

# The Big Story

**When a mega-policy issue—health care reform—runs up against the Information Age, the result is likely to be increased earnings and career-making opportunities for journalists.**

**BY PAUL STAROBIN**

**W**ho stands to gain the most from health care reform? The American people, President Clinton says. Washington lobbyists, cynics smirk. But consider a third possibility: the press.

Whole forests are being felled to supply newsprint for health stories—31 pages worth in the Oct. 4 issue of *Newsweek* alone. Faster than you can say stethoscope, millions of dollars in advertisements bought by health insurers and others are pouring into television stations and mainstream and niche publications from *The Washington Post* to *National Journal*.

The Fourth Estate is being stroked and petted by everyone from Bill and Hillary Rodham Clinton—who've hosted briefings for suit-and-tie newspaper columnists as well as for longhaired radio talk show hosts—to lobbying groups that have lined up to pay journalists to speak at industry forums.

"You could make a lot of money doing this," said Dr. Robert Arnot, CBS News's

chief medical correspondent, who has made paid appearances this year at forums including the Palm Beach (Fla.) convention of the National Association of Chain Drug Stores. "I guess there could always be a conflict there," Still, Arnot added: "I don't get paid compared to [ABC News's] Ted Koppel. It's a four-figure thing" per speech.

What's shaping up to be the most heavily lobbied bill in congressional history is also likely to be the most intensively covered. A mega-policy issue has collided with the Information Age. There are career ladders to be climbed, prizes to be won and book contracts to be snagged.

"It is very, very clear that *The New York Times* is gunning for a Pulitzer prize on this," a reporter said. *The Times's* star health policy reporter, Robert Pear, has racked up more than 40 front-page bylines this year, gotten enough news leaks to fill Lake Erie and become a lightning rod for Administration officials and other reporters who complain that he's often wrong.



Reporters take notes as Hillary Rodham Clinton testifies on health care plan.

Richard A. Blum



oversee enrollment of every individual in health plans, supervise the marketing activities of the plans, collect and publish detailed information for consumers about the plans, adjust payments to plans to compensate for the share of high-risk individuals they enroll, conduct bidding and negotiation processes with the plans and bear responsibility for meeting their part of the federal budget.

## A LAYERED LOOK

There are, of course, existing federal agencies that deal with complex health care matters, notably the Health and Human Services (HHS) Department. So why create a new National Health Board? The answer seems to be, at least in part, that the Administration once again wanted to play down the appearance of Big Government. "We could have put all [those functions] in HHS," Zelman said. "We're separating that out because [this] is a private system, and we think it's appropriate that there be an overseer of the private system that is dif-

ferent than HHS, which generally has overseen the public programs." ed administrative issues imaginable. Any one who thinks a board can run a complex government program is wrong. It's a prescription for failure," said Ronald C. Moe, a Congressional Research Service specialist in government organization and management. Moe also worries that the new agencies would be set up in the naive hope that some important political questions can be buried in bodies that are insulated from direct political control. "We're taking the economics of the medical field away from the individual and giving it to the political realm. The idea that this can be depoliticized is absurd."

The National Board and the alliances would also put several more layers between government and the doctors and hospitals than are found in Canada, where representatives of the provincial government talk directly with doctors and hospitals. It even has one more layer than is found in the German system, from which much of this structure seems borrowed. In the German system, a national health board allocates spending targets to regional quasi-governmental authorities

ment sets a cap on how much it will give to the provinces for health care spending, but the province can decide to raise and spend more if it so chooses. "If there's a budget, it should be enacted for each state on what people in that state want to spend," Etheredge said. "You could cap national contributions, but the rates of change are so different in different states. I don't see how one can fairly decide to do this with a national top-down budget."

But adding new levels can confuse the issue of accountability. "One thing the Clinton plan does is diffuse responsibility for that decision making in a way that involves lots of parties," Yale professor Mashaw said. "So if in the year 2000 the health care system is still gobbling up greater shares of gross domestic product, it's harder to point at any one particular institution responsible for that."

Interposing several layers of decision makers and as well as private health care plans between the government and America's consumers may also make it difficult for consumers to know where to turn if federal spending decisions ultimately translate into inadequate care.

Alliances, for example, would be created by the states and answer to the states on most issues—except the budget, which is set by the federal government. If consumers have complaints about the budget, how much help is an alliance? "There's a big disconnect between the flow of authority and the flow of money, which is traditionally a troublesome thing for accountability," University of Wisconsin professor Kettl said.

Zelman said that despite the complexity, the public will be able to find help easily. Health care, he said, "is one-seventh of the economy. If people feel they are being shortchanged by their health care system, I suspect it will take two to three hours for that dissatisfaction to reach their local Congressperson. And if it reaches enough local Congresspeople, it will reach the floor of Congress, and the national board, and there will be debate on whether the system is working properly, or if the allowable rate of growth is too tight and ought to be relaxed. Congress has the right to relax it at any time."

Like some genetic engineer, the Administration is trying to create a new, improved species of health care system that has all of the benefits of government intervention but that comes with none of its administrative or political aftertaste. The White House maintains that it has done so with an ingenious mix of public, quasi-public and private-sector involvement. But skeptics—some of whom find much else to like in the Clinton plan—worry that the new hybrid might simply obscure the workings of government rather than transform them. ■



**Congressional Research Service specialist Ronald C. Moe**  
The economics of the medical field would be shifted "to the political realm."

ferent than HHS, which generally has overseen the public programs."

Health care policy and management experts see all kinds of potential problems with a National Health Board and the alliances. There are, for example, major questions about whether their designs match their functions. Some analysts worry that the entities are being loaded with too many technical tasks and would require huge bureaucracies. "This is going to be one of the most complicat-

that then negotiate directly with doctors and hospitals, rather than with health plans.

Adding more layers doesn't necessarily mean decentralizing decisions. Indeed, the Clinton plan is, in at least one key respect, more centralized than even the Canadian system. Under the Clinton approach, spending decisions would be made at the federal level. In Canada, they are made closer to the people—at the provincial level. The central govern-



The Washington Post's David S. Broder and Haynes Johnson are collaborating on a health politics book for Little, Brown & Co. Inc., leaving veteran health reporters to grumble about the invasion of their once-sleepy beat by bigshots who don't know an MRI test from a CAT scan.

The story is so big and so competitive that scoop-oriented trade newsletters are having trouble finding fresh material. "We used to be able to beat the papers," moaned Janet Firshein, editor of *Medicine & Health*, a weekly newsletter published by Faulkner & Gray. But this hasn't kept publishers from launching newsletters—such as *Health Care Reform* and the *103rd Congress*—aimed at specialized audiences who'll pay big bucks for the inside skinny.

So how well are the news media covering this story? Not very well, many journalists say. "You should do a long piece about how abominable it has been," said Edwin Chen, a health policy reporter in the Washington bureau of the *Los Angeles Times*. "It is so complicated that few people understand it, and that includes a lot of people in the media." CBS's Arnot said, "The threshold for health stories is getting low," health policy reporter Hilary Stout of *The Wall Street Journal* said, "It seems as if every editor in the country, including my own, will take anything with a slug called health."

Reporters and others say that during the weeks when the Clinton plan was being developed, the press went overboard in reporting the latest, often misleading, twist, or the newest option on this or that segment of the proposal. And now that the plan has been revealed, the press may yet revert to its sports-coverage mind-set—who's winning, who's losing—once debate heats up in Congress.

Don't ask Paul Starr, who won a Pulitzer prize for a book on the history of American medicine and is now a White House health aide, for a favorable review of the news media's coverage. "A lot of things were sensationalized," Starr said. "Everything is to get a scoop. The result is a lot more confusion than illumination."

Of course, the White House's spin doctors aren't above creating a little razzle-dazzle of their own—not least in the deployment of Hillary Clinton as lead pitchwoman for their election-type campaign to generate momentum for congressional action. Reporters have slurped up the story: Maureen Dowd of *The New York Times*, for example, wrote a piece comparing the historic value of Mrs. Clinton's testimony before Congress with the handshakes on the White House lawn between the Israelis and the Palestinians.

Whether you love or hate the press, the widely held assumption in Washing-

ton is that the news media have the power to make or break health care reform. Press coverage, always an important element in the smoke and fire of public policy battles, could prove crucial on this one.

"We're about to witness an all-out war to talk the American people into what they believe" about health care reform, said Drew E. Altman, president of the Henry J. Kaiser Family Foundation in Menlo Park, Calif., which focuses on health care issues. "For better or worse, the best referee we have is the media. We will live and die with the media on this."

### THE OTHER HILARY

*The Wall Street Journal's* Hilary Stout loves sports, swimming in particular. Susan Dentzer of *U.S. News & World Report* is an opera buff. John MacDonald of *The Hartford Courant* likes to read American history.

These tidbits on a few of the reporters covering health care reform were included in a recent issue of *The Health Care Reporter*, a new, \$398-a-year, newsletter published by TJFR Publishing of Ridgewood, N.J., and devoted to how the press is covering health care issues. For \$49.95 each, dossiers on select health care reporters and editors are available by fax. The editors will also do customized investigative projects for a special fee.

Asked about his enterprise, Dean Rotbard, TJFR Publishing's owner and a former "Heard on the Street" columnist for *The Wall Street Journal*, delivered a high-minded sermon worthy of Joseph Pulitzer himself. "The public has a very strong interest and right to know the backgrounds and experience level of the journalists who are going to weigh in on any meaty public policy issue," Rotbard said. "For elected, appointed and other public officials, the media spares no privacy whatsoever."

In fact, subscribers to *The Health Care Reporter* are mostly public relations people working for clients with a stake in health care reform. The general public probably doesn't give two hoots whether Hilary Stout prefers swimming to tennis, but no detail about the health care reporting pack seems too trivial for the trench warriors in this battle. Stout has been fielding phone calls from PR mavens who try to warm up the conversation with a reference to her recreational tastes.

No reporter is talked about more than *The New York Times's* Pear. He has driv-



The three major news magazines are filled with stories on Clinton's health plan.



en the coverage—and has also driven rival journalists, and many policy makers, nuts. "I have heard stories about him calling health care sources as late as 2 in the morning. He's unbelievable. There's nobody I would less want to compete with than Bob Pear," Chen of the *Los Angeles Times* said.

A recent *Columbia Journalism Review* article on health care coverage ventured that Pear was the recipient of "trial balloons" deliberately floated by Clinton's health task force to take the measure of policy makers and lobbyists around town. Many reporters doubt that and point to episodes at odds with the trial-balloon theory. For example, on Sunday, Sept. 12, Pear reported in a page-one article that Administration officials were actively considering several options, including a federal tax on hospitals, to pay for health care reform. White House health care aide Ira C. Magaziner, later that day, held an on-the-record briefing for reporters—a very unusual move for him—and flatly denied that such a tax was being considered. Several sources said that Hillary Clinton had been furious about Pear's story.

"He has really been wrong a lot," a health policy reporter for a national news organization said of Pear. "It was just total bullshit. [Administration officials]

couldn't believe it when he saw a front-page story by Pear on Sept. 30 reporting that the American Medical Association was urging patients to lobby against Clinton's health plan. "It was totally wrong," said Nelson, whose newspaper reported that the doctors' organization was taking a neutral position. "It ain't the gospel because it's *The New York Times*—that's for damn sure."

A White House aide said angrily of Pear: "He is constantly exaggerating, overdoing, creating conflict. It is a real problem. He has misled people." A Pulitzer for *The Times*? "They ain't going to get it with Robert Pear on the beat," another White House aide thundered.

This press Superman, who didn't respond to requests for an interview, has the unassuming look and mild manner of a Clark Kent: thick glasses, business suits and a soft, whispery voice. Hobbled by a bad back, Pear has taken to typing his stories standing up in *The Times's* Washington bureau.

## HEALTH PLAN OF COVERAGE THE SPENDING



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### AMBITIOUS GAMBLE

Relying on Big Savings  
Through Regulation  
and Competition

By ROBERT PEAR

Special to The New York Times

WASHINGTON, Sept. 10 — After seven months of secret deliberations, President Clinton has settled on a bold plan to guarantee health insurance for all Americans while vastly expanding Federal power to control private spending on medical care.

Lobbyists and lawmakers feigned on fresh details of the proposal today as they pried loose a bootleg copy of the

cent of his client's fee—which can range from \$7,500 to as much as \$25,000 per speech.

"Virtually every pharmaceutical company desperately" is trying to line up press speakers, Cosby said. They're driven, he said, by "the FUD factor—fear, uncertainty, doubt" about what's happening on a complex issue. "Journalists come in two different flavors," Cosby added, "those that are politically bent—i.e., they have a direction that is well-known—and those that are basically thinkers."

Cosby has assembled *Newsweek's* Eleanor Clift, *The Washington Post's* Juan Williams and *The New Republic's* Fred Barnes into *Diverse Opinions*—a panel discussion group that, according to CC&L's marketing brochure, "deals with pressing national and international issues in a unique and captivating manner." They debuted back in April, with a discussion of health care reform at a Washington conference sponsored by the Health Industry Distributors Association,

an Alexandria (Va.)-based trade association for medical product distributors. The trio received \$7,500. Only \$7,500 for all three of them? "We've doubled it out of town," Cosby said.

Other Cosby clients who've addressed the health industry include CBS's Arnot and Dr. Art Ulene, the health commentator on ABC's *Home Show*, whom Cosby has booked for companies including Glaxo Inc., a big pharmaceutical firm based in North Carolina.

The health industry, of course, is hardly alone in signing up bigwig journalists for speaking engagements. For example, the Society of the Plastics Industry, a Washington-based trade group, is a perennial on this circuit. At a North Carolina golf resort last October, *New York Times* Washington bureau chief R.W. Apple gave a talk on election-year politics to executives in the society's polymeric materials producers division. "I do not cover and have never covered the plastics industry," Apple said.

Jane Bryant Quinn, *Newsweek's* consumer affairs columnist, gets \$10,000 per speech; giving speeches "is part of her income," assistant Lynn Kane said. Quinn, who writes frequently about health care issues, appeared in Palm Beach before the chain drugstores group.

Should journalists be taking money



**New York Times health policy reporter Robert Pear**  
Administration officials and other reporters complain that he's often wrong.

were not as confused as they were made out to be" by *The Times*. The reporter added that "the thing that drives you crazy is that if it's in *The Times*, you've got to follow it. That's how our editors think."

Jack Nelson, the Washington bureau chief of the *Los Angeles Times*, said he

### HOLLYWOOD ON THE POTOMAC

Joseph E. Cosby, chairman of CC&L Speakers Group in McLean, Va., can't complain. The health care industry is practically throwing money at the journalists he represents to get them to speak at their events, and the agent gets 20 per



from interests with a vested stake in subjects that the reporters write about? It wasn't that long ago that many journalists were screaming for a ban on honoraria paid to Members of Congress for the same sorts of speeches. "I think we are in a different category than Congressmen," said Clift, who has written about health care as part of her White House coverage for *Newsweek*. "We don't pass legislation."

Arnot said CBS News executives earlier this year "laid down the law" on ethical minefields for journalists covering health care. "We had this talk—they sat me down" and asked: "What kind of speeches have you done? Do you own drug company stock?" Arnot added: "I used to give 30 or so [speeches] a year. Now, with the increase in workload here, and with the guidelines, I've cut them down to almost nothing."

Dentzer of *U.S. News* received a \$3,000 honorarium for a recent speech at a forum sponsored by the American Hospital Association and then donated the fee to a Washington community group that tutors inner-city children. "That's a no-brainer," she said of her decision not to pocket the fee.

"Groups are constantly, constantly calling," *Wall Street Journal* reporter Stout said, adding that her newspaper doesn't allow reporters to take money from lobbies they cover.

Richard Harwood, a former *Washington Post* reporter and editor who now writes a column for that paper that often focuses on the media, said: "I don't think journalists ought to go around taking money from these special-interest groups. . . . They're not Congressmen, they don't pass legislation, but in theory they are in the business of influencing the passage of legislation." He added that "most journalists are not particularly qualified to speak in an analytical way about the Clinton program. I don't think I would invite David Broder to come make a speech on the Clinton health care bill."

Delivering speeches isn't the only way some journalists are capitalizing on health care reform. When veteran health newsletter journalist Jerome F. Brazda isn't editing *Managed Care Report*, he's running Health Speakers Inc. in partnership with Timothy H. Bell, a Reston (Va.)-based health care public relations consultant. The firm gets a fee for booking speeches for such clients as Princeton health economist Uwe Reinhardt. Brazda said he had the idea for the enterprise with *Washington Post* health reporter Victor Cohn, but *The Post* refused to let Cohn participate, saying that he shouldn't take money from sources he covers.

"This is a great year for health speakers," Brazda gushed. Along with the magazine *Modern Healthcare*, Health Speakers Inc. is co-sponsoring a two-day conference on health care reform in early November at the National Press Club. For a fee of \$635, conference participants are being promised a lineup including Reinhardt and other private economists, lawmakers and other government officials, and such journalists as Spencer Rich of *The Washington Post*. Bell said Reinhardt would get his usual fee of \$5,000, the journalists would be offered a "nominal, token fee" of \$500 and government speakers wouldn't get a dime.

## KEEP FIRING AWAY

The end of the Cold War was good news for the nation but bad news for advertising managers of Washington publications that had been living off those glossy defense-contractor ads of fighter jets and attack helicopters. To the rescue comes health care.

Bob Wallace, the ad director for *Congressional Quarterly Weekly Report*, recently told *Advertising Age* that health care "may very well be the largest advertising category we have for at least the next two years." But Wallace's magazine faces competition for these ads from *National*



Richard A. Bloom

**Health policy reporter Hilary Stout of The Wall Street Journal**  
**"It seems as if every editor . . . will take anything with a slug called health."**

*Journal and Roll Call*, the Capitol Hill newspaper.

National newspapers are also getting a piece of the action. On the day of the President's health care reform speech to Congress on Sept. 22, the Health Insurance Association of America plunked down more than \$100,000 for full-page

ads in *The New York Times* and *The Washington Post* in the form of a letter to Clinton from HIAA president Willis D. Gradison Jr.

Outside-the-Beltway television stations and newspapers stand to benefit if—as is expected—health industry players run ads aimed at swaying lawmakers' constituents.

Nobody familiar with the news business expects *The New York Times* or any other quality news operation to sell its editorial soul to advertisers. Nevertheless, the *Columbia Journalism Review* routinely hands out "darts" to newspapers and TV stations at which the traditional separation between the editorial and business sides of the house is not so scrupulously honored—and Altman of the Kaiser Family Foundation, for one, is concerned about the potential for abuses in this instance.

The bloodier the battle, the better for business. The HIAA recently ran an aggressive TV spot attacking Clinton's

... 75 CENTS

## Sweeping Proposal

### Clinton Health Plan:

### Push Competition,

### Be Ready to Regulate

### Comprehensive Care Scheme

### Will Set Terms of a Battle

### Not Soon to Be Resolved

### Strong Arm of Government

By RICK WARTZMAN and HILARY STOUT  
 Staff Reporters of THE WALL STREET JOURNAL  
 WASHINGTON — President Clinton's ambitious health-care proposal promises to rely on the unseen hand of the marketplace, but its real power stems from the strong arm of government.

As outlined in a 239-page draft circulating in Washington, the Clinton proposal is a sweeping yet intricate blueprint for overhauling the country's nearly \$1 trillion health system. Through new requirements on employers, the plan would guarantee a comprehensive package of health benefits to all Americans while taking unprecedented steps to halve the projected growth rate in national medical spending by the late 1990s.

plan: the Democratic National Committee (DNC) immediately countered with a \$50,000 buy for a 30-second ad assaulting the insurance industry. The HIAA has already spent some \$4 million on print and television ads this year and is preparing a fresh round of spots. The DNC, under the direction of former Ohio Gov.



Richard F. Celeste, plans to raise \$3 million for its media campaign on behalf of the plan. "We will respond to every negative attack," Celeste told reporters.

Advertisers are piggybacking on the programs. Before NBC viewers heard Clinton's speech to Congress, they saw an ad placed by Aetna Life & Casualty Co. touting managed health care plans. The following day, during its national broadcast of a Tampa (Fla.) town meeting with Clinton on health care, ABC ran an Aetna health care ad for which the insurance company paid about \$80,000.

According to *Advertising Age*, ad purchases are also expected by tobacco companies, which are threatened by Clinton's proposed cigarette tax, as well as by drug companies, employers, labor unions, doc-

also just published a quickie paperback of health care backgrounders prepared by *New York Times* staff writers and edited by Erik Eckholm, a special-projects editor at *The Times* who is helping to coordinate the paper's health care coverage.

## ANTI-SPIN

If in this debate there's no shortage of spin controllers, from the White House to health insurers to employer groups, there is a dearth of sources to which journalists can turn for the straight dope.

Many reporters are turning to Altman's Kaiser Family Foundation, which has established itself as a sort of tutor for journalists on health care issues and has become a generous sponsor of projects to

Nor does Kaiser spare on frills: The fellows and guests, including White House health policy spokesman Kevin Anderson, a former *USA Today* reporter, munched on wild mushroom tortillas and sipped chardonnay at a recent reception at the trendy Red Sage restaurant in Washington.

Kaiser is also channeling \$375,000 into a fellowship program for minority internships in urban health reporting and another \$265,000 or so into a project to monitor health care reform reporting in partnership with the Times Mirror Center for The People & The Press and *Columbia Journalism Review*.

The foundation was started by Henry J. Kaiser, a high-school-dropout-turned-wealthy-industrialist, who was also the

founder of Kaiser Permanente, the giant health maintenance organization (HMO). At one time, the foundation operated very closely with the HMO and promoted a managed health care policy, according to foundation spokesman James. But the connection was severed, James said, and the foundation holds no stock in Kaiser Permanente; though some Kaiser family members serve on the foundation's board, neither they nor any other members of that board are on the HMO's board. "We are not Kaiser Permanente," he said.

If the press is running short of unbiased experts on health care reform, reporters can always interview each

other. On the eve of Clinton's speech, it was no surprise when a gaggle of interest groups clogged the fax machines of Washington's news organizations with notices of the availability of their leaders for interviews. But the fax traffic also included a "media advisory" from the Bureau of National Affairs Inc., a Washington publisher of various policy-oriented publications, encouraging reporters to call Paul Albergo, the managing editor of *BNA's Health Care Policy Report*, for "informed background and analysis."

Only two did, however. "I would assume that journalists are just naturally reluctant" to interview each other, Albergo said. "I would not allow our reporters to do that."



**Janet Firshein, editor of *Medicine & Health*, a weekly Washington newsletter**  
**"We used to be able to beat the [daily] papers" on health care issues. Not any more.**

tors, nurses, hospitals, trial lawyers and groups on both sides of the abortion debate. The American Association of Retired People has prepared an ad warning against efforts by special interests to derail health care reform. Everyone's coming forward: *National Journal* sold space to the Paralyzed Veterans of America for an ad cautioning against tinkering with the veterans' health care system.

Book publishers see an opportunity, too. Five days before Clinton's speech to Congress, and much to the ire of the White House, 100,000 paperback copies of a leaked draft of the Administration's health plan were rolling off the presses of Random House Inc. Random House has

monitor and improve press coverage. The foundation has held numerous briefings for health care journalists, and its experts field a daily raft of calls from journalists.

Kaiser recently committed \$1.2 million to a media fellowship program that kicked off this year by awarding \$45,000 stipends to six health journalists, including *National Journal's* Julie Kosterlitz, chosen from 116 applicants. The Nieman Foundation at Harvard University offers a \$25,000 grant, and the Alicia Patterson Foundation offers \$30,000. "We had received many complaints from reporters and editors alike who said that the [other] fellowship stipends weren't enough," Kaiser spokesman Matt James, a former Democratic Hill aide, said.

FAULKNER & GRAY'S

## Medicine & Health.

Vol. 47/No. 37/September 28, 1991

### Magazine Defends Reform Plan's Controls on Health Spending

By moving quickly to lower the annual rate of growth in private and public health spending, the White House hopes to "tighten a fist" under a health reform plan that is both "realistic and sufficient" for the long term, says White House chief health reform spokesman. In a Sept. 18 on-the-record briefing with health reporters, Magazine defended Clinton's target of \$218 billion in Medicare and Medicaid savings over six years as part of the President's plan to reduce the U.S. health deficit. "This is a modest goal and to say that new means bring savings too is by changing the numbers and creating the right kind of environment to just make it happen," he said. The Administration will not "go to the American people and say 'We are going to raise a big, broad-based tax as we can find the sufficient [1990 billion] needed to meet everything,'" he added. Magazine called the "tax" over the Medicare and Medicaid targets "unrealistic" and argued that fact that under the plan, more people will be covered and new long-term care and prescription drug benefits will be available. Putting in the 20-year experience as a constraint to business faced with intense competition.

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F&G Janet Firshein, Editor

Magazine noted that few industries ever get a 10-year warning to become efficient before a fiscal house is reformed. Under the Clinton plan, the savings in public and private spending growth will be 10% in 1991, 15% in 1992, and 20% in 1993. Even though some Democrats on Capitol Hill are raising their eyebrows over the speed savings targets, the Administration's budget goals are no less realistic than those advanced in bills by Rep. Jim McDermott (D-WA) and Sen. Dan Rostenkowski (D-IL) in a mid-July debate on the plan. Magazine said that White House officials also said:

Q The Administration is not worried in the area of forcing firms with fewer than 1,000 employees into regional health alliances. But the alliances have to be big enough so they can offer a choice of plans, be architecturally sound, and meet the same quality standards Magazine said he doesn't think there is any "single number" but believes a cut-off of 100 workers, the minimum most employers have, is too low. "We have an interest in aggressively creating big structures. What we do have an interest in is making companies hard on risk."

Q President Clinton is still deciding whether to impose taxes on alcohol and whether to assess a tax on corporations to help cover the cost of the small business activity and to boost the public health infrastructure. The Administration had initially proposed a new percent markup on self-insured companies that are not in the regional alliance. The White House is now giving a green light into the possibility to be paid by all companies.

Q The Administration will introduce legislation in the first or second week of October along with a revised, final version of the plan that includes a detailed analysis of financing. The White House already has made 150 technical changes in the legislation and privileged 2,100 page draft documents including changes in the way that state health department contractors guarantee the federal subsidy fund, and pave for medical training of nurse practitioners.



Bank lobbyists also hope that free of his political ball and chain, Riegle will see the light and agree to water down the 1991 law that tightened bank regulatory standards. Don't bet on it. He may well accelerate efforts, however, to enact legislation that would consolidate now-fragmented bank regulatory responsibilities under the control of a single, independent regulator.

This won't be easy. The Treasury Department would have to agree to let go of the Office of the Comptroller of the Currency, which oversees nationally chartered banks, and the Office of Thrift Supervision, which oversees what remains of the savings and loan industry.

Liberal advocacy groups are comfortable with Sarbanes, who has solid liberal

credentials on civil rights and related issues, but remain doleful about losing Riegle. "There aren't a lot of Members who genuinely relate to working-class people," ACORN's Bhargava said. "It's not really his liberal [bent] that I'm going to miss—it's just where his soul is. . . . I think pretty highly of Sarbanes, but there's no replacing that fire in the belly." ■

## HEALTH AGENTS FIGHTING FOR SURVIVAL

BY W. JOHN MOORE

**T**he Clinton Administration's health care plan has put health insurance agents in intensive care, their condition critical and the prognosis poor.

Unless Congress prescribes the right cure, the insurance agents may not survive. The Administration, it is clear, envisions a health care future without agents.

"As we read the plan, we will be gone not by default but by design," said Michael D. Lane, executive vice president of the National Association of Health Underwriters (NAHU), a 12,000-member trade group for health insurance agents. In preparing its proposal, he added, the White House deliberately kept agents out of the policy-making loop.

The agents are targeted for extinction in a single sentence buried in the voluminous proposal: "Health plans and their agents are prohibited from attempting to influence an individual's choice of plans in conjunction with the sale of any other insurance."

Under the proposal, government-mandated purchasing cooperatives would replace insurance agents as brokers for health plans.

As a result, health care reform is a life-or-death issue for the agents, who are prepared to fight for their livelihoods. The NAHU has hired Thomas A. Scully, a former Bush Administration official who is now with the well-connected Washington law firm of Patton, Boggs & Blow, to lobby on the issue. (See *NJ*, 8/21/93, p. 2093.)

Meanwhile, the Association of Health Insurance Agents, a division of the National Association of Life Underwriters, has hired another Patton, Boggs lobbyist, John F. Jonas, a former tax counsel



**Michael D. Lane of health agents group**  
**We lose "not by default but by design."**

to the House Ways and Means Committee, and H. Stuart Van Scoyoc, president of Van Scoyoc Associates Inc., a Washington lobbying firm.

For the health agents, the latest buzzword is "choice." "This is part of a much broader policy debate over the best way to structure the system," Jonas insisted. Why should the medical system become a monopoly like the U.S. Postal Service, he asked. Some states, including California and Florida, have established purchasing alliances, but participation is voluntary, not mandatory, he said.

The agents, Van Scoyoc said, "need a system that would have enough flexibility that professional insurance agents will continue to have a role to play."

To push their concept of choice, the

health insurance agents have joined a broad-based group, the Voluntary Health Alliance Coalition, which includes agent groups: major insurance companies; and such trade associations as the National Association of Wholesaler-Distributors and the National Retail Federation, whose members use agents to help them choose the least costly health insurance plans. Under the Clinton plan, Lane contended, "the only choice for business is to pay 80 per cent of the bill."

"This policy issue," Jonas said, "will be decided for reasons broader than the fate of the agents."

The coalition intends to mobilize health insurance agents in every congressional district. According to Lane, the anti-agent language in the proposal has helped to galvanize public support for their cause and encouraged a debate about the agents' role in the health care system. Several months ago, nobody had focused on the issue of mandatory versus voluntary participation in purchasing alliances, he said. "Now we're confident that it is one of the top three issues in the debate."

The agents have also begun talking to Members of Congress. "Right now we are meeting with just about every Member of the House and the Senate," Van Scoyoc said.

The health insurance agents may support the Republican alternative to the Administration plan that has been offered by Sen. John H. Chafee of Rhode Island and Senate Minority Leader Robert Dole of Kansas. But, Lane said, the GOP's proposal still favors the alliances.

The agents will need all the help they can get. "Right now we are not a favored class under the Clinton health care scheme," Jonas conceded.

Nevertheless, Lane remains upbeat.



## FROM THE K STREET CORRIDOR

**T**he western mining industry has a new look this fall as its supporters attempt to shape legislation to revamp the 1872 Mining Act. Joining the mining company executives who have traditionally pounded the pavement in Washington is a new group, the Women's Mining Coalition, which represents women in the mining industry.

Mining industry consultant Kathleen Benedetto, one of the founders of the Reno (Nev.)-based women's group, said that though mining is traditionally viewed as a man's realm, women hold about 20 per cent of the jobs in the mining industry in Nevada.

Benedetto said that she and two other women formed the organization out of concern that women working in mining could be the first to lose their jobs if Congress enacts legislation that she said would force mining companies to move overseas. Acknowledging that mining companies are underwriting some of the group's travel expenses to Washington, she said that the industry does not control the group's agenda.

In May, the Senate approved a mild mining reform bill; this fall, the House Natural Resources Committee is expected to approve and send to the House floor a tougher mining bill.

The environmental community, too, has bolstered its lobbying forces, bringing out the "environmental air force" to help illustrate its contention that a strengthening of the mining law is needed. Bruce Gordon, the executive vice president of LightHawk, an Aspen (Colo.)-based airplane service, issued a standing offer to fly policy makers and journalists over public lands that critics say have suffered environmental damage from mining. "Mining areas are restricted, and the public usually can't see the devastation," Gordon said. "We give the land a voice."

—Margaret Kriz

**T**he engineers are coming to the capital. The 75,000-member Society of Manufacturing Engineers (SME), based in Dearborn, Mich., expects to open a two-person Washington office on or about Dec. 1, according to Robert E. King, a government relations officer with the professional group.

"We're seeing an increased interest in manufacturing in Washington," King said, especially in the areas of defense conversion and job creation.

The SME will not lobby, King said. The society, he explained, wants to boost its revenues through those old reliables, government contracts and conferences. The SME also wants to use more government-generated information in its publications, King added.

"If we want to remain a major player in the area of manufacturing-data dissemination, we have to find ways to work with those government agencies which are funding research and development," King said.

—W. John Moore

**A**s the White House ponders the deeper meaning of the nationwide computer network called the "information superhighway," the private sector has formed a new Washington-based trade association to build it.

Late last month, electronics giant Rockwell International, GTE Telephone Operations and four baby Bell regional telephone companies founded the National Telecommuting and Telework Association to represent companies that either employ, or manufacture equipment for, people who work at home via personal computers, fax machines and computerized telephone connections. Telecommuting is becoming so popular that the association expects to have 1,000 member companies by the end of the decade, staff director Tom Gibson said.

—Graeme Browning

"We have come a long way in two months, and we're pretty confident of winning on this issue as well," he said. ■

## MOBILIZING AGAINST TAX

BY PETER H. STONE

**T**he tobacco industry is starting to mobilize its Washington lobbyists and grass-roots networks to fend off the Clinton Administration's proposed cigarette excise tax hike.

The Administration is weighing a proposal to increase that tax by 75 cents to \$1 per pack to defray some of the costs of its proposed health care reforms.

WASHINGTON INC.

In Washington, the Tobacco Institute, an industry trade group, has deployed a few of its longtime lobbyists on Capitol Hill to oppose any tax increase. James C. Healey, for example, a principal at Black, Manafort, Stone & Kelly Public Affairs Co. in Alexandria, Va., who is lobbying for the tobacco group, has discussed the tax proposal with Dan Rostenkowski, D-Ill., his former boss and the chairman of the House Ways and Means Committee, as well as with senior committee aides.

In the House, opposition has been fueled by about 30 tobacco-state Members. A letter to the White House opposing any tax hike is now being circulated for signatures among these Members by two North Carolina Democrats, H. Martin Lancaster and Stephen L. Neal.



Tobacco state Members oppose a tax hike.



## President Clinton wants a cigarette tax hike to help pay for his health care reform plan.

In the Senate, the tobacco group's case is being pressed by L. Andrew Zausner, a partner in the Washington law firm of Dickstein, Shapiro & Morin, and David E. Johnson, the vice president of the Washington lobbying firm of Griffin, Johnson & Associates and a former aide to Senate Majority Leader George J. Mitchell, D-Maine.

Meanwhile, North Carolina-based RJR Nabisco Inc.'s network of 15 regional directors is moving into high gear. In recent years, the regional field force has been nurturing smokers' rights groups that have the names of at least 50,000 activists in their computers. Several of the field directors are conducting training sessions for smokers' rights groups in how to make persuasive pitches to Congress.

The company, a major tobacco manufacturer, also has a long-standing relationship with Walt Klein & Associates, a North Carolina-based political consulting and advertising firm: potential protesters against a cigarette tax increase can call an 800 number that is run out of the Klein firm's headquarters.

In the spring, the tobacco giant helped bring several hundred employees to a rally on the Capitol steps against a tax increase.

RJR is also counting on the Washington office of Akin Gump Strauss Hauer & Feld, a Texas law firm, to tell its story to the Administration. One of the firm's partners, Vernon E. Jordan Jr., sits on the RJR board and is a close adviser to President Clinton.

Philip Morris Cos. Inc. is expected by year's end to launch a large grass-roots lobbying and public relations campaign with the help of the Washington office of Burson Marsteller. And Black, Manafort is one of a few key lobbying firms Philip Morris regularly uses. ■

## CAPITOL HILL WATCH

**H**ouse Minority Leader Robert H. Michel's long-expected retirement announcement on Oct. 4 set off a predictable round of jockeying by some of his fellow Republicans, who announced or were weighing an attempt to step up the leadership ladder. But Minority Whip Newt Gingrich of Georgia moved quickly to put on the mantle of inevitability and discourage serious competition.

Gingrich, copying a tactic used by, among others, Jim Wright of Texas when he announced early commitments by House Democrats in his successful effort in 1986 to succeed Thomas P. O'Neill Jr. of Massachusetts as Speaker, telephoned scores of Republican colleagues; aides reported that most were supporting him. Gerald B.H. Solomon of New York was the first Republican to enter the contest against Gingrich, virtually assuring the selection in 1995 of a new ranking Republican on the Rules Committee, a key post that the party leader fills.

In announcing his departure plans, the 70-year-old Michel waxed nostalgic about his years as a House Member from Illinois and about the spirit of bipartisanship that has faded in recent years. "I guess when I came down here some 37 years ago, my charge was out of the junior chamber of commerce," he told reporters. "It wasn't anything about revolutionizing this and changing this and that . . . other than on pretty much just plain old philosophical grounds. But [the House has] changed." Tributes from both parties emphasized Michel's ability to work across party lines.

—Richard E. Cohen

▲ ▲ ▲  
**M**ichel's decision added to the growing number of open House seats that are likely to be competitive next year. House Democratic campaign strategists, who have conceded that their party could face double-digit losses, hope the departures will leave the GOP on the defensive in some districts.

Though Michel usually won easily in his Peoria-based district, the area voted narrowly for Bill Clinton in last year's election, and local observers are predicting a close contest to succeed Michel. Democrats will be favored to win Republican seats to be vacated by Ron Machtley of Rhode Island and Rick Santorum of Pennsylvania, both of whom have announced plans to seek statewide office; in 1992, President Bush won 28 per cent of the vote in Machtley's district and 30 per cent in Santorum's.

But Democrats will have difficulty defending some of their open seats. Their early problems include the centrist districts of retiring Reps. Marilyn Lloyd of Tennessee, Timothy J. Penny of Minnesota, Jim Slattery of Kansas and Al Swift of Washington.

—R.E.C.

▲ ▲ ▲  
**C**alling the battle over the North American Free Trade Agreement (NAFTA) a "key political test for the Democratic Party," party centrists have taken a swipe at organized labor, one of the pact's strongest opponents, and a key Democratic ally.

In a report made public by the Progressive Policy Institute, the think tank affiliated with the Democratic Leadership Council, the leading faction of party centrists, PPI senior fellow Paula Stern acknowledges that though "many congressional Democrats understandably find it difficult to resist such demands by loyal constituents," such as labor, "with Democrats now in control of both the White House and Congress, the party's challenge is to demonstrate its capacity to govern in the nation's interests rather than legislate on behalf of narrow interests." Stern's paper notes that most studies have shown that the United States will gain jobs under NAFTA and warns that "fears of cheap-labor nations are grossly exaggerated."

—James A. Barnes



# AT A GLANCE

## A Weekly Checklist of Major Issues

### Budget



#### Balancing act:

Forces for and against a constitutional amendment that would require a balanced federal budget are polishing their arguments for a skirmish that's expected later this month in the Senate. Sen. Paul Simon, D-Ill., a longtime supporter of such an amendment, wants to bring it to the floor soon; if it passes, action will follow quickly in the House, where last year the measure fell just nine votes short of the two-thirds majority needed to pass it. Changes in membership in both chambers have the amendment's opponents worried. A new study by the Center on Budget and Policy Priorities dusts off and sharpens some of the arguments against the amendment, chief among them that it could trigger large program cuts or tax hikes in periods of slow economic growth, dragging the nation's economy down further. By requiring a balanced budget as early as 1999, it says, the measure could force major fiscal retrenchment on top of the deficit cuts made in the recently enacted reconciliation bill. And by requiring a three-fifths vote to waive the balanced budget requirement in any year, the center also argues, the amendment would increase the power of congressional minorities, which could threaten to block a waiver unless major policy concessions are granted.

### Congress



#### Texas Senate race:

Sensing an unexpected opportunity following last month's indictment of Sen. Kay Bailey Hutchison, R-Texas, prospective Democratic opponents have begun

to attack one another as they weigh whether to run. Rep. Martin Frost, D-Texas, told a Dallas-area meeting of steelworkers that Democrats have suffered when they have not stood by their convictions. Citing Hutchison's defeat last spring of Sen. Robert Krueger—who had been appointed to the seat by Gov. Ann W. Richards, D-Texas—Frost said, "They took the easy way out and looked for someone in the middle of the road who wouldn't offend anyone." Frost, who postures himself as a relative liberal in Texas Democratic politics, reportedly will decide this month whether to run in the March primary. Sources report that Rep. Michael A. Andrews, a more conservative Democrat, is likely to run. The big imponderable is whether Housing and Urban Development Secretary Henry G. Cisneros will take the plunge.

### Defense Policy



#### Off the hook: The

tangled skein of blame that resulted from the 1991 Tailhook Convention unraveled a little on Oct. 4 when Defense Secretary Les Aspin announced that he would not fire Adm. Frank B. Kelso II, the Navy's chief of naval operations. Navy Secretary John H. Dalton had recommended his firing on the ground that Kelso, as the Navy's most senior military officer, should be held accountable for the actions of his subordinates, including the Navy and marine pilots who allegedly assaulted dozens of women at the infamous convention in Las Vegas. In a statement, Aspin acknowledged that the Navy traditionally holds captains responsible for the actions of their crews but said that "the time for

applying such a standard to Kelso's behavior has passed." Administration officials urged Aspin to overrule Dalton's recommendation because they feared that firing Kelso would further antagonize President Clinton's strained relationship with the military, which has resisted his efforts to lift the ban on gays in the armed services. Kelso's offer to resign in June 1992 over Tailhook, and his stellar record on opening combat jobs to women, also weighed in his favor, according to press reports. In a statement, Dalton, a graduate of the Naval Academy, said that he'd reached his recommendation "only after much soul-searching and agonizing consideration. I believe that the damage done to the Navy's reputation by the incidents of Tailhook could have been prevented or minimized by aggressive leadership and foresight by senior Navy officials."

### Economy



#### Bad-news bearers:

New data from the Census Bureau paint a bleak, if unsurprising, picture of poverty, income and health insurance trends—and could boost legislative efforts to reverse the patterns. In 1992, the nationwide poverty rate rose to 14.5 per cent—a slight increase over 1991 and the highest level since the recession of the early 1980s. At the same time, the share of family income held by both the richest 5 per cent and the richest 20 per cent of all households increased in 1992 from the year before. Against this backdrop, liberal Democrats on Capitol Hill are renewing their push for ameliorative legislation. Martin Olav Sabo, D-Minn., the chairman of the House Budget Committee, said on Oct. 4 that he will

introduce legislation to raise the minimum hourly wage from \$4.25 to \$6.50 and to limit tax deductions for executive pay. On the health care front, the new census data may also boost President Clinton's bid for universal coverage: The share of Americans without health insurance rose from 14.1 per cent in 1991 to 14.7 per cent last year. According to the bureau, 37.4 million Americans don't have health insurance. (See *NJ*, 9/11/93, p. 2176.)

### Environment



#### Shivering timbers:

Officials of the Agriculture Department's Forest Service have been accused of routinely blocking public access to documents requested under the Freedom of Information Act and of interfering in internal investigations of wrongdoing at national forests. John McCormick, the former head of the Forest Service's whistleblower unit, told the House Post Office and Civil Service Subcommittee on Investigations on Oct. 5 that officials of the Forest Service frequently denied the existence of internal documents requested by the public and, in one case, rewrote an incriminating report before releasing it. The Forest Service was also criticized for allowing higher-ups to interfere with and retaliate against law enforcement employees who were investigating alleged infractions at the national forests. A report by the General Accounting Office found more than 180 cases in which Forest Service managers allegedly blocked internal investigations of such things as timber thefts at the forests. In some cases, the report said, investigators at the Forest Service have had to investigate the managers to



# HILLARY CLINTON IS ON A ROLL . . .

**E**ven by her fourth appearance before a congressional committee in less than 30 hours, Hillary Rodham Clinton was performing so perfectly and so tawningly that you wanted to gag. She read parts of her opening comments to the House Education and Labor Committee, belying her reputation for speaking without notes. But she had obviously mastered not only the substance of the Administration's health care proposals, which she'd played such a crucial role in crafting, but also the politics.

The package of reforms contained "a number of features that will alleviate that situation in southwestern Pennsylvania," she told Rep. Austin J. Murphy, D-Pa., adding, "I know something that's of particular importance to you because of your wife's profession." (Murphy's wife is a nurse.) As he and other committee members asked their allotted question apiece, she would nod like a mechanical doll and barely blink. She was as obsequious to the Republicans as to the Democrats. "Yes, Congressman, we are especially concerned about rural areas," she said to Bill Barrett of Nebraska. To Thomas E. Petri of Wisconsin: "We will certainly look at that proposal."

"That's a good question," she told T. Cass Ballenger, R-N.C., a staunch conservative and the owner of a small business, who'd asked if a group of companies with 5,000 or more workers would be able to arrange for health care on their own. "We will get you an answer specifically."

"Thank you, ma'am," Ballenger replied.

Along with her ingratiating manner and intimidating command of facts, Hillary Clinton showed a glint of steel. But even her tart exchange with Rep. Richard K. Armey, R-Texas, seemed calibrated and controlled. She wore a vast smile as she flung back at him the side-swiping reference to Dr. Jack Kevorkian that he had used earlier in labeling the Administration's proposals. After he bested her jab with his own (at her "overstated" charm and "understated" wit), the grin didn't fade from his face for 10 minutes or more.

But her point had been made. "Seeing how you impaled my comrade-in-arms," Rep. Harris W. Fawell, R-Ill., said to her a few questions later. "I will proceed cautiously."

This clearly wasn't the cookie-baking wife whom the public saw during the

presidential campaign. White House spokesmen deny, however, that there's been any makeover. "This is Hillary Clinton being Hillary Clinton," Lisa M. Caputo, her press secretary, said.

But her attention to detail and to image seemed to be no accident. A White House official privately acknowledged that market research—polling and focus groups, financed by the Democratic National Committee—had been conducted not only on health care but on Mrs. Clinton's role. Even to some of the female lobbyists on hand, the teal blue suit she wore on her second day testifying looked indistinguishable from the grass-green suit she'd worn the day before. (Teal blue is a bright but conservative color, fashion experts say, that many professional women in Washington favor.) She sported one of the smoother of the nuanced versions of the shorter hairstyle she got last spring. "A versatile woman with a versatile haircut," Caputo said.

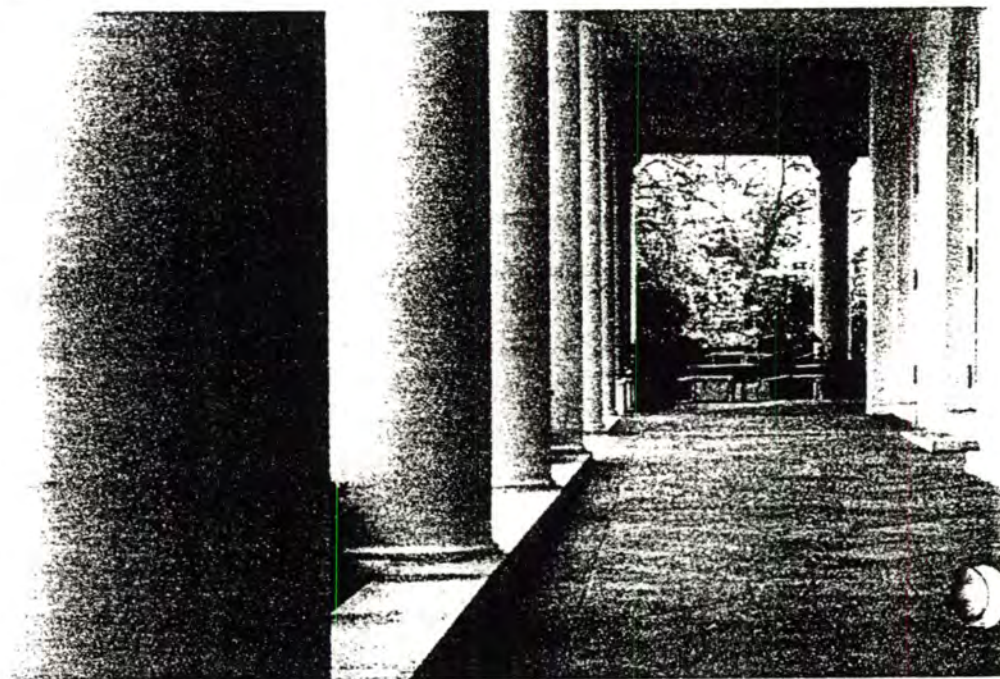
Indeed, the rollout for the policy maker as well as for the policy smacked of Madison Avenue. "She's sort of a new product, if you will," said Rob Shephardson, a partner at Shephardson, Stern & Kaminsky, a New York City advertising and communications firm. "In advertising, we talk of 'tone and manner,'" he added, and in Hillary Clinton's case, "it seems to me they've hit it."

"If you didn't like the September 1992 Hillary Rodham Clinton, you will love the September 1993," Jerry Della Femina, the legendary New York City adman, said. "They know how to present her now. They're doing a masterful job."

Della Femina, a lifelong Republican who voted for Bill Clinton last fall, likened the White House's tactics to those that Hollywood moguls used in the mid-1930s in introducing a new starlet—redoing the hairdo, the voice, the posture and the clothes until they got it just right.

Whether Hillary Clinton can keep her political touch seems sure to count for a lot in assuring her husband's political fate. The success of his presidency, after all, is likely to hinge on his achievements in health care, in which his wife is playing a pivotal role. Caputo described her as the "chief spokesperson for the plan and probably the chief advocate." She may testify some more before Congress and will consult often with Members as the many months of chiseling a compromise ensue.

Her public role may matter even more. Before October is half over, she'll have tried to peddle the Administration's health care plan in Rhode Island, Florida and New York in stops that White House officials hope the television networks won't ignore. On Oct. 14, she's scheduled to tape a segment of PBS's *Sesame*





whom they report. In May, the GAO estimated that timber thefts in national forests may exceed \$100 million.

## Foreign Policy



**Roller-coaster:** In the wake of his nationally televised speech to Congress on health care reform, President Clinton's job approval ratings seemed to be on the mend. But the continuing crisis in Somalia threatens to pull them back down. In a poll conducted by ABC News on Oct. 5—after the evening news programs aired footage of a dead American soldier being dragged through the streets, among other chilling war scenes—53 per cent of the respondents said that they disapproved of the way Clinton is handling the situation in Somalia, up from 29 per cent in June. And nearly two-thirds said that the United States "should pull its troops out of Somalia very soon, even if there is no functioning civil government in place." (See this issue, pp. 2443 and 2448.)

## Health



**Patient rights:** The Justice Department has filed its first lawsuits under the 1990 Americans With Disabilities Act alleging illegal discrimination against individuals with the AIDS virus. The suits, filed on Oct. 4, charge a Houston-based dental chain and a New Orleans dentist with denying treatment to HIV-positive patients. Denying such care violates the law, the Justice Department contends, because it is based on stereotypes with no medical justification. Both the American Dental Association and the

Health and Human Services Department's Centers for Disease Control and Prevention oppose the denial of care to HIV-positive individuals and instead recommend precautions that they say virtually eliminates the risk that the virus will be transmitted.

## Labor



**Worker woes:** A federal program designed to assist workers who lose their jobs because of imports isn't meeting the training and reemployment goals established by Congress, an audit by the Labor Department's inspector general has concluded. In reviewing the performance of nearly 1,200 participants in the trade adjustment assistance program, the inspector general found that fewer than 4 of every 10 found jobs that paid—or had the potential to pay—at least 80 per cent of their former wages. Despite the requirement that workers enroll in training programs as a condition of receiving benefit payments, the audit found that workers who didn't want to attend training sessions were almost always granted waivers. The law intended that such waivers be granted sparingly, the audit, which was released on Sept. 30, said. It also found that the Labor Department and the states managed the program without specific training or reemployment goals, and that states were not required to monitor the quality of training. The program was recently reauthorized through Sept. 30, 1998. The audit was published as the Clinton Administration struggles to develop a program to help workers who would be adversely affected by the North American Free Trade Agreement. The Labor Department recently

unveiled a proposal to create a comprehensive worker adjustment program for permanently laid-off workers, but it has not yet proposed the program to Congress because of problems in finding the money to pay for it.

## Legal Affairs



**Open sesame:** The Justice Department has revoked regulations for the Freedom of Information Act that were issued in 1981 by the Reagan Administration in favor of a new policy that endorses a "presumption of disclosure" when the Justice Department reviews another agency's decision on the release of government documents. In a statement issued on Oct. 4, President Clinton said that "federal departments and agencies should handle requests for information in a customer-friendly manner." Attorney General Janet Reno said in a government-wide memo that the Justice Department will defend an agency's assertion of a FOIA exemption "only in those cases where the agency reasonably foresees that disclosure would be harmful to an interest protected by that exemption." Pledging to reduce the backlog of existing FOIA requests, Reno also said that the Justice Department will review all pending FOIA cases as well as its own FOIA regulations. The Clinton Administration's proposals came just a day before a Justice Department official was to convene a closed-door meeting of 600 FOIA experts in the government. Associate attorney general Webster L. Hubbell, however, ordered that the meeting be open to the public. The Administration's new FOIA rules barely addressed the issue of the public's access

to government documents in electronic form, such as computer tapes. John D. Podesta, the White House's staff secretary and a FOIA expert, said that it's unclear whether legislation is needed to broaden the public's access to electronic data. Sen. Patrick J. Leahy, D-Vt., sponsored such a bill last year and is expected to introduce similar legislation soon.

## Lobbying



**Target marketing:** The National Rifle Association is stepping up its efforts to reach the large and lucrative women's market by running a series of multipage advertisements in magazines with large female readerships. A test campaign focusing on three cities—Houston, Miami and Washington—is under way in regional editions of such magazines as *Ladies Home Journal*, *People*, *Redbook* and *The Washingtonian*. A four-page ad, headlined "How to Choose to Refuse to Be a Victim," will be test-marketed for eight weeks; if the ad is successful, the NRA says that it will be rolled out nationwide. Although the campaign is supposed to educate women about self-defense and doesn't ask for contributions or urge handgun purchases, the ad includes a toll-free telephone number and suggests that women call for information about the NRA's "Crime-Strike" program, a grass-roots effort that the group says is intended to "restore tough justice in our criminal justice system." The ad features a photograph of a woman walking through a dark garage, holding her daughter's hand. By one estimate, the number of American women who own guns has risen from 12 million in the late 1980s to about 25 million today.



# ... BUT HEADING FOR SOME MINEFIELDS

Street—a few minutes with Big Bird—to be broadcast when the educational show for children kicks off its 25th year next month.

"I think she has become a symbol of health care in America," Skip Rutherford, an advertising executive in Little Rock, Ark., and a frequent White House adviser, said.

So far, her performance has been rousing received. Not only Members of Congress, who are used to an excess of manners, but even seasoned Washingtonians have gushed. "The most impressive testimony on a complex program anyone could remember," Adam Clymer, a veteran journalist at *The New York Times*, wrote about her five congressional appearances in a span of three days. Joseph W. Canzeri, a Washington operator who was an image-maker for President Reagan, declared, "She's on a roll."

And not for the first time. What she's doing in health care brings to the minds of Arkansans her role in 1983, when her husband pushed a package of educational reforms that became the centerpiece of his tenure as governor. She was put in charge of the commission that fashioned it and was central in selling it. In doing so, she wowed the legislators as well as the public. She had been a political liability to her husband, as a Yankee in a southern state who hadn't taken her husband's last

name and had borne some of the blame in his 1980 defeat for reelection. That changed for good in 1983. Never again was she so visible, but her standing with voters didn't fade.

Now, as the President's wife, she has taken pains to practice the old-fashioned part of a First Lady along with her untraditional one. "I'm very conscious of the social and hostess responsibilities," she told Donnie Radcliffe, the author of *Hillary Rodham Clinton: A First Lady for Our Time* (Warner Books, 1993). "But at the same time, I have the need to do something I feel is important."

So far, the public has approved of her tightrope act. A poll conducted for CNN and *USA Today* while she was presenting the health care plan to Congress put her popularity at 61 per cent, considerably higher than her husband's. She was deemed an ideal First Lady by nearly as many respondents as said that of Barbara Bush, who never held a job outside the home. In the survey, 78 per cent described her as a good role model for women, 71 per cent as warm and likable and 47 per cent—a plurality—as qualified to be President. A GOP pollster said that he considered her "a tremendous asset for the President," especially among women, including many Republicans.

But to remain a political asset will take tiptoeing through minefields. For one

thing, she may come under political assault in a way that no President's wife has. In taking such a prominent role in a hard-fought issue, "I think she's on very thin ice," Sheila Tate, who spent four years as Nancy Reagan's press secretary, said. "She's become a political target. . . . She'll have to take it as well as dish it out."

She faces other political hazards, too. Canzeri sees a potentially fatal risk for the President, if he starts to falter, in the two-fifths of Americans who say she is smarter than he is—twice as many, in the CNN-*USA Today* poll, as thought the reverse—and may start to wonder who's in charge of the country. She has been careful to avoid any suggestion that she is running things. (She sat demurely in the House balcony as her husband sketched his hopes for health care and refrained from joining him the next night on ABC's *Nightline*.) White House officials seem aware of the dangers of overexposure. "I'm not sure it's a problem yet" that Hillary Clinton is too far out in front, a White House official said, but "you can't rule it out" as a possibility.

She must also be sure to seem nice. "She is nice," Mark D. Gearan, the White House's communications director, said. But 46 per cent of the CNN-*USA Today* survey judged her too pushy. As a high-powered lawyer in Arkansas, she was said to be warm to her friends but not to secretaries in her law firm. Nor did she seem to enjoy the political shmoozing her husband revels in.

A President's kinship with the public, after all, is not only like a prime minister's but includes some of a king's. "It's a very personal relationship that people have with the President and the First Lady," Shepardson, the New York advertising man, said.

For Mrs. Clinton, this means there are lines that are politically hazardous to cross, though they are prone to shift as the cultural standards of politics evolve. She may be permitted, for instance, to strike at an opponent but only if she's been provoked.

The thoroughly modern woman who lives in the White House seems to be disciplined enough not to make many mistakes. But any slipups could hurt her husband. If her jab about Kevorkian had been a little nastier or had been hurled at someone more vulnerable, the smiles might have changed to clenched teeth. ■





November  
1993

LADIES' HOME

# Journal

SPECIAL 110th  
ANNIVERSARY ISSUE

## WHEN NOT TO LISTEN TO YOUR DOCTOR



**Prince  
Charming**  
JFK Jr.'s  
OWN STORY

## BEST OF OUR BEST RECIPES

From a century of great cooking

## SEX & THE MARRIED WOMAN

"HOW I PUT THE PASSION  
BACK IN OUR BED"



**ROSEANNE**

She talks about  
her face-lift and  
why she wants  
to be pretty

## 50 FOODS THAT PREVENT DISEASE



**SUSAN  
LUCCI**

opens her  
family album  
to you

**WISE UP** Don't be stung  
by repairman rip-offs



**EXCLUSIVE  
HILLARY'S  
HEARTFELT  
MESSAGE TO  
AMERICAN  
WOMEN**





# The fight for **WOMEN'S HEALTH**

NOT LONG AGO, the health-care needs of wives, mothers, daughters and sisters were exiled to the fringes of medical treatment and research, causing women to watch their illnesses and symptoms be discounted or ignored. Today, women and their special health concerns are finally coming into view. We are speaking up. We are being heard. We are making progress.

But the health of American women still needs improvement. Women have unique health problems, unique symptoms and unique responses to treatments. And as the primary caregivers for children and aging parents, women play a unique role in safeguarding the overall health of our society.

Now, as our nation struggles to resolve its health-care crisis, women must make their voices heard. We know better than most the rewards of good health—and we know better than most the costs of bad health. So it's up to us to create a new philosophy, a new mindset about health care in America.

Reforming our health-care system is important for all Americans, but especially for women. Why? Because women have never enjoyed the security they deserve when it comes to health care and have never fully benefited from the kind of care they need most.

Too many women—about six-

teen million—don't have any health insurance. Too many women suffer from ailments that have been overlooked for decades in the scientific community. Breast, cervical and ovarian cancer. Osteoporosis. Immunological illnesses such as lupus and multiple sclerosis. Certain forms of mental illness. Eating disorders. Endometriosis.

Even the most universal female experience—menopause—is barely understood today. As a result, women are bombarded with confusing and often conflicting messages about their own health at crucial moments in their lives.

A comprehensive survey of women's health released last summer showed that one third of all women did not receive basic preventive services, such as Pap smears, clinical breast exams or complete physicals, in the previous year. Among women over fifty, only 44 percent received a mammogram. Often the reason cited was expense or lack of insurance.

This study offered sad proof that women in the 1990s continue to be more vulnerable to serious illness when they reach old age—largely because they lack preventive care.

For decades, the common assumption was that women's health problems were the same as men's. Women live an average of eight years longer

(continued)

**During its 110-year history, the *Journal* has counted among its contributors a number of First Ladies, including Eleanor Roosevelt. For this special issue, we thought it only fitting that the most powerful First Lady of our time talk directly to *Journal* readers about one of the most urgent issues facing us as a nation.**

**By Hillary Rodham Clinton**







(continued) than men, so they must be healthier, right?

Not quite. American women have a biological edge in terms of life expectancy, but they don't have a medical edge when it comes to funding, research and treatment of the illnesses that afflict them most.

Too frequently, the so-called bonus years when women outlive men are not really bonuses at all, but instead are times when women suffer through needless ailments and insufficient care.

Even today, women reach old age with few hints about the health problems confronting them. Breast cancer is an obvious example. We don't know what causes it. We don't know how to cure it.

It's ironic that we have technology sophisticated enough to direct missiles to targets thousands of miles away, but we don't have technology sophisticated enough to detect every fatal lump in women's breasts.

Every three minutes a woman is diagnosed with breast cancer. Every twelve minutes a woman dies from it. More than 2.6 million women have the disease, and the chances of getting it are double what they were just thirty years ago.

Are environmental factors such as toxins, pollutants, diet and drugs responsible for the rise in breast-cancer rates? As with so many diseases that strike women, we don't really know the answers to these life-and-death questions.

Even with ominous breast-cancer statistics, treatment of the disease has not changed appreciably in thirty years. While new therapies are being explored today, most women continue to rely on surgery, radiation and chemotherapy for treatment. That costs more than \$6 billion a year in medical bills, lost productivity and unnecessary suffering.

Fortunately, we are making progress. A few years ago, a group of women scientists and grass-roots advocates alerted us to the inequities in funding for research of diseases that primarily afflict women.

Groups such as the Society for the Advancement of Women's Health Research showed us the shocking degree to which women were routinely excluded from major clinical trials of major illnesses.

We learned that even when women are victims of the same diseases as men, such as coronary heart disease and strokes, research has tended to focus on men.

Although hypertension is two to three times more common in women—and most prevalent in African-American women—drugs to treat it have largely been tested on men.

A major study on the relationship between cholesterol and heart disease involved fifteen thousand men—and no women.

And one of the most significant clinical trials of coronary disease in the 1980s failed to include a single woman among twenty-two thousand patients screened—even though heart

disease is the leading cause of death among women, followed by cancer and strokes.

This pattern is not only unfair to women, who comprise 51 percent of the population, it's economically unsound. Ignoring the health problems of women costs our nation far more than any investment we can make to prevent and control these diseases.

Look at the costs of osteoporosis, a painful ailment that often results in deformities and loss of mobility. Nearly 75 percent of women over sixty-five suffer from it. The disease causes 1.3 million bone fractures each year. And the annual medical bills associated with it total nearly \$10 billion.

If we knew more about osteoporosis and developed ways to prevent its onset, we could simultaneously enrich life for elderly women, reduce hospital visits and stays in nursing homes, and save billions of dollars a year. All of these benefits could result from targeting that one disease.

Slowly, we are developing a more realistic view of women's health. And the federal government's interest in promoting it is greater than ever before.

The President has signed the National Institutes of Health bill, which includes the newly created Office of Research on Women's Health as part of the statute. The NIH is also sponsoring a fourteen-year effort called the Women's Health Initiative that will explore long-term patterns of heart disease, cancer and osteoporosis in women. And the Congressional Caucus for Women's Issues is working on a Women's Health Equity Act and has organized task forces to study specific areas of women's health.

Improving women's health care should be elemental to improving our nation's health care overall and is part of the changes the President envisions in health-care reform.

The President's health-care plan offers a fresh start in tackling the problems women face. First and foremost, it encourages new approaches to prevention and primary care to help all Americans, particularly women and children.

We have no choice but to change our mind-set in this country and to focus more energy on preventive and primary care. We must offer a system that keeps people healthy, not a system that only treats patients once they're sick.

If we achieve health-care reform, women will enjoy a comprehensive benefits package that offers regular tests and screenings—like Pap smears, pelvic exams and mammograms. Prenatal care, immunizations and regular medical checkups will be available to all women. And there will be incentives for patients to get diagnostic tests that pinpoint problems early, rather than wait until an illness becomes acute.

Perhaps most important, the President's plan provides American women and their families with health security. Every American can be assured of

(continued on page 275)

**It's ironic that we have technology sophisticated enough to direct missiles to targets thousands of miles away, but we don't have technology sophisticated enough to detect every fatal lump in women's breasts.**

**MAKE YOUR VOICE HEARD** IF YOU WANT TO SHARE YOUR FEELINGS WITH MRS. CLINTON ABOUT HEALTH CARE FOR WOMEN, PLEASE CALL THE WHITE HOUSE COMMENT LINE AT 202-456-1111. THIS IS A TOLL CALL.



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They're a colorful way to make all your baking really special...

## The fight for women's health

*continued from page 206*

health coverage—regardless of income or geographic location or whether someone is already sick or not.

Security also means retaining the right to choose your doctor. And it means having a doctor-patient relationship that encourages personal interaction, not abbreviated office visits and batteries of unnecessary tests.

With reform, we will keep the best parts of our system—our extraordinary hospitals, our fine doctors and nurses, and our sophisticated technology. But we will also address weaknesses that undermine those same hospitals, doctors and nurses and make the use of our technology prohibitively expensive.

Above all, we must control costs and streamline the system. Instead of spending hours upon hours filling out forms and paperwork, health-care professionals must be allowed to focus more energy on caring for the whole person. Instead of rewarding doctors for performing unnecessary tests, there must be incentives that restore common sense and sound clinical judgment to the practice of medicine.

Of course, prevention is the best way to lessen the huge personal, social and economic tolls exacted by poor health. With that in mind, we will continue to strengthen the government's commitment to research so that we stamp out diseases like breast cancer once and for all.

Already, the administration has targeted more money for research on prevention, treatment and general health promotion. For women's health alone, the budget will increase for breast and cervical cancer screening, education, quality standards for mammography, and other programs.

And the President is determined to promote women's health research even further, particularly in areas such as chronic and recurrent illnesses, pediatric health, mental

health and substance abuse, infectious diseases, behavioral science and the environment.

To be sure, our goals are enormous. They must be, because we find ourselves at a critical moment in our history when we cannot afford to maintain the status quo. Failure to get control of spiraling costs and failure to shift our priorities will be catastrophic for the next generation of Americans.

Yet the government's efforts alone will not be enough. No matter how we reform the system, no matter what cures and treatments scientists discover in the coming years, we must all be more responsible for our own good health.

As women, particularly, we must take better care of ourselves. And that's not always easy when you're working hard, looking after children, tending to aging parents and trying to keep a household functioning.

We can begin to make our own health better by improving our diets, exercising regularly, quitting smoking, examining our breasts each month and getting regular medical checkups. We can take advantage of the technology that does exist, such as mammography screening. We can change our behavior.

As Hippocrates wrote more than two thousand years ago: "The patient must combat the disease along with the physician."

This is important because, to me, health-care reform is not just about reducing bureaucratic hassles, not just about balancing the number of specialists and primary-care physicians, not just about curbing the number of unnecessary surgeries performed each year.

Health-care reform is really about our own vision of what it means to be healthy as individuals and healthy as a society.

So, please, for your sake and for the sake of your families, be vigilant about your health needs.

Remember that women can make a difference. And women will make a difference if we join together and show a new spirit of responsibility and commitment. ■



So open your hand and smile.

### Fun Cookies™

- 2 cups all purpose flour
- 3/4 tsp baking soda
- 3/4 tsp salt
- 1 cup (8oz) softened butter or shortening
- 2/3 cup granulated sugar
- 1/2 cup firmly packed brown sugar
- 1 egg
- 1 tsp vanilla extract
- 12 oz package (1-3/4 cups) "M&M's"™ Semi-Sweet Chocolate Candies
- 3/4 cup chopped nuts (optional)
- Preheat oven to 375°F. Combine flour, baking soda and salt; set aside. Cream together butter or shortening and

sugars until light and fluffy; beat in egg and vanilla. Blend in flour mixture slowly. Stir in "M&M's"™ Semi-Sweet Chocolate Candies and nuts. Drop heaping teaspoonfuls onto an ungreased cookie sheet. Bake 8-11 minutes until browned. Cool 1 minute on cookie sheet; place on wire cooling racks. Makes about 5 dozen 2-inch cookies.



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**The debate over the screening tests is fiercer than ever. And the age group that stands to benefit the most isn't getting the message.**

**By Jeanmarie Marshall**

## WHO NEEDS A MAMMOGRAM?

**I**n all the controversy surrounding mammography and breast cancer, one fact is unassailable: More than 75 percent of breast-cancer cases occur in women older than 50, who have the most to gain from regular screening mammograms. Unfortunately, many of these women aren't getting them: According to a recent poll, only half have had one or more mammograms. And a recent study funded by the American Cancer Society revealed that many older women don't think they need the test. "We're not getting the message across that mammography is a good tool for them," says Susan Love, director of the UCLA Breast Center.

Part of the problem is that the models in ads touting mammograms have been conspicuously youthful. "Breast cancer becomes more common the older you are," says Love, "but you'd never know it from the way the disease is depicted in the media, including the public service ads." This month the American Cancer Society is co-sponsoring the first-ever public service campaign that encourages women older than 60 to get mammograms; actress Anne Bancroft will provide the voice-over for the TV and radio spots.

The ACS and the National Cancer Institute recommend that women have mammograms every one to two years between ages 40 and 49, and every year after age 50. (They also recommend annual clinical exams and monthly self-exams.) But the recommendation for younger women is under increasing attack. Susan Love points out that "there's no good randomized data to show mammograms are useful as screening tests in women under fifty." The American College of Surgeons was asked to endorse the ACS's guidelines but declined. So did the American College of Physicians. Cindy Pearson, spokesperson for the National Women's Health Network, a Washington advocacy group, supports their decisions. "Painful as it is," she says, "given the enormous need for detection of breast cancer in younger women, we do not recommend mammography screening before fifty or before menopause." Both Pearson and Love suggest that younger women use mammography only to evaluate suspicious lumps.

Even the NCI's support may be wavering. Last February it held a two-day meeting in Washington, D.C., issuing a statement noting that studies of mammography in women aged 40 to 49 "have not been conclusive." According to an agency spokesperson, the NCI is reviewing its screening guidelines for women under 50.



There is some evidence that screening mammograms don't reduce mortality rates in younger women. Researchers speculate that this is because certain breast cancers tend to be especially aggressive in premenopausal women, and early detection through mammography may not do any good. In addition, younger women tend to have dense, fibrous breasts, which may lead to many false negatives—as well as false positives. Studies have shown that mammography misses as many as half of all breast cancers in younger women.

**S**till, the ACS stands behind its recommendation of mammograms for women in their 40s. "There is no good research that says this is not a good thing to do," says ACS spokesperson Joanne Schellenbach. The ACS bases its mammography recommendation for younger women on its Health Insurance Plan study done in New York during the 1960s and 1970s, which showed a marginal benefit from screenings for women younger than 50. The 1992 Canadian National Breast Screening Study, however, found no evidence that women under 50 benefit from regular screening mammograms. Three other studies performed in Sweden, and one in Edinburgh, Scotland, since the HIP study do not greatly conflict with the Canadian research. (Great Britain, Canada, and Sweden, in fact, do not recommend mammography for younger women.)

All of these studies, however, have been criticized. Schellenbach points out, for example, that in the Canadian research "the mammography equipment was not state-of-the-art, there was only ▶ 56



# HEALTH

one view taken instead of two, and the studies were not adequately designed to test the hypothesis." On the other hand, in the earlier HIP study, the women who did benefit from mammograms were closer to 50 than 40 at the start of the study. Further, most of the lumps were found in women who were older than 50.

Some insiders wonder whether the profit motive contributes to the push to enlist women younger than 50 for regular mammograms. "One factor is the natural desire to find some intervention that truly reduces the suffering and death from breast cancer," says David M. Eddy, professor of health policy and management at Duke University. "It is also undeniable, however, that some parties in this debate have a strong financial incentive to do mammography. I prefer to think this is not a very strong motivating factor."

Baby boomers, many of them now in their 40s, are exceptionally health-conscious and attuned to the idea of preventive medicine. They make a good target for a mammography campaign, which

may help to explain why the TV ads paid for by General Electric, Du Pont, and Eastman Kodak—all manufacturers of mammography equipment—have featured younger women. In fact, nearly 40 percent of women younger than 50 have had at least one mammogram. And if all women in the United States aged 40 to 49 followed the American Cancer Society guidelines, the mammography industry would gross close to \$1 billion per year.

Meanwhile, many younger women are tempted to get a screening mammogram despite the questions. Aside from cost, they figure that there's little downside: With the new low-dose machines, the risk of side effects from radiation exposure is minimal. "The jury is still out on this issue," says Sharon Green, executive director of Y-Me, a national breast-cancer support organization. "But there's still a segment of women in their 40s whose breast cancer *will* get picked up by mammography. Although mammography is not a perfect tool, it's the best tool we have right now." ●

## BRIEF SUMMARY OF PRESCRIBING INFORMATION FOR THE PATIENT

### PREMARIN® Brand of conjugated estrogens tablets, USP

This Summary describes when and how to use estrogens and the risks of estrogen treatment.

#### ESTROGEN DRUGS

Estrogens have several important uses but also some risks. You must decide, with your doctor, whether the risks of estrogens are acceptable in view of their benefits. If you decide to start taking estrogens, check with your doctor to make sure you are using the lowest possible effective dose. The length of treatment with estrogens will depend upon the reason for use. This should also be discussed with your doctor.

#### USES OF ESTROGEN

To reduce menopausal symptoms: Estrogens are hormones produced by the ovaries. The decrease in the amount of estrogen that occurs in all women, usually between ages 45 and 55, causes the menopause. Sometimes the ovaries are removed by an operation, causing "surgical menopause." When the amount of estrogen begins to decrease, some women develop very uncomfortable symptoms, such as feelings of warmth in the face, neck, and chest or sudden intense episodes of heat and sweating ("hot flashes"). The use of drugs containing estrogens can help the body adjust to lower estrogen levels.

Most women have none or only mild menopausal symptoms and do not need estrogens. Other women may need estrogens for a few months while their bodies adjust to lower estrogen levels. The majority of women do not need estrogen replacement for longer than six months for these symptoms.

To prevent brittle bones: After age 40, and especially after menopause, some women develop osteoporosis. This is a thinning of the bones that makes them weaker and more likely to break, often leading to fractures of vertebrae, hip, and wrist bones. Taking estrogens after the menopause slows down bone loss and may prevent bones from breaking. Eating foods that are high in calcium (such as milk products) or taking calcium supplements (1,000 to 1,500 milligrams per day) and certain types of exercise may also help prevent osteoporosis.

Since estrogen use is associated with some risk, its use in the prevention of osteoporosis should be confined to women who appear to be susceptible to this condition. The following characteristics are often present in women who are likely to develop osteoporosis: white race, thinness, and cigarette smoking.

Women who had their menopause by the surgical removal of their ovaries at a relatively young age are good candidates for estrogen replacement therapy to prevent osteoporosis.

To treat certain types of abnormal uterine bleeding due to hormonal imbalance.

To treat atrophic vaginitis (itching, burning, dryness in or around the vagina).

To treat certain cancers.

#### WHEN ESTROGENS SHOULD NOT BE USED

Estrogens should not be used:

During pregnancy: Although the possibility is fairly small, there is a greater risk of having a child born with a birth defect if you take estrogens during pregnancy. A male child may have an increased risk of developing abnormalities of the urinary system and sex organs. A female child may have an increased risk of developing cancer of the vagina or cervix in her teens or twenties. Estrogen is not effective in preventing miscarriage (abortion).

If you are breast feeding: Many drugs are excreted in human milk and can be passed on to your baby. Therefore, estrogen therapy should be used only when your doctor decides it is clearly necessary.

If you have had any heart or circulation problems: Estrogen therapy should be used only after consultation with your physician and only in recommended doses. Patients with a tendency for abnormal blood clotting should avoid estrogen use. This includes patients who currently have clots in the leg (thrombophlebitis), or any other part of the body (thromboembolic disorder). (See below.)

