March 15, 1994

TO: SENATOR DOLE

FROM: SHEILA BURKE

SUBJECT: REMARKS TO AMERICAN COLLEGE OF PHYSICIANS

You are scheduled to give brief remarks to this group tomorrow morning at 9:30 a.m. We have informed them that you will only be there for about 20 minutes.

There will be about 50 physicians present representing about 25 states -- no Kansans are scheduled to be in attendance. This is the second legislative meeting they have done -- the first having occurred last year.

The American College of Physicians has approximately 81,000 members nationwide. All of their members are internists and about one-half have subspecialty training in such areas as cardiology. They are primary care oriented and are outspoken proponents of universal coverage.

While they have not endorsed the Clinton plan, they do want to see "comprehensive reform" and like employer mandates as a way to achieve this goal and are prepared to support mandatory alliances for small employers.

I think these folks need to hear some straight talk about the need to find some middle ground that appeals to both sides. They also need to be reminded of the risks associated with having the government assume too great a role in ensuring coverage. It may result in price controls, rationing and a reduction in quality.

The other two speakers scheduled to follow you are Lynn Ethridge (a health care policy analyst who was with us in Annapolis) and Senator Rockefeller.

ABOUT THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians is the largest medical specialty society in the United States, with 77,000 members practicing internal medicine.

Doctors specializing in internal medicine provide non-surgical medical care to adults and adolescents. General internists diagnose and treat illness involving any of the body's internal organ systems. Subspecialists in internal medicine have additional expertise in one particular area, such as allergy and immunology, cardiology, endocrinology, gastroenterology, hematology, infectious diseases, medical oncology, pulmonary disease, or rheumatology. Internists, including subspecialists, provide much of the nation's primary care, managing their patients' overall health care and making referrals to other health professionals when necessary.

Founded in 1915, the College's mission is to foster excellence in the practice of medicine through continuing education and the development and advocacy of public policies affecting public health and medical practice. The College publishes *Annals of Internal Medicine*, the most widely cited medical specialty journal in the world.

The American College of Physicians, the nation's largest medical specialty society, calls for comprehensive reform of America's health care system to assure everyone access to high quality care while also controlling costs. Only fundamental reform can change the damaging course the present system is traveling.

"Universal Insurance for American Health Care" envisions substantial change — universal access, uniform benefits, consolidation of public programs, limits on spending, fee negotiations, a national health care commission representing all sectors of society, and insurance reform.

At the same time, the College plan incorporates values important to American society — excellence and innovation, competition and choice, and a limited role for government. The ACP plan also draws on the virtues inherent in both the "play-or-pay" and single-payer approaches to reform.

ACCESS

"Universal Insurance for American Health Care" provides everyone living in the United States with all medically effective and appropriate care, even through job changes and unemployment. Both the government and employers sponsor insurance plans, and both meet the same national guidelines.

Employer-sponsored coverage

Employers may sponsor coverage for their employees or pay a tax to enroll their workers in a publicly sponsored plan. To make employer-sponsored insurance affordable, the public system covers older workers and people of any age needing high cost care.

Publicly sponsored coverage

Publicly sponsored insurance covers everyone not enrolled in employer-sponsored plans, including:

- the unemployed or those not in the job market;
- retirees;
- employees over age 50; and
- those in need of more than $50,000 of medical care annually.

The public system consolidates all current public programs, including Medicaid and Medicare, and it offers the same benefits as private plans. All employers and individuals benefit from the public plan, forming a constituency sufficiently broad to ensure the system's viability.

FINANCING

Private sector

An insurance-based system offers the best means of fostering an array of practice arrangements to suit the preferences of patients and providers. However, the ACP plan requires these reforms:

- Insurers accept all applicants regardless of pre-existing conditions.
- Premiums are based on the health status of the entire community, not an individual group. This action spreads the risk and the cost of insurance, making it more affordable to small employers.

Insurers compete by offering lower premiums or better value, not by avoiding risk or reducing reimbursement to providers. Premiums can be lowered through efficient administration. Value can be increased by organizing a group of providers believed to offer higher quality care or more choice of providers.

Employers and employees share the cost of private sector insurance. Employers pay at least 50 percent of the premium.

Public sector

Funding for publicly sponsored insurance comes from:

- payroll taxes from companies not sponsoring insurance and their employees;
- income-related premiums from retirees, collected through the tax system;
- funds now paying for Medicare, Medicaid, and other government health programs; and
- increased alcohol and cigarette taxes.

