become even more urgent. The Governors recommend the following changes that will contribute to controlling those costs.

7.2.1.1 Managed Care Waivers. There is a national trend in health care service delivery toward systems of care. These systems or networks have been shown to provide cost-efficient care while ensuring that the patient has a reliable place from which to seek primary care and to which specialty care can be directed. Although the private sector is moving aggressively toward these networks, the Medicaid program continues to require states, in virtually all cases, to apply for a waiver from fee-for-service care in order to enroll Medicaid beneficiaries in such networks. And while the Bush and Clinton administrations have taken significant steps toward simplifying the application and renewal process, states still must apply for renewals every two years. Moreover, states have been unable to sustain networks where there is a predominance of Medicaid beneficiaries because, under current law, states are permitted only one nonrenewable three-year waiver to have beneficiaries served in a health maintenance organization (HMO) where more than 75 percent of the enrollees in the HMO are Medicaid beneficiaries. This requirement should be repealed.

If the nation is serious about controlling health care costs, it is essential to give states the opportunity to establish networks in Medicaid (including fully and partially capitated systems) through the regular plan amendment process. Governors recognize the special significance of consumer protections and assurance of solvency in establishing these systems of care and support federal guidance through the regulatory process.

7.2.1.2 **Comprehensive Waivers.** States have begun to look seriously at comprehensive systems of health care where the artificial categorical barriers of Medicaid are removed and where they can establish statewide networks of care for Medicaid beneficiaries. Unfortunately, there are no provisions in the Social Security Act that can be used to establish such programs on an ongoing basis.

Currently, states have been developing these more comprehensive networks through the research and demonstration provisions of the Social Security Act (Section 1115a). Section 1115a, however, was designed for research purposes and has some important limitations. States must demonstrate, through the application process, that they are testing an innovation. The law requires an evaluation that, in some cases, requires control groups. Projects approved under the 1115a process are approved for a limited time period, usually three to five years at the discretion of the administration, and require special statutory changes to go beyond the demonstration period. Finally, these projects must be cost neutral over the life of the project.

Section 1115a is essential to ensure the testing of alternative health and social policies. However, the current statute falls short by requiring statutory changes if a state wants to continue its successful effort. In short, once a state has proven that its research project works, it cannot continue without congressional action. Governors support changes to the Social Security Act so that a state may apply through the executive branch of government for renewable waivers of their innovations. This waiver process should be consistent with the streamlined approaches used by the Clinton administration and states should have to reapply for these waivers no less than every five years.

7.2.1.3 **Boren Amendment.** The Boren Amendment to the Medicaid provisions of the Social Security Act was passed in the early 1980s to give states greater flexibility in establishing reimbursement rates for hospitals and nursing homes and to encourage health care cost containment. Instead, it has led to havoc in the administration of Medicaid programs. Court decisions have interpreted the Boren Amendment to embody a restrictive and unrealistic set of requirements in setting reimbursement rates, and have in effect given judges the power to establish reimbursement rates levels and criteria. Because of these decisions, states remain frustrated in their ability to bring some discipline to their budgets and have been thwarted in their attempts to achieve the original purpose of the amendment.

The nation's Governors believe that any coherent approach to national health reform must address the issue of the Boren Amendment. They believe that a statutory change to this amendment is an important tool necessary to bring Medicaid institutional costs under control. Therefore, the Governors urge the administration and Congress to adopt these or other changes to the Boren Amendment that will give states the relief they need.

Statutory and Regulatory Changes. The Governors agree that standards for establishing adequate reimbursement rates for hospitals, nursing facilities, and intermediate care facilities for persons with mental retardation (ICF/MRs) must be designed to promote access to care for Medicaid patients, quality of services, cost containment, and efficient service delivery. The Governors support a strategy that would replace the current cost-efficiency-based standard in the Boren Amendment with provisions that establish "safe harbor" standards where a state meeting any of these "safe harbor" provisions would satisfy the statute. Standards might include the following.

- The payment rate is equal to the Medicare-based upper payment limit.
- The payment rate is no less than the rate agreed to by the facility for comparable services paid for by another payer (e.g. payment rates for Medicaid patients would not have to be higher than rates paid by any large managed care plans or large business).
- Regarding nursing facilities, the aggregate number of participating licensed and certified nursing home beds in the state (plus resources devoted to home or community-based care for the elderly) is at least equal to a specified percentage of the population age 65 or over.

- The reimbursement rate is sufficient to cover at least 80 percent of the allowable costs of all facilities in the class in the state in the aggregate, or is sufficient to cover the allowable costs of 50 percent of all facilities in the class in the state.
- The reimbursement rate is equal to a benchmark rate plus inflation no less than the rate of inflation for the overall economy according to a general index (national or state), such as the consumer price index (CPI) or the gross domestic product (GDP-IPD). The benchmark rate would be the approved rate as of the date of enactment of the statute or the current rate approved by the Health Care Financing Administration. This standard is satisfied by a rate methodology currently in effect and approved by HCFA that contains a provision for inflation adjustments.

The Governors also believe that the procedural requirements in the current Boren Amendment must be streamlined. Finally, the Governors support strategies that would reduce or eliminate the costs of prolonged and costly litigation.