If you have had undiagnosed vaginal bleeding: If you have ever had abnormal bleeding from the vagina, estrogens should not be used unless you have talked to your physician about this problem.

If you have had cancer: Since estrogens increase the risk of certain cancers, you should not take estrogens if you have ever had cancer of the breast or uterus. In certain situations, your doctor may choose to use estrogen in the treatment of breast cancer.

When they are ineffective: Sometimes women experience nervous symptoms or depression during menopause. There is no evidence that estrogens are effective for such symptoms. You may have heard that taking estrogens for long periods (years) after menopause will keep your skin soft and supple and keep you feeling young. There is no evidence that this is so and such long-term treatment may carry serious risks.

#### DANGERS OF ESTROGENS

Cancer of the uterus: The risk of cancer of the uterus increases the longer estrogens are used and when larger doses are taken. One study showed that when estrogens are discontinued, this increased risk of cancer seems to fall off quickly. In another study, the persistence of risk was demonstrated for 10 years after stopping estrogen treatment. Because of this risk, it is important to take the lowest effective dose of estrogen and to take it only as long as you need it. There is a higher risk of cancer of the uterus if you are overweight, diabetic, or have high blood pressure.

If you have had your uterus removed (total hysterectomy), there is no danger of developing cancer of the uterus. If you have your uterus, please refer to the section titled "OTHER INFORMATION."

Cancer of the breast: The majority of studies have shown no association with the usual doses used for estrogen replacement therapy and breast cancer. Some studies have suggested a possible increased incidence of breast cancer in those women taking estrogens for prolonged periods of time and especially if higher doses are used.

Regular breast examinations by a health professional and self-examination are recommended for women receiving estrogen therapy, as they are for all women.

Gallbladder disease: Women who use estrogens after menopause are more likely to develop gallbladder disease needing surgery than women who do not use estrogens.

Abnormal blood clotting: Taking estrogens may increase the risk of blood clots. These clots can cause a stroke, heart attack or pulmonary embolism, any of which may be fatal.

Heart disease: Large doses of estrogen in men have been shown to increase the risk of certain heart diseases. This may not necessarily be true in women. In order to avoid the theoretical risk of high doses, the dose of estrogen you take should not exceed the dose recommended by your doctor.

Excess calcium in the blood: Taking estrogens may lead to severe hypercalcemia in women with breast and/or bone cancer.

#### SIDE EFFECTS

In addition to the risks listed above, the following side effects have been reported with estrogen use:

- Nausea, vomiting, pain, cramps, swelling, or tenderness in the abdomen
- Yellowing of the skin and/or whites of the eyes
- Breast tenderness or enlargement
- Enlargement of benign tumors of the uterus
- Breakthrough bleeding or spotting
- Change in amount of cervical secretion
- Vaginal yeast infections
- Retention of excess fluid. This may make some conditions worsen, such as asthma, epilepsy, migraine, heart disease, or kidney disease.
- A spotty darkening of the skin, particularly on the face; reddening of the skin; skin rashes
- Worsening of porphyria
- Headache, migraines, dizziness, faintness, or changes in vision (including intolerance to contact lenses)
- Mental depression
- Involuntary muscle spasms
- Hair loss or abnormal hairness
- Increase or decrease in weight
- Changes in sex drive
- Possible changes in blood sugar.

#### REDUCING RISK OF ESTROGEN USE

If you decide to take estrogens, you can reduce your risks by carefully monitoring your treatment.

See your doctor regularly: While you are taking estrogens, it is important that you visit your doctor at least once a year for a physical examination. Special attention should be given to blood pressure, breasts, abdomen, and pelvic organs. A Pap smear should be taken and tested at this visit. If members of your family have had breast cancer or if you have ever had breast nodules or an abnormal mammogram (breast x-ray), you may need to have more frequent breast examinations. Also be sure to let your doctor know if you have ever had liver or kidney disease, as this may affect the decision to use estrogen.

Reevaluate your need for estrogens: You and your doctor should reevaluate your need for estrogens at least every six months.

Be alert for signs of trouble: Report these or any other unusual side effects to your doctor immediately.

- Abnormal bleeding from the vagina
- Pains in the calves or chest, a sudden shortness of breath or coughing blood indicating possible clots in the legs, heart, or lungs
- Severe headache, dizziness, faintness, or changes in vision, indicating possible clots in the brain or eye
- Breast lumps
- Yellowing of the skin and/or whites of the eyes
- Pain, swelling, or tenderness in the abdomen

#### OTHER INFORMATION

Some physicians may choose to prescribe another hormonal drug to be used in association with estrogen treatment for women with a uterus. These drugs, progestins, have been reported to lower the frequency of occurrence of a possible precancerous condition of the uterine lining. Whether this will provide protection from uterine cancer has not been clearly established. There are possible additional risks that may be associated with the inclusion of a progestin in estrogen treatment. The possible risks include unfavorable effects on blood fats and sugars. The choice of progestin and its dosage may be important in minimizing these effects.

Your doctor has prescribed this drug for you and you alone. Do not give the drug to anyone else. If you will be taking calcium supplements as part of the treatment to help prevent osteoporosis, check with your doctor about the amounts recommended.

Keep this and all drugs out of the reach of children. In case of overdose, call your doctor, hospital, or poison control center immediately.

This Summary provides the most important information about estrogens. If you want to read more, ask your doctor or pharmacist to let you read the professional labeling.

This Brief Summary for Direct-to-Consumer Advertising is based on the current Premarin Tablets insert, P-4060-1, issued June 6, 1990 with the incorporation, in lay language, of pertinent text from the Physician insert, CI 4079-1, issued May 23, 1991.

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IN AUGUST 1987, AMERICAN BAR ASSOCIATION PRESIDENT ROBERT MacCrate embarked on a mission he knew would make many fellow lawyers hot under their buttoned-down collars. After years of denial, the very male, very stuffy ABA was taking on the painful subject of sexism in the legal profession—in law firms, classrooms, courtrooms, and, ultimately, in the law itself. The dozen or so members of the new Commission on Women in the Profession ran the ideological gamut from Southern conservative to ardent feminist. Now MacCrate needed a chair who could bring them together and push them hard, yet be on the same professional wavelength as all the swaggering male egotists who didn't want to hear how mean they were.

So he placed a call to the genteel Rose law firm in Little Rock, Arkansas, where Hillary Rodham Clinton was a ninety-thousand-dollar-plus-a-year senior partner specializing in commercial litigation. But the woman who a few years later would redefine the role of the American political spouse and, in the process, be branded a left-wing radical by some, a feminist heroine by others, surprised him. She said no.

"Her initial response was that this was not the kind of thing she had been doing," MacCrate says. "I think she was reluctant to become a feminist activist." Commission member Lynn Hecht Shafran, attorney for the National Organization for Women Legal Defense Fund, recalls, "She said she didn't want to take on the position because she didn't see what the problems were. She had managed to make her own way, and she was expecting [most of the complaints to come from] women who hadn't been very successful and had a few sour-grape stories."

Sexual harassment and the glass ceiling were not barriers the first lady of Arkansas had encountered in her workplace. Nor was the one-time Goldwater Girl comfortable in the victim mode—her style was too sensible. Besides, deep in her well-educated, upper-middle-class, Methodist soul, she knew she was too fortunate to feel sorry for herself or people like her. Clinton was more interested in being a role model for overachievement. "Which was exactly why I wanted her," MacCrate says. "I tried to relate it to how significant it could be to other women to permit them to do what she had done. Finally, she succumbed."

Much has been made of the enigma that is Hillary Rodham Clinton and of the significance of a first lady who doubles as a powerful policymaker. But for all the talk about what Hillary's role *means*, few have looked closely at what Hillary has actually *done* during her career. Her five years chairing the ABA panel have been largely overlooked, as have several other pivotal assignments. Examined closely, this work history offers a

# It's her

revealing glimpse into the essential Hillary. Since the transformation of the \$900 billion health-care industry has been entrusted to her care, that record is well worth pondering.

**The ABA Case.** "Lawyers are problem solvers," says Nancy Bekavac, a friend from Yale who is now president of Scripps College. "You pay attention to the procedure before even getting to the merits: What kind of evidence do we need? What is the range of responsibilities? What are the liabilities? What's the precedent?" At the ABA, Hillary quickly saw that success with a bunch of lawyers lay in treating gender bias less as a cause than as a case, with demonstrations, citations, and proofs.

Years of heading up committees had taught her how to coax people into getting along. "She could see what five or six people who thought they disagreed with each other really had in common," recalls member Jamienne Studley. Says Executive Director Elaine Weiss, "A good leader lets the men feel comfortable enough to say, 'Maybe I'm a racist, sexist pig, but I disagree with that.'" Through it all she was funny and down-to-earth. One result: "I

OTHER  
WOMEN BUMP  
UP AGAINST  
THE GLASS  
CEILING AT  
WORK.  
HILLARY DID  
SO IN A FAR  
HARDER  
PLACE—  
HER MARRIAGE

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# MOTHER JONES

CLINTON'S COMPROMISES

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OF HATE

In

Susan Faludi,  
Nicole Hollander,  
and others join  
the bristling  
women's studies  
debate

Why did Al Gore  
back down on the  
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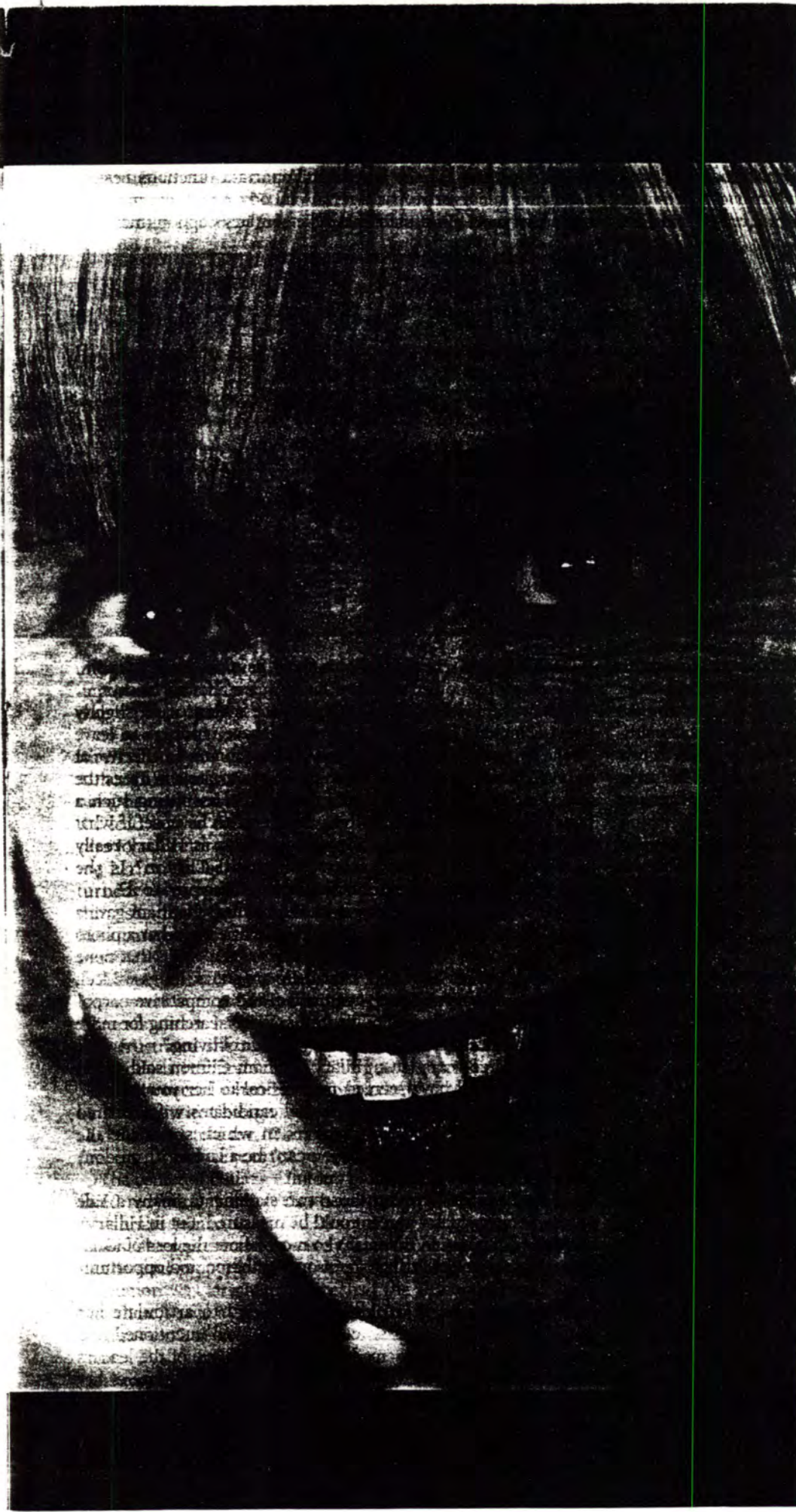
The first  
Clintonite  
muzzled

# HILLARY'S GLASS CEILING

What she muzzles the country, the question remains:  
**WHAT CAN AND CAN'T SHE DO?**







think the commission members will be friends for life," Weiss says.

The panel's first report was a one-page resolution asking members to condemn gender bias in the profession at large, attached to a skimpy-looking document that summed up the problem in language meant to educate, not blame. It passed unanimously. All the while, Hillary Clinton was on the stump, declaring that gender bias was bad for men and business as well as for women.

"She didn't come at it with the attitude of 'I'm a feminist,'" says Weiss. "Her approach was, 'I'm a lawyer like everyone else, and let me tell you what women lawyers are experiencing.' She is far from a knee-jerk liberal. Her style and her strategy work because she represents the mainstream viewpoint."

"I regard her as making an epic change in the position of women in the ABA and therefore in the larger profession," MacCrate says. Yet, when examined closely, Clinton's tangible accomplishments amounted to little more than a few reports and manuals and a lot of speeches—a good deal less than we will expect of the architect of health-care reform. Her main

...may be that the only way to  
...the president to his promise  
...the constitution no  
...power. Already the limi  
...created by a statutory  
...have been...  
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...the...  
...Bill (Delaney, page 39)  
...and... ("Where are you  
...page 41), and the White  
...Washington ("Tough  
...page 50). Stephen  
...Pizzo comments on Bill's prob  
...with a blind Justice Depart  
...on page 42.



strength was communicating why the status quo had to change, and making her listeners believe that change was possible—beginning a process that made it inevitable. She embodied that future; she was her own most eloquent message.

**What He Sees Is What We Get.** The look in Bill Clinton's eyes at this briefing just five days into his term is not an expression we have ever seen on the face of an American president speaking about his wife. His matter-of-fact mixture of pride and

drug costs, or limiting medical-malpractice claims. He seems to praise Hillary's accomplishments, but closer analysis shows he's really praising her skill at the *process* of accomplishing—the way she can break down big issues and problems into manageable chunks and persuade people by making them feel included.

Bill suggests that she has other important functions besides achieving a legislative package: to embody a political message, and to serve as his human flak jacket. Hillary's appointment is a

# HILLARY

HILLARY, THE PROGRESSIVE

BUT IS HILLARY THE  
REDESIGNING OUR  
HEALTH-CARE SYSTEM?



confidence is all the more striking when we consider how much he seems unsure of already—later today, he has meetings about gays in the military and a replacement for Zoë Baird. But now he's explaining why he has decided to put Hillary in charge of health-care reform. "She's better at organizing and leading people from a complex beginning to a certain end than anybody I've ever worked with in my life," he says. Meanwhile, aides are handing out decade-old clippings about her work accomplishments.

Hillary, wrapped in a heavy wool cardigan one might save for doing the laundry, slouches at the long table in the Roosevelt Room of the White House along with the other members of the new task force. She listens alertly but with a studied coolness, sometimes whispering to her neighbor, hardly acknowledging her husband's praise. Although she resents how much notice is paid to her hair, some will think it significant that her black headband (banned during the campaign as too yuppie or harsh) is defiantly in place again. After months of tea-and-cookie apologies, of aides playing down "Elect one, get one free," the headband seems to announce that the old Hillary—the take-charge, glutton-for-punishment policymaker—is back. As if anyone had really doubted she would be.

"I think that in the coming months," Bill says, "the American people will learn, as the people of our state did, that we have a first lady of many talents, but who most of all can bring people together around complex and difficult issues to hammer out consensus and get things done."

The president's words go down smoothly, yet they present a curious set of contradictions. On the one hand, he invites reporters to look at his wife's professional record more closely. On the other, he waves them away, flourishing one of his favorite rhetorical devices, the vague specific. He does not want anyone making the awkward but entirely appropriate observation that establishing a neonatal unit or organizing a conference is hardly equivalent to instituting managed competition, slashing

signal to the American public of "how passionately I am committed to doing something about health-care reform," he says.

Meanwhile, Hillary sits there, her face majestic and slightly peeved, looking like she just wants all these reporters to leave so she can get to work. Does the woman who was so effective at the ABA have her own compelling message to project? Does the fact that she is doing something radical in assuming such a powerful job mean that we aren't supposed to be upset if what she accomplishes is far from sweeping? Who is Hillary really working for—the American people or Bill Clinton? Is she redefining the role of the political wife, or falling prey to it?

**The Glass-Ceiling Marriage.** In 1969 Hillary Rodham gave a speech at her graduation from Wellesley that earned her a photo in *Life* magazine. "We are, all of us, exploring a world that none of us understands," she said. "But there are some things we feel, feelings that our prevailing, acquisitive, and competitive corporate life . . . is not the way of life for us. We're searching for more immediate, ecstatic, and penetrating modes of living."

Twenty-three years later, Hillary Rodham Clinton said something that would have seemed nonsensical to her younger self. "For goodness sakes," the presidential candidate's wife declared in the same session with reporters in which she made the famous cookies-and-tea gaffe, "you can't be a lawyer if you don't represent banks."

In the distance between those two statements, many a Yale Law School graduate's career could be measured. But in Hillary's case, the gap between them isn't so much about the loss of idealism as about the thwarting of personal ambition and opportunities for achievement.

The twenty-one year old who struggled to articulate her yearnings was so smart, so confident, so well-intentioned and -credentialed that she seemed destined to be one of the leaders of her generation. "She had a very bright political future of her own," a Yale Law School classmate says wistfully. But the mature



woman who tried to answer questions about her work last spring was *married* to one of the leaders of her generation.

Other women bump up against the glass ceiling at work: Hillary Clinton did so in a far more difficult place—her marriage. It wasn't just a question of following Bill Clinton to Arkansas when she could have gone to Washington or New York. Starting from 1976, a year after their marriage, when he was elected attorney general, her choices about work became

worked most closely with men. Some were threatened, but many others were smitten, in awe of how she pulled together all the elements of her life with determination and efficiency, but also with humor and grace. Several judges are said to have adored her. "She doesn't defer to men," says Rudy Moore, a lawyer and judge in Fayetteville who was Bill Clinton's 1978 campaign manager and first-term chief of staff. "She engages them on their own level. She's very gracious, but it's not an obvious type of charm.



more and more limited by the realities of being married to an important politician in a small, conservative state. She couldn't take a public-interest job lest she come into conflict with him. Even as a private attorney, she had to be careful about conflict of interest and about getting involved in controversial cases. Although she was an excellent trial lawyer with a zest for winning, her political schedule meant that only rarely could she be the lead lawyer on a complicated case. "She was hamstrung," says John Brummett, an Arkansas columnist who's been watching her career for more than a decade. "Almost every way she turned, there was something that kept her from doing everything she might do." Her earnings were limited, too: while some Rose partners earned up to \$300,000 a year, she usually fell in the \$70,000 to \$100,000 range.

Studying her résumé, one is struck by how her career resembles a patchwork stitched from the remnants left to her once Bill Clinton's career had been cut out. The pattern gives a hint of how frustrated she must have been at times, but also shows a tremendous resourcefulness. The guiding principle, as Elaine Weiss discovered when her husband decided to run for office as an alderman in Chicago, was a kind of emotional self-preservation: "Hillary told me, 'Don't ever lose your own identity in this process. Don't lose yourself to your husband's career.'"

The center of Hillary Clinton's professional life was the poker-faced red-brick building that housed the prestigious Rose firm, which she joined in 1977. Despite her later comment about banks, she represented relatively few of them; her specialty was intellectual-property law—trademark infringements, etc. Her reputation was formidable. "She had the best judgment of anyone there," says a former partner, Carol Arnold. She had "the jugular-vein instinct," says Little Rock attorney William Wilson, "not . . . vicious, but . . . going to the essence."

Throughout her career, Clinton formed many friendships with women, but in the courtroom, in business, and in politics, she

She uses her analytical skills."

"I don't think women see it. Men do," says Sid Johnson, past president of the Arkansas Education Association. "I'm trying not to use the word 'sexy.' She's not a sex bomb, but she's a very attractive person to many men. She has a sparkle, but she's not flirtatious. When she walks along, she almost has a regal bearing about her, much more royal than Princess Diana."

For all this admiration and power, her Rose firm work was not enough to satisfy her yearning to do good. She founded several nonprofit organizations, such as Arkansas Advocates for Children and Families, and joined innumerable boards and task forces. She continued her close relationship, begun at Yale, with the Children's Defense Fund. Jimmy Carter appointed her to the board of the Legal Services Corporation in 1977, and she soon became the first woman elected its chair. But these organizations, too, satisfied only pieces of her ambition, perhaps because they were essentially bureaucracies whose paths had largely been determined by other people.

In 1983, when Bill Clinton appointed Hillary as head of his committee to establish educational standards for Arkansas, she found her mission. The period preceding her appointment had been the most turbulent of their marriage. In addition to Bill's 1980 election defeat, rumors about his affairs had begun to circulate widely. One of the most difficult parts for Hillary "was to have made all those sacrifices for him and then to be blamed for his defeat," John Brummett says. Still, she did what she had to do to help him get reelected—plotted strategy, took his last name, took a leave of absence from the firm. Voters responded well, and by 1983 they were ready to accept Hillary in a policy role.

**The Arkansas School Case.** It was hard to spend much time in Arkansas and not notice its abysmal school system and the low

**HILLARY (left to right):**  
at Wellesley her senior  
year; addressing the  
American Bar Association,  
August 9, 1992; in  
Japan this summer;  
with Chelsea in 1984.



expectations that were both a prime cause and a convenient excuse. The state was poor and vociferously antitax; because businesses had so much clout, the industrial tax base was meager, and funds were spread thin—even the dinkiest town had its own school district, 371 in all. The dropout rate was high; teachers' salaries, a rock-bottom fifteen thousand dollars a year.

The education package is probably the closest parallel to health-care reform in Hillary's portfolio, and therefore deserves special scrutiny. The elaborate strategy the Clintons devised was the very essence of what Brummett calls their "mainstream pragmatic progressivism." In trying to appeal to the middle class, they treated education like a consumer product. Improvement would mean taxes on businesses and middle-class voters,

and educational standards would be pitched as a way of giving them something for their money. Consolidating districts was probably the key to real reform, but it was politically impossible; forcing districts to meet standards, such as offering advanced math, science, foreign languages, and kindergarten, was a backdoor means of encouraging the poorest ones to merge voluntarily.

Once this strategy was worked out, Hillary's job

was twofold: As chair of the committee, she would hammer out a consensus about what the educational standards should be. And in public, she was to do much the same thing with the Arkansas people, to communicate and to listen, to radiate purpose.

Hillary threw herself into this work in a way she had done with nothing else in her career. The commission held hearings in every one of the state's seventy-five counties, where hundreds of people would show up at school gymnasiums to ask questions or air complaints for five or six hours at a stretch. "Unlike Bill Clinton, she is direct," says Paul Root, Bill's former high school history teacher, now chair of the education department at Ouachita Baptist University. "She will tell you exactly what she thinks at any time on any subject. People really responded to that."

But her performance was not flawless. One person who was not charmed was the Arkansas Education Association's executive director at the time, Kai Erickson, who got into a battle with Hillary—about a one-time teacher test—that nearly overshadowed the whole reform movement and soured relations with teachers, perhaps unnecessarily, for years. "It appeared she pretty much had in mind what she planned to do," Erickson says. "She was a little brusque. I thought the issues and the challenges would cause one who was not an expert to be more tentative than she was." Even the effusive Sid Johnson, of the Arkansas Education Association, was flabbergasted when Hillary announced that there would be teacher testing even though it had not been one of the commission's recommendations. ("She snookered us good," he says. "Bob Dole better watch out—she'll snooker him too if she can.") Erickson says she made teachers, who had done more than any other group to press for reform, into the movement's scapegoats: "I was feeling the same as I suppose the doctors do now."

In the end, the campaign was only a partial success. Hillary fulfilled her role—including a bravura legislature appearance that led one redneck lawmaker to declare that voters had elected the wrong Clinton—but the teacher-testing issue, which was viewed as a bone to businesses and parents to give them accountability in return for a tax hike, did not stop businesses from lobbying lawmakers. As a result, individuals bore the entire brunt of the costs through a regressive one-cent rise in the sales tax.

More significantly, the money hasn't bought many measurable improvements. Schools in Arkansas are better than they would have been, but only in a state like Arkansas would such a minor package—improved curriculum, student testing, higher salaries—be labeled "reform." While it's true that SAT scores are up, only the top 6 percent of Arkansas students take the test, and other indicators haven't changed since 1972. According to 1991–1992 statistics, spending per capita on public schools has risen from fiftieth to forty-eighth in the nation, but the state has slipped from fortieth to forty-first place in spending per capita at colleges.

Blant Hurt, a conservative columnist for the *Arkansas Business Journal*, is among the disappointed: "My problem with Hillary has been that she has this [reputation] of being a reformer . . . and that is a real stretch. I don't think people are looking at the facts—it's rhetoric. She's a good speaker. She's very smart. People want to believe she's going to fix health care. But they're going to be sorely disappointed, because there's not a salient fact that shows a thing has been accomplished [in Arkansas]."

Former Clinton education aide Don Ernst, who has since gone to work for school reform at the national level, acknowledges these limits, but adds, "Hillary used this as an opportunity to engage the people of Arkansas for the first time in a real conversation about education. To me, that was the most significant accomplishment."

**The Child-Welfare Case.** In 1991 a handful of Arkansas legal-aid groups filed a lawsuit against Bill Clinton over an issue that Hillary had made one of the focal points of her nonprofit work, child welfare. While she was going around the country talking about the need to improve the lives of poor children, "basically, the state's child-welfare system was an abysmal failure," says John Brummett.

According to William Grimm, a lawyer for the National Center for Youth Law, which coordinated the suit, organizations had been complaining to Governor Clinton for years about the neglect of abused children and the lax oversight of foster-care providers. But Bill (and Hillary) kept concentrating on more politically popular problems like education. Among the groups finally joining the battle were Arkansas Advocates for Children and Families and Ozark Legal Services, both of which Hillary had helped establish. "There were many ironies here," Grimm notes wryly.

What finally got the Clintons' attention was the upcoming election—a settlement was reached five days after the New Hampshire primary. ("I wish all the people I sued were running for president," Grimm jokes.) But in June, after the issue was safely out of the public eye, the governor's office decided to appeal the consent decree, arguing that what it had agreed to do was tougher than federal law requires. The appeal was sent back to the lower courts on a technicality.

The lawsuit highlights how fundamentally middle-class Hillary's best-known work has been, whether on education or at the ABA. And it shows how her involvement

**RAISED A REPUBLICAN, HILLARY HAS ALWAYS BEEN MUCH MORE MODERATE THAN PEOPLE ON EITHER THE LEFT OR THE RIGHT HAVE WANTED TO ADMIT.**

**HILLARY concludes  
on page 43**



in issues of poverty, such as child welfare or legal aid, have been driven largely by her own needs to be a leader. Hillary has always been more moderate than people on either the left or the right have wanted to admit. She was, after all, raised as a Republican. And although the Vietnam War provoked a change in her politics, as it did for many in her generation, it had little effect on her core values, which remain traditional, if not conservative.

The child-welfare lawsuit also shows the limits of Hillary's effectiveness as a policymaker when she works for, and with, her husband—something that is of crucial importance to the country as we contemplate her role in health-care reform. No matter how accomplished and brilliant she is, or what she wants, or what she has done, or what she stands for, in the end it is her husband's agenda—and career—that always comes first.

**Visionary Without a Vision.** There was a story going around Washington earlier this year that Bob Dole was trying to keep his Republican senators away from Hillary Clinton. He was afraid they would come away with the same reaction Alan Simpson is reported to have had after encountering the first lady: "That is the most incredible woman I have ever met." The hard-bitten Senate minority leader is said to have been almost as impressed, although he is loath to admit it. Maybe he has recognized in her something of himself. "She's got a darker side," says her old friend Rudy Moore. "For example, she knows that Bob Dole's the enemy, and always will be the enemy. But on the other hand, she's smart enough to see that she can deal with him on an equal basis."

In the months since Bill Clinton handed Hillary the health-care-reform assignment, her stock in Washington has gone way up and his has gone way down. Her role has been the same as in much of her earlier work with Bill. According to Ron Pollack of the consumer group Families USA, "She goes into the lion's den and makes converts, or at least she really reduces the intensity of the opposition." Hillary is seen as more blunt than Bill and less likely to try to wriggle out of a position once pinned down; in a city of workaholics, her energy and determination win raves. She's proven herself again to be a quick study on policy issues (one lobbyist says she can read and absorb a complicated document so quickly that "it really freaks [people] out"). Politically, she has incorporated the lessons of Bill's mistakes on the budget package into her role as health-care reformer—most notably, courting the Republicans from the beginning, staying focused on one issue, and taking her message on the road as much as possible.

The message, too, has echoes of her speeches to the ABA or to Arkansas parents: the status quo isn't good enough, we need to do better, we need to fix these problems. It is not a message about social revolution (nor is the program the Clintons have come up with), but rather about giving more people access to what many insured Americans already have. If anything, one of its chief purposes is to assure listeners that health-care reform will be as painless and cost-effective as possible, whether those listeners run big corporations or work at minimum wage. It is a message that, while going beyond politics, is fundamentally political in that it stresses what is possible and necessary; at its most soaring, it could be described as rational. Hillary states it well, but one yearns for something more from her.

And though she gets high marks as a spokeswoman, the task-force process, with its five-hundred-plus members, is widely

criticized as "a waste of time" and "a complete fraud," to quote Sidney Wolfe, who heads the Public Citizen Health Research Group, which, like many consumer groups, favors a single-payer, Canadian-style system—something the Clintons dismissed out-of-hand as politically impractical. "When you decide on day zero that you're not going to get rid of the health-insurance industry, that's not reform," says Wolfe.

Other critics charge that the task force dithered too long, provoking people to begin asking hard questions before the administration could provide hard answers.

Inside the Beltway, people tend to blame other task force leaders or Bill Clinton for these errors, but Hillary's past work shows that she and her husband are usually on the same wavelength. Both are political moderates and pragmatists; both aim for the middle; both have a healthy respect for business. Both are compromisers: Bill because he's weak and eager to please; Hillary because she believes in process and because she's good at it—it is a source of power for her.

Hillary's speech in Austin, Texas, just before her father's death in April, revealed much about her lack of vision. Her demeanor—that of an anguished daughter struggling to make sense of the philosophical and emotional issues her father's illness had raised for her close-knit family—was raw and sincere in a way that

her policy talks have not been. But her statements about America's "sleeping sickness of the soul" and the need for a "politics of meaning" were unformed and sticky enough to make a lot of people squirm. When she said that "we lack, at some core level, meaning in our individual lives and meaning collectively," she sounded very much like the twenty-one-year-old Wellesley commencement speaker, well-intentioned but without a clear notion of how to accomplish the good she aspires to, or even what that good might be.

Earlier this year, Hillary told a reporter, "I've often thought of myself and my friends as transitional, maybe more sure of where we were coming from than where we are going." In many ways, the same could be said of her work on a range of issues, including, now, health-care reform. She and Bill are not going to save the world or radically reform the health-care system—that is going to depend on the rest of us. Relying on the power of their good intentions to challenge successfully a system of entrenched power would be naive and, ultimately, disappointing.

What the Clintons have done, however, is to begin the process of change. Maybe Bill was right in that first press conference: the most important thing about Hillary's reform role is that she is involved in the process. The most inspiring thing about her is not that she cares but that she tries. And the same can be said of Bill. Theirs isn't a feminist message, nor a radical one, nor even an idealistic one. But it's a human message, and that's something worth holding on to in these cynical times. □

*Nina Martin writes often about legal and health issues.*

**HER PAST SHOWS  
THAT SHE AND BILL  
ARE ON THE SAME  
WAVELENGTH. BOTH  
ARE COMPROMISERS:  
BILL BECAUSE HE'S  
WEAK AND EAGER TO  
PLEASE; HILLARY  
BECAUSE SHE  
BELIEVES IN PROCESS  
AND IS GOOD AT IT.**



# National Journal

THE WEEKLY ON POLITICS AND GOVERNMENT

OCT. 9, 1993/NO. 41

**WHO'S** President Clinton's health care reform plan avoids the appearance of government control by diffusing and delegating authority to a host of new institutions. The net result, ironically, is that the system he proposes may be less accountable to the public than one in which government's role is more straightforward and direct.

**IN**

**CHARGE**

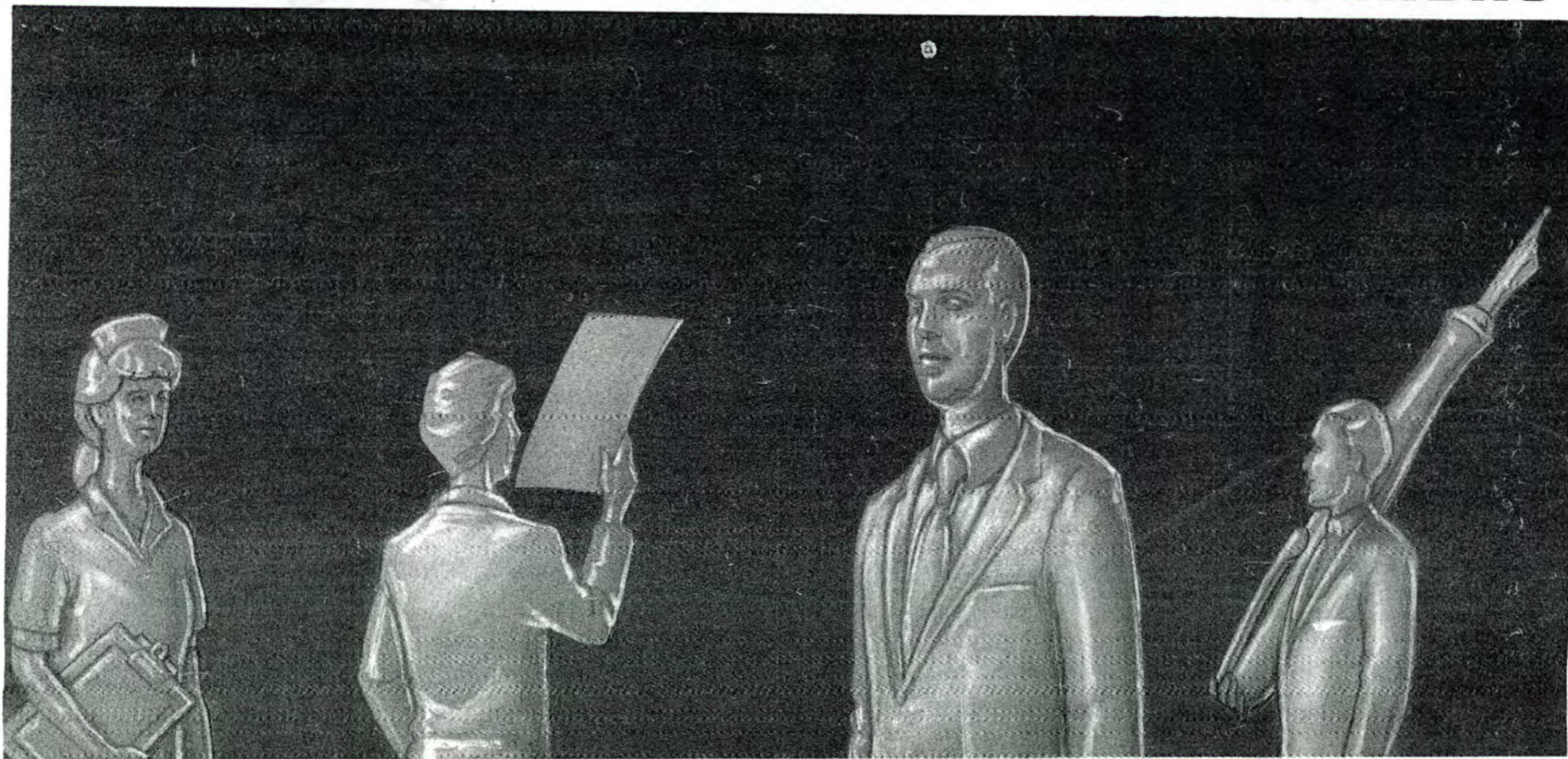
**HERE?**



*Special Report*

PHOTOCOPY  
PRESERVATION

## HEALTH-CARE REFORM: THE CLASH OF INTERESTS AND AGENDAS







## *Shattering the Old Order In Health-Care Politics*

BY NAFTALI BENDAVID

**T**he day President Bill Clinton announced his health reform plan, Public Citizen lobbyist Sara Nichols proclaimed it "a fraud on the American people." Lacking realistic financing, she said, "the Clinton plan is like science fiction. . . . Public Citizen is deeply disappointed."

The same day, Ronald Pollack, executive director of Families USA, gushed in a written statement, "It's great for American families! The president's reform will absolutely guarantee that you'll never lose your health insurance, no matter what. . . . We're very enthusiastic in our support."

Public Citizen and Families USA are two of the leading health consumers groups. For years they've sung in harmony, eloquently decrying the lack of affordable care and advocating a change to a Canadian-style "single payer" system.

But by actually presenting a reform plan, President Clinton has split the consumer movement. And it's the same story with nearly every bloc that cares about health reform, as the accompanying

SEE SPLINTER, PAGE S25

Illustration by Fred DeVita

Supplement Editor: Tom Watson

PHOTOCOPY  
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A user's guide to 25 major interest groups battling to shape the outcome of the health plan—their hopes, their fears, and their hired guns.

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coverage has more to do with preserving the status quo in the financing of health insurance and with the political need to avoid big tax hikes than it does with any grand vision for reform.

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Management of long-term disease, not acute care, is where we should put our money and our mouths.

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Clinton's plan is likely to make some employers winners, but



many others losers, including law partners.

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# Clinton Reform Plan Splits Old Alliances, Spawns New Ones

## SPLINTER FROM PAGE S23

guide shows. (See "Handicapping Health Care's Major Players," Page S28.)

For years, unions, businesses, senior citizens, doctors, and insurers each remained vaguely unified on reform—if for no other reason than that debate about change was couched only in broad, murky terms. But now that they are faced with a specific plan with a realistic chance of passage, they are split in two ways: between idealists and pragmatists, and—perhaps more important—between big outfits that stand to benefit from reform and little ones that could be wiped out by it.

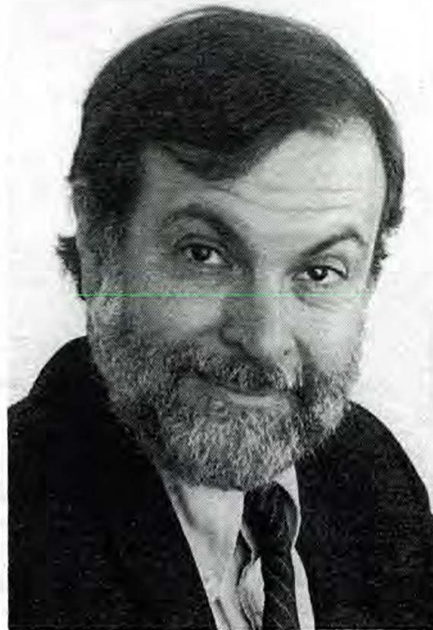
The Clinton plan now circulating on Capitol Hill—which calls for universal health coverage, big consumer cooperatives, and large networks of health providers—is changing the political landscape in seismic ways that will long outlive this debate. It's a bewildering, ever-changing scene, with alliances coalescing, splintering, and re-forming. Groups find themselves staunch allies on one key detail of health reform and harsh enemies on another.

## Divide and Conquer

And that's not surprising, given how much the health-care industry has grown and diversified since the last time anyone attempted a major overhaul.

"You're talking about a \$900 billion industry, and any proposal is going to affect different people differently," says Warren Greenberg, a professor of health economics at George Washington University. "To talk about six or seven interest groups, when you're talking about health reform, is no longer enough."

It's been said that the Clinton reform



**Joshua Weiner: AMA doesn't necessarily speak for all doctors.**

single-minded group as represented by the AMA."

As physicians increasingly move into health maintenance organizations, medical schools, and large group practices, their interests are not necessarily represented by the AMA, says Joshua Weiner, senior fellow at the Brookings Institution and a member of the Clinton health task force.

At the same time, tension is growing between family doctors and the high-paid specialists who have more to lose under reform.

The result: Doctors cannot muster unified opposition to Clinton's reform, as

they have to other efforts to transform health care over the years.

The American College of Physicians, smaller and more liberal than the AMA, supports the Clinton plan far more vigorously than does its big cousin. The 5,500-member Physicians for a National Health Program is arguing loudly for Canadian-style reforms that the AMA hates. The American Hospital Association has emerged from the shadows with its own priorities.

And those who have traditionally been kept on the sidelines of medicine—nurses, physician assistants, chiropractors—see the reform process started by President Clinton as a chance to grab influence.

"There is a sense that Gulliver is being besieged by Lilliputians," Young says. "The psychologists, the social workers, the whole list of brother and sister professions have constantly clawed away, and they are starting to be effective."

## The Center Cannot Hold

Insurance companies, meanwhile, are, if anything, more fragmented than doctors. The Health Insurance Association of America, with 250 member companies, has long acted as sole representative of the industry. As Clinton's plan gained momentum, the HIAA tried to please all its members by making halfhearted moves toward reform.

Instead, it pleased no one. The five biggest insurance companies—which stand to benefit greatly from the president's proposal—dropped out and formed their own association, the Alliance for Managed Competition. And 25 smaller insurance companies, terrified that the ad-

ministration's plan will squash them, also created their own group, the Council for Affordable Health Insurance.

This disintegration of alliances is not limited to medicine. Other groups that care about health—unions, consumers, the elderly—all are split to some degree over Clinton's plan.

## Dissension in the Ranks

Since the New Deal, most liberal activists have favored national health insurance, under which—unlike Clinton's proposal—all citizens would buy health jointly through the federal government.

But these activists are delighted to be insiders after 12 years in the cold, and many believe that it would be stupid to ignore a chance for real reform. On Sept. 21, AFL-CIO President Lane Kirkland announced that his organization unequivocally supports the Clinton plan, a position reaffirmed at last week's AFL-CIO convention.

But at least one left-leaning union, the Oil, Chemical & Atomic Workers, refuses to jump on board and continues to endorse passionately a single-payer system. This reflects a sentiment widespread in the labor movement, says Pete Strader, OCAW's international representative.

"We think it's going to be difficult," Strader says of his group's bid to gain support for a single-payer plan despite the opposition of the AFL-CIO leadership. "But once this thing is getting debated, which is starting now, we think American workers and the American public will understand where we're coming from."

SEE SPLINTER, PAGE S27



sity. "To talk about six or seven interest groups, when you're talking about health reform, is no longer enough."

It's been said that the Clinton reform package provides a seductive tidbit for every important interest group. But the true political genius of the plan is that it is crafted, intentionally or not, to pull those groups apart, making unified opposition impossible.

"The administration has absorbed the classic political-science literature, which says that a split opposition makes all the difference," says James Morone, a political-science professor at Brown University who edits the *Journal of Health Politics, Policy and Law*. "Once they had the basic outlines of the plan, they very much had in mind to split the opposition and get the plan through."

The divide-and-conquer strategy echoes some of the major lobbying battles of the past. In *Showdown at Gucci Gulch*, Jeffrey Birnbaum and Alan Murray's book about the legislative fight over the tax reform of 1986, then Deputy Treasury Secretary Richard Darman is quoted musing that if someone would raise a sign saying, "Everyone interested in killing this bill, meet in the next corridor," the reform would be crushed.

That unity never materialized. Tax reform passed. And so far, unity is equally elusive for opponents of the Clinton health package.

### An Ailing Lobby

Nowhere is the disarray more apparent than in the medical profession itself. The American Medical Association, once the sole voice of medicine, has watched its influence wane for 20 years, and health reform has spectacularly highlighted this weakness.

"I am old enough to remember an age when nothing happened in health policy without AMA's initiation, or at least sanction," says Quentin Young, 70, former president of Physicians for a National Health Program. "That is certainly past. I spend a lot of time clarifying that doctors are not one monolithic, reactionary,

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Small business strongly supports H.R. 9, including the Small Business Legislative Council (SBLC), the independent, permanent coalition more than 100 trade and professional associations representing the interest of more than 4 million small businesses in manufacturing, retailing distribution, professional and technical services, construction, transportation and agriculture. The insurance industry stands virtually alone for price fixing and against increased competition.

Although the record fully supports repeal, H. R. 9 is not on outright repeal of the McCarran-Ferguson antitrust exemption. It is a compromise. It specifically immunizes from any antitrust challenge activities that are unique and essential to the insurance industry. The state regulation of insurance provisions of the Act remain intact.

Industry is attempting to miscast H.





health and business issues. The insurance industry's price fixing, its access to unfairly priced drugs, and the consequential denial of consumer equal access to participate in insured concerns. H.R. 9 will reestablish for these programs the hallmarks of our private prescription drug marketplace: consumer choice and fair competition.

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# HEALTH-CARE INTERESTS AND AGENDAS

## SPLINTER FROM PAGE S25

Meanwhile, business groups are fighting their own civil war.

Big companies like the Chrysler Corp., which spends more on health than it does on steel and foots the medical bills for an army of retirees, are greeting Clinton's plan with relief.

But that's not the case with small business. "The large employers have been paying a lot for health insurance," says Greenberg, the GW professor. "Jack's Records or Harry's Cleaners have perhaps been paying none. Suddenly, the small businesses have to pay, and they don't like it."

In fact, the National Federation of Independent Business—the leading association of small businesses—was so angry at Clinton's proposal it refused to testify before the president's health-care task force. The NFIB also has assembled a 57-page report for distribution to Congress estimating how many jobs Clinton's plan would eliminate.

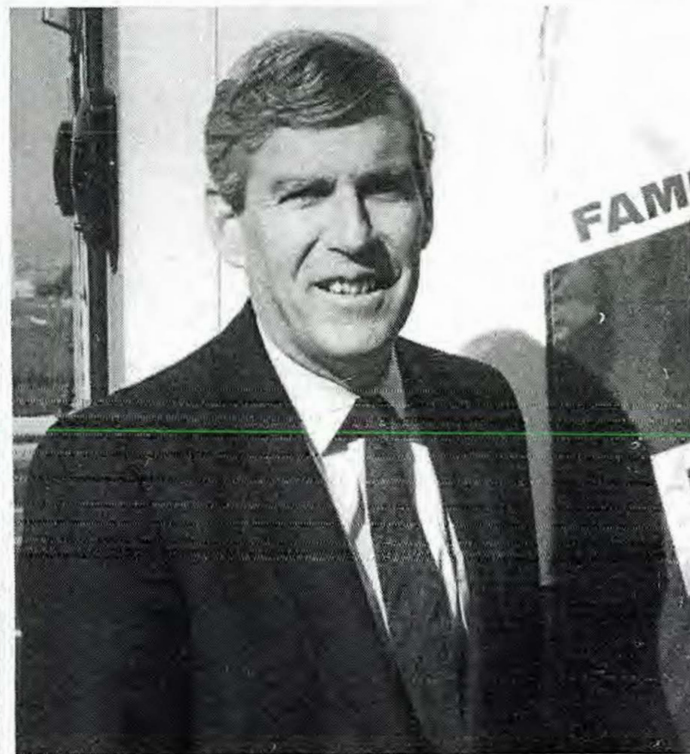
## Playing Musical Coalitions

While some groups are splintering, others are coalescing. Interests across the spectrum eagerly announce the formation of a coalition, only to jump to a new one with each fresh turn in the debate—often leaving it unclear just how much the members had in common to begin with.

The AFL-CIO's journey illustrates this coalition-mania. In 1991, AFL-CIO President Kirkland joined something called the Alliance for Health Care Reform, created by Sen. John Rockefeller IV (D-W.Va.).

At the same time, many AFL-CIO unions joined the National Leadership Coalition for Health Care Reform, co-chaired by former Presidents Jimmy Carter and Gerald Ford, which issued a health-care proposal two years ago.

Then, last February, the AFL-CIO jumped into the Coalition to Preserve Health Benefits, a group of business or-



PHOTOS BY PATRICE GILBERT

Sara Nichols of Public Citizen (left) and Ronald Pollack of Families USA have traditionally seen eye-to-eye on the issue of health reform, but Clinton's plan has divided the two consumer advocacy groups.



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Then, last February, the AFL-CIO jumped into the Coalition to Preserve Health Benefits, a group of business organizations opposed to the taxation of benefits. But many labor leaders were uncomfortable with that coalition's conservative leaning, and the AFL-CIO dropped out in May.

Now all three of those coalitions have been relegated to the sidelines by the president's plan. So on Sept. 10, the AFL-CIO joined yet another alliance—the Health Care Reform Project, a broadly pro-reform front including labor, business, and seniors groups.

One message seems to be that today's friend is tomorrow's enemy.

"In the '90s, you can't really frame the debate in terms of adversaries and allies," says Bernadette Budde, vice president of the Business-Industry Political Action Committee and a veteran of numerous political battles. "I see too many particles out there. How you do frame it, I'm not quite sure yet."

#### Friend and Foe Together

The chaos is summed up by the tale of the tobacco and alcohol industries. Both belong to the Coalition Against Regressive Taxation, and they jointly have fought proposals for a new sales tax to finance health reform.

But President Clinton split the fraternity when he decided to tax cigarettes, but not alcohol. Tobacco supporters turned on their former allies, loudly complaining that Clinton should spread the pain by taxing alcohol as well. This, of course, has infuriated liquor's minions.

Ken Stinger, secretary of the Coalition Against Regressive Taxation, insists the spat has cooled off. It's critical that relations remain smooth, he adds, if alcohol and tobacco are to have any hope of killing the sales tax.

"The question is, 'Will they stick together or not? Will they be more united?'" says Stinger. "Hopefully, they'll realize it would be smarter to stick together and not point fingers. This is the beginning of the effort, not the end. And at the beginning, you want to be united." □

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# Handicapping Health Care's Major Players

*Months of pre-season jockeying are over. Position papers have been distributed; slogans have been drafted. The TV ads are on the air. The Clinton health reform package has been unveiled. And the greatest lobbying bonanza in memory has begun.*

*In an effort to sort out who's doing what to whom, Legal Times presents a user's guide to 25 major health-care players—their wish lists, lobby weapons, and field position in the titanic battle to overhaul American health care.*

*This guide was written by Naftali Bendavid, T.R. Goldman, and Sheila Kaplan, with assistance from Robert Schmidt. Political action committee data are included where applicable; figures were compiled by the Federal Election Commission, except where otherwise indicated.*

PHOTOCOPY  
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## Health-Care Providers



## AMERICAN MEDICAL ASSOCIATION

- **BUDGET:** \$205 million total, \$8 million for D.C. office.
- **MEMBERS:** 300,000 physicians.
- **KEY LOBBYISTS:** James Todd, executive vice president. Lee Stillwell, senior vice president of government and political affairs. Richard Deem, director of federal affairs.
- **PAC:** Spent \$6,263,920 in the 1991-92 election cycle and \$747,250 in the first eight months of 1993.
- **BOTTOM LINE:** Wants patients to have the power to choose their own doctor.

"1993 Campaign Action Kit" offers the following comments for doctors when addressing local business and civic groups and, as encouraged, television and radio talk shows.

"I am a doctor, and the more I hear politicians and pundits talk about health system reform, the more I realize the one voice they don't hear anymore is the voice of my patients," the script reads. "... It has been left to physicians to stand up as the only advocates with enough clout to speak out for what is best for their patients."

But the AMA's pro-patient line has been undercut by a rival group, the 80,000-member **American College of Physicians**, which backs the Clinton plan. Naturally, relations between the two groups are not friendly.

The AMA is a federation of medical-specialty groups ranging from radiologists to eye doctors; the ACP, which is a member group within the AMA, represents internists and other doctors who treat internal organs. While the ACP has generally been a loyal follower of its parent's lead, President Clinton's health package has created a rare public rift between the two. ACP leaders have not been shy about publicizing their disappointment with the AMA's stance.

"I think the AMA is frankly somewhat duplicitous," says **Robert Chlopak**, who lobbies for a health reform

Doctors can also claim victory over the administration's proposal to change the "collateral source" rule. Under the Clinton plan, jury awards would be offset by any amount the victim received from other sources, such as workers' compensation or health insurance. That offsetting amount could reduce the amount paid out by doctors. The change represents the kind of practice guideline that doctors have long pushed for.

But the AMA faces formidable opposition on the malpractice provisions from the **Association of Trial Lawyers of America**, which keeps watch over the interests of plaintiffs attorneys, and from **Congress Watch** and the **Health Research Group**, both affiliates of consumer crusader Ralph Nader's **Public Citizen**.

As it girds for battle, the AMA is not relying much on outside help. Its political strength has traditionally stemmed from its grass-roots lobbying strength and its political action committee, which consistently ranks among the most generous PACs in the country. The group is advancing its cause via an extensive ad campaign and the trench work of some 20 in-house lobbyists. And the AMA's executive vice president, Dr. **James Todd**, has been a fixture on the press-conference circuit.

—Sheila Kaplan



1993.  
● **BOTTOM LINE:** Wants patients to have the power to choose their own doctor.

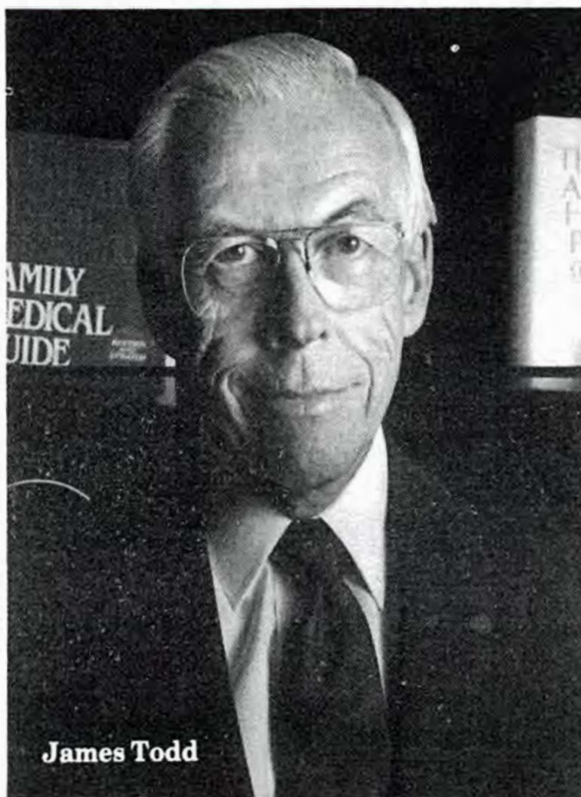
**T**he American Medical Association has a credibility problem.

Although its advocates maintain that the group supports health-care reform, the doctors lobby has hit the administration package hard in newspaper ads and in missives to its members.

For instance, the AMA has sent leaflets to 630,000 doctors for display in their offices, with the heading: "Is the Clinton proposal for health reform good for you and your family? You need to think about these 10 questions." That's followed by questions designed to raise public concerns about the plan, from "Will I still be able to see my own doctor?" to "Will the quality of care my family

receives be maintained under a new system?" The AMA literature meant for public consumption omits the doctors' foremost concern—reduced medical fees.

At the heart of the AMA's advocacy is the claim that it is speaking for patients, not just for doctors. The group's



James Todd

PATRICK GILBERT

"I think the AMA is frankly somewhat duplicitous," says **Robert Chlopak**, who lobbies for a health reform coalition that includes the ACP. Despite AMA members' objections to the Clinton plan, "they don't want it to appear as if physicians have a real problem with this. . . . It's important that they clarify where they are," Chlopak says.

Some insiders believe that when the smoke clears from the debate, the ACP's profile and clout will have risen—at the AMA's expense.

"There's one overarching issue that permeates everything," observes one health-care advocate, "and that's who is going to represent medicine in Washington—the AMA or ACP?"

The challenge to the AMA's influence from within the physicians' community comes at an especially tough time for the group. Once the undisputed dominant force in medical politics, the AMA since the 1970s has seen a decline in the percentage of doctors who sign up. And unlike some groups in the current health-care fray, who are free to focus on one or two discrete parts of the package, the AMA's members stand to be affected by virtually every facet of the massive Clinton plan.

In addition to the issue of patients' choice of physicians, which the group fears will be limited by the proposed regional health alliances, the AMA is lobbying on several other fronts. The group is using its longtime counsel, Chicago's **Sidley & Austin**, in a bid to prevent Clinton from including limits on physicians' fees—an idea the administration's health team has batted around, but did not include in the proposal. The law firm issued a pre-emptive strike, reporting to the AMA that fee limits could constitute an illegal taking under the Fifth Amendment.

The AMA will continue to push for relief from existing antitrust laws, which bar physicians from combining to negotiate with larger entities. The Clinton plan eases the antitrust restrictions on hospitals, but not on doctors.

The AMA will also be lobbying Congress to keep two benefits that it has already secured in the package: deregulation of clinical laboratories and increased protection for doctors charged with malpractice. The malpractice protections include permission for those found liable to pay compensation in installments, rather than the lump-sum payments required under current law, as well as a provision limiting plaintiffs lawyers' fees to one-third of the total damages in a case. Attorneys in medical malpractice cases rarely charge more than that, but in the ongoing tug of war between doctors and lawyers, the provision is a clear win for the doctors' camp.

circuit.

—Sheila Kaplan

## AMERICAN COLLEGE OF PHYSICIANS

- **BUDGET:** \$41 million overall, \$1 million in D.C. office.
- **MEMBERS:** 80,000 physicians practicing internal medicine and its subspecialties.
- **KEY LOBBYISTS:** John Ball, executive vice president. Howard Shapiro, director of public policy.
- **BOTTOM LINE:** Backs most of the Clinton plan; has some concerns about medical malpractice and the threat posed by regional health alliances to doctors' autonomy.

**F**irst, the American College of Physicians called for universal health care. Next, it endorsed a national health budget and backed most of the Clinton reform plan, calling it "a moderate and uniquely American approach to reform that will be the vehicle for building consensus and moving legislation through Congress."

More noteworthy than this enthusiastic endorsement by a doctors group, however, is the ACP's lobbying strategy on the Clinton plan. The ACP has sent shock waves through the medical community by picking a public fight over the plan with the longtime kingpin of health politics, the **American Medical Association**. The division among doctors, who normally close ranks on health-care policy, could be a harbinger for the Clinton administration—a sign that the health-care package will not die due to monolithic opposition from physicians.

The two doctors groups differ in several ways. While the much larger AMA represents the range of medical specialties, the ACP, whose members are technically part of the AMA, represents doctors who practice internal medicine and its subspecialties, such as cardiology and gastroenterology. As a result, ACP members are more likely to be providers of primary care and much less likely than specialists, such as surgeons, to see their fees cut under the Clinton plan.

As a rule, the ACP's members are younger than the AMA's. As for D.C. lobbyists, the ACP has about five



## HEALTH-CARE INTERESTS AND AGENDAS

professional staff members, while the AMA has 20. The AMA dwarfs the ACP financially, with an annual budget roughly five times larger. And while the AMA is an old hand at lobbying, the ACP, which considers itself more research-oriented than the AMA, is still shy about lobbying, or at least acknowledging it.

"We don't use the word *lobbying*," says a spokeswoman in the group's Philadelphia headquarters. "We educate." Hiring outside consultants is not part of the ACP's "education" program.

The AMA initially stated its support for the notion of reform, then blasted much of the Clinton package once it was unveiled. The ACP, on the other hand, jumped aboard the Clinton train early and began working closely with other groups to try to ensure the plan's passage on Capitol Hill.

"Physicians recognize that the system wasn't serving patients and wasn't serving physicians," says **Howard Shapiro**, the group's director of public policy.

In addition to its grass-roots operation, the ACP has joined forces with one of the more potent health coalitions, the **Health Care Reform Project**, whose member groups, ranging from the AFL-CIO to the **League of Women Voters**, represent an army some 55 million strong.

The ACP does not march in lock step with its coalition-mates on every issue, however. The group has expressed concerns about the medical malpractice portion of President Clinton's plan, arguing that it does not provide adequate protection for doctors. In contrast, most members of the Health Care Reform Project worry that it does not provide adequate protection for consumers.

The ACP also parts company from many in the umbrella organization in its concern that the Clinton plan will subject doctors to several tiers of confusing federal and state government control.

—S.K.

## GROUP HEALTH ASSOCIATION OF AMERICA

- **BUDGET:** \$10 million annually.
- **MEMBERS:** 350 health maintenance organizations, who treat 32 million patients.
- **KEY LOBBYIST:** Karen Ignagni, president. Formerly top health lobbyist for the AFL-CIO.



GHAA's Karen Ignagni

nationwide standards for all health providers and opposing caps on health premiums.

The GHAA also would like to weaken the health alliances, or large consumer purchasing cooperatives, envisioned in the Clinton plan. The alliances will be haggling with HMOs over prices and benefits, so the less leverage they have, the better for HMOs.

—Naftali Bendavid

## AMERICAN NURSES ASSOCIATION

- **BUDGET:** \$21 million annually.
- **MEMBERS:** 200,000 nurses.
- **KEY LOBBYIST:** Donna Richardson, director of governmental affairs.

Doctors will be the nurses' primary foes in the health reform fight, which is not surprising. Tensions between the two groups, who work side by side on the front lines of health care, are time-honored. The biggest doctors group, the AMA, "has always lobbied against nurse practitioners and other kinds of advanced-practice nurses—particularly when it comes to getting the money," says **Debra Hardy Havens**, a nurse and lobbyist with **Capitol Associates Inc.**, who is helping the ANA as an outside consultant.

The ANA has brought in other outsiders for support, notably the lobbying and public-relations giant **Burson-Marsteller** and a D.C.-based shop, **Health Policy Alternatives Inc.** The group has also sought to expand its reach by joining no fewer than 40 coalitions, many featuring various consumers groups. It is particularly active in the **Health Care Reform Project**, the **National Leadership Coalition for Health Care Reform**, the **Campaign for Women's Health**, and the **Long-Term Care Campaign**.

—S.K.

## AMERICAN HOSPITAL ASSOCIATION

- **BUDGET:** \$70 million annually.
- **MEMBERS:** 5,000 hospitals and more than 50,000 hospital personnel.
- **KEY LOBBYISTS:** Richard Davidson, president. Richard Pollack, executive vice president for legislative affairs. James Bentley, senior vice president for policy. Beryl Anthony Jr., partner, D.C. office of Chicago's Winston & Strawn.
- **PAC:** Spent \$757,825 in the 1991-92 election cycle and \$264,140 in the first eight months of 1993.
- **BOTTOM LINE:** Wants to ensure that hospitals enjoy a prominent decision-making role within community health plans. Opposes cuts in Medicare.

If lining up heavy-hitters is any key to how well a group will fare in the coming battle over health care, then the American Hospital Association is off to a good start. The group, which represents 5,000 of the nation's hospitals, has solidified its position as a



- **BUDGET:** \$10 million annually.
- **MEMBERS:** 350 health maintenance organizations, who treat 32 million patients.
- **KEY LOBBYIST:** Karen Ignagni, president. Formerly top health lobbyist for the AFL-CIO.
- **PAC:** Spent \$24,050 in the 1991-92 election cycle and \$5,500 in the first half of 1993.
- **BOTTOM LINE:** Wants nationwide standards for health providers so that HMO chains won't have to vary programs from state to state. Wants complete freedom for HMOs to sign up only those doctors and hospitals they want.

**F**ounded in 1959, the Group Health Association of America is the lobby of the HMO industry. HMOs have a huge advantage in the health fray: They've been doing "managed care"—that is, administrative control over doctors to cut costs—longer than anyone else. And managed care is the heart of the Clinton reform.

On the other hand, some view HMOs as an experiment that has failed. Critics paint HMOs as places where patients get substandard care and can't choose their doctors.

The GHAA raised its profile significantly several months ago by hiring **Karen Ignagni**, a well-known, well-connected health lobbyist for the **AFL-CIO**. This signals a major change in style for the group. Former GHAA President **James Doherty** was tough and ideological; Ignagni is young and polished. Most of all, she's a consensus-builder.

Ignagni is a former staffer at the Senate Labor and Human Resources Committee. That committee, chaired by Sen. **Edward Kennedy** (D-Mass.), is central to health reform.

"We think it's important to raise the profile and visibility of our industry to an even greater level," says GHAA spokeswoman **Susan Pisano**, noting that Doherty was scheduled to retire in any case. "We believe she's a person who can do that."

The GHAA is largely happy with the Clinton plan. That's not surprising; it would dramatically shift the way most Americans get health care from a fee-for-service system to the HMO approach, under which patients pay a flat annual fee.

GHAA leaders have no plans for an advertising campaign in support of the plan, Pisano says, and they've hired no outside consultants. While that may save the group money, it may not do much to help President Clinton—who needs all the active and vocal supporters he can get.

In lieu of high-profile advocacy, the GHAA is pursuing low-key goals in quiet ways, pushing

- **BUDGET:** \$21 million annually.
- **MEMBERS:** 200,000 nurses.
- **KEY LOBBYIST:** Donna Richardson, director of governmental affairs.
- **PAC:** Spent \$336,050 in the 1991-92 election cycle and \$25,024 in the first half of 1993.
- **BOTTOM LINE:** Wants to increase insurance reimbursement for nursing services.

**T**he American Nurses Association provides a case study in the benefits of playing heads-up politics.

The group, which moved its headquarters from Kansas City, Mo., to Washington in March 1992, was the first major trade group among health-care providers to endorse candidate Clinton. That decision paid off when President Clinton's advisers began charting the course of health-care reform. The **American Medical Association** ended up without a single seat on the 47-member professional advisory review committee to Hillary Rodham Clinton's health task force. The nurses had 12.

Not surprisingly, the ANA is pleased with the emerging shape of the Clinton package. While the plan as currently written does not specify a larger role for nurses, the final version is expected to expand their role as providers of everyday medical care by qualifying nurses for insurance reimbursements for their services.



An ANA spokeswoman says the group's lobbyists have met with Ira Magaziner of the White House health task force three times in recent weeks and have been assured that the legislative language will support them.

"This plan means that consumers . . . will be able to choose an advanced-practice nurse for care if they wish," says ANA President **Virginia Trotter Betts**. "It means that advanced-practice nurses will be able to diagnose, treat, and prescribe medications for everyday health-care needs without unnecessary, costly oversight."

Still, the ANA is leaving nothing to chance as the package winds its way through Congress. The group has increased its political action committee contributions in the past six months. It has six people regularly meeting with Magaziner and dozens more in its Washington office working the issue. And it has spawned an offshoot, the **Nurses Strategic Action Team**, to mobilize grass-roots members.

The ANA's primary pitch: that there are more nurses than doctors in the United States, and that nurses are far less expensive. The group tries to ram that point home in a line from its ad campaign: "In the future, your family doctor may be a nurse."

**I**f lining up heavy-hitters is any key to how well a group will fare in the coming battle over health care, then the American Hospital Association is off to a good start. The group, which represents 5,000 of the nation's hospitals, has enlisted the lobbying help of former Rep. **Beryl Anthony Jr.** (D-Ark.), one of the most sought-after legislators among those who retired from Congress last year.

Anthony, who served as chairman of the Democratic Congressional Campaign Committee and held a seat on the House Ways and Means Subcommittee on Health before landing in the D.C. office of Chicago's **Winston & Strawn**, is constrained by the rule that bars a former lawmaker from making direct contact for one year with ex-colleagues on Capitol Hill. But that hasn't prevented Anthony from lobbying the executive branch on health care or from helping the AHA map out its congressional strategy.

"There's no question that, given his background, he is able to help us understand how these [Arkansas] folks view a variety of different situations," says **Richard Pollack**, the group's vice president for legislative affairs. "He's helpful in terms of presenting things to them in a way that is easy for them to understand and easy for them to digest, from the perspective that he knows how those folks react and how to appeal to them."

Anthony may also enjoy an inside track on any legal developments that could crop up over health care: His wife, **Sheila Foster Anthony**, is assistant attorney general for legislative affairs.

Anthony's efforts so far haven't hurt. The AHA supports the concept, included in the Clinton package, of grouping community-based health providers into integrated partnerships that oversee all facets of patient care. Where the group may differ from the president is over control.

The AHA would like hospitals to play a central role in overseeing patient care in the new health plans. President Clinton has not committed to that idea.

"We hope that hospitals will provide a leadership role as being more than a vendor," Pollack says. "We think they should be part of the building of the plan."

While the Clinton plan is still sketchy in this area, Pollack is confident that his group's voice is at least being heard. "They heard us on a lot. On other things, they just listened," he says.

The AHA is pressing for federal guidelines that would, among other things, give community-based hospitals and clinics an advantage over for-profit health companies from out of town. On that score, the group has an ally in the **American Medical Association**,



## HEALTH-CARE INTERESTS AND AGENDAS

which is also troubled by the network plan, viewing it as a threat to doctors' autonomy.

The AHA is also seeking to avoid cuts in Medicare, which it fears would come out of its members' hides, and is wary of the plan to earmark hospitals for about \$80 billion in cuts.

Joining Winston & Strawn in the hospital group's campaign is New York-based **Ogilvy Adams & Rinehart** and D.C.'s **Health Policy Alternatives Inc.**

Also making a splash in the health-care waters is the trade group of for-profit hospitals, the **Federation of American Health Systems**, which represents more than 1,400 privately owned hospitals, management companies, and other health providers. FAHS has geared up to fight Clinton's proposal for a national health-care budget and also has targeted the proposed cap on increases in insurance premiums.

FAHS, whose executive director, **Michael Bromberg**, is viewed as one of the savvier trade-association lobbyists in town, has enlisted the help of **Thomas Scully**, a former Office of Management and Budget official now at D.C.'s **Patton, Boggs & Blow**. The group has also lined up its own Arkansans, the Little Rock firm of **Williams & Anderson**.

FAHS participates in several coalitions, most notably the **Healthcare Equity Action League**, a large business-and-insurance coalition opposing Clinton's plans to require that employers provide health insurance for their workers and to cap insurance premiums.

—S.K.

## MENTAL HEALTH LIAISON GROUP

- **BUDGET:** Coalition members fund their own activities.
- **MEMBERS:** Includes the 38,000-member American Psychiatric Association, 114,000-member American Psychological Association, and about 50 other mental-health service providers and consumers groups.
- **KEY LOBBYISTS:** Leslie Scallet, director, Mental Health Policy Resource Center. Tipper Gore, wife of the vice president.
- **BOTTOM LINE:** Wants mental-health benefits treated like other medical benefits with...

spokesman on health-care reform, who has talked publicly about suffering from manic-depressive illness; **Philip Lee**, assistant secretary for health in the Department of Health and Human Services and a longtime friend of the mental-health community; and **Bernard Arons**, recently named acting director of HHS's Center for Mental Health Services.

But Scallet says the biggest boost for mental-health advocates is the generational change in the nation's leadership.

"There are a lot of people now in the administration who are baby boomers or younger, many of whom have had good experiences with mental-health care or for whom mental-health care is something they or people they know have relied on," she says.

Still, the Clinton plan does not provide all Scallet and others sought. They don't, however, blame Tipper Gore.

"She is extraordinarily effective," says Scallet. "But she doesn't have the right to make decisions. I think she's done an excellent job of making sure the mental-health issues are being treated seriously. This never would have happened without Tipper Gore."

Scallet lays the blame on the number-crunchers in the administration, whom she says are basing their economic calculations for mental-health costs on outdated medical practices that are more costly than those now used.

Challenges to those numbers will be among the lobby's many tasks on Capitol Hill, where the chief allies on mental health are likely to be Rep. **Mike Kopetski** (D-Ore.), who has introduced a resolution calling for non-discriminatory coverage, and Sens. **Pete Domenici** (R-N.M.), **Edward Kennedy** (D-Mass.), and **Paul Wellstone** (D-Minn.).

—S.K.

## AMERICAN DENTAL ASSOCIATION

- **BUDGET:** \$50 million annually.
- **MEMBERS:** 140,000, or three out of every four dentists.
- **KEY LOBBYISTS:** John Zapp, executive director; a dentist and vice president for government affairs...

The ADA is also planning to add three more in-house lobbyists to its stable of five already in Washington.

—T.R. Goldman

## AMERICAN HEALTH CARE ASSOCIATION

- **BUDGET:** \$8 million annually.
- **MEMBERS:** 11,000 providers of long-term care in nursing homes and other facilities.
- **KEY LOBBYISTS:** Bruce Yarwood, legislative counsel. D.C.'s Policy Research Group, a division of R. Duffy Wall and Associates. D.C. office of Miami's Greenberg Traurig.
- **PAC:** Spent \$559,050 in the 1991-92 election cycle and \$187,620 in the first eight months of 1993.
- **BOTTOM LINE:** Wants increased government funding of nursing-home care for the poor and increased insurance coverage for nursing-home care.

**D**espite their presence in almost every U.S. community, nursing homes have been virtually omitted from the Clinton health plan. Long-term care through nursing homes is a major expense for Americans—it cost some \$65 billion in 1992—but the president's plan gives their woes short shrift. Instead, the focus is on keeping people out of such facilities in the first place.

That hasn't set well with groups like the American Health Care Association, a federation of 51 affiliated associations that represent 11,000 providers of long-term care.

"Sometimes we feel like the poor stepchild of the health-care debate," says **Winthrop Cashdollar**, a lobbyist for the group. "We think home care should be available to people who need it, but you need to be careful not to mistake it as a substitute for nursing-home care. They serve two different populations."

AHCA's members, which





- **KEY LOBBYISTS:** Leslie Scallet, director, Mental Health Policy Resource Center. Tipper Gore, wife of the vice president.
- **BOTTOM LINE:** Wants mental-health benefits treated like other medical benefits, with no financial caps and no limits on visits.

**M**ental-health problems may carry less of a stigma than they did 10 years ago, but paying for them hasn't gotten much easier.

And it won't any time soon under the Clinton health plan. The plan does call for phasing in stronger mental-health benefits through the year 2001. But

overall, the package is a disappointment to mental-health advocates.

Their key objections are that the plan covers only 50 percent of the costs of mental-health care and that it limits to 30 the number of annual visits for outpatient psychotherapy.

But the plan does boast some important mental-health benefits, including reimbursement for



**Leslie Scallet**

alternatives to hospitalization and for medication for mental-health disorders.

The mental-health lobby is now turning to Congress to protect its gains and achieve non-discriminatory coverage in the final health plan.

"We want mentally ill patients treated the same as the physically ill patients," says **Jay Cutler**, director of government relations for the **American Psychiatric Association**.

Cutler's association is among those in the Mental Health Liaison Group that decided in 1990 to spawn yet another group to lobby for non-discriminatory access, the **Access to Health Care Committee**. Advocates were concerned about the disparity between insurance benefits for mental illnesses and those for other medical problems.

Now the Access to Health Care Committee is applying the same test to the Clinton plan—and seems better positioned than ever before to get results. Headed by **Leslie Scallet**, director of the **Mental Health Policy Resource Center**, the group has a major advocate in **Tipper Gore**, a longtime crusader on mental-health issues who headed the administration's health reform task force on mental health and substance abuse.

And Gore, the wife of Vice President Albert Gore Jr., has a number of strong supporters in the administration, including **Robert Boorstin**, chief White House

- **MEMBERS:** 140,000, or three out of every four dentists.
- **KEY LOBBYISTS:** John Zapp, executive director; a dentist and vice president for government affairs at the American Medical Association for 19 years. Dorothy Moss, the ADA's top D.C. lobbyist; formerly Zapp's top deputy at the AMA.
- **PAC:** Spent \$1,661,000 in the 1991-92 election cycle and \$205,400 in the first eight months of 1993.
- **BOTTOM LINE:** Wants dental benefits for no- and low-income people.