COST CONTAINMENT

The American College of Physicians commits to working under a national health care budget, which will discourage unnecessary use of expensive procedures and technology. A national health care commission, with extensive input on population demographics and health care needs, recommends national and state-level budget allocations to Congress. Costs are contained through effective management of price, supply, and demand.

Price

Individual practitioners, managed care organizations, hospitals, and other providers negotiate fees with all payers in a state. The fees are based on a systematic method of valuing services, such as those methods used by Medicare. All fees within a sub-state region are uniform. When multiplied by expected utilization, fees cannot exceed the state's budget allocation for that year. If they do, adjustments are made, such as a reduction in the following year's fee increase, but necessary care continues.

Supply

Under federal guidelines, communities set targets for health resources including the supply and distribution of physicians and other professionals, hospital beds, and capital investments. The targets are linked to the payment system.

The mix of physicians is changed from 65 percent specialist/35 percent generalist to a more even balance. This change reduces the bias toward use of costly procedures and specialized care by increasing preventive and early intervention services. The shift is accomplished through improved reimbursement for generalists and through financial and other incentives in graduate medical education, including:

- weighting payments for graduate medical education to favor the training of generalists;
- reduced-interest or interest-free loans to residents training to be generalists; and
- other regulatory approaches affecting the number of residency slots for specialists.

Demand

Efforts to reduce unnecessary demand include:

- patient education on disease prevention and the reasonable expectations of medicine;
- co-payments, except for low-income patients; and
- payment reform to reduce incentives to perform unnecessary procedures.

QUALITY CARE

All health plans — both publicly sponsored and employer-sponsored — provide the same set of medically effective and necessary health services rather than a pre-determined insurance package. Benefits are determined by the national health care commission based on medical effectiveness research and judgment of medical value. This approach provides a mechanism to address the allocation of resources explicitly rather than tacitly.

Quality is also improved by:

- practice profiling to identify physicians performing below acceptable standards of care (replacing intrusive case-by-case review and freeing physicians for the direct care of patients);
- a more responsive malpractice award system;
- increasing health services research; and
- improving the supply and geographic distribution of primary care physicians.

THE FUTURE

"Universal Insurance for American Health Care" is the product of five years of research and collaboration and follows a 1990 College paper supporting universal access. The College will continue its work with the next phase focusing on cost projections and financing arrangements. The College will also continue to work with other medical organizations, with Congress and the Administration, and with all who have a stake in the future of reform to forge a consensus on this crucial issue.

American College of Physicians

KEY PRINCIPLES FOR A NATIONAL HEALTH WORKFORCE POLICY

- A national health workforce policy should be part of health care reform legislation.
- A national health workforce policy and a national health workforce commission are needed to better coordinate the supply and distribution of the health care workforce to better meet the nation's health care needs.
- The nation currently has too many specialists and not enough generalist physicians. National health workforce policy should seek to achieve a more even balance among specialists and generalists. A balance of 50/50 should be set as an initial national goal.
- Improving the environment of medical practice for physicians who provide primary care will be the most important means of increasing the attractiveness of careers as generalists. However, in the short-term, a combination of legislative, regulatory and voluntary actions are required.
- A national workforce commission should be empowered to set targets for the aggregate number of physicians and the number of physicians by specialty. To achieve these targets, the commission should have authority to allocate residency training positions among accredited training programs.
- The overall number of physician residency training positions should be limited in relation to national needs and the number of students who are graduating from medical schools. Service needs of institutions should not dictate the numbers of physicians that are trained. Transitional funding and/or waiver provisions should be available for areas, particularly inner cities of large metropolitan areas, that are now heavily dependent on resident physicians for meeting their patient service needs and would be adversely impacted by cutbacks in residency training positions.
- All payers of health care should share in the costs of graduate medical education. The federal government should continue to provide financial support to institutions for the direct costs of graduate medical education and training and for the additional costs associated with teaching programs. Federal loan and financial assistance programs should also be maintained to help assure that opportunities for medical careers are available to financially disadvantaged students and students from underrepresented minority groups.

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HEALTH ALLIANCES

If downsized and structured wisely, alliances can offer these benefits to a reformed health care system:

- Increase choice for consumers;
- Foster the development of community-based health plans, serving the best interests of consumers, physicians and quality health care;
- Effectively implement and monitor insurance reforms;
- Effectively monitor risk selection by insurers; and
- Spread risk fairly.

The American College of Physicians seeks a compromise on alliances which will retain their effectiveness while allowing the twin goals of guaranteed coverage and financing to move forward. These are the ACP's recommendations:

- Alliances should be mandatory for some segment of the population in every area where numbers are sufficient.