7.2.2 **Employee Retirement Income Security Act.** Although the Governors are extremely sensitive to the concerns of large multistate employers, the fact remains that one of the greatest barriers to state reform initiatives is the Employee Retirement Income Security Act (ERISA). ERISA preempts all self-insured health plans from state regulations and subjects those plans only to federal authority. As a result of judicial interpretations of ERISA, states are prohibited from:

- establishing minimum guaranteed benefits packages for all employers;
- developing standard data collection systems applicable to all state health plans;
- developing uniform administrative processes, including standardized claim forms;
- establishing all payer rate-setting systems;
- establishing a statewide employer mandate;
- imposing premium taxes on self-insured plans; and
- imposing provider taxes where the tax is interpreted as a form of discrimination on self-insured plans.

7.2.2.1 **ERISA Flexibility.** Governors call on the administration and Congress to modify the ERISA statute to give states the flexibility they need to move ahead on health reform. This may be done either by establishing the flexibility directly in statute or through the establishment of waiver authority. The flexibility could include a requirement that the state demonstrate broad-based support for the change, such as by passage of state legislation. States must be assured, however, that the flexibility is stable and not time limited.

7.3 A Call to Action

The nation's Governors call upon President Clinton and Congress to pass health care legislation this year that includes, at a minimum, the following.

7.3.1 **Insurance Reform.** We support minimum federal standards that result in portability of coverage; guaranteed renewability of policies; limitations on both medical underwriting and preexisting conditions exclusions; and modified community rating that limits the variation in rates that different individuals and groups are charged.

7.3.2 **State-Organized Purchasing Cooperatives.** Through purchasing cooperatives, affordable insurance products will be made available. States and the federal government must work together to ensure that states have flexibility in establishing and operating these cooperatives.

7.3.3 **Core Benefits and Access.** In order to ensure portability of coverage, Governors believe that there must be a core benefits package that is comparable to those that are now provided by the most efficient and cost-effective health maintenance organizations. The cornerstone of this package must be primary and preventive care. All employers must make the core benefits package available to those employees who wish to purchase it. While Governors do not agree on whether employers should be required to pay for any portion of the premium, Governors agree that coverage should be available.

7.3.4 **Tax Deductibility of Health Care Premiums.** Health insurance premiums should be tax deductible to the value of the core benefits package regardless of who pays the premium. Governors do not support

limiting health benefits; however, policies that afford benefits above the limit should be subject to taxation. The Governors do support tax changes that would correct the inequities now suffered by self-employed individuals. These individuals would be eligible to purchase fully deductible health insurance within the federal limit.

7.3.5 **Low-Income Subsidies.** Low-income families and individuals will require subsidies in order for them to afford health care. Governors support a streamlined eligibility process for these subsidies, and believe that the subsidies must be sufficient to make this goal a reality. Governors also look forward to a system of subsidies that provides low-income families and individuals with a core benefits package that Governors believe will be a more effective method for providing care than the current Medicaid program. This program could be financed partially through revenues resulting from limits on tax deductibility.

7.3.6 **Changes to the Current Medicaid System.** Governors strongly believe that some critical changes to the Medicaid program must be made now to improve the cost efficiency of the program. Specifically:

- States should have the ability to move their Medicaid populations into managed care settings through a plan amendment rather than through a waiver.
- During the phase-in of the new low-income subsidy program, states must have the flexibility to establish new programs that expand eligibility to a larger indigent population. This flexibility would require additional waiver authority under Medicaid.
- In addition, states have been unable to control the costs of reimbursement rates to institutional health care providers as a result of judicial interpretation of the Boren Amendment. States must be given legislative and regulatory relief from these interpretations in order to get better control of these costs.

7.3.7 **Medical Malpractice and Liability Reform.** Another important step in developing a rational health care system is the modification of current medical malpractice and liability statutes. We believe that minimum standards should be set by the federal government. Alternative dispute resolution is among the strategies that should be explored to reduce the amount of litigation in this area.

7.3.8 **Relief from Antitrust Statutes.** More and more Americans are receiving their care through health delivery networks. Establishing these networks requires new approaches to cooperation among providers and businesses that heretofore have been competitors. The current antitrust statutes must be revised to accommodate this new health care environment.

7.3.9 **Relief from the Employee Retirement Income Security Act.** ERISA must be modified to give states the flexibility they need to move ahead on state reform. At a minimum, Congress should enact ERISA waiver authority for states that meet certain criteria for health care reform.

7.3.10 **Federally Organized Outcome and Quality Standards.** If meaningful choices are ever to be made in health care, research must be supported to develop outcomes and quality standards for use by providers and consumers alike. Also, information systems must be developed that include price and quality information for all providers and consumers of health care services in a given geographic area.

7.3.11 **Administrative Simplifications.** The administrative complexity of the current system must be reduced. At a minimum, we must adopt a single national claims form and electronic billing.

We believe that these provisions should be included in any reform strategy. As Governors, we do not vary in our support of these changes, and we urge Congress and the President to act as quickly as possible.

Time limited (effective February 1994-February 1996).
Adopted January 1994.