**D**entists like to say that they've always followed the dictates of President Clinton's health reform plan. Unlike medical doctors, most dentists are general practitioners, not specialists. They've long practiced preventive dentistry, such as cleaning and X-rays. And consequently, dental costs have gone up at just about half the rate of the rest of medical care.

"The model dentistry has today is probably the model they're trying to create for the entire medical system," says Dr. **John Zapp**, a longtime lobbyist for the



**American Medical Association** who was recently appointed executive director of the American Dental Association. "Very competitive with good cost containment."

Unfortunately, despite that track record and one of the wealthiest PACs in the medical profession, dentists got their teeth kicked in by the Clinton health plan.

Employer-mandated coverage under the plan provides only minimal dental benefits—far less than the benefits the 100 million people who currently have dental insurance enjoy.

And instead of a plan that offers dental care to the poor and low-income—a population plagued by what Zapp describes as an "incredible backlog of dental diseases"—the Clinton plan provides a dental package only to children. Regular checkups, X-rays, and teeth cleanings will be offered to everyone 18 years or younger. In what ADA members hope is an oversight, fillings are not included.

"Why count a cavity if you're not going to fill it?" wonders Zapp.

To give itself a fighting chance in fashioning the final package, the ADA, which employs 400 staffers in Washington and Chicago, is paying the politically connected **Wexler Group** about \$200,000 for a six-month contract to prepare background papers and push the ADA's views on Capitol Hill. (The contract runs through December.) Wexler recently added **Betsey Wright**, Clinton's longtime chief of staff in Arkansas, to its bipartisan roster.



**Nancy Taylor**

substitute for nursing-home care. They serve two different populations."

AHCA's members, which are mainly for-profit companies, care for about one million people in nursing homes and other long-term care facilities.

The group has a small Washington office, with only six lobbyists, led by Legislative Counsel **Bruce Yarwood**. It has also relied on **Don Muse**, president of the **Policy Research Group**, a division of R. Duffy Wall and Associates, and of counsel **Nancy Taylor** and associate **Stuart Kurlander** of the D.C. office of Miami's **Greenberg Traurig**. Taylor previously lobbied for AHCA while working with **Deborah Steelman** at Steelman's D.C. firm; an AHCA lobbyist says Steelman no longer works for the group.

AHCA's lobbying is buttressed by the efforts of the larger chains. **Manor Care Inc.**, based in Silver Spring, Md., has used D.C.'s **Patton, Boggs & Blow**, for example.

The other major trade group in the long-term care field is the **American Association of Homes for the Aging**, which represents some 4,500 not-for-profit nursing homes, senior-housing providers, and other long-term care providers. With a budget of \$8.4 million and a Washington staff of about 15, the AAHA has usually relied on in-house lobbyists.

This year, though, the AAHA brought in D.C.'s **Cassidy and Associates**, "to help us get some access," according to spokesman **Scott Parkin**. "It was difficult in the early part of this to be heard," Parkin says.

The nursing-home industry has made some gains under the Clinton plan. There are additional tax incentives to encourage people to buy long-term care insurance, as well as a loosening of the requirement that the elderly "spend down" to their last \$2,000, exclusive of housing, to qualify for Medicaid. Under the administration proposal, individuals can qualify with \$12,000 in assets.

And the nursing homes got another break in the plan's Medicare provisions: Most of the funding cuts appear to be taken from hospitals, not nursing homes.

"We hope that's true," Cashdollar says.

AHCA and the AAHA may also pick up some support from the **American Association of Retired Persons**, which will discuss the issue at its meeting next month. The AARP could decide to mobilize its forces to urge that protection against rising nursing-home costs be added to the health reform package.

—S.K.



## HEALTH-CARE INTERESTS AND AGENDAS

Health-Care  
Consumers

## AFL-CIO

- **BUDGET:** \$62 million annually.
- **MEMBERS:** 87 unions, comprising 14.1 million members.
- **KEY LOBBYISTS:** John Sweeney, chairman, Health Care Committee. Gerald Shea, director, Employee Benefits Division.
- **PAC:** Spent \$1,174,500 in the 1991-92 election cycle and \$189,100 in the first eight months of 1993.
- **BOTTOM LINE:** Wants employers to pay a hefty share of workers' health premiums. Does not want health benefits taxed. Wants unions with excellent health packages to keep them.

Organized labor has long been a supporter of a Canadian-style "single payer" system, under which all citizens buy health care as a single bloc. But the AFL-CIO has decided that the Clinton plan is the best it's going to get and is throwing its considerable weight behind the administration's package.

"At this stage of the game, we must face the fact that this is the plan, not some hypothetical alternative," AFL-CIO President **Lane Kirkland** told reporters Sept.

21. "There were a variety of views about the most desirable way of organizing the system, but we have reached a complete consensus in support of this plan."

As the Clinton proposal gets battered about in Congress, the

AFL-CIO and its member unions will fight especially hard to keep certain elements from being knocked out. They want universal coverage, so if their members lose their jobs they won't lose their health insurance, too. They want employers to pay a big part of the premiums; under President Clinton's plan, employers pay fully 80 percent.

And labor's guardians want guarantees that unions that have negotiated better benefits than those in the Clinton reform will get to keep those benefits.



John Sweeney

And labor likely can count on support from senators like Majority Leader **George Mitchell** (D-Maine), **Edward Kennedy** (D-Mass.), and **Tom Harkin** (D-Iowa), who have always been attentive to labor's concerns.

The AFL-CIO has magnified its influence by joining a broad coalition called the **Health Care Reform Project**, which includes the **American Association of Retired Persons**, the **American Nurses Association**, and other groups generally supportive of Clinton's initiative.

Inside the AFL-CIO, the powerful **Service Employees International Union**, which represents more health-care workers than anyone else, is taking the lead. SEIU President **John Sweeney** heads the AFL-CIO's Committee on Health Care, and he has just brought in **Gerald Shea**, who was the SEIU's top health-care expert, to fill a similar role for the AFL-CIO.

Kirkland, meanwhile, has named **John Perkins**, the AFL-CIO's retired director of political education and a longtime Washington operator, to head a task force charged with getting health reform passed.

Unions will spend an estimated \$4 million to pass health care, says AFL-CIO spokeswoman **Colleen O'Neill**. The AFL-CIO has hired no outside consultants, she says; while an ad campaign is likely in the future, none is imminent.

Instead, the AFL-CIO is working the grass roots. It has 180 "legislative action committees" whose job is to lobby lawmakers back home; 80 of these were created specifically to push health reform. The AFL-CIO faxes regular updates, on health reform and other issues, to

Despite recurring rumors of its political demise, the labor movement has a lot of ammunition for this battle. Several of its top warriors have landed administration positions—most notably **Jerry Klepner**, formerly the top lobbyist for the **American Federation of State, County, and Municipal Employees**, who is now assistant secretary for health and human services.

700 local labor leaders. Many unions, of course, are running their own campaigns in addition to the AFL-CIO push.

At least one union, the 90,000-member **Oil, Chemical & Atomic Workers**, is bucking the AFL-CIO line and loudly proclaiming the superiority of a single-payer system. But it will be tough for any union dissidents to compete with the might, money, and members of the AFL-CIO.

"We are going to approach it as though it were a very, very important election campaign, which in effect it is," Kirkland said at the Sept. 21 press briefing. "We will leave no stone unturned."

—N.B.

AMERICAN ASSOCIATION OF  
RETIRED PERSONS

- **BUDGET:** \$305 million annually.
- **MEMBERS:** 33 million people who are 50 years and older, roughly two-thirds of whom are retired.
- **KEY LOBBYIST:** John Rother, legislative director.
- **BOTTOM LINE:** Wants Medicare funding for drug prescriptions and some form of long-term care.

Charitably described by one House staffer as "a 900-pound gorilla," the American Association of Retired Persons, the nation's largest membership organization, has a habit of getting its way on Capitol Hill.

The 33 million-member group—which represents one out of every two Americans 50 years and older—probably made out better than any other special

interest when the Clinton health plan was unveiled. A host of the AARP's wish-list items was fulfilled: Under the plan, prescription drugs are included in Medicare coverage, a home- and community-based package of long-term care is put in place, and a large chunk of medical insurance for many early retirees is picked up by the government.

"We see this as a promising package," says **John Rother**, the AARP's top lobbyist for nearly 10 years,

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## HEALTH-CARE INTERESTS AND AGENDAS

with evident understatement.

"They played it very well," agrees **Jon Lawniczak**, senior health policy analyst at the **National Council of Senior Citizens**, a labor-oriented lobby for older Americans with five million members, which often works alongside the AARP. "They set out to get what they wanted, and they did."

It's not surprising. The group suffered a major setback when a 1988 catastrophic health-care initiative backed by the AARP was overturned following a roar of public disapproval. But the group made a swift recovery and has returned to its legendary levels of influence.

The AARP's power derives in part from sheer size. With an annual budget of \$305 million and a staff of some 1,000 in its ultra-modern Washington headquarters, the group boasts a membership base that reaches into virtually every community in the nation.

Bolstering its clout is a legislative and research division that is 100 staffers strong and a cadre of 16 full-time lobbyists working the Hill, seven of whom concentrate on nothing but health care. Last year, the AARP's governmental affairs division had a lobbying and research budget of \$27 million.

"Every Congress is terrified by them," remarks one lobbyist.

The AARP says that it's not hiring any outside lobbyists to help push its position, but it has spearheaded a wide-ranging alliance formed this fall: the **Health Care Reform Project**. Ranging from the **AFL-CIO** to the **League of Women Voters** to the **Catholic Health Association**, the two-dozen members—each of whom has chipped in \$5,000—represent an underlying membership of some 55 million people.

The Health Care Reform Project is paying the D.C.-based public-relations firm **Chlopak, Leonard, Schechter & Associates** \$20,000 a month to advocate health-care reform and "take on anyone who is irresponsible, dishonest, or uses misinformation," according to partner **Charles Leonard**. The group's first target: the **Health Insurance Association of America**, a

## DISABLED AMERICAN VETERANS

- **BUDGET:** \$60 million annually.
- **MEMBERS:** 1.2 million veterans with war-related injuries.
- **KEY LOBBYIST:** John Heilman, legislative director.
- **BOTTOM LINE:** Wants to protect the \$16 billion nationwide system of VA hospitals, but also to allow veterans the chance to opt out and participate in any other health-care system.

**C**hronically underfunded, the \$16 billion hospital system run by the Department of Veterans Affairs is often criticized for providing poor care and being overly bureaucratic. Veterans groups entered the battle over the Clinton health plan hoping to save the VA system—both by preserving its autonomy and by opening it up more to competitive market forces to prevent it from becoming isolated and technologically obsolete.

The groups are succeeding on both fronts.

"It's a win-win plan conceptually for veterans," says

**David Gorman**, assistant national legislative director for medical affairs at the Disabled American Veterans, which has taken the lead in lobbying on health care for the community of veterans groups. The DAV's 1.2 million members have a special interest in the VA system: They've all suffered service-related injuries during wartime.

Even before he was elected, President Clinton pledged that the VA system would be an active participant in any health reform plan. And the appointment of **Jesse Brown**, the DAV's former Washington director, as secretary of veterans affairs helped ensure a front-line position in the debate.

The VA system of 171 hospitals and 350 outpatient clinics now services just 9 percent of the nation's 26 million veterans, and many of those are either indigent or don't have work-related medical insurance of their own. Many veterans groups had feared that with Clinton's package providing medical care for all Americans, there would be little reason to maintain a special health-care system open only to veterans.



**T**he boosters of a Canadian-style "single payer" system, under which all citizens buy health care jointly through the government, are a ragtag assortment of consumer groups, labor unions, seniors groups, and churches. They function less as a formal coalition than as voices who form a chorus from time to time.

The Clinton plan presents left-leaning activists with a choice: Do they hold out for a single-payer system? Or do they jump aboard the Clinton bus, figuring it's the last, best chance for health reform?

**Public Citizen**

The result is a split. Many consumer organizations—**Families USA** and

**Consumers Union**, for example—are cheerleading for the Clinton reform. "The president has given us a plan we can work with," says **Gail Shearer**, a policy analyst with Consumers Union. "We continue to believe single-payer is the best system, but we can work with this plan."

But a vocal band of warriors continues to insist that the Clinton plan won't cure the nation's health problems and that the only logical route is a single-payer system.

It's simple and it's fair, they argue. And according to the Congressional Budget Office, a Canadian-style system could cover everyone in the United States and still cut the nation's health bill by \$14.2 billion a year.

A loose confederation called the **Campaign for Health Security**—spearheaded by the **Communication Workers of America**, the **International**



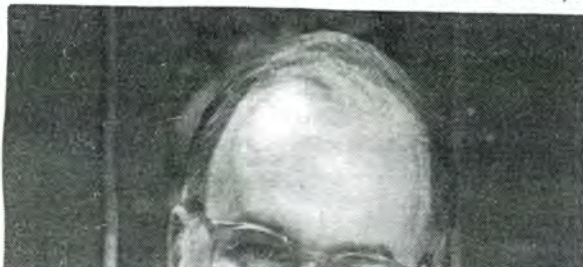
**Sidney Wolfe**

**Ladies Garment Workers Union**, and the consumer group **Citizen Action**—sends mailings to 200,000 people and organizes rallies and town meetings.

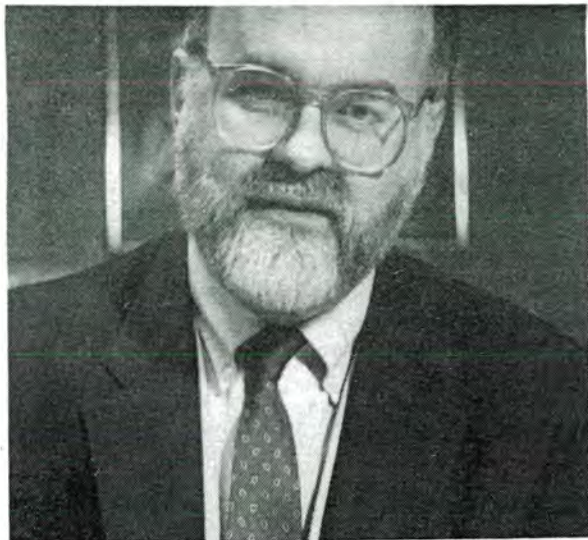
**Public Citizen**, the consumer group founded by Ralph Nader, has 140,000 members and a star spokesman in the form of the bespectacled, tousled Dr. **Sidney Wolfe**. Public Citizen sends reams of suggestions to the White House, members of Congress, and local activists.

Then there's the **Universal Health Care Action Network**, a coalition of roughly 900 local groups favoring a Canadian-style system, and **Physicians for a**

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**AARP's John Rother**

group of 250 health insurers. After the project and other groups complained, the HIAA pulled an allegedly misleading ad criticizing the Clinton plan for excessive bureaucratic meddling.

The AARP's carefully cultivated image as a membership-service organization and advocate for the elderly sometimes obscures the group's own very commercial elements. Founded in 1958 by a retired school principal incensed that the elderly had trouble getting health insurance, the group quickly started offering its own. And it still does. Fully \$84 million of the group's \$305 million operating revenue last year was generated by its supplemental health plans, sponsored by the Prudential Insurance Co.; its auto insurance plans, sponsored by the Hartford Insurance Co.; and its mobile-home insurance, sponsored by the Foremost Insurance Group. Another \$102 million came from member dues, and \$40 million came from its magazines, *Modern Maturity* and the *AARP Bulletin*. (The remaining revenue came from programs, royalties, interest, and the like.)

With its aggressive legislative agenda, the AARP has no shortage of critics. One Senate staffer who deals with the group says it's developed a "certain Darth Vader reputation" over the years. "They drop in without making an appointment and expect everybody to drop everything because AARP is here."

But, as evidenced in the health reform plan, AARP lobbyists often come out on top. "Nobody wants to take them on," says the House staffer. "Why would they?"

—T.R.G.

package providing medical care for all Americans, there would be little reason to maintain a special health-care system open only to veterans.

Under the Clinton plan, the VA medical system will survive, but with one caveat: It will compete head to head with other health-care providers. And that's good news for VA supporters, who argue that only through competition will the oft-maligned system be forced to improve.

"The VA has been called on to compete, which has been our goal all along," says **John Hanson**, director of veterans affairs and rehabilitation at the **American Legion**, whose three million members make it the country's largest veterans organization.

Congressional pressures to pare down the system, or close it entirely, are a constant threat. But it is a fight the veterans groups—which also include the **Veterans of Foreign Wars of the United States**, the **Paralyzed Veterans of America**, and the **Vietnam Veterans of America Inc.**—feel they have no choice but to fight.

"Vets should be well-served if the plans go through as proposed," says Hanson. "The problem is, there are still 535 people who have something to say about it."

In fending off congressional encroachment, the veterans groups can rely on some powerful and loyal allies. Rep. **G.V. "Sonny" Montgomery** (D-Miss.), chairman of the House Veterans' Affairs Committee, barely survived a challenge to his leadership at the outset of the 103rd Congress, but Montgomery, who spent more than half his life in the Army and the National Guard, is not about to abandon his pet cause. And Vietnam veterans have a well-placed friend in Rep. **David Bonior** (D-Mich.), the House majority whip, who served in Vietnam.

—T.R.G.

## SINGLE-PAYER ADVOCATES

- **BUDGET:** Roughly \$8 million, the vast majority of which represents Public Citizen's budget.
- **MEMBERS:** At the heart of this loose cluster are three groups—Public Citizen, Physicians for a National Health Program, and the Campaign for Health Security—which have a mailing list of 345,500.
- **KEY LOBBYIST:** Sidney Wolfe, Public Citizen Health Research Group.
- **BOTTOM LINE:** Wants it to be easy for states to choose a single-payer system.

Then there's the **Universal Health Care Action Network**, a coalition of roughly 900 local groups favoring a Canadian-style system, and **Physicians for a National Health Program**, whose 5,500 members concentrate on convincing their fellow doctors that single-payer is the way to go.

These groups are rallying around a single-payer bill written by Rep. **Jim McDermott** (D-Wash.), the only psychiatrist and one of only two trained physicians serving in Congress.

The McDermott measure has 89 co-sponsors; a companion bill introduced in the Senate by Sen. **Paul Wellstone** (D-Minn.) has five. Single-payer supporters say they are now going after wavering lawmakers such as Sens. **Barbara Boxer** (D-Calif.) and **Russell Feingold** (D-Wis.).

"Twenty to 40 members of Congress said they wouldn't co-sponsor single-payer until they saw the president's plan," says **Sara Nichols**, a Public Citizen health lobbyist. "Now that it's out, groups are going to organize furiously at the grass-roots level."

The **Congressional Black Caucus**, many of whose members support a single-payer system, is a pivotal bloc. "They'll hold out longer than anyone in the single-payer crowd," Nichols predicts. "They made power plays on the budget, and it worked. They've seen how to get their way."

The caucus will release its position on health reform within days, says **Joyce Larkin**, spokeswoman for Rep. **Louis Stokes** (D-Ohio), who heads the caucus's health-care task force.

The debate seems to be moving away from the Canadian option, but that doesn't mean the coalition can't fight for changes in President Clinton's plan, like making it easier for individual states to choose a single-payer system. Many believe that if a handful of states experiment successfully with a Canadian-style system, it will spread through the country.

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## HEALTH-CARE INTERESTS AND AGENDAS

Business  
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MANUFACTURERS  
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**Gerald Mossinghoff**

Most health-care analysts still see the plan as a net minus for drug companies, however, and the industry is feeling decidedly beleaguered.

"They still need somebody to beat up on" is one industry executive's rationale for the rough treatment the industry has received at the administration's hands.

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with evident understatement.

"They played it very well," agrees **Jon Lawniczak**, senior health policy analyst at the **National Council of Senior Citizens**, a labor-oriented lobby for older Americans with five million members, which often works alongside the AARP. "They set out to get what they wanted, and they did."

It's not surprising. The group suffered a major setback when a 1988 catastrophic health-care initiative backed by the AARP was overturned following a roar of public disapproval. But the group made a swift recovery and has returned to its legendary levels of influence.

The AARP's power derives in part from sheer size. With an annual budget of \$305 million and a staff of some 1,000 in its ultra-modern Washington headquarters, the group boasts a membership base that reaches into virtually every community in the nation.

Bolstering its clout is a legislative and research division that is 100 staffers strong and a cadre of 16 full-time lobbyists working the Hill, seven of whom concentrate on nothing but health care. Last year, the AARP's governmental affairs division had a lobbying and research budget of \$27 million.

"Every Congress is terrified by them," remarks one lobbyist.

The AARP says that it's not hiring any outside lobbyists to help push its position, but it has spearheaded a wide-ranging alliance formed this fall: the **Health Care Reform Project**. Ranging from the **AFL-CIO** to the **League of Women Voters** to the **Catholic Health Association**, the two-dozen members—each of whom has chipped in \$5,000—represent an underlying membership of some 55 million people.

The Health Care Reform Project is paying the D.C.-based public-relations firm **Chlopak, Leonard, Schechter & Associates** \$20,000 a month to advocate health-care reform and "take on anyone who is irresponsible, dishonest, or uses misinformation," according to partner **Charles Leonard**. The group's first target: the **Health Insurance Association of America**, a



## DISABLED AMERICAN VETERANS

- **BUDGET:** \$60 million annually.
- **MEMBERS:** 1.2 million veterans with war-related injuries.
- **KEY LOBBYIST:** John Heilman, legislative director.
- **BOTTOM LINE:** Wants to protect the \$16 billion nationwide system of VA hospitals, but also to allow veterans the chance to opt out and participate in any other health-care system.

**C**hronically underfunded, the \$16 billion hospital system run by the Department of Veterans Affairs is often criticized for providing poor care and being overly bureaucratic. Veterans groups entered the battle over the Clinton health plan hoping to save the VA system—both by preserving its autonomy and by opening it up more to competitive market forces to prevent it from becoming isolated and technologically obsolete.

The groups are succeeding on both fronts. "It's a win-win plan conceptually for veterans," says



**David Gorman**, assistant national legislative director for medical affairs at the Disabled American Veterans, which has taken the lead in lobbying on health care for the community of veterans groups. The DAV's 1.2 million members

have a special interest in the VA system: They've all suffered service-related injuries during wartime.

Even before he was elected, President Clinton pledged that the VA system would be an active participant in any health reform plan. And the appointment of **Jesse Brown**, the DAV's former Washington director, as secretary of veterans affairs helped ensure a front-line position in the debate.

The VA system of 171 hospitals and 350 outpatient clinics now services just 9 percent of the nation's 26 million veterans, and many of those are either indigent or don't have work-related medical insurance of their own. Many veterans groups had feared that with Clinton's package providing medical care for all Americans, there would be little reason to maintain a special health-care

**T**he boosters of a Canadian-style "single payer" system, under which all citizens buy health care jointly through the government, are a ragtag assortment of consumer groups, labor unions, seniors groups, and churches. They function less as a formal coalition than as voices who form a chorus from time to time.

The Clinton plan presents left-leaning activists with a choice: Do they hold out for a single-payer system? Or do they jump aboard the Clinton bus, figuring it's the



last, best chance for health reform?

The result is a split. Many consumer organizations—**Families USA** and

**Consumers Union**, for example—are cheerleading for the Clinton reform. "The president has given us a plan we can work with," says **Gail Shearer**, a policy analyst with Consumers Union. "We continue to believe single-payer is the best system, but we can work with this plan."

But a vocal band of warriors continues to insist that the Clinton plan won't cure the nation's health problems and that the only logical route is a single-payer system.

It's simple and it's fair, they argue. And according to the Congressional Budget Office, a Canadian-style system could cover everyone in the United States and still cut the nation's health bill by \$14.2 billion a year.

A loose confederation called the **Campaign for Health Security**—spearheaded by the **Communication Workers of America**, the **International**



**Sidney Wolfe**

**Ladies Garment Workers Union**, and the consumer group **Citizen Action**—sends mailings to 200,000 people and organizes rallies and town meetings.

**Public Citizen**, the consumer group founded by Ralph Nader, has 140,000 members and a star spokesman in the form of the bespectacled, tousled Dr. **Sidney Wolfe**. Public Citizen sends reams of suggestions to the White House, members of Congress, and local activists.

Then there's the **Universal Health Care Action Network**, a coalition of roughly 900 local groups favoring a Canadian-style system, and **Physicians for a**





**AARP's John Rother**

group of 250 health insurers. After the project and other groups complained, the HIAA pulled an allegedly misleading ad criticizing the Clinton plan for excessive bureaucratic meddling.

The AARP's carefully cultivated image as a membership-service organization and advocate for the elderly sometimes obscures the group's own very commercial elements. Founded in 1958 by a retired school principal incensed that the elderly had trouble getting health insurance, the group quickly started offering its own. And it still does. Fully \$84 million of the group's \$305 million operating revenue last year was generated by its supplemental health plans, sponsored by the Prudential Insurance Co.; its auto insurance plans, sponsored by the Hartford Insurance Co.; and its mobile-home insurance, sponsored by the Foremost Insurance Group. Another \$102 million came from member dues, and \$40 million came from its magazines, *Modern Maturity* and the *AARP Bulletin*. (The remaining revenue came from programs, royalties, interest, and the like.)

With its aggressive legislative agenda, the AARP has no shortage of critics. One Senate staffer who deals with the group says it's developed a "certain Darth Vader reputation" over the years. "They drop in without making an appointment and expect everybody to drop everything because AARP is here."

But, as evidenced in the health reform plan, AARP lobbyists often come out on top. "Nobody wants to take them on," says the House staffer. "Why would they?"

—T.R.G.

Many veterans groups had feared that with Clinton's package providing medical care for all Americans, there would be little reason to maintain a special health-care system open only to veterans.

Under the Clinton plan, the VA medical system will survive, but with one caveat: It will compete head to head with other health-care providers. And that's good news for VA supporters, who argue that only through competition will the oft-maligned system be forced to improve.

"The VA has been called on to compete, which has been our goal all along," says **John Hanson**, director of veterans affairs and rehabilitation at the **American Legion**, whose three million members make it the country's largest veterans organization.

Congressional pressures to pare down the system, or close it entirely, are a constant threat. But it is a fight the veterans groups—which also include the **Veterans of Foreign Wars of the United States**, the **Paralyzed Veterans of America**, and the **Vietnam Veterans of America Inc.**—feel they have no choice but to fight.

"Vets should be well-served if the plans go through as proposed," says Hanson. "The problem is, there are still 535 people who have something to say about it."

In fending off congressional encroachment, the veterans groups can rely on some powerful and loyal allies. Rep. **G.V. "Sonny" Montgomery** (D-Miss.), chairman of the House Veterans' Affairs Committee, barely survived a challenge to his leadership at the outset of the 103rd Congress, but Montgomery, who spent more than half his life in the Army and the National Guard, is not about to abandon his pet cause. And Vietnam veterans have a well-placed friend in Rep. **David Bonior** (D-Mich.), the House majority whip, who served in Vietnam.

—T.R.G.

## SINGLE-PAYER ADVOCATES

- **BUDGET:** Roughly \$8 million, the vast majority of which represents Public Citizen's budget.
- **MEMBERS:** At the heart of this loose cluster are three groups—Public Citizen, Physicians for a National Health Program, and the Campaign for Health Security—which have a mailing list of 345,500.
- **KEY LOBBYIST:** Sidney Wolfe, Public Citizen Health Research Group.
- **BOTTOM LINE:** Wants it to be easy for states to choose a single-payer system.

Then there's the **Universal Health Care Action Network**, a coalition of roughly 900 local groups favoring a Canadian-style system, and **Physicians for a National Health Program**, whose 5,500 members concentrate on convincing their fellow doctors that single-payer is the way to go.

These groups are rallying around a single-payer bill written by Rep. **Jim McDermott** (D-Wash.), the only psychiatrist and one of only two trained physicians serving in Congress.

The McDermott measure has 89 co-sponsors; a companion bill introduced in the Senate by Sen. **Paul Wellstone** (D-Minn.) has five. Single-payer supporters say they are now going after wavering lawmakers such as Sens. **Barbara Boxer** (D-Calif.) and **Russell Feingold** (D-Wis.).

"Twenty to 40 members of Congress said they wouldn't co-sponsor single-payer until they saw the president's plan," says **Sara Nichols**, a Public Citizen health lobbyist. "Now that it's out, groups are going to organize furiously at the grass-roots level."

The **Congressional Black Caucus**, many of whose members support a single-payer system, is a pivotal bloc. "They'll hold out longer than anyone in the single-payer crowd," Nichols predicts. "They made power plays on the budget, and it worked. They've seen how to get their way."

The caucus will release its position on health reform within days, says **Joyce Larkin**, spokeswoman for Rep. **Louis Stokes** (D-Ohio), who heads the caucus's health-care task force.

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billion in domestic sales of medical technology.

Being left off the list has its advantages. The Clinton plan contains no direct controls on industry prices, leaving HIMA's members free from an unwanted form of government intrusion. Neither does the plan contain any explicit efforts to limit the kinds of expensive procedures that the association specializes in facilitating.

Still, HIMA remains wary. "We're not directly targeted, but we worry about bureaucratic shrapnel,"

Speil says.

Already, there is pressure in the cost-conscious health-care industry to curb the use of high-tech equipment. And HIMA's four registered lobbyists are desperate to keep technology assessment from being added to the duties of the National Health Board proposed by the Clinton plan. Should that happen, the board would be empowered to decide which



Alan Magazine

technologies become part of the standard benefits package—and which technologies are left out in the cold. The group also fears that any bid to limit insurance premiums could also indirectly curb the use of medical technology.

HIMA is represented on the public-relations battlefield by its president, **Alan Magazine**, a respected former head of the private-sector Council on Competitiveness, who joined the trade group in 1990. Though he doesn't lobby the Hill, Magazine serves as the industry's spokesman and is responsible for the group's increasingly visible profile.

His work will be buttressed by a strengthened grass-roots effort. The group plans to phase out its PAC by the end of the year, preferring to focus on visits by HIMA members to congressional district offices.

HIMA has also revamped its government affairs office in Washington, installing a new three-person team this year. The association employs 73 staffers in all.

These efforts are intended to ensure that HIMA's interests are not inadvertently trampled by a Congress bombarded by groups more directly affected by the health plan.

"We're worried about how medical technology will be treated in any kind of health-care reform plan," says

HIMA's vice president for government affairs, **Greg Raab**, who is a former lobbyist for Medtronic, a Minneapolis-based manufacturer of medical devices. "If there's any fallout, we want [members of Congress] to be making conscious decisions, to let them understand what they're doing to medical technology." —T.R.G.

## NATIONAL ASSOCIATION OF MANUFACTURERS

- **BUDGET:** \$16 million annually.
- **MEMBERS:** 12,500 companies, with more than 200,000 employees.
- **KEY LOBBYIST:** Sharon Canner, assistant vice president for industrial relations and director of employee benefits.
- **BOTTOM LINE:** May accept employer-mandated health insurance with subsidies for small businesses and lower-wage employees, depending on the rest of the package. Worried about payroll tax on self-insured companies.

In a move that surprised many business lobbyists, the National Association of Manufacturers has indicated a willingness to accept the Clinton administration's proposal to require employers to pay for employee health insurance.

"It may be the bitter pill we have to swallow," says NAM health-care lobbyist **Sharon Canner**.

Canner says that NAM may go along with the employer mandate—depending on the rest of the package. One reason for the group's support is surely the sweetener the administration has thrown in: a bailout for companies paying health-care costs for employees who accept early retirement during downsizing.

But NAM is still in a wait-and-see mode. The group's health task force met last week in California with its executive committee and board of directors to discuss the Clinton plan. NAM has not yet given its full endorsement.

Staffers at NAM's 50-person Washington lobby shop and NAM member companies have been sponsoring a

series of breakfast meetings with lawmakers and administration officials to discuss their concerns. In late September, the heavy hitters of the group—including **Ashland Oil Inc.**, **Merck & Co.**, the **Ford Motor Co.**, the **Eastman Kodak Co.**, the **Hewlett-Packard Co.**, and **RJR Nabisco Inc.**—had a breakfast meeting with White House aide Ira Magaziner to try to unearth the details of the plan.

"A lot of members feel that this is such a moving target right now. Every three weeks we get new pieces," says NAM spokesman **Andrew Smart**. "The more people sift through what's in the proposal, the more they come up with things that may concern them."

Should the NAM decide to back President Clinton to the hilt on the employer insurance mandate, the group will not be alone in the business sector. The U.S. **Chamber of Commerce**, noting that health insurance premiums for its members have risen as much as 30 percent in recent years, has also offered to go along with the employer mandate. The chamber, which represents about 215,000 companies and 1,200 trade groups, and has a \$70 million annual budget, is not mounting a major effort.

One proposal that has raised eyebrows among NAM members is the possibility of a 1-percent payroll tax on self-insured companies to finance teaching hospitals. They're also concerned about the possibility that Clinton will move to impose wage-and-price controls.

Considered one of the most effective business lobbies in town, NAM has been having a great year. The group formed a coalition that proved instrumental in defeating the BTU energy tax and having it replaced with a tax on transportation.

NAM's strength derives not from outside hired guns, but rather from its own members' clout; together, they represent 85 percent of all manufacturing companies in the country. In recent years, NAM has also emerged as a voice for non-manufacturing businesses.

Canner says that NAM has held numerous regional conferences and meetings to inform its membership about the health plan.

"I spend a lot of time on the phone," she says. "There's a misunderstanding by some companies that because the administration puts out a plan, that that's the plan. We need to explain that that's just the beginning."

—S.K.



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## HEALTH-CARE INTERESTS AND AGENDAS

## NATIONAL FEDERATION OF INDEPENDENT BUSINESS

- **BUDGET:** \$65 million annually.
- **MEMBERS:** 607,000 small-business owners, who employ an average of five to eight workers.
- **KEY LOBBYISTS:** John Motley, vice president of federal governmental affairs. Jack Faris, president; former executive director of the Republican National Committee's finance panel.
- **PAC:** Spent \$303,180 in the 1991-92 election cycle and \$28,600 in the first eight months of 1993.
- **BOTTOM LINE:** Opposes requiring businesses to pay for employee health insurance.

The leading trade groups representing big business—the **U.S. Chamber of Commerce** and the **National Association of Manufacturers**—may be amenable to the notion of employers paying a portion of employees' health insurance. But on that issue the nation's small-business advocates have drawn a line in the sand.

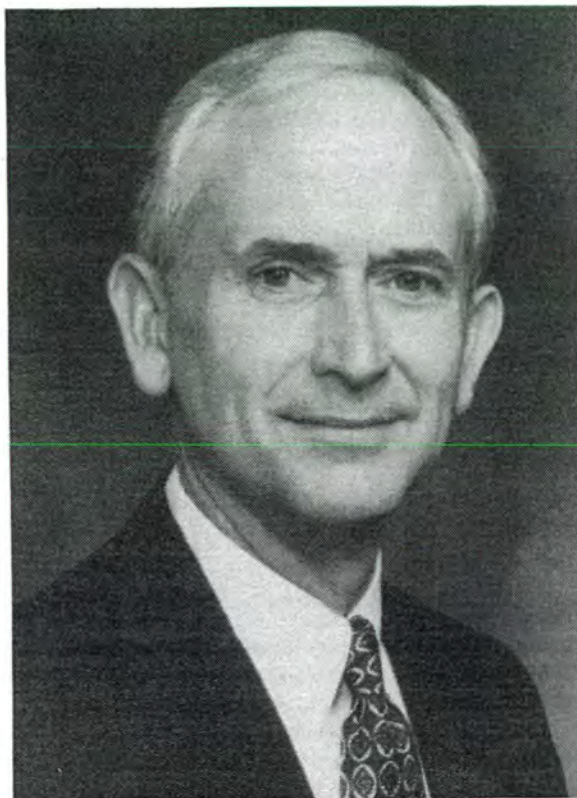
"Even when sugar-coated with promises of a government subsidy, small business isn't swallowing this bitter pill," says **Jack Faris**, president of the

National Federation of Independent Business.

The largely Republican group let its opposition be known shortly after it became clear that President Clinton's package would include a proposal to mandate employer insurance—a proposal that advocates claim would save money.

The NFIB released a study concluding that the plan would cost up to 1.5 million jobs.

NFIB members are using such dire predictions as a lobbying weapon, arguing that the plan could jack up unemployment in lawmakers' districts and cost them precious constituent support. And when the NFIB talks, lawmakers tend to listen, mindful of the economic clout



NFIB's Jack Faris

of the group, whose business owners rack up gross annual sales of about \$250 billion.

Also effective on Capitol Hill is another small-business group, the **National Association of Wholesaler-Distributors**, which echoes many of the NFIB's concerns about the Clinton plan.

Lobbyists for both groups bristle at administration suggestions that small-business owners are looking for a free ride. To the contrary, says one recent NFIB survey, most of its members would be pleased to pay for employee health insurance—if only they could afford it.

The NFIB has strengthened its hand by joining a coalition called the **Healthcare Equity Action League**. HEAL has a \$160,000 annual income from its 80 steering committee members, including the **Aetna Life & Casualty Co.**, the **Pharmaceutical Manufacturers**

of America, and the **Federation of American Health Systems**, the trade group that represents for-profit hospitals.

Besides fighting the employer mandate, HEAL is helping the NFIB with its campaign against Clinton's proposed national health-care budget, which it rejects as health-care "rationing," and against the administration's plan to permit regional health alliances to cap insurance premiums.

"Premium caps are price controls by another name, and we know from history that price controls do not work," says **Alan Kranowitz**, senior vice president for government relations of the wholesaler-distributor group and executive secretariat of HEAL.

The NFIB is getting a big boost from the alliance it has forged with the Federation of American Health Systems. One health lobbyist describes it as a classic political horse trade.

Recalling a conversation he had with **Michael Bromberg**, executive director of the federation, this lobbyist says: "Bromberg said, 'We have this deal with NFIB. We're going to fight back to back and protect each other. If they help me on cost containment, I'm going to help them on employer mandate.'"

Ironically, the NFIB may also benefit from the Chamber of Commerce's strong support for the Clinton plan. "The Chamber of Commerce and NFIB compete for members," Kranowitz says. "I suspect that the chamber's position is going to be a big membership boon for NFIB."

Both the NFIB and HEAL have praised the two major Republican proposals on health care, which omit the employer mandate, as well as legislation introduced by Reps. **Jim Cooper** (D-Tenn.) and **Charles Stenholm** (D-Texas), which also spares employers.

As they wade into battle, NFIB members have one intangible factor weighing in their favor. The group suffered a major defeat when Congress liberalized rules that govern employees' ability to leave work to tend to pressing family concerns. Fresh from that defeat, the NFIB is determined not to take another loss.

"They have been very aggressive, very focused on this one issue," says one health lobbyist. "They have a good chance of winning."

—S.K.

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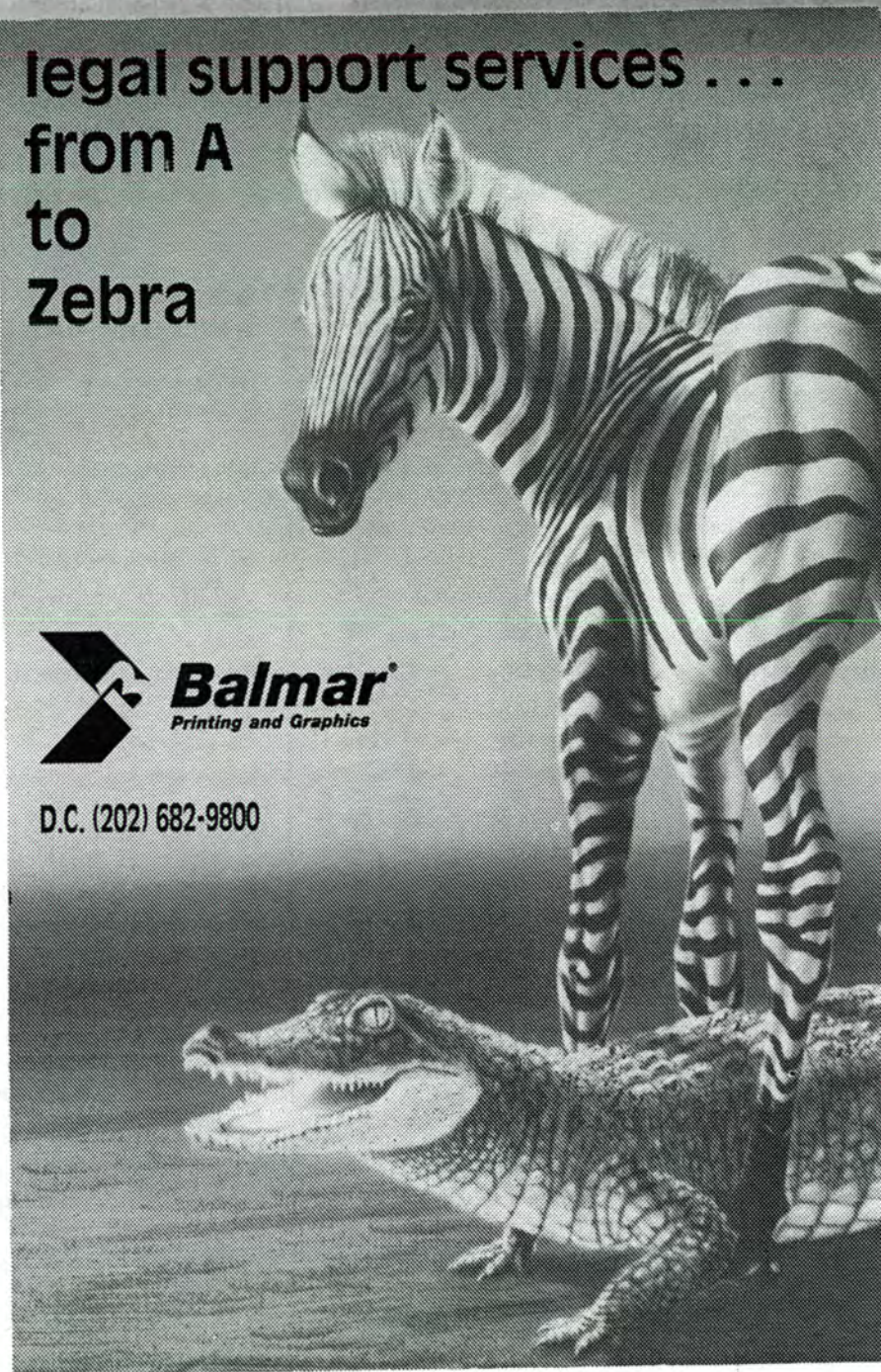
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## Insurers



### HEALTH INSURANCE ASSOCIATION OF AMERICA

- **BUDGET:** \$20.6 million annually.
- **MEMBERS:** 250 insurance companies, boasting 189 million policyholders.
- **KEY LOBBYIST:** Willis Gradison Jr., president. Former ranking Republican on House Ways and Means Subcommittee on Health.
- **PAC:** Spent \$301,400 in the 1991-92 election cycle and \$50,900 in the first half of 1993.
- **BOTTOM LINE:** Does not want purchasing cooperatives to determine what health plans consumers can buy. If that happens, the HIAA is terrified that many of its members will be shut out and, ultimately, forced to fold.

**T**he Health Insurance Association of America is probably the most desperate of the health lobbies, and its tactics reflect its panic. The citizens' cooperatives envisioned under President Clinton's plan will buy policies only from insurance companies that meet certain standards, and this could drive many companies out of business.

Not only does the prospect of health reform have the group on the run; it has depleted the HIAA's power. Four mammoth insurance companies—which, unlike the rest of the industry, will prosper under Clinton's reforms—abandoned the HIAA to form their own group. (A fifth joined them without actually quitting the HIAA.)

And two dozen of the smallest companies, which have the most to lose under reform, also have created their own organization.

The HIAA is left to flail away in the middle. And the White House, figuring the insurance industry is the one entity despised more than government, has been happy to engage in a public fight.

On Sept. 7, the HIAA distributed to the press a statement headlined, "Bureaucrats choose, consumers

want reform as much as the American people and you do."

But what has upset the HIAA's opponents most have been its television commercials, on CNN and targeted local stations, showing a middle-aged, middle-income couple distraught that Clinton's plan won't let them choose their insurance.

The **Democratic National Committee** aired counter ads stressing that the HIAA spots were funded by the insurance industry. The consumer group **Families USA** jumped in with commercials declaring the HIAA ad misleading. And a broad coalition called the **Health Care Reform Project**—with members ranging from the **AFL-CIO** to the **Chrysler Corp.**—blasted the ads in a Sept. 15 statement.

The ads have been withdrawn. An HIAA spokeswoman said they've "served their purpose."

HIAA spokesman **Richard Coorsh** says insurance companies are being unfairly attacked. "This is a well-orchestrated campaign to somehow come up with a villain," Coorsh says. "Regrettably for us, we've been cast in that role."

The HIAA has signed up **CMF&Z**, a Des Moines-based firm, which is getting \$200,000 for public-relations work; **Mellman-Lazarus-Lake**, a D.C. Democratic polling outfit; and **O'Brien Calio**, a D.C. political consulting firm, to plot legislative strategy.

But the HIAA's big gun is Gradison, an 18-year House veteran who joined the group in February, bringing his connections and an extensive knowledge of health-care policy. As ranking Republican on the House Ways and Means Subcommittee on Health, Gradison, a moderate, worked closely with subcommittee Chairman **Pete Stark** (D-Calif.). Stark will have a central role in shaping whatever health-care reform package emerges from Congress.

The HIAA has apparently settled on the ever-popular "choice" slogan as its chief sales message—in this case denoting a consumer's freedom to choose his or her own insurance company. Consumer groups ridicule the notion that anyone cares about that.

The HIAA is also spearheading a group called the **Coalition for Health Insurance Choices**, which includes insurance agents, small businesses, and others.

Despite its wounds, no one doubts the HIAA's power to influence the health-care debate.

"They have tremendous clout because they have the agents on their side," says **Robert Hunter**, president of the **National Insurance Consumers Organization** and a longtime HIAA critic. "And the agents are politically powerful because they are the small-business people in every town."

Formed in March, Oldaker, Ryan & Leonard is especially well-positioned to push its client's agenda. **William Oldaker** is a major Democratic fund-raiser, having cemented ties to congressional leaders as a top aide to then House Speaker Jim Wright. **Robert Leonard** was staff director of the House Ways and Means Committee until earlier this year. And **Thomas Ryan** was the top staffer at the House Energy and Commerce Committee several years ago.

The alliance's advertising has thus far been confined to a single ad earlier this year, taken out in such inside-the-Beltway publications as *National Journal* and *Roll Call*, says CIGNA spokesman **Randall Gerber**.

"We believe in immediate and fundamental reform of America's health care system," says the ad, apparently intended to contrast with the HIAA's less-enthusiastic endorsement of reform.

In recent weeks, the alliance has hired as media director **John Gibbons**, who had been working as a consultant to the **Pharmaceutical Manufacturers Association**. Before that, Gibbons was deputy spokesman to then Health and Human Services Secretary Louis Sullivan.

The alliance's lobbying has been quiet. "We have chosen not to be as strident as the HIAA," Gerber says. "We find we're most effective in sharing our vision of health care and managed care in one-on-one meetings with decision-makers."

The alliance mostly likes the Clinton plan; its main goal is killing the cap on insurance premiums. The Big Five also would love to weaken the consumer cooperatives that will be bargaining with them over prices and benefits.

Among the group's likely champions is Rep. **Barbara Kennelly** (D-Conn.). She's from Hartford—where most big U.S. insurance companies are based—and, as the Democrats' chief deputy whip in the House, is in charge of lining up votes on key issues.

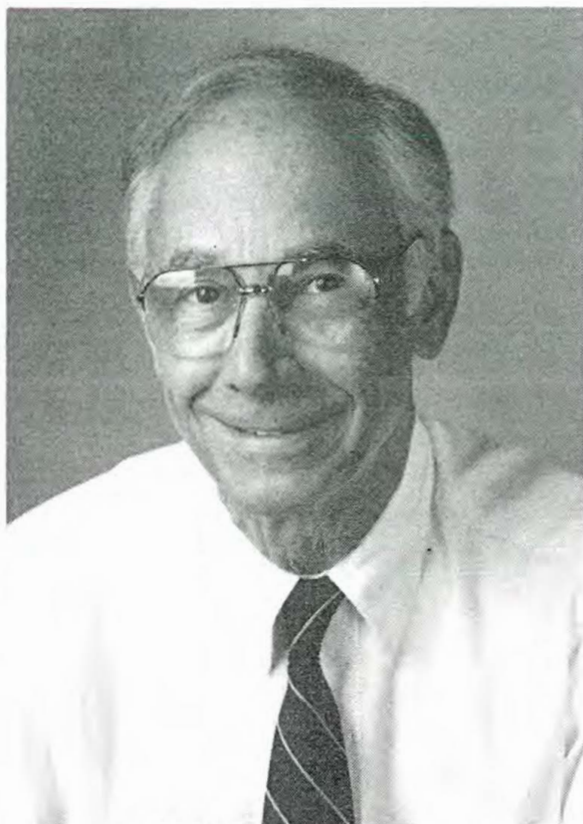
—N.B.

### BLUE CROSS AND BLUE SHIELD ASSOCIATION

- **BUDGET:** \$131 million annually.
- **MEMBERS:** 69 Blue Cross and Blue Shield plans, boasting 68 million policyholders nationwide.
- **KEY LOBBYIST:** Mary Nell Lehnhard, senior vice president.
- **PAC:** Spent \$228,070 in the 1991-92 election cycle and \$72,610 in the first half of 1993.



On Sept. 7, the HIAA distributed to the press a statement headlined, "Bureaucrats choose, consumers



HIAA's Willis Gradison

lose under Clinton health reforms." The next day, the White House shot back in its daily newsletter that "HIAA appears to be saying they don't want health care reform." HIAA President Willis Gradison Jr. answered with a letter saying, "The White House Communications Office should know better than to say what it said."

Meanwhile, Goddard\*Claussen/First Tuesday, a media company based in Malibu, Calif., is running a \$1.5 million advertising campaign on the HIAA's behalf. It includes newspaper ads that shout "Surprise!" and insist that insurance companies strongly favor reform. On the day of Clinton's Sept. 22 speech unveiling his health-care package, the HIAA ran full-page ads consisting of an open letter from Gradison to Clinton, saying, "We in the health insurance industry

the National Insurance Consumers Organization and a longtime HIAA critic. "And the agents are politically powerful because they are the small-business people in every town."

—N.B.

## ALLIANCE FOR MANAGED COMPETITION

- **BUDGET:** Roughly \$1 million.
- **MEMBERS:** The five largest insurance companies, with a clientele of 60 million policyholders.
- **KEY LOBBYISTS:** Executives of the top five insurance companies.
- **BOTTOM LINE:** Wants no caps on insurance premiums.

**W**hen the CIGNA Corp. left the Health Insurance Association of America in 1991, it was a bad omen for the group. CIGNA, with its chain of 49 HMOs, had much to gain from changes in the health-care system stressing HMO-type care, and its executives were impatient with what they perceived to be the HIAA's dillydallying on reform.

For the HIAA, decisions about reform have meant reconciling the often competing interests of its members. Many small firms in the group could fold if they're shut out by the large purchasing cooperatives envisioned in the Clinton plan. But large insurers—many of which, like CIGNA, own lots of HMOs—are favored under the reform and so support it.

Eventually, three other large insurers followed CIGNA out of the HIAA. And early this year, these four defectors and one other who has kept ties with the HIAA went a step further.

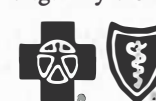
CIGNA, the Prudential Insurance Co., the Metropolitan Life Insurance Corp., The Travelers, and the Aetna Life & Casualty Co.—the nation's five largest health insurance companies—formally created a brand-new trade association, the Alliance for Managed Competition, to throw their weight behind the Clinton effort.

The alliance has no office suite. Instead, its lobbying is coordinated by two Washington political consulting firms, The Ridley Group and Oldaker, Ryan & Leonard.

- **KEY LOBBYIST:** Mary Nell Lehnhard, senior vice president.
- **PAC:** Spent \$228,070 in the 1991-92 election cycle and \$72,610 in the first half of 1993. Including regional PACs, Blue Cross spent \$307,450 in the 1991-92 cycle, according to the Center for Responsive Politics.
- **BOTTOM LINE:** Wants no caps on health premiums. Wants purchasing cooperatives to be voluntary, not mandatory.

**T**he nation's 69 Blue Cross and Blue Shield companies are odd creatures in the health-care jungle.

Unlike other insurance firms, they are non-profit, are tied to specific regions of the country, and were originally created to insure those with lower incomes.



This gives them the aura of being above the profiteering of the rest of the health-care industry.

Yet Blue Cross operations have been torn by mismanagement scandals over the past decade, draining their resources, hurting their image, and reducing their clout. New York's Empire Blue Cross and Blue Shield, for example, is accused of filing misleading data with the state.

The Blue Cross and Blue Shield plans, which are independent, together insure more than one-quarter of the U.S. population, at all income levels. And they rely heavily on managed-care networks like HMOs; this positions them to take advantage of the Clinton reforms, which also stress such networks.

For more than a year, the Blue Cross and Blue Shield Association has depended on Joseph O'Neill, president of the lobbying firm Public Strategies Washington, to coordinate its attack. O'Neill was a top staffer to Treasury Secretary Lloyd Bentsen when Bentsen was in the Senate.

The Blue Cross programs are pushing much the same things as other insurance companies. They want to kill the cap on insurance premiums, and they want the health alliances—groups of consumers who will buy health care jointly—to be voluntary, not mandatory.

The alliances will become huge bureaucracies otherwise, they argue. But it's also true that making the alliances voluntary would weaken them, to the advantage of those—like the Blue Cross and Blue Shield plans—who will be selling the alliances health care and bargaining over the terms.

—N.B.

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## HEALTH-CARE INTERESTS AND AGENDAS

## Miscellaneous

## DEMOCRATIC NATIONAL COMMITTEE

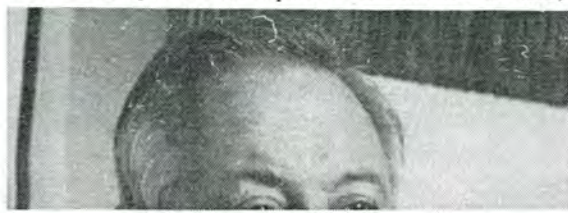
- **BUDGET:** Plans to raise \$1 million to \$3 million by year's end.
- **MEMBERS:** 45 million people voted for Clinton in 1992.
- **KEY LOBBYIST:** Richard Celeste, former Ohio governor.
- **BOTTOM LINE:** Pass the president's plan, or watch the party's political fortunes plummet.

It's got bumper stickers, campaign buttons, television ads, a petition drive, an 800 number, even a slogan: "Health care that's always there."

Never has a political party so resembled a lobbying group. And never has a lobbying effort so resembled a political campaign.

The Democrats' unprecedented National Health Care Campaign is chaired by former Ohio Gov. **Richard Celeste**, who served his years in office, 1983-91, alongside then Gov. Bill Clinton. Political consultant **Celia Fisher**, who ran the Clinton-Gore campaign in Pennsylvania, is handling nuts and bolts for the group. **C. Everett Koop**, the popular former surgeon general, has been enlisted as a liaison to physicians. And the party plans to raise \$1 million to \$3 million for the campaign by year's end, says Democratic National Committee spokeswoman **Catherine Moore**.

A coordinator is heading up the effort in each state, and a dozen staffers have been assigned to the campaign at DNC headquarters on Capitol Hill. Teams of doctors,



and pharmaceutical industries. The DNC has already aired one ad directly attacking an insurance-industry commercial that was critical of the Clinton plan. The insurers wound up pulling their ad.

"Part of our responsibility as a campaign is to identify the opposition," Celeste says. "If people will take on the Clinton health-care reform, they need to be held accountable."

It's become a cliché that the political parties have largely lost their traditional roles of forging platforms, selecting candidates, and keeping officeholders in line. By using the DNC to sell a huge social program instead of a candidate, the Democrats just may have found a new role for the party, a role more in tune with current politics: The political party is becoming, in many ways, one more big lobby.

The **Republican National Committee**, in contrast, has nothing so grand in the works. The GOP is not especially eager to make health care a partisan fight, or so its congressional leaders have suggested. And there's a further obstacle to following in its rival's path: Unanimity would be difficult to achieve, given that there are now three Republican plans afloat, one introduced by Sen. **John Chafee** of Rhode Island, another by Sen. **Phil Gramm** of Texas, and a third circulating in the House.

—N.B.

## DISTILLED SPIRITS COUNCIL OF THE UNITED STATES

- **BUDGET:** \$9 million annually.
- **MEMBERS:** 24 liquor manufacturers.
- **KEY LOBBYIST:** Timothy Dudgeon, federal relations director.
- **PAC:** Spent \$70,760 in the 1991-92 election cycle and \$18,270 in the first half of 1993.
- **BOTTOM LINE:** Opposes using alcohol taxes to pay for health care.

If there's been a big victory in the early skirmishing over health reform, it belongs to the Distilled Spirits Council.

President Clinton's health-care team was eyeing a tax on alcohol during the planning stages. But when the package was unveiled, liquor manufacturers had dodged

creates as many health problems as tobacco," Lancaster wrote Hillary Clinton on July 19. "Tobacco does not cause the injuries from spouse abuse, child abuse, automobile accidents, etc., that alcohol does."

And 57 groups, ranging from the **American Medical Association** to the **National PTA**, have signed onto a statement favoring alcohol taxes as a way to cut down on unhealthy drinking.

In the end, President Clinton simply realized he didn't need another enemy, says **George Hacker**, director of the **Alcohol Project** at the **Center for Science in the Public Interest**. "The administration decided they didn't want to fight too many fighters in the ring," Hacker says.

But the match is not over. There is much pressure to find more money for health reform, and liquor taxes have always been tempting to politicians. To ward off the temptation, the Distilled Spirits Council will pound away at the point that raising taxes doesn't mean more revenue if fewer people drink.

"We're going to keep that information in front of people as long as we can," Board says. "It's hard to explain to people why you want to tax them more when the tax isn't even working."

—N.B.

## TOBACCO INSTITUTE

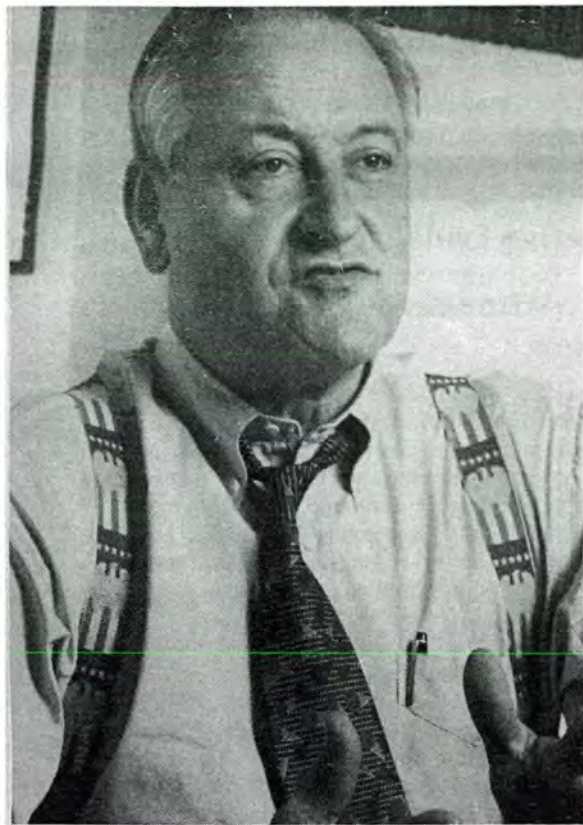
- **BUDGET:** \$38 million annually.
- **MEMBERS:** 13 cigarette companies, led by RJR Nabisco and Philip Morris.
- **KEY LOBBYIST:** Walker Merryman, vice president.
- **PAC:** Spent \$184,650 in the 1991-92 election cycle and \$46,900 in the first half of 1993.
- **BOTTOM LINE:** Wants to kill the cigarette tax.

The July 19 letter from Rep. **Martin Lancaster** (D-N.C.) to first lady Hillary Rodham Clinton did not bother with niceties. "A plan which focuses only on tobacco is political dynamite in my district," wrote Lancaster, who represents a major tobacco-growing region. "It will break my heart to do so, but please know that I will do everything in my power to defeat a health care reform package which singles out tobacco for a confiscatory tax."

Meanwhile, back in rural Seven Springs, N.C., a group called **Friends of Tobacco** is running a "green

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PATRICE GILBERT

### DNC's Richard Celeste

nurses, and business representatives are being assembled to speak in their communities.

About 500 health-care "house parties" were held Sept. 22, the night of President Clinton's address to the nation on health care. More parties are planned, and a video is being prepared for showing at these events.

"This is not a usual political campaign, where you target your opponents if they happen to be Republicans," Celeste says. "We need to draw in people we might not ordinarily be working with."

The Democrats originally planned to create an independent health reform campaign with offices outside DNC headquarters. But that plan was dropped in June, following protests over the Democrats' intent to keep contributors' names a secret.

The goal, of course, is to prime the pump for a torrent of letters and calls to congressional offices urging enactment of the Clinton reforms. The campaign's message: Clinton's plan will give you security, and the cost of doing nothing is greater than the cost of change.

The war-room mentality of Clinton's presidential campaign is fresh in the minds of Democratic activists, and they relish taking on such enemies as the insurance

over health reform, it belongs to the Distilled Spirits Council.

President Clinton's health-care team was eyeing a tax on alcohol during the planning stages. But when the package was unveiled, liquor manufacturers had dodged the bullet—an achievement looked upon with envy by their comrades in the tobacco fields.

The stage was set by the beer and wine lobbies, which are not part of the Distilled Spirits Council. These two groups had made it clear that if the president tried to tax them, they would drum up opposition from Joe and Jane Six-Pack. They have powerful congressional allies like House Majority Leader **Richard Gephardt** (D-Mo.), whose St. Louis district is home to the Anheuser-Busch brewery, and the delegation from California's wine region.

So the threat of a beer and wine tax was quickly shoved out of the picture. That ratcheted up the pressure on the much smaller hard-liquor industry, represented by the Distilled Spirits Council.

With a small staff and little time, council staffers ran a scrappy campaign, designing ads in-house. They conceived the idea of buying a four-page insert in *The New York Times*' Washington-area delivery run. They saved thousands by running ads on *The Washington Post*'s "Federal Page" on a standby basis—whenever a slot opened up, rather than on a scheduled day.

"The issue was changing daily, if not hourly, and we couldn't afford the time for an agency or a designer," says **Elizabeth Board**, the council's public-issues director. "We're talking about [using] a PageMaker [software program] on our own computer. These ads were literally delivered at the last minute."

First lady Hillary Rodham Clinton and presidential adviser Ira Magaziner refused to meet with the liquor makers. So they turned to a strategy of wooing reporters, who then pressed administration officials on points the council wanted to make.

The group's pitch went as follows: When the alcohol tax was raised in 1991, fewer people drank, so revenue actually went down. Liquor is already the most heavily taxed product in American stores. A tax is unfair to those who drink responsibly.

"The problem was to make sure, in this morass of people running around talking about health care, that the important people became familiar with our arguments," says council President **Fred Meister**. "We had to find a way to cut through the noise level."

The Distilled Spirits Council also had to fend off an attack on its flank from tobacco boosters like Rep. **Martin Lancaster** (D-N.C.), who is urging the president to ease the burden on cigarettes by hitting the alcohol industry also.

"At least in the perception of my constituents, alcohol

please know that I will do everything in my power to defeat a health care reform package which singles out tobacco for a confiscatory tax."

Meanwhile, back in rural Seven Springs, N.C., a group called **Friends of Tobacco** is running a "green ribbon" campaign, modeled on the yellow-ribbon



movement that sprang up during the Persian Gulf War. To protest the tobacco tax in the Clinton health plan,

Tobacco Belt residents are pinning green ribbons on everything from trees to stores to lapels.

Such is the range of the tobacco lobby, which includes the powerful Tobacco Institute in Washington, the independent campaigns of mammoth corporations like the **Philip Morris Cos.** and **RJR Nabisco Inc.**, and farmers' groups like **Friends of Tobacco** and the **Tobacco Growers' Information Committee**.

So far, the tobacco lobby has failed in its only health reform goal—keeping cigarette taxes out of the Clinton plan. In contrast to his decision to spare the alcohol industry, the president is proposing a tax of 75 cents to \$1 per cigarette pack.

Clinton can get away with this because tobacco has become so despised. In an April 1989 Gallup poll of 1,000 adults, the Tobacco Institute was the only interest group with an unfavorable rating higher than its favorable rating—61 percent to 26 percent.

"They make their living selling a lethal product, and they lie about it," says **Phillip Wilbur**, spokesman for the **Tobacco Tax Policy Project** of the **American Cancer Society**. "It's not a way to get popular."

The tobacco lobby also must contend with **C. Everett Koop**, the popular former U.S. surgeon general, who is publicly pushing for a cigarette tax as high as \$2 a pack.

Ads are not an effective tool for tobacco lobbyists because 70 percent of the public has already decided it disagrees with them. "It has never been part of the strategy to go mass marketing with this," says Tobacco Institute spokesman **Thomas Lauria**.

But the tobacco industry is not to be underestimated. While they've given up on killing the tax outright, industry leaders argue that it's only fair to spread the pain to other "luxury" products, especially alcohol.

The Tobacco Institute Political Action Committee gave \$184,650 to congressional candidates in the 1992 campaign. And its two biggest members made contributions far exceeding that: **RJR Nabisco's** PAC gave \$846,363, and **Philip Morris' PACs** gave \$694,741. All gave additional cash to the political parties themselves.



## HEALTH-CARE INTERESTS AND AGENDAS

As Rep. Lancaster's plaintive letter suggests, lawmakers from tobacco regions—led by the likes of Rep. **Charles Rose** (D-N.C.) and Sen. **Jesse Helms** (R-N.C.)—will fight fiercely. And tobacco country is not defined by the North Carolina border; according to industry supporters, 23 states are home to tobacco farmers.

At a Sept. 28 congressional hearing, Rep. **Jim Bunning** (R-Ky.) asked Hillary Clinton why alcohol was not hit, too. The first lady answered that, unlike alcohol, cigarettes are unhealthy even when used as intended. Such skirmishes are likely to define the cigarette-tax debate.

A legion of lobbyists is helping the Tobacco Institute make its arguments. Perhaps the key figure is **James Healey**, a principal at Alexandria, Va.'s **Black, Manafort, Stone & Kelly**. He formerly worked for Rep. **Dan Rostenkowski** (D-Ill.), chairman of the House Ways and Means Committee, which will have a big part in crafting the health-care reform.

Healey estimates that 13 to 20 House members will vote against any plan that contains a tax on tobacco alone, a bloc that could prove critical to the plan's chances.

Some tobacco-industry leaders, feeling pummeled, want to strike a compromise with Clinton now on a 48-cent tax. Others argue that such a compromise would be premature, that the tax would only be raised in later negotiations.

Tobacco's most potent argument is that a cigarette tax will cost jobs, unfairly targeting the Southeast. In case anyone in Congress misses the point, the Tobacco Institute has drawn up lists of how many jobs would be eliminated in each state.

Says Lauria: "Name a state and a tax amount, and I can give you what the impact could be."

—N.B.

## ASSOCIATION OF TRIAL LAWYERS OF AMERICA

- **BUDGET:** \$19 million annually.
- **MEMBERS:** 60,000 plaintiffs lawyers.
- **KEY LOBBYISTS:** Alan Parker, deputy executive director; a former chief counsel to the House

Bush—according to a study by the Center for Responsive Politics.

While ATLA has worked quietly, holding private meetings and sending volumes of information to the White House, it has also created a united front with consumer groups like **Public Citizen** and the **Public Interest Research Groups**—which don't work so quietly.

Public Citizen held a dramatic press conference June 29 featuring five people who had lost children or suffered terrible injuries because of medical malpractice. The Public Interest Research Groups plan to stage similar events throughout the country.

Says one typical Public Citizen statement: "We should not try to cure the economic problems facing the health care system on the backs of seriously injured victims of medical malpractice."

—N.B.

## NATIONAL GOVERNORS' ASSOCIATION

- **BUDGET:** \$10 million annually.
- **MEMBERS:** Governors from 50 states and five territories.
- **CHIEF LOBBYIST:** Raymond Scheppach, former deputy director, Congressional Budget Office under then Director Alice Rivlin.
- **BOTTOM LINE:** Wants ultimate enforcement and budgetary control over the health alliances, which are run by the states under the Clinton plan. Wants to fold Medicaid into the new health-care package.

**S**tates now spend nearly one-fifth of their entire budget on Medicaid, contributing about \$43 billion of the program's \$100 billion annual cost—and hemorrhaging money from hard-pressed state treasuries in the process. Health-care reform has long loomed large on governors' radar screens.

So, how'd they do? So far, not so well. True, the new



the process. President Clinton was the group's chairman in the mid-1980s and remained on the NGA's health task force until two years ago.

Early on in the debate, Scheppach brought top state health officials to Washington for days at a time, making sure their perspective was represented in the working groups that met weekly with task force co-chairs Ira Magaziner and Judith Feder.

But the NGA has its own particular problems that make getting its way a bit difficult. For one thing, Congress has historically treated the states like poor stepchildren, treading on their jurisdiction and giving them short shrift in financial aid. For another, getting 55 headstrong members to agree on anything but the broadest of policy outlines is challenging. And Scheppach and his lobbying team must stay within strict policy parameters established at the group's biannual meetings.

"It's not a free-wheeling organization," says one health-care consultant who knows the group well.

—T.R.G.

## NATIONAL RIGHT TO LIFE COMMITTEE

- **BUDGET:** \$13.5 million annually.
- **MEMBERSHIP:** Does not release membership figures, but estimates range up to 400,000.
- **KEY LOBBYIST:** Douglas Johnson, legislative director.
- **PAC:** Spent \$2,088,890 in the 1991-92 election cycle and \$84,440 in the first half of 1993.
- **BOTTOM LINE:** Wants to remove coverage for abortions now provided under the Clinton plan.

**A**mong the myriad competing groups in health-care reform, most are at least willing to sit down at the bargaining table, separate fact from hype, and work out a compromise on their differences.

Not these folks.

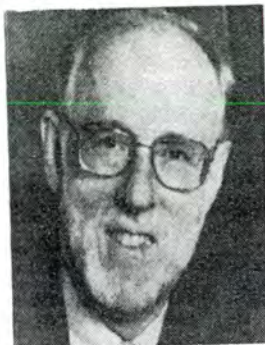
In the battle over whether abortion will be covered under the Clinton health plan, two implacable foes are facing off: the National Right to Life Committee Inc., a grass-roots organization with 3,000 local chapters, and



- **BUDGET:** \$19 million annually.
- **MEMBERS:** 60,000 plaintiffs lawyers.
- **KEY LOBBYISTS:** Alan Parker, deputy executive director; a former chief counsel to the House Judiciary Committee. Thomas Boggs, partner, D.C.'s Patton, Boggs & Blow.
- **PAC:** Spent \$4,433,590 in the 1991-92 election cycle and \$959,300 in the first half of 1993.
- **BOTTOM LINE:** Fiercely opposes curbing patients' right to sue doctors.

The advantage held by the Association of Trial Lawyers of America in the health-care battle is that it cares about only one thing: squashing any proposal that would interfere with suing doctors.

The group faces big obstacles. Much of the public supports changing the malpractice system. And the **American Medical Association**, whose cooperation the administration badly needs, is pushing hard for reforms like capping pain-and-suffering awards and limiting attorney fees.



Alan Parker

But lawyers warn that it is patients who will suffer, and careless or unscrupulous doctors who will benefit, if malpractice suits are curtailed.

President Clinton has split the difference, proposing no cap on pain-and-suffering payments, but limiting attorney fees to one-third of the jury award. This balancing act has not satisfied anyone, and both doctors and lawyers are carrying the fight to Congress.

The trial lawyers' style has always been to fight behind the scenes. **Eugene Pavalon**, a partner at Chicago's Pavalon & Gifford, chatted with Vice President Albert Gore Jr. about health reform at a Democratic fund-raiser earlier this year. **Philip Corboy**, a partner at Chicago's Corboy & Demetrios, sent a letter recently to first lady Hillary Rodham Clinton, whom he's known for years.

ATLA's high-powered staff of 150 is supplemented by such outside talent as **Thomas Boggs**, perhaps the most influential lobbyist in Washington. And the trial attorneys boast numerous friends (and ex-lawyers) in Congress, notably Sen. **Ernest Hollings** (D-S.C.).

ATLA gives lots of money to congressional candidates, mostly Democrats, through its PAC. In addition, individual trial lawyers gave \$481,179 to the Clinton campaign—eight times what they gave George

So, how'd they do? So far, not so well. True, the new



NGA's Raymond Scheppach

regional health alliances, in charge of buying health-care packages and ensuring their quality, will be run by the states. The problem for the governors is that the authority for making sure those alliances serve all citizens, and the fiscal power to ensure they don't run over budget, stays with the federal government.

"The rub is, who's going to enforce those budgets, and what is our accountability?" says **Raymond Scheppach**, executive director of the National Governors' Association.

Under the plan, a newly created National Health Board would oversee the alliances. In addition, if a state fell short of meeting its federally mandated obligations to provide adequate health care, the Treasury Department could step in, imposing a payroll tax to cover the cost of operating the system. That sort of federal intrusion riles the nation's governors.

"If this is a state-based system, then we ought to be in charge," argues Scheppach, who adds that the states ought at least to be given the option of running the show. "But those issues are still somewhat up in the air."

Medicaid, too, remains outside the health-care reform package. The states had wanted that massive federal program included, so that they would be in charge of just one health plan, not two, thus streamlining their health bureaucracy.

The early setbacks for the states are somewhat surprising, given that the NGA has a powerful friend in

Not these folks.

In the battle over whether abortion will be covered under the Clinton health plan, two implacable foes are facing off: the National Right to Life Committee Inc., a grass-roots organization with 3,000 local chapters, and the **National Abortion Rights Action League**, the political arm of the abortion-rights movement.

Though the right to an abortion is not explicitly spelled out in the Clinton plan, administration officials have made it clear that under the plan's "family planning and pregnancy related services," abortions are included.

And this has set the stage for a firestorm of activity among those opposing abortions as a matter of religious principle and those favoring a woman's right to choose abortion as a matter of basic health care. The fight could end up on the floors of the House and Senate.

Abortion foes brag that they have the political clout to kill the entire health-care package if the coverage of abortions is not removed.

Already the National Right to Life Committee has run ads in Washington political journals pillorying the plan on two fronts—that it rations health care and compels every taxpayer to fund abortion services on demand.

"The president won't be able to pass health-care reform that includes taxpayer funding for abortions—in either house," says **Ralph Reed Jr.**, executive director of the **Christian Coalition**, a politically active, 400,000-member, pro-family group. "This is an up-or-down vote, and the momentum is on our side."

Leading the abortion-rights battle is the 700,000-member NARAL, whose longtime president, **Kate Michelman**, is a well-known Capitol Hill figure.

NARAL, whose D.C. office has a staff of 35 and a budget of \$4 million, is already airing two television ads and placing two print ads, produced by its longtime advertising agency, D.C.-based **Greer Margolis Mitchell Burns & Associates**. "America: Protect Women's Health" is the message that shouts from the print ad.

Both sides have very strong grass-roots operations—the National Right to Life Committee with its 3,000 chapters and NARAL with its 40 state branches.

And they have their traditional allies to bolster their positions. For the anti-abortionists, there's the Chesapeake, Va.-based Christian Coalition, as well as the D.C.-based **National Conference of Catholic Bishops**.

The abortion-rights position is touted by a loose coalition known as the **Campaign for Women's Health**, featuring dozens of national organizations devoted to women's health-care needs. Chief among them is the New York-based **Planned Parenthood Federation of America** and the D.C.-based **Women's Legal Defense Fund**.

—T.R.G.



PHOTOCOPY  
PRESERVATION

# Who Will Manage The Physician?

BY M. GREGG BLOCHE

**T**hrough most of the 20th century, American physicians amassed clinical authority, staking their claim to sovereignty over health and illness upon the public's faith and awe. But in the 1980s, the large employers and insurers that pay American medicine's bills began to use their market power to resist this authority. Today, clinical decisions are increasingly regulated by these payers, who have become convinced that doctors waste huge sums on unnecessary care.

The momentum now building behind President Bill Clinton's health reform plan portends a dramatic acceleration of this trend. The plan's designers aspire to transform medical care into a tightly managed enterprise, able to ensure that dollars are spent to achieve benefits that consumers want.