- Individuals, not employers, must choose health plans.

- The threshold for mandatory participation by employers could range from 100 to 500 workers. To start with the smallest possible viable alliance, participation should be required by firms with 100 or fewer employees. Firms with up to 500 workers could enter at a risk-adjusted rate, on a phased-in basis as risk-adjustment technology is refined.

- Alliances should be non-competing, non-governmental, not-for profit entities largely representing purchasers and patients, with allowance for representation by salaried, staff-level physicians who have no ownership in any health plan and by similar physicians representing underserved areas. Alliance boards should be elected by purchasers and employers, not appointed by governors or political bodies.

- Notwithstanding the merits or problems of alliance premium negotiation and premium caps, alliances should accept all state-certified health plans.

- The scope of alliance duties should be as limited as possible. Administration of premium and co-payment subsidies should not be an alliance function.

- Alliance staff should be limited by a ratio corresponding to alliance membership. Alliance staff duties should be limited to policy-making, negotiation and minimal administration. Operational functions should be contracted out.

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ACP PRINCIPLES ON QUALITY ASSURANCE

The ACP urges the Congress to adopt provisions in health reform legislation that will eliminate the existing system of case-by-case utilization review, and instead establish a system that stresses quality improvement, using practice profiling data to measure success. Our specific policy recommendations are:

- All health plans should have a quality improvement program and participate in the national effort to develop measures of quality.

- There should be no individual case review performed on a routine basis. The task of external oversight should be the profiling of care -- either outcomes, processes, or both -- at the local, state and national levels. The entity which carries out this function should not have any disciplinary or regulatory authority. This will allow practitioners to work in conjunction with individuals who are doing the profiling. To the extent possible, physicians should help develop the profiles.

- Because utilization of services, quality, and cost are interrelated, the same entity should profile all these aspects of care.

- The profiling function could be located within a new entity or at an existing institution and overseen by a representative council made up of practitioner and patient interests.

- When the profiling indicates a possible lapse in quality, the entity should work with the relevant health plan to investigate the cause of the data variation, and improve the quality performance of the plan if indicated.

- When a profile of an individual, an institution, or a community suggests a potential serious problem with quality, that information should be forwarded to appropriate credentialing or licensing authorities.

- In so far as is practical, profiling should be based on reviews of outcomes, as well as criteria which derive from well-developed practice guidelines. To the greatest extent possible, practicing physicians should help develop these guidelines.

- The licensing of health professionals, hospitals, and health plans should remain the responsibility of state government. The credentialing function should be the responsibility of hospitals and health plans.

- Increased research and development is needed on practice guidelines, profiling, and health plan report cards. We must ensure that information provided on report cards is clinically relevant and appropriate. The impact of report cards on consumer choice of health plan also requires careful study.

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ACP PRINCIPLES ON PHYSICIANS' RELATIONSHIPS WITH HEALTH PLANS

Physician-Owned Health Plans

The ACP supports changes in law to enable physicians to own and govern health plans. Consequently, the ACP recommends:

- **Physician-governed Health Plans Should Not Be Subject to the Same Capital and Solvency Requirements as Traditional Health Plans.** Other methods should be used to ensure that providers are paid and that patients receive the care they need.
- **Inter-agency Legal Counsel.** Health reform legislation should create a new federal inter-agency office of legal counsel that will provide advisory opinions to potential health plans on anti-trust, fraud and abuse, self-referral, taxation, and other issues.
- **Technical Assistance.** Grants or loans for physicians trying to establish a health plan.

Physician Empowerment Within Health Plans

Health reform legislation should also contain provisions that empower physicians regardless of who governs the health plan. ACP's recommendations are:

- **Physicians in Charge of Health Plan's Clinical Components.** To best ensure quality, physicians should supervise the clinical component and utilization review process of health plans.
- **Elimination of Case-by-Case Utilization Review.** We should develop a system of quality assurance that stresses ongoing quality improvement, using profiling data to measure quality.
- **Standards for Utilization Review.** The criteria used by utilization reviewers are often kept secret from physicians, vary by payer, are not consistently applied, and are not based on scientific evidence. We must address these issues in legislation.

The ACP is also working to protect the rights of physicians who are negotiating and contracting with health plans. As a result, ACP recommends:

- **Disclosure:** Every health plan should be required to disclose its ownership, governance, and contracting information including its selection criteria for choosing physicians, all medical and economic grounds for assessing physicians' practice, as well as grievance and appeals procedures for physicians.
- **Due Process:** Should a health plan seek to terminate a physician's contract, that doctor must be accorded due process protections.