What remains up for grabs in the president's proposal is who will do the managing. White House health planners have

backed away from the pure managed-competition model, which envisions a medical marketplace populated by vertically integrated,

private plans relatively unconstrained by government. Instead, the Clinton plan calls for overlapping, potentially conflict-



essary to clarify their authority to deny services and to define better the roles of the system's regulators. In particular, it will be important to specify the managerial and regulatory roles of these actors when empirical evidence does not provide clear answers to clinical questions.

To do this will be exceedingly difficult for Congress, given the exigency of avoiding statutory language that might alienate one or another interest group with the power to scuttle a deal. Most likely, the clarifying work will fall to administrative agencies, especially the National Health Board.

The National Health Board could minimize the risk of wasteful and paralytic conflict between the system's managerial levels by structuring the regulatory process to avoid administrative overlap.

## Data for the People

For starters, the board should not itself attempt to micromanage clinical decision-making by imposing its own, detailed practice protocols. Nor should the board require health alliances to regulate practice protocols in fine detail as part of the task of approving health plans for marketing to consumers.

Rather, the board could best pursue the Clinton blueprint's goal of empowering consumers by insisting: (1) that health plans make their practice protocols widely available, (2) that plans publish candid

COMMENTARY



cally integrated, private plans relatively unconstrained by government. Instead, the Clinton plan calls for overlapping, potentially conflicting layers of federal, state, and private authority over clinical decision-making.

At its best, the White House plan is a diplomatic tour de force, artfully fashioned to sooth competing constituencies into the acquiescence needed for high-stakes reform. But it does so by putting off hard questions about the distribution of power. Should the plan be enacted in anything like its current form, these questions will need to be settled by administrative agencies and courts in 50 state capitals, as well as Washington, over the next decade or more.

### Many-Headed System

Like the managed-competition model from which it evolved, the Clinton proposal takes off from the premise that medical decisions are ill-supported by scientific data and insensitive to cost. The function of management, within each model, is to develop and implement rules of clinical practice keyed to the scientific study of treatment outcomes and to consumer awareness of medical costs.

Under pure managed competition, the private sector would perform this function, spurred by tax-law changes that would increase consumer exposure to cost differences between plans. Government's role would be limited to development of uniform reporting requirements respecting quality of care, support for clinical-outcomes research, and financing of universal access to a minimum level of care.

The Clinton proposal, by contrast, creates an administrative maze of federal and state entities empowered to issue practice protocols and to review those developed by private health plans. Private plans are to compete by implementing their own protocols, but a new federal agency, the National Health Board, is to develop regulatory criteria for the approval of such protocols.

The task of applying these criteria, in turn, devolves on the so-called health al-



PATRICE MOERMAN

liances—state agencies (or non-profit corporations) charged with certifying health plans for marketing to consumers. The National Health Board is to monitor compliance with its regulatory requirements by both health alliances and private plans.

All this makes for a notable lack of clarity about the distribution of managerial authority over medical practice. The possibilities for paralytic conflict are immense.

One can imagine patients or practitioners, upset over the denial of benefits, taking their challenges to the health alliances, the National Health Board, and state and federal courts. One can as easily predict objections by private plans to disapprovals of practice protocols by health alliances or to National Health Board criteria for such protocols.

### The Elusive 'Best' Care

The difficulties such disputes present are greatly magnified by the uncertainty inherent in medical decision-making. No crash program of clinical-outcomes research will soon change the reality that we lack scientific answers to most of the quandaries physicians face in practice. More often than not, drafters of compre-

hensive protocols for the payment of claims or provision of services will be unable to make empirically well-informed choices between diagnostic or therapeutic alternatives.

This reality accounts for the wide variation in practice patterns today. It confounds the task of containing medical costs via the centralized management of care. In combination with the protections against arbitrary decision-making afforded by state and federal administrative law, the problem of scientific uncertainty sets the stage for ongoing conflict over when managed plans should pay for care.

Today's health reformers should draw a lesson from the states' sorry experience with regulation of new capital investment in medical facilities during the 1970s. This cost-control strategy barred large investments absent a showing of medical need before a state agency. But disputes over the determination of need often led to administrative paralysis, followed by endless litigation as losers challenged agency decisions that could not be defended on scientific grounds.

To reduce the risk of similar gridlock on a larger scale as health plans try to manage care under the new system, it will be nec-

consumers by insisting: (1) that health plans make their practice protocols widely available, (2) that plans publish candid explanations of their reasons for refusing to provide or pay for services accepted by at least a respectable minority of practitioners, and (3) that plans distinguish between protocols backed by scientific data and rules that reflect the need to set limits in the face of uncertainty and high costs.

Health alliances could enforce such disclosure requirements without themselves becoming clinical micromanagers. This information, in turn, would enable others, including researchers and persons interested in offering *Consumer Reports*-style rating services, to study clinical decision-making within health plans.

It can be argued that the centralized management of medical decisions is an inherently wasteful approach to providing care even when done by private plans without intrusive regulation. Perhaps, as happens elsewhere in the industrialized world, the federal government could manage medical costs by deciding upon national health budget ceilings and determining providers' fees accordingly.

But this option is beyond the pale of political viability in the United States. Managed care it will almost certainly be, albeit with budget ceilings as a backup. In pursuit of an alternative to the perceived evils of price setting, we are about to embark on the most ambitious venture in the history of the modern regulatory state.

Does the Clinton plan achieve political feasibility only by putting off hard questions destined to paralyze its implementation? Or have Hillary Rodham Clinton's health planners devised a flexible, even brilliant, scheme for the management of conflict over the governance of medicine in a manner that both empowers consumers and contains costs? Stay tuned.

*M. Gregg Bloche, a physician and attorney, is an associate professor at the Georgetown University Law Center and co-director of the Georgetown-Johns Hopkins Joint Program in Law and Public Health.*



## HEALTH-CARE INTERESTS AND AGENDAS

PHOTOCOPY  
PRESERVATION

# MISPLACED MANDATE: WHY INDIVIDUALS, NOT EMPLOYERS, SHOULD PICK UP THE TAB

BY MICHAEL J. GRAETZ

**M**y message here is simple. First, universal health insurance, like universal auto accident insurance, requires that coverage be mandated. Second, many current proposals either fail to face the mandate issue or, as in President Bill Clinton's proposals, put the mandate in the wrong place: on employers. Both alternatives increase the danger of stumbling into health-care reforms that will fail to provide the secure, portable, adequate, universal, and reasonably priced medical care we all want.

The impetus for employer-mandated health coverage is not grounded in a vision of appropriate delivery of health insurance coverage, but rather concerns for maintaining existing sources of health insurance financing and the political need to

minimize taxes to finance health reform. If universal health insurance coverage is the government's responsibility, like providing roads

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and libraries, it is simply bizarre public policy to link health coverage to employment and then fill in the gaps for those unemployed or retired.

The only reason for this link is that employment now provides much such coverage, and no one is willing to challenge that status quo. Employer mandates have far less to do with where we wish to take health reform than where we are now.

The current failing health-care financing apparatus in the United States has resulted from a series of incremental policy decisions that have had little or nothing to do with the development of a coherent national health system. Employer-provided health coverage received an important stimulus from the exemption of such fringe benefits from the wage and price

cents of additional health coverage is worth a dollar of cash wages for most of their employees, and, therefore prefer paying health benefits over cash wages.

Finally, the Employee Retirement Income Security Act of 1974 (ERISA), concerned principally with protecting

If we really mean *everyone* when we say "universal," then a government requirement—a mandate—to purchase health insurance seems inevitable. Many young healthy people regard the purchase of health insurance as a bad deal now, and the forthcoming community rating of

own insurance, but instead through shifting these costs onto others.

To be sure, a mandate would have to be accompanied by subsidies for the poor, many of the disabled and elderly, the unemployed and at least a very large number of middle-income families. But this pattern of subvention would not be new in health-care financing; federal, state, and local governments now pay large subsidies for each of these groups, albeit in a haphazard and often uncoordinated way.

Many key political actors, including President Clinton, have accepted the view that a mandate is necessary to make health reform work, but have chosen to mandate employers to provide health insurance coverage for their employees. For those mostly large employers who already provide good health coverage there is, of course, little burden associated with a requirement to provide a standard package of health insurance benefits; these firms just would not be permitted to drop coverage below the level of the government's mandate. On the other hand, for small businesses, who do not now provide employees with health insurance, mandated coverage would substantially increase the costs both of keeping their employees and of hiring new ones.

Those who support employer mandates must have concluded that current circumstances demand that we preserve the existing health insurance base by prohibiting employers from abandoning existing employee coverage, and the quest for universal coverage moves them to require that other employers also provide equivalent health coverage for their employees.

The consequences of an employer mandate, however, would be quite different from a requirement that all individuals or families obtain health insurance coverage. For those employers who wished to



tional health system. Employer-provided health coverage received an important stimulus from the exemption of such fringe benefits from the wage and price controls of the 1940s.

An enduring further boost was provided by the exemptions from income and Social Security taxes for employer-provided health insurance. Because of the tax advantages, employers find that about 65

*Michael J. Graetz is the Justus S. Hotchkiss Professor of Law at Yale University. He served as deputy assistant treasury secretary for tax policy from 1990 to 1991 and as assistant to the secretary and special counsel in 1992. This commentary is adapted from an article that appeared in the fall 1993 health-care issue of Domestic Affairs.*

health benefits over cash wages.

Finally, the Employee Retirement Income Security Act of 1974 (ERISA), concerned principally with protecting employee pension benefits, made employers' self-insurance of employee health benefits desirable by insulating employer self-insurance plans from state premium taxes and regulations.

Despite uneven effects, these incentives for employer health coverage have enjoyed some success: Employers provide health insurance to about 60 percent of the U.S. population, and employment-based insurance accounts for about one-third of total health-care spending. The government loses about \$65 billion of tax revenue annually. But this nation can no longer rely on voluntary employer health insurance as the backbone of health-care finance.

health insurance seems inevitable. Many young healthy people regard the purchase of health insurance as a bad deal now, and the forthcoming community rating of health insurance, which will bar insurers from taking good health (as well as bad) into account in setting premiums, will raise costs for healthy people (although some of this increase may be offset by the purchasing power of the entity purchasing large quantities of insurance). To spread the financial risks of poor health across the whole populace, coverage must be mandatory.

Moreover, the existence of the medical safety net—porous as Medicaid and free hospital emergency room care are—demands mandatory health insurance coverage. Otherwise people who experience remote risks, but expensive costs, of bad health will be paid for not through their

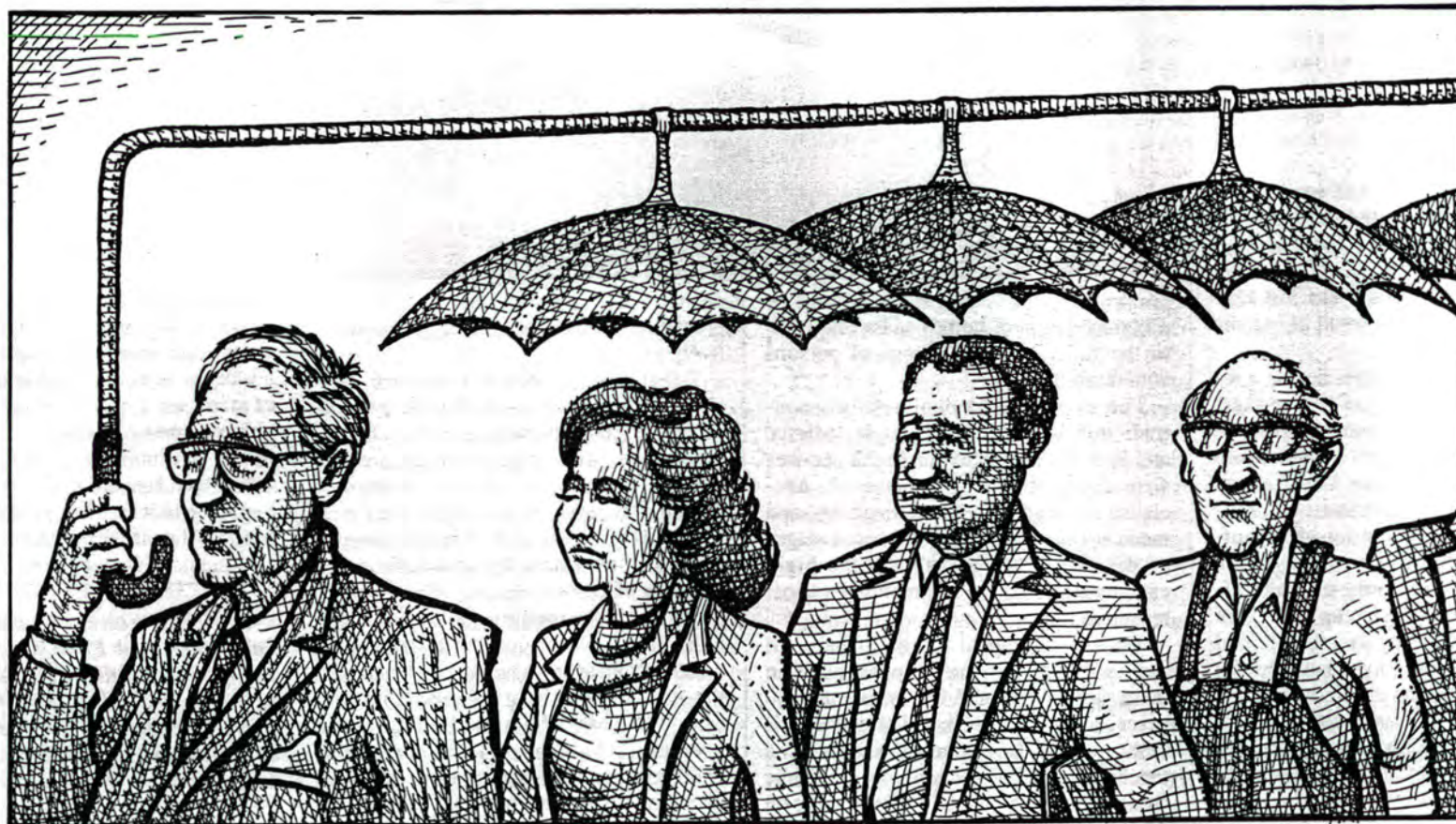
The consequences of an employer mandate, however, would be quite different from a requirement that all individuals or families obtain health insurance coverage. For those employers who wished to circumvent such a mandate, there could be incentives to use temporary help, overtime, cash transactions, and independent contractors rather than employees.

### Adverse Consequences

The adverse consequences of employer mandates would be harshest for marginal employees and marginal businesses. Often, Congress attempts to avoid some adverse consequences of mandates by exempting small businesses. Such exceptions are not possible in health-care reform, however, if coverage is to be universal. The percentage of employees

SEE GRAETZ, PAGE 45

PHOTOCOPY  
PRESERVATION





# Managing Chronic Illness Should Be the Priority

PHOTOCOPY  
PRESERVATION**BY DANIEL M. FOX**

**P**olicy-makers and most health industry trade groups insist that the priority of health reform is not managing chronic illness, but providing Americans with access to treatment when they are acutely ill. They usually minimize the importance of care for chronic illness by describing it as consisting of only "long-term care," for which they propose only limited insurance coverage. As a result, care for chronic disabling illness will continue to be delayed and unnecessarily expensive, whatever reforms become law in the

## COMMENTARY

next several years.

Care for the symptoms of chronic disease is, however, the major activity of the health industry. Most visits to physicians and most pharmaceutical purchases are the result of chronic illness. Most Americans

policy deriving from the implications of the need to manage chronic disease. Nevertheless, as Americans lived longer, and ate, drank, and smoked more, the demand for medical services for chronic disorders grew.

In order to accommodate this surge, physicians and hospitals defined their priority as offering treatment to persons with chronic disease when their symptoms became acute; that is, when they assembled the symptoms of infections and injuries. Insurance was most generous for treating acute episodes and terminal stages of illness.

### Neglected Interventions

Interventions at different stages in the course of disease received lower priority. These relatively neglected, and uninsured, interventions included early detection, health education, rehabilitation, and the

subspecialties have the highest status and often privately deride the intellectual challenge of primary care.

Leading scientists have long been exceptions to this skewing of priorities. For half a century, funding for research has accorded priority to understanding more about chronic degenerative diseases. As a result of studies sponsored by the National Institutes of Health and private organizations, this country has provided most of the world's knowledge about the causes and consequences of chronic diseases as well as what can be done to prevent or treat their symptoms and manage their consequences.

The leading interest groups in health affairs still insist, however, that the priorities of policy are prolonging life and alleviating pain. Lobbyists for medical and hospital associations agree that preventing or postponing disease, disability, and

need less than two hours a day of professional care.

A better question for policy than the melodramatic "Who shall live?" is "How shall we live?" Each decision about whether to use heroic measures and expensive technologies is usually the cumulative result of ignoring opportunities to prevent or better manage that person's chronic illness. The solvable problem for policy is not who should be eligible for life-saving technologies, but how to improve and prolong people's lives by applying lower-cost technologies much earlier in the course of their diseases.

Similarly, the basic question about controlling the annual increase in health-care costs should be: To what services should we allocate savings from avoidable expenditures for specialized acute care services? Reallocation will take time and political coverage. Hospitals must shrink, physicians must change their priorities (as well as their current hierarchy and distribution of income), and some people will have to find new jobs. But if we do not reallocate resources in order to manage



case is, however, the major activity of the health industry. Most visits to physicians and most pharmaceutical purchases are the result of chronic illness. Most Americans struggle to find and pay for care for their own chronic illness or those of family members—care that should be available at home, or in assisted housing or facilities for congregate living, or in nursing homes.

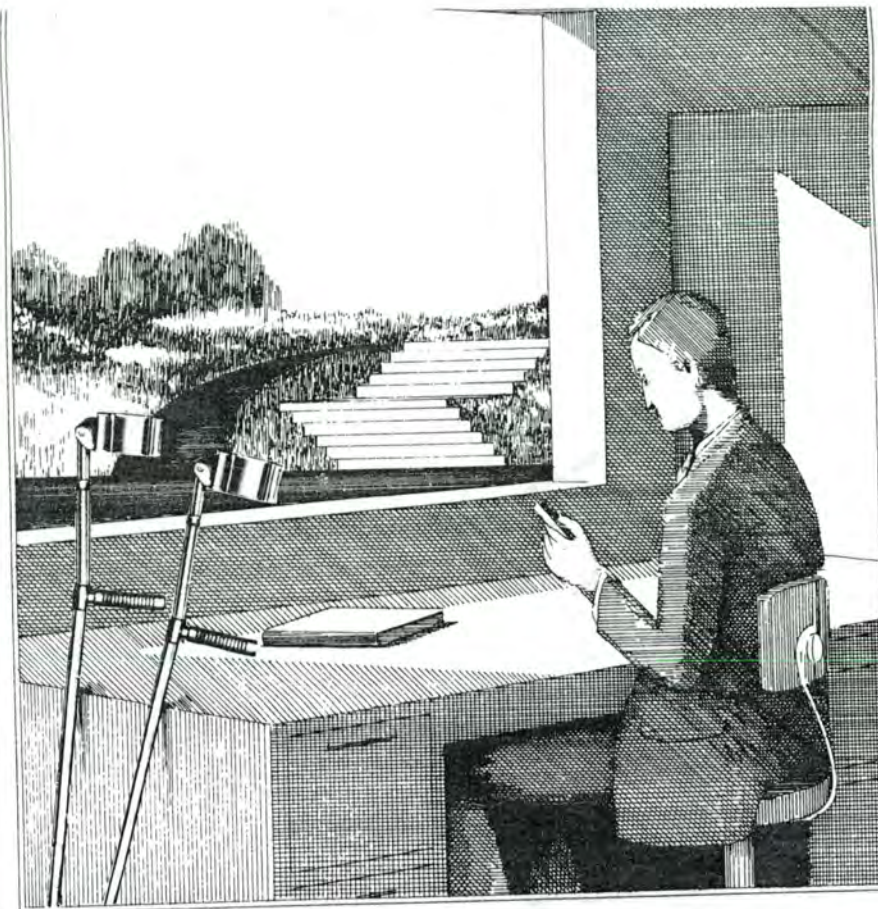
Access to care for acute conditions is obviously essential. Everyone wants treatment that relieves pain and prolongs life. But most of us also want care that permits us to work and to live as independently as possible with the chronic diseases—often several at once—that wear us down from adulthood (for many, from childhood) through old age.

Policy-makers and health-care providers have long ignored evidence that the priorities of our health-care system are inconsistent with the burden of chronic illness. Each year for the past three-quarters of a century, most deaths and disabilities have been caused by chronic degenerative diseases, and especially by cancer, diabetes, and heart, kidney, and lung disease.

The U.S. Census for 1920 was the first to record that chronic diseases were the leading cause of death. Sickness surveys in the 1920s and 1930s documented that more than a fifth of Americans lost time from work each year as a result of chronic disease.

For centuries most people died as a result of infection and injury. Policy-makers and health professionals assumed that the unexpected surge of deaths from and care provided for chronic disease was a statistical aberration. Despite the evidence, therefore, government and foundation officials, leading doctors and the media continued to accord priority in health affairs to building and equipping acute care hospitals and increasing the number and skills of specialized physicians. In the 1940s and 1950s, they added two new priorities: health insurance coverage and research to find cures for more diseases.

Physicians, philanthropists, and politicians continued to resist any change in



accommodation of homes and workplaces to the functional limitations of persons with disabilities.

The experts who deplored this contradiction between why people suffered and how the resources for health services were allocated were not persuasive. Specialists in surgery, invasive diagnosis, and medical treatment of the advanced stages of disease continue to have the highest prestige and to command the most resources.

Tax-exempt capital has built space for more public and private hospital beds than these physicians could fill; on average, 40 percent of our acute hospital capacity is empty every day. Medical schools and teaching hospitals maintain an academic culture in which physicians in acute care

premature death is desirable, but prohibitively expensive.

Debates about whether medical care should be rationed exemplify the general acceptance of outmoded priorities. Organ transplants and intensive care are expensive in individual cases. In the aggregate, however, they account for much less of the growing cost of health services than does treatment for avoidable acute episodes of chronic disease. Cost savings (or at least postponing the costs of expensive acute services to other years) would result from reducing, for example, the incidence of lung cancer, heart disease, and stroke; from the birth of fewer premature babies; or from home and community-based alternatives to hospitals and nursing homes for frail elders who

bution of income), and some people will have to find new jobs. But if we do not reallocate resources in order to manage chronic disease more effectively, the demand for acute services will continue to grow at an unacceptable rate. This demand will continue to frustrate efforts to use either regulation or competition to contain prices and profits in the health-care industry.

As a practical matter, reallocation must follow the enactment of measures to make health insurance more available and affordable. It makes no political sense to try to change priorities in the same legislation that promises the uninsured minimal access to basic medical and hospital services. But the reforms now on the political agenda could be the prelude to changes in priorities.

Change would be possible in the future if current negotiations place every American in an insured group that is large enough to share the high costs of his or her chronic illnesses. If over the next decade we can agree that the major problem for health policy is preventing and managing chronic disease—that acute intervention is essential but not the highest priority—we can look forward to a health policy suitable for the 21st century.

For the past century, health policy stimulated the creation of health-care hierarchies dominated by specialized physicians and acute-care hospitals. That policy began to be obsolete soon after its inception as a result of an unexpected change in the causes of sickness and death. A century of policy cannot be reversed quickly, but it is hardly too soon to begin to redefine the problem for which health policy is the answer.

*Daniel M. Fox is president of the Milbank Memorial Fund in New York, an endowed foundation concerned with public health and policy. He is the author of Power and Illness: The Failure and Future of American Health Policy, recently published by the University of California Press.*



## HEALTH-CARE INTERESTS AND AGENDAS

# WHEN THE BILL COMES, WHO WILL COME OUT AHEAD?

BY JERROLD J. HERCENBERG

**P**resident Bill Clinton's health-care plan has one principal objective: to ensure that affordable health care is available to all Americans. Although the Clinton proposal is not intended to achieve income redistribution, many of its key features are likely to produce savings to some businesses at the expense of others. Indeed, under some scenarios, the Clinton

plan will impose costs on high wage earners that make the recent tax increases to upper-bracket taxpayers modest by comparison.

## ANALYSIS

Under the proposal, all employers (except those with more than 5,000 workers or with collectively bargained health and welfare trust funds) must purchase their health insurance through regional health-care alliances rather than directly from health insurance companies, health maintenance organizations, or other providers of health benefits. By consolidating purchasing power, these alliances are expected to reduce the cost of health insurance for many businesses, especially small companies that often are forced to pay rates far above those charged to large employers. Under the Clinton plan, a single premium will be set for all employers in a geographical region—the "community rate."

What an employer actually pays, however, will depend not only on the community-rated premium, but also on the company's average wages. An employer's



As a result of the cap, Employer A would pay only \$2,370 per employee (the average payroll salary of \$30,000 multiplied by the cap of 7.9 percent), even though prior to the Clinton plan, the employer's yearly share of the existing community rate was \$4,000 (80 percent of

potentially hefty indirect tax on health benefits provided to the well-to-do. This is dramatically different from today's insurance market, which bases insurance rates on the insurance risk of the insured. Accordingly, employers with low-wage employees, such as retail stores, farms, food-

plan, both in benefits and the percentage of the premium that employers pay. Theoretically, under the Clinton plan, employers in this situation may be able to pay substantially less.

For example, it is not uncommon in the auto industry to find health-care premiums

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What an employer actually pays, however, will depend not only on the community-rated premium, but also on the company's average wages. An employer's contribution will equal either the full community-rated premium or a fixed percentage of the employer's payroll, whichever is less. This "cap" is intended to make coverage affordable for small businesses.

### Wild Card

The interplay between the cap and the community rate, however, is the wild card in predicting whether the Clinton plan will save money for all employers or simply shift costs to high-wage employers and self-employed professionals.

Due to the cap, many employers with low-wage employees will contribute substantially less as their share than they now do. Accordingly, health plans will have to adjust their existing community rates to account for those employers who do not pay their fair share. Some health plans are also beginning to make these adjustments. How much adjustment is needed will be the key to determining the winners and losers among employers under the Clinton plan.

Set forth below are three examples of how the payroll cap could influence employer liability, where, for example, the existing community rate is \$5,000 for family coverages; 50 percent of the population will have premiums capped below the existing community rate, and the average community rate will rise by at least 50 percent, to make up for subsidized rates of low wage workers.

• Employer A, a retailer, has 400 employees with a relatively low average annual wage of \$30,000. Even though this company is profitable, with annual earnings of \$2 million per year, under the Clinton plan, it would pay substantially less than the existing community rate for the region and below what it now pays for health insurance.

*Jerrold J. Hercenberg is counsel to the health department of the D.C. office of McDermott, Will & Emery.*

pied by the cap of 7.9 percent), even though prior to the Clinton plan, the employer's yearly share of the existing community rate was \$4,000 (80 percent of \$5,000). This employer will save \$1,630 per employee, or a total of \$650,000 compared with the existing community rate.

• Employer B, an accounting and consulting firm with 200 employees has an average payroll of \$80,000 per employee. Its cost for health insurance is capped at \$6,300 per year (\$80,000 times 7.9 percent) under the Clinton proposal. This is \$2,300 above the existing community rate.

If the community rate rises to \$7,500 (to make up for underpayment of premiums from businesses like Employer A's) then Employer B will actually pay \$460,000 more per year under the Clinton plan.

• Employer C, a law firm with 100 employees and 100 partners, currently averages \$6,000 per employee for family coverage, because it offers generous coverage. Because each partner is self-employed, each is assessed separately for health insurance, while the firm pays 100 percent of its employees health benefits. Since the average salary of employees in the firm is \$50,000, the firm will have its premiums capped at \$3,950 per employee.

Each individual partner, however, will have to pay the lesser of the 7.9 percent payroll cap or the actual community-rated premium. If the community-rated premium rises to \$7,500 per year, each partner will have to pay \$2,500 above the existing community rate in order to subsidize the costs of employees who work for Employers A and B.

If the community rate rises more dramatically, then a partner earning \$200,000 per year would be liable for the higher community rate up to as much as \$15,800 (7.9 percent of \$200,000) per year. The amount each partner will have to pay will depend on how much subsidy is shifted in the community rate to higher wage employers and how high such costs rise relative to the 7.9-percent cap.

The cross subsidy inherent in a 7.9-percent payroll tax imposes a new and

ance market, which bases insurance rates on the insurance risk of the insured. Accordingly, employers with low-wage employees, such as retail stores, farms, food-service companies, and the like, would be relative winners under the cross subsidy, while employers who rely on high-income employees, such as high-technology companies, universities, health-care institutions, and law firms and other self-employed professionals are likely to be losers.

The subsidy to the low-wage employer does not by itself guarantee that the low-wage employee will be able to afford health care. Under the Clinton plan, each employee would be required to make up the difference between the *presumed* employer contribution (which is credited at 80 percent of the average community-rated plan, even if the employer pays less because of the capped amount) and the actual premium charged by the health plan that is selected by the employee from those available through the health alliance. For example, if an employee selects a high-cost plan with an annual premium of \$9,000 (because he has a disabled family member and is reluctant or unable to join an HMO), then the employee will be charged the difference between 80 percent of the community rate (80 percent of \$7,500) and the full rate of \$9,000. This could mean that a relatively low-wage employee could have to pay \$3,000 per year, even if his annual salary is only \$25,000. Accordingly, if health plan community rates rise because of the cross subsidy between employers, some modest-income employees will actually have to pay more for health insurance than under current rates. Only employees below 150 percent of the federal poverty standard would receive a governmental subsidy for the employee's share of health-care premiums charged through the regional alliance.

Collective bargaining will also interact with aspects of the Clinton plan to create a new set of issues and priorities for employers and unionized workers. Many unions have negotiated health coverage that is far more generous than the Clinton

employers in this situation may be able to pay substantially less.

For example, it is not uncommon in the auto industry to find health-care premiums costing as much as 17 percent of payroll for unionized employees. If the average union auto worker receives \$60,000 per year in salary, an automaker conceivably will pay no more than \$4,740 per worker (7.9 percent of \$60,000) as opposed to \$10,200 (17 percent of \$60,000); pay the employee's share of the high-cost plan (20 percent of \$10,000 per year); and still save \$3,460 per unionized employee.

The scenario is unlikely, however, because the union will have no incentive to accept a more economical health plan that reduces benefits to its members. Furthermore, as long as the costs of the unionized plan are absorbed in the community rate subsidized by other higher-wage employers, and as long as the plan is offered in the regional alliance, the employer who negotiates with a collectively bargained plan may be willing to offer generous benefits through the regional alliance.

The plan also has the potential for changing the options that unions may negotiate for their members through the regional alliances. If, in the past, unions have negotiated standardized indemnity plans (like traditional Blue Cross/Blue Shield plans), but these plans cannot compete in the health alliance, it might no longer be available for collective bargaining. As a result, collective bargaining is likely to shift a defined contribution approach, in which the employer promises to contribute a fixed sum for the employee's share of the premium, or to contribute an amount based upon the median community rate charged in the regional alliance. Geographic disparities may also affect these collective-bargaining arrangements as employers face multiple regional alliances based on the location of their employees.

Finally, with a standardized benefits package becoming the politically favored approach, and benefits in excess of that



## HEALTH-CARE INTERESTS AND AGENDAS

## HERCENBERG FROM PAGE 43

package potentially subject to taxation after 10 years, both unions and employers may be more willing to accept voluntarily the Clinton formula for cost sharing. This may come in exchange for other concessions that unions are likely to seek, such as increased wages, job security, training, and other labor demands. This can be a two-edged sword to employers, especially if they employ large numbers of low-wage employees, because the greater the salary paid, the more the employer will have to contribute to the regional alliance for the employer share of health benefits.

Large employers will also be faced with a difficult decision once the Clinton plan is under way. Each large employer with 5,000 or more employees is permitted at the outset of the Clinton plan either to form a corporate health alliance or to enroll employees in regional alliances. If the large employer elects the regional alliances, the employer then pays the lesser of the community rate or the 7.9-percent payroll cap. Many large employers are fearful, however, that the payroll cap is merely a lure designed to induce them to join regional alliances with no opportunity to opt out if costs later rise.

Employers fear that the payroll cap will inevitably be raised, even doubled, once it becomes obvious that the Clinton plan's financing scheme cannot work. This concern derives from two factors: First, the community rate with the premium cap system may not be realistic if it results in disparate but excessively high community-rated premiums, subsidized by the most affluent. Second, such a system might not work if it provides insufficient payments to support the participating health plans. Either way, large employers worry that they ultimately will be taxed to make up any deficits of health plans offered by regional alliances.

In addition, many large employers that self-insure fear that whatever purchasing power they now have will be diminished under the Clinton plan, because all but super employers (who are dominant in a specific community) will have less purchasing power than the regional alliances. Accordingly, large self-insured employers may continue to subsidize the cost of health care because they cannot negotiate favorable rates in comparison with government payors.

Elimination of self-insurance for firms with under 5,000 employees is another area where large and midsize employers could absorb added costs under the Clinton plan. Nearly 65 percent of such employers self-insure the health costs of employees, supplementing this coverage with stop-loss insurance to cover catastrophic events. Because all employers participating in the regional alliance would be required to purchase a fully insured product, they will no longer be able to save the "risk charges" and "profit" charged by health plans for underwriting the insurance risk. These costs will again be added to the community rate charged to employers in the participating alliance, who will be affected to a greater or lesser extent based upon the payroll cap of each employer.

Expanded choices of health plans to employees could also materially affect the costs of employer contributions. By mandating participation in regional alliance, employees will be given many more choices. This contradicts the trend among employers to consolidate health insurance to a few options in order to avoid segregation of financial risks among multiple health plans. For example, Employer D has 50 employees, 25 with single coverage and 25 with two-parent family coverage. Employer D historically offered only two low-cost HMOs and paid an average premium per employee of \$2,700 (90 percent of \$3,000).

Under the Clinton plan, each employer would be obligated to offer all health plans available in the regional alliance. The premiums due from each employer (assuming that the employer's contribution is not capped) is 80 percent of whatever is the average costs of coverage for each of four classes of categories of employees (singles, childless couples, single-parent families, and 2 parent families), regardless of which health plans that employer's workers actually elect to choose. Accordingly, if the regional alliance offers health plans that cost far more than the \$3,000 annual costs of the HMOs available before the Clinton plan, Employer D might have to pay 80 percent of the much higher average costs per plan available through the health alliances, even if Employer D's employees still remain in the same two HMOs. Thus, Employer D achieves no savings by encouraging employees to join a less expensive health plan.

### Conglomerates

Lack of level playing fields between conglomerates and single businesses might also become a sticking point in the Clinton plan. Some employers fear that the subsidization of small employers by large employers will lead to unfair competition against large conglomerates. For example, if a large manufacturer with a relatively high wage base purchases a subsidiary company with a lower wage base, the conglomerate might have to pay substantially more for health benefits than the amount that is common among the competitors of that subsidiary. This can result because companies that compete with the low wage subsidiary may very well receive a subsidy based on the cap offered by the Clinton plan, while the conglomerate is required by federal tax rules to treat equally all of its employees and therefore must pay the full costs of health care based upon higher cost benefits offered to its high-wage employees. This could discourage certain businesses from integrating and consolidating.

Under the Clinton plan, each employer would be obligated to offer all health plans available in the regional alliance. The premiums due from each employer (assuming that the employer's contribution is not capped) is 80 percent of whatever is the average costs of coverage for each of four classes of categories of employees (singles, childless couples, single-parent families, and 2 parent families), regardless of which health plans that employer's workers actually elect to choose. Accordingly, if the regional alliance offers health plans that cost far more than the \$3,000 annual costs of the HMOs available before the Clinton plan, Employer D might have to pay 80 percent of the much higher average costs per plan available through the health alliances, even if Employer D's employees still remain in the same two HMOs. Thus, Employer D achieves no savings by encouraging employees to join a less expensive health plan.

Under this example, if the average community rated premium for two-parent families were \$7,500, an employer under the Clinton plan would pay only \$4,000 for two-parent family coverage (80-percent of \$7,500, divided by 1.5 workers per family). The employer of the working spouse would also contribute \$4,000; if there was no working spouse, the employee would be required to pay the difference of \$3,500 (\$7,500 less \$4,000 contributed by the employer).

### • Part-time and seasonal workers.

Part-time and seasonal workers, who are often not covered in employer health plans, would be entitled to receive a prorated employer contribution toward a health plan based on the hours worked by that employee. This could have a substantial impact on many businesses, but will not affect businesses hiring college or high-school students who remain under their parents' coverage. Among the types of businesses most likely to be affected by this provision are fast-food restaurants or convenience stores, retailers, seasonal service companies (e.g., lawn gardening), and many entertainment businesses.

### Three Mechanisms

The Clinton plan provides three mechanisms that attempt to create systemic savings in health-care costs for all employers. First, the consolidation of health-plan purchasing presumably will condense the health insurance market of thousands of HMOs, insurance companies, and third-party administrators, eliminating



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and retirees must pay the full costs of health care based upon higher cost benefits offered to its high-wage employees. This could discourage certain businesses from integrating and consolidating.

While full details on the Clinton plan for such special populations as retirees, part-timers, and spouses and dependents of employees are still being resolved, these categories of covered persons may have a substantial impact upon various types of businesses.

• **Retirees.** For the past several years, large and midsize publicly traded companies have struggled with the impending requirement that they disclose their liabilities for retiree health-care costs, even for employees who have not yet retired. Several court cases have determined that if an employer fails to reserve its right to terminate or modify its obligations for retiree benefits, those benefits may be the obligation of the employer for the life of the retiree, even if the retiree benefits far exceed the original costs at the time that the employee first retired.

The Clinton plan has not specified how it will include or separate retirees in relation to the regional alliances. If retirees are included in the regional alliances but are not separately rated for each employer, then it is likely that even greater cost shifts will be imposed on employers of high-wage employees to subsidize collectively the costs of retiree health care. If, however, retirees are excluded from the regional alliances, then individual employers will continue to be saddled with retiree health-care liabilities that many cannot alter.

• **Dependents and spouses.** Employers who now pay the full costs of dependent and spouse coverage will have their obligations reduced under the Clinton plan and shifted either to employees or to other employers. Instead of requiring large and midsize employers to continue paying the majority share of dependent coverage, the Clinton plan adjusts the employer contribution for each of four categories of coverage, taking into account the prevalence of working spouses in the work force.

Thus, unless an employer voluntarily undertakes to pay more for health cov-

proyers. First, the consolidation of health-plan purchasing presumably will condense the health insurance market of thousands of HMOs, insurance companies, and third-party administrators, eliminating inefficient carriers. Second, the consolidation of purchasing power will reduce much of the relative percentage of administrative overhead costs of health plans. Third, alliances will be held accountable to rigid federal budgetary targets by holding premium rate increases to limits that are linked to the national rate of inflation. Health plans that do not adhere to these pricing standards could be excluded by regional alliances if their premium rates exceed the norm by more than 20 percent.

Despite these efforts toward cost control, several obstacles to passage of the Clinton plan loom ahead. The resolution of these problems will affect the division of employers into winners and losers.

First, large employers have been given no guarantees that health-care costs will be made more affordable. Only companies with bloated health benefit costs from overly generous health plans can expect to make a short-term windfall from the payroll cap offered in regional alliances.

Second, even the 7.9-percent payroll cap, while a moderate price for health-care premiums to some, appears illusory to big businesses and insufficient to cover the increased demands from expanded coverage of underinsured workers.

Third, even while the Clinton plan attempts to remain neutral toward collectively bargained plans, it is likely to affect substantially many union negotiations in all but the largest companies or for unions who participate in union sponsored health plans.

Finally, the payroll cap itself could skew community-rate pricing by health plans and could result in sticker shock for self-employed professionals as well as companies that rely on highly paid workers. But because this issue may not arise until health alliances are actually in place, it may not create significant opposition to passage of the Clinton plan and is likely to be overlooked as the country is swept up in the emotional appeal for health security for all. □



# Employer Mandate Ties Health Coverage to Employment

## GRAETZ FROM PAGE 41

lacking health coverage is much higher in smaller firms—and there are roughly four million small businesses with 50 or fewer employees.

Any employer mandate certainly will be accompanied by some new subsidy for small or marginal businesses—additional charges on the Treasury that seem unlikely either to be well-targeted or equitable. Only adjusting the amount of the subsidy based on workers' incomes would address these problems, but this would make them individual subsidies, which seem incompatible and administratively difficult to coordinate with an employer mandate.

Enacting employer mandates now makes far more likely a health insurance delivery system forever tied to employment, rather than a system in which one's health insurance coverage is independent of where or for whom one works. And if we are serious about disengaging health coverage from job lock or job changes—given the secretary of labor's estimate that workers change jobs an average of eight times—an employer mandate seems a very bad prescription, indeed. What we are confronting is the familiar, but difficult, issue of transition from one public policy to another. Recognizing this to be a transitional issue, however, demands that we ask where are we heading and where do we want to end up.

We will never wean ourselves from employer-provided health insurance unless the employer-based tax incentives for health insurance are dramatically revised, and that will be no easy task. But if such change ever is to be accomplished, it should be done now while the nation is setting a new course for the delivery and financing of health care.

We need to redesign our public subsidies to create a fair and effective system that facilitates mandated purchases of

An employer  
mandate would  
be a big mistake  
that we can and  
should avoid.



to everyone. Such a progressive distribution of benefits might resemble Social Security's schedule of retirement benefits.

Such a universal tax credit financing system for health insurance coverage would have employment effects directly opposite an employer mandate. Since low-

income workers would come to jobs with their health insurance largely financed, they would become less expensive to hire—not, as under an employer mandate, substantially more expensive.

Such revision of our health coverage financing system would be compatible

with virtually any approach to health-care reform not employer-based. To be sure, transitional difficulties in the short run might be avoided by patching an employer mandate onto the current system. But if we are bold now, we can move to a rational and stable, yet flexible, system of health-care finance well-suited to a modern mobile labor force—a system in which no one would lose, or even have to change, their health insurance because of job change or job loss.

If, instead, we opt for an employer mandate, we simply will have deferred the need to rationalize the system—and in the meantime, added to the costs of, and thereby jeopardized, employment. Moreover, we will fail to address the underlying concerns that working people now have about the affordability and fragility of health coverage. Moving to an employer mandate, instead of an individual mandate, would be a big mistake—a mistake that we can, and should, avoid. □

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change ever is to be accomplished, it should be done now while the nation is setting a new course for the delivery and financing of health care.

We need to redesign our public subsidies to create a fair and effective system that facilitates mandated purchases of health insurance for all U.S. families. To the extent that employers want to purchase or finance health insurance for their employees, the system should facilitate that. But individuals, not employers, should have the legal responsibility for obtaining health insurance.

An essential step in moving to such a system is to phase out the current tax exclusions for employer-provided health insurance and to replace them with a tax credit or voucher for the purchase of health insurance. Within the existing system there is enough money to fund a standard package of insurance coverage for all Americans, including equitable and generous tax credits.

#### **Leaping the Transition Hurdles**

With enough reshuffling of existing expenditures, additional government financing should not be necessary. The political trick—and no one should underestimate how great a trick it is—is to manage the transition from the system we now have to a system of individually based universal coverage.

In order to reduce windfalls where employers are now providing health coverage for their employees, employers could be required to maintain their current efforts for some period of transition. Such a maintenance of effort requirement should allow, or even encourage, employers to substitute cash wages for health insurance as individual tax credits are phased in.

To ensure universal health insurance coverage, the tax credits or vouchers should fully finance the standard health insurance benefits for people at the poverty level and decline gradually as family income rises. To avoid limiting their availability to those who meet a means test, and also not unduly increase the taxes of people who currently enjoy employer-provided health insurance, some minimum amount of credit should be made available

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## COVER STORY

# Clinton Pushes Health Debate To Center Stage in Congress

*Members fear backlash if turf battles and special interests block action*

**W**hen President Clinton speaks to a joint session of Congress Sept. 22 and unveils his health-care overhaul, he will be doing more than opening a major legislative debate.

He will be rewriting the job description of the 103rd Congress.

The health-care plan is so far-reaching that it will demand attention from almost every member of Congress in the months ahead.

A host of committees and subcommittees will deal with the legislation. It will need the strong guiding hand of congressional leaders and the White House to coordinate its diverse parts. And it will touch so many constituencies that virtually every member will try to be part of the action.

"It is truly going to affect everyone in the United States," said Sen. John H. Chafee, a Rhode Island Republican deeply involved in the issue. "There aren't many bills that do that."

"Every member will take part," said Rep. Sherwood Boehlert, a New York Republican who is studying up even though he sits on no health-related committee. "No one is ceding anything to anyone on this issue. This will dominate for the year."

At this stage, much remains uncertain about how Congress will handle the bill: which committees will do what, how their efforts will be coordinated, what timetable they will follow.

There is no precedent for processing health legislation so sweeping in scope. Clinton's plan would set up an entirely new system for purchasing and regulating health insurance through regional alliances. It would require employers to provide employ-



REUTERS  
Hillary and Bill Clinton greet a child with health problems at a White House health-care forum Sept. 16.

ees with insurance and to pay most of the cost. (*Details*, p. 2458)

The challenge for Congress will be to lead the emerging national debate on health care without lapsing into partisan bickering, turf fights and special-interest pandering. Public expectations are now so high that a health initiative may be the sine qua non for a successful 103rd Congress. Whatever else it does — on trade, welfare and other social policies — the 103rd Congress likely will be judged a failure if it does not produce a major health bill that enjoys broad public support.

## Clinton's Speech

For many members of Congress and others involved in health policy, Clinton's Sept. 22 speech will provide few surprises about the contents of his health-care plan. Many of the details already have been leaked to lawmakers, lobbyists and journalists.

But for most Americans, Clinton's nationally televised speech will be their first comprehensive introduction to the plan. And for Clinton, it is his best chance to set the tone of debate.

Clinton is expected to stress the need to make people more secure than they are under the existing health-care system, in which people suddenly can lose their insurance due to job changes or illness. By emphasizing the security theme, said a White House official who requested anonymity, Clinton will try to show that the plan will help people who now have good coverage as well as those who have none.

Formal debate in the Senate will begin Sept. 28, when the Finance Committee and Labor and Human Resources Committee hold a joint hearing. The lead witness will be first lady Hillary Rodham Clinton, who headed the White House panel that drafted the plan.

## The Committee Labyrinth

Finance and Labor are the two committees at the center of health-care debate in the Senate: Finance, because it handles taxes, Medicare and Medicaid; Labor because it oversees public health programs and labor standards. Both panels have some jurisdiction over the law governing employee benefits, the Employee Retirement Income Security Act (ERISA).

In the House, the key panels are Ways and Means, which handles taxes and Medicare; Energy and Commerce, which handles Medicaid, public health and parts of Medicare; and Education and Labor, which handles labor standards and employee benefits.

Many other committees may get into the act to handle peripheral parts of the plan. The House and Senate Judiciary committees may consider proposals affecting medical malpractice and antitrust law. The Armed Services committees oversee changes in the military's health-care system. The Veterans' Affairs committees handle changes

By Janet Hook



## No Shortage of GOP Input

**E**ven before President Clinton officially unveiled his health-care overhaul plan, Republicans of all stripes were laying out their alternatives. The Senate GOP proposal was reasonably close to the White House's, raising expectations that a compromise will be achieved in the 103rd Congress.

The House and Senate GOP weighed in Sept. 15 with their plans. The House's, from the Leader's Health Care Task Force, was signed by 106 of the 175 Republicans. The Senate plan is the fruit of three years' work by the Republican Health Care Task Force. Twenty-three of the 44 GOP senators signed the plan.

Both plans accept the notion that the health-care system needs fixing. But neither would go as far as Clinton in overhauling the financing and delivery of care.

The picture emerging on Capitol Hill is of a spectrum of possible changes in the country's health policy. They range from a limited restructuring of health insurance and malpractice laws (the House GOP plan) to a radical redesign of the flow of money between patients, doctors and the government (the Democratic single-payer proposal). Somewhere in the middle are the programs outlined by Clinton and by Senate Republicans led by moderate John H. Chafee, R.I.

Administration officials say they view moderate Republicans as crucial to the bill's ultimate passage and will work to accommodate them.

### Senate Republican Plan

While the Senate GOP plan shares elements with the draft Clinton plan that circulated in Washington the week of Sept. 13, there are some major differences:

- The GOP plan sets a goal of universal coverage but goes no further than saying that by 2000 every American should have "access" to health insurance coverage. It would phase in a requirement that all Americans buy insurance. The Clinton plan would require everyone to have insurance by 1997 and would require employers to pay 80 percent of the premium cost of a standard plan.

- The GOP plan includes a basic benefits package similar to Clinton's, but it would allow consumers to opt out and instead choose a catastrophic benefit plan in combination with a medical savings account. The Clinton plan would require everyone to have at least the basic benefits package.

- The Republican plan would subsidize those who cannot afford coverage but would phase in the support between now and 2000. Clinton's plan would get all its subsidies rolling by 1997. In 1995, the GOP plan's first year, those with incomes below 90 percent of the federal



R. MICHAEL JENKINS

Chafee heads the Republican Health Care Task Force in the Senate.

poverty level would get vouchers to help pay for their coverage. The income levels would rise until 2000, when those with incomes of 240 percent of the poverty line would be eligible for assistance.

- The GOP plan relies on cost savings it hopes to wring out of the system and on limiting Medicare and Medicaid growth to 7 percent a year. Clinton's plan calls for higher cigarette taxes, employer mandates, Medicare and Medicaid limits, and cost savings.

- While Clinton's plan features both market reorganization and a variety of backup government mechanisms to control costs, the Senate GOP plan looks to market competition to keep costs down. Like Clinton's, it would establish uniform billing and reform the malpractice and antitrust laws.

- The GOP plan essentially leaves the health insurance indus-

try intact. It calls for buying cooperatives, which would bargain with insurance companies, but these would not be as powerful as Clinton's health alliances.

### House Republican Plan

The House GOP plan tinkers with the existing health-care system but makes no major changes. It would require employers to offer their employees insurance but would not require them to pay for it. It does not purport to achieve universal coverage.

The plan would limit the ability of insurance companies to refuse coverage to a business or individual, or to charge differing rates to small businesses. It would allow low-income consumers who do not qualify for Medicaid to buy into the Medicaid system.

It would require insurance companies to offer all small companies at least three options, including a standard plan, a catastrophic plan and a plan featuring Medisave accounts that could be used to pay deductibles and health-care premiums. Under Medisave plans, consumers would buy health insurance policies with deductibles of at least \$1,800, or \$3,600 for families.

Health-care purchasing cooperatives similar to those in the Senate Republican plan would be encouraged.

The plan seeks to control costs by requiring that all disputes go through an alternative dispute resolution system before they go to court, by capping non-economic damages and attorneys' fees, by simplifying paperwork and by loosening antitrust restrictions.

The plan would pay for itself by raising the minimum federal retirement age from 55 to 62 and phasing out Medicare subsidies for individuals with incomes over \$100,000 and families with incomes over \$125,000.

—Thomas H. Moore



in veterans' care.

"I wouldn't be surprised if, by the time this is over, both the Merchant Marine Committee and the ethics committee have a hand in it," said Rep. Fred Grandy, R-Iowa.

It is impossible to know exactly which part of the plan will be handled by which committee until the White House translates the president's plan into formal legislative language. That will not be sent to Congress until two or three weeks after Clinton's speech, according to Ira Magaziner, a top White House adviser on the issue. Adding to the confusion, the plan would set up entities Congress has never considered before — such as insurance purchasing alliances — so no one is certain what path they will take through Congress.

Especially in the House, where committee barons are more turf-conscious than in the Senate, decisions about how the bill is channeled through the committee system could have serious consequences for the pace and outcome of the debate.

For example, the Labor committees of both chambers are more likely to produce legislation with a liberal bent than other panels. They might produce more stringent employer mandates than if that part of the plan went to another committee.

Turf fights could slow progress. Clinton's plan touches on subjects that traditionally have been the source of conflicts between House committees: Ways and Means has a history of squabbling with Energy and Commerce over Medicare jurisdiction; Education and Labor has often fought with Ways and Means over ERISA.

The situation is simpler in the Senate, where the Finance Committee has clear jurisdiction over most of the bill.

### Leadership Role

The process cries out for strong leadership to see that the pieces reported by different committees come together into a coherent policy.

"You want to do this in a way that ensures you have a bill where the individual parts add up to a healthy whole," said Rep. Ron Wyden, D-Ore.

House and Senate leaders plan no formal mechanism to guide the process. But aides said the leadership will meet soon with committee chairmen to set the framework and timetable for action.

Many of the top congressional leaders have expertise on health issues.

Senate Majority Leader George J. Mitchell, D-Maine, is a member of the Finance Committee and was chairman

## Turf

President Clinton's health plan will be handled by many committees. Following are the major players and their jurisdictions. (Other panels such as the Veterans and Post Office committees may handle peripheral issues.)

### HOUSE COMMITTEES

#### Ways and Means

Taxes; Medicare; tax provisions of the Employee Retirement Income Security Act (ERISA), which governs employee benefits.

#### Energy and Commerce

Medicaid; Medicare payments for doctors; public health; biomedical research, medical education.

#### Education and Labor

Labor standards including ERISA.

#### Judiciary

Malpractice, antitrust laws.

### SENATE COMMITTEES

#### Finance

Taxes; Medicaid; Medicare; tax provisions of ERISA.

#### Labor and Human Resources

Labor standards including ERISA; public health; biomedical research, medical education.

#### Judiciary

Malpractice, antitrust laws.

of its Health Subcommittee the last time Congress passed a major revision of federal health benefits: the 1988 measure providing catastrophic coverage for Medicare recipients. That law was repealed one year later, under fire from elderly people who did not want to pay more for benefits.

Senate Minority Leader Bob Dole, R-Kan., is a former chairman of the Finance Committee who was active in the debate on catastrophic coverage.

House Majority Leader Richard A. Gephardt, D-Mo., was a longtime member of the Ways and Means Committee. Ironically, Gephardt first made his mark in health care by leading the opposition to the last Democratic president who tried to propose major changes in the medical system: In 1979, Gephardt helped kill President Jimmy Carter's hospital cost control plan.

### Timetable for Action

No official timetable for action has been set, but no one expects Congress to complete work on the health-care plan this year. At best, most members predict that committees might com-

plete hearings by year's end.

"We want a national discussion; we don't want to railroad this thing through," said Magaziner. "We hope it can get passed early next year; we certainly hope by next spring."

Many on Capitol Hill think that timetable is optimistic and do not expect final action before mid-1994.

"This is obviously going to take some time and care," said Wyden.

House Minority Leader Robert H. Michel, R-Ill., said many members were chastened by their experience with catastrophic health insurance. "Members are going to remember that and say, 'I don't want to go through that again.'"

### Republican Players

It is clear that debate on this issue will be very different in tone from the bitterly partisan fight over Clinton's economic program earlier this year. For months, Republicans sat on the sidelines, immovable in their opposition to tax increases and all but irrelevant to shaping the bill.

Not this time. Separate groups of House and Senate Republicans during the week of Sept. 13 unveiled their own plans to change health care. Despite differences over key points like employer mandates, White House officials said they expect eventually to find common ground with many Republicans. (*GOP plans, p. 2456*)

"We think a coalition will come together of moderate Republicans, liberal Democrats and moderate Democrats that will pass the bill," Magaziner said.

However, what Republicans gain in influence they may lose in unity because their party is deeply divided over health policy. On one side are Republicans allied with Chafee, a moderate who has proposed a plan cosponsored by 22 other Senate Republicans. Like Clinton's plan, it would set up regional health insurance purchasing alliances, but it would make participation in them voluntary.

On the other side are conservative Republicans — led by Sen. Phil Gramm, R-Texas and including most House Republicans — who favor more modest changes in the existing system. Some conservatives say Chafee's approach is so similar to Clinton's that they call it "Hillary II."

But Gramm said he viewed the divisions among Republicans as a sign of lively intellectual debate.

"People are really thinking about this," Gramm said. "People are searching their minds and hearts." ■



## COVER STORY

# Clinton's Health Plan Envisions Reorganized Marketplace

**P**resident Clinton's far-reaching proposal to overhaul the American health-care system envisions the government as an omnipotent clock-maker, setting in motion new market mechanisms that eventually will run the system on their own.

His plan aims to reorganize the market to give consumers the power to control their health-care costs. But to do that he requires consumers to enter into new financial relationships with health-care providers and proposes restricting the power — and the profitability — of the health industry.

Clinton's plan purports to rely on competitive forces to bring down prices and improve services, but it is backed up by heavy government regulation.

Administration officials have been careful to underscore that the proposal, which has been circulating for the past week in Washington, is only Clinton's opening move. But lawmakers say it will frame the debate, much as President George Bush's clean air bill did in 1989. Unlike proposals by other recent presidents, Clinton's plan is being taken seriously by interest groups and receiving cautiously optimistic reviews from moderate Republicans, whose votes will be crucial to its passage.

Preliminary readings produced a barrage of questions on Capitol Hill, signaling that although a majority of lawmakers support reform, they will seek some fundamental changes in Clinton's plan.

Already, White House experts are tinkering with it to head off criticism from key allies. More than 150 changes have been inserted in the 245-page proposal, which is the result of about eight months of study by a task

By Alissa J. Rubin

## Financing the Plan

(in billions of dollars)

| New Savings                                                       | Amount        | New Spending                                 | Amount        |
|-------------------------------------------------------------------|---------------|----------------------------------------------|---------------|
| Savings in Medicare                                               | \$ 124        | Long-term care                               | \$ 80         |
| Savings in Medicaid                                               | 114           | Medicare drug benefit                        | 72            |
| Other federal health programs                                     | 47            | Public health/administration                 | 29            |
| Sin taxes and/or corporate assessment                             | 105           | Subsidies for low-wage workers and companies | 169           |
| Revenue effects of employer mandate and changes in tax deductions | 51            |                                              |               |
| <b>TOTAL SAVINGS:</b>                                             | <b>\$ 441</b> | <b>TOTAL SPENDING:</b>                       | <b>\$ 350</b> |

SOURCE: White House documents

force of health experts led by first lady Hillary Rodham Clinton. More changes are expected before the president's scheduled speech to a joint session of Congress on Sept. 22. "We don't believe that we have all the answers," said Ira Magaziner, the chief White House adviser for health policy. "We're not coming down from the

**"We don't believe that we have all the answers. We're not coming down from the mountain with the tablets."**

—Ira Magaziner, chief White House adviser for health policy

mountain with the tablets."

Despite the lengthy outline, many aspects of the plan are not yet clear. Lawmakers and voters may need several months to understand the new system and its impact.

Contrary to early reports, the plan does not fit neatly under a rubric such as "managed competition." It draws

on aspects of the market-oriented managed-competition system California uses to provide health insurance to many state employees. It takes elements from the Canadian single-payer system, in which the government collects premiums and administers benefits, cutting out the role of insurance companies. And it gives state governments considerable leeway in running their own systems.

### New Requirements

Anchoring the proposal is a new entity created by the government: the regional health alliance. Funding

much of the proposal is a new government mandate: All employers must pay for a portion of their employees' health care.

The health alliance links doctors to patients and moves the money through the local health system. It is not analogous to any existing government or private entity, but it most resembles a public utility board that bargains with the water, telephone and gas companies to buy services at the lowest price for consumers.

The health alliance will bargain with local health plans for low-cost, quality care. Health plans will be made up of hospitals, doctors and other providers, such as physical therapists. Thus in Toledo, Ohio, almost all consumers in the city and surrounding suburbs would select their health insurance plan through a list provided by the Toledo health alliance. The list would include several local health maintenance organizations (HMOs) as well as traditional fee-for-service plans of the type many consumers have now.

Employers, employees and others would pay their premiums to the health alliance; the alliance in turn would pass the money to the health



plans based on the number of subscribers. The alliance also would ensure that the plans keep the premium price within the budget set by the federal government, which will cap annual increases at the rate of inflation, plus changes in population.

Under this arrangement, the alliance essentially acts as the broker between consumers and their health care — funneling the money and reviewing the plans to make sure they meet federal requirements. Such an arrangement largely eliminates the traditional role of insurance companies. However, someone still will have to organize doctors, hospitals and clinics into health plans. Insurance companies could do that and handle the paperwork.

The following is a look at how the system would work and how money would move through it:

**Patients.** Under the Clinton plan, all consumers would be required to buy health insurance and employers would shoulder at least 80 percent of the cost. Government subsidies would be available for low-paid workers and the unemployed. Medicare would remain intact for the elderly and disabled. Everyone except illegal aliens would have health insurance by 1997. The insurance, purchased through a local health alliance, would provide coverage for a federally mandated minimum package of benefits — or more. The minimum package is more generous than most plans available today, except for certain union or corporation plans that, for example, require little or no cost-sharing by employees. (*Story, p. 2462*)

However, whether people pay more now or more later would depend on what their current plan costs. Annual premiums would average about \$360 for an individual and \$840 per family. Plans offering a broader selection of doctors or expanded benefits could cost more. A healthy person without insurance today clearly will be paying more under the Clinton plan. The reward is that the insurance is permanent and portable. No one would lose insurance after a job change or loss.

Administration officials underscore that because all providers will offer the same menu of services, consumers will be better able to compare them.

**Employers.** The Clinton system will be a boon or a burden for employers, depending on whether they currently provide health insurance. For those who do, it could be less expensive; for those who do not, it will cost



**First lady Hillary Rodham Clinton led the task force that produced the proposal.**

more. All employers will be required to pay something toward their employees' health care regardless of how much they earn and whether they work full time or part time. Most employers will pay 80 percent of the premium, which administration officials estimate will cost about \$1,440 for a single employee and about \$3,360 for an employee who wants a family plan. Under the proposed financing arrangement for married couples, each spouse's employer would pay only a portion of the total.

Clinton wants to lighten the burden for employers with fewer than 50 workers, who earn low wages, by offering government subsidies. The portion of payroll that small employers will have to spend on insurance could be as low as 3.5 percent. All employers would be capped at 7.9 percent. Employers currently offering self-insurance plans would have to make their plans conform in most respects to those offered through the health alliances.

**Providers.** The Clinton proposal would have the greatest impact on health-care providers: doctors, hospitals, other professionals, the technology industry and insurers. The new cap on the annual increase in insurance premiums, designed to halve the current 11 percent health-cost inflation rate, will force providers to reduce profits and limit salary increases. Some health professionals may have more job opportunities, but the

health industry in general will see fewer profits. Medical practice will have to become more cost-conscious — a radical change in a culture that traditionally puts care above cost.

Clinton's new marketplace relies heavily on a controversial reorganization of the medical system into "health plans." Currently, most Americans choose their own doctor. If they need specialized care, the doctor refers them to someone the doctor knows; if they need hospitalization, they are sent to the hospital where the doctor can admit patients.

Under the Clinton system, doctors would be pressured to work for managed-care plans — largely because they will cost less than other plans and many patients will choose them. An HMO is an example of a managed-care plan. Under such a plan, the doctor acts as a gatekeeper to specialists, expensive tests and hospitalization. Subscribers are required to see a primary-care doctor, who refers them to specialists who work for the plan and to hospitals affiliated with the plan. This is a fundamental departure from current practice, and critics say it intrudes unnecessarily on the day-to-day practice of medicine. However, several policy experts say it is necessary to streamline medical practice to save money.

The Clinton plan does include provisions that providers are likely to favor. It cuts administrative paperwork. Doctors would use a single form for billing. The proposal also provides limited malpractice reform and relief from the threat of antitrust action.

### Financing

Over the next seven years, the government expects to save or raise \$441 billion, spend \$350 billion on new health costs and use the remaining \$91 billion to reduce the federal deficit.

The relatively low price of \$350 billion — about \$50 billion annually — would be achieved largely by relying on the private sector to pay for much of the system's cost. The government would finance its share through savings in existing programs, a cigarette tax and increased tax revenues. The government expects that employers will spend less on health care, resulting in higher taxable profits.

Almost every aspect of the financing is controversial.

The employer mandate is unpopular on Capitol Hill, although from



# Clinton's Changes to the System ...

The U.S. health-care system would come in for radical changes under President Clinton's proposed overhaul. The 245-page draft proposal shown to members of Congress and several news organizations outlines a number of ways that existing aspects of the system would be affected. Here is a snapshot of what would happen to:

## Antitrust Laws

Insurance companies would be subject to federal antitrust laws for the first time in more than 50 years. However, the laws would be loosened for small hospitals that have trouble filling their beds; they would be able to merge with other institutions after a 90-day review by the Justice Department and Federal Trade Commission. Joint ventures undertaken by hospitals — such as the purchase of expensive high-technology equipment — also would be reviewed on an expedited basis. Similarly, doctors would be able to form networks with hospitals, clinics and other health providers.

## Auto Insurance and Workers' Compensation

Consumers and employers would continue to get coverage for auto-related and work-related injuries, but injured consumers would receive care through their own health plans. Insurers and workers' compensation insurers would be required to provide medical benefits through the health alliances, which also would set uniform fee schedules and act as the brokers for all reimbursed payments.

## Choosing a Physician

A consumer in an urban area would be able to choose among several health plans. The consumer could choose the plan his or her current doctor joins. The type of plan, however, will determine its price. If the doctor works on a fee-for-service basis, the consumer could stay with that doctor but would pay a higher premium. If a doctor joined a health maintenance organization (HMO), the consumer could join that plan and pay the standard premium. Otherwise, a consumer would have to choose a new doctor who worked with the plan he or she selected.

States with large rural populations could require urban health plans to serve rural areas as a condition of participation in the new system. The plan would also offer additional tax incentives for physicians and non-physicians to work in rural areas.

## Employer Health Insurance

Employers would be required to pay 80 percent of the average cost of a health plan in the alliance, with employees paying the other 20 percent. The employee also would pay extra if choosing a plan more expensive than the average. The projected average annual cost of a plan for an individual would be about \$1,800; thus the employer would pay about \$1,440 and the employee, \$360.

For a two-parent family, the employer would pay 80 percent of the average family premium divided by the average number of workers per family in that health alliance. Family premiums are estimated to cost about \$4,200. Thus, for a two-worker family in a region where

the average number of workers per family is 1.5 and 80 percent of the average premium is \$3,360, the per worker contribution for each employer would be \$2,240.

Those employees who earn \$10,455 or less a year would receive government subsidies to cover their share of the premium. The money would go to the health alliance, which would then pay for the health plans.

The plan would impose a cap on insurance premium increases based on a formula that includes inflation and population change.

Employers with fewer than 50 workers would have their contributions capped as a percentage of payroll — with the cap ranging from 3.5 percent to 7.9 percent, depending on average salaries. Regardless of size, no employer would be required to spend more than 7.9 percent of total payroll on health insurance.

Employers who cannot afford to pay for their employees' premiums would be eligible for federal subsidies, which would be phased in over eight years.

## Health Insurance

Instead of buying insurance from a health insurance agent or receiving it through an employer, a consumer would obtain health coverage through a new entity, a local health "alliance" that would act as a purchasing agent. All plans in an alliance would be required to offer a federally mandated package of health benefits, at a minimum. The alliance plans would have to include at least one fee-for-service arrangement, similar to the kind now paid for by indemnity insurance companies.

Insurance companies could be involved in setting up the health plans, which would be made up of networks of doctors and hospitals.

Companies large enough to write insurance policies for employees themselves could buy into a health plan through an alliance if the companies had fewer than 5,000 employees. Companies with more than 5,000 employees could bypass the local alliance and form a "corporate alliance" to bargain with health plans, as long as the plans met national standards. These company plans would also be subject to additional state taxes that now are pre-empted under federal pension and employee benefit law.

## Job Displacement

While White House officials say there will be a net job gain under the Clinton plan, some sectors of the health-care industry (such as insurance) and small businesses probably would suffer job losses. The administration still is trying to calculate how much the loss would be, and how the federal government should deal with it is "still under review," according to the report.

New jobs would be created among ancillary health professions, such as physician's assistants, nurses and other primary care providers. Physicians who may be asked to change their specialties would receive help with retraining.

## Malpractice

All health plans would have to have an alternative dispute resolution arrangement, which plan members



## ... Would Have a Wide Reach

would have to turn to first if they believed they had been injured by a doctor, nurse or other health-care provider. If the consumer was not satisfied with the outcome of the dispute resolution, they could then take the provider to court. Lawyers' fees would be limited to one-third of the award.

The plan makes no mention of punitive damages awarded by juries. Several lawmakers who support changes in federal tort laws want to limit the discretion of juries to award punitive damages.

### Medicaid

The joint state and federal health insurance program for the poor would continue to subsidize the costs of poor families with dependent children and those who receive supplemental security income: the aged, blind or disabled. That covers about 60 percent of the total Medicaid population. The government would pay both the employer share of the health alliance premiums and subsidize the employee share.

Medicaid would pay the health alliances about 95 percent of the average premium costs, but the alliances would blend the money with full premiums paid by employed payers, so that providers would not know that they were seeing Medicaid patients who were paying less.

The remaining 40 percent of current Medicaid recipients, who include pregnant women and children and people needing institutional care, would go into the local health alliance. If they were employed, their employers would be required to pay a share of the premium; if they had no jobs, they would receive subsidies from the federal government.

Overall, Medicaid would be cut an estimated \$114 billion over the years 1996-2000.

### Medicare

The government's health insurance program for the elderly would remain intact, but those with incomes in excess of \$100,000 for individuals and \$125,000 for couples would pay higher premiums for the voluntary "Part B" side of the program, which pays for outpatient physician services.

Medicare would offer two broad new benefits: prescription drugs (see below) and some long-term care, including extended home health care.

Over the five years from 1996-2000, the federal government would attempt to slow the program's cost growth by reducing the rate of increase in an array of programs and in reimbursements to hospitals and providers, saving an estimated \$124 billion.

### Prescription Drugs

The cost of prescription drugs automatically would be covered by all health plans. However, health plans would be given carte blanche to establish a specific list of drugs that they will pay for — for instance, using only generics, where available, instead of more expensive brand-name products.

Patients would have to pay a \$250 deductible for prescriptions, after which they would pay a 20 percent co-payment up to a maximum out-of-pocket cost of \$1,000 a year. The elderly, who receive their insurance through the federally funded Medicare program, would be covered in the same way.

Physicians could be required by the secretary of Health and Human Services (HHS) to obtain prior approval before prescribing specific brand-name drugs in lieu of generic products to Medicare patients.

As a condition of participation in Medicaid and Medicare, drug manufacturers would have to sign rebate agreements with the HHS secretary. Some drugs would require a 15 percent rebate.

### Self-Employed

Self-employed and unemployed individuals would have to pay the employer share of the premium in addition to the employee share, unless they were eligible for government assistance based on their incomes. The premium payment would be 100 percent tax-deductible.

### Tax-Deductibility

Employers and employees would be able to deduct the premiums they pay for the standard benefit package, but both would be taxed for benefits that go beyond the national standard package.

Currently, employers may deduct all health premium payments. An exception would be made for benefits that were in place in January 1993, which would be tax-exempt for 10 years; this is an issue of special importance to unions that have negotiated contracts with generous health benefits in lieu of pay increases.

### Uninsured

Everyone who qualifies for health coverage — "American citizens, nationals, legal residents and long-term immigrants," as listed in the Clinton plan — would have to enroll in a health plan through a local health alliance.

Individuals or families would be required to pay 20 percent of the average premium for the plans offered by that alliance.

Families and individuals with incomes below 150 percent of the federal poverty level would be eligible for federal subsidies. The poverty line in 1993 for a family of three is \$11,890; 150 percent of that is \$17,835.

Illegal immigrants with no regular employment would be prohibited from enrolling in a health-care alliance. However, if they were working, their employers would be required to pay for their care, and they would receive the same health benefits as American citizens.

Health alliances could not reveal any information about a plan member's immigration status to the Immigration and Naturalization Service.

—Alissa J. Rubin



## What Would Be Covered . . .

One of the foundations of President Clinton's proposed health-care reform is a minimum benefits package.

This chart shows the benefits contained in Clinton's

draft plan. It includes better mental health and substance abuse coverage than most Americans now have, but excludes any discussion of abortion coverage.

—Thomas H. Moore

| Service Covered                                                         | Definition of Service                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Limitations                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hospital and emergency services</b>                                  | Inpatient, outpatient and emergency room services at a hospital. Includes room and board, therapeutics, and lab, diagnostic and radiology services.                                                                                                                                                                                                                                                                                                                                                                   | No private room accommodations.                                                                                                                                                                                                                                                                                                                   |
| <b>Physicians and other health professionals</b>                        | Inpatient and outpatient medical and surgical services, including consultations, in home, office, ambulatory-care or institutional settings.                                                                                                                                                                                                                                                                                                                                                                          | No private-duty nursing, cosmetic or sex-change surgery, or custodial care. No investigational treatments, but routine medical expenses incurred during an approved research trial would be covered.                                                                                                                                              |
| <b>Clinical preventive services</b>                                     | Physicals every three years for those age 20-39, every two years for those age 40-65, and annually thereafter. Checkups for young children. Mammograms every two years for women 50 and over. Pap smears and pelvic exams every three years until age 50, when they are paid for every two years. Cholesterol screenings every five years beginning at age 20. A range of immunizations, including hepatitis B vaccine for children and annual flu shots for the elderly. More frequent tests for high-risk patients. |                                                                                                                                                                                                                                                                                                                                                   |
| <b>Inpatient mental health and substance abuse</b>                      | Comprehensive inpatient mental health services by 2001. Covers inpatient care for psychiatric and substance abuse disorders at hospitals and other residential treatment centers.                                                                                                                                                                                                                                                                                                                                     | Initially, patients would be limited to 30 days per episode, with an annual maximum of 60 days. Health plans could grant more time for patients deemed dangerous to themselves or others. By 1998, the maximum would rise to 90 days. Inpatient care available only when non-residential or less-restrictive residential services are inadequate. |
| <b>Non-residential and outpatient mental health and substance abuse</b> | Partial hospitalization, psychiatric rehabilitation, ambulatory detoxification and home-based services; professional psychiatric and substance-abuse services, diagnosis and medical management; substance abuse counseling and relapse prevention; outpatient psychotherapy.                                                                                                                                                                                                                                         | Greater cost-sharing than with other benefits; this would be phased out by 2001. Initially, outpatient psychotherapy visits would be limited to 30 per year.                                                                                                                                                                                      |
| <b>Family planning and pregnancy-related services</b>                   | Prenatal and well-baby services. Otherwise, not specified.                                                                                                                                                                                                                                                                                                                                                                                                                                                            | No in-vitro fertilization coverage.                                                                                                                                                                                                                                                                                                               |
| <b>Hospice</b>                                                          | Same as Medicare benefit: nurses' and doctors' care, social services, short-term inpatient care, medical supplies, physical or occupational therapy and speech-language pathology.                                                                                                                                                                                                                                                                                                                                    | Limited to the terminally ill and would be available only as an alternative to hospitalization.                                                                                                                                                                                                                                                   |

Clinton's standpoint it avoids a broad new tax that surely would be rejected beyond the Beltway. A sin tax on cigarettes — expected to yield \$105 billion over seven years — is unpopular with lawmakers from tobacco states.

Under the Clinton plan, Medicare would save \$124 billion over seven years — a cut twice as deep as the one just put in place by the Clinton deficit-

reduction bill (HR 2264 — PL 103-66). That would further reduce payments to doctors and hospitals. (*Weekly Report*, p. 2376)

Medicaid would save \$114 billion over seven years. A portion of the Medicaid program would cease to exist as beneficiaries entered health alliances. Some of the "savings" would be transferred into the new health system

to pay for subsidies for small businesses, the poor and the uninsured.

### Government

Although the White House says the plan is not regulatory, it gives the federal government extensive new power to regulate health-care prices and to mandate how much money businesses spend on their employ-



## ... Under Clinton's Health Plan

| Service Covered                                                   | Definition of Service                                                                                                                                                                                                                                        | Limitations                                                                                                                                                                                                                                                     |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Home health care</b>                                           | The Medicare benefit: Nurses' care, social services, medical supplies, physical or occupational therapy and speech-language pathology. The plan would also cover prescribed home infusion therapy and outpatient prescription drugs and biological products. | Patient would be re-evaluated at 60 days. Available only as an alternative to hospitalization.                                                                                                                                                                  |
| <b>Extended-care services</b>                                     | Inpatient services in a skilled nursing or rehabilitation facility.                                                                                                                                                                                          | Available only after an acute illness or injury, as an alternative to hospitalization. Limited to 100 days per calendar year.                                                                                                                                   |
| <b>Ambulance services</b>                                         | Ground or air ambulance services.                                                                                                                                                                                                                            | Covers air transport only when other means are inadvisable.                                                                                                                                                                                                     |
| <b>Outpatient laboratory and diagnostic services</b>              | Prescribed laboratory and radiology services, including diagnostic services, to those who are not patients of a hospital, hospice or extended care facility.                                                                                                 |                                                                                                                                                                                                                                                                 |
| <b>Outpatient prescription drugs and biologicals</b>              | Drugs, biological products and insulin.                                                                                                                                                                                                                      | Must be for outpatient use; no special limits on quantities. Health plans would be allowed to establish a list of drugs that physicians could prescribe, and to set up systems of substituting generic drugs, mail-order programs and drug utilization reviews. |
| <b>Outpatient rehabilitation services</b>                         | Occupational and physical therapy and speech-pathology services.                                                                                                                                                                                             | To be used only to restore capacities or minimize limits on physical or cognitive functions after an illness or injury. Must be re-evaluated after 60 days.                                                                                                     |
| <b>Durable medical equipment, prosthetic and orthotic devices</b> | Durable medical equipment; prosthetics that replace internal organs, eyes or limbs; braces for legs, arms, backs and necks; training for these items.                                                                                                        | Would not cover custom devices. Items must improve functional abilities. No cosmetic orthodontia.                                                                                                                                                               |
| <b>Vision and hearing care</b>                                    | Routine eye and ear exams; diagnosis and treatment for vision defects. Eyeglasses and contact lenses for children under 18.                                                                                                                                  | No eyeglasses or contact lens coverage for adults; routine eye exams limited to one every two years for persons 18 or over. No hearing aids.                                                                                                                    |
| <b>Dental services</b>                                            | Initially, services only for children. Includes treatment for prevention of dental disease and injury, maintenance of dental health and emergency dental treatment after an injury. Adult preventive care would be added by 2001.                            | No cosmetic orthodontia.                                                                                                                                                                                                                                        |
| <b>Health education classes</b>                                   | Education or training that reduces behavioral risk factors and promotes healthy activities. May include: smoking cessation, nutrition counseling, stress management, skin cancer prevention, physical training classes.                                      |                                                                                                                                                                                                                                                                 |

ees' health care.

The federal government will enforce overall budgets and employer mandates. It also will set national quality standards and redirect the medical profession into the field of primary care.

State governments also will have a broad hand in setting up the new system. By 1997, they must pass legisla-

tion to set up alliances, administer subsidies, certify health plans and regulate alliance finances. States will be free to create a single-payer system, in which the state is the sole payer for health plans.

Nationally, many aspects of the system will be run by a new government entity: the National Health Board. It will set national quality

standards and oversee the establishment of alliances. The board also would have power to determine the kinds of services health-care plans could cut to meet their budgets.

Enforcement power over the system as a whole would rest with the Federal Trade Commission and the departments of Labor, Justice, and Health and Human Services. ■



## APPROPRIATIONS

# Senate Labor-HHS Measure Drops Abortion Limits

The Senate is girding for a major abortion battle that could lead to relaxed restrictions on federally financed abortions for poor women for the first time in 17 years.

The outcome could have far-reaching ramifications for all women because both sides agree that it is likely to affect whether abortions will be covered routinely under a national health-care plan envisioned by the Clinton administration.

The Senate Appropriations Committee Sept. 14 approved a fiscal 1994 spending bill (HR 2518) for the departments of Labor, Health and Human Services, and Education that included no limit on abortions paid for by Medicaid, the joint federal-state health insurance program for the poor. The committee approved the bill 27-1, with Phil Gramm, R-Texas, casting the only dissenting vote.

Tom Harkin, D-Iowa, chairman of the Labor-HHS Appropriations Subcommittee, had removed all abortion-restricting language from the measure before the panel considered and approved it by voice vote earlier the same day.

Besides Medicaid, the \$256.7 billion measure pays for loans and grants to college students, grants to local school districts and childhood immunizations, as well as job training, medical research, and other items.

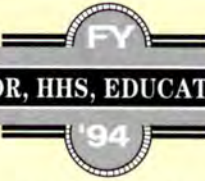
## Waiting for the Floor

Don Nickles, R-Okla., considered tackling the abortion issue in committee, but Chairman Robert C. Byrd, D-W.Va., suggested that he wait until the bill was on the floor. Byrd said he had the votes in committee to beat Nickles.

Current law prohibits Medicaid from paying for an abortion except when the life of the woman is in danger. Crafted by Rep. Henry J. Hyde, R-Ill., the abortion restriction was first enacted by Congress in 1976; it has not been altered since.

Two things have changed to make it possible that Congress will relax limits on federally financed abortions.

This year, the House voted when



**LABOR, HHS, EDUCATION**

**BOXSCORE**

**Bill:** HR 2518 — H Rept 103-156, S Rept 103-143.

**Latest action:** Senate Appropriations Committee approved 27-1, Sept 14.

**Next likely action:** Senate floor.

**Background:** The bill funds the departments of Labor, Health and Human Services, and Education, and related agencies.

**Reference:** Weekly Report, pp. 1735, 1657, 1486.

considering its version of the Labor-HHS bill to allow Medicaid to pay for an abortion not only to save the woman's life but also in the case of a pregnancy resulting from rape or incest. Though the broader language is still being called the Hyde amendment, the change amounted to a reversal of past House positions. During the 1980s, House conferees consistently rejected Senate-passed language that permitted Medicaid abortions in all three circumstances.

Also, if Congress does send a less restrictive bill to the White House, it will not be vetoed. Lawmakers knew that President George Bush would veto any bill that permitted Medicaid-financed abortions in cases other than when the woman's life was threatened.

"Knowing that the bill won't be vetoed will help the Senate go further," said Susan A. Cohen, a senior associate with the Alan Guttmacher Institute, a reproductive health research group. "The whole political context has changed dramatically."

## Broader Ramifications

The outcome of fights on the Senate floor and possibly in a House-Senate

conference will affect whether President Clinton will fight to protect abortion as a service offered under his health-care plan. (*Health plan*, p. 2455)

"If Congress renews the Hyde amendment, we think that strengthens our position to keep mandatory abortion coverage out of any national health plan," said Douglas Johnson, legislative director of the National Right to Life Committee.

Two of the three women senators on the Appropriations Committee, Patty Murray, D-Wash., and Barbara A. Mikulski, D-Md., said after the committee action that they intend to see that the abortion restrictions stay out of the bill.

"We believe we have enough votes to win our position," Mikulski said.

Mikulski would not say how many votes she has, but she will need only a simple majority — 51 — to win.

Recently, a thin pro-abortion rights majority asserted itself when the Senate voted 48-51 against retaining a decadelong ban on taxpayer financing of abortions through health-care plans for federal workers.

The ban — long a part of the Treasury-Postal Service appropriations bill (HR 2403) — was dropped by the House, and Nickles attempted to have it reinstated. He also modified its language to allow women to receive abortions through their health-care plans only if they paid a separate premium for the abortion coverage. (*Weekly Report*, p. 2157)

The vote occurred Aug. 3, when Mikulski raised a parliamentary point of order that the Nickles amendment amounted to legislating on an appropriations bill — an action in theory prohibited by Senate rules but not always enforced by the membership.

Mikulski's point of order was sustained by the presiding officer, and Nickles lost a motion to have the amendment ruled germane.

A similar scenario could occur when the Labor-HHS bill reaches the floor. "It's going to be a fairly close vote on whether to restore the House-passed language," Johnson predicted. He said a few of the senators to watch on the issue include: Harris Wofford,

By Jill Zuckman



St. Petersburg Times  
5/25/92

TEL:

5.25.92

## Fund-raising effort targets senior fears

■ Critics say the National Committee overstates threats to Social Security and Medicare benefits to raise money.

By DAVID DAHL  
Times Staff Writer

WASHINGTON — A direct-mail organization is raising \$30-million a year by sending senior citizens alarmist letters asking for money to protect their Social Security and Medicare benefits from cuts in Washington.

Where does the seniors' money go?

Some of it pays the salaries of lobbyists and staff at the organization, called the National Committee to Preserve Social Security and Medicare.

Some of it goes into the campaign accounts of members of Congress.

And at least half of it is spent to send out more fund-raising letters.

The National Committee, as it is known, has been criticized by the Social Security Administration and other senior citizens' groups for sending letters that overstate threats to Social Security and Medicare benefits.

"The whole notion of trying to frighten

people into giving contributions is abhorrent," said Gwendolyn King, commissioner of Social Security. "I would strongly recommend that they ignore solicitations that show up in the mail."

After receiving complaints from consumers, King's agency this month asked the National Committee to halt fund-raising appeals containing "insinuations" that led seniors to "fear that their benefits are being reduced or going to stop."

The group's letters are familiar to many senior citizens. They measure 11-by-13½ inches — research shows large envelopes

Please see SENIORS 3A



## Seniors from 1A

are less likely to be discarded — and they carry big-print warnings.

"WATCH OUT!" one letter says in red and blue ink. "Washington is trying a new fast shuffle with your Medicare Benefits!" (The warning refers to an attempt in April to curb Medicare and other entitlement spending by permitting increases only for inflation and population growth. The effort failed.)

Inside the envelopes, a letter typically describes the latest "assault" on benefits and asks seniors for \$10 in annual dues plus "special donations" to finance the fight against cutbacks. Separate but similar appeals are sent two or three times a year to raise money for its political action committee (PAC), said Max Richtman, the group's executive vice president.

"Our intent is not to scare them into contributing. Our intent is to inform them about what's happening in Congress and what's coming down the road," he said.

### Profile: National Committee

The National Committee to Preserve Social Security and Medicare raises money for two separate accounts: a political action committee and the group's operating budget.

The PAC collected nearly \$2.6-million in 1989 and 1990 and is raising thousands more in preparation for the 1992 elections. Virtually all of the money is spent to support candidates of both parties or donated to accounts of the political parties themselves.

The group's operating account collected \$30.6-million from membership dues and other assessments collected through its fund-raising letters in the year that ended March 31, 1991, according to the Internal Revenue Service.

It spent nearly \$13-million on printing and publication costs, \$3.9-million on postage and shipping, \$1.3-million on professional fund-raising fees and nearly \$2.5-million on salaries and other compensation, the IRS says.

The group is exempt from federal income taxes, but donations to it are not tax deductible. It claims more than 5-million members.

— David Dahl

Once criticized for exaggerating its lobbying presence, the group now says it lists about 20 registered lobbyists among its 70 staffers. The president is a former acting Social Security commissioner, 68-year-old Martha McSteen, who is paid \$160,000 a year. Richtman, 45, formerly the top staff member at the Senate Special Committee on Aging, puts his salary at about \$110,000 a year.

The committee also operates the largest of two PACs focusing directly on senior citizen issues. More than 280 candidates have accepted money from the controversial group, including a few top members of Congress, such as House Majority Leader Richard Gephardt, as well as one-time critics, such as Arizona GOP Sen. John McCain, and dozens of rank and file members.

Nine members of Florida's House and Senate delegation have received money from the controversial group. "Do they have a serious agenda? Yes," said Sen. Bob Graham, a Democrat who received \$6,000. "They're aggressive, but I don't think they go over the line in Washington."

Graham, like many of the lawmakers receiving contributions from the group, supports one of the main planks in the National Committee's platform — a bill that would boost in benefits for so-called "Notch Babies." These retirees, born after 1916, are angry that law gives them lower benefits than other seniors born earlier.

The group's letters rarely fail to bring up the Notch issue, calling it "Notch justice." One mailing provided charts that show seniors how much they have been "short-changed."

King opposes the legislation, saying the senior citizens in that age group are not getting cheated at all but simply collect less than the seniors before them because of the way Congress structured the benefits. King suggests that the National Committee has worked to expand the "Notch Baby" age group by five years in order to increase its potential contributors.

"It seems like a good, fertile ground for fund-raising," the Social Security commissioner said in an interview.

McSteen, the National Committee president who signs the fund-raising letters, opposed Notch legislation while she was acting commissioner of Social Security under President Reagan, according to congressional testimony.

Now, though, McSteen says the Social Security Trust Fund is in better shape to absorb the \$45-billion cost of the Notch Baby benefits. (While the trust fund does report surpluses now, its balance is expected to dip as the baby boom generation ages.)

The Notch surfaces in the National Committee's political strategy as well.



## Where the PAC money goes

Since the beginning of 1991, the National Committee to Preserve Social Security and Medicare political action committee has contributed \$526,556 to 283 members of Congress. Here are the Florida lawmakers and a sampling of key lawmakers from around the country who have accepted money from the group's PAC since 1991:

### Floridians

Sen. Bob Graham, D, \$6,000  
Rep. Jim Bacchus, D, \$2,500  
Rep. Michael Bilirakis, R, \$1,000

Rep. Harry Johnston, D, \$1,000  
Rep. William Lehman, D, \$500  
Rep. Pete Peterson, D, \$700  
Rep. Ileana Ros-Lehtinen, R, \$1,000  
Rep. Larry Smith, D, \$1,500  
Rep. C.W. Bill Young, R, \$1,000

### Congressional leaders

Michigan Democratic Rep. David Bonior, House majority whip, \$5,000  
Missouri Democratic Rep. Richard Gephardt, House majority leader, \$6,000  
Arizona GOP Sen. John McCain, \$5,000  
California Democratic Rep. Leon Panetta, chairman of the House Budget Committee, \$1,000  
California Democratic Rep. Pete Stark, chairman of House Ways and Means subcommittee on health, \$4,000

Besides its widespread political donations, the National Committee has given a dozen or so favored members of Congress its "Friends of Seniors" award. Rep. Michael Bilirakis, a Palm Harbor Republican who supports the Notch legislation, received the award this year at a meeting the group organized in North Pinellas.

But the group's enemies also are punished, as North Florida Democratic Rep. Earl Hutto learned this week.

At a May 14 congressional hearing on deceptive mailings, Hutto criticized the National Committee's fund-raising activity tied to the Notch. The group's response: to highlight Hutto as a "foe" of the popular Notch legislation in the "Senior Flash" telephone hotline National Committee members can call for updates on what is happening in Washington.

"... 12-million seniors affected by the Notch inequity won't be convinced that the Notch exists merely because the National Committee tells them that it does," the hotline's recorded message said. "They see the results every month in their Social Security checks."

Hutto, though, says his constituents are upset by the letters they receive from the group. "They are frightened. They are scared to death," Hutto said. He called the "Senior Flash" telephone line "part of their propaganda."

One senior citizen, who was not identified, wrote Congress last year to complain about the group. "These people cause a lot of pain and worry and are getting rich off old people who cannot afford to keep sending them \$10 every month. I wish you all could stop them," the person wrote.

Nor is the National Committee accepted entirely by other senior citizens groups. The Leadership Council of Aging Organization,

whose 33 members include the American Association of Retired Persons, will not let the National Committee join, said Larry Smedley, chairman of the leadership council.

"It is not what I would call a legitimate membership organization. It's more of a big list of names established by the mail house," Smedley said.

Highly emotional appeals are not unique in modern direct-mail fund-raising, though they usually don't target seniors. Yet even its critics say the National Committee has improved its image significantly since its high-profile fight to kill the 1989 law that extended health coverage to people hit by the costs of catastrophic illness.

In the 1980s, lawmakers often lambasted the group for fund-raising letters that looked like they were coming from the government and contained appeals even more emotional than those sent out now. The group's leader at the time was the late James Roosevelt, son of former President Franklin Roosevelt, and he frequently invoked his father's name.

The National Committee's attempts to legitimize itself has brought its lobbyists to the negotiating table over a bill that gives workers time off for family emergencies and efforts to increase Social Security's operations budget. It quickly mobilized a grass-roots lobbying campaign among members in 1990 when budget negotiators announced they were going to cut \$60-million from Medicare. The cuts were later minimized to about \$44-billion.

One former critic is Sen. McCain, who told a constituent earlier this year that he now has "the highest regard" for the group and that "it has been a great joy" to work with McSteen. McCain backs the committee's efforts to lift the Social Security earnings penalty that working senior citizens ages 65-69 must pay.



# Ambiguity on Health Care

With the budget battle won, Bill Clinton launched an even more bruising battle this week over health care. Addressing American governors, he was, well, vintage Clinton: reassuring to everyone, satisfying to no one.

He promised bipartisanship, flexibility, no new taxes and universal coverage. All that sounds terrific. But how these pieces would fit together remains as much a mystery today as it was when he first appointed Hillary Rodham Clinton to figure it all out.

Mr. Clinton promised that he would seek Republican support. That is good news, because the course he chose in the budget fight — not to woo Republicans — makes no sense on health care: Democrats alone cannot overhaul an industry that accounts for about one dollar in every seven that Americans spend.

He also vowed to cover every American, without a major tax hike, primarily by dumping the cost on employers — requiring them to pay the lion's share of insuring their workers. To fend off charges that this would destroy jobs, he promised to provide subsidies to limit the cost to employers. And he proposed phasing in the mandate over five to seven years.

Employer mandates are easy to criticize; they are an indirect tax on wages and discourage companies from hiring low-paid workers. But most Americans already receive coverage through employers, and Mr. Clinton has reasonably decided to preserve this system rather than totally rebuild an \$800 billion industry from the ground up.

Thereafter, Mr. Clinton's remarks became maddeningly vague. Washington would define a generous package of basic benefits to which every American would be entitled. But at what cost? And how could generous coverage be extended to 40 million uninsured people without a new and substantial tax hike?

Mr. Clinton renewed his promise that competition, not regulation, would be the key to containing costs; health-care plans would compete for business by offering high-quality, affordable care. But in the next breath he suggested an overall budget cap, probably in the form of caps on the rate of increase in insurance premiums. That could effectively gut incentives for providers to find ways to deliver better health care if they would raise costs and, therefore, premiums.

Mr. Clinton also promised to give states

leeway to design their own reforms. Yet his advisers have recently been talking about plans under which Washington would dictate exactly what type of policies — and at what cost — insurers would be allowed to offer.

The governors expressed anxiety that Mr. Clinton would overreach. They pointed to progress that states are making on their own — in Florida, Minnesota, Oregon and Vermont — to reform health care. What they need from Washington is not a blueprint but a set of ground rules, or more accurately incentives.

Once providers are forced to compete to survive, and consumers encouraged to make cost-conscious choices, Washington can let states figure out their own solutions. If Mr. Clinton travels that path, he can forge bipartisan spirit. Health-care reform is already happening in the states. The danger is that Mr. Clinton — once he gets beyond the vague principles down to the dirty details — will bring these reforms to a crashing halt.

— THE NEW YORK TIMES.

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# *Health Care's Free Riders*

SOME 30 MILLION Americans work for employers who give them no health benefits. Those employers are getting a free ride, much of it at the expense of other employers who provide health insurance. The subsidy is direct when the uninsured worker is the dependent of someone who works for another company that provides family health coverage. It's an indirect subsidy when the uninsured worker can't pay hospital bills and pushes up the rates for those who can. Hillary Rodham Clinton declared the other day that the free ride is about to come to an end under the administration's plan to guarantee health coverage to everyone.

The administration's solution is going to be a requirement that all employers pay at least a part of the cost of health insurance for all of their employees. But that raises other concerns.

Two-thirds of all Americans currently have health insurance through their jobs or the jobs of someone in their families (although that proportion has dropped significantly in recent years, as an analysis last month by the Urban Institute showed). The tradition of providing health insurance through employers is now firmly established in this country. That creates a dilemma.

Most of the jobs with no health protection are at the lower end of the wage scale. The average spending on health care per person is now around

\$3,300 a year. For a person working full-time, that comes out to something like \$1.70 an hour, even setting aside the question of benefits for dependents. That's a pretty substantial addition to the minimum wage of \$4.25 an hour and would inevitably mean fewer jobs for unskilled workers. The administration might want to think about that before it pushes ahead with its proposal to increase the minimum wage.

Western Europe has gone much farther than the United States in loading the costs of social benefits onto payrolls. They contribute to the rigidity of European labor markets and to high unemployment there, particularly for young people. One possible way to ameliorate the effects here might be to subsidize health insurance with public funds at the low end of the wage ladder. But that's expensive, and subsidizing low-wage employment raises other questions of fairness.

Reform of health care financing is essential. The present system is in deepening trouble as the costs rapidly increase and insurance coverage shrinks. But health care has become the largest American industry, and any real changes will have, as the doctors say, important side effects. The reform plans need to be judged not only by their impact on health care but also by their broader impacts on the way the whole economy operates.



From U.S. law to 'L.A. Law,' the nation is rife with evidence that for most women today, equal opportunity is more a fantasy than a reality.

# Women's unfulfilled dream

**73 years after suffrage, equal pay, opportunity lacking.**

It's 73 years today since our foremothers finally pried the right to vote out of a reluctant male Congress. Suffragist Carrie Chapman Catt noted that it had taken, among other heroic measures, 56 referenda to get state legislatures to submit suffrage amendments and 19 successive congressional campaigns for women to win access to the ballot box.

But suffrage also signaled a triumph of truth over fiction:

The truth of women's power, endurance, skill and centrality to America's public life over the fiction of women as inferior, passive, eternally home-centered auxiliaries to men's ambitions.

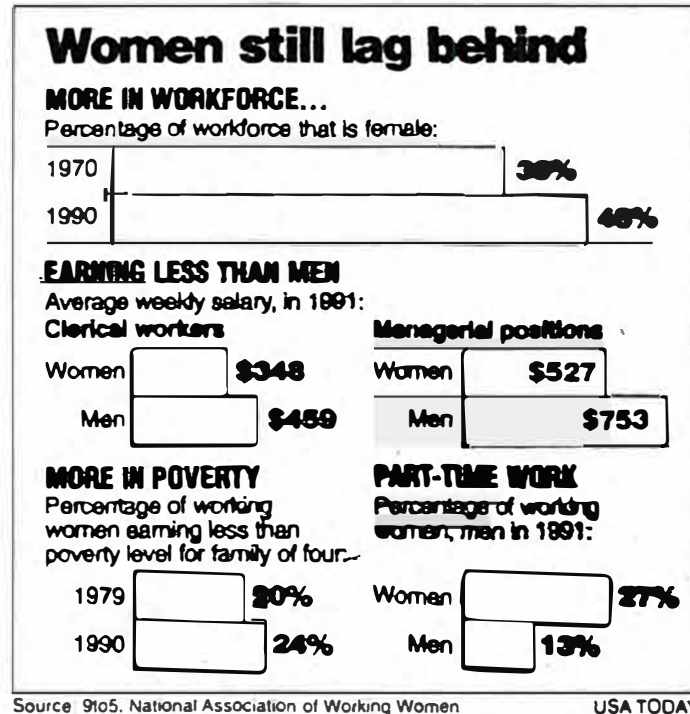
As the august Congressman Frank Clark of Florida asserted to his fellows in the House in May 1919, "I am opposed to woman suffrage because I agree that the place for the women is at home. That is where they belong. . . . The real mothers — I do not mean all of them, but the great majority of them — do not want it. The men of America have protected them for a century and a third, and they will do it yet. But when this comes, women have got to take a stand on a level with men."

Today, while the right to vote has been permanently secured, the struggle between women's reality and men's fantasies endures.

Take the case of Susan Rut-



**By Karen Nussbaum,** director of the Department of Labor's Women's Bureau.



tan — until recently an actor with a leading role portraying a secretary on *LA Law*:

When the producers gave preference in raises to the cast members playing lawyers, she objected.

"Why, Susan, you're just a secretary," she was told — as though the job classification she played should determine the compensation she received as an actor!

Hollywood isn't the only bastion of fantasy about women's lives. A member of my staff at the Department of Labor's Women's Bureau recently told me she was starting research on a publication about working women and poverty.

"We weren't able to do much work on this issue during the last administrations," my colleague related.

"They didn't really like the word poverty." She paused. "Well, it's really the concept they didn't care for."

Like the producers at *LA Law*, recent administrations seem to have lived in a world of make-believe, oblivious to

women's real circumstances. During their watch, more than 4 million families headed by women struggled to survive below the poverty line — an increase of more than 25% from 1980 to 1990.

Poverty isn't the only women's real-world indicator that shot up. Unemployment, temporary and part-time work, moonlighting, wage inequities, stress-related illness, discrimination complaints and the level of despair all escalated.

Meanwhile, real wages, benefits, good jobs and basic fairness plummeted.

Fortunately, with a more woman- and worker-friendly administration in place, we have an unprecedented opportunity to confront the fantasies that obstruct our day-to-day realities.

In some cases, we have only to exercise our rights under existing laws — and the Clinton administration has sent a clear signal that enforcement will no longer be a mirage.

► The Family and Medical Leave Act went into effect this

month, affirming the reality that working people need time to deal with family crises like birth and illness without jeopardizing their jobs.

► Our legally mandated wage and hour standards will be more than a legal fiction. The Food Lion grocery chain recently agreed to pay \$13.2 million in back wages for violating overtime and minimum-wage laws.

► Equal pay and promotional opportunity, in a workplace free of sexual harassment and pregnancy discrimination, is finally a realistic goal — and violations like those alleged at the National Institutes of Health will be vigorously pursued and rectified.

In other cases, the laws have yet to be written. We look forward to the day when we have affordable, quality child care and elder care. When women receive equal pay for work of comparable value, and the minimum wage is high enough to lift a family out of poverty.

But it won't be easy.

There are still plenty of fantasies to overcome. Like the resilient myth that most women would, or should, have to choose between family and career, or that most women who suffer sexual harassment are "asking for it."

To hear those views fulsomely expressed, you need not look farther than the guys at the corner bar, the jocks at the local high school or the workers at your neighborhood construction site.

Sometimes, when you read about an incident like Tailhook, or view the Thomas/Hill hearings, or watch Jesse Helms carry on about reproductive rights, you can hear echoes of those sentiments in the corridors of power.

— But in this our 73rd anniversary and their victory 73 years ago, we know that the fantasies can be made to yield to reality. We intend to see that they do. That's the least we owe them — and ourselves.

PHOTOCOPY  
PRESERVATION



From Boston Globe Page 1

# A policy primer on Clinton program

By Elizabeth Neuffer  
GLOBE STAFF

WASHINGTON — The nation's schoolchildren are sharpening their pencils and dusting off their notebooks, getting ready to return to school and study the "three R's." But they are not the only ones with preparation to do.

With President Clinton expected to outline his health care program next month, the entire nation must go back to the classroom — to study whether his program will really offer them the "three S's" of health care: security, savings and simplicity.

The Clinton administration will seek to overhaul how health care is paid for and delivered, proposing changes affecting everything from the cost of a hospital aspirin to coverage for a child's visit to the dentist. Heated debate is expected when the White House sends its bill to Congress this fall.

But understanding that debate, as well as the Clinton plan's confusing terms and complex proposals, will not be easy.

Much of the plan is finished, but Clinton still has key decisions to make. Among them: How much to raise taxes on cigarettes to pay for the plan, and whether also to boost taxes on alcohol; when to have states enter the new system; how best to reform malpractice insurance, and what rate to set at which health care costs can grow.

What follows is a guide, based on interviews with White House aides, to the proposals President Clinton is expected to outline to Congress in an address said to be set for Sept. 22. What it would look like; the big picture

employers or an insurance company, or go without coverage. Under the Clinton plan, all Americans would receive coverage through their employers or a "health alliance" composed of consumers and businesses. The alliance would act as a purchasing pool, using the muscle of its membership to negotiate health care prices.

Each state would decide how many alliances to have. Those with many alliances should have more of a managed competition system based on free market competition; those with just one alliance might have a single-payer system, like the Canadian system.

In turn, doctors, health providers, and hospitals would form "health plans" to compete to offer services to alliances.

A National Health Board would set the rate of growth in health care costs for each state, establish guidelines for quality care, and update what benefits should be in the national package. But though the federal government would set guidelines for the new system, each state would decide how best to implement those reforms.

## Benefits

All Americans would receive a guaranteed package of health benefits. No one could be denied coverage because of an existing health condition.

Access to health care would be through a "health security card," which could be taken from state to state and job to job. Once enrolled, the employer or health alliance would offer a choice of plans, but all must include the national benefit package.

Deductibles and copayments would differ depending on the plan. Guaranteed coverage of the national benefit package would be paid for through tax-deductible contributions by individuals and their employers.

Employee contributions would be based on the

ability to pay, up to 20 percent; companies would pay up to 80 percent. People who are self-employed would pay for the benefits themselves, but it would be 100 percent tax deductible.

Among benefits in the national package, the White House says, are: preventive care, unlimited hospital and doctors' visits; some drug treatment and therapy for mental health, and children's dental needs.

The benefit package would include pregnancy-related services, such as abortion, when deemed "medically necessary or appropriate," but would not override state abortion laws.

Health care services not included in the national package, such as cosmetic surgery, would not be tax-deductible. In-vitro fertilization is not expected to be covered.

## Choice and quality

Each health alliance or employer would offer at least three health plans: a traditional fee-for-service plan, in which you can choose all of your doctors; a managed care plan, in which all services are offered under one roof; and a preferred provider organization plan, or PPO.

Prices would vary, with the fee-for-service plan expected to be the most expensive. The amount of the deductible and copayments would also differ.

Those choosing the managed care plan are likely to have no deductibles and a \$10 copayment per service. The fee for service plan might have a \$400 family deductible, a 20 percent copayment and a maximum of \$3,000 that families would have to pay per year.

Patients could follow their doctors into a health plan. It is unlikely that all of a person's doctors would end up in the same plan, but doctors could join multiple plans.

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PRESERVATION



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The Clinton plan would ask consumers to evaluate care through report cards, noting everything from waiting times to the frequency with which a particular operation is performed. Doctors and health providers must also meet performance standards and be subject to review, thus spurring competition and driving down prices.

#### Employers' role

The plan would require all employers and employees to pay for health care. A national pool funded by savings from the new system would be created to help small business bear the cost of such coverage.

The administration is also proposing that the amount employers contribute would be capped at between 3.5 and 7 percent of payroll, depending on the firm's size and average wage.

Large companies, or unions of 5,000 or more members, that now offer health plans would act as a health alliance, negotiating with plans on behalf of employees. They must offer the nationally guaranteed benefit plan.

#### Who pays what:

The elderly, poor  
and retired

The plan would ask everyone to contribute something to health coverage. The amount would depend on income. The unemployed without health benefits would be covered under a health alliance, contributing what they can.

Retirees without coverage must also contribute, but they would be eligible to have 80 percent of their benefits paid for. Medicaid recipients would be phased into the new system, and be guaranteed coverage. Medicare recipients would still receive it, unless they want to join the new system. They would also receive a new drug benefit.

The health plan would also offer some coverage for home- and community-based care for the elderly. Eligibility would depend on a person's physical disability and need.

The health portion of the worker compensation

and automobile insurance system would be integrated into the new system, saving employers up to 25 percent of workers' compensation costs.

#### Financing and savings

The administration will ask for higher taxes on cigarettes and possibly alcohol to pay for the new system. But it is relying on the following reforms to generate savings and reduce costs.

First, plans would compete to offer services to health alliances, lowering prices. Second, a limited "budget" would be set on the rate of growth of some health care costs, such as the national benefit package, Medicare and Medicaid. This is expected to save millions.

Savings would also come from curbing health care fraud, estimated at \$80 billion. The plan would ban self-referrals by doctors; strengthen antikickback statutes, and toughen penalties for wrongdoers.

Reforming the current system of malpractice law would also save money, the White House says.

Proposals might include capping attorney fees and limiting awards for pain and suffering.

#### Effect on providers

More doctors would become generalists. Under the plan, teaching hospitals that receive federal funds must train 50 percent of their students as generalists in five years.

Academic health centers, whose care is more expensive because it pays for research, would receive federal assistance.

Insurance companies would redefine their role. Some may become health providers, bringing doctors and hospitals together in a network.

The White House says that by eliminating unnecessary medical paperwork its new health plan would cut back on clerical staff, and the Department of Labor is exploring ways to retrain hospital and insurance workers in other health-related jobs.

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# Tsongas loses ruling on firm's defense in aide's fraud trial

Work classified  
as a contribution

By John W. Mashek  
GLOBE STAFF

WASHINGTON — He failed in his effort to become president last year, he incurred massive debts in the process, his chief fund-raiser was indicted on charges of defrauding the campaign, and now Paul E. Tsongas, the former Massachusetts senator, must absorb a new blow.

The Federal Election Commission ruled 5 to 1 this week that any donations made by his law firm to help defray legal expenses in connection with the fraud case are considered contributions to his 1992 campaign, which means they can be given only in limited amounts.

"If you lose, you just don't lose, you lose big time," said FEC Commissioner Danny Lee McDonald, noting that winning presidential candidates have little trouble raising funds to pay campaign debts, but that losers are usually strapped with heavy debts.

The sole dissenting commissioner, Lee Ann Elliott, said the FEC was being "unduly harsh" on the Tsongas campaign, noting that its main donors have already given the legal maximum in contributions. "The committee may have to hoard their remaining money for their own defense before the commission," she said.

Tsongas' former chief fund-raiser, Nicholas A. Rizzo Jr., is awaiting trial on multiple federal charges of mail fraud, bank fraud and making false statements to the FEC. Authorities allege that he bilked the Tsongas campaign out of more than \$1 million in loans and contributions, and swindled

money from several New England businesses.

Rizzo, a close friend of Tsongas and a longtime Democratic fund-raiser, allegedly persuaded contributors to loan large amounts of money to the campaign, skirted FEC disclosure regulations and diverted the money for other uses, including paying off gambling debts, charges say.

The Tsongas campaign committee has been cooperating with the federal investigation into Rizzo by the Internal Revenue Service and the Department of Justice. Tsongas has never been implicated in the case.

Foley Hoag & Eliot, the law firm where Tsongas practices, was hired to advise the committee during the investigation, and the firm requested the FEC's ruling to clarify whether it could legally make donations to assist the committee in the case.

Gary Crossen, a partner in the firm, was vacationing on Cape Cod and said he had not read the ruling. But he said the campaign had been "cooperating with the investigation for more than one year. This ruling is only going to make it difficult for the committee to get additional contributions."

Crossen said the campaign still had funds, but not enough to meet its liabilities.

FEC commissioner Joan Aiken, while voting with the majority, said she might have voted differently had the firm associated with Tsongas not been involved.

"It is extremely difficult to separate responsibility to the Department of Justice" and compliance with election laws, she said.

PHOTOCOPY  
PRESERVATION



THE WALL STREET JOURNAL WEDNESDAY, JULY 14, 1993

# What's Wrong With the Clinton Health Plan

By MARTIN FELDSTEIN

Health care finance is likely to be the most substantial legislative battle of the Clinton presidency. The plan being promoted by the White House staff would set marginal tax rates by more than 12 percentage points for most taxpayers and make it more difficult to slow the growth of health care spending. Fortunately, such radical increases in taxes is not needed to extend comprehensive insurance to the currently uninsured and to protect others against the termination of their insurance through unemployment, early retirement or the loss of a spouse.

The proposal that will soon be on President Clinton's desk looks something like this:

The government will design a standard insurance package, specifying a broad

limit costs and to produce health care efficiently. Since patients would pay little or nothing out-of-pocket at the time of care, they and their doctors would have no incentive to seek lower-cost sources of care. Major employers that now use preferred provider plans to negotiate lower costs from hospitals and physicians would no longer have any incentive to do so if their costs are set by the 10% payroll tax. The future discipline on health care spending would have to be increased government regulations, with an inevitable decline in the quality of care and personal service.

• *It provides no mechanism for patients and their doctors to express their true preferences about spending on health care.* Personal health care now exceeds one-fifth of all consumer spending, with an even larger fraction for lower income families. Many households might prefer to spend more on housing, food and other things and less on health care. But with comprehensive insurance designed by Washington bureaucrats, households have no way

rates. Future budget deficits would also be enlarged by cost overruns when the massive cost savings that White House officials attribute to "managed care" do not materialize.

My own preferred approach to health care reform, described briefly in the box accompanying this article, would be very different. But I also want to suggest an alternative plan that is much closer to the style and spirit of the current White House plan and therefore more likely to appeal to President Clinton and his advisers. This alternative, dubbed the A-plan (for Alternative), avoids the four serious defects of the current White House proposal.

The A-plan provides health insurance for the entire population in a way that limits the maximum health care costs to the same fraction of each family's income as the White House plan. Yet it avoids the large increases in marginal tax rates and the enlarged budget deficit. It also helps to control costs and to make health care

## Board of Contributors

age of covered services and the amount out-of-pocket deductibles and co-insurance that patients will pay. Medicare will continue to provide the coverage for those 18 and 65.

Current health insurance premiums will be replaced by a tax equal to 10% of family income up to a maximum of \$5,000 a family income of \$50,000. Because of limited taxes paid by lower-income families, a substantial shortfall would remain to be financed. Although no declines have been made about how to finance this gap, the likely annual cost of at least \$50 billion is equivalent to a further 5-tenth rise in all personal income taxes.

### "Payroll Premium"

The effect of all this would be to raise marginal tax rates dramatically for families with incomes under \$50,000. With the new taxes in place, a family with \$40,000 income would face a combined marginal tax rate of more than 60%; the new 10% health insurance tax, the current 15% employer/employee Social Security tax, the 28% federal income tax rate (raised to at least 31% to finance the projected health insurance shortfall), a typical state income tax rate of 6%, plus state and local sales taxes.

In an attempt to disguise the true nature of the health insurance tax, the White House plan would describe it as a "payroll premium" to be paid by employers, with a complex adjustment process to deal with 3-earner families and with nonpayroll income. But a tax is a tax. For families with incomes under \$50,000, the payroll premium would require the family to pay an additional 10 cents out of every additional dollar of income.

The payroll premium tax would not go to Washington but would be paid to state-level Health Insurance Purchasing Cooperatives (HIPC) that, in turn, would contract with health care providers—health maintenance organizations, managed care plans run by insurance companies, hospital-based care systems, etc.—to offer a package of benefits designed by the government. In principle, all plans would open to everyone without regard to pre-existing conditions.

In my judgment, this radical reform is bad in four significant ways.

• *It raises marginal tax rates on the 70% of families with incomes below \$50,000 by at least 12 percentage points:* a 10% health insurance tax and higher income taxes to finance the \$50 billion shortfall. Families with incomes over \$50,000 would pay the 10% health tax plus additional income taxes.

• *It does not strengthen incentives to*

**A Workable Alternative**

**T**here is a growing political consensus that something should be done to extend coverage to the uninsured. But what? The current White House plan is a bad idea. It would raise marginal tax rates on the 70% of families with incomes below \$50,000 by at least 12 percentage points. It would require the family to pay an additional 10 cents out of every additional dollar of income. It would not go to Washington but would be paid to state-level Health Insurance Purchasing Cooperatives (HIPC) that, in turn, would contract with health care providers—health maintenance organizations, managed care plans run by insurance companies, hospital-based care systems, etc.—to offer a package of benefits designed by the government. In principle, all plans would open to everyone without regard to pre-existing conditions.

**A** The A-plan provides health insurance for the entire population in a way that limits the maximum health care costs to the same fraction of each family's income as the White House plan. Yet it avoids the large increases in marginal tax rates and the enlarged budget deficit. It also helps to control costs and to make health care

of influencing how they allocate their incomes between health care and other things.

• *It would substantially increase future budget deficits.* The government revenue calculations assume that the health insurance taxes would not alter taxpayer behavior. But raising the marginal tax rate to 62% from 48% on middle-income taxpayers—a 25% reduction in the net-of-tax share kept by taxpayers from each additional dollar of taxable income—would reduce work effort and cause shifts from taxable compensation to nontaxable fringe benefits. If this 26% reduction caused a fall of even 5% in the taxable incomes of affected taxpayers, the government would lose more than \$50 billion a year in income and payroll taxes.

The government's failure to take this into account means that future deficits would be "surprisingly" large by an equal amount. But recognising it explicitly would reduce political support for the health plan by requiring even higher tax

responsive to the preferences of patients and their physicians. If President Clinton likes the current White House plan, he should like the A-plan even more.

Under the A-plan, the government would specify the same range of covered services as under the White House plan. Employers and employees would pay 10% of income (up to a \$5,000 maximum) to a HIPC, just as under the White House plan. The government would make up the cost shortfall from general revenue.

Up to that point, the A-plan is essentially identical to the current White House proposal. But there the similarity ends. The critical difference is that under the A-plan the family would receive a Low Claim Refund at the end of the year equal to the difference between their medical bills and the amount that they and their employer paid to the HIPC. Thus a family with \$40,000 of income and \$1,200 of medical bills would receive a Low Claim Refund of \$2,800.

The Low Claim Refund has two distinct



# Hoping quality care continues



One in a series of profiles of Tampa Bay families and businesses and how health care reform will affect them

■ The Blounts know the value of good, affordable health care. But they worry — will health reform come at a cost, in dollars and level of care?

By CHARLOTTE SUTTON

Tampa Staff Writer

**TOWN 'N COUNTRY** — In the time it takes to make a glass of chocolate milk, Kathy and Dale Blount learned the value of good insurance.

When he was just 9 months old, their son Ryan toppled into the backyard pool while Kathy was stirring chocolate syrup and milk in the kitchen. He was pulled out quickly, but oxygen had been cut off long enough to damage his brain.

Today, more than three years after the accident, Ryan is improving at a rate none of his doctors expected. He is

walking and talking — and his parents credit the hundreds of hours of therapy he has received, thanks to their excellent health insurance coverage.

"At one point, he was diagnosed as being in a persistent vegetative state," said Kathy, watching her son, now 4, toddle around the family room. "He's far from that."

As the nation waits for the release of President Clinton's health reform plan, the Blounts worry whether their son's intensive therapy could continue under such a program. Like other Americans who currently enjoy excellent health care benefits, they wonder whether the Clinton plan will mean higher cost and lower quality.

On the other hand, the Blounts' current insurer has stepped up scrutiny of Ryan's treatments, and they wonder how long it will continue to cover Ryan's enormous costs.

Please see REFORM 2A

## Reform from 1A

Clinton's advisers have been telling reporters the plan will offer families like the Blounts the opportunity to retain their traditional insurance, as long as they're willing to pay extra for it.

How much extra, however, is still unknown. The Blounts' family budget can't absorb much more. They had assumed they'd become a two-income family again once Ryan started school, but that was before the accident. Instead of returning to her career as a hospital social worker, Kathy's days are filled with shuttling her son to his nine therapy sessions each week.

Lately, the rewards have been great. A few months ago Ryan started walking. He just recently started speaking intelligibly. Mentally, he is as sharp as, or even sharper than, normal children his age.

His parents attribute his progress to intensive therapy — occupational, physical and speech. Last year, his medical bills topped \$50,000.

But thanks to Dale's health insurance policy through his job at Siemens Medical Systems, their out-of-pocket expenses were around \$3,000.

the extent it has," said Dale, 37. For instance, he said, if he opted for the \$50-a-month HMO his company offers, rather than his major medical policy, only six hours of therapy would have been covered.

Currently, insurance premiums for medical and dental coverage cost about \$150 a month for the family of four (the Blounts have another son, Jason, 7). Dale pays about 23 percent of the premium costs, with his company picking up the rest. They could get insurance more cheaply, but because of Ryan's condition, they have chosen to purchase the highest level of coverage his company offers.

The insurer, Cigna, pays 80 percent of Ryan's bills until the deductibles (\$150 per individual, \$450 for the family, plus \$1,000) are met. Then 100 percent of the bills are covered.

Every six months, Cigna reviews Ryan's case, and the Blounts hold their breath. If the insurer decides the child has been given unnecessary care, it won't pay. The questioning has become more intense lately, and the Blounts, while they understand the need for scrutiny, fear their claims could be rejected.

Friday, Kathy received a letter from the insurance company, saying they were still reviewing

curred over the last two months would be covered.

"I'm on pins and needles," she said. "You don't want to stop him from going (for treatment), yet you don't know if it will be paid for."

The Blounts say there's no way they could pay for the therapy themselves.

"We're living paycheck to paycheck," said Dale, who is a supervisor at Siemens, responsible for service on sophisticated scanning machines.

Ryan's parents fear any let-up in his rigorous therapy regimen could rob him of the progress he has made.

"We've noticed changes in him that made us think he was regressing. What happens is, as he grows, he gets clumsier," Dale said. "If he doesn't have therapy as he's growing, it will really be detrimental to his development."

Added Kathy: "Compared to a normal child, he's got a long way to go. I'm concerned Ryan won't get as far as he could go."

Kathy, 35, keeps a thick file of Ryan's bills by the phone, in preparation for her weekly conversations with the insurance company.

But the hassles pale when she thinks about the people who don't have such a generous insurance plan. "I can't complain about our



## Editorial Notebook

# 'Socialized Medicine' Revisited ✓

## How Doctors Doomed Truman's Health Plan

Nowadays everybody likes Harry Truman, the subject of a best-selling biography and of admiring remarks by Presidents Bush and Clinton. This was not the case on Nov.

19, 1945, when Truman became the first President to propose a comprehensive medical insurance program for Americans of all ages.

For this, Truman was reviled by the American Medical Association and its most visible spokesman, Dr. Morris Fishbein, editor of the A.M.A. Journal. The tone of the debate was established by this overheated editorial in the country's most widely read medical publication:

"The movement for placing of American medicine under the control of the Federal Government through a system of federal compulsory sickness insurance is the first step toward a regimentation of utilities, of industries, of finance, and eventually of labor itself. This is the kind of regimentation that led to totalitarianism in Germany and the downfall of that nation."

Whatever health care package is proposed by the Clinton Administration, it's unlikely to provoke any such outbursts. Yet allergy to "socialized medicine" has passed into the political bloodstream, and helps explain why we are the only industrial society (South Africa excepted) without universal health care coverage.

Nobody today has the medical-political clout of Dr. Fishbein, who dominated the A.M.A. from the mid-1920's until his departure from the journal in 1949. Millions knew him as author of a daily newspaper column and of innumerable articles and speeches. Any form of group medical practice was anathema to Dr. Fishbein.

When a Committee on Costs of Medical Care, after a five-year study, spoke favorably in 1932 of group practice, the A.M.A. magazine thundered against "medical soviet," and warned that public health officials and foundations were inciting a socialist revolution. Even after the A.M.A. formally approved hospital insurance in 1938, the editor of its journal questioned the wisdom of all prepayment plans, voluntary or compulsory.

And so the A.M.A. waged total political war against

Harry Truman's health plan. This baffled the President. He found it dismaying that one in three Americans was rejected for military service on medical grounds. He saw nothing "socialistic" in a decentralized insurance plan that permitted free choice of doctors, with a 4 percent "health tax" on the first \$3,600 in wages.

"Most people can't pay \$12 to \$25 a day for a hospital room and \$500 for a minor operation," he recalled in 1954. "... So I thought and I still think that a nest egg held out of regular pay, as is social security, might meet the situation. If the propaganda of the A.M.A. is studied, you'd find the doctors don't want guaranteed payment for fees. Why I'll never know."

The medical association opposed the initial Truman plan, and its scaled-down successors put forward in his second term. Whitaker and Baxter, the wily Californian consultants, were retained to orchestrate a national campaign on this theme: "American medicine has become the blazing focal point in a fundamental struggle which may determine whether America remains free or whether we are to become a socialist state."

So pompously overwrought was this language that it embarrassed even its promulgators. Lyndon Johnson sensed this, and outfoxed the A.M.A. in 1965 as he was implementing Medicare health coverage for Americans over 65. When the A.M.A. threatened to boycott the new plan, Johnson summoned its leaders to the White House, where he expressed his deep respect for physicians, recalled at length his family's devoted doctor, and said he was sure doctors would cooperate with a plan worked out under exacting democratic rules.

Within weeks, the A.M.A. pulled back from a boycott, and soon 95 percent of all American doctors were enrolled in Medicare. With symbolic justice, Johnson signed the Medicare legislation in Harry Truman's presence in Independence, Mo. Truman remarked that no single honor had touched him more deeply. Yet think how much healthier for America and its body politic if Truman had prevailed in 1945.

KARL E. MEYER



^ (complete writethru background)

^ Hillary Clinton predicts bi-partisan support for health reform

^ By MICHAEL KIRKLAND=

WASHINGTON (UPI) Hillary Rodham Clinton said Wednesday the health care reform legislation she is drafting will go to Congress soon after lawmakers approve the president's budget package.

House and Senate negotiators are working to complete a compromise \$500 billion deficit package and get it passed before recessing for the rest of summer, starting Aug. 6.

The health care plan was first scheduled to be proposed in May, but its complexity and the priority of the budget legislation set it back.

"We're on the same time table we've always been on," Clinton told reporters on Capitol Hill. Congress will get the plan "as soon as the (budget) reconciliation bill is finished."

The budget package is a political hard sell for the president, and the first lady conceded health care reform will be tough, too.

"Anything we do (on health care reform) is going to be controversial," she said. "It's a very big issue."

Clinton spoke after a meeting with the House Small Business Committee, one of her lobbying efforts with Congress for health care reform. Committee Chairman John LaFalce, D-N.Y., called the package "as important as Social Security," and predicted it will pass the House.

LaFalce's committee will start reviewing health care reform issues next week, hearing from several small business groups about their concerns. He said the universal health coverage plan will include no payroll tax, but will involve every business, even those not currently offering employees health care packages.

He said workers' compensation, an expensive proposition for most businesses, will be folded into the eventual health care plan.

LaFalce said the plan would benefit some small firms being forced to close because of the cost of providing employee insurance and for those retirees who find themselves without insurance when their former employers can no longer afford to pay for it.





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Thursday, August 5, 1993

## TODAY'S NEWS

- Workers' compensation should remain "risk adjusted"** under national health reform, National Association of Manufacturers testifies Aug. 4 . . . . . **Story below**
- ERISA exemption bill pushed by Washington State representatives** to further state's effort at health care reform . . . . . **Page 2**
- Health care administrative expenditures to improve quality of care should rise** under reform plan, *NEJM* editorial urges; underinvestment in Canada cited . . . . . **Page 3**

**WORKERS' COMPENSATION UNDER HEALTH REFORM SHOULD REMAIN "RISK-ADJUSTED,"** the National Association of Manufacturers (NAM) asserts in a position paper presented at an Aug. 4 House Small Business Committee hearing. Experience rating for the medical component of workers' compensation is necessary, the document says, to "ensure that prior safety and wellness efforts by employers and employees are reflected and encouraged to continue."

Both President Clinton and First Lady Hillary Clinton have said that the Administration's forthcoming health care reform proposal will attempt to integrate the health components of workers' compensation programs, which currently are administered by states, into a national health care plan. However, the Administration has not signaled whether it favors a "merger" approach, where employers would pay workers' comp premiums directly to health purchasing cooperatives, or a "coordinated" system, under which employers would continue to pay premiums to state funds or private insurers, which would in turn would pay health alliances for medical claims.

Within the employer community, widespread agreement exists that workers' compensation costs have escalated far too rapidly over the last decade. On behalf of NAM, Ronald Bullock, president of Bison Gear and Engineering Corporation, testified that from 1981-90, workers' compensation costs increased 184%. "Estimates for indemnity and medical benefits for 1993 are likely to be near \$70 bil., thus continuing this trend," he said. "Any cost increases in workers' compensation insurance will make it more difficult for small businesses to purchase workers' compensation insurance."

But bringing down employer-paid workers' compensation costs will not be simple, the NAM position paper warns. "While the cost of workers' compensation medical services are an increasingly important expense component, the majority of workers' compensation expense is still devoted to providing [indemnity] benefits related to time lost from work which also needs to be effectively controlled," it states. "As a consequence, an employer's current ability to influence medical treatment decisions, thereby, facilitating rehabilitation and an employee's speedy return to work, must not be compromised in any new proposal."

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In addition to experience rating, NAM will seek changes in workers' compensation programs to ensure that overall costs — including those associated with litigation — are reduced, Bullock said. The ability to self-insure also should be maintained under health care reform, he told the committee, and employers should be allowed to "choose the provider of workers' compensation care and services."

House Small Business Committee Chairman John LaFalce (D-N.Y.) indicated that he plans to hold a hearing to more fully explore options for reforming workers' compensation health financing mechanisms. Under the current system, all medical care costs are paid by the employer. The NAM document contends that "whether or not there is a role for cost sharing by employees will have to be further explored."

Regardless, "if the medical portion of workers' compensation is included in the national health care reform proposal, all workers' compensation medical programs under both state and federal laws should be included," NAM argues. "Individual jurisdictions should not have the option to opt out of the system."

National Federation of Independent Businesses VP-Federal Governmental Relations John Motley told the committee that rolling the workers' comp program into a managed competition-style health care system appears unlikely to "solve all of the small business community's problems with the current system." Stating that 63% of NFIB members polled to date oppose combining the two systems, Motley said that "we remain skeptical that an integration policy will truly improve the system or bring significant savings."

In contrast, Gary Petty, who testified on behalf of the Small Business Legislative Council, commented that "we are certain cutting workers compensation costs would be a very attractive inducement for accepting any mandatory responsibility" for providing health care benefits. For example, he said, the government could require a company to pay 50% of the health insurance costs of its employees in return for "government setting a cap of, say, 50% of the current state workers compensation rate, or require the employer to pay the entire premium of at least a basic health care insurance which would include coverage of all workers' compensation claims."

National Small Business United Executive Vice President John Galles countered that "by folding these [workers' comp medical] costs into the overall [health care] system, we would only be reapportioning them, not eliminating them — and the overall costs to many small business might not be reduced at all." He concluded that "we are concerned that [the] benefits [of a combined system] are being greatly exaggerated."

**WASHINGTON DELEGATION PUSHING ERISA EXEMPTION BILL** so the state can pursue its health care reform efforts. At an Aug. 4 press conference announcing the legislation, Washington's congressional members said they are seeking an exemption from eight ERISA provisions including one that precludes states from requiring employers to pay for health insurance coverage for their workers. The Washington state plan requires employers to pay at least half the cost of employee health benefits.

Rep. Mike Kreidler (D-Wash.) introduced the bill in the House, and freshman Sen. Patty Murray (D-Wash.) sponsored the Senate measure. Kreidler is joined by five of his nine Washington delegation colleagues.

The Employee Retirement Income Security Act pre-empts states from regulating employee benefits, including health and pension benefits. The Washington health reform plan would establish state standards with respect to basic health benefits, availability and cost, all of which pose potential ERISA problems. Staffers to Kreidler said the Washington reform cannot be implemented without the ERISA waiver.

ERISA "is a federal law that offers many important protections for workers," Rep. Maria Cantwell (D-Wash.) said in a prepared statement. "ERISA also places tough restrictions on how states can regulate employee health plans. Those restrictions have been important in the past, but the game has changed, and now it's time to change the rules."

Other states attempted to gain ERISA exemptions to further their health care reform efforts in budget reconciliation legislation (HR 2264) now being considered by Congress. An exemption was requested for Hawaii, Maryland, Minnesota and New York by the House Education and Labor Committee. The panel said in its reconciliation



## ===== ELEMENTS OF REFORM =====

### \*4 VIEWS ON REFORM: THE PROBLEMS AND THE SOLUTIONS

**A WORKABLE SOLUTION:** THE NEW REPUBLIC's Contributing Editor Robert Shapiro writes, "At the heart of the debate over health care is not a question of health or even of health policy, but a simple question of economics: What should the government do when people want more of some good than the economy will produce at prices they're willing or able to pay?" On restraining patient demand for health care, Shapiro writes that limiting tax deductibility of premiums and requiring employers and workers to contribute toward health insurance isn't enough: "For real impact, you would also need to limit the deductibility of employer-provided health insurance to the cost of the cheapest package of basic benefits available. ... Second, you would need to heighten the pressure on everyone by counting as a person's taxable income part of the premiums or payroll fees paid in his or her name by an employer." On forcing providers to compete on the basis of price and value, Shapiro writes, "You need incentives for the HMO's doctors and nurses to recommend fewer and cheaper services," and "to drive up the average HMO's cost effectiveness, the reforms have to include broad malpractice protection for physicians practicing standard but not extraordinary medicine, and perhaps incentives for employee ownership or profit-sharing by HMO physicians and nurses." Shapiro on "Clinton's challenge:" "The president has to convince Americans who feel they can barely afford health care today that they should accept additional costs and burdens in order to keep their coverage secure and the economy sound" (8/16 issue).

**WHAT THE PUBLIC WANTS:** American Enterprise Institute's Norman Ornstein writes in THE NEW REPUBLIC about the "gap between public expectations and the harsh realities of what we can expect from a health policy." Ornstein cites poll data showing "a substantial majority of Americans believe the health care system is broken," but "by wide margins, Americans are pleased with their own health care." Ornstein: "To the public, reform means more services for less money, with the difference paid for by reining in and taxing the special health interests who are responsible for the current mess. ... If public opinion is any indication, the health care revolution is not around the corner, or even down the street" (8/16 issue).

**PRAISING THE PROCESS:** Sen. Edward Kennedy (D-MA) writes in the BOSTON GLOBE, "President Clinton and Hillary Rodham Clinton made what may turn out to be the most important decision of all on health reform. They decided that the traditional policy-making process in Washington was inadequate." Kennedy writes that the work of the WH health care task force has meant that "every significant point of view has been exhaustively analyzed. It will be difficult, if not impossible, for special interest groups to overwhelm the plan with misleading arguments, statistics and public relations tactics." Kennedy concludes that the "prospects" for passage of reform "are excellent," which is "no small accomplishment for a new administration" (7/30).

**HISTORY LESSON:** Karl Meyer writes in the N.Y. TIMES'



badly in months to come as Congress considers health care, welfare, trade and other issues" (Labaton, 7/20). NBC's Lisa Myers: "Formal charges against Rostenkowski would be an ominous sign for President Clinton's domestic agenda. Rostenkowski's formidable political skills are critical to passage of both deficit reduction and health reform" ("Nightly News," 7/19). CHICAGO SUN-TIMES reports the admin. had no comment on the latest development, but WH Dep. Comm. Dir. Rahm Emanuel "indicated the [WH] would support its key legislative ally:" "He's been a true champion of the president's program" (Basil Talbott, 7/20).

### \*3 SELLING THE PLAN: WILL THE BUS TOUR BE BACK?

WH "image mechanics are considering putting the [Clinton-Gore campaign] bus back in service. If it helped Clinton sell himself, maybe it could help the president sell a new health care system to 258 million Americans and 535 members of Congress." ST. PETE TIMES reports the admin.'s health reform "marketing strategy remains a work in progress, aiming to combine" successful campaign tactics with the "unique advantages of the presidential bully pulpit."

HILLARY ON THE REFORM TRAIL: TIMES notes "so far" it has been Hillary Rodham Clinton who has used the bully pulpit to "preach" reform (Ceci Connolly, 7/18). Speaking at the inner-city Los Angeles' Charles R. Drew Univ. of Medicine and Science 7/19, she stressed her commitment to access for all. Clinton: "We have to take our system and make it available to everyone, with an emphasis on primary and preventive health care" (N.Y. TIMES, 7/20). A Balto. SUN editorial notes that while H.R. Clinton is highlighting Hawaii as a model for reform, Maryland may have something to offer. SUN: "What may be in the works is some sort of nationwide marriage between the Hawaii plan and the Maryland plan. While Hawaii has probably done the best job in providing universal coverage, as Mrs. Clinton suggested, Maryland is one of the nation's leaders in containing hospital costs in a system that delivers the same standard of care to all patients" (7/20).

WILHELM/DNC ROLE: Fmr. DNC Chair John White "said members of Congress will need support at home to vote for an overhaul:" "If you can't sell this locally to hospital boards and the medical community, you've got a pretty small chance of passing it in Congress. White said DNC Chair David Wilhelm "has to be willing to go and say and do things to the other side that the president, in good taste, can't or won't do."

PRES. CLINTON ON TV: "Some veterans" of previous admins. have suggested that Clinton "give a nationally televised speech reviewing" the current problems, explaining the reform process and "pledging to stay committed to overhaul." GOP adviser Deborah Steelman said delivering an address before the August recess would give members of Congress some "good news" to bring to their home districts. ST. PETE TIMES: "Once the plan is released, Clinton 'cannot stop talking about it for at least three weeks,' Steelman said, or opponents will dominate nightly newscasts" (Connolly, 7/18).

INTERAGENCY ACTIVITY: The WH's "Health Care Reform Today"



Essay

WILLIAM SAFIRE

# The Fifth Person

WASHINGTON

Within a few years, health insurance will be universal and irrevocable; that's a given.

Reality #1: The four out of five Americans who are presently covered will have to pay for the fifth person's insurance: that is logically inescapable. Four must pay for five.

Let us not be misled by phrases like "employer mandates"; that means only that the cost of a payroll will rise and be paid by the consumer. In the same way, "government subsidies" to small business, and to the unemployed, mean that the cost of insurance will be paid by the taxpayer. The consumer and the taxpayer are the same person.

The huge new benefit — the social justice of changing charity to an entitlement — will have a price. President Clinton would have us believe that the cost of insuring the fifth person will be made up by eliminating paperwork, by rejiggering present Federal programs for the elderly and poor, and by extracting \$365 a year from the pack-a-day

## Let Bernadine debate Hillary.

smoker. (About time the poor paid their fair share.) That cost concealment is a fraud that betrays the promise of health insurance reform.

Reality #2: Republicans huddling in secret conclave have decided not to be out-compassioned by anybody. The party line is to embrace the President's goals, to remember Nixon's plan and declare health to be "above politics," and to suggest that minor differences in the details of approaches will be ironed out in Congressional hearings. That concealment of principled opposition is also a fraud; we should not be fearful of constructively opposing the wrong means to a good end.

Reality #3: The Clinton plan imposes price controls. Its chokepoint on a free economy is the insurance premium: Put that in Washington's hands, and the Feds dictate everything from the price of bypasses to the price of aspirin. Most people like the idea of price controls until they are faced with the shortages and black markets and rationing — and wage controls — that always follow.

Clinton's proposed price control dares to be aboveboard on new drugs. By putting researchers on notice that a supreme court of health will determine the price of newly developed medicines, the Clintons have chosen to inhibit private investment in potential cures for AIDS, brain diseases, cancer or the common cold. If there is no big profit payoff, there will be no corporate roll of the dice; that's capitalism. The last thing reform should do is reduce the current investment in new drugs that may curtail expensive hospital stays.

Reality #4: Buyers' cooperatives usually contribute to competition, realizing savings by buying in bulk; but the Clinton co-ops — called "alliances" — are to be state monopolies, not subject to competition from other co-ops. Government-directed monopolies are inherently bureaucratic, and no government operation is purified by failure; the person who loaded the wrong speech into Mr. Clinton's teleprompter was not fired for incompetence. To claim that the cost of the fifth person's coverage will come out of "bureaucratic savings" or paperwork reduction is to hypnotize yourself.

Reality #5: Notwithstanding the previous realities, the Clintons have touched the nation's guilty conscience: The poor should not have to choose between food and medicine. "Pre-existing condition" are dirty words. Emergency-room care is wasteful. Forms can be standardized. Malpractice threats that trigger expensive tests and doctors' insurance costs should be curbed.

Reality #6: The heat is on conservatives not to merely tinker with a statist plan, but to come up with one that protects individual choice. Senator John Chafee, Republican of Rhode Island, has a voucher-based plan on the table whose costs are more readily accountable and where the quality of today's care is less diluted.

Who will espouse the alternative that emerges? Dr. Bernadine Healy left liberal Senator Jay Rockefeller an expostulating wreck on yesterday's NBC Brinkley show; before any of us decide on health care, we should be educated by a formal two-hour televised debate between Dr. Healy and Hillary Rodham Clinton.

Remember: Nothing is for nothing. The generous four will pay to cover the fifth person with higher taxes, higher prices and higher premiums. Let's not also pay in our personal freedom by lurching toward a command economy. □



# Nafta and the Environment ✓

Environmentalists, accustomed to unified struggles against common enemies like air pollution and Ronald Reagan, have fallen to fighting among themselves over the North American Free Trade Agreement. Grass-roots organizations like Friends of the Earth say it will create a polluters' paradise in Mexico and degrade America. Mainstream groups like the National Wildlife Federation say it all but guarantees a cleaner hemisphere.

Nafta's critics are even more jittery now that a Federal appeals court has ruled that the White House can forward the agreement to Congress without an environmental impact statement. A careful reading of Nafta should ease their worries.

No previous trade agreement tackles as many pollution issues as Nafta does. The General Agreement on Tariffs and Trade — the basic document governing international commerce — doesn't even mention the word "environment." Nafta, by contrast, includes numerous environmental protections; a side agreement makes them even stronger. Mexico is more likely to become a cleaner nation with Nafta than without.

Nafta's opponents raise three main complaints, all overstated.

**Nafta Undermines Laws.** Critics say the agreement threatens global environmental treaties as well as stiff U.S. laws that, they fear, could be challenged by either Canada or Mexico as unfair barriers to free trade. But Nafta explicitly protects the international pact prohibiting illegal trade in wildlife, the Basel Convention against shipment of hazardous waste, and the Montreal Protocol phasing out production of ozone-destroying chemicals.

Nafta also protects the right of each country to set any standards it wants as long as they seek a "legitimate" environmental objective, are based on scientific data and apply to foreign and domestic products alike. Given this language, it seems highly unlikely that Mexico could, for example, successfully challenge a U.S. decision to prevent the import of fruits sprayed with pesticides banned by U.S. law.

**Nafta Won't Clean the Border.** The boundary between Mexico and the U.S. is undeniably a cesspool. "Dirty" U.S. industries like petrochemicals have flocked to the border zone because, under Mexican law, the goods they manufacture can be shipped back to the U.S. duty-free.

Nafta addresses the border problem in two ways. First, the side agreement promises \$8 billion for water and sewage treatment, although the money has yet to be appropriated. More important, all of Mexico will become a duty-free zone under Nafta, thus removing any incentive to concentrate industry on the border.

**Nafta Will Ruin Mexico.** Although Mexico has strong environmental laws, it rarely enforces them. Thus, critics say, America's dirtiest industries — tempted not only by Mexico's lower wages but by its regulatory indifference — will now infest every nook and cranny of Mexico, adding greatly to Mexico's existing pollution overload.

However, Nafta explicitly binds all three parties to the agreement from creating "pollution havens" by waiving or ignoring environmental laws for the purpose of seeking investment. The trick is to insure that this pledge is honored. To that end, the side agreement sets up a three-nation mechanism, the Commission on Environmental Cooperation. Any country (or private group like the Sierra Club), believing that a nation is not enforcing its laws, can complain. If the commission finds a pattern of violations, it can impose fines of up to \$20 million on the offending country and, if that doesn't work, invoke trade sanctions.

The procedure is cumbersome and hardly foolproof. But at least it will bring to bear international pressures that do not now exist, giving Mexico an incentive to obey laws it routinely ignores.

Nafta will not turn Mexico, Canada or the U.S. into a preindustrial paradise. It simply seeks to protect the environment against the economic explosion that Nafta is supposed to let loose. Those who claim otherwise haven't done their reading.



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which no physician can charge in fee-for-service plans, may make them more affordable to middle-, and even lower-middle-income people.

But, ultimately, the alternative to price competition is one price for all, and it is difficult to envision such a model in the American scheme. Finding the balance between providing an acceptable level of care for all and a price the nation could afford might prove impossible. Thus the Clinton plan's compromise: guarantee all the same benefits, delivered in a quality setting; allow those who wish to pay more for the same benefits delivered with more amenities and options the right to do so.

To win support from both sides of the health care debate, the president's supporters will need to convince skeptical individuals and organizations that the plan is truly a synthesis of the best each approach has to offer rather than a political compromise between them; that good politics, in this case, is also the best policy. They will have to convince both sides that their glasses are three-quarters full—that the market vs. government intervention debate is no longer, if it ever was, a zero-sum game.

WALTER ZELMAN, architect of California's Garamendi plan, helped draft the Clinton health care proposal.

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## Regional hospitals: a health care cure?

# HOME REMEDY

By Sherwin B. Nuland

While Hillary Rodham Clinton and Ira Magaziner were focusing the attention of their health task force on benefits packages and consumer alliances, short (or no) shrift was being given to one of the greatest concerns expressed by the actual users of our medical care system: the equitable distribution of high-quality medical services throughout the country. Whether they choose to enter their local hospital or a big city medical center, patients want to be assured that they will have access to diagnostic and treatment facilities that are of equal caliber.

The issue of local access to excellence has never been satisfactorily addressed by the vaunted Canadian system; it continues to be one of their program's glaring defects. To benefit from sophisticated medical technologies, Canadian patients often must be transferred to major medical centers in cities far from home, sometimes hundreds of miles away. And yet, in one form or another, a solution to the access question has been proposed over and over again for more than a century—ever since a prototype first hit print in *Hygeia, A City of*

*Health*, a utopian book written in 1876 by an Englishman named Benjamin Ward. For a variety of reasons, conditions never seemed ripe to carry it out. Without doubt, the time has finally come.

The solution is to be found in the fact that, with few exceptions, each of our nation's 126 medical schools is potentially capable of overseeing the needs of the region in which it is situated. Also, thanks largely to the Hill-Burton program of the Truman administration, the United States is endowed with a network of local hospitals that can satisfy the needs of their surrounding populations. The health care delivery scheme that would provide an organized structure for the Clinton plan is one divided among the 126 centers. From each of these centers expertise would radiate through a system of closely linked affiliations with every community hospital in the region. Such a system lends itself to the principle of flexibility of choice that is basic to the Clinton proposals and to the protection of each state's or region's option to choose its own payment and organizational methods.

The most recent attempt at regionalization was made in 1964 as part of Lyndon Johnson's Great Society. Sadly, the president's efforts fell prey to bad press and poor organization. Called "Regional Medical Planning," a part of the Heart Disease, Cancer and Stroke Amendments of 1965, the Great Society's legislation aimed to promote regional centers of excellence at universities, from which the fruits of medical progress were to be disseminated to community hospitals. But the program's goals were unclear and its scope led to fears that government would intrude on the lives of average Americans. In time, each of the participating groups (hospitals, organized medicine and the public) began to mistrust each others' motives. Opposition grew when it was discovered that universities would be permitted to use federal dollars to pursue their own pet projects. Even worse, medical schools at the time were inept at providing good basic primary and secondary care; they were also inefficient and very expensive. As William Kissick—now a professor of health care systems at the University of Pennsylvania, but then a legislative assistant to the RMP planning group—put it at a recent reunion of the program's participants, the regionalization of three decades ago "was the right concept, presented to the wrong culture .... Much has been changed in a quarter of a century. We need regionalization more than ever."

Not only the economy but the entire atmosphere of the American medical care system is vastly different than it was thirty years ago. In that biomedically simpler time, only 6 percent of America's gross national product went to health. Today, that figure is 14 percent, and it is expected to rise to 18 percent by 2000. We are trapped in what has been called the iron triangle of health care: cost containment, quality and access. Widening one angle only narrows the others. Regionalization offers a way out of this trap, for it addresses quality and access, and perhaps cost containment as well.

*continued on page 22*



to endorse the means (e.g., mandates), the government intervention or the expenditures necessary to make the system serve everybody.

By contrast, many moderate and most liberal Democrats have demanded universal coverage, and have been willing to impose a mandate on employers or government to get there. Most important, they've believed that the goal of guaranteed coverage with cost control would inevitably mean relying more on government intervention than on market-driven reforms and adjustments.

The Clinton plan represents an attempt to enlist the best ideas of both market reform and government intervention. It embraces the goal of coverage for everybody, and recognizes that some degree of government intervention—including asking all to pay a share—will be required to achieve that goal. But it resists the temptation to micromanage the system, and leaves the bulk of delivery system reform and cost-control tasks to the private marketplace. It embraces means generally associated with conservatives (competition) to achieve ends (guaranteed coverage for all) generally associated with liberals.

The mix of government intervention and market reform is sequential. It begins with intervention to restructure the insurance market—community rating, competition on price and service, etc.—and to create health alliances, to strengthen the market power of consumers and employers. It also advocates a limit on insurance premium increases as a guarantee that cost-control goals are reached. But in between these book-ends of intervention, it expects market competition to be the true engine of reform, the primary means to control costs, improve quality, enhance consumer choice and generally increase the value of our health care dollars. Advocates of both purer government intervention and purer market-based strategies may object to such a hybrid. But there are sound political and policy reasons for avoiding the purism of either approach.

On the competition side, the Clinton plan borrows heavily from managed competition. It creates purchasing cooperatives, called health alliances, run by boards of employers and consumers, that contract with competing health plans to deliver a federally guaranteed set of standardized benefits. Consumers may choose any plan offered by the alliance. Though the plans are allowed to charge different premiums, they must accept all who choose to enroll (capacity allowing). They are paid by the alliance on a risk-adjusted basis. Plans that enroll higher cost populations will be compensated for doing so.

Applying these rules and principles will force health plans—be they HMOs, preferred provider arrangements, conventional fee-for-service insurers—to compete on price, service and quality before a more informed, cost-conscious consumer. Such competition should produce not just lower prices, but greater efficiency and value in the delivery of care as well. Of course, many market-oriented advocates won't be satisfied. They will object, for one thing, to the exclusion of most health care benefits from taxable income. And they're right that the exclusion subsidizes benefits compared with other com-

modities, and that consumers would be more cost-conscious if they had to pay for their share of health plan costs with after-tax dollars. But it would be difficult, if not impossible, for the president to offer a proposal that would be viewed by many as a heavy tax on middle-income Americans.

As an alternative, the Clinton plan says that if employers contribute more than 80 percent of the average premium cost, they must offer the employee choosing a lower cost plan the difference—in cash—between the cost of that plan and the employer's contribution. In this way the employee will always have some economic incentive to choose a lower cost plan.

Many market-oriented reformers may also oppose the Clinton plan's proposed limit on health care spending. They fear that it might restrict the flow of capital to health plans. Moreover, a fear that future premium increases will be restricted could deter health plans from pricing aggressively, thus undermining the capacity of managed competition to achieve cost-reduction goals.

These are real worries, and the exact positioning of spending caps will have to be closely watched. But the targets are only safety nets for—not the driving force of—cost containment: if the competitive mechanisms work as the market-oriented reformers expect, they won't be exceeded. The reassurance of a spending limit is essential because if government is going to ask all businesses and individuals to purchase health care, and provide subsidies to those who cannot afford their share, then the government must also guarantee the participants that increases in their payments will stay within reasonable bounds. Without such a guarantee, reform would have no chance.

**F**or the government interventionists, the Clinton plan also has much to offer. They will like the universal coverage, the proposals for community rating and other insurance reforms and the limit on health care spending. They'll also appreciate the ability of states to choose the single-payer approach. And while some might prefer that all individuals be in one pool, they will also recognize that regional health alliances will be large, composed of all except those individuals who work for employers of 5,000 or more and those in Medicare.

Still, many who have advocated more regulatory approaches—especially those who favor the Canadian-style "single-payer" approach—may be dissatisfied with a plan that relies so heavily on market forces. Specifically, they may object to the way in which health plans are allowed to compete on price. Such competition, they fear, could produce a two-tiered system in which low-income individuals become isolated in lower-cost—and lower quality—HMOs.

The president's plan includes a variety of measures aimed at preventing such an outcome: many low-income individuals will be subsidized to average-cost, not just lowest-cost plans; quality measures and consumer satisfaction measures can warn against declining quality and access in lower-cost plans; and a fee schedule, above



men are related doesn't taint the survey. What really matters, Merritt stresses, is that the survey itself is accurate. But that's just the problem—it isn't. According to Arthur Miller, a polling expert at the University of Iowa, the study is "biased" and "unscientific."

Thanks to the support of nearly every national police organization, a variety of new gun control measures are on the books: from an assault weapons ban in California to a one-handgun-purchase-a-month provision in Virginia. But if the gun lobby can convince the public that these uniformed impostors represent the views of the nation's law enforcement community, then timid politicians will once again withdraw their support for gun legislation. And if that happens, the war in our streets will continue to escalate, beyond reason or control.

OSHA GRAY DAVIDSON is author of *Under Fire: The NRA and the Battle for Gun Control* (Henry Holt).

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## A defense of Clinton's health plan.

# THE HORSE'S MOUTH

By Walter Zelman

For any major change to occur in an area as important and as fraught as health care, at least three conditions must be met. First, there must be a sense of crisis: one that affects most segments of society. Second, there must be leadership from the executive branch. Without it, few initiatives can override the fragmentation of American government and politics. Third, change this deep doesn't arrive in America when one philosophical side narrowly overcomes another: it comes only with the emergence of broad consensus on how a crisis can be addressed. The first two conditions have already been met. The Clinton plan—a unique blend of health care reforms—has the potential to achieve the third.