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ACP PRINCIPLES ON ANTITRUST

There are a number of antitrust issues raised by health reform legislation. The Administration has developed guidelines to clarify for physicians what types of organizations are legal, and which are subject to challenge. In addition, the enforcing government agencies, the Federal Trade Commission and the Department of Justice have promised that entities seeking an advisory opinion will receive a response within 90 days. The Health Security Act incorporates these regulatory "safe harbors", and virtually all the other health reform bills contain similar provisions.

The ACP supports these regulatory changes. In addition, we support the provisions within the Health Security Act that allow physicians to collectively negotiate a fee schedule with alliances. We must ensure, however, that under these negotiations primary care physicians receive adequate reimbursement. As a result, we oppose any efforts to designate a particular organization that would have responsibility for negotiating on behalf of all physicians.

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ACP PRINCIPLES ON MEDICAL LIABILITY REFORM

Meaningful tort reform is a necessary component of national health care reform. The medical liability system must be changed to provide relief to physicians who feel threatened, as well as help to patients that have been injured. Specifically, we recommend:

- **Caps on Non-economic Damages** -- The ACP reiterates its call for a $250,000 cap on non-economic damages. A recent US Office of Technology Assessment study concluded that " the one reform consistently shown to reduce malpractice cost indicators is caps on [non-economic] damages."

- **Mandatory Binding Alternative Dispute Resolution** -- No malpractice case should be brought to court without first requiring the parties to go through alternative dispute resolution (ADR). The results of the ADR should be binding on the parties or there must be a strong disincentive for the plaintiff to proceed to trial after completing the ADR process.

- **Certificate of Merit** -- Before a case can go forward, a screening panel comprised of attorneys and physicians must review a plaintiff's case and determine if there was a probability of negligence and that the negligence caused the injury claimed.

- **National Practitioner Databank** -- We recommend that the data in the Databank remain unavailable to the public.

- **Collateral Source Rule** -- Damage awards should be reduced by recoveries from other sources such as health insurance, disability insurance, or any other source.

- **Limiting Attorney Contingency Fees** -- Attorney contingency fees should be limited to less than 33 and 1/3% based on a sliding scale to decrease the incentive to seek excessive damages.

- **No-fault Demonstrations** -- Federal support for demonstrations of no-fault malpractice systems such as using Accelerated Compensation Events (ACEs) should be encouraged.

- **Practice Guidelines Studies** -- There should be federal support for studies to determine the use and effects of practice guidelines in malpractice litigation.

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EMPLOYER MANDATE

Achieving universal coverage through an employer mandate has significant benefits in health reform:

- **Builds on the current system** -- Most people now receive their health insurance through their workplace, including those who work for small businesses. Nearly two-thirds of all small businesses provide coverage. The status quo gives a minority of businesses a free ride at the expense of the majority. An individual mandate would undermine the current system by giving employers who now provide coverage an incentive to stop. If their employees could receive coverage at subsidized rates, there would be less reason to provide health benefits.

- **Eases enforcement** -- Enforcing an employer mandate would be far easier than enforcing an individual mandate. The later would require the IRS verifying coverage of millions of Americans.

- **Limits can be placed on the costs to all employers** -- An employer mandate can place limits on the percentage of payroll that all businesses, small and large, contribute to health insurance. With effective cost controls on the system overall, employers would have less exposure to rising costs than ever before. Employee cost sharing requirements will induce price sensitivity among consumers who will pay more if they chose more expensive health insurance coverage.

- **Reduces public expenditures** -- Universal coverage under an employer mandate will require smaller public subsidies than an individual mandate. It will ensure that the majority of low-income Americans receive their health insurance coverage through the workplace rather than through federal or state treasuries.

- **Impact on small businesses must be cushioned** -- Since many physicians run small businesses with high overhead costs, they are acutely aware of the implications of a mandate for others. To lessen any potential negative impact: there should be limits on percentage of payroll contributed to health coverage; adequate subsidies should be available for low-wage employees; and the phase in period should be adequate to allow businesses to recover the associated incremental costs.

Alternatives to the employer mandate are unsatisfactory: The single payer option discards the current employment-based system, requires an unacceptable level of taxes, and puts the entire health system in the hands of the federal government. An individual mandate places a heavy burden on the family, encourages businesses now providing care to drop it, and would be unenforceable without a huge bureaucratic effort. The option of a new public program for Medicaid and all uninsured creates a program without mainstream political support, leading inevitably to two-tier medicine; it also concentrates a huge share of the market, with Medicare, in the federal government.