For some time there has been agreement on what the current crisis now is. Thirty-seven million Americans are without insurance coverage, and every month another 2 million lose their insurance for some period of time. Millions more have just bare-bones policies, and the rest are (or should be) anxious about maintaining the coverage they have. Costs—for families, employers and government—are rising at rates two to three times that of inflation, and in many cases much faster, threatening the ability of private employers to maintain current benefits, and diminishing the country's capacity to invest and engage in other public and private enterprises.

The insurance marketplace is also dysfunctional.

Competition among insurers over quality, service and price has given way to competition to find the least risky consumers. When 10 percent of individuals account for 75 percent of system costs, competition among insurers will be more over whom to enroll and less over how to care for all enrollees efficiently. The ties between insurance and employment compound the problem. Millions are unwilling to switch jobs for fear of loss of insurance or imposition, by a new employer's insurance program, of restrictions on treatments for which they or a family member are already covered.

Finally, there are inequities in our current financing structure. It is not just a case of the current system lacking progressivity; it can be outright regressive. Large employers or high-wage firms are more likely to insure their employees with more generous benefits and to pay higher shares of insurance premiums than are smaller or lower-wage employers. Large firms are also better able to self-insure, lowering administrative costs and using their purchasing power to drive harder bargains with providers. By contrast, smaller employers, with no market clout, have to buy insurance in the marketplace and pay what are often exorbitant administrative costs. Thus, those with the most secure and highest paying jobs usually get the best insurance and pay the least, while those with lower wages are more likely to get less insurance (if they have it at all) and pay more for it.

There is even considerable consensus around the causes of the health care crisis. When it comes to health care, the balance of power between the supply and demand sides has been anything but balanced. Most buyers have little information about the quality of service delivered by health care providers—doctors, hospitals, health maintenance organizations or insurance companies. It is difficult, if not impossible, to compare the value of all the plans offering marginally different levels of benefits and consumer cost-sharing. In fee-for-service medicine, still the main way we get health care, the incentive is to do (supply) more when less might be acceptable, or even better. And with consumer cost consciousness as low as it is (after all, the employer pays most of the premium, and the insurer most of the bill), the individual consumer has little incentive to question the decision to spend more.

In short, the demand side has had little ability to keep the supply side in check. (Indeed, in the ultimate violation of market economic theory, suppliers largely determine demand, telling us what we need and when we need it.) In the face of this failure, proponents of reform have generally fallen into two categories, each of which has had a political component (access and coverage) and an economic component (cost containment). Some—mostly Republicans and conservative Democrats—have advocated market-oriented solutions. They want reforms that will create a more level insurance playing field to reduce or eliminate the propensity of insurers to compete on risk selection. They may also endorse the creation of modest-sized purchasing pools to strengthen the market power of small employers. However, these reformers have generally been reluctant



achieve cost savings through tort reform, electronic claims processing and admin. simplification (Cooper release, 10/4).

EFFECTS: DALLAS MORNING NEWS reports that "unlike the president's plan, employers would be required to offer workers health care coverage but would not have to pay for it." Also, businesses with as few as 100 employees could opt to self-insure, whereas under Clinton's plan only employers with 5,000 or more workers could do so. The plan would end the Medicaid program and "trim" \$6.5B/yr. from Medicare spending, "but it lacks any comprehensive reform to limit the soaring growth in health entitlement programs." One of the plan's 45 co-sponsors, Rep. Mike Andrews (D-TX) "estimated" the subsidy for "the unemployed, the working poor and families that earn less than twice a state's poverty rate ... would cost \$25[B] annually. That would be paid for by limiting corporations' tax deductions and with a \$1/pack tax on cigarettes" (Dodge, 10/6).

REAX: CBS' Linda Douglass: "In Congress, bipartisan support is building for a health plan that would be quite different from the Clinton's." Rep. Grandy: "We have minimal bureaucracy and that may be the greatest selling point." Cooper: "The key thing is [to] minimize the government coercion, and only target the folks you should target." Douglass: "The health plan that finally emerges will be a compromise, but no matter which plan passes the Congress, it's likely President Clinton will get the credit for health care reform" ("Evening News," 10/5). Citizen Action's Cathy Hurwit called the bill "a plan even a mother couldn't love. Not only has Rep. Jim Cooper come up with a bad bill, he has come up with a bad bill twice. In July, the [CBO] told Rep. Cooper that his previous managed competition bill would increase national health spending by \$214[B] over the period 1995-2000 and leave 25 million Americans uninsured. Rep. Cooper's new and not improved version is just more of the same" (release, 10/6).

HOW THE WH WANTS YOU TO ASSESS IT: The WH's "Health Care Reform Today" provides a list of 12 questions "we want you to ask ... as alternatives to the president's plan are introduced: Does it guarantee you will always have health coverage? Does it guarantee that no matter who you work for, where you work or where you live that you will have health care coverage? Does it guarantee that if you get sick, or anyone in your family gets sick, they will have health coverage? Does it guarantee that you will have a comprehensive package of benefits that amount to good decent health care coverage? Does it make sure that the health care system is simplified, getting rid of paperwork and that it cuts through red tape? Does it give you a choice as to which doctor you see and the hospital you use and who can provide your health care? Does it guarantee quality? Does it make sure that you know more about what works and then works to make it more available to everyone? Does it help you save money in the system you currently use? Does it begin to weed out waste, fraud and abuse? ... Does it make everyone responsible? Does it eliminate the free ride that too many people have so that when they show up to get health care, you pay the bill?" (10/6).



people who have worked together to help solve a problem that is a national one, but for which you didn't wait like every other state has to see what would come out of Washington. Instead you really took your own destiny in hand 20 years ago and have built on that in a way that deserves a lot of close attention from the rest of the country" (Hooper, 7/14). Clinton: "A lot of concerns [the public has] are: Will everybody be taken care of? Will we have security no matter who I work for, no matter what my health condition is? And the only place in our country that's even come close to answering those is Hawaii" (Balto. SUN, 7/14).

**CLUES FOR THE FUTURE:** N.Y. TIMES on Clinton's 7/13 meetings: "Speaking at a heavily scripted community forum," Clinton "previewed the sales pitch she will take on the road this fall to make her case for extensive changes in the nation's health care system." According to the TIMES, Clinton told reporters 7/12 that the admin.'s health plan would "probably include" cigarette taxes, state flexibility, a provision allowing employers to deduct the cost of preventive care, and an emphasis on patient responsibility (Gwen Ifill, 7/14). NPR's Mara Liasson on Clinton's meetings with reporters: "Mrs. Clinton also went out of her way to criticize the Canadian style single-payer system. ... Although the Clinton administration has never suggested it might propose a Canadian-style system, there was hope among single-payer advocates that Hillary Clinton was a secret supporter of single payer. Her remarks today appear designed to put an end to that wishful thinking" ("Morning Edition," 7/13). CNN's Wolf Blitzer: "She tells reporters that the Clinton administration's health care reform package will probably be released sometime in September after the economic plan is enacted. ... She says she does not anticipate that it will include a major tax increase, although she does leave open the possibility there will be increased cigarette taxes to pay for infrastructure. She's rejecting the notion of a single-payer system that's advanced by so many members of Congress. She says her proposals -- the Clinton administration's proposals -- will be a unique proposal -- a hybrid, she says" ("Inside Politics," CNN, 7/13).

**WHERE WAS BILL?:** NPR's Liasson: "The president and his family are on vacation in Hawaii, but although Bill Clinton found some time for golf, First Lady Hillary Rodham Clinton is busy making policy. While daughter Chelsea swam with friends and her husband teed off, the first lady held a three-hour strategy session with aides under a Banyan tree at the Kahala Hilton" ("Morning Edition," 7/13). WASH. TIMES reports President Clinton had originally planned to attend the health care meetings 7/13, but "scrubbed" his plans to go on "an early-morning snorkeling expedition" with daughter Chelsea (Frank J. Murray, 7/14).

## **\*2 BUDGET CONFERENCE: PREPARING TO HASH OUT DIFFERENCES**

House and Senate conferees will begin to work on resolving differences in their respective budget bills 7/15. N.Y. TIMES reports the conference "is expected to take at least two weeks, with a final vote likely the first week in August." The WH has put Dep. Treas. Sec. Roger Altman in charge of coordinating



# AMERICAN HEALTH LINE

## THE DAILY BRIEFING ON HEALTH CARE REFORM

--- Tuesday --- July 13, 1993 --- Vol. 2 --- No. 73 ---

### "FRESH" FROM THE CAMPAIGN TRAIL

Many new members of Congress campaigned on health care last year. Are they fulfilling their promises? A look at House health reform bills and which new members have signed on as co-sponsors. (see story #2)

### A RELIABLE TEST?

Yesterday's Harris poll showed health care as the nation's top concern. But today's Public Opinion Strategies poll shows only 6% see health costs as the most important issue, behind the economy (16%), unemployment (11%) and the deficit (9%). (#13)

### HEALTH CARE HOT TOPIC IN STATES

DE holds public forums with reform plan deadline set for 3/94 (#6), and PA now has a single-payer alternative to Gov. Casey's bill. (#8)

### CONTENTIOUS ISSUES

Both sides of the abortion issue debate its inclusion in VT's benefit plan. (#10)

SPEAKING OF ... "Dateline NBC" features an interview with Surgeon General-designate Joycelyn Elders tonight.

### SPOTLIGHT

#### SUMMER SPECULATION

The decision to introduce the health plan after passage of the budget has done more than give opponents a chance to organize -- it has created a void for reporters who were covering the developing plan and now are speculating about the level of damage done.

CASE IN POINT: Over the past weeks, BOSTON GLOBE interviewed key Dems and "top policy players" to analyze the current climate: momentum is gone, with fingers pointed at the task force, Magaziner and the WH delay of the plan. "Many" Dems now "believe the bill can only be passed in modest increments."

SILVER LINING: But GLOBE also reports "many in Washington still agree ... Clinton and Magaziner could pull off one of the great social policy coups of the century." (#1)

### QUOTE OF THE DAY

"I think the options that came out of the deliberation were pretty much apparent to anyone who understood the health care system at the beginning."

-- NEJM Editor Emeritus Arnold Relman on the WH task force. (#1)



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## ===== FACT OF THE DAY =====

Fifty-two percent say the nation will benefit from health care reform and 30% say they will personally benefit from reform.

--Olsen HealthCare/USA TODAY, 7/12



===== POLITICS & POLICY =====

**\*1 POLITICS OF REFORM: CAN THE WH REGAIN ITS MOMENTUM?**

"There was a moment last winter, as a newly-inaugurated President Clinton triumphantly announced a task force to revamp the nation's health care system in 100 days, when almost anything seemed possible. But today, numerous advocates of health care overhaul fear that moment may have come and gone," BOSTON GLOBE reports. Obstacles to reform that "pile up by the day" include: polls showing rising disapproval of Clinton's handling of health care; the delayed plan has given its opponents "much-needed time to plot strategy;" and some congressional Dems "criticize the plan as overly-complex and disdain the man who helped design it" -- WH aide Ira Magaziner (Peter Gosselin/Elizabeth Neuffer, 7/13). KANSAS CITY STAR editorial: "Many Americans are losing their enthusiasm for the presidential campaign pledge of health reform. ... Clinton, who promised a reform package early this year, has lost his advantage" (7/11).

CRITICISM OF MAGAZINER: GLOBE reports Magaziner "is the lightning rod for [reform] advocates' anger. ... Advocates say the task force and its huge working groups led to the delay ... with endless studies of minor issues, while confusing the public about how Clinton would guarantee affordable, quality health coverage for all." GLOBE reports interviews with admin. officials, policy players and congressional Dems reflect this view. Critics say Magaziner made two major mistakes. First, the nearly 500-member task force, sworn to secrecy, meant "newspapers ran leaked stories, many erroneous, about the administration's approach, raising public expectations." According to the GLOBE, Magaziner's second mistake was telling task force members to "define the best policy and we'll worry about the politics later." This approach "seems wildly naive" to "Washington veterans" who say, "time spent with congressional staff members on the task force might have been more wisely devoted to brokering deals with Congress." Fmr. HEW head Joseph Califano: "Suppose all the time was spent talking to [House Ways and Means Chair Dan] Rostenkowski (D-IL), [House Ways and Means health subcmte. Chair Pete] Stark (D-CA), [Sen. Labor and Human Resources Chair] Teddy Kennedy (D-MA). It might have been better spent." GLOBE: "Worse yet, some experts say, Magaziner and the task force do not appear to have come up with any breakthroughs in solving the problem of rising health care costs."

BLAME GAME: NEJM Editor Emeritus Arnold Relman: "I think the options that came out of the deliberation were pretty much apparent to anyone who understood the health care system at the beginning." GLOBE: "To be sure, even Magaziner's harshest critics admit they would be hard-pressed to formulate a plan for overhauling the entire health care system in a matter of months. And some critics acknowledge that their most serious complaints are less about Magaziner than the 'managed competition' approach." Some admin. officials admit the reform process did not go as smoothly as hoped for, "but they trace the problem not to the task force, but to the White House's decision to delay release of the plan until Congress approves its budget package."



**CAN THEY OVERCOME?:** Sources say Magaziner is confident that when Clinton unveils the plan in September he can regain the political momentum needed to pass the plan. **GLOBE:** "But even if Clinton regains the initiative, he has lost the advantage, some health care experts say. Before May, he could have pushed some kind of overhaul plan through Congress in a single, dramatic step. Now, many Democrats believe the bill can only be passed in modest increments, and will require painstaking negotiations with Capitol Hill's committee barons." However, **GLOBE** also writes that others "in Washington agree that Clinton and Magaziner could pull off one of the great social policy coups of the century. Experts in some fields say Magaziner already has accomplished much, having pushed ahead thinking in their specialties by as much as a decade" (Gosselin/Neuffer, 7/13).

**HILLARY'S ROLE:** N.Y. **NEWSDAY** editorial: "The Clintons are taking unprecedented risks in the way they have crafted the first lady's role -- too much risk, in fact, by putting her in charge of health care reform." **NEWSDAY** calls H.R. Clinton's spearheading of the reform effort "a grave political mistake," noting "Clinton can never put even the slightest distance between himself and the proposal. ... To use the bluntest shorthand, when things go wrong, he can't fire his wife." Some "key" Dems "doubt her political instincts" and "fear she is too reflexively liberal and strident in tone to sell well over the long haul" (7/11).

## \*2 HOUSE HEALTH BILLS: A LOOK AT FRESHMEN CO-SPONSORS

Following is a list of selected health "reform" bills that have been introduced this year in the U.S. House of Representatives and the newly-elected members who have co-sponsored them listed alphabetically by state. Criteria used to select the bills include the sponsor, the number of co-sponsors and the direct relationship between the bill and elements of reform currently at the center of the nat'l debate. The number next to the bill's sponsor indicates the number of co-sponsors as of 7/12/93.

### H.R. 16 - NATIONAL HEALTH INSURANCE ACT

Sponsor: John Dingell (D-MI) (3)

Freshman co-sponsor: Steve Buyer (R-IN)

### H.R. 101 - ACTION NOW HEALTH CARE REFORM ACT OF 1993

Sponsor: Robert Michel (R-IL) (69)

Freshmen co-sponsors: Ken Calvert (R-CA), Tillie Fowler (R-IL), John Linder (R-GA), Michael Crapo (R-ID), Don Manzullo (R-IL), Roscoe Bartlett (R-MD), Rod Grams (R-MN), Jack Quinn (R-NY), Bob Inglis (R-SC)

### H.R. 136 - PAPERWORK REDUCTION IN HEALTH CARE ACT OF 1993

Sponsor: Larry Combest (R-TX) (15)

Freshman co-sponsor: Jack Kingston (R-GA)

### H.R. 144 - HEALTH CARE COST CONTAINMENT ACT

Sponsor: Christopher Cox (R-CA) (12)

Freshman co-sponsor: Peter Blute (R-MA)

### H.R. 150 - HEALTH CARE CHOICE AND ACCESS IMPROVEMENT ACT OF 1993

Sponsor: J. Dennis Hastert (R-IL) (15)

Freshmen co-sponsors: Howard McKeon (R-CA), Tillie Fowler (R-



FL), Jack Kingston (R-GA)  
H.R. 200 - HEALTH CARE COST CONTAINMENT AND REFORM ACT OF 1993  
Sponsor: Pete Stark (D-CA) (2)  
Freshman co-sponsor: Carlos Romero-Barcelo (D-PR)  
H.R. 286 - HOSPITAL COOPERATIVE AGREEMENT ACT  
Sponsor: Constance Morella (R-MD) (11)  
Freshmen co-sponsors: Howard McKeon (R-CA), David Levy (R-NY)  
H.R. 727 - CHILDREN AND PREGNANT WOMEN HEALTH INSURANCE ACT OF 1993  
Sponsor: Robert Matsui (D-CA) (24)  
Freshmen co-sponsors: Earl Hilliard (D-AL), Walter Tucker (D-CA), Lynn Woolsey (D-CA), Carrie Meek (D-FL), Luis Gutierrez (D-IL), Carolyn Maloney (D-NY), Melvin Watt (D-NC), Leslie Byrne (D-VA)  
H.R. 1200 - AMERICAN HEALTH SECURITY ACT OF 1993  
Sponsor: Jim McDermott (D-WA) (84)  
Freshmen co-sponsors: Earl Hilliard (D-AL), Xavier Becerra (D-CA), Sam Farr (D-CA), Dan Hamburg (D-CA), Lucille Roybal-Allard (D-CA), Walter Tucker (D-CA), Lynn Woolsey (D-CA), Carrie Meek (D-FL), Cynthia McKinney (D-GA), Bob Underwood (D-Guam), Luis Gutierrez (D-IL), Mel Reynolds (D-IL), Bobby Rush (D-IL), Bennie Thompson (D-MS), Maurice Hinchey (D-NY), Carolyn Maloney (D-NY), Jerrold Nadler (D-NY), Nydia Velazquez (D-NY), Eva Clayton (D-NC), Melvin Watt (D-NC), Elizabeth Furse (D-OR), Carlos Romero-Barcelo (D-PR), James Clyburn (D-SC), Eddie Bernice Johnson (D-TX), Robert Scott (D-VA)  
H.R. 1246 - TOBACCO HEALTH TAX ACT OF 1993  
Sponsor: Mike Andrews (D-TX) (9)  
Freshman co-sponsor: Michael Huffington (R-CA)  
H.R. 1526 - HEALTH INSURANCE FAIRNESS ACT OF 1993  
Sponsor: Richard Durbin (D-IL) (10)  
Freshmen co-sponsors: Tim Hutchinson (R-AR), Alcee Hastings (D-FL), Mel Reynolds (D-IL), Albert Wynn (D-MD), Martin Hoke (R-OH), Leslie Byrne (D-VA), Thomas Barrett (D-WI)  
H.R. 1625 - MEDICAL MALPRACTICE LIABILITY REFORM ACT OF 1993  
Sponsor: Nancy Johnson (R-CT) (17)  
Freshman co-sponsor: James Barcia (D-MI)  
H.R. 2261 - IMPROVED MEDICAL AND HEALTH INSURANCE INFORMATION, PROVISION  
Sponsor: William Thomas (R-CA) (4)  
H.R. 2386 - PRIMARY CARE HEALTH PRACTITIONER INCENTIVE ACT OF 1993  
Sponsor: Edolphus Towns (D-NY) (1)

#### ===== ELEMENTS OF REFORM =====

### \*3 THE FRAMEWORK: WASH. POST FEATURE EDUCATES READERS

In its "Health" section cover story titled "Handing Off the Health Reform Plan: The Broad Outlines Are Done -- Now the Crucial Moves Are Up To Clinton," WASH. POST outlines the structure of the admin.'s reform plan and how it will affect people. POST reports that people would buy a health insurance policy from a local health plan, which "from a consumer's perspective ... would be a collection of doctors, hospitals, clinics, etc." Consumers would pay an annual fee and possibly



deductibles and copays, would be able to choose or change health plans once a year, and would have a choice of doctors. POST outlines possible financing mechanisms and notes the "current favorite" tax proposals are a hospital tax; a cigarette tax; an employer contribution for part-time and seasonal workers; and workers' premium contributions would be based on "adjusted gross income" to include income sources other than salary (Dana Priest, 7/13). But NBC's Brian Williams reports H.R. Clinton said the plan will not require any major tax increases but may include a cigarette tax ("Today," 7/13). POST outlines likely cost control mechanisms and how self-insured cos. and fed. programs would be affected. In addition, it gives details how the plan would change the roles of gov't, business, doctors and insurance cos., examines "the different faces of managed care," and includes a flow chart of the current system and the proposed system and a health care glossary (Priest, 7/13).

**VALUES-BASED PLAN:** POST reports that questions about the content of the reform plan "are questions about American values" and Clinton's final decisions about the plan "will give people a window into his own values. ... For the public, the test will be what values they want the plan to embody and to look for policies that will lead to them" (Priest, 7/13).

**\*4 ADVICE: GET "BASIC INCENTIVES" RIGHT; NO PRICE CONTROLS**

**WHAT TO DO:** Stanford Univ.'s Alain Enthoven writes in the WASH. POST: "The main reason health care costs are soaring is that practically all the incentives in the field reward decisions to increase cost. Fee-for-service payment encourages doctors and hospitals to choose the most costly method of treatment. Meanwhile, insured patients have little or no reason to care about the costs. ... The cure for this perverse incentive is a cap on the employee's tax break, set at amounts (for individual, couple and family coverage) that do not exceed the prices of the lowest-priced plan that meets quality and coverage standards. ... To achieve good policy, the president must be willing to fight for a plan that gets the basic incentives right. A consensus favoring an ineffective program might be a short-term political success, but it would be a long-run economic failure" (7/13). A WASH. TIMES editorial argues, "The major problem with the health of Americans is not one that all the managed competition in the world can address. How long and how well you live is far more likely to be determined by your level of education and income than by the type of health plan you have. ... As even Mrs. Clinton's policy wonks should understand, poverty and ignorance are not under the control of a country's health care system, not even the most ambitious one" (7/13).

**WHAT NOT TO DO:** Attorney Mary Walker writes in the JOURNAL OF COMMERCE that putting price controls on prescription drugs "would stifle capital investment in drug research and development, leaving less money available to produce new treatments." Walker notes that after France instituted price controls, its share of the world market in new drugs "fell from 18% to less than 8% in just a few years" (7/12).



===== THE PLAYING FIELD =====

**\*5 MANAGED CARE: GHA TO BE ACQUIRED BY HUMANA**

Humana Inc. announced 7/12 it had signed a letter of intent to buy Group Health Assn., "a troubled nonprofit" Washington, DC, HMO, for about \$50M, BLOOMBERG/INVESTOR'S BUSINESS DAILY reports. GHA "said increased competition, reduced market share and spiraling health care costs compelled it to seek a way to continue to serve its 134,000 members" (7/13). WASH. POST calls the move "a deal that illustrates the financial difficulties besetting HMOs across the nation." GHA officials "said the sale ... is necessary because the company lacks size and money to provide the coverage and services the marketplace now demands." GHA was faced with a declining membership and increasing costs before the acquisition as its patient pool aged, GHA Pres. and CEO Robert Pfothner said. Pfothner: "I think we were, simply put, a victim of our own 56 years of success. None of our major competitors have existed for more than 10 or 12 years in this area. The mix of patients they all serve is a younger, healthier mix." POST reports that in theory, GHA "should be able to control costs more effectively" than other delivery systems because the non-profit cooperative employs their own physicians and personnel and owns its own facilities. Humana has agreed to continue to cover all GHA members and use GHA doctors. Proceeds from the sale will establish a charitable health care foundation (Albert Crenshaw, 7/13). IBD reports the deal must be approved by two-thirds of GHA's 91,500 voting members and insurance commissioners in MD, VA and Washington, DC (7/13).

FACTS: Since '84, GHA's market share has shrunk from 41% to less than 8%; its patient base has dropped by 21,000 since 1/92. It currently serves 134,000 people and has 1,370 employees. '92 revenues were \$256M and profit was \$3.1M (Karen Riley, WASH. TIMES, 7/13).

===== STATELINES =====

**\*6 DELAWARE: COMMISSION HOLDS PUBLIC FORUMS**

"The Delaware Health Care Commission is gearing up to prepare a comprehensive reform plan for the state," Wilmington SUNDAY NEWS JOURNAL reports. Last week, two days of public hearings featured over 30 speakers, "including a variety of health care providers, representatives of groups such as the mentally ill, small business people and other citizens." Commission Chair Sally Gore: "We can't reach consensus unless we get all the different perspectives on the table early. And all the players have to work together." SUNDAY NEWS JOURNAL notes Gov. Tom Carper (D) has charged the commission with developing a reform plan for the state by 3/94 (Nancy Kesler, 7/11).

PUBLIC MEETINGS: Gore said the purpose of last week's public meetings was to examine the impact of various reform proposals being considered at the state and nat'l level (Joyce Mullins, DELAWARE STATE NEWS, 7/9). Speakers at a DE Technical and Community College meeting included businessman Ernst Danneman, Dover city councilman Irving Levitt and Northwestern



Univ.'s Edward Hughes. Danneman outlined his DelaCare Inc. plan, first presented to the commission two years ago, which would set up a standard insurance package, pool Delawareans into 10,000-member groups, lower prices through competition and institute a payroll tax. Levitt recommended that the Dept. of Health and Social Services' office that investigates Medicaid fraud be combined with a similar office in the state AG's office, that federal Medicaid waivers be sought to allow the state to set up a managed care plan for all residents and that the state contract out Medicaid services on an annual, capitated basis. His "strongest criticism" was that BC/BS of DE is not under the control of the state Insurance Dept. Hughes outlined 11 reform options (Joyce Mullins, 7/9). At the Sussex County public forum 7/8, Health Care Providers Assn. of DE's Grover Biddle noted the economic impact of reform: "Any legislation aimed at (the health care industry) will have a profound impact on the economic welfare of thousands of health care workers." Beaston's Boat Rentals' Steven Beaston focused on the concerns of small business owners. He "urged the commission to examine excessive costs and administrative inefficiency in the areas of workman's compensation" and "recommended that the commission support national development of a comprehensive, 'no-fault' health care program and that participating insurance companies be permitted to market 'Medicare-like supplemental insurance.'" DuPont Co.'s David Helms "urged the commission to support federal reform over state reform" (Joyce Mullins, 7/9).

**COMMISSION MEETING:** At a Health Care Commission meeting 7/8, members approved funding for Danneman's plan (see AHL, 12/11) at "10%, up to \$250,000, of any other funding that Mr. Danneman's group found." As of 7/93, Dannemann had qualified for \$17,000 in commission funding. The commission also discussed the status of its Healthy Children cmte.'s project to identify all public and private children's health services in the state. The commission approved additional funding "for a retreat to study and finalize a strategic plan" (Joyce Mullins, 7/9).

#### **\*7 INDIANA: BUDGET GIVES GOV. "TOOLS" TO CUT MEDICAID**

Gov. Evan Bayh (D) was given "nearly all the tools [he] sought to slash spending for Medicaid" in the state budget approved 6/28, the INDIANAPOLIS STAR reports. But the General Assembly allocated "virtually nothing to improve health care ... or control its skyrocketing costs" and "only" \$165M in new Medicaid funds. IN Health Commis. John Bailey: "We're still paying for a la carte medicine." During the next two years, \$540M is supposed to be cut from the Medicaid program. So far, only \$137M of the cuts has been identified by the Bayh admin. IN Medicaid Dir. James Verdier "says the department will shift its payment systems over two years to systems meant to encourage providers to be more efficient." He noted total payments to doctors and hospitals will be reduced, but cuts won't be made in payments to primary care physicians. Dr. Michael Abrams, a lobbyist for the IN State Medical Assn., "said he hopes that along with cutting payments, the state will figure out a way to cut Medicaid's bureaucratic hassles." STAR reports the admin.



"continue[s] to work on a 'case management' system that would assign Medicaid patients to a family doctor" and "wants to get more Medicaid patients into" HMOs. Verdier said both measures could save about \$15M over the next two years. "With some fancy accounting footwork," the admin. hopes to capture an additional \$45M in federal matching funds for the disproportionate share program, which pays extra money to hospitals that treat a high proportion of poor patients.

LEGISLATIVE WRAP-UP: STAR notes the Bayh admin. tried to pass some "overall health care reform" but it "fell victim to the partisan battle that forced the General Assembly into special session." Proposals to alter health insurance laws and to allow hospitals to work together to eliminate duplication of services "died" and a "highly touted loan forgiveness plan to lure young Indiana University School of Medicine graduates to practice in underserved rural areas also failed." In addition, the GOP-controlled Senate rejected a proposal "that would have forced doctors to get advance permission to prescribe a brand name drug" when a generic was available. Critics believed the plan would create "more bureaucracy." The only measure that passed allows nurse practitioners to write prescriptions under "certain circumstances" (Eric Schoch, 7/6).

**\*8 PENNSYLVANIA: A SINGLE-PAYER ALTERNATIVE TO CASEY'S BILL**

State Rep. David Richardson (D) introduced a single-payer alternative to Gov. Casey's (D) managed competition bill (see AHL, 5/21) 6/28. According to single-payer supporters PA Health Care For All, Richardson's bill, the "PA Unified Health System House Bill," would: provide universal access and physician choice; eliminate premiums, deductibles and copayments; prohibit small insurance companies from duplicating the "guaranteed benefit package;" and include abortion services and nursing home care. Richardson's bill is co-sponsored by eight other PA state reps. According to PA Health Care For All, Casey's bill would: provide universal access, "but it's a multi-tiered system based on employment status and income;" not include physician choice; would require a 10% contribution to the cost of the premium and to unspecified deductibles and copays; retain a large role for insurers; and "maybe" include comprehensive benefits, specifically excluding abortion, nursing home services and medical exams (PA Health Care For All release, 7/2).

**\*9 TENNESSEE: THE ROLE OF HEALTH DEPTS. IN TENNCARE**

Nashville TENNESSEAN reports that a 7/6 Governor's Task Force on Medicaid Reform meeting was devoted to discussion of the role of managed care in the proposed TennCare program (see AHL, 4/9) (Duren Cheek, 7/6). TENNESSEAN reports that at the meeting, "Medicaid officials were questioned about whether the innovative new program would mean the end of public health care." TN Bureau of Medicaid's Manny Martins: "In many areas of the state, both urban and rural, local health departments and other community health clinics are the only provider," but he assured that would not change under TennCare. Martins: "We would see rates being negotiated between the provider and the health department, much



as they would be with a private physician's office" (Gail McKnight, 7/7). TENNESSEAN ran a table outlining the monthly income eligibility guidelines and premium options under TennCare. TENNESSEAN reports that a "new wrinkle" in the plan is an option allowing TennCare participants to choose either a low-deductible or high-deductible plan (Duren Cheek, 7/6).

TENNCARE ADVICE: TENNESSEAN editorial: "The prospects for implementation looked promising at" the 7/6 task force meeting. "Insurers are interested; 10 managed care groups showed up." TENNESSEAN notes that while "hearing the concerns and questions about the program" are important, "a big part of the transition ... needs to be centered on getting the information out to those who will be affected." TENNESSEAN warns that if TennCare doesn't get federal approval, "the state undoubtedly will make slashing cuts in the Medicaid program" (7/8).

#### \*10 VERMONT: ABORTION TO BE INCLUDED AS OUTPATIENT SURGERY

Under a benefit plan "envisioned" by the VT Health Care Authority, abortions would cost \$5, the BURLINGTON FREE PRESS reports. Although it is not mentioned in the first draft of the Uniform Benefit Plan released by the authority (see AHL, 6/4), abortion would be covered under outpatient surgery and would cost patients the same as "many services." Authority member Veronica Celani: "It's a non-issue as far as I'm concerned. By putting in a new health care system now, we're not changing anything. Abortions are available now." The VT Supreme Court has ruled that abortions are allowed under the state constitution and VT tax dollars and fed. Medicaid money has been routinely spent on the procedure. VT Women's Health Center's Rachel Atkins: "Abortion is the number one surgical procedure in this country for women." VT Right to Life Cmte.'s Sharon Fraser: "Certainly we don't think Vermonters should have to participate in the killing of unborn children, which they'll be forced to do if their tax dollars and employer dollars are used to fund health care reform." Atkins also hopes the number of doctors who perform abortions will increase: "Here's this incredible public health phenomenon, this very common health procedure, and there's this little small group that's providing this service. We have this whole range of providers who are not giving women the full range of health care" (Betsy Liley, 7/12).

#### ===== SURVEYS & POLLS =====

#### \*11 CNN/USA TODAY/GALLUP: CLINTON APPROVAL RATINGS

1,002 adults, surveyed 7/9-11; margin of error +/- 3%.

|             |     |      |      |     |      |      |      |      |
|-------------|-----|------|------|-----|------|------|------|------|
| CLINTON JOB | NOW | 6/30 | 6/21 | 6/6 | 5/23 | 3/14 | 2/28 | 1/26 |
| Approve     | 45% | 46%  | 39%  | 37% | 44%  | 53%  | 59%  | 58%  |
| Disapprove  | 48  | 47   | 50   | 49  | 46   | 34   | 29   | 20   |

|                                 |     |      |      |      |
|---------------------------------|-----|------|------|------|
| CLINTON HANDLING OF THE ECONOMY | NOW | 6/30 | 4/24 | 2/14 |
| Approve                         | 34% | 35%  | 43%  | 45%  |
| Disapprove                      | 60  | 59   | 50   | 35   |



**\*12 ELDERS: 57% FAVOR CONDOM DISTRIBUTION IN H.S.**

1,004 adults, conducted 4/17-20 by Peter Hart (D) and Bob Teeter (R), margin of error +/- 3% ("Dateline NBC," release, 7/12).

**DISTRIBUTION OF CONDOMS  
IN HIGH SCHOOL**

|        | ALL | 18-34 | 35-49 | 50-UP |
|--------|-----|-------|-------|-------|
| Favor  | 57% | 70%   | 59%   | 43%   |
| Oppose | 39  | 27    | 36    | 52    |

**GREATEST WORRY W/H.S.  
STUDENTS HAVING UNPRO-  
TECTED SEX**

|                     |     |
|---------------------|-----|
| Unplanned child     | 29% |
| Contracting disease | 44  |
| Both equally        | 23  |
| Neither             | 2   |

**\*13 P.O.S.: HEALTH CARE COSTS RECEIVE 6%**

Public Opinion Strategies (R) surveyed 800 adults, conducted 6/29-7/1, margin of error +/- 3.46% (release, 7/9).

**CLINTON JOB**

|                   |     |
|-------------------|-----|
| Strongly approve  | 14% |
| Somewhat approve  | 27  |
| Somewhat disappr. | 16  |
| Strongly disappr. | 28  |

**"CONGRESS ISN'T DOING THE**

|                              |         |
|------------------------------|---------|
| JOB WE ELECTED IT TO DO" NOW | 7/91    |
| Strongly agree               | 54% 38% |
| Somewhat agree               | 24 32   |
| Somewhat disagree            | 12 17   |
| Strongly disagree            | 4 8     |

**MOST IMPORTANT ISSUE FACING U.S. (selected answers)**

|                         |     |                              |    |
|-------------------------|-----|------------------------------|----|
| Economy/recession       | 16% | Drugs                        | 4% |
| Unemployment            | 11  | Education                    | 4  |
| Deficits/federal debt   | 9   | Taxes/unfair taxes           | 3  |
| HEALTH CARE COSTS       | 6   | Poverty/hunger/homeless      | 3  |
| Crime                   | 5   | Pres. Bill Clinton           | 3  |
| Decline in moral values | 5   | Gov't corruption/bureaucracy | 3  |

**DIRECTION OF U.S.**

|             |     |
|-------------|-----|
| Right track | 23% |
| Wrong track | 64  |



# HILLARY ALERT

*A special project of the American Conservative Union.*

Dear Fellow American,

Here is your opportunity to do what you couldn't do in 1992...

...vote FOR or AGAINST First  
Person Hillary Rodham Clinton.

Please, take out a pen right now and sign the enclosed HILLARY BALLOT. Then rush it back to me today.

Hillary "Rodham" Clinton is now the second, if not the first, most powerful person in the world.

She sits in on Cabinet meetings...

... her lackeys are in charge of, among other things, the Justice Department and the Department of Health and Human Services;

... she has a huge taxpayer-paid staff and flies on U.S. military aircraft at your and my expense;

... her lavish offices take up nearly an entire floor of the West Wing of the White House;

... and even though Hillary is in the process of dictating what health care will be available to you...

... she was elected by no one and is accountable to no one.

You and I didn't have a chance to vote for or against "First Person" Hillary Clinton before.

But you can now. And this time, I'll personally make sure your voice will be heard.

So please, do not delay your response. Complete your HILLARY BALLOT and rush it back to me today. Your HILLARY BALLOT will be tabulated in our national processing center here in Washington. D.C.

Your vote will be kept strictly confidential.

But the overall results will be sent to the White House, Congress, and to the national media.

Our goal: to counter the biased media's ridiculous claim that Americans approve of Hillary and her enormous illegitimate (or illegal) power. What's more, we want to use the results of our HILLARY BALLOTS to force Bill Clinton to rein in his wife before she



can do any serious and long term damage to our nation.

"Billary" (Bill and Hillary) fooled America last November. They deliberately misled voters into believing that Hillary would not have enormous power.

We all know now that this was not true. We know that Hillary's "down home" act and cookie baking were all a charade.

And we know that Hillary intends to rule the White House and our nation with an iron fist.

In fact, that is exactly what she is already doing:

- \* Hillary demanded that Bill Clinton pick a woman for Attorney General -- no matter how many times it took to get it right;
- \* Hillary played a major role in nearly all Cabinet appointments making sure her friends, such as the ultra-liberal Donna Shalala, were chosen over others;
- \* Hillary sits in on all Cabinet meetings, was a major player in the White House/Governors conference, and has already begun lobbying -- and bullying -- Senators and Congressmen from both political Parties.

Do you ever wonder why Bill Clinton caters so much to the radical homosexual crowd?

Why he insists on homosexuals in the military? Or why he wants AIDS infected immigrants to come to America?

Part of the answer is "Queen Hillary."

Her radical agenda includes special privileges for homosexuals, feminists, abortionists and other left-wing kooks.

It also includes... sky-high taxes... oppressive government regulations... a massive redistribution of wealth... an expansion of the welfare state... racial quotas... federally funded pornography... the complete dismantling of the military and the CIA...

... and total control over your life and your income.

That's why she told Bill Clinton to give her the one job in the one area in which she can cause the most damage -- health care.

Nothing frightens me more than Hillary deciding for me and for you what kind of health care we should have. Because any plan Hillary comes up with will almost certainly include:

- \* rationed health care;
- \* new taxes on Social Security, income and health care benefits;
- \* long waiting periods and delays



- in treatment;
- \* fewer doctors, less drug research,  
and poorer health care quality.

This is the future if Hillary is allowed to decide our nation's health care system -- guaranteed.

Guaranteed because Hillary is a pro-socialist, pro-Marxist leftist who will lead our nation down the same path as the Soviet Union, Eastern Europe and other nations who have bankrupted themselves by trying to provide "free" government run health care.

The bottom line my friend is that nothing is "free." One way or another, you and I will always pay for health care.

But with Hillary in charge, the health care we get will be far worse than what we get now.

That's why you and I have to stop her.

And why, I hope I can count on you to join "HILLARY WATCH," a special project of the American Conservative Union (ACU).

My name is David A. Keene. I am Chairman of both HILLARY WATCH and the ACU. The ACU was founded in 1964 by aides to Barry Goldwater's Presidential campaign.

Considered by many to be the most respected and effective grassroots organization in America, the ACU is the one group that truly frightens the liberals.

And for good reason.

From standing up for the "Silent Majority" in the 1960s... to limiting the damage caused by Jimmy Carter in the 1970s.. to helping Ronald Reagan build his conservative "revolution" in the 1980s...

... the ACU has helped make history.

And with your support today, we intend to continue to make history in opposing the socialist agenda of Bill and Hillary Clinton.

We believe in lower taxes... less government... a strong defense... the traditional family values that made America great.

In short, the ACU stands for everything Bill and Hillary detest... God, family, and patriotism.

That's why one of our top priorities is using HILLARY WATCH to limit the power of Hillary "Rodham" Clinton. In many ways, she is far more dangerous than her husband because she fanatically believes her leftist philosophy. And about all that stands in her way right now are you, me, and the taxpayers of America. That's why, in addition to your HILLARY BALLOT...

... I also hope I can count on you to rush the ACU a most



generous donation of \$15, \$20, \$25, \$50, \$100 or more today.

Please, your gift is just as important as your HILLARY BALLOT.

You see, in taking on Hillary Clinton we are taking on the darling of the media, Hollywood, and the entire establishment Left.

To counter this force, we need to:

- \* distribute a minimum of 3 million HILLARY BALLOTS nationwide as soon as possible;
- \* recruit an army of 100,000 Americans willing to flood the White House, the Congress and the radio talk shows in a sea of petitions, phone calls and letters demanding Bill Clinton rein in his radical wife;
- \* create and publish a HILLARY WATCH newsletter which will track and expose every move made by our new "First Person";
- \* form an alliance of Congressional leaders who will help us fight Hillary's socialist health care proposals in the House and Senate.

My friend, this is indeed a massive endeavor. And it will take your support, both political and financial to make it work.

But with your help, it can and will work. As long as we begin today, before it's too late.

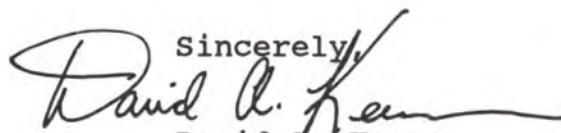
The ACU needs your completed HILLARY BALLOT today so we can launch a counter strike against her biased allies in the media.

And we need your gift of \$15, \$20, \$25, \$50, or \$100 to fund this counter strike.

So please, complete your HILLARY BALLOT and then rush it back to me today along with your most urgent, most generous donation.

Thank you.

Sincerely,

  
David A. Keene  
Chairman

P.S. In an arrogant and symbolic slap in the face to all Americans, Hillary Clinton changed her name to Hillary "Rodham" Clinton after the election. This use of her maiden name is Hillary's way of saying, "I fooled you in November. Too bad. I'm in power now and there is nothing you can do stop me!"

Please, help me and the ACU prove Hillary "Rodham" Clinton wrong -- today.



# AMERICAN HEALTH LINE

## THE DAILY BRIEFING ON HEALTH CARE REFORM

--- Friday --- July 9, 1993 --- Vol. 2 --- No. 71 ---

### NOT THIS TIME

Standing firmly behind Surgeon General-designate Joycelyn Elders, the WH is preparing a strategy to deflect conservative attacks. (see story #1)

### THE NUMBERS GAME

An OTA report finds estimates on how much reform will cost/save vary a great deal -- from billions in spending to billions in savings. (#2)

### SEEKING SUPPORT

Single-payer supporters issue a report criticizing HMO cost-savings and quality of care. A separate study finds HMOs may undermine the family doc/specialist relationship. (#3)

### WHAT'S A STATE TO DO?

CT Health Care Access Commission report says the state should set up a health care authority to oversee expected changes coming from federal reform. (#6)

### TUNE IN OR CALL IN

C-SPAN airs a live viewer call-in at 6:30 p.m. featuring HHS' Judith Feder and ASIM's Dr. Alan Nelson.

### SPOTLIGHT

#### SMOKE-ENDERS?

It's "gross," "nasty," "dirty," and "should be banned." It's about cigarette smoking: 85% of AZ teens questioned offered anti-smoking comments (#13). A more scientific OH survey found support for smoking in public has dropped by 25% since '86. (#12)

IS IT ENOUGH?: While anti-smoking efforts are changing public attitudes and behavior and state legislation is increasing the cost of smoking, a new CDC study has found blacks have more trouble quitting than whites or Latinos. While the reasons are unclear, the CDC and Nat'l Medical Assn. are launching a \$200K anti-smoking campaign (#11).

RACE OR POLITICS?: In IL black lawmakers are joining tobacco lobbyists to oppose a \$.14 cig tax hike. See #7 to find out why.

### QUOTE OF THE DAY

"We're going to the mat on this one."

-- HHS spokesperson Avis LaVelle on the WH/HHS efforts to support Joycelyn Elders' nomination as surgeon general. (#1)



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## ===== FACT OF THE DAY =====

State taxes per pack of cigarettes in the U.S. are the highest in DC at 65 cents and the lowest in neighboring VA at 2.5 cents.

-- Tobacco Institute report (#14)



===== POLITICS & POLICY =====

**\*1 WORD FROM WASHINGTON: SHALALA GIVES VIEWS ON CONGRESS**

**ELDERS:** ARKANSAS DEMOCRAT-GAZETTE reports the Clinton admin., "which has been stung by attacks that tarnished or derailed other controversial nominees, appears determined to stand by" the appointment of Joycelyn Elders to be surgeon general. Following the 7/7 press conference held by her opponents (see AHL, 7/8), representatives of over 100 groups supporting her nomination "gathered with [WH and HHS] officials to plan their strategy." HHS spokesperson Avis LaVelle said the WH "plans to take the unusual step today of issuing an information packet" which includes responses to "specific criticisms" of Elders. LaVelle: "We're going to the mat on this one." The packet will be distributed to the media, lawmakers and interested groups nationwide. Sen. Labor and Human Resources Cmte. hearings are set for 7/16, where the nomination is expected to be approved. Elders has the support of Cmte. Chair Ted Kennedy (D-MA). Elders' opponents "hope to carry their fight to the Senate floor, where she could encounter more opposition" (Jane Fullerton, 7/9).

**SHALALA:** In an interview with the Balto. SUN's editorial board, HHS Sec. Donna Shalala discussed the relationship between Congress and the admin.: "It's not so much that there's tension in that relationship. It's a very different Congress than it was a generation ago. It has a very sophisticated staff and on the issues that the president wants to move ahead on, it's quite literate. There are members of Congress that are among the nation's leading experts on health care. They know a lot. They've spent 12 years learning health care. They know a lot about health care and how it will play in their neighborhood. And so it is a stronger Congress with a very strong staff with very strong views on a range of issues" (7/9). At a groundbreaking ceremony for the new HCFA buildings, Shalala "promised ... to try to make major improvements" in the Social Security Admin. "that would benefit the public and workers" saying there was "no rhyme or reason" for the personnel cuts during the Reagan and Bush admins. She also "noted that the administration has made a short-term budget request to improve automation and deal with a backlog of disability claims" (John Fairhall, 7/9).

**MCDERMOTT:** Under the header "Whoops!" Rep. Jim McDermott's (D-WA) latest issue of AMERICAN HEALTH SECURITY NEWS reports AARP is asking audiences to fill out feed-back forms after hearing AARP speakers outline their "Health Care America" reform plan. But instead of endorsements, "a large majority of those responding" have preferred a single-payer reform plan. The newsletter also notes a study in Urban Institute's POLICY BITES and a book published by Economic and Social Research Institute have found that a single-payer plan would be more cost-effective than an employer mandate or managed competition plan. Also, McDermott will hold the first in a series of seminars 7/14 on health reform and his bill, H.R. 1200, for members of Congress and health LAs (McDermott release, 7/7).

**GEBBIE:** DALLAS MORNING NEWS editorial: "[AIDS Coordinator



Kristine] Gebbie brings excellent credentials to the post. ... Her background suggests that the administration is intent on treating AIDS as a public health matter, as it should be, and not as a political issue, as it sometimes has been. But, ultimately, her success will be decided by whether President Clinton gives this job of 'czar' the authority it requires" (7/5). L.A. TIMES: "The Clinton administration ... has increased the national AIDS funding by 28% in 1994 and last week named a top epidemiologist, Kristine Gebbie, to be the government's AIDS coordinator. While that's encouraging it doesn't substitute for a collective willingness for a top-to-bottom effort to confront the disease. It would indeed be a shame if the wisdom gained by four years of solid, thoughtful and compelling work by the [AIDS] commission is ignored" (7/6).

STARK: Rep. Pete Stark (D-CA) announced his Ways and Means health subcmte. will hold a hearing 7/13 on implementing a national health care budget (Stark release, 7/2).

SENATE AGING CMTE.: Sens. David Pryor (D-AR) and Bill Cohen (R-ME) announced the Sen. Special Cmte. on Aging will sponsor a forum 7/15 on "mental health and the elderly." Remarks will be made by Pryor, Cohen, Tipper Gore, Cmte. Staff Dir. Theresa Forster and NIMH's Barry Liebowitz (cmte. release, 7/9).

#### ===== ELEMENTS OF REFORM =====

\*2 **COST OF REFORM: OTA REPORTS ESTIMATES RANGE FAR AND WIDE**  
BLOOMBERG BUSINESS NEWS/INVESTOR'S BUSINESS DAILY reports an OTA report "warns policymakers to be 'wary of giving too much credence' to any one analysis or estimate of cost or savings for various health reform plans" (7/9). OTA found that managed competition estimates for a one-year span range from \$47.9B in increased spending for '93 to \$21.8B in savings for '94. Single-payer estimates for one year cover an even wider range, from \$21B in increased yearly spending to \$241B in savings for '91 (OTA report, 6/24). BLOOMBERG/IBD: "Estimates vary because economists are defining the health plans differently and aren't using the same economic models, the report said. One analysis may assume the government will impose price controls, while another doesn't. Economists may also part over what segments of the economy they include in their assessments." Sen. Ted Stevens (R-AK) who requested the report: "We are comparing apples to oranges to peaches." OTA said an analysis that predicts a plan will produce savings makes at least one of these assumptions: the gov't will impose price controls or spending limits; universal coverage won't be guaranteed or fewer benefits will be offered; or reforms will reduce administrative and other costs. BLOOMBERG/IBD notes that Hillary Rodham Clinton said in 5/93 that the WH health care task force would be reconciling cost and savings estimates from five fed. agencies (7/9).

\*3 **MANAGED CARE: COSTS MORE AND DIVISIVE FOR DOCS?**  
COST-SAVING?: A 7/8 report released by the Physicians for a Nat'l Health Program (PNHP) "challenged" the Clinton's admin.'s "assumption that greater use of [HMOs] will cut medical costs



while maintaining quality care," the WASH. POST reports. The report by two Harvard physicians "argu[es] that research on HMOs during the last decade is insufficient to conclude that HMOs and similar plans cut costs," and claims research "suggests that HMOs 'can undermine the quality of care that some patients receive.'" PNHP has 4,500 members who support a single-payer system. Report coauthor Steffie Woolhandler: "We've seen the rise of HMOs in the last 15 years and we've had no slowdown in the rise of health care costs." The report maintains that between '82 and '91, HMO premiums "increased at a rate virtually identical" to the rate of traditional plans while having a greater percentage of "administrative costs, overhead and profits than traditional plans." The report also cites a Rand Corp. study done in the 1970s that "suggests that the quality of care is lower in HMOs." GHAA's Susan Pisano "said the PNHP is wrong -- that in the last five years, HMO premium increases have slowed more than premiums for traditional coverage, and other research shows that quality at HMOs is as high as that of traditional plans" (Kathleen Day, 7/9).

DISHARMONY: "Relationships between family doctors and specialists suffer under some managed care plans, a study suggests," the W.S. JOURNAL reports. A survey of 39 doctors who work with both HMO and traditional fee-for-service patients "found that physicians were less likely to discuss patient care with specialists in HMOs or to get written reports back on care provided." They also "said they were more likely to refer an HMO patient to a specialist they didn't know." "Most" doctors who took part in the survey "belong to several HMOs and have only minor stakes in any one plan." HRSA's Fitzhugh Mullan said the report "paints a disturbing picture of that aspect of managed care." However, JOURNAL explains, "The survey was small and may reflect disruptions to be expected in physician referrals soon after managed care organizations set up doctor networks" (Ron Winslow, 7/9).

#### \*4 CITY BUDGETS: HEALTH COSTS A NIGHTMARE

A Nat'l League of Cities survey "found a majority of cities ranked health care costs as the biggest factor adversely affecting their budgets," the W.S. JOURNAL reports. The survey showed most cities and towns are experiencing financial difficulties with 63.3% of "responding jurisdictions saying they are less able to meet their financial needs this year than they were last year." Seventy-two percent expect similar troubles in '94; more than 70% raised taxes or fees in the last year. The survey also found 38% of U.S. cities "froze" municipal hiring in '93 and 40.4% cut municipal jobs. NLC Pres. and Minneapolis Mayor Donald Fraser: "Local economies are still struggling and the sputtering weakness of our national economic indicators is the sum total of these local conditions. A national economic recovery will depend on actions that will serve to strengthen our local economies" (7/9).



===== STATELINES =====

**\*5 CONNECTICUT: COMMISSION ISSUES REPORTS; GOV. SIGNS BILLS**

The final report of the state's Health Care Access Commission called on Gov. Lowell Weicker (I) to create a state health care authority "to oversee the delivery of health care under the sweeping changes expected to be enacted during the Clinton administration." State Rep. Joseph Courtney (D), chair of the commission, "said it has become clear that under the Clinton reforms, the states 'are going to have a very large role to play' in devising rules that ensure all of their citizens get health coverage under the system called managed competition." The authority would be "modeled on similar agencies recently created in Florida, Washington, California and Minnesota." HARTFORD COURANT reports the commission "credits Weicker with playing a central role in" limiting budget increases for hospitals this year but "also suggested that Weicker has not given health care reform the prominence it has been given by" other governors. The commission report "implores the governor to exert the full weight of his office behind a reform effort in Connecticut." Commission members "acknowledged" they were unable to agree on the kind of reform the state should implement. Last year, the commission had been considering a single-payer or a play-or-pay plan. Courtney: "Managed competition developed so quickly as a consensus, it kind of mooted the proposals we were working on up to that point" (Frank Spencer-Molloy, 7/1).

LEGISLATIVE WRAP-UP: COURANT reports that as the General Assembly finished its '93 regular session, Weicker signed a number of health-related bills, including a bill that expands the Medicaid program to families whose incomes exceeded current eligibility limits. The new law "raises the annual income limit for a family of three from \$15,816 to \$22,000." He also signed a bill that "requires state assistance for handicapped children, which now starts at age 3, to begin at birth." Weicker: "This is landmark legislation for Connecticut that puts the power of education and health care access behind those people in our state who most desperately need them: our children with disabilities" (Mark Pazniokas, 7/3). A provision in another bill signed by the governor would increase the copayment from \$10 to \$12 on prescription drugs subsidized through the state's Connpace program. The move would save the state about \$2M (Larry Williams, COURANT, 7/1). In addition, Weicker signed into law a bill limiting construction of new nursing homes "in an effort to control costs for the state, which spends \$780[M] annually on nursing home care for 20,000 patients" (Pazniokas, 7/1). But he vetoed a bill "that would have made Medigap insurance more affordable to some senior citizens" by preventing insurers from basing rates on "age, sex or medical condition." Weicker said the bill would end up driving up insurance premiums for everyone. Groups backing the bill, including AARP, "said they will ask legislators to override Weicker's veto when the Assembly convenes July 12 in special session" (Michelle Jacklin, COURANT, 7/3). Weicker also signed a bill repealing the state's no-fault automobile insurance law, but focused on the bill's shortcomings.



Weicker: "While this may help to facilitate managed care, this legislation places an unfair burden on those citizens without health insurance or protection against wage loss which is currently provided under the basic reparations coverage of our no-fault law this legislation repeals" (Pazniokas/Williams, 7/2). Laws taking effect 7/1 included a prohibition against physicians or members of their family owning pharmacies and a \$.02/pack increase in the cigarette tax (Williams, 7/1).

**\*6 ILLINOIS: LOBBYISTS AND MINORITY LAWMAKERS BLOCK CIG TAX**

Under the header "Lobbyists Burn Tobacco Tax," CHICAGO SUN-TIMES reports tobacco industry lobbying efforts have stalled a cigarette tax hike proposal that would have replaced a \$6.30/day tax on nursing home beds (see AHL, 7/2). SUN-TIMES: "The tobacco lobby's success has been a combination of well-connected operatives and a powerful economic message." They say cross-border sales would decrease and the poor would be hit hard if the tax was passed as part of the state budget. House Spkr. Michael Madigan (D) said the regressive tax argument has been effective in turning minority Dems against the tax: "Several of the black legislators have articulated the view that smoking is a poor person's pleasure. ... Poor people don't have enough money to go to a health club and they may take a cigarette from time to time" (Charles Wheeler III/Ray Long, 7/7). Other lawmakers have said "privately" they will not back a tobacco tax if minority lawmakers do not. Gov. Jim Edgar (R) said 7/6 "he believes minority lawmakers are opposing a proposed increase in cigarette taxes in hopes of getting more money for welfare programs," the CHICAGO TRIBUNE reports. Edgar: "My sense is their concern has more to do with maybe the size of the public aid budget more than it does how we'll raise the money for the Medicaid assessment. ... It's hard to fathom that African-American Democrats from [Chicago] are opposed to the Medicaid assessment program. That boggles my mind if you think of who should be especially for it." State Sen. Dem leader Emil Jones said Edgar was wrong to think an increase in welfare spending would cause minority lawmakers to support the cigarette tax (Rick Pearson, 7/7).

PRO-TAX: SUN-TIMES editorial: "The hostages are poor people currently receiving care in a hospital or nursing home. ... The problem? Legislators refused to pass a 14-cent-a-pack cigarette tax to fund Medicaid. Why would the Legislature choose smoking over health? Because that's where the lobbying dollars were spent as the budget target neared. ... While they're at it, maybe the hospitals' lobbyists can remind legislators that their responsibility is not to protect the tobacco industry -- it's to provide health care to the poor" (7/7). TRIBUNE editorial: "Aside from being a funding source, cigarette taxes provide significant social benefits. They place economic pressure on smokers to quit, which is good for the smoker, good for those around them, and good for health care cost containment, since smokers develop more long-term health problems than non-smokers do" (7/3).

ANTI-TAX: SUN-TIMES editorial page editor Mark Hornung: "Contrary to popular perception, grannies across the state did



not shoulder the burden" of the tax on nursing homes. A few thousand affluent senior citizens paid extra to the benefit of grannies who were really struggling. ... The 60 percent of Illinois' senior citizens who were actually struggling on Medicaid benefitted from the tax. Hornung: "The tobacco lobby and retailer groups opposed to the tax simply outworked the political leadership. More to the point. These affluent and powerful lobbies had a compelling point when they argued that the granny tax was better public policy than the proposed cigarette tax" (SUN-TIMES, 7/7).

**\*7 TEXAS: HEAR YE! HEAR YE! GET YOUR FREE IMMUNIZATIONS!**

AUSTIN AMERICAN-STATESMAN reports TX children will receive free immunizations starting this month as part of a campaign launched 7/6 by Gov. Ann Richards (D) and state Health Commissioner David Smith. The program will be funded with the additional \$17M allocated for immunizations by the TX Legislature (see AHL, 4/22). Richards: "Immunizations for preventable childhood diseases -- like measles and mumps and whooping cough -- saves children's lives. It saves needless suffering. It saves the taxpayers a lot of money." Currently, TX children must be immunized before they attend school, but health officials "say it is important for children to receive immunizations by the time they are two." Currently, only 30% of TX children are immunized by the time they are two. Smith said health officials hope to increase the rate to 90% by '98 (David Elliot, 7/7).

ALSO: TX Insurance Commis. Georgia Flint ordered FL-based Life General Security Insurance Co. to cease writing new policies in Texas until it pays unpaid claims and corrects financial "problems," the HOUSTON CHRONICLE reports. About 5,000 Texans, most of whom work for small businesses, are covered by the co.'s policies. In response, Life General obtained a temporary restraining order from a state district court in Austin "that bars the commissioner's order from taking effect, [an Insurance Dept. spokesperson said]". Such orders normally last many weeks until a hearing is held. An Insurance Dept. report said the co. "has a history of high complaint volume with unsatisfactory settlement, denial of claims and delays in claims handling." Independent insurance agent Ron Bibble, who filed a complaint, "said that in 25 years of business, he had never seen a health insurance company take so long to pay a claim." Patricia Nelson, president of Health Access TX, a small-business group: "Large insurance companies are not interested in you, if you're a small business" (Debra Beachy, 7/8).

**\*8 VERMONT: ITS SINGLE-PAYER PLAN NOT TRUE TO THE CONCEPT?**

A health policy expert criticized the VT Health Care Authority's single-payer proposal as one that will "short change Vermonters because it retains an unnecessary and wasteful role for insurance companies," RUTLAND DAILY HERALD reports. David Himmelstein, a Harvard Univ. physician and founder of Physicians for a National Health Program, was joined by Rep. Bernard Sanders (VT-I) and state Sen. Cheryl P. Rivers (D) -- both single-payer advocates -- in a meeting 7/6 and charged the authority with



"failing to meet its directive from the Legislature to develop a single-payer model."

**ADMIN. COSTS THE ISSUE:** Sanders "[said] not only does the draft model appear to include a role for private insurers ... but the authority has not figured administrative savings to be had by essentially banning all but one insurance company, leaving only the single payer." Himmelstein: "The approach is essentially public financing of insurance companies." Himmelstein also cited the following statistics: BC/BS of MA had 6,682 employees for administering health insurance for 2.5 million people, more than all of Canada has with a population of 27 million; in the past 20 years, 40% of new jobs in the health care field have been administrative and clerical positions; and administrative costs are 24% in the U.S. compared to 10% in Canada. VT Health Care Authority Exec. Dir. Rachel Block "said the authority had made no decisions about a role, if any, for insurance companies under the single-payer model." "We've not specifically included or excluded insurers one way or the other in terms of their role in relation to integrated delivery systems," she said (Bryan Pfeiffer, 7/7).

#### ===== ACCESS/QUALITY/COST =====

##### \*9 **CONTACT LENSES: WHO SHOULD BE ALLOWED TO SELL THEM?**

**BUSINESS WEEK** reports on the "fray involving contact-lens manufacturers, eye-care professionals and, ultimately, the estimated 25 million wearers of contact lenses in the U.S. At issue: Can lens makers and doctors legally restrict how their eye-care products are sold?" The FL Atty. General is conducting a "wide-ranging investigation" into lens manufacturers' refusal to sell to mail-order cos. and discounters that don't have on-site eye-care professionals and optometrists' refusal to release prescriptions so that patients can order lenses by mail. Eye-care professionals say they are worried by mail-order lenses because of the problems of incorrectly-filled prescriptions and lack of follow-up care. But mail order cos. say they are being shut out of the market by economic concerns, not by concern for patients (G. DeGeorge/J. Weber/M. Maremont/R. Shoretz, 7/12 issue).

#### ===== FOCUS =====

##### \*10 **SMOKING: CDC FINDS IT'S HARDER FOR BLACKS TO QUIT**

"Saying that evidence shows black Americans have a much tougher time giving up cigarettes permanently than whites and Latinos, federal health officials announced a new anti-smoking campaign [7/8] designed to help them kick the habit for good," L.A. TIMES reports. CDC and the Nat'l Medical Assn. -- an organization of black physicians -- are launching the \$200,000 advertising campaign.

**STATISTICS:** An estimated 46 million Americans smoke and 400,000 die each year from smoking-related illnesses, including over 45,000 blacks last year. CDC's Robert Robinson: "Smoking represents a serious health risk for all smokers, but the 6



million African Americans who currently smoke face higher rates of lung cancer, other cancers, heart disease and stroke when compared to whites." A new CDC study found that while 49% of black smokers could stop for a day compared with 40% of white smokers, only 8% of blacks could quit smoking for a month, compared with 14% of whites and 16% of Latinos.

**ANALYSIS:** Robinson said that experts don't know why blacks have more difficulty quitting smoking, but that "black smokers appear to be more dependent on nicotine than whites." Robinson said other possible reasons are: blacks smoke cigarettes with higher tar and nicotine contents, such as menthol cigarettes; they lack access to "culturally sensitive materials about smoking cessation;" the tobacco industry gears advertising towards them; and discount cigarettes make continued smoking more affordable (Marlene Cmons, 7/9).

**FIGHTING BACK:** REUTERS/WASH. POST reports the CDC and the Nat'l Medical Assn. plan to use radio, television, billboards and public transit to spread the word about health risks for blacks who smoke. The TV and radio spots contrast the deaths of black civil rights leaders "who died for their beliefs" with the needless deaths of blacks who smoke (7/9). **TIMES:** "The tobacco industry reacted angrily to [the] announcement." Tobacco Institute's Thomas Lauria criticized the ad campaign as a "paternalistic approach" which "implies (blacks) need special health information that others don't." The tobacco industry spends \$4B annually on advertising (Cmons, 7/9).

#### ===== SURVEYS & POLLS =====

##### \*11 POLL I: SUPPORT FOR PUBLIC SMOKING CONTINUES TO DECLINE

The Institute for Policy Research at the Univ. of Cincinnati interviewed 816 OH residents 5/3-14 for the CINCINNATI POST and the Univ. of Cincinnati. Margin of error +/-3.4% (Univ. of Cincinnati release, 7/5).

|                                          | <u>2/86</u><br>(N=796) | <u>2/87</u><br>(N=813) | <u>10/91</u><br>(N=630) | <u>5/93</u><br>(N=790) |
|------------------------------------------|------------------------|------------------------|-------------------------|------------------------|
| Restrict Smoking to<br>Designated Areas  | 77.5%                  | 78.1%                  | 83.8%                   | 85%                    |
| Smokers Have Right to<br>Smoke in Public | 22.5                   | 21.9                   | 16.2                    | 15                     |

##### \*12 POLL II: MOST TEENS VIEW SMOKING NEGATIVELY

The Behavior Research Center interviewed 250 people ages 13-17 at teen "hangouts" throughout Phoenix, AZ's Maricopa County during 6/93 (Behavior Research Center release, 7/1).

|              | ANTI SMOKING<br>COMMENTS | PRO SMOKING<br>COMMENTS | NEUTRAL |
|--------------|--------------------------|-------------------------|---------|
| Total        | 85%                      | 8%                      | 7%      |
| Male         | 89                       | 7                       | 4       |
| Female       | 81                       | 9                       | 10      |
| Age 13 to 14 | 89                       | 2                       | 9       |
| 15 to 17     | 82                       | 12                      | 6       |



|              |    |    |   |
|--------------|----|----|---|
| Minority     | 88 | 4  | 8 |
| Non-minority | 84 | 10 | 6 |

## MAJOR COMMENT CATEGORIES

|                                  |     |
|----------------------------------|-----|
| Should be banned                 | 28½ |
| Bad for you                      | 22  |
| Leading cause heart/lung disease | 23  |
| Gross, nasty, dirty              | 14  |
| Not for me                       | 4   |
| Makes people smell bad           | 5   |
| Dying/death                      | 4   |
| Harmful to health                | 4   |
| Bad breath/rotten teeth          | 2   |
| I enjoy smoking                  | 6   |
| Relieves tension                 | 1   |

**\*13 CIGARETTE TAXES: HOW HIGH CAN THEY GO TO FINANCE REFORM?**

Following is a list of state cigarette taxes calculated as cents/20-pack of cigarettes (Tobacco Institute release, 7/8).

|          |         |         |         |         |         |       |
|----------|---------|---------|---------|---------|---------|-------|
| VA 2.5   | KY 3    | NC 5    | SC 7    | WY 12   | GA 12   | MO 13 |
| TN 13    | IN 15.5 | AL 16.5 | WV 17   | MS 18   | AZ 18   | ID 18 |
| MT 19.26 | LA 20   | VT 20   | CO 20   | NM 21   | SD 23   | OK 23 |
| KS 24    | DE 24   | OH 24   | MI 25   | NH 25   | UT 26.5 | OR 28 |
| AK 29    | IL 30   | PA 31   | AR 31.5 | FL 33.9 | NE 34   | NV 35 |
| CA 35    | IA 36   | MD 36   | RI 37   | ME 37   | WI 38   | NJ 40 |
| TX 41    | ND 44   | CT 47   | MN 48   | MA 51   | WA 54   | NY 56 |
| HI 60    | DC 65   |         |         |         |         |       |

AR increased from 22 cents to 34.5 cents 2/1/93; cut to 31.5 cents effective 7/1/93

CT increased from \$.45 effective 7/1/93; will increase to \$.50 7/1/94

DC increased from \$.50 effective 7/1/93

HI 40% of wholesale price was replaced with \$.60 7/1/93; if Congress passes local purchasing requirement for military, will increase to \$.70.

MO increased from \$.13 effective 10/1/93

NE increased from \$.27 effective 7/1/93

NM increased from \$.15 effective 7/1/93

NY increased from \$.39 effective 6/1/93

ND increased from \$.29 effective 7/1/93

WA increased from \$.34 effective 7/1/93; will increase to 56.5 cents 7/94; will increase to \$.74 7/95 and \$.75 cents 7/1/96



# Clinton Health-Plan Interim Controls On Insurers Draw Fire From Industry

By GREG STEINMETZ

Staff Reporter of THE WALL STREET JOURNAL

Interim controls on the insurance industry under the Clinton administration health plan could hasten the exodus of small insurers from the health-insurance business but big insurers would feel little impact, according to industry officials.

Nevertheless, the officials charge the rules cast the entire industry as the

## Small-Business Uncertainty

Unanswered questions about the Clinton health plan's proposed subsidies for small businesses are making it harder to determine which businesses can get the break, and how much the program will cost. Enterprise, page B2.

"bogeyman" in the health-care debate by accusing them of abuses they argue have largely been eliminated by state legislation.

The Clinton plan calls for rules "to reduce the potential for disruption in the health-insurance industry during the transition" to the Clinton system.

## Ban on Dropping Customers

Among the proposed rules are requirements that insurers not drop sick customers during the transition and that they stop isolating specific individuals and groups for hefty rate increases. The draft of the Clinton plan also calls for the creation of a pool, subsidized by the insurance industry, to cover people whom insurance companies turn down.

The prospect of interim controls isn't new. Clinton administration officials disclosed last spring that such a step was likely because they feared some insurers would try to dump people from their rolls before a new health system was up and running. Indeed, the short-term insurance industry regulations are discussed in a 239-page draft of the Clinton health proposal that has been floating around Washington for weeks.

But the issue has gotten renewed attention in recent days after senior White House adviser Ira Magaziner spoke to reporters about it.

Insurance officials say the administration appears to be promoting the transition rules because they provide a platform to blast the industry. That, in turn, would make it easier to pass health-reform measures the industry finds objectionable, they say.

"I think it's peculiar that they bring this out as an issue," said Chip Kahn, executive vice president of the Health Insurance Association of America. "I think there's an organized campaign to make it look like insurers are against reform."

## Rules Against Abuses

By prohibiting insurers from selectively jacking up rates and dropping sick people, the proposed rules make it seem as if such practices are widespread. Mr Kahn said. But, he said, most states have already passed rules against those abuses. Besides, most people are covered by self-insured plans and government plans, such

as Medicare, where such abuses have never been a problem, industry officials argue.

Nevertheless, some small insurers do rely on their ability to raise rates and drop customers. By forcing insurers to keep every customer without being able to charge that customer more for coverage, the administration is saying to insurers "stay in the business and get burned," said Thomas Pyle, an executive with Metropolitan Life Insurance Co.

The Clinton health plan already puts the squeeze on small insurers by encouraging health maintenance organizations over traditional fee-for-service medicine. Small insurers don't have the money to set up HMOs, potentially driving many of them out of the health-insurance business. The transition rules would only hasten their departure, industry officials say.

Consumer advocates, however, say the transition rules are a must, in part because the state reforms are riddled with loopholes. "The protections are needed as an interim step," said Gail Shearer of Consumers Union. "The president is trying to curb some of the most insidious abuses." They also say the creation of a pool to pick up people not covered by insurers is essential, and goes well beyond anything the states have.



## HEALTH

# Developing the Sales Pitch For the Overhaul Plan

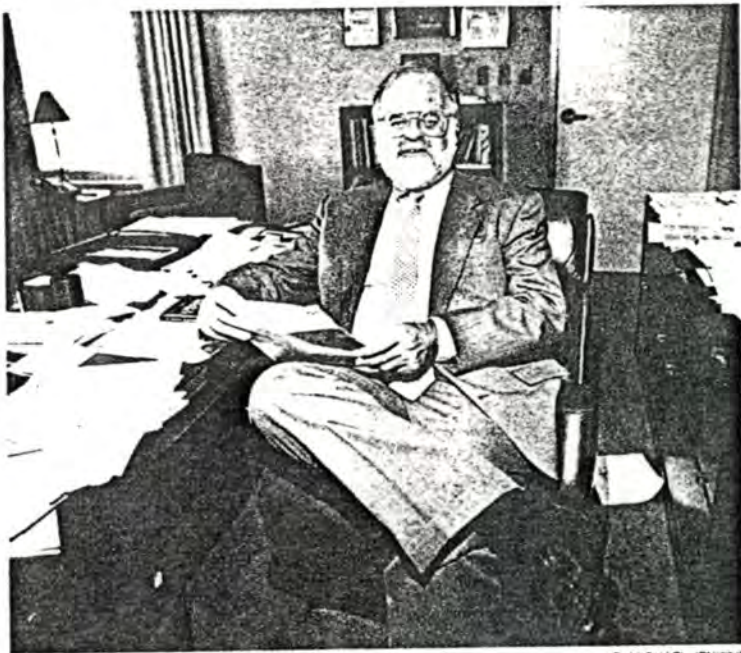
*Analysts say Clinton needs to devise a message, win over the public, seal the deal with Congress*

Remember Bill and Al's magical bus tour — the ultimate political road trip carried Bill Clinton and Al Gore all the way across America and into the White House?

Gracing for what is likely to be Clinton's second biggest campaign, the White House image makers are considering bringing the bus back in force. If it helped Clinton himself, maybe it could help the president sell a health-care system to 150 million Americans and 100 members of Congress. The administration's overhaul proposal is far from complete, and advocates say that what matters most are the critical decisions on how to provide care for every American without spending much more money. But the best ideas need to be marketed, and White House strategists are developing a public relations campaign even as the policy debate continues.

Without such a strategy, the administration risks alienating Congress by relinquishing the agenda-setting role to the opposition. Some argue that the marketing need not wait for the prod-

"To the degree the White House remains silent and doesn't speak to the American people in a direct way, it leaves the field to others," said Bruce Vladeck, a health-care expert who advised President Clinton during the transition and now works for The Kler Group, a lobbying organization.



R. MICHAEL JENKINS

John Rother, legislative director for the American Association of Retired Persons, will head the Health Reform Project, a nonprofit coalition of pro-reform groups.

Already, groups as diverse as the American Medical Association (AMA) and the Beer Institute have unleashed money, postcards and people to mold public opinion against certain likely components of the Clinton plan. And in Congress, Republicans and some Democrats are drafting their own alternative proposals. (Story, p. 1808)

At the same time, Democrats, who sat on the sidelines 12 years while Republicans Ronald Reagan and George Bush held the White House, know they are expected to break the gridlock between Congress and the president. Party leaders are spreading the message that they will closely monitor loyalty to the president on the subject of health care.

Rep. Vic Fazio, Calif., chairman of the Democratic Congressional Campaign Committee and Democratic

Caucus vice chairman, "is making it clear health care is an issue the party has to deliver on," said Rep. Ron Wyden, D-Ore.

Meanwhile, the administration's marketing strategy remains a work in progress, aiming to combine the best components of the 1992 campaign with the unique advantages of the presidential bully pulpit. To make sure Clinton wages the health-care campaign on his own battlefield, the president and his strategists want to stir up public interest in an issue that affects virtually everyone. They want Clinton to do much of the selling himself with simple, credible messages stressing that the problem will only get worse if left unattended.

## Lining Up the Ducks

So far, it has been first lady Hillary Rodham Clinton who has used the pulpit to preach the need for an overhaul of America's health-

care system. After overseeing her husband's Task Force on National Health Care Reform, she is now testing certain themes — "security," "choice" and "quality," for example — with members of Congress and special interest groups. The labels battle will be critical. The administration hopes to win support by depicting its plan in comforting, affordable terms, while opponents try to characterize it as expensive, experimental and per-



By Ceci Connolly



# Chiles Throws Down the Glove

If President Clinton is to enact a new national health-care system, he will need more than solid policy ideas. He will need a good sales pitch — and perhaps a pair of surgical gloves and a bottle of aspirin.

In Florida, Democratic Gov. Lawton Chiles sold his health-care overhaul to a jittery public and a divided state Legislature with a complex public relations strategy that included everything from backroom negotiations to staged public events, from sophisticated technology to simple, eye-catching props.

It will be a long time before anyone can measure the success of Florida's "Healthy Homes" plan, which creates regional consumer alliances to purchase medical care wholesale. But from a public relations standpoint, the six-month campaign was an indisputable triumph.

Since the April victory, in which the Legislature approved the plan 29-10 in the state Senate and 110-3 in the House, Chiles and his advisers have become sometime health-care gurus. They appear on TV talk shows, jet to Washington for White House consultations and field calls from advocates and officials eager to follow their model. The Florida experience also provides a window into the likely divisions of the national debate.

"We basically fought the battle they're going to be fighting," said Lisa Hutcheson, spokeswoman for Florida's Agency for Health Care Administration.

## Horse-Trading — Chiles' Style

Chiles opened the debate with an extreme position — strict government control over health-care delivery — and a two-day summit of 200 key players. The November 1992 meeting brought together providers, insurance companies and consumers. The coalition-building brought Chiles some much needed political capital.

"He got some consensus going," said Gerry Soud, a spokesman for the Florida Medical Association (FMA). "It was a very favorable dialogue, but I'd be remiss if I didn't say we had some major differences on implementation."

Opponents of the overhaul argued that it would not save money but would reduce quality care and eliminate consumers' control.

"Scary thing is, some of these proposals will take away our right to choose the doctor or health-care plan we prefer," said one radio ad by the medical association. "I don't want some outsider deciding who will be taking care of me and my family when we're sick."

Unlike some strategists in Washington, the Chiles operation downplayed the notion of good guys and bad guys in its debate.

"Even though the FMA was out there bashing the plan, he didn't get into that," Hutcheson said. "We figured, in the



As state Rep. John Cosgrove watches, Florida Gov. Chiles uses surgical gloves to illustrate a reform point at a March 3 news conference in Tallahassee.

end, we're going to have to work with these people."

Independent pollster Robert Joffe said the key for Chiles was teaming up with the state's leading business group, Associated Industries of Florida. The governor also knew when to modify his position. "Lawton Chiles is a horse-trader," said John French, a lobbyist and attorney who represents the Florida League of Hospitals. "He knew to ask for twice what he was going to get."

So as the legislative session wore on, Chiles backed off his early attempts to establish government-run agencies to purchase medical care. The agencies

now will review proposals, but individuals and companies still will choose their own coverage plan. "It was a face-saving compromise by both sides," French said.

The governor's team set up a "war room" in Tallahassee, which became the central meeting place for lawmakers, advocates and the media. Staff members wore beepers, carried cellular phones and beamed the governor all over the state via satellite links. While on the road, Chiles called the war room on a special hotline.

With camera crews in tow, Chiles visited health fairs and emergency rooms. "The story almost wrote itself for reporters," said the governor's spokesman, Ron Sachs. "He would meet real people with no insurance who wanted insurance. They were day laborers, retired teachers. It was basically a mirror of Florida. These dramatic anecdotes were there to help sell the plan."

Chiles kept the pressure on lawmakers too. "He ate breakfast, lunch and dinner" with them, Hutcheson said. "He kept reminding legislators by going into their districts," said Susan A. MacManus, a public administration professor at the University of South Florida in Tampa. "He put them on the spot, because a lot of them were up for re-election, running from new districts; they couldn't afford not to act."

But lawmakers were pressured from the other side too.

"The people advocating change were not the groups and individuals that line campaign coffers," Sachs said. "Organized medicine and the insurance industry have been more kind to campaigns, and they received more than polite listening."

And when things got tough, Chiles simply pulled out a pair of gloves and two aspirin. He would tell the audience the gloves cost \$19 on a hospital bill but were just 16 cents at a wholesale store.

"Anybody who runs a business or manages a family's budget knows that you save money when you buy in volume," Chiles would say. "The same rule should apply when you're shopping for health care." And with that, Chiles would pop the two aspirin in his mouth.

—Ceci Connolly



haps resulting in worse care.

Other messages will be tailored to specific audiences.

"Managed competition," a term that describes the president's plan to provide universal medical coverage in a market-driven environment, is a popular phrase with businesspeople "who see themselves as people who manage and compete," said Brookings Institution scholar Joseph White.

In recent speeches, Hillary Clinton has emphasized the pieces of health reform most appetizing to each audience. To the AMA, she pledged to reduce cumbersome regulations on laboratories; to a group of governors, she promised state flexibility.

Deborah Steelman, a health-care adviser in the Reagan administration, said the Clintons are making a strategic mistake in "saying exactly what each group wants to hear."

The approach, Steelman said, creates unrealistically high expectations and invites advocates to dig in their heels rather than compromise.

Inside the White House, Clinton campaign veterans are re-creating the famous "war room," a staff of eight people who will work together in the same room. The team, headed by White House aide Jeff Eller, will handle what has been dubbed rapid response, deflecting incoming criticism and responding to the likely barrage of media requests. Elsewhere in the White House, staff members will be designated as liaisons to key constituencies such as small businesses or insurance companies.

Like the presidential race, this campaign will unite high-tech and human contact. While fax machines, satellite dishes and computerized E-mail systems spread the "theme of the day" by modern means, the Clintons will return to old-fashioned stumping — perhaps even by bus — to rally support.

The Democratic National Committee (DNC) has been enlisted to galvanize grass-roots support, although it stumbled initially.

Chairman David Wilhelm tried to form a nonprofit, nonpartisan foundation to raise money and lobby for reform. But under criticism that it was not the role of a major political party to create a bipartisan tax-exempt lobbying group, the operation folded before it was fully established.

Now, a reconstituted, partisan Health Care Campaign is a "special project" of the DNC, relying heavily on supporters from the presidential

race. The staff of two dozen includes fundraisers, policy experts, field organizers and publicists.

John White, chairman of the DNC under President Jimmy Carter, said members of Congress will need support at home to vote for an overhaul. "If you can't sell this locally to hospital boards and the medical community, you've got a pretty small chance of passing it in Congress," he said.

But more important, Wilhelm "has to be willing to go and say and do things to the other side that the president, in good taste, can't or won't do," White added. Strategists prefer that the most strident name-calling, leaking and arm-twisting emanate from the DNC offices rather than from the White House.

Former Republican National Committee (RNC) Chairman Frank Fahrenkopf agreed, noting that former RNC Chairman Rich Bond "was very, very aggressive in going after Clinton and the Democrats, a lot more than Bush was."

### Health Reform Project

In the wake of the collapse of the DNC's bipartisan effort, Sen. John D. Rockefeller IV, D-W.Va., invited activists from several groups to his home to form an umbrella coalition of pro-reform organizations. John Rother, legislative director for the American Association of Retired Persons (AARP), will head the group, tentatively named the Health Reform Project.

The nonprofit, nonpartisan coalition, which includes unions, the American Hospital Association, the American Nurses Association and Families USA, hopes to recruit some business groups as well.

"We will promote the cause of health reform," Rother said. But, fearful they may not agree on every facet of Clinton's proposal, the coalition plans to "keep an arm's-length relationship with the administration."

Although it is unlikely that the groups will share mailing lists or lobby jointly, Rother said the coalition will pool other resources, such as information on the plan and advertising. The coalition's potential impact is enormous. Most member groups have money and people at the ready. The AARP has trained 1,500 volunteers to hold community forums on the proposal; 600 AFL-CIO union leaders have been primed for action; and the consumer-oriented Families USA is tapping into its "misery bank" to pre-

pare a film documenting the health-care struggles of several families.

Few groups are prepared to say what they will spend on the health-care debate, but in 1990, when Congress considered much smaller reforms, the AFL-CIO spent \$3 million.

### Selling Congress

When Clinton unveiled his \$16.3 billion economic stimulus package in a joint session of Congress on Feb. 17, Democrats were flush with optimism.



Two days later, Clinton hit the trail as the House quickly moved the bill through key subcommittees. But the president became distracted with other political brush fires, including tensions overseas and his proposal to lift the ban on gays in the military. Having strong-armed the House, Clinton underestimated the power of a Republican filibuster in the Senate. The GOP stole the agenda, successfully characterizing the package as new taxes for new programs. What started on a presidential high note in February was dead by late April. (*Weekly Report*, p. 1001)

Today, some Democrats worry that the health-care overhaul will follow a similar course.

"They've been so engrossed in how to arrive at the plan, now they need to turn to the very important task of devising a strategy to take it to Americans," said Colorado Gov. Roy Romer, the Democratic chairman of the National Governors' Association.

As the White House formulates its proposal, "they better reach out more," Wyden said.

White House advisers said they have learned from the fate of the stimulus package to do a better job consulting Congress. "There are some basic concerns in the House and Senate following the economic plan: 'Can the White House pull it off?'" one adviser said. "Our job is to show we have learned from our mistakes."

But many fear that the administration has faltered on health care by allowing Clinton's task force to operate in secret and by failing to keep attention focused on inadequacies in the current system rather than the potential pitfalls of any future overhaul.

"As bits of information about options ... have leaked out week by



week, the critics of comprehensive reform have been able to make a lot more news than its supporters," Sen. Harris Wofford, D-Pa., said in a recent speech.

Some Democrats are not waiting for the White House.

In the House, Majority Leader Richard A. Gephardt, Mo., has given health-care duties to three lieutenants.

Fazio, stressing party loyalty, will focus on home-district pressures and ultimately decide who will receive party support in the 1994 elections. Caucus Chairman Steny H. Hoyer, Md., is responsible for educating members on what is in the Clinton plan and why reform is needed. And Majority Whip David E. Bonior, Mich., will remain the lead head-counter, gauging how many votes he can muster for various pieces of the plan.

Several key Democrats have begun evaluating where the fault lines might lie in the House, tracking what health-related industries are prominent in which districts and any other factors that might affect members' positions. Names constantly shift from one list to another as information is gathered. The data will form the basis of Bonior's formal head counts.

The Senate, where members are more immune to single-district pressures and work under looser rules than the House, has no similar structure. But several leaders have emerged.

Rockefeller has been the most prominent voice on the issue, making the rounds of TV programs and editorial boards.

Sen. Tom Daschle, D-S.D., has instituted weekly meetings of a core group known as the "message board" to discuss what one Senate staff member called "external message and internal coordination."

Sen. Edward M. Kennedy, D-Mass., who has fought for national health insurance for nearly three decades, is expected to help line up Senate support in a more behind-the-scenes capacity. Considered one of the most proficient legislators in Congress, Kennedy brings to the process strong rhetorical skills and an ability to work with Republicans.

Democratic strategists on and off the Hill are debating the value of creating "enemies" to target in the over-

haul fight. As one party operative put it: "You need an enemy screaming and yelling, otherwise you don't have a crusade."

But the administration's limited attacks on such health-related industries as drug manufacturers have bruised some egos. Kenneth E. Feltman, executive director of the Employers Council on Flexible Compensation, said administration rhetoric about "price gouging" by drug companies has caused "irreparable damage" in some sectors of the busi-

ness community. The council, made up of small and large businesses, opposes most government regulation of health insurance benefits.

haul fight. As one party operative put it: "You need an enemy screaming and yelling, otherwise you don't have a crusade."

rectly to the American people." Yet, time and the public's patience may be running short. Polls indicate that voters sense the president is easily distracted and is having difficulty delivering on campaign promises. They question whether he can stay focused on health care.

Steelman, a veteran of the Reagan administration, said Clinton's new counselor, David R. Gergen, "would know this like the back of his hand. It requires discipline and organization, which he knows."

Many suggest that Clinton give a nationally televised speech reviewing the problems in the current system, explaining the reform process and pledging to stay committed to overhaul.

Steelman said a presidential address delivered before the August congressional recess would enable members to "go home and have good news to give out."

Once the plan is released Clinton "cannot stop talking about it for at least three weeks," Steelman said, or opponents will dominate nightly newscasts.

Some opponents already are trying. "It seems everybody with a fax in Washington, D.C., has got it cranked up and is predicting the virtual end of Western civilization as a result of health reform," Wyden said.

The administration "will have an enormous problem selling this turkey to voters," said Robert Dreyfuss, spokesman for Physicians for a National Health Program. The 5,000 doctors in the group have been writing in medical journals arguing against Clinton's managed competition approach and in favor of a system in which the government would pay for everyone's care through taxes. They tout this single-payer approach to their patients and politicians.

"Our doctors are very active talking to citizens groups, labor unions, church organizations, elderly organizations," Dreyfuss said. "Our contact with members happens where it counts: back at home."

The group is having an impact — about 80 House members have indicated that they support the single-payer concept over managed competition.

In Washington lobbying circles the mantra on health-care reform is: "The train is leaving the station; either hop



If Clinton does not set the agenda, others will. Groups such as the American Medical Association already are running ads aimed at influencing the debate.

### Presidential Pulpit

Although the administration's talks with members and certain interest groups have been effective, "the debate needs to be elevated to an even higher level," said Fried of The Wexler Group. "Ultimately, Bill Clinton must speak di-





## Clinton Is Ready His Roadshow...

While President Clinton is busy formulating a political strategy that his advisers say he needs to sell his health-care overhaul plan to the nation, members of Congress are drafting their own proposals.

Several plans already are on the table, and in the absence of any presidential proposal, large blocs of members are signing on to them. At least 290 House members — including more than 110 Democrats — have allied themselves with alternatives to Clinton's plan.

In the Senate, Clinton probably will have the support of a majority of Democrats, who have coalesced around Majority Leader George J. Mitchell, D-Maine. Mitchell supports Clinton's plan to create "health alliances," large consumer purchasing pools that could bargain for better health insurance prices under a system of "managed competition." But several senators favor a "single payer" system, in which the government would pay most costs.

The 44 Republican senators are divided into two camps: a moderate group that supports managed competition and a conservative contingent that would rely on medical savings accounts and malpractice reforms.

Working in Clinton's favor is that there is bipartisan support to change the system, and lawmakers are willing to work to get some reforms through Congress. "Although there are a number of different plans, there are a number of common elements and a number of points of consensus," said Pamela G. Bailey, president of the Healthcare Leadership Council, a health-care industry group that has been working on overhaul strategies for the past five years. "The points of consensus are what the debate will have to come back to," she says.

But while Clinton figures out his strategy, the opposition already has taken its cause on the road. Citizens Against Rationing Health, a coalition that draws support from Republican conservative groups, unveiled its overhaul plan June 30 and announced its intention to fight Clinton's proposal.

"Of course we'll wait to see the administration's plan," said former Texas Rep. Beau Boulter, co-chairman of the group. "But if it seems to be government-assisted rationing, which we expect it will, we will fight it, and we are gearing up."

The group includes conservative grass-roots organizations as well as the American Conservative Union, the United Seniors Association, which represents the elderly; and the American Legislative Exchange Council, which represents conservative state legislators. They paint Clinton's proposal as one step away from a Cana-

dian-style single-payer system and argue that rationing of health services is just around the corner.

The argument is likely to resonate with the public, which in polls displays a virtual allergy to any suggestion that health-care consumption should be limited.

Other groups representing the insurance industry and small businesses also have sprung up. Like Citizens Against Rationing Health, they support the plan for modest change being pushed in the Senate by conservative Republicans Phil Gramm of Texas, Trent Lott of Mississippi, John McCain of Arizona and others.

With so many lawmakers already aligned, Clinton has little choice but to deal with blocs with whom he has deep-seated philosophical differences. "If you go into this with the mind-set that the federal government must come up with all the answers ... you are going to create such a complicated red-tape-bound plan that it will not generate the support of the American people," Bailey says. "But if the president would stick to the points of consensus ... he could see legislation enacted much sooner than most people have predicted."

A quick look at the proposals gives a sense of where the fault lines lie and where Clinton may have to give ground to win enough votes to get any plan through Congress.

### In the House

Three factions shape House health-care politics: Republicans, conservative Democrats and those liberal Democrats who support a single-payer plan.

While chances are slim that more than a few Republicans would back Clinton's plan, they do not yet have



Cooper, top, wrote the conservative Democrats' plan, which is similar to Clinton's. McDermott supports a single-payer system.

aboard or you will get left behind." So even the people likely to oppose Clinton's final plan spent much of the spring trying to influence the task force's deliberations. After the task force disbanded in May, the activity split between those still trying to bend the administration's ear and those waging the fight elsewhere.

The governors, for instance, like

Clinton's idea of creating "health-care alliances," quasi-government entities that would buy coverage for large groups of consumers. But most state leaders want the power to set limits on how big the alliances will be and how many will be established in each state.

"We figure our best hope on state-federal relationship issues is to get it right in the first place and then fight

to keep it in," said Nikki McNamee, executive assistant to Gov. Carroll A. Campbell Jr., R-S.C.

In return for their seat at the table, Clinton is looking for 20 governors to support his plan from Day One, said Vermont Democratic Gov. Howard Dean.

Others, like the pharmaceutical manufacturers, hold little hope that



## ... But Alternatives Are Already on Tour



In the Senate, Chafee, top, supports managed competition; Gramm wants medical savings accounts and malpractice reform.

their own bill. A few, including Fred Grandy, Iowa, and George W. Gekas, Pa., are looking at allowing states to experiment with health-care coverage and delivery.

The 50-member Conservative Democratic Forum is quietly gathering support for a managed competition plan similar to the one introduced last year with about 30 cosponsors. The plan, written by Jim Cooper, Tenn., and backed by Michael A. Andrews and Charles W. Stenholm, both of Texas, is similar to Clinton's.

However, it differs in the politically sensitive area of financing. Clinton plans to introduce a wage-based insurance premium that would tax people with higher salaries at a higher rate. Instead of that, the conservative Democrats want to limit the health-care tax deduction for businesses. Under existing law, businesses deduct the entire cost of providing health care to employees. If employers could deduct only a portion of those costs, the balance would be taxable. If the deduction only covered a basic plan, any business that offered a more expensive plan would have to pay taxes on the portion that exceeded the basic package. That would give businesses an incentive to choose low-cost plans. Cooper is waiting for Clinton to unveil his plan before re-introducing his bill.

The largest bloc of House Democrats has signed on to a single-payer plan by Jim McDermott, Wash., a physician. McDermott has the support of 84 members, including most of the New York City delegation, the California delegation, 11 committee chairmen and the chairmen of the Congressional Black Caucus and the Congressional Hispanic Caucus.

Under his proposal, the government would provide insurance, but people would continue to choose their own

doctors and hospitals. In contrast to the British system, in which doctors and hospitals are paid by the government, providers would continue to be self-employed or work in groups. This system could save more money than any other overhaul plan by cutting out private insurance costs. But that would erase thousands of jobs, eliciting vociferous opposition.

Some lawmakers, including Pete Stark, D-Calif., chairman of the Ways and Means Subcommittee on Health, have introduced their own single-payer bills. Stark's would expand Medicare, the government's health insurance program for the elderly, to the entire population.

### In the Senate

John H. Chafee, R-R.I., a moderate, has been working for more than two years with more than a dozen Republicans on a proposal with goals almost identical to those of Clinton and conservative House Democrats. "We want to get coverage out there to everybody in our society, and we want to reduce the rate of increase in costs for the private sector, for the government sector and for individuals."

The Republicans support a managed competition model, but unlike the Democrats, they want it phased in slowly, perhaps over five years or more. They do not have a financing proposal yet, but like the conservative House Democrats, they would limit the deductibility of benefits to the standard package. Chafee says he knows that will not cover the cost of universal coverage. The group is looking for an additional funding source.

Conservative Republicans, led by Gramm, want to keep the existing system intact. Under their plan, everyone would be required to purchase a catastrophic health insurance plan and employers would have the option of offering employees an insurance plan for non-catastrophic costs or putting an equivalent amount of money into a savings account for employees. When people were sick, they could dip into their savings account to pay their doctors' bills; if they didn't use up the money, they would get to keep it at the end of the year.

"They could roll over the unused portion from year to year. . . . This money could then be used for such things as retirement, housing, education or a financial emergency," says McCain, who supports the plan.

The package also includes comprehensive malpractice reform, with caps on attorney fees and on damages for pain and suffering.

—Alissa J. Rubin

they will alter the administration package. Early comments by both Clintons about large profits and large executive salaries at the drug companies have put the manufacturers on the defensive.

"There have been a number of allegations and sharp criticism, some based on distortions," Pharmaceutical Manufacturers Association spokes-

man Jeff Trehwitt said, noting that his association has begun a massive advertising campaign. "Those impressions need to be corrected."

A few groups will attack the debate on several fronts.

"The AMA plans to use extraordinary means to communicate with patients, physicians, the Congress and other decision-makers," says the

group's written campaign strategy.

But Steelman, arguing that the presidency "is the only megaphone in town," said the early lobbying by activists will have minimal impact.

She says, "What they are trying to do is soften the environment in which the megaphone will be blasted in the hopes their people will react to the megaphone in some more directed way."



1/2

## Curing Health Care May Cause Short-Term Pain

By SARA FRITZ  
TIMES STAFF WRITER

WASHINGTON—When President Clinton pledged to reform the health care system, he promised that his efforts would improve U.S. economic competitiveness in the world by slowing the growth in medical costs.

Yet, with the President's proposal still being drafted at the White House, there is evidence that health care reform will bring slower growth, fewer jobs and smaller profit margins long before it pays the economic dividends that Clinton has promised.

In anticipation of health care reform, some companies are already deferring hiring, hospitals and drug companies are laying off workers, managed-care companies are declining to sign up new specialists and the pharmaceutical industry's stock prices are in a tailspin.

Such hardships are to be expected, according to some economists, whenever the government sets out to revamp an industry as vital to the economy as health care.

Mark Zandi, an economic consultant in West Chester, Pa., likened the economic effect of Clinton's health care reform plan to the decline in gasoline prices in the 1980s. While it ultimately proved to be a boon to the economy, it brought considerable short-term hardship, especially in oil-producing states.

"In the long term, health care reform is an unambiguous positive," Zandi said. "But initially, certain elements of the health care industry, and those employers who are going to pay for it, are going to suffer negative consequences."

While the President's plan for reform will not be unveiled at least until September, the plan's general outline is already known: Clinton favors using a combination of free-market forces and price controls to restrict health care spending and

**Please see REFORM, A8**



# REFORM: Short-Term Costs Seen in Health Care Proposal

Continued from A1

provide coverage for all Americans.

In the long term, Clinton's proposal is expected to ease the pressures that have fueled a nearly sevenfold increase in U.S. medical expenditures in the last three decades. By some estimates, it could trim health care spending by more than \$700 million by the year 2000.

If those estimates are correct, reform not only would help dampen inflation and slow the rising federal budget deficit, it would also ease the tremendous impediment that high health care costs have put on U.S. employers as they compete with the Japanese in world markets.

Most economists say they agree with the principal goal behind Clinton's plan. As the President has stated repeatedly: "We will never revive our economy or cope with the deficit until we get health care costs under control."

In the first two years after enactment of health care reform, however, some economists predict that the economic disruption it causes could shave between 0.2% and 0.5% off the nation's annual economic growth rate and deprive the economy of as many as 750,000 new or existing jobs.

Hardest hit would be the Northeast and Midwest, whose economies are more dependent on the health care industry, the economists said. In the South and Southwest, where a higher percentage of employers do not now offer health coverage to their workers, the cost of doing business would increase.

While health care reform is supposed to dampen demand for expensive medical services in the long run, some economists predict that it will increase demand for medical services initially as 35 million currently uninsured people are provided with coverage. Increased demand could, in turn, fuel

a surge in inflation in the first few years after reform.

"Initially, it means a giant increase in demand and a lot more money going into the industry. . .," said John Shiels, a health care economist for Lewin-VHI, a consulting firm in Alexandria, Va. "The increase in demand will also create bottlenecks, causing price increases in areas where there are shortages."

Estimates vary widely on how reform will affect overall health care spending in the first few years. According to a summary of economic forecasts published recently by Congress' Office of Technology Assessment, some analysts foresee an initial annual savings of nearly \$22 million under Clinton's reform plan, while other forecasters predict a nearly \$50-million increase.

Audrey Freedman, a labor economist in New York City, cautioned that, even though 35 million more people would be insured under Clinton's plan, demand will not increase as dramatically as those numbers suggest.

Freedman said many uninsured people now receive treatment but often not until they need high-priced emergency care. Thus, while the demand for routine services surely will increase once these people are insured, she predicted, the demand for emergency care is likely to decline.

Yet despite an anticipated increase in demand, many sectors of the health care industry are girding for leaner times because they expect the President's plan to impose a new cost-cutting discipline on them.

"The health care industry has been growing in recent years in anticipation of rising prices as far as the eye can see," Zandi said. "Now, they know they are going to have to control growth in costs."

Hospital officials say they expect

**'The only thing that Karl Marx managed to get right is that in the end the worker pays all of the bills.'**

JOHN SHIELS

Health care economist for Lewin-VHI

to feel the crunch almost immediately, especially if Congress also follows through on a plan to cut Medicare payments. Hundreds of hospitals are likely to close in the next few years under pressure to eliminate excess capacity, according to the American Hospital Assn., and many of those that remain open will be forced to scale back their operations.

Layoffs already are spreading through the hospital industry. At Rush-St. Luke's Hospital in Chicago, for example, the management recently announced plans to lay off about 800 employees.

Likewise, some economists predict that Clinton's health care plan will cause hundreds of small insurance companies to go belly up. The plan favors the big insurers that already are abandoning high-priced indemnity health insurance in favor of establishing more economical managed-care networks of physicians.

"It will wipe out many small insurance companies and wreak havoc on the free-standing hospitals and the free-standing clinics that are not part of a vertically integrated network of providers," said Uwe E. Reinhardt, a health care economist at Princeton University.

Lewin-VHI has estimated that the system advocated by Clinton could save more than \$11 million a year in insurers' administrative and paperwork costs. But that also means some insurance company employees involved in billing and administration can expect to be out of work.

Like hospitals, manufacturers of

pharmaceuticals and medical devices are also beginning to lay off workers as part of cost-cutting moves prompted by Clinton's criticism of their earlier price increases, according to the Pharmaceutical Manufacturers Assn. Drug industry stock prices are down 15% so far this year.

Under the system of managed care that is fast supplanting indemnity health insurance across the nation, primary-care physicians are supposed to act as the "gatekeepers" who control patient access to high-priced specialists. But insurers reported that there is already a critical shortage of primary-care physicians and a surplus of specialists.

A recent survey conducted by Group Health Assn. of America, a trade group, and the U.S. Public Health Service, found that more than half of the nation's health maintenance organizations are finding it increasingly difficult to recruit primary-care physicians.

If the shortage of primary-care physicians continues, as expected, Reinhardt predicts that market forces will quickly boost pay for lower-paid general practitioners and lower wage scales for high-priced specialists. Soon, he said, physician salaries in excess of \$300,000 a year will be rare.

Well-positioned to benefit from the shortage of general practitioners are nurses and physician assistants, who are widely deemed to be capable of performing many of the less complex procedures usually carried out by doctors. But some economists said many nurses are

likely to be laid off by hospitals before their occupation benefits from the changes wrought by health care reform.

Not all of the economic turmoil caused by reform will occur within the health care industry, of course. Because Clinton aims to require all employers to provide health care coverage, proprietors of many struggling enterprises have predicted that they will be forced out of business by health care reform.

The National Federation of Independent Business, which opposes a mandate on employers to provide insurance, recently published a list of as many as 18 million jobs that would be "at risk" if Clinton were to ask all small-business owners to pay for covering their employees.

Many economists say they are skeptical of the federation's projections. Reinhardt predicted that no more than 100,000 small-business jobs would be lost because of a mandate; Shiels said the figure would not exceed 60,000.

Even many big employers that already provide health insurance are nervous, fearing that a proposed new payroll tax to fund health care reform could exceed their current outlays. Only in the auto industry, where health care accounts for about 20% of total payroll costs, are employers confident that they will be paying less under the President's plan.

Freedman acknowledged that some layoffs will result from these higher costs, but she predicted that reform eventually would help create more jobs than it destroys by trimming payroll costs in heavy manufacturing. "It would be job-creating," she said, "because it would relieve the pressure on many old-line companies to contract out and move jobs overseas."

Many employers are frightened by Shiels' prediction that reform could increase the aggregate costs of health care to U.S. firms by as

much as \$132 million. But until Clinton decides on a financing scheme, the estimates are speculation.

Whatever the increased cost of reform, Shiels predicted, it will result in lower pay for workers. "The only thing that Karl Marx managed to get right," he said, "is that in the end the worker pays all of the bills."

While health care reform will require some sacrifice in all of these areas, experts were quick to note that Americans also will pay dearly if Clinton and the Congress fail to agree on a plan. Unrestrained, health care costs can be expected to continue to erode profits and add to the federal deficit.

As Freedman put it: "Leaving the system alone is a decision too, and an expensive one."

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California, Business, Calendar, View

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World Report

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# CURBS ARE IMPOSED ON SUPERCOLLIDER

Secretary of Energy Is Hoping  
to Keep the Project Alive  
by Placating Congress

WASHINGTON, Aug. 5 (AP) — Energy Secretary Hazel R. O'Leary has shaken up the management of the Superconducting Supercollider in an effort to gain support for the project by answering Congressional complaints.

Ms. O'Leary's decision strips the responsibility for building the supercollider from the prime contractor, the Universities Research Association, a nonprofit consortium in charge of the design and scientific components of the \$10 billion atom smasher. Critics accuse the consortium of failing to track the project's costs.

The consortium will retain control of the supercollider laboratory, which employs some 2,000 people in DeSoto, Tex., south of Dallas, and it will operate the collider after it is completed.

A new contractor will be sought to handle the construction, Ms. O'Leary told the Senate Energy and Natural Resources Committee on Wednesday.

## Senate Vote Ahead

Ms. O'Leary's decision, which followed a 30-day review of the supercollider's management, comes as the project is threatened with cancellation. The House voted in June to kill its financing, and the Senate will debate its future next month. The Senate rescued the supercollider last year after a similar House vote.

The supercollider would race subatomic particles through its 54-mile-long tunnel at nearly the speed of light, then have the particles collide. Scientists say that study of the collisions will increase their understanding of the fundamental forces of nature.

After Ms. O'Leary testified, she was asked if she expected the changes to shore up support in the Senate. She said, "We can do a lot to make it a better-managed project, so I hope that that does add significantly to support for this project."

She pledged that the supercollider's cost would be held to the final estimate of \$8.25 billion made by the Bush Administration, plus the additional costs that would be caused by stretching out the completion of the project by four years, to the year 2003.

The General Accounting Office, the investigative arm of Congress, has said the project has incurred overruns that will push its price tag to \$11 billion or more. And Senator Dale Bumpers, an Arkansas Democrat who opposes the project, contended Wednesday that the project would cost at least \$13 billion, more than double the Energy Department's original estimate, in 1987, of \$5.9 billion.

# Health Care Overhaul Is Approved in Oregon

Special to The New York Times

PORTLAND, Ore., Aug. 5 — Just before sunrise today the State Legislature approved a five-year experiment to expand health care for Oregon's poor and to require employers to provide health insurance for workers.

On the final day of the longest legislative session in the state's history, the lawmakers approved the plan, which will provide Medicaid to an additional 120,000 Oregonians living below the poverty level, a 50 percent increase in the number of people covered. The state now provides coverage to about 245,000 poor residents.

A 10-cent increase in the state's cigarette tax will help raise the \$65 million needed for the initial phase of the plan, said Jean I. Thorne, the state's Medicaid director. The plan is expected to cost an additional \$400 million over four years.

"When you get past all the haggling, Oregon's done it," Gov. Barbara Roberts said today. "In one year's time we will have affordable, accessible health

care for 120,000 Oregonians who did not have it before."

Under the plan, which has taken five years to enact, 688 medical procedures have been ranked according to their costs and benefits. Oregon Medicaid will cover the top 568 services on the list; it will not pay for the remaining procedures, which are considered by state officials as too costly or benefiting relatively few individuals.

## Triage for Services

Services that fall below the new cut-off point include liver transplants for patients with liver cancer, nutritional counseling for obese people and fertility services, as well as medical treatments for the common cold, chronic back pain, infectious mononucleosis, phlebitis and acute viral hepatitis.

Donna E. Shalala, the Secretary of Health and Human Services, gave the plan the necessary Federal waiver in March.

While it is now certain that every Oregonian living below the poverty level will have guaranteed access to health care, a second aspect of the plan is more tenuous.

Legislators bickered long and hard on Wednesday over the contentious issue of requiring employers to cover all full-time workers for health care.

The bill initially called for requiring employers to start providing the insurance in 1995, but after strenuous lobbying by businesses, the Republican-dominated House of Representatives voted Wednesday to delay the employer mandate until July 1997 for mid-sized and large businesses and until July 1998 for small businesses.

## Stalemate Develops

In response, the Senate, with a slim Democratic majority, refused to accept the G.O.P.'s revised proposal, fearing that the delay would jeopardize the insurance part of the plan.

"It was pretty high-stakes poker," said Robert Shoemaker, a Senate Democrat from Portland. "They gave us an ultimatum. We did not concur. We wanted to force the issue."

Late Wednesday, the Governor and legislative leaders reached a compromise to impose the new law on businesses with 26 or more employees in March 1997 and on those with fewer employees in January 1998.

"The message was, we're so close, we cannot let this die," said Governor Roberts, Democrat. "It would be criminal."

Similar choices are being confronted on a national level. The proposals being drafted by Hillary Rodham Clinton resemble the Oregon plan, which Mrs. Clinton has praised.

When the legislators adjourned just after 4 A.M. today, Governor Roberts told reporters that President Clinton should follow her state's example. "It does seem insurmountable at times," she said. "But you just have to keep working it through."



# U.S. and Cuba Team Up Against a Pilot

By LARRY ROHTER  
Special to The New York Times

MIAMI, Aug. 5 — In a rare instance of cooperation between the United States and Cuba, Federal law-enforcement officials are pursuing, with Havana's help, criminal charges against a pilot who commandeered a Cuban commuter flight last year and flew the airplane and its 52 passengers to freedom.

To the alarm and anger of the large and powerful Cuban exile community here, crew members who had returned to Cuba were brought back to Miami this week to meet with Federal prosecutors, according to lawyers for the pilot, Carlos Cancio Porcel. The lawyers said the Cuban witnesses were seen entering the Federal Courthouse here today to testify before a grand jury that was meeting there.

The Government's decision to proceed with the case against Mr. Cancio comes amid several recent signs that Washington and Havana want to lessen the mutual hostility that has prevailed since Fidel Castro seized power 34 years ago. Since the Clinton Administration took office, Mr. Castro, who has seen Cuba's economy sharply decline with the collapse of the Soviet Union, has made repeated overtures to the United States, while Washington has made some modest proposals of its own.

Late last month, the State Department announced it would lift the limits on the number of telephone circuits between the United States and Cuba, while allowing Havana half the revenue from the toll calls. Since the start of an American embargo of Cuba more than 30 years ago, Cuba's share of the revenue, now more than \$80 million, has been frozen in a bank account.

## Talks on Immigration

In addition, American and Cuban officials have acknowledged that the two countries have begun discussing an agreement that would normalize immigration and deportation procedures. Such an accord was reached in 1984, but Mr. Castro canceled it a year later to protest American radio broadcasts to Cuba.

The inquiry into Mr. Cancio has been approved by senior Justice Department officials in Washington, according to a person who has been briefed about the case. Attorney General Janet Reno was State Attorney in Dade County when Mr. Cancio and the other passengers defected.

"I believe this has more to do with a policy change toward the Government of Cuba," Jose Quinon, a lawyer for Mr. Cancio, said of the proceedings against his client. "With all this talk of normalizing immigration and other signs of cooperation, we don't know whether Mr. Cancio has become a pawn in an international game that is much beyond his reach."

The Government's decision to proceed with the case has enraged Cuban-Americans here, many of whom risked their lives aboard boats, rafts or planes to flee the Communist regime of President Castro and consider Mr. Cancio a hero.

His arrival here in December was greeted with jubilation in Little Havana, where his fellow exiles exulted at Mr. Cancio's declaration that he had been able to embarrass Mr. Castro. He remains a celebrity in the Miami area, and Cuban-Americans often approach him to congratulate him on his feat. Now, however, alarmed exile groups and Spanish-language radio stations here have attacked the prosecutors as unjust and have suggested that the Clinton Administration is softening its position on Mr. Castro.

"There was no crime committed, and to single out this man is an outrage," Manuel Vazquez, another of Mr. Cancio's lawyers, said in an interview. "I don't think they have a leg to stand on regarding air piracy. A pilot cannot hijack his own plane, and the relevant

international conventions make that clear."

Waving protest placards and shouting insults at Fidel Castro, scores of Cuban-Americans demonstrated outside the Federal Courthouse here this morning. The Cuban-American National Foundation, the most influential exile group here, has urged its supporters to write letters to President Clinton and Attorney General Janet Reno "asking that they stop this injustice and do not permit the U.S. Government to become an accomplice to the crimes of Fidel Castro."

Asked to comment, Andres Rivero, a spokesman for United States Attorney Roberto Martinez, would say only that the case against Mr. Cancio remains open. "It would be inappropriate to comment on any matters that may or

## Inquiry into a daring escape irks Cuban exiles.

may not relate to a grand jury investigation," he said. "The entire episode relating to Mr. Cancio's diversion of the flight from Cuba will be considered solely on the facts and the law."

Mr. Cancio was piloting a turboprop plane from Havana to Varadero on Dec. 29 when friends and family members flying with him immobilized two other crew members, enabling him to divert the flight to Miami, where he and all but five of the people on board requested political asylum. The Cuban Government immediately condemned the incident as a terrorist act of aerial piracy that violated international hijacking agreements.

## View of International Law

But Mr. Cancio and his lawyers argue that he was acting within his authority as captain and thus did not violate international law. It was the five people who returned to Cuba who endangered the flight, Mr. Vazquez said. Aviation conventions clearly "give immunity to members of the

crew, or any passenger, who assist in subduing people who threaten the safety of the aircraft," he added.

In an interview on Wednesday night, Mr. Cancio said he was baffled and worried by the Government's failure to abandon proceedings against him. "All I wanted was to get my family away from that murderous regime and bring them to freedom," he said. "I've never had any trouble with the law in my entire life. That's why I am so astonished this is happening. It really punctures the hopes I had for life in this country."

Leaders of Cuban exile groups have complained that Federal prosecutors here are treating Mr. Cancio with undue harshness while simultaneously failing to proceed against Cuban officials who they say are involved in drug trafficking. At this morning's demonstration, they demanded that Mr. Martinez, who is of Cuban descent, issue an indictment against Cuba's Minister of Defense, Raul Castro, who is said to be the subject of a Federal drug investigation.

Several lawyers here who are not involved with Mr. Cancio's case also contend that Federal prosecutors were mainly trying to make a political point. The lawyers, who spoke on condition that they not be identified, said it was extremely unlikely that any jury in Dade County, whose population is composed primarily of refugees and immigrants from Cuba and other Latin American countries, would ever convict Mr. Cancio if the case went to trial.

The Cancio case has also been dragged into the emotional debate about immigration policy. Advocates for Haitian refugees here contend that Mr. Cancio has been treated leniently compared with a former Haitian soldier who hijacked a plane to Miami earlier this year. The soldier, Woody Edouard, is scheduled to go on trial soon on air piracy charges. He argues that he should be treated as a political refugee.

"I see no connection between the two cases," Mr. Cancio said. "I diverted the plane of which I was the captain, while he had to hold a gun to the head of the pilot."



Atient on  
Melanne  
Vreer

We thought HRC would  
get a laugh out of this  
some pretty funny.  
HC Chirisp.  
Pm 412



# Hillary Rodham Clinton's Definition of Health Terms

over

|                        |                                     |
|------------------------|-------------------------------------|
| Vein.....              | Conceited                           |
| Artery.....            | The study of paintings              |
| Bacteria.....          | The back door of a Cafeteria        |
| Barium.....            | What doctors do when a patient dies |
| Bowel.....             | A letter like a, e, i, o, or u      |
| Caesarean Section..... | A neighborhood in Rome              |
| Cat Scan.....          | Searching for kitty                 |
| Cauterize.....         | Make eye contact with her           |
| Colic.....             | A sheep dog                         |
| D & C.....             | Where Washington is                 |
| Dilate.....            | To live long                        |
| Enema.....             | Not a friend                        |
| Fester.....            | Quicker                             |
| Genital.....           | Not a Jew                           |
| G.I. Series.....       | Soldier ball game                   |
| Hangnail.....          | Coat hook                           |
| Impotent.....          | Distinguished, well known           |
| Labor Pain.....        | Getting hurt at work                |
| Medical Staff.....     | A doctors cane                      |
| Morbid.....            | A higher offer                      |
| Nitrates.....          | Cheaper than day rates              |
| Node.....              | Was aware of                        |
| Outpatient.....        | A person who fainted                |
| Pap Smear.....         | A fatherhood test                   |
| Pelvis.....            | A cousin to Elvis                   |
| Postoperative.....     | A letter carrier                    |
| Recovery Room.....     | A place to do upholstery            |
| Rectum.....            | Dang near killed 'em                |
| Seizure.....           | Roman Emperor                       |
| Tablet.....            | A small table                       |
| Terminal Illness.....  | Getting sick at the airport         |
| Tumor.....             | More than one                       |
| Urine.....             | Opposite of you're out              |
| Varicose.....          | Nearby                              |

Dear Hilary this was very funny  
around an hospital about you and  
your Health Care reform. Its a joke.  
You say please don't include Doctors and nurses



# The Clinton Health Plan and You ✓

**Q.** I'd like information on survivor's benefits for insurance. I'm on my husband's policy now, but I'd like to know how the proposed plan would affect me. What would happen under the president's plan if my husband should die?

**A.** All persons would be covered under the plan, but your required contribution if your husband should die would depend upon your circumstances.

I assume from your question that your husband now works and receives health insurance from his job for the two of you. If you are not employed, after his death you would be asked to contribute both a 20 percent "family" share and the 80 percent share normally contributed by an employer.

If your income is less than about \$20,000 per year, though, you would be eligible for special subsidies and in no case would you have to pay more than 3.9 percent of your income toward the costs of the insurance premium.

**Q.** How would the plan actually work in dividing up premiums for two-income couples with families? How will employers coordinate the amount each employee pays toward insurance and how the benefits are determined?

**A.** The proposal has carefully calculated how two-earner families would be treated. One of you would pay the family share at work through payroll deductions. Both employers would pay their shares on your behalf, according to a formula.

They each would pay more than half of the costs of the employer contribution to the premium, but this is designed

so that across the alliance, contributions on behalf of working families are sufficient to cover the costs of both one- and two-earner families.

**Q.** Would the plan cover in vitro fertilization or any of the other techniques that help people with fertility problems?

**A.** In vitro fertilization is specifically listed as an excluded

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service. Other services to help people with fertility problems are not explicitly addressed by the proposal, so it is not clear whether they would be covered.

**Q.** Would President Clinton's plan have coverage for people who lose their hearing? Will it pay for aural therapy, speech reading and hearing aids?

**A.** The plan specifically excludes hearing aids from coverage. Therapy for hearing problems might be covered, depending upon the circumstances. If therapy would improve functioning and the hearing problem occurred as a result of injury or illness, it would be covered. If, on the other hand, the hearing problem arose from a congenital problem and not illness or injury, it appears it would not be covered.

**Q.** Does the plan cover the cost of prescription drugs?

**A.** The plan covers the cost of prescription drugs. Persons in a high cost-sharing plan would be assessed a 20 percent copayment. In the low cost sharing option, plan members would pay only \$5 for a prescription.

**Q.** Is plastic surgery covered under the plan?

**A.** Plastic surgery is only covered under the plan if it is required to correct a congenital anomaly or to restore or correct problems from injury or disease. Surgery and other procedures performed solely for cosmetic purposes are specifically excluded.

Best  
+A





## The Clinton Health Plan and You

**Q.** *I'm a middle-class Washingtonian, a mental health professional with an income of about \$50,000. And I'm concerned I will be tied into whatever plan the District has, rather than Maryland, where I work. I'm told that I would be better off living in Maryland or Virginia, given their systems and demography. If I stay in the District, would I be tied into a lesser plan catering to the needs of people who make a lot less?*

**A.** You will be required to join an alliance based on where you live. However, each alliance will offer a variety of plans that will likely vary in terms of the premiums charged. The basic benefits package for all plans would be standardized and quite generous by existing standards. However, some plans may choose to offer amenities that cater to higher-income families and hence carry a higher price tag. Plans will also be allowed to offer supplemental policies if they wish. Since all plans must offer the same basic services, if the alliance does a good job in controlling the quality of the plans, the more expensive plans would not necessarily be better.

**Q.** *I belong to the federal employees' health plan. I understand we will be incorporated into the new health plan. How will that happen and when?*

**A.** The Clinton proposal would terminate the Federal Employees Health Benefits Program as of Dec. 31, 1997. After that, you and other federal employees would be treated in the same way as other workers. This would mean that all requirements in the proposal regarding enrollment, family premium payments and employer premium payments would be applied to federal workers.

**Q.** *If I take my child to the home of a day-care provider for about 40 hours a week while I work, do I have to pay part of the day-care provider's health care premium?*

**A.** In this example, your day-care provider would likely be considered self-employed (assuming that he or she cares for several children at once). In that case, you would not be required to make a payment for the provider. Self-employed persons are required to pay into the system on their own behalf.

**Q.** *I'm a Christian Scientist, and I want to know what effect the health care plan would have*

*on people like me who rely on God for healing and don't use medical help. Are we going to be assessed the same as everybody else even though we don't use it?*

**A.** The proposal does not contain exemptions for Christian Scientists. Consequently, you would be required to enroll in a plan and make required contributions.

**Q.** *I'm self-employed and I'm still confused as to whether I would be required to pay a percentage of my income or a flat rate for insurance. Can you tell me?*

**A.** The proposal is confusing in terms of required contributions. Contributions from the self-employed for both the family share and the employer share of the insurance premium are based on flat dollar amounts. But special protections are also offered for some people, and these are expressed as percentages of income. For example, as a self-employed person you would be considered a small business. You would be eligible for special protections if your income is below \$24,000 per year. Even if your income is higher, however, you would never have to pay more than 7.9 percent of your income from your business toward the cost of the employer share you would owe. Similarly, the family share is capped at no more than 3.9 percent of your family's total income. Thus, your liability would depend upon your income and you might pay either a flat dollar premium or a percentage of your income depending upon your own circumstances.

■ ■ ■

In the Nov. 30 column, it was incorrectly reported that the Federal Trade Commission would not have a role in regulating insurers. The earlier column outlined the role of states in overseeing plans. In addition, the FTC would also have some important duties. The McCarran-Ferguson Act would be amended so that the current exemption from the antitrust laws enjoyed by insurers would be repealed. This would eliminate the ability of health plans to collectively determine rates charged or to collude in other ways. The FTC would be in charge of enforcing the antitrust provisions to encourage price competition among plans. On the other hand, the proposal also includes provisions for establishing guidelines to allow mergers and joint ventures by hospitals and physicians, for example. ■

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## The Clinton Health Plan and You

**Q.** I'm interested in knowing if I must provide health insurance for the woman who cleans my house once a week.

**A.** If the woman who cleans your house works for you for fewer than 10 hours each week, you would not be required to make a contribution on her behalf. If she does work for at least that many hours, you would make a partial contribution, but it would likely be quite small.

**Q.** Under the Clinton plan, if you lose your job, I understand that you are not supposed to lose your insurance. But how is it different from the current setup under COBRA where you can carry your insurance but pay both the employee and employer premiums? Who will pay the premiums for people between jobs, or will they be low enough so that the unemployed person can afford them?

**A.** The major difference between the Clinton proposal and the COBRA protections is that the Clinton proposal would offer special subsidies for people with low incomes who are not working. They would be required to make a contribution, but the amount would be limited by their ability to pay. In addition, there is no time limit on the availability of this coverage. COBRA is limited to 18 months of coverage after leaving a job.

**Q.** I am a retired teacher. I am now on Medicare and also receive supplemental insurance; I pay part of it, as I do for Medicare, but my former employer pays the rest. I am very satisfied with my health plan. It covers most things that I need, and I've worked very hard to get it. Will I be able to continue with this plan, or do I have to switch to something else?

**A.** If you are satisfied with the Medicare coverage that you now have, you would be able to keep it. The basic Medicare program would not change, although there will be some new cost sharing required for laboratory services and home health care. The Clinton proposal also would expand coverage under Medicare to include prescription drugs and require that people on Medicare pay a new premium equal to one fourth of the costs of that coverage. If your supplemental policy includes drug coverage, the costs of that supplemental policy would likely fall in response to this new coverage.

**Q.** I have heard that there could possibly be age limits for certain expensive procedures in this new health program. For example, people over 55 may not be covered for kidney dialysis, transplants, etc. Is this true?

**A.** The Clinton proposal has no age limits for expensive procedures. For people of all ages, coverage would include all medically appropriate or necessary services, either through the new health plans or Medicare, depending on which program you will be in.

**Q.** I was born with what is called a clubfoot; it has taken long-term care, braces and surgeries for the last 40-some-odd years. How is President Clinton's plan going to care for people with congenital birth defects such as myself? I've been fortunate that private insurance providers have taken care of me, but what about people who follow me? With health-care cost limits, instead of having corrective surgery would they be limited to wearing braces because it would be "cost effective"?

**A.** The intent of the health care cost limits is to make insurance plans and, in turn, hospitals, doctors and other providers of care more efficient. The expectation is that this will limit unnecessary procedures but not ones that are medically appropriate. This does likely mean that some services will be more restricted in the future, but corrective surgery that could substantially improve the outcome for the type of problem you describe would likely not fall into that category. There is one limitation that may affect people with birth defects, however. Outpatient rehabilitation services include only those services used to restore functional capacity or minimize limitations that result from an illness or injury.

**Q.** I see a homeopath. Would the health proposal cover that?

**A.** Certification of health professionals such as homeopaths is left to the states. The plan indicates that if a state allows practitioners of alternative medicine to offer professional health services that would otherwise be provided by physicians, the services would be covered. Currently, states vary considerably in terms of their policies in this regard. The intent of the Clinton proposal is to encourage more flexibility, but considerable variation across states is still likely.

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## The Clinton Proposal and You

**Q.** *I am on workers' compensation as a federal government employee. How would the Clinton proposal affect me? Will the plan also affect employers' costs for workers' compensation?*

**A.** President Clinton's proposed health care plan indicates that services covered by workers' compensation would be provided by your own insurance plan. This would assure that you would receive care from your regular physician and it would be well coordinated with other services. If special services were needed (such as those provided by occupational therapists), the plan might contract with outside providers. Any costs that you normally would be paying to see doctors in your plan would likely be waived for these services.

**Q.** *A lot of emphasis in the health care proposal is put on HMOs and preferred provider networks (PPOs), which contract with doctors to provide care to patients. What happens in an emergency, when you're taken to a nonparticipating hospital or doctor? What happens if you're out of your area or even out of the country?*

**A.** The health care proposal indicates that emergency services or urgent care would be covered when people are out of their alliance area.

**Q.** *How would the plan treat preexisting conditions?*

**A.** No insurance plan would be allowed to use preexisting health conditions to exclude coverage of individuals for any services. Thus, this restriction would no longer be an issue for anyone.

**Q.** *If you need a major organ donation, would it be covered?*

**A.** The Clinton proposal has been very careful to indicate that acute care services that are deemed medically necessary and appropriate will be covered. Unless an organ transplant is considered "investigational" (that is, its value as a medical treatment is still not confirmed), the transplant would be part of the benefit package. And even if it were "investigational," people participating in clinical trials would be covered and plans could at their own discretion offer such coverage.

**Q.** *Will illegal aliens be able to get coverage in the health plan?*

**A.** The proposal states that only people residing in the United States "under color of law" would be eligible to participate in the health plan. Thus, undocumented aliens would not be entitled to an insurance card that allows them to get services. However, the proposal recognizes that since illegal aliens are likely to need health care, it will be necessary to provide resources to clinics and hospitals to specifically serve this population.

**Q.** *What will be the role of the Federal Trade Commission in regulating insurers? Will anyone be watching over them? And what will happen to brokers who sell insurance now?*

**A.** The FTC would not have a role. Health plans that operate under the proposed system would have to be certified by the states. The states would establish and publish qualifications for becoming a certified plan. These would include quality, financial stability and the capacity to deliver services. States then would monitor the plans to determine whether they continue to meet the criteria that have been established. States are also required to ensure that there are a sufficient number of plans operating in each area to offer individuals choices among plans, particularly in traditionally underserved areas. The National Health Board would evaluate whether states have met the responsibilities outlined for overseeing the plans.

In addition, the regional alliances that negotiate with the plans and make them available to consumers would monitor the performance of the plans and publish information concerning quality and other relevant information for helping people choose among the plans. A review board for complaints is also established under the Department of Labor.

The health plan would largely eliminate the role of insurance brokers. Some brokers may continue to offer their services to corporate alliances, which will be formed by large companies to serve their own employees. ■

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# Effects of the Clinton Plan

**Q.** Under President Clinton's health care proposal, who is responsible for children's insurance coverage if the parents are divorced? Is there any sort of mechanism to ensure that each parent be responsible for part of the coverage?

**A.** In the case of divorced parents, the intent of the Clinton plan is to require only one parent's employer to pay family coverage and only one of the parents to pay a premium based on family coverage. The other parent (and his or her employer) would then be liable for just single coverage. If support of the children is shared by the parents, arrangements to equalize the burdens of family payments could take place between the parents, but outside the mechanisms for financing the health care system.

**Q.** I am the treasurer of a neighborhood association that runs a small swimming pool in Northern Virginia. Each summer, we hire neighborhood youths to be our lifeguards. Are we going to have to start paying health care benefits for those three months?

**A.** The Clinton proposal exempts children who are employed but are already covered by their family's health plan. The neighborhood children described in this question most likely would be covered by their parents' plan and thus you would not have to pay into the regional alliance on their behalf.

**Q.** The Washington area poses an unusual geographic question about the president's plan. What sorts of restraints will there be for people who may work in one jurisdiction but live in another? For example, what about an employee who lives in Virginia, works for a company in the District but has a doctor he likes in Maryland? With the health alliances formed in the Clinton plan, could he still go to the doctor in Maryland?

**A.** There are no regional restrictions laid out in the Clinton plan, but in the implementation of the plan some restrictions may arise. There is nothing in the plan itself to restrict individuals from seeing doctors outside their immediate area. Residence in Maryland does

not preclude getting care from doctors or other health professionals who practice in Virginia or the District. However, there are geographic factors involved. Regional alliances set up by the states will make health plans available to consumers. The three local jurisdictions have very different traditions of health care delivery and regulation. People would enroll in alliances based on their place of residence and not on their workplace, and their choice of doctors would depend on which plan they choose. Patients who use a fee-for-service plan should be able to cross state lines for care. So should those who use a managed care plan that allows them to go outside the plan's network of doctors.

**Q.** Will people who have been diagnosed with serious illnesses be allowed to seek medical advice at medical centers operating outside of their geographic area? For instance, would someone diagnosed with cancer be able to go to the Memorial Sloan-Kettering Cancer Center in New York or Mayo Clinic in Minnesota?

**A.** People will be free to travel elsewhere to get care if they wish to do so. All plans are required to allow patients to use health care professionals on a fee-for-service basis, although this would usually require the higher copayment schedule (20 percent of the fees of physicians, for example). Thus, patients would be free to go to places like Mayo or Sloan Kettering. Further, the Clinton proposal specifically requires that health plans contract with academic health centers that have expertise in treating particular conditions in order to assure patients access to such centers.

**Q.** What happens under President Clinton's plan to people who are paid an hourly wage at part-time jobs? Some of these people put together several part-time jobs but may not have withholding at all of them.

**A.** Employers would be required to pay on behalf of workers employed for 40 or more hours a month. The employer would make a partial premium contribution depending on the number of hours worked by the employee. If a person works for two or more employers, each employer would pay. The workers pay only one family (or individual) share.

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## How Health Reform Would Work

**Q.** *I am a federal retiree over age 65 covered by Medicare, and I have a supplemental policy that I'm very happy with. What will happen to my coverage? Will I still choose my own doctor? Will my supplemental premiums change? If I want to join an HMO, will I have to give up my Medicare and supplemental insurance?*

**A.** The proposal states that federal government retirees with Medicare coverage would remain in Medicare and receive a subsidized Medigap plan. The Office of Personnel Management would contribute to the cost of the premium so that retirees would not have to pay more than they currently pay for supplemental coverage. For most people, this would mean that coverage will be very much as it is at present. You can stay in Medicare and choose your own doctors just as you do now. You may also opt to join a health maintenance organization. In this case, Medicare would continue to contribute to the cost of the HMO premium. You would not choose the HMO through your regional health alliance but through Medicare as a special option. If you were to join an HMO, you might find your choice of doctors and hospitals more limited than it is now—but your out-of-pocket expenses could well be lower.

**Q.** *Would President Clinton's plan cover the costs of purchasing durable medical equipment, such as wheelchairs, neck braces and walkers?*

**A.** Durable medical equipment, including wheelchairs, would be covered under the Clinton plan. So would prosthetic devices, artificial limbs and eyes, and leg, arm, back and neck braces. But these items would be covered only if they improve your ability to function or they prevent further deterioration. Dental prosthetic devices would not be covered. For people in the low cost-sharing plan, usually an HMO, there would be no copayment for medical equipment. The higher cost-sharing plans might require a 20 percent copayment.

**Q.** *I am covered by Medicare and a supplemental insurance policy. I have melanoma in my eye and go to a Philadelphia hospital for treatment and I also go to a specialist in Baltimore for treatment of hypertension. Under the reform proposal, will I be able to continue going to Philadelphia and Baltimore for these treatments?*

**A.** As a Medicare beneficiary, you would not be limited in your choice of doctors or hospitals if

### Durable medical equipment is covered under the plan.

you continued with your traditional fee-for-service coverage. That means you could travel to another city to receive treatment. One problem might be that the doctor you would like to see may have joined a specific network of health-care providers and could not take you as a fee-for-service patient.

**Q.** *My husband is going to be retiring in a couple of years when he reaches 65, but I will not. I have a preexisting medical problem, so as things now stand I won't be able to buy insurance. I wonder if I will be able to under the new plan and how it will work. What will it cost me? We also have two dependent children; what about them?*

**A.** You are a good example of those people who would stand to benefit greatly if the Clinton plan were passed. The principle of universal access will make insurance available to everyone. When your husband retires at age 65, he could choose to remain in the regional health alliance and continue in the same plan that covered you both before retirement. Or he could enroll in Medicare. In either case, you and your children would still have access to insurance. You would have to make a contribution, which would vary depending on your income and work status.

**Q.** *I am a retired federal employee over the age of 65. What premiums will I be paying? Will I have to have a separate policy for myself and my wife? Right now, I have Medicare and my federal health insurance, and I choose my own doctor. I don't want to join an HMO.*

**A.** Under the Clinton plan, Medicare would not change greatly. You and your wife would still be covered by the federal health program. Because you are a retired federal worker, the government would also help defray the costs of purchasing a supplemental policy. You would not be forced to join an HMO. But there might be some cost savings to you if you were to select an HMO or other plan that limits services to a network of doctors and hospitals.





## What Readers Want to Know About Health Reform

**Q.** *What about students who are 23 years old, still in college but basically on their own. Once they graduate and are looking for a job, how would they get insurance?*

**A.** This example is not clearly identified in the Clinton plan. But it appears that if a student is not covered as a dependent by his or her family, the student would not likely have to pay very much.

Technically, an unemployed person would have to make the required individual contribution of 20 percent and the "employer" contribution of 80 percent—but only to the extent that the person had unearned income. If his reported income is low, then he would pay only a small amount toward his family contribution. Support from a family may not count as income.

**Q.** *I employ a full-time babysitter, for whom I do not currently buy insurance. Will I be required to under Clinton's plan, and how much will I have to pay?*

**A.** The employer of a full-time babysitter would have to pay the employer's share of the insurance plan, or 80 percent. But since most babysitters would be at the low end of the pay scale, this family would be treated as a subsidized small employer and its contribution would be reduced and the federal government would make up the difference.

If, for example, the babysitter is paid \$14,000 a year, the limit on the employer contribution would be 3.8 percent of her wages, or \$532. The babysitter would also have to pay at least part of her own family share.

**Q.** *Will the new health plan include payment for medicine?*

**A.** Prescription drugs will be covered under the plan, and patient contributions depend on the type of plan chosen. A low cost sharing plan (probably an HMO) will require a \$5 payment for each prescription. A high cost

### Arrangements would undoubtedly be made for Americans traveling overseas.

sharing plan will require a \$250 deductible and 20 percent copayment.

**Q.** *What happens to people with renal disease? Will the current benefits for dialysis remain or partially or completely disappear? What about the coverage for renal transplants and subsequent medication?*

**A.** Since people with renal disease are covered by Medicare, they will continue in the Medicare program and receive the same benefits as they do now. Prescription drug coverage will be added to Medicare (with a \$250 deductible and 20 percent copayment).

**Q.** *Does Clinton's health care plan cover Americans traveling overseas? Would they have to pay overseas and be reimbursed? What about large organizations, such as embassies, that have foreign citizens as employees? Can they participate in the plans offered by regional alliances?*

**A.** Arrangements would undoubtedly be made for Americans traveling overseas. Special arrangements would be made for foreigners residing here who do not have regular resident status.

The proposal indicates they could buy into qualified health plans in certain circumstances. These items are not fully addressed in Clinton's plan, and details will have to be worked out once a plan is approved.

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# Some Answers to Questions About How Plan Will Affect Consumers

By Albert B. Crenshaw  
Washington Post Staff Writer

Here are some questions and answers concerning the potential impact of President Clinton's health care reform proposal, compiled from information by benefits experts Frank McArdle of Hewitt Associates and John Erb of A. Foster Higgins & Co.:

**Q** When will all this begin to affect me?

**A** Not any time soon. President Clinton will send Congress a detailed legislative proposal next month, which the lawmakers will then debate. There are competing plans offered by Republicans and conservative Democrats as well as by a number of lawmakers who prefer a Canadian-style government-financed plan. These competing interests must all be resolved, so that next year is the earliest that anything could be expected to happen.

Keep in mind, though, that many large employers are already adopting policies that resemble parts of the Clinton proposal, so your own health insurance may change without any congressional action.

**Q** Let's assume that the Clinton plan becomes law. Basically, how would it work?

**A** In some ways, the program would resemble the federal employees health care system, with health plans within the separate regions competing for patients, and with workers choosing a plan once each year during an enrollment period.

Regional "health alliances" would be formed to purchase health care services from health maintenance organizations (HMOs) and other companies that in turn contract with doctors, hospitals and other providers. Americans, other than those on Medicare and a few other groups,

such as military personnel, would be eligible to choose a health care plan offered by their alliance. The health care plan must provide a standard set of benefits, comparable to what many employer-sponsored health plans now provide.

The alliances would offer several types of plans, typically including one or more HMO-like plans, traditional fee-for-service plans and some hybrids of the two. You would be able to choose one, based on your preference.

Employers would make payments to the regional alliance on behalf of their workers equal to at least 80 percent of the average cost of a premium. Workers would pay up to 20 percent.

Americans would receive a health security card, which would serve as proof of eligibility for coverage.

**Q** Today when I need health care, I go to my doctor, he treats me and I submit the bill to my insurance company. Under the Clinton plan, what would I do?

**A** That would depend on what kind of plan you choose from your regional or corporate alliance. With an HMO-type plan, you might simply pay a "co-pay" of \$10 for the office visit and nothing more. With a fee-for-service plan, you would probably have to pay a deductible and a portion of the doctor's bill beyond that. As for forms, there would be far fewer, and much of the information would be handled electronically.

**Q** I work for a large company that has workers here and in other parts of the country. How is my health insurance going to change?

**A** It depends on how large your company is. The plan distinguishes between very large companies and others. Very large companies—those employing 5,000 or more workers—would have the option of purchasing health

care for their workers on their own in what would be called "corporate alliances." Workers at other companies would join regional alliances. Some big companies might choose not to form a corporate alliance but instead allow its workers to obtain care through the regional alliance.

**Q** Suppose I am transferred to another office in a different part of the country? What happens then?

**A** If you are in a corporate alliance, you would continue to get care through the plans offered by it. If you are in a regional alliance, you would join a plan offered by the regional alliance in the new area. There would be no restrictions on your ability to join, nor would there be a waiting period. Also, you would pay the same premium that everyone else in that plan pays; the plan could not make you pay more if you are already sick.

**Q** My company now provides excellent benefits and pays most of the premium. Would I pay more under the Clinton plan? Would my benefits be reduced?

**A** That depends to a large extent on your employer.

Benefits experts say that generally if you work for a large employer, you probably would get to keep the benefits you have now, with the company paying some or all of the extra cost. Ten years after the program becomes law, though, you would have to pay income tax on the portion of those benefits that exceeded what is in the standard package.

Employers would be allowed, though not required, to pay more than 80 percent of the premium, so that if your employer is paying more than 80 percent now, it can continue doing so.

One important point: Currently the law allows employees to pay a portion of health insurance premiums and medical costs with pretax dollars through a flexible bene-

fits plan. That would be repealed, and all out-of-pocket expenses would be paid by workers with after-tax dollars.

**Q** I work for a small company that does not now provide health care coverage. What happens to me?

**A** You would be eligible to get coverage under the regional alliance, and the plan would require your employer to contribute 80 percent of the cost of the average standard benefits package.

**Q** I work for a small company that doesn't provide health insurance, but I am covered under my spouse's policy at a bigger company. What happens to me? What about our kids, who are now on my spouse's plan?

**A** In most cases your entire family would get its care through the regional alliance. Your employer and your spouse's employer would divide the cost based on a formula specified in the Clinton proposal.

However, if one of you worked for a company with more than 5,000 workers, your family could get its care through one of the corporate alliance's plans. In that case, your spouse's employer would pay the corporate alliance.

**Q** Okay, but what happens to me if the small computer company folds and I become unemployed?

**A** You would continue to get coverage through the regional alliance, but you would have to pay the entire premium yourself. The Clinton plan would include subsidies for families with incomes less than 150 percent of the poverty line. But if you are unemployed and have other income—from, say, investments—you would have to pay the whole tab. Self-employed people also would have to pay 100 percent. It would be tax-deductible for people in both categories, however.



## PROJECTED SPENDING FOR HEALTH CARE

In 1994 estimates in billions of dollars

### HEALTH SERVICES/SUPPLIES 1,029.6

Administration 61.9

Government public health activity 32.9

Personal health care 934.8\*

Hospitals 408.8

Physicians' services 194.9

Dentists' services 47.5

Other professional services 54.0

Home health 22.2

Nondurable medical products 80.2

Durable medical equipment 15.5

Nursing home care 85.5

Other personal health care 25.2

RESEARCH 15.0

CONSTRUCTION 15.8

TOTAL \$1,060.5

SOURCE: Commerce Department projections, U.S. Industrial Output 1994  
\* Figures don't add because of rounding

### WHERE HEALTH CARE WORKERS ARE

1993 in thousands, for fiscal year ended June 30

Hospitals 5,184.6

Nursing and personal care facilities 1,614.5

Offices and clinics of medical doctors 1,547.9

Offices and clinics of dentists 562.0

Home health care services 473.1

Total 9,382.1

SOURCE: U.S. Dept. of Labor, Bureau of Labor Statistics

## Health Reform and You

**Q.** Does President Clinton's plan exclude postal workers?

**A.** Postal workers, like federal government employees, would be folded into the alliance after Dec. 31, 1997. But the proposal, as described in the Sept. 7 draft, would also ensure that postal workers who are eligible for a higher employer contribution than the new system requires would continue to receive those benefits.

**Q.** My question concerns the Medicare program. I'm within two years of qualifying for Medicare. What will happen to me?

**A.** The Clinton proposal indicates that people who become eligible for Medicare after having participated in the health care plans offered by the local health alliances will get to choose one of two options. They may go into the traditional Medicare program and pay the Medicare premium. Or they

## HEALTH CARE COSTS AS A PERCENTAGE OF GROSS NATIONAL PRODUCT

1990 data from selected countries

United States 12.6

Canada 9.2

France 8.9

Sweden 8.8

South Korea 6.6

Britain 6.1

India 6.0

Mozambique 5.9

South Africa 5.6

Poland 5.1

Bolivia 4.0

Bangladesh 3.7

Mexico 3.2

Egypt 2.6

SOURCE: World Bank, World Development Report 1993

may stay in their alliance plan if it is a managed care option. In that case, they would be required to pay the difference between a new, higher premium (which reflects their plan's estimate of the costs of providing benefits to that person who is now 65 years old) and what Medicare would normally contribute on their behalf. This is likely to mean a substantial increase in the premium because Medicare's insurance package is less generous than that contained in the Clinton proposal.

For example, the benefit package for younger persons would have lower deductibles than Medicare and a guaranteed limit on the amount that individuals would owe in out-of-pocket costs, a protection not available to Medicare beneficiaries.

**Q.** My husband is on Medicare, but I'm not yet. If President Clinton's plan is approved, would he continue on Medicare or would he join my plan?

**A.** As the Clinton proposal is now structured, your husband would not be allowed to formally join a plan offered by the local alliance. His only option would be to join a special Medicare managed care plan offered by a qualified plan that participates in the alliance. Thus, you and your husband could be in similar but not identical plans.

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## Health Reform and You

**Q.** *In the Clinton plan, what happens to people who choose not to pay their premium if they are unemployed?*

**A.** The Clinton proposal includes the requirement that all people enroll in a health care plan—what is called an “individual mandate.” Employed persons would be required to sign up through their employers. Unemployed people who chose not to pay the premium would be assessed a fine when they showed up for care without an insurance card. The proposal says the fine would be the greater of \$5,000 or triple the amount of back premiums owed.

**Q.** *In the Clinton plan, do mental health benefits include marriage counseling or marriage therapy?*

**A.** The language on just what services are covered under the mental health benefit is not very clear, making it difficult to indicate whether marriage counseling or marriage therapy would be treated as a mental health benefit. Since such services are now often covered as part of mental health benefits in private plans, it is likely that this would also be covered.

**Q.** *My 13-year-old daughter has cerebral palsy and, as a result, she's unable to walk unassisted or talk clearly or use her hands very well. Our insurance company in the past paid for two wheelchairs, two bath chairs, braces and assorted other minor pieces of equipment. It has also provided outpatient physical therapy and speech therapy. Will these services be affected by changes in health care?*

**A.** Children born with cerebral palsy and other disabilities would have most needed services covered. Durable medical equipment, such as the wheelchairs and other devices you mention, are explicitly identified in the proposal as covered services—if they improve functioning or prevent further deterioration in functioning. All acute-care services needed by such children, such as surgery, also would be covered. The gray area in the plan, which has caused some concern about coverage, refers to the Clinton proposal's attempt to draw the line between acute and long-term-care services for rehabilitation and therapy, including home health and extended-care services. The language says such care would be limited to those who need it because of “illness or injury.” The administration has indicated that this language was not intended to specifically exclude children with congenital problems. New language is being considered, but the existing language would seem to exclude some services for those born with disabilities.

**D**o you have a question about President Clinton's health proposal or about the other bills in Congress? The Washington Post has opened a special line in its free telephone information service to take questions from readers about how the plan could affect them. If you have a question, call POSTHASTE at 202-334-9000 on a touch-tone phone and enter category code 8500 (in Prince William County, 703-690-4110). Health economist Marilyn Moon of the Urban Institute provides answers in this column based on information from the White House, Congress and other sources. While she cannot answer all questions or give personal advice, she will answer a broad selection of inquiries.

THE WASHINGTON POST

TUESDAY, JANUARY 18, 1994



# Russian Reformers Lose Ground

## Cabinet Seen Shifting Toward Proponents of Slow Economic Change

By Fred Hiatt  
Washington Post Foreign Service

MOSCOW, Jan. 17—The value of the ruble plunged today as the pro-reform bloc in President Boris Yeltsin's government continued to unravel, raising fears of a retreat from tough measures to reshape Moscow's command economy.

Yeltsin accepted the resignation of deputy prime minister Yegor Gaidar, architect of Russia's free-market reforms. And Finance Minister Boris Fyodorov, another pro-reform stalwart, seemed set to follow Gaidar out of the cabinet, leaving it dominated by former Soviet bureaucrats who favor more state control over the economy and a slower shift to the free market.

Fyodorov said tonight he will remain only if Yeltsin fires his conservative Central Bank chairman and a conservative deputy prime minister in charge of agriculture. Both have been reported likely to be reappointed.

Yeltsin, in a letter to Gaidar, pledged to continue reform policies.

But Gaidar's departure seemed likely to end a period of coalition government in which reformers and centrists often battled each other to a standstill. Prime Minister Viktor Chernomyrdin, a longtime manager in the Soviet gas industry, and his industrialist allies now may have a clear field for their policies of slower privatization and easy credits for state-owned companies.

Responding to that possibility, and to fears of further drift in economic policy, the market value of the ruble declined by more than 3.5 percent in one day, to a record low of 1,402 to the dollar.

U.S. officials, who only two days ago were toasting Yeltsin and his reform policies at the close of President Clinton's Moscow visit, played down the significance of the personnel changes. U.S. Ambassador Thomas R. Pickering said he was "disappointed" that Gaidar was leaving, but added that "we have had a very strong reinforcement during the summit at all levels" that reforms will continue.

But German Finance Minister Theo Waigel called Gaidar's departure "a serious sign," adding, "I hope Yeltsin is able to stick to his reform course." Gaidar said Sunday he was leaving because Chernomyrdin was no longer taking into account his pro-reform views.

Gaidar's Russia's Choice party, which fared poorly in Dec. 12 parliamentary elections, welcomed his Sunday announcement, saying reformers for too long had been taking the blame for government policies they opposed. While Gaidar and his party said they still consider themselves Yeltsin supporters, they denounced Chernomyrdin and his policies.

"The leadership of the Russian government regularly departs from the course of stabilization and reform, while declaring itself true to it," Russia's Choice said in a statement today.

Two Russia's Choice supporters seem likely to keep key positions: Foreign Minister Andrei Kozyrev and Deputy Prime Minister Anatoly Chubais, who heads the privatization program.

The government shakeup reflects the changed political landscape following the election, in which Communist and ultranationalist parties won a dominant position in the lower house of parliament, the Duma. Gaidar and his supporters argued in the election's wake that reforms must be accelerated, to show people real benefits before the next elections in two years. But Chernomyrdin and his allies said the election showed that reforms must be slowed to ease the social pain and dislocation.

Gaidar and his allies argue that Chernomyrdin's "gradualism" only prolongs the pain of economic transition, allowing inefficient factories to keep operating and preventing new jobs from being created. They warn that doling out more credits to the state sector will cause hyperinflation. Chernomyrdin and his allies say Gaidar's "shock therapy" is too stressful for Russia and would cause too much poverty and unemployment.

Yeltsin has long tried to walk a line between the two, telling the West that he favors rapid reform while assuring Russians that he wants more social protection. In accepting Gaidar's resignation today, he stressed "the unchangeability of the president's course toward deep and democratic reform of Russian society, its economy and political institutions." The reforms, Yeltsin wrote, "will be continued."

The new obstacles to that were underscored today by the assignment of committee chairmanships in the Duma.

The Communist-leaning New Regional Policy faction will head the committee on property and privatization. The Communist Party will head the committee on internal security, and the ultranationalist party of Vladimir Zhirinovskiy will chair five committees, including one on "geopolitical questions."

That seemed something of a consolation prize to Zhirinovskiy, who had wanted to head the foreign affairs committee. Instead, that panel will go to the outgoing ambassador to Washington, Vladimir Lukin, a pro-reform moderate.



Meshkov spoke with reporters in Crimea after casting ballot in Sunday's presidential election.

## Russian Nationalist Leads Crimea Vote

By Robert Seely  
Special to The Washington Post

KIEV, Ukraine, Jan. 17—An ethnic Russian nationalist emerged today as the leading vote-getter in the first round of presidential elections in Crimea, a quasi-autonomous region of Ukraine that has become an emotional battleground between Ukraine and Russia.

Yuri Meshkov, a lawyer with the Crimean prosecutor's office, won nearly 40 percent of Sunday's vote with a campaign that called for full independence from Ukraine and reunion with Russia, a stance he seemed to modify significantly today.

"No one is talking about separating from Ukraine," Meshkov told the Reuter news agency after the vote. "The main task, if I become president, is to decide on economic ties with Russia and an agreement on cooperation with Ukraine. No one is talking about changing borders."

Meshkov's closest rival, Nikolai Bagrov—the only one of six candidates who campaigned for continued Ukrainian sovereignty in Crimea—won just 17.5 percent of the vote. Finishing third with about 14 percent was another Russian nationalist whose supporters would likely back Meshkov in a runoff election set for Jan. 30.

In Kiev, Ukrainian President Leonid Kravchuk played down the vote in Crimea, which has been under Ukrainian jurisdiction since 1954 after centuries as part of Russia. "We must heed the will of the [Crimean] people," he told reporters. At the same time, however, a senior presidential aide declared that the vote was illegal and that the Kiev government would study its implications further.