SPEAK

Wed, March 16
btw. 9:30-11:30
Wash. Court Hotel

American College of Physicians

Howard B. Shapiro, PhD
Director
Public Policy

Per Sheila ...
He should do this if he can.

OK
9:30

March 9, 1994

Ms. Sheila Burke
Chief of Staff
Office of the Senate Minority Leader
S-230 Capitol Building
Washington, DC 20510

Dear Sheila:

I am writing to invite Senator Dole to speak at ACP's Leadership Day on Capitol Hill, on Wednesday morning, March 16. As you know, the College is the nation's largest medical specialty society representing about 81,000 physicians.

Our President, executive officers, and physician leaders from across the country will be present. They are in Washington to learn about health reform issues and meet with their Senators and Representatives. We are hoping to have a bi-partisan discussion about health reform in the morning. Senator Rockefeller has already agreed to speak, and our members would very much like to hear Senator Dole provide the Republican view.

The meeting will be at the Washington Court Hotel on Capitol Hill. We can accommodate the Senator anytime between 9:30 to 11:30.

Please let me know if he's available.

Sincerely,

Howard

Howard B. Shapiro

Sheila -

It's very important that we hear a Republican perspective. Can you help us get one of the Senators? The time commitment would be very short. Thanks!

HS

SENATOR BOB DOLE

AMERICAN COLLEGE OF

PHYSICIANS

WEDNESDAY, MARCH 16, 1994

A GREAT DEAL HAS HAPPENED

SINCE LAST YEAR WHEN THE PRESIDENT

FIRST TALKED ABOUT HEALTH CARE

REFORM. I'D LIKE TO THINK WE'VE

LEARNED A LOT ABOUT WHAT THE REAL

NATURE OF OUR PROBLEMS ARE, AND HOW BEST TO RESOLVE THESE CONCERNS.

BUT SADLY, MUCH TIME AND EFFORT HAS BEEN SPENT ARGUING OVER WHETHER WE HAVE A PROBLEM OR A CRISIS AND OVER WHO IS MOST AT FAULT.

WE ALL KNOW THE STATUS QUO IS NOT ACCEPTABLE.

WE ALL KNOW THAT THERE ARE MANY FAMILIES IN THIS COUNTRY WHO HAVE REAL PROBLEMS.

WE ALL KNOW THAT PEOPLE ARE FEARFUL OF GETTING SICK AND LOSING THEIR COVERAGE; OF LOSING THEIR

INSURANCE WHEN THEY LOSE THEIR JOB; OR OF LOSING THE ACCESS TO THE QUALITY HEALTH CARE SERVICES THEY NOW ENJOY BECAUSE OF RATIONING OR PRICE CONTROLS.

YES, UNIVERSAL COVERAGE SHOULD BE OUR GOAL. LIKE MANY AMERICANS, I AM HERE TODAY, IN LARGE PART, BECAUSE OF

PROFESSIONALS LIKE YOURSELF --

BECAUSE OF THE REMARKABLE

HOSPITALS, NURSES AND OTHERS THIS

NATION HAS PRODUCED. I'VE

BENEFITTED FROM THE ENORMOUS

INVESTMENTS IN RESEARCH AND

DEVELOPMENT MADE BY HEALTH CARE

MANUFACTURERS AND PHARMACEUTICAL

COMPANIES IN THIS COUNTRY.

OTHERS IN OUR NATION SHOULD EXPECT NO LESS.

BUT SOME ARE ATTEMPTING TO SELL PRICE CONTROLS, GLOBAL BUDGETS AND GOVERNMENT MONOPOLIES AS THE ANSWERS TO THESE VERY REAL PROBLEMS.

WHAT MANY OF US, BOTH REPUBLICANS AND DEMOCRATS REFUSE TO ACCEPT IS A DESTRUCTION OF THE FINEST HEALTH CARE SYSTEM IN THE WORLD UNDER THE GUISE OF MAKING CARE AVAILABLE TO ALL.

OVER THE PAST FOUR WEEKS OR SO, THE FINANCE COMMITTEE HAS HELD A SERIES OF VERY USEFUL HEARINGS

ALLOWING US TO HEAR FROM EXPERTS FROM ALL OVER THE COUNTRY. THEY ARE NOT THERE BECAUSE THEY ARE DEMOCRATS OR REPUBLICANS. THEY ARE THERE TO HELP ALL OF US DEVISE A PLAN THAT CAN MUSTER SUPPORT FROM BOTH SIDES.

AT YESTERDAY'S HEARING I ASKED THE PANELISTS WHAT WE SHOULD DO

TO ACHIEVE COMPREHENSIVE REFORM GIVEN THAT THE SUPPORT FOR INDIVIDUAL MANDATES AND BUSINESS MANDATES SEEM TO BE DECLINING. I THINK IT IS FAIR TO SAY WHILE THEY DID NOT AGREE ON ONE SINGLE PROPOSAL, THEY DID URGE US TO BE CAUTIOUS, MAKE CHANGES WITH CARE, AND DO WHAT EACH OF YOU MUST STRIVE TO DO EACH DAY -- DO NO HARM.

LAST YEAR, I OUTLINED SIX PRINCIPLES WHICH I BELIEVED WERE NECESSARY TO HEALTH CARE REFORM. THOSE SIX PRINCIPLES HAVE REMAINED UNCHANGED OVER THE PAST YEAR.

1. PROTECT QUALITY: IN OUR WISH TO LOWER COSTS AND BETTER MANAGE OUR RESOURCES, LET'S NOT

THROW AWAY OUR MEDICAL MIRACLES.

2. PRESERVE CHOICE: CONSUMERS, NOT THE GOVERNMENT, SHOULD BE THE ONES TO MAKE CHOICES ABOUT WHERE THEY GET THEIR CARE AND FROM WHOM.

3. PRESERVE JOBS: INCREASES IN TAXES AND MANDATES WILL PUT PEOPLE OUT OF WORK, AND WILL NOT INCREASE THE NUMBER OF PEOPLE WHO HAVE ACCESS TO HEALTH CARE AND INSURANCE.

4. NO GOVERNMENT-

CONTROLLED CARE: WE'RE NOT SWEDEN OR GERMANY OR CANADA. THE GOVERNMENT SHOULD BE THERE TO HELP THOSE WHO NEED IT AND HAVE NO OTHER RESOURCES -- IT'S NOT THERE TO CONTROL OUR LIVES.

5. CONTROL COSTS, NOT CARE: GLOBAL BUDGETS AND PRICE CONTROLS TRANSLATE INTO REDUCED QUALITY AND RATIONED CARE.

6. REAL TORT REFORM: IN NO OTHER INDUSTRIALIZED COUNTRY DO HEALTH CARE PROVIDERS CONFRONT THE

DAY-TO-DAY THREAT OF

LITIGATION.

THE PEOPLE ARE PROVING THAT HEALTH CARE REFORM IS NOT JUST AN "INSIDE THE BELTWAY ISSUE." IT'S AN ISSUE THAT AFFECTS EVERY HEALTH CARE PROVIDER, EVERY PATIENT, AND EVERY AMERICAN. IF ANY REFORM BILL THAT PASSES IS TO WORK, IT MUST

HAVE THE SUPPORT AND CONFIDENCE OF THE AMERICAN PEOPLE. AND AS THE FACTS GET OUT . . . AS YOU GO HOME AND HELP EXPLAIN THE REPERCUSSIONS OF THE PROPOSALS WE ARE CONSIDERING, THE AMERICAN PEOPLE'S SUPPORT MAY BE TOUGH TO GET.

OUR HEARINGS IN THE FINANCE COMMITTEE HAVE A COUPLE OF MONTHS TO RUN.

I STILL BELIEVE REPUBLICANS AND DEMOCRATS CAN COME TO AN AGREEMENT ON A BILL THIS YEAR. IT MAY NOT LOOK LIKE THE CLINTON PLAN, OR THE COOPER PLAN, OR THE CHAFEE

PLAN, OR THE NICKELS PLAN -- BUT THEN NONE OF THOSE BILLS ARE REMOTELY CLOSE TO HAVING THE VOTES TO PASS.

WHAT CAN PASS -- AND I BELIEVE WHAT ULTIMATELY WILL PASS --IS A BILL THAT TAKES THE BEST ELEMENTS OF THOSE PLANS -- A BILL THAT HELPS THOSE AMERICANS WHO CAN'T AFFORD,

CAN'T OBTAIN, AND CAN'T KEEP HEALTH INSURANCE. AND THAT'S A GOAL THAT CAN BE ACCOMPLISHED WITHOUT TURNING THE BEST HEALTH CARE SYSTEM IN THE WORLD UPSIDE DOWN.