In any event, the election is certain to fuel tensions among militant nationalist groups in both Russia and Ukraine and could complicate Kravchuk's efforts to win parliamentary approval of the disarmament accord signed last week by Ukraine, Russia and the United States. The pact is designed to rid Ukraine of its inherited Soviet nuclear weapons, but many legislators have argued for keeping them as a defense against any resurgence of Russian expansionism.

A spokesman for Chernomyrdin said he would meet with Yeltsin Tuesday to discuss the composition of a new government in light of the reformers' departures. Without Gaidar, the lone first deputy prime minister was reported likely to be Oleg Soskovets, another Soviet industrialist who favors an active state role. "Only a proper state policy will help us, first of all, to strengthen our position in the international market and, second, to provide protection on the domestic market," Soskovets said in a recent interview. "The government cannot leave domestic industrialists to the mercy of fate."

THE WASHINGTON POST

TUESDAY, JANUARY 18, 1994



# Yes, There Is a Health Crisis

No crisis; no big fix needed. That is the emerging Republican mantra on health care. And it is wrong.

By any reasonable definition, there is a crisis in insurance coverage when tens of millions of Americans remain uninsured and live in constant fear of bankruptcy should they become ill. There is a cost crisis when virtually every family and most employers face ever-rising insurance premiums and ever-higher medical bills. And there is a governmental crisis when skyrocketing Medicare and Medicaid costs crowd out public spending on education, training, scientific research and infrastructure.

If Congress balks at radical reform now, Americans will face worsening consequences for a generation. That, too, is a crisis.

Senator Daniel Patrick Moynihan, Democrat of New York, recklessly pronounced on national television that health care was not in crisis. He has since implied the statement was too sweeping and was never intended to derail major reform, but Republican Senators Bob Dole of Kansas, the minority leader, and Phil Gramm of Texas went much further. They point to two facts to buttress their no-crisis argument: Almost 80 percent of Americans are satisfied with their insurance; and last year medical prices rose by little more than 5 percent, half the rate in 1990.

But the Senators conveniently leave out uglier facts. Total health expenditures, which includes the volume of medical services as well as prices, rose more than 10 percent last year — guaranteeing that health care's steadily rising claim on the nation's output would continue. And though Americans who can afford coverage are generally pleased with their policies, there are almost 40 million Americans at any moment who lack insurance. Nearly 60 million — almost a quarter of the population — are uninsured at least once in any given year. That is an enormous number of people who need protection.

According to studies by the nonpartisan Kaiser Family Foundation, one-third of the uninsured are poor. A majority are "near poor," and many of these say they can't find affordable policies. Less than 10 percent of the uninsured say they chose their status voluntarily. The rest lost coverage when, for example, their employer discontinued coverage, they were laid off or changed jobs.

The Kaiser studies also highlight the social pathology: The uninsured receive less treatment,

are sicker and suffer higher mortality rates than the insured. It is not true, as some claim, that virtually all Americans get decent care and the only issue is who has to pay for it. Lack of insurance results in poorer medical care.

Senator Dole asserts that health care problems can be solved by small-bore fixes. Congress, according to this argument, need only provide subsidies to the poor and pass some simple laws to prohibit insurers from discriminating against the chronically ill and discontinuing coverage for dislocated workers.

But these measures would not guarantee that dislocated workers could afford to maintain their old policies or that they, or anyone else, could find new affordable coverage. Nor does Mr. Dole, or the rest of the no-crisis brigade, propose measures that would do anything to control costs. And as costs continue to escalate, Medicare and Medicaid will continue to erode the funds available for other public spending.

Indeed, Mr. Dole's measures would not fix much of anything. Take the proposal to ban discrimination against the sick. Insurers have devised subtle ways to discourage AIDS victims and other chronically ill applicants. That is why President Clinton and Representative Jim Cooper would have most Americans buy coverage through regional purchasing cooperatives. Among other responsibilities, the cooperatives would transfer money from plans that evade the chronically ill to plans that sign them up. Under Mr. Dole's do-nothing bills, health plans that accept all applicants would be hard pressed to survive when others discriminate against the sick.

Nor would Mr. Dole's miniature reforms improve health care. Studies show that as much as one-third of current health care expenditures — hundreds of billions of dollars worth — is for wasteful or ill-advised procedures. President Clinton and Mr. Cooper would restructure private markets so that health plans would be forced to go after wasteful and bad treatment practices; Mr. Dole would let them fester.

Health care will not bankrupt the nation even without reform. But that is a myopic view of the issue. Mr. Dole and friends do not see a crisis when sick children go untreated because their parents cannot afford health insurance, or when 60 million Americans a year face the fear of bankruptcy from medical catastrophe. But for the rest of us, there are enough bad consequences to warrant fundamental reform.

## Some Good Out of Chiapas

Mexico's peasant rebellion has brought death, reports of grave human rights abuse and serious embarrassment to President Carlos Salinas de Gortari. It has also created some awkwardness for Washington, which identified itself with the Salinas Government on the North American Free Trade Agreement, and which lent Mexico helicopters for drug interdiction only to see the aircraft used in early operations against the rebels.

But the Chiapas revolt has also yielded some positive results. It woke up a political system whose backward and authoritarian ways clashed with Mexico's efforts to build a modernized economy. It brought long-overdue dialogue between Mexico City and the peasants of Chiapas. And now it has brought agreement between all of Mexico's main parties on ground rules for fairer, less money-tainted presidential elections this August.

In an added benefit, it has also brought two key governmental appointments that could be important to Mexico's political health down the road. The first is the appointment of Jorge Carpizo McGregor to the Ministry of Interior, or Gobernación, which is responsible not only for internal security but also the supervision of elections.

When the revolt broke out, the Interior Minister was Patrocinio González Garrido, a former Governor of Chiapas with a reputation for aloofness and repression who clearly had to go. To replace him,

Mr. Salinas chose a respected human rights advocate and crusader against official corruption. Mr. Carpizo gives Mexicans and interested outsiders reason to believe that this year's election will be more credible than the fiasco six years ago, when computers mysteriously halted, ballots disappeared, and many thought that fraud had denied the presidency to the leading opposition candidate, Cuauhtémoc Cárdenas.

The other significant appointment assigned Manuel Camacho Solís to negotiate with the rebels. Several months ago, President Salinas came close to naming Mr. Camacho, a longtime associate, as his designated successor. Instead, he chose Luis Donaldo Colosio Murrieta. But since the peasant revolt, Mr. Camacho, a man who established special credibility among disaffected sectors of Mexican society, has all but eclipsed Mr. Colosio. There is now even talk of reviving his presidential candidacy before formal ballot positions are decided in March.

Dazzled by his own economic reforms and diplomatic triumphs, Mr. Salinas was humbled by the surprise guerrilla offensive that began New Year's Day. But since then, he has moved with impressive political skill. One way or another, the events of this month are likely to accelerate overdue democratic change. That is good for Mexico and for the U.S.



# Medicaid Costs Balloon Into Fiscal 'Time Bomb'

A-1

First of four articles

By Dan Morgan  
Washington Post Staff Writer

It was 7:30 in the morning on Oct. 16, 1990, and Rep. Henry A. Waxman (D-Calif.) had just spent the night in a windowless room in the Capitol haggling with senators over mind-numbing technicalities of the budget for Medicaid, the huge federal-state health care program for the poor, disabled and low-income elderly.

Officials and aides were "hallucinating, green," recalled one of those present. But the short, balding chairman of the House Energy and Commerce Committee's subcommittee on health and environment looked as fresh and chipper as if he had slept in his bed in Bethesda.

Waxman, who had been working for years to expand the government's safety net for the medically needy, had every reason to be pleased.

Buried in the legislation was language that would add \$2 billion to the federal government's spending on Medicaid over the next five years. One provision guaranteed Medicaid coverage for every poor child under 19 by the year 2002. Another designated new federal money for the home care of "frail" elderly citizens and the developmentally disabled. Still another required federal and state governments to pay the Medicare



BY RAY LUSTIG — THE WASHINGTON POST

premiums of even those elderly people with incomes well above the poverty line.

The irony was that the legislation was part of a deficit-reduction measure, one that was supposed to slow overall federal spending by \$496 billion over five years.

"The frustration was that what was supposed to be a massive deficit-reduction act became an expansion of Medicaid," recalled Gail R. Wilensky, who sat in on the deliberations as administrator of the Health Care Financing Administration, the agency that regulates federal Medicaid payments.

Over the past decade, under the nose of a

## HOW MEDICAID GREW

THE POLITICS OF EXPANSION

Rep. Henry A. Waxman (D-Calif.), who has led efforts for Medicaid, says federal government should play a role in citizens' health care.



Republican-controlled White House and fiscal conservatives in Congress, Waxman and a bipartisan handful of congressional allies reshaped Medicaid in numerous ways, vastly expanding the coverage it offers to poor, uninsured Americans and to some middle-class families as well. Cutting deals, massaging the numbers and sometimes just plain outlasting adversaries, they transformed the federal government's role in the nation's health care at a cost to taxpayers of billions of dollars.

See MEDICAID, A18, Col. 1



David S. Broder ✓

file

## The Pen, Yes, but The Votes?

Viewed solely as a piece of political rhetoric, President Clinton's State of the Union address was one of the best speeches of his presidency. It showed him as a feisty, emotional chief executive with strong convictions—all qualities Americans admire in the Oval Office.

But a State of the Union address is not just another stump speech; it is a governing document. Along with the budget, it sets the tone and direction for a president's dealings with Congress. By making the centerpiece of his speech an explicit and dramatic threat to use a veto pen on any health reform bill that does not guarantee universal coverage, Clinton consciously set himself an even more difficult challenge on Capitol Hill.

If Clinton's popular support continues to grow, the veto threat may stiffen Democratic backbones and wilt

### Did Clinton leave himself maneuvering room?

enough wobbly Republicans to get Clinton a health care victory that eclipses anything that Franklin Roosevelt, Harry Truman or Lyndon Johnson accomplished in that field.

On the other hand, that threat was vivid enough to leave Clinton with very little crawl space, if in the end he has to compromise. Like George Bush's memorable "Read my lips" pledge to veto any new taxes, it's a television vignette that can be replayed over and over if Congress forces Clinton—as it did Bush—to back down.

In the short term the president's theatrical gesture was a big hit only with House liberals who favor a single-payer plan and key committee and subcommittee chairmen, such as Dan Rostenkowski (D-Ill.) of Ways and Means, John Dingell (D-Mich.) and Henry Waxman (D-Calif.) of Energy and Commerce, who have to get the Clinton plan off the drawing board and into position for floor action later this year.

They have to be in a position to assure wavering House Democrats that if they stick with the president in the face of strong interest group pressure from home, he will not abandon them—as he did on last year's broad-based energy tax proposal. House Democratic leaders whipped the troops hard to support the Btu tax last spring, only to see the president drop the proposal as soon as objection surfaced among key Senate Democrats.

The White House recognized the need for such a health care guarantee—and it was one reason Clinton decided to make the veto threat.

But the working assumption of the White House and of legislative strategists on all sides of the debate is that any measure that passes must have the support of many conservative Democrats and at least some Republicans. In the House, moderate and conservative Democrats, clustered in the South, will be needed to overcome what is expected to be near-solid Republican opposition to the Clinton plan.

In the Senate, the requirement of 60 votes to end a filibuster demands that the measure be made palatable to some of the 44 Republicans. Many of the middle-road Democrats and almost all the Republicans—including Senate Minority Leader Bob Dole (R-Kan.)—have been arguing for an incremental approach that would provide health insurance for millions more people and increase the security of those who fear their current policies may be canceled. They claim this can be done without the employer mandates and the complex system of tax subsidies Clinton would use to give every American citizen a "health security" card.

Rep. Jim Cooper (D-Tenn.), principal sponsor of one of the half-a-loaf alternatives, likes to point out that in Hawaii, where a state-run "universal coverage" plan has been in effect for five years, some people remain uncovered. Cooper says it's as high as 6 percent of Hawaii's population; the state says 2 percent to 4 percent.

Similarly, Sen. Dave Durenberger (R-Minn.), one of the GOP senators most interested in forging a compromise, says that the veto threat makes sense—but only if Clinton is prepared to reopen discussion of how to get as close as possible to total coverage.

But the threat was not welcome news to Senate Finance Committee Chairman Daniel Patrick Moynihan (D-N.Y.). Moynihan wants—and believes he needs—Dole to be aboard the health reform bill that emerges from the Finance Committee. The chairman has expressed his own doubts about the intricate design of the Clinton plan and appears to be using Dole's objections to deflate the White House's ambitions.

The debate between the "incrementalists" and the "universalists" is not confined to Capitol Hill; it also has been raging inside the White House. White House chief of staff "Mack" McLarty and counselor David Gergen have been talking regularly with Cooper and his Senate counterpart, Sen. John Breaux (D-La.) about possible areas of compromise. Meanwhile, First Lady Hillary Rodham Clinton and health policy adviser Ira Magaziner, backed by pollster Stan Greenberg, have been urging the president to hold out for the whole prize.

The inclusion of the veto threat was a victory for the "hard-liners" in the White House. They were vindicated by the striking success it achieved as a piece of political theater. What remains to be seen is how it plays out in the real world of legislation.



Jack Anderson and Michael Binstein ✓

## Nebulous Health Care Numbers

The Clinton administration is anxiously awaiting a verdict on health care reform from one of the most influential juries in Washington—the nonpartisan Congressional Budget Office. Early next month CBO will deliver its opinion on whether the plan's financing is based more on fantasy than fact.

But a leap of faith may be more accurate for the budget side of the 1,342-page bill. At least that's the essence of an early verdict rendered by a member of President Clinton's own Cabinet, which played a major role drafting the plan and "scrubbing the numbers."

Office of Management and Budget Director Leon Panetta defends the Health Security Act as honest and conservative but warns about what might be termed the X factor: The administration's numbers may prove wrong, although not through deception. Forecasting the future of health care is an imperfect undertaking.

We recently asked Panetta whether some parts of the plan may be only as reliable as the models on which it was based: "Exactly. I can say we have the best estimates in the business only because we have the only estimates in the business. . . . You bring 30 million to 40 million Americans onto the health care rolls—who knows what the utilization is, who knows what the impact is, who knows what those families are going to do?"

Panetta believes the potential rewards of reform override the risk but cautions against putting too much

faith in the models. "The largest part of the time we spent in the first six months was developing models, . . . so we can say, 'If we're going to bring these people into a health care system, what are we going to need, for example, in terms of subsidies to help the smaller businesses? How much is this going to cost?'"

If the administration's math doesn't add up, chalk it up to the fact that officials were operating in uncharted waters. "We know what the estimates are in the area of Medicare or Medicaid," Panetta said. "You have some [private] insurance actuaries, . . . you have some sense of what the costs are there. But suddenly when you are going to be applying a plan that is comprehensive, that involves a basic benefit plan and covers all Americans, that's new."

Panetta said everybody who participated in the process—including health policy architects Ira Magaziner and Hillary Rodham Clinton—understood these problems from the beginning. That's why so much time was spent developing models. The second approach was to be very conservative in the estimates filtering into the White House from agencies. He revealed that cost estimates for different planks in the plan often varied among agencies, and the highest estimate would get incorporated into his final projections.

Panetta also touched on what may become the most incendiary issue in the debate: spending caps. To avoid

getting "caught in that problem of estimates," Panetta said, the concept of caps took hold. "The reason we established caps was we knew we were dealing with a system where we didn't want to create another open-ended entitlement."

Caps are reassuring to those worried about the budget. For others, caps are a recipe for rationing of care. Republicans would love if the battle over health care centered on the word "ration," which could be used almost interchangeably with socialism to depict the administration's plan. As budget director, Panetta seems whipsawed by those worried mainly about cost and those who worry about choice. He hinted that Congress and the administration would exceed the caps before they cut off spending.

"It's not likely the president and the Congress are going to want to [restrict care]," Panetta said. "[Politicians] are going to be required to confront the issue that for some reason the costs have gone through the caps. And what's wrong with that? What's wrong with the president and Congress saying to the American public, 'Where we thought we were has for some reason not worked out. We've got to come back to the issue.'"

This may be a model for good government, but if the numbers are wrong, the administration will have to answer for it in 1996.

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file

# Compromise on Health Care

Hillary Rodham Clinton has ruled out compromise with the sponsor of the only bipartisan health care bill in Congress, Representative Jim Cooper, Democrat of Tennessee. Her animus is odd, because his bill is the closest cousin to the proposal she drew up on behalf of the Administration.

The Cooper bill improves upon the basic framework of the Clinton plan. But it also contains a fatal deficiency: Mr. Clinton would guarantee coverage to everyone; Mr. Cooper would not. That mistake can be fixed. Congress's best choice is a marriage between the two bills.

**Purchasing Cooperatives.** The core of Mr. Cooper's plan, and the President's, is the creation of regional purchasing cooperatives. The cooperatives would offer small employers and individual buyers a choice of private health plans at attractive prices. Under Mr. Clinton's bill, everyone except employees of some of the largest companies — those with more than 5,000 employees — would join a cooperative. But that threatens to pile enormous power in the grasp of the cooperative, a government agency.

Mr. Cooper would infuse competition into the system by permitting companies with more than 100 employees to negotiate coverage on their own. The problem with this idea is that too many small companies would be eligible to shun the cooperatives, hire only healthy workers and thereby negotiate low premiums on their own. A good compromise would set the threshold between 200 and 500.

**Premium Controls.** Mr. Clinton would impose unrealistically severe caps on private insurance premiums. If health plans are not allowed to raise premiums to recapture the cost of expensive investment, they are not likely to innovate. And overly tight caps will drive health plans to skimp on care sick people need.

Mr. Cooper does away with controls altogether. A good middle ground is to set targets for premiums, which if exceeded would trigger an examina-

tion by the cooperatives to diagnose why premiums were rising so fast.

**Tax Cap.** The way to force health plans to hold down costs is to encourage individuals and companies to weigh costs before choosing insurance. That calls for taxing expensive policies. Mr. Clinton backs down from any such tax; Mr. Cooper would raise taxes on employers that provide high-cost coverage — thereby encouraging them to limit tax-free benefits to workers.

**Universal Coverage.** Major reform comes along at most once in a generation. The President has promised every American ample health insurance. That humane stand should not be compromised. Mr. Clinton would make this happen largely by requiring employers to pay about 80 percent of the cost of covering their workers. Republicans oppose this employer mandate because, they say, it would force employers to cut back employment. But studies show that companies would absorb the cost by lowering wages, not by laying off workers.

Mr. Cooper wouldn't require individuals to buy coverage or employers to pay for coverage. He would provide subsidies for families earning twice the poverty-line income or less to buy insurance through the cooperatives. But that could still mean a family earning \$30,000 would have to buy a \$5,000 policy on its own. Mr. Cooper calls that universal access; we call it merciless.

Some in Congress want to put the burden on individuals, not employers, to buy insurance with the help of government subsidies. So far, no one has put forward a workable scheme that would not require a huge tax hike. That leaves Mr. Clinton's employer mandate as the best idea in sight.

Mrs. Clinton is right to focus on universal coverage, but she should not blind herself to the virtuous parts of Mr. Cooper's bill. Rather than casting Mr. Cooper's proposal aside entirely, the Administration should embrace its strengths and preserve an employer mandate to overcome its weakness.



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# Moscow Trip Called Nice but Irrelevant

## Russians Display New Attitude Of Nationalism, Resentment

A-1

By Fred Hiatt  
Washington Post Foreign Service

MOSCOW, Jan. 15—President Clinton left Moscow this morning after successfully playing a duet of partnership with President Boris Yeltsin during their first Moscow summit. But the dominant theme of Russian politics this week, like a discordant bass line beneath that duet, was of nationalism and resentment of the West.

As a new parliament convened, it became clear that the debate over Russia's future has shifted and that every politician, from Yeltsin ally to Yeltsin foe to Yeltsin himself, now feels the need to sound the motif of Russian greatness and superpowerdom. And while Bill and Hillary Rodham Clinton favorably impressed many on a personal level, ordinary Russians and many politicians alike dismissed the summit as pleasantly irrelevant or worse.

The rising nationalism could, at worst, sour relations with the United States, persuade Ukraine not to cede its nuclear weapons despite an agreement signed here Friday and endanger the fragile independence of many of Russia's neighbors.

Whether it will have such effects is still far from certain. Many Western-leaning Russians seemed to be raising a flag of reasonable nationalism this week

See RUSSIA, A36, Col. 1

precisely to undercut the newly powerful ultranationalists who would seek to restore Russia's empire.

Moreover, resentment of the West was far from unanimous. Many people seemed captivated by Clinton's Phil Donahue-style performance on Russian television Friday afternoon and said they wished their political leaders would similarly talk to them instead of lecturing them from above.

Clinton himself sought to enter the debate during his television performance by telling Russians that greatness depends on democratic and economic achievements, not on military strength.

"I believe that the greatness of nations in the 21st century will be defined not by whether they can dictate to millions and millions of people within and beyond their borders," the U.S. president said, "but instead by whether they can provide their citizens, without regard to their race or gender, the opportunity to live up to the fullest of their ability."

But many Russians seemed in no mood to listen to American advice. "We don't need any tips," Nikolai Travkin, leader of the centrist Democratic Party, said curtly.

"We don't need any help from the West," agreed a 70-year-old woman as she watched Mrs. Clinton's motorcade with her granddaughter, Dashinka, 4. "We're God-loving, hard-working people. And whatever people say, we didn't live badly before *perestroika*," the economic reforms that preceded the collapse of the Soviet Union.

Russian resentment of the West often mixes old, Cold War propaganda with new frustration at what seems to many here a sudden impoverishment and loss of status. In the same breath, many Russians will dismiss the United States as a fading superpower—and then berate it for not delivering as many billions of dollars as Russians believe themselves entitled to.

In a typical commentary this week, the pro-Communist newspaper Pravda said the United States' only goal is to claim the position of "solitary superpower" while forcing the "disarmament of its former en-

emy number one." The article then complained about the "insultingly small sum" the West has provided to build housing for Russian servicemen and their families.

Russian television reported in an evening broadcast this week that Washington sent Russia \$1.5 billion in aid last year—less, the commentator complained, than either Israel or Egypt had received.

Such resentments found eloquent expression in parliamentary elections last month, when the ultranationalist party of Vladimir Zhirinovskiy emerged as one of the most powerful in the new Duma, or lower house.

But what became strikingly evident this week is that Zhirinovskiy is far from holding a monopoly on the nationalist message in the new po-



# The fascinating first lady

**From policy-maker to Vogue model,  
Hillary Clinton breaks new ground.**

**8A** THE DES MOINES REGISTER ■ TUESDAY, DECEMBER 28, 1993

**I**n a small-picture way, Hillary Rodham Clinton is more interesting to watch than her husband. America expects only one, albeit big, thing of him: leading the United States. It doesn't know what to expect of her, even after her first year as first lady.

On the health-care reform front line, lawyer Hillary Rodham Clinton gave as good as she got, gaining respect, however grudging from critics, as she pushed the cause in Congress and around the country. Most people, high- and low-powered, appeared to accept or applaud her policy-making role given her considerable talent for it, even though it's not the sort of thing the nation has expected a first lady to do.

Yet it was her office that unveiled the official White House Christmas card featuring a portrait of the president and first lady. *Just* the sort of thing the nation expects a first lady to do. And she let it be known, a little gratuitously, that she helped daughter Chelsea decorate cookies.

But she mostly kept Chelsea out of the limelight, even off that official Christmas card, to protect her from public glare. Who can't appreciate that? She enrolled the 13-year-old in a choice private school rather

than chance a public-school system with a terrible reputation. That seemed to win her megapoints as a good mother; those calling her a hypocrite for betraying public education didn't do so very loudly, or for long.

Then, in a year-end interview, she found herself in the embarrassing position of a wife denying allegations of a husband's extramarital sex.

And there is Hillary Rodham Clinton in December's Vogue magazine, photographed by Annie Leibowitz, in an elegant black number that forever put her frumpy fashion days behind her. Wow. Those were some sensual images. And they gave new fodder to the commentators, professional and amateur, forever analyzing just who is this woman and what is she (really) up to?

Despite the discomfort of not being able to easily define her, many Americans have come to think a lot of Hillary Rodham Clinton. A CNN-USA Today poll Sunday said she and President Clinton are the man and woman most admired by Americans. That is no small feat on her part, as she breaks new ground as a first lady, way out front politically and personally, willing to be herself and to have some fun, too.

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to press



# The Philadelphia Inquirer

Wednesday, February 2, 1994

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## No health-care crisis? Nonsense!

By HARRIS WOFFORD

Some "just-say-no" Republicans finally have found a novel idea to contribute to the nation's debate over health-care reform. Their comforting message to Americans is: "There is no health-care crisis, only a little health-care problem."

I suppose we should all feel better now.

No crisis? Americans already rendered their verdict whether to reform our health-care system. Now that we finally moved to the question of how to do it, the historic opponents of reform are trying to turn back the clock. Aided by millions of dollars in deceptive advertising from the Health Insurance Association of America and other like-minded groups, they are saying that since there's no real crisis, we need no solution.

Nonsense. No crisis when companies avoid hiring new workers on account of skyrocketing health-care costs? No crisis when some 40 million Americans already are uninsured; when two million more lose their coverage at some point each month; and 100,000 never regain it? No crisis when 85 percent of the increase in federal entitlement costs is in Medicare and Medicaid?

No crisis when, as I saw during my four years as Pennsylvania's secretary of labor and industry, more and more labor disputes are caused not by the issue of wages, but by a decision over who would pay for health-care benefits? When talented workers stay in unrewarding jobs because a pre-existing condition will keep them from getting coverage if they make a move elsewhere?

Crisis when, as I heard at a meeting I conducted at Chester on Monday, single mothers on welfare say they are afraid to take job training and work opportunities because they and their children could lose the health benefits Medicaid provides if they stay unemployed? No crisis when a cancer patient



For The Inquirer / JOHN OVERMYER

health costs.

No crisis when some lose their health coverage by losing a job, while others lose their insurance getting a job and many more lose their coverage by retiring from one. When millions of retirees — including many in Pennsylvania — are seeing their promised benefits become broken promises?

No crisis? Not according to the Pennsylvanians I've met during the past three years.

There is a crisis for the Philadelphia small businessman who began by providing health coverage for his employees, but after years of 25 percent premium increases and benefit cutbacks finally had to drop a health plan altogether in order to stay in business. "Our business is constantly hurt by the loss of quality employees," he told me. Many of them leave for lower-paying jobs or even go on welfare in order to qualify for Medicaid. "They are forced to leave,"

said one child had grown up severely retarded and blind due to viral encephalitis. Another was diagnosed with a rare form of cancer at age three. No one would guarantee continued coverage of these pre-existing conditions. Her frantic search for coverage finally resulted in a bare-bones policy costing \$6,000 per year plus high deductibles. "At times, it's all we can do to hold on financially," she told me.

There is a crisis for the older citizen in Ambler who worked almost 40 years for a major computer manufacturer and was enticed to take early retirement by the promise of low-cost medical benefits, only to see those benefits cut. A cancer survivor with diabetes and heart disease, he said that with these pre-existing conditions, "obtaining health insurance for myself and my wife would be cost-prohibitive. It not impossible altogether."

based on ability to pay rather than on medical need. ... Access to adequate health care is every citizen's birthright."

His Republican colleagues who cannot now see that perversity or accept the idea that affordable health care ought to be a basic right of citizenship may believe that they are contributing an important view to a great national debate, a debate that was first joined in Pennsylvania during my 1991 campaign.

If recent history — and common sense are any guide — these politicians will instead find themselves on the sidelines. Elected officials who say the current health-care system is basically fine and needs only some slight tinkering should keep in mind what happened to Dick Thornburgh, my 1991 opponent, and George Bush.

For even if most Americans are rightly skeptical of the government's ability to solve every problem, they are even more cynical about politicians who just don't seem to live in the real world. (This was why my proposal — now achieved — to end free health care for members of Congress had such powerful symbolic appeal.)

Americans are equally frustrated with insurance companies whose bureaucracy and paperwork seem to exist primarily for the purpose of denying them coverage.

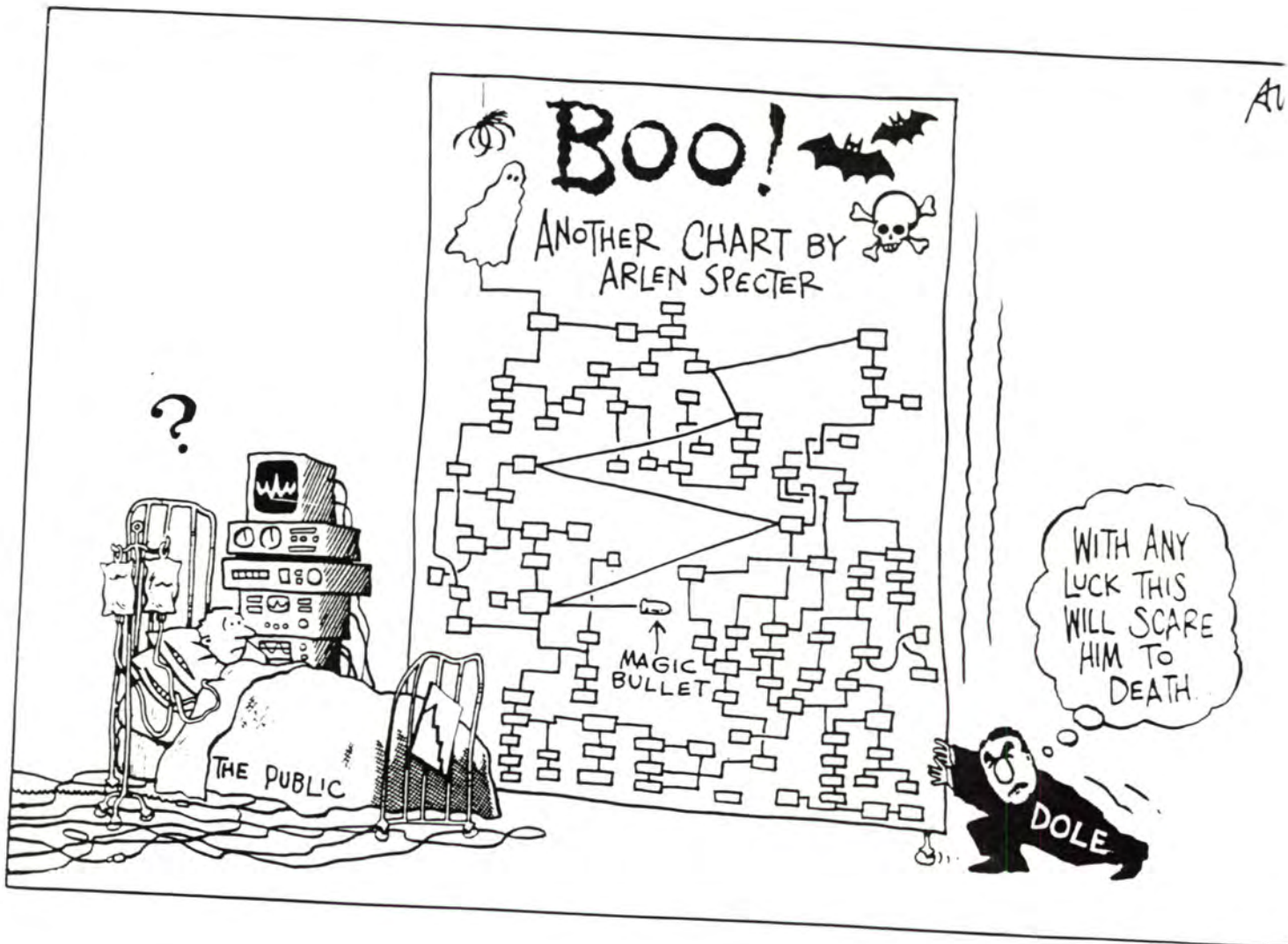
Those chanting the "no crisis" mantra don't seem to realize that health care is a defining issue of our time — and not because of an election or any politician's rhetoric. It's because of the everyday experience of millions of Americans who are seeing their premiums skyrocket and their benefits shrink.

Whipping up fears about any potential change is easy. But I don't believe that most Americans will buy the argument that the status quo isn't so bad after all and that do-nothing solutions are better than real action. Fifty years after Harry S. Truman first called for universal health care,



# The Philadelphia Inquire

Wednesday, February 2, 1994





# Small Business Gives Health Plan Second Look

## A-1 Many Firms Find Cost of Providing Insurance Is Less Than Expected

By Steven Pearlstein  
Washington Post Staff Writer

Nashville restaurateur Jeff Brandon spoke to the fears of many small-business owners last month when he told ABC News anchor Peter Jennings in a broadcast interview that he would be driven out of business by the Clinton health plan and its requirement that he pay for health insurance for his employees.

But a few days later, after calculating that it would cost him as little as \$2,100 more each year to cover

his eight employees and their families, Brandon had a change of heart.

"I think it's a great idea," said Brandon of President Clinton's plan as he rung up the last check one recent afternoon at the Sports Page restaurant in downtown Nashville. "I could certainly swing \$2,100 more to cover everybody."

In the political to and fro over the Clinton health plan, few issues pack more political punch than the plan's impact on small businesses. Last week alone the chairmen of the three House committees that will consider the Clinton package each cited the small-business impact as

the major hurdle that the legislation has to overcome.

Because they account for almost two-thirds of all workers without any health insurance, small-business owners long have viewed with trepidation Clinton's call for "universal" health insurance.

Now that they have had a chance to review it, many of the business owners said the plan could force them to raise prices, live with lower profits, defer pay raises or lay off a few employees. But they reject the notion, popularized by opponents of

See SMALL BUSINESS, A30, Col. 1

### SMALL BUSINESS, From A1

the Clinton plan, that it sounds a death knell for the small business in America.

One such dire prediction was offered by Sen. John McCain (R-Ariz.) on a recent edition of the TV program "The McNeil-Lehrer News Hour."

"If you put this tax on small-business employers in my state, they're going out of business," McCain said.

### 'A Little More Difficult'

The Washington Post asked McCain's office for a list of firms in his state that might fail under the burdens of the Clinton health plan. Of the nine owners contacted from a list of 10, not one thought the plan would force their firms to close. Two, in fact, calculated they would actually save money.

"It won't drive me out of business—but it's one more thing that will make life a little more difficult," said John Anson, president of Copper State Lighting of Phoenix, in what was a typical response.

No group has waged a stronger lobbying effort against the Clinton plan than the National Federal of Independent Businesses (NFIB). "Our members tell us they have a great fear that this will put them out of business," Jack Farris, NFIB president, told viewers of "Face the Nation" last Sunday.

Of five business owners contacted at the suggestion of the NFIB, however, two did talk of selling out or closing their doors—a small recreational vehicle dealership in Kansas and a family-owned Pennsylvania construction firm. Two others discovered they would save money under the plan while one said he would trim his staff.

"Will I survive? Sure—I'm no quitter," said NFIB member John Brinson, whose Lehigh Valley Racquet & Fitness Centers in Allentown, Pa., would see its health care costs almost triple to \$104,000 from \$40,000 under the Clinton plan. Brinson predicts he would lay off three employees to pay for better insurance for the 175 who remain.

### Breaks for Small Business

If the financial impact of the Clinton plan on small business is less than many had feared, it's no accident—it was carefully designed that way. As part of the plan, the administration proposes giving small businesses and low-income workers \$90 billion a year in discounts on their health insurance premiums by the time the Clinton plan would be fully implemented in 1998. The subsidies will go to firms whether they offer health insurance now or not.

Taken together, the employer and employee subsidies total eight times the annual budget for the government farm subsidy program in 1998, nine times the budget for foreign aid and almost three times the allocation for food stamps. They exceed the combined annual operating budgets of the Departments of Commerce, Education, Energy, Interior, Justice and State.

In fact, the subsidies could give small businesses in labor-intensive service industries a significant cost advantage over large competitors. Under the plan, a small business could have health costs of 3.5 percent of payroll, while a large national firm in the same business would pay more than double that.

"Under the Clinton plan, McDonald's will be hit harder than the neighborhood pizza parlor," said Carlos Bonilla, chief economist for the Employment Policies Institute, a Washington research group closely allied with the restaurant industry.

### Who Will Bear Costs?

Even with the generous subsidies, more small businesses are likely to face increases in health costs than decreases—and how they adjust to those costs is the crux of the economic debate surrounding the Clinton plan.

Economists long have believed that business owners in most industries pass added health care costs directly to their employees in the form of lower pay raises in the future.

"There go the Christmas bonuses," said Kathleen Diamond, executive director of Language Learning Enterprise, as she toted up the \$10,000 bite the Clinton plan would take from her Washington translation and language-training company. The firm has nine employees.

This somewhat invisible process of passing on added costs to employees can take a number of years. And in low-wage industries, minimum wage laws may make it impossible to pass it on at all, in big companies and small.

At Red Coats Inc. of Bethesda, 4,000 of 4,500 employees work part time providing janitorial services to Washington office building. None of the part-time workers is offered health insurance.

"If we had to offer it, it would ruin us," said owner Bill Peel, who figures the Clinton plan would add 5 percent to his cost of doing business.

Rather than cut his staff, Peel could try to raise his prices 5 percent to cover the cost of employee health care with the knowledge that all of his competitors would be facing the same dilemma of having to offer

employee health care for the first time. That's what happened recently in the District when the minimum wage was raised by 25 cents. But Peel predicted that an increase in the cleaning bill wouldn't go down so easily.

"Passing through a cost increase to a half-empty building is pretty hard to do," Peel said.

Building owners, however, are not so sure.

"I can't imagine that we wouldn't accept it," said Michael Shehady, vice president of the management arm of the Charles E. Smith Co. in Crystal City. The only alternative to

swallowing the increase would be to risk cleaning less often—something tenants would not accept, Shehady said.

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# Players in Health Care Debate Mobilize Consultants, Lobbyists

By Dan Balz and David S. Broder  
Washington Post Staff Writers

The battle for health care reform, the biggest mobilization of money and talent in Washington in many years, has begun to resemble in cost and complexity a presidential campaign without the candidates.

With President Clinton, Hillary Rodham Clinton, the White House staff and the Democratic National Committee already in full campaign mode, other players in the debate are snapping up political consultants and lobbyists for what they expect to be a yearlong battle.

The White House initially had the advantage because of the ability of the president and First Lady to command national attention. As Marlin Fitzwater, press spokesman for Presidents Ronald Reagan and George Bush, quipped, this White House "does PR the way [former chairman of the Joint Chiefs of Staff] Colin Powell does war: maximum use of force."

But this will be a war of attrition, fought out in more than a dozen congressional committees and subcommittees—and in town meetings and the news media across the country.

"It's like a presidential campaign," said Richard F. Celeste, the former Ohio governor tapped by the Democratic National Committee to coordinate its grass-roots health care lobbying activities. "But you don't know when Election Day will be. And you've got a moving target; the bill today is not the bill they'll be voting on next year."

The DNC has field organizers in 23 states and may spend \$3 million by the end of the year promoting Clinton's health care reform plan. But many private groups have decided it is smart strategy to hire matched pairs of Democratic and Republican consultants so they can play both sides of the street.

Linda DiVall, a Republican pollster, for example, finds herself working with Democratic pollster Mark Mellman for the Alliance for Managed Care, an organization of five big insurance companies that is supportive of key elements of the Clinton proposal.

The Health Insurance Association of America, representing mainly small insurers who fear for their survival under the big health care purchasing alliances that Clinton envisages, has its own matched pair of pollsters, Republican William McInturff and Democrat Bill Hamilton.

They conducted daily tracking polls immediately after Clinton's Sept. 22 speech to Congress and the nation to gauge the shifts in public opinion—something presidential campaigns do only in the final weeks of the race.

But it is not just the big guys who are gearing up for this one. Smaller associations and even individual firms whose economic lives can be changed by the proposal also are getting into the game.

Thus the chairman of Amgen Inc., a California biotechnology

Press Club this month to explain how the administration's proposal may hurt his industry. The event was arranged by Peter Teeley, George Bush's former press aide who is now a Washington consultant, working with two prominent Democrats, John C. White and Robert Neumann.

Celeste said coalition-building has been made difficult by the concerns of many potential allies over specific details of a Clinton proposal that has not yet been put into legislative form.

But everyone knows the stakes are enormous in an initiative that would restructure one-seventh of the U.S. economy and affect literally every citizen in the land. As a result, what one lawmaker dubs "the Godzilla of legislative initiatives" is also proving to be the Lobbyist and Consultant Preservation Act of 1993.

"It seems to me there is more energy in it than there was in the tax reform [fight] of '86, which was the previous high mark," said Frank Mankiewicz, vice chairman of Hill and Knowlton, which is working for the Health Care Leadership Council, an industry umbrella group, and a number of drug companies.

Some political consultants are affiliating along expected lines. Clinton's campaign media advisers Mandy Grunwald and Frank Greer have been enlisted to produce commercials by groups pushing for comprehensive reform—Grunwald for the DNC and Greer for Families USA, a consumer organization. Victor Kamber is allied with labor unions.

But there is also deliberate counter-programming. Lawrence F. O'Brien III, a Democratic activist and lawyer-lobbyist, has been hired by HIAA, the biggest of the insur-

ance associations, along with his partner, Nicholas Calio, the former head of congressional liaison in the Bush White House.

The battle has spawned groups who see their mission in part to counter the claims made by other groups. The Health Care Reform Project is one. Started by Sen. John D. "Jay" Rockefeller IV (D-W.Va.), the project is an amalgam of groups that support comprehensive reform, including the AFL-CIO, American Airlines, Chrysler Corp., the American College of Physicians and the League of Women Voters.

The group has contracted with Robert A. Chlopak, former executive director of the Democratic Senatorial Campaign Committee, and Charles Leonard, former campaign director at the National Republican Congressional Committee, to manage the day-to-day activities, and they already have shown campaign-style aggressiveness by attacking television ads aired by the HIAA.

"What people from campaigns bring [to the fight] is an energy level, a . . . driven sense to get things done," Leonard said.

As in a presidential campaign, which goes from the preliminary stage of attracting attention, to the intraparty fight to win the nomination and eventually to the general election, the health care fight will go through a number of phases. In the end, much of the battle will take place over what is and is not included in legislation. Right now, everyone is vying for public attention, hoping to guarantee a seat at the table when the drafting begins.

Jody Powell, who was President Jimmy Carter's press secretary and whose public relations firm is working for a number of big pharmaceutical companies bundled under the name Rx Partners, said the legislative process in Washington now requires a much greater emphasis on communication with the public.

"A lot is still handled in the hallways and the cloakrooms [of Capitol Hill], but an increasing amount of it gets fought out in a broader arena," Powell said.

Republican National Committee Chairman Haley Barbour sent a memo to Republicans around the country urging them to challenge Clinton's plan for creating a new federal bureaucracy, which the memo said could jeopardize the quality of health care and harm the economy.

While the divided Republicans have not set up a counter-political operation comparable to the DNC effort, conservative groups are trying to fill the void.

Organizations such as the American Conservative Union, United Seniors Union, Citizens for a Sound Economy and the National Taxpayers Union have joined to form Citizens Against Health Rationing.

To get their message across, the coalition plans to hold town hall meetings in different parts of the nation. The first was in Rhode Island and the second will be in Oklahoma. "Going out into the grass roots, we can get a better hearing,"

## Christopher, Aspin, Nunn, Howe on TV

Guests to be interviewed today on major network talk shows:

Secretary of State Warren Christopher, Senate Minority Leader Robert J. Dole (R-Kan.), Senate Armed Services Committee Chairman Sam Nunn (D-Ga.) and retired Adm. Jonathan T. Howe, United Nations special envoy to Somalia, on "Meet the Press" (NBC, WRC), 10:30 a.m.

Defense Secretary Les Aspin, Sen. Bill Bradley (D-N.J.) and Adm. Howe on "This Week With David Brinkley" (ABC, WJLA), 11:30 a.m.

U.S. Ambassador to the U.N. Madeleine Albright, Sen. John McCain (R-Ariz.), House Foreign Affairs Committee Chairman Lee H. Hamilton (D-Ind.) and conservative commentator William Kristol on "Face the Nation" (CBS, WUSA),



## Feeling the Pinch

How any one company responds to a sudden increase in health costs depends on the competitive environment in which it operates and how essential the service is. Economists said those most threatened are firms operating in industries with too many competitors offering services that people could do without.

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### SMALL BUSINESS, From A30

Rainbow Plantscapes Inc. of Baltimore, for example, which offers no health insurance to its 20 employees, would get socked with a \$32,000 premium bill under the Clinton plan at a time of fierce price competition in the interior landscape industry. With few new buildings going up and strapped landlords cutting back on "frills," such as interior plantings, prices have been declining.

"There are simply too many companies chasing too little work," said Gary Bowers, Rainbow's president. "There's hardly a day that goes by that some existing customer doesn't call and say, 'Either you lower your

prices or I'll go with someone else.'"

Bowers said the Clinton plan would force him to lay off at least one employee.

Restaurants face a similar squeeze. Because waiters, waitresses, pantry help and busboys generally get no insurance, restaurants face significant cost increases under the Clinton plan. But some restaurateurs fear that raising menu prices to cover the added cost could be counterproductive, leading customers to eat less—or eat out less often.

"People these days are downscaling if they go out to eat, and drinking a lot less," said Linda Deffinbaugh, owner of Fred & Harry's, a seafood restaurant in Silver Spring. "I'm try-

ing to figure out a way to reduce my prices, not raise them."

Deffinbaugh could see her health premiums for 16 employees rise \$10,000 under the Clinton plan. She can't pass the cost on to the employees, she said, because they haven't had a raise in five years. Nor can she take it out of profits—"I lost \$12,000 last year."

### Pain on Economy's Fringes

In restaurants as in other industries, the health plan is likely to make the weak firms smaller and weaker and the strong firms bigger and stronger without a major impact on the overall economy, economists say.

Eddie Mills, who has been selling

eyeglasses in St. Petersburg, Fla., for 24 years, drove to Tampa two weeks ago to voice his complaints about the Clinton health plan to the president himself, at a town meeting organized by ABC-TV's "Nightline."

Annual premiums to cover his three employees would increase \$900. But Mills-Anderson optical was facing hard times even before the Clintons waged into health care reform. Last year Mills was forced to close two of his three storefronts as costs increased while sales lagged because of fierce competition from superstores like Visionworks and Lens Crafters. The extra \$900 Mills might pay in health premiums, he admits, pales in importance to the more basic threat from competitors who pay \$29.95 for eyeglass frames that cost him \$49.95.

In other instances, the Clinton plan would help level the field of business competition among small firms, for instance, in the Capitol Hill restaurant market.

Menu prices are relatively steep at La Colline, a French restaurant on Capitol Hill, in part because it provides health insurance to all employees. One result is that sales have declined in recent years. Another is that owner Paul Zucconi has been busy making the firm more efficient, streamlining some food preparation and installing his own laundry to wash table linens.

Zucconi would save \$35,000 in insurance costs under the Clinton plan that he would be free to invest in

***"It's the layer after layer, tax after tax, that kills you. The constant battle is not with your competitor, but with the government."***

— James Early,  
owner of Capital Technographics

lower prices. Meanwhile, some of his toughest competitors—Sfuzzi at Union Station, Bice near Judiciary Square and La Brasserie on Capitol Hill—face up to a 4 percent increase in their operating costs as they are forced to offer health insurance for the first time.

"They'll have to raise their prices," Zucconi said, "and that will drive a few customers back to me."

Economists who have tried to tote up the impact of all of these effects warn that it is almost impossible to do—a point echoed last week by Laura D'Andrea Tyson, the chairman of the White House Council of Economic Advisers, at a briefing for reporters.

## Everyone Has an Opinion

But while the economic predictions may be fuzzy, opinions about the Clinton plan among small-business owners almost always are stated sharply. They are opinions that are as likely to be shaped by political views as financial ones.

"It sounds like I'd save \$10,000, but I doubt that will come to reality," said William Cole, who operates Eastern Shore Human Services Inc., which provides transportation to and from doctors offices for low-income patients in Wicomico County, Md.

Like many businesses, he has watched another government-mandated insurance program—Workers' Compensation—double in the last two years. "Maybe the subsidy will be there the first year, and the second," Cole said, "but I can see that evaporating, leaving us holding the bill."

"It's the layer after layer, tax after tax, that kills you," said James Early, owner of Capital Technographics in Springfield, which provides services to architects and engineers. "The constant battle is not with your competitor, but with the government. It can't go on like this."

This "straw-that-broke-the-camel's-back" is the nearly universal complaint of the Clinton health plan from its small-business critics, who are quick to point out that small businesses have created the bulk of new jobs in the U.S. economy over the past decade.

And yet the critique is built around an illogical paradox: How is it that small business could have been creating all those jobs at the same time small businesses were being "crushed" under the burden of federal taxes and regulation?

But the critics are not the only ones whose views are colored by their basic underlying political beliefs.

"I don't care if it costs more or less," said David Elliot, president of U.S. Assist Inc. of Washington, which could see a \$95,000 increase in its health care premiums. "It's the right thing to do."

Staff writer David Broder  
contributed to this report.

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## New Law Lets Medicaid Tap Middle-Class Seniors' Estates

*Last of two parts*

**S**tate Medicaid budgets have been soaring—up a huge 123 percent over the past four fiscal years.

President Clinton's proposed health care program would sharply cut back spending growth. But a cap won't work as long as middle-class people keep abusing the system by using Medicaid benefits that were originally designed for the poor.

Under a newly passed federal law, many middle-class seniors who get Medicaid will discover that, eventually, they will have to pay the government back.

Here's the problem, in a nutshell:

People who have money and enter a nursing home for the rest of their days are expected to pay their own way. If their money runs out, Medicaid (read: taxpayers) picks up their remaining expenses. Medicaid has both state and federal financing, and is run by the states.

But many families hate to see their elders' savings spent on nursing home expenses. After all, say the adult children, "that's my inheritance." So the senior contrives various ways of giving the money to the kids. That makes the senior "poor," which forces Medicaid to pay.

The new budget law closes several of the loopholes that seniors use to give money away and qualify promptly for Medicaid. But the law also backs a second approach, to reach the middle-class people who still wriggle into the program. When they die, their estates may be tapped to reimburse Medicaid for their expenses. (Your estate is all the money and property you own at your death.)

In short, you either pay now for your nursing home care or you pay later.

As of Oct. 1, all states are required to have estate recovery programs. At present, 28 states have such laws on the books, although they vary in effectiveness. In fiscal 1992, \$63 million was recovered for the taxpayers, from 26 states. That's a drop in the bucket compared with a \$122 billion national Medicaid expense. But if the states start getting tougher about it, the amount could increase.

Under an estate recovery program, the state puts an attachment or a lien on the senior's home (providing that the spouse or certain other relatives aren't living there) or on other property. The taxpayers then collect what they are owed before the estate passes to the heirs.

Here's how some of the states are doing:

- Wisconsin recovered \$3.3 million in the latest fiscal year, from 443 estates. To track down the loot, the state's two-year-old program employs one part-time and four full-time sleuths, at a cost of \$162,400—a bargain given the money they help bring in. Most of the work is done by county income-maintenance workers, for which the state pays the counties 5 percent of the collections. Gerald Whitburn, secretary of Wisconsin's Department of Health and Social Services, says that last year, Medicaid became the state's largest expense, running on a \$2 billion budget.

- Massachusetts's 23-year-old program, with a staff of 10, recovered \$8.6 million in fiscal 1993, from 535 cases. That compares with a Medicaid budget of \$3.2 billion. The state is considering using a private contractor to increase the recovery ratio.

- Oregon's 30-year-old program, with a staff of 12, costs the state \$550,000 and recovered \$7.5 million in fiscal 1992, compared with a Medicaid budget of \$1.2 billion.

- Washington state's lenient program was allowing adult children to take a substantial portion of the estate before Medicaid stepped in. Two months ago, however, it dropped those provisions and expects collections to jump fourfold at least.

- In Connecticut, Indiana and New York seniors can avoid estate recovery by buying long-term-care insurance; California will start a program next year. The approaches vary. In Connecticut, every dollar of potential Medicaid expenses that the policy covers is a dollar saved for the seniors' estates. It's too early to tell whether this approach will save Medicaid much money. The new law prohibits any more states from adopting the plan.

Very important: The new law encourages the states to change their laws, so that seniors can't evade estate recovery by putting property into joint names or living trusts. Without these changes, abuse of Medicaid will continue.

Forgetting the taxpayers for a moment, it's in the seniors' best interest to minimize the number of nursing home residents on Medicaid, says long-term-care consultant Stephen Moses of LTC Inc. in Kirkland, Wash. "Medicaid isn't paying enough to sustain good care," he says. "Only the higher costs charged private patients keep quality in the nursing home system."



...to defend itself. ... army has managed to win back some of the ... ry stolen over the course of the war. It should not be hobbled in this effort.

President Clinton has responded well to a situation fraught with diplomatic duplicity. He has resisted both French pressure to get U.S. troops involved on the ground and British appeals to prod the Bosnian Muslims to accept an unjust partition of

would.

Italy or ...

main White House push ... to lift the senseless arms embargo; it should also support trade sanctions against Croatia unless its troops are withdrawn from Bosnia in double-quick time.

## Editorial Notebook

# Fear-Mongering on Health Reform

Thousands of Americans pronounce judgment on President Clinton's health care plan; probably fewer than a dozen have read its 1,364 turgid pages. Perhaps that is why a five-page attack by Elizabeth McCaughey in *The New Republic* magazine has soared to prominence. Conservatives, ranging from Senator Bob Dole to the columnist George Will, have embraced her broadside as gospel. The rule seems to be if you know you don't like the plan but do not bother to master its details, let Ms. McCaughey do your thinking.

But Ms. McCaughey's analysis is careless, misleading and wrong. Her litany of criticisms-by-page number gives the article an aura of scholarship. But true scholars are precise; Ms. McCaughey is not. The White House labels Ms. McCaughey's assertions as lies. That implies that her distortions are deliberate, which may be unfair. In any case, the issue is not her character but her fear-mongering falsehoods that threaten to warp the debate.

Start with the title, "No Exit." Ms. McCaughey argues that Mr. Clinton would stop you from buying medical services you want to buy. You are, she says, entitled only to benefits the Government deems necessary and appropriate: "Escaping the system and paying out-of-pocket to see a specialist ... will be almost impossible." Wiggle word ("almost") aside, the declaration is false. The bill unequivocally protects your right to buy out-of-pocket any treatment from any doctor at any price.

Under the bill, government would set the benefits included in the basic package that every American would be required to buy. And government would set the prices that doctors charge patients who use insurance to pay for these basic benefits. But government would not stop you from buying supplemental policies that offer additional benefits — beyond those deemed necessary and appropriate. Nor would government set the price you pay for supplemental benefits or for any service you decide to pay for out of your own pocket (outside your own insurance policy). Yes, Ms. McCaughey, there are exits.

## The Clinton Plan Misrepresented

Ms. McCaughey points with alarm to a provision that empowers states to make "mandatory, nondiscretionary reduction in payments" to doctors and hospitals if health care costs exceed preset budgets. But what she forgets to tell readers is that the citation comes from a section of the bill describing the states — which the Administration expects to be few, if any — that reject Mr. Clinton's managed-competition approach and adopt instead a Canadian-style single-payer system.

She scares readers more by citing a provision that seems to require government rationing: Officials would "set yearly limits on payments to fee-for-service doctors in each field of medicine, like cardiology or pulmonology." But Ms. McCaughey forgets to say that this citation comes from a section describing a regulatory option that states could, but are not expected to, adopt.

Ms. McCaughey raises fears another notch when she cites "mandatory" practice guidelines that would "compel doctors to uniformly practice low-budget medicine." What she doesn't say is that treatment guidelines would not be compulsory. They would merely be recommended procedures that, if followed, could serve as a backstop against malpractice suits. Health plans would still decide how to treat patients. Mandatory is her word, not Mr. Clinton's.

Her misrepresentations have spread quickly. George Will repeats several, and then adds a juicy one of his own. The plan must ration care, he reasons, or why else would it need to propose 15-year jail terms for bribery? One reason is to punish patients who bribe doctors to help defraud insurance companies; another is to punish plans that bribe officials running state regulatory agencies.

Even many of those who favor managed competition — the basis of Mr. Clinton's bill — want the President's plan drastically amended. But that's no excuse for scaring the public silly with tendentious accusations.

MICHAEL M. WEINSTEIN

PHOTOCOPY  
PRESERVATION

From the Desk of  
MELANNE VERVEER

*file*



# Crucial Lawmaker Criticizes Clinton Welfare Plan

By JASON DePARLE  
Special to The New York Times

WASHINGTON, Jan. 26 — The Democrat who will preside over the Clinton Administration's welfare plan in the House of Representatives today denounced one of its central provisions: a work program that is set at the minimum wage.

The Congressman, Harold E. Ford of Tennessee, said that he supported rules requiring welfare recipients to work but that the jobs should pay at least \$9 an hour.

"We can't expect welfare recipients to flip hamburgers at \$5 an hour," said Mr. Ford, who heads the House Ways and Means subcommittee responsible for welfare policy. "That won't come out of this committee."

In a two-hour meeting with reporters, Mr. Ford sketched a vision of welfare overhaul vastly more expensive than the Administration's.

He spoke of creating nearly one million \$9-an-hour jobs in the public and private sector and offering them not only to people on welfare but also to others in need.

Mr. Ford also took issue with the Administration's plan to finance a welfare proposal without increasing the

federal deficit, by cutting other programs for low-income people. "I'm not sure that can be done," he said.

Mr. Ford gave no cost estimates for his own proposal and conceded that he had not thought through many of its details. Guaranteeing welfare recipients jobs that pay \$9 an hour, for instance, would give lower-paid workers a large incentive to quit and go on welfare.

Rough estimates indicate that a program of the magnitude Mr. Ford described could easily spend \$30 billion a year.

Administration officials, who have said their program, when fully implemented, would cost about \$6 billion a year, chose their words carefully when asked about Mr. Ford's comments. "We have to keep in mind our budget constraints," said Bruce Reed, a White House domestic policy aide who is co-chairman of a task force drafting the Administration's plan.

While Mr. Ford expressed confidence that the differences could be bridged, his remarks underscored the fractious Congressional fight, within the Democratic Party alone, that is likely to greet Mr. Clinton's plan.

Last October, 77 centrist House Democrats sent Mr. Clinton a letter urging him to impose a two-year limit on welfare benefits, after which welfare recipients would have to join a work program. But a month later, a letter signed by 89 other Democrats called the limits arbitrary and said they could "hurt needy families."

In Tuesday night's State of the Union Message, the President promised to send Congress a bill this spring and repeated his intent to expand the education and training that welfare recipients receive in their first two years of aid.

But after that, he said, they will be required to work "in the private sector wherever possible, in community service if necessary." A confidential draft of the Administration plan, obtained last month, said the work program would pay the minimum wage, though states could raise it if they wanted.

Representative Rick Santorum of Pennsylvania, co-author of a Republican work plan, said the Government could not offer welfare recipients \$9-an-hour jobs without discriminating against other low-wage workers. He said Mr. Ford had "absolutely no concept of how the marketplace works."

## Clinton Has a Plan That Would Pay Some People for Not Driving to Work

By DAVID E. ROSENBAUM  
Special to The New York Times

WASHINGTON, Jan. 22 — If President Clinton has his way, many commuters will get pay increases if they give up their parking spaces.

The President will propose in the budget he sends to Congress next month that some employers who subsidize their commuters' parking bills be required to give the workers the same amount of money in cash if they relinquish their parking spots. The aim is to reduce air pollution by encouraging people not to drive to work.

That means, for example, that workers who now park in a lot that charges their employers \$100 a month would have to be offered \$100 in additional pay if they forgo the free parking.

People who do not get subsidized parking would not be affected by the proposal. Employees who take mass transit are covered by another program, in which employers can pay up to \$60 a month tax free for mass transit passes for their workers. Anything above that is taxable to the employee.

The rules would require legislation before they could be put into effect, and the prospects in Congress, which returned to a new session on Tuesday, cannot be gauged yet.

### Not Applicable to All

In answer to inquiries, Administration officials acknowledged that the parking proposal would be part of the budget, but they said that the details were still being worked out. They said the cash option would almost certainly be required only in cases in which employers pay the parking fees at lots owned by someone else. The rules would not apply to the more common situation in which commuters park free on a company lot.

The money workers would receive in place of subsidized parking would be fully taxable, the officials said.

The new proposal is separate from the tax law that went into effect last year requiring employees who get free or subsidized parking to pay income taxes on the value that is worth more than \$155 a month. That law has caused considerable consternation on Capitol Hill, where officials enjoy a very coveted perk: free parking.

Congressional administrators have yet to decide what value to place on the free indoor reserved parking spaces of senators, representatives and their top staff assistants. Assuming the administrators determine the value according

to Internal Revenue Service regulations issued last month, the lawmakers and their aides would owe several hundred dollars more in taxes this April than they might have expected. Those regulations specify that the value of free parking should depend on what the taxpayer would have paid at the same lot or one nearby. Reserved parking spaces at indoor lots nearest the Capitol run more than \$300 a month.

### Gore Is Chief Advocate

The cash-for-parking proposal's main advocate has been Vice President Al Gore, who argues that it would improve the environment. The Government estimates that car trips from home to work and back produce almost 10 percent of the country's carbon emissions.

According to a 1990 survey by the Department of Transportation, 76 per-

## An incentive for cutting air pollution.

cent of all workers drive to work alone; another 13 percent drive in car pools.

Ninety-five percent of the people who drive to work, including more than half the commuters who work in the central business districts of the nation's largest cities, receive subsidized parking from their employers, the department's data show. The Government apparently does not have reliable statistics on how many of the 95 percent park at lots owned by someone else — the only commuters who would be affected by the new rules.

### A Choice Can Raise Taxes

The cash-for-parking proposal grows out of an anomaly in the Federal income tax law. The law gives employers a tax deduction for money they spend on their employees' parking and does not tax the worker on the value of the fringe benefit as long as it is below \$155 a month. But if the employer allows workers to choose between free parking and the cash equivalent, the full value of the parking becomes taxable to the workers.

That has become important in California, where a state law that went into effect last year requires employers in

certain high-smog areas to offer workers a cash alternative to free parking. In theory, workers in those areas who opt for free parking should pay taxes on its value on their 1993 Federal returns. But few workers even know about the law, and it is not clear how stringently the I.R.S. will enforce it.

Under the Administration's cash-for-parking proposal, parking worth less than \$155 a month would be tax-free even if a cash alternative were offered, but if the worker accepted the cash the money would be taxable.

### Optimistic Guessing Game

Based largely on a study by Donald C. Shoup, a professor of urban planning at the University of California at Los Angeles, the Transportation Department has calculated that the cash-for-parking proposal would raise \$1.3 billion a year in additional tax revenue by the end of this century. But the Treasury has not made an official estimate, and some tax specialists think it might be exaggerated.

The additional revenue would come from tax payments by workers who accepted money in place of a tax-free parking subsidy. Since no one knows how many people would cash in their parking privileges, the revenue that would be derived from the proposal is no more than a guess.

Robert D. Reischauer, the director of the Congressional Budget Office, said in an interview that his specialists had not examined the proposal but that he was skeptical it would raise anywhere near \$1.3 billion a year.

To raise that much money, more than 30 million workers, one-quarter of the nation's work force, would have to be entitled to free parking for which their employers pay an average of \$100 a month, and 10 percent of those workers would have to opt for cash instead.

Some tax lawyers believe the proposal might even lose the Government revenue. Mary B. Hevener, a lawyer here who is an authority on fringe benefits, said she expected that many workers who do not get free parking now would ask their employers to reduce their taxable income and give them tax-exempt parking as a fringe benefit instead.

The Times Book Review,  
every Sunday

THE NEW YORK TIMES, THURSDAY, JANUARY 27, 1994



# G.O.P. Line Gels on Idea Of No Real Health Crisis

By ADAM CLYMER  
Special to The New York Times

WASHINGTON, Jan. 26 — After months of struggling to find a position on health care, the Republicans now have a party line: there is no crisis.

"Our country has health care problems, but no health care crisis," Senator Bob Dole of Kansas, the minority leader, said in his nationally televised response to President Clinton's State of the Union Message on Tuesday night.

Representative Bill Goodling of Pennsylvania, the ranking Republican on the House Education and Labor Committee, said after Mr. Clinton's speech that all the nation's health care system needed was fine tuning.

In talking points issued to its members before the President's speech, the Senate Republican Policy Committee proclaimed: "The President insists on calling health care a crisis, but public opinion surveys indicate that the vast majority of Americans are satisfied with their own health care."

It added, "The real crisis in health care is the one President Clinton's one-size-fits-all plan would create."

## 'Common Sense' Advice

The Republican National Committee, in its pre-speech advice to party members, emphasized the desirability of finding "common sense solutions that can be enacted now" in contrast to Mr. Clinton's proposal for universal health insurance, which would be much harder to pass. It said, "Clinton proposes health care that is always there, but what he is prescribing is Government that's always there."

No position in politics is permanent. The Republicans might well fall back to some of the more conciliatory positions they took in the past if their new position sells badly to the public, in the way that President George Bush's efforts to insist that there was really nothing wrong with the economy in 1992 persuaded voters that he was the problem.

The Republicans have changed tack because they found that they were not getting very far on the year's biggest issue by saying, in effect, Yes, there is a crisis, but the President is taking the wrong way out.

And for all the talk of compromise that Mr. Clinton and his wife, Hillary, showered on Republicans, especially on moderate Senators, members of the minority party saw little movement their way and had little sense that they would end up getting much credit for any bill that emerged.

## Vague Party Line

The party is not in lock step. Some Republicans, like Senator John H. Chafee of Rhode Island, will say — if asked — that there really is a health care crisis. Mr. Chafee's complaint on Tuesday night was over Mr. Clinton's threat to veto any health plan that did not include universal coverage that could not be taken away.

But if there are political risks in just going along, more or less, there are also dangers in arguing that there is no crisis when 84 percent of the public, in a mid-January Gallup Poll for the Cable News Network and USA Today, said there was.

Bill Kristol, the Republican strategist who came up with the no-crisis position, said Republicans ought to contradict the notion that there is a crisis no matter how widely it was held, because it was a superficial answer to a poll question, not a serious perception. "No risk, no glory," he said.

At the center of the Republican dilemma is Mr. Dole, who sounds different notes from time to time, sometimes saying universal coverage must be legislated, sometimes saying that all that is needed is to announce universal coverage as the nation's eventual goal.

Mr. Dole may be seeking to solidify his party behind him for a third run for its Presidential nomination in 1996, but he insists he is not thinking about that.

But one thing he plainly is trying to

do is unify the Senate Republicans behind him. And although only one of the 44, Senator James M. Jeffords of Vermont, has signed on with the President's proposal, there is a wide range of thinking in the party today, expressed in at least four different bills.

For most of last year, Mr. Dole was involved with Mr. Chafee's legislation, the most sweeping of all the Republican bills and one that if it did not quite promise universal coverage — as the Clintons diplomatically said it did — promised to try to get to universal coverage. Mr. Dole negotiated on the terms of the bill and insisted on one key step in loosening its rules — by saying membership in an insurance purchasing alliance must be voluntary, not mandatory.

He won that point, but then ended up as a co-sponsor of the other major Republican bills, too. And on Tuesday Mr. Dole proposed an approach that would be less generous than any of them. His argument was that steps like barring insurance exclusion of pre-existing conditions or allowing self-employed individuals to deduct all of their premiums from their taxes could be done quickly because everyone wants them and that the tougher issues could be left for later.

The strategy to deal with only issues on which there is widespread agreement sounds more like an argument for Republican unity, behind Mr. Dole, than a serious proposal for legislating. Just last week, Mr. Dole told The Boston Globe that he did not want to support only popular ideas and leave the harder issues for future battles.

A key to Mr. Dole's strength is the threat of a filibuster, which would mean that it would take 60 votes to get legislation through the Senate. He has

## Republicans change tack to leave the sideline on health care.

not directly threatened a filibuster, but his sometime Democratic ally, Senator Daniel Patrick Moynihan of New York, has repeatedly said that compromises sufficient to find 60 votes are essential.

Mr. Moynihan, chairman of the Finance Committee, has also joined the Republicans in asserting there is no crisis in health care. He did that on the NBC News program "Meet the Press," and then retreated on the Charlie Rose Show, which has a much smaller audience, saying that the nation had excellent health care but that on "health care costs, you've got a crisis."

But Mr. Moynihan's fundamental argument, and Mr. Dole's, is that 60 votes will be needed to break a filibuster. Today, Senator Edward M. Kennedy of Massachusetts, chairman of the Labor and Human Resources Committee, challenged that expectation and in effect dared the Republicans to obstruct the bill.

He told a committee hearing, "The nation deserves a vote, an up or down vote, on all the key issues."

He also said: "As to a filibuster, American people won't tolerate it. The people of this country will not accept a filibuster on health care."

And Senator Nancy Landon Kassebaum of Kansas, the committee's senior Republican and a moderate who hardly ever crosses Senator Dole, joined in, saying, "I am very confident there won't be a filibuster."

She added, "There is a genuine desire to work together to put a constructive health care plan forward."

THE NEW YORK TIMES, THURSDAY, JANUARY 27, 1994



# The Philadelphia Inquirer

Wednesday, February 2, 1994

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## No health-care crisis? Nonsense!

By HARRIS WOFFORD

Some "just-say-no" Republicans finally have found a novel idea to contribute to the nation's debate over health-care reform. Their comforting message to Americans is: "There is no health-care crisis, only a little health-care problem."

I suppose we should all feel better now.

No crisis? Americans already rendered their verdict on *whether* to reform our health-care system. Now that we've finally moved to the question of *how* to do it, the historic opponents of reform are trying to turn back the clock. Aided by millions of dollars in deceptive advertising from the Health Insurance Association of America and other like-minded groups, they are saying that since there's no real crisis, we need no solution.

Nonsense. No crisis when companies avoid hiring new workers on account of skyrocketing health-care costs?

No crisis when some 40 million Americans already are uninsured; when two million more lose their coverage at some point each month; and 100,000 never regain it?

No crisis when 85 percent of the increase in federal entitlement costs is in Medicare and Medicaid?

No crisis when, as I saw during my four years as Pennsylvania's secretary of labor and industry, more and more labor disputes are caused not by the issue of wages, but by a decision over who would pay for health-care benefits? When talented workers stay in unrewarding jobs because a pre-existing condition will keep them from getting coverage if they make a move elsewhere?

No crisis when, as I heard at a hearing I conducted at Chester on Monday, single mothers on welfare say they are afraid to take job training and work opportunities because they and their children could lose the health benefits Medicaid provides if they stay unemployed?

No crisis when a cancer patient told me she's worked all her adult life, but was without health insurance and didn't go for treatment because she couldn't afford it. Now she's afraid she'll have to quit her job and go on welfare to cover

health costs.

No crisis when some lose their health coverage by losing a job, while others lose their insurance *getting* a job, and many more lose their coverage by retiring from one. When millions of retirees — including many in Pennsylvania — are seeing their promised benefits become broken promises?

No crisis? Not according to the Pennsylvanians I've met during the past three years.

There is a crisis for the Philadelphia small businessman who began by providing health coverage for his employees, but after years of 25 percent premium increases and benefit cutbacks finally had to drop a health plan altogether in order to stay in business. "Our business is constantly hurt by the loss of quality employees," he told me. Many of them leave for lower-paying jobs or even go on welfare in order to qualify for Medicaid. "They are forced to secure health care even at the expense of giving up their dignity," he said.

There is a crisis for the West Chester mother of four whose husband's company had its insurance canceled because of skyrocketing

costs. One child had grown up severely retarded and blind due to viral encephalitis. Another was diagnosed with a rare form of cancer at age three. No one would guarantee continued coverage of these pre-existing conditions. Her frantic search for coverage finally resulted in a bare-bones policy costing \$6,000 per year plus high deductibles. "At times, it's all we can do to hold on financially," she told me.

There is a crisis for the older citizen in Ambler who worked almost 40 years for a major computer manufacturer and was enticed to take early retirement by the promise of low-cost medical benefits, only to see those benefits cut. A cancer survivor with diabetes and heart disease, he said that with these pre-existing conditions, "obtaining health insurance for myself and my wife would be cost-prohibitive, if not impossible altogether."

The late Sen. John Heinz knew there was a crisis. In 1990, he wrote, "America's health-delivery system is fundamentally flawed. It is absolutely perverse that, in a nation of such great affluence as ours, we operate under a system that is

based on ability to pay rather than on medical need. . . . Access to adequate health care is every citizen's birthright."

His Republican colleagues who cannot now see that perversity or accept the idea that affordable health care ought to be a basic right of citizenship may believe that they are contributing an important view to a great national debate, a debate that was first joined in Pennsylvania during my 1991 campaign.

If recent history — and common sense are any guide — these politicians will instead find themselves on the sidelines. Elected officials who say the current health-care system is basically fine and needs only some slight tinkering should keep in mind what happened to Dick Thornburgh, my 1991 opponent, and George Bush.

For even if most Americans are rightly skeptical of the government's ability to solve every problem, they are even more cynical about politicians who just don't seem to live in the real world. (This was why my proposal — now achieved — to end free health care for members of Congress had such powerful symbolic appeal.)

Americans are equally frustrated with insurance companies whose bureaucracy and paperwork seem to exist primarily for the purpose of denying them coverage.

Those chanting the "no crisis" mantra don't seem to realize that health care is a defining issue of our time — and not because of an election or any politician's rhetoric. It's because of the everyday experience of millions of Americans who are seeing their premiums skyrocket and their benefits shrink.

Whipping up fears about any potential change is easy. But I don't believe that most Americans will buy the argument that the status quo isn't so bad after all and that do-nothing solutions are better than real action. Fifty years after Harry S. Truman first called for universal, *private* health insurance, we finally have a President and a Congress, Democrats and Republicans, ready to go forward. Now is no time to turn back.

Harris Wofford is a Pennsylvania senator.



For The Inquirer / JOHN OVERMYER



## **THE FIVE BIGGEST LIES** **ABOUT THE PRESIDENT'S HEALTH CARE APPROACH**

**Lie #1: The President wants a government takeover of the health care system.**

**Truth:** The President specifically rejected a government-run system. His approach builds on the current system, preserving what's right and fixing what's wrong. It's the least disruptive approach, building on today's system, where 9 out of 10 people get their insurance through their employer.

He wants guaranteed private insurance for every American. And his approach would make two critical changes. First, it would guarantee comprehensive benefits that can never be taken away. And second, it would provide greater power for consumers and small businesses to choose quality health insurance at lower cost.

**Lie #2: The President wants the government to choose your doctor and health plan.**

**Truth:** You will be able to choose your own doctor and health plan. In fact, our approach actually increases the choices most consumers will have. Under the Clinton approach, all Americans will be able to choose from several kinds of health plans, no matter where they work. And everyone will have the option of a traditional fee-for-service plan, where you go to any doctor you want and pay individually for each test or procedure. And people will be able to switch plans every year if they're not satisfied with their care or service.

In fact, it's today's health care system that is limiting people's choices. In 1988 , 89% of employers offered fee-for-service plans but, by 1993, this number had dropped to 65%. [*"1992 Health Care Benefits Survey"*, Foster Higgins, 1992; *"Health Benefits in 1993"*, KPMG Peat Marwick]



### **Lie # 3: Price controls will cause rationing.**

**Truth:** The President specifically rejected price controls. His approach does include a limit on how much insurance companies can raise premiums year to year. And the insurance companies are trying to scare you because that would limit their freedom to jack up rates. Rationing is a classic scare tactic; but experience shows that you can control health care costs and provide quality care.

This debate is about insurance companies that want to keep picking and choosing whom to cover or drop, and when to increase rates. The Clinton approach puts people in charge. It will be illegal for insurance companies to drop you, refuse you, or jack up rates because of your medical history or age.

### **Lie #4: The new system will be a bureaucratic nightmare.**

**Truth:** Nothing could be more complex than what we have now. Today's patchwork system is the result of insurance companies competing to cover only the healthiest people.

The important thing is what happens to the consumer and the Clinton approach will make life easier for people. You'll know what you're getting without having to read insurance company fine print. And you'll have a Health Security Card and fill out one standard claims form -- without all the insurance company red tape -- when you go to the doctor's office. The Washington Post says the Clinton approach will create a "surprisingly simple" world for consumers.

### **Lie #5: Reform will be a job-killer.**

**Truth:** High health costs today are killing businesses, large and small. The Clinton approach will help businesses compete by bringing costs under control. The Wall Street Journal called the Clinton approach "an unexpected windfall" for small businesses that currently provide insurance. And all small businesses will get increased bargaining power and discounts on the price of insurance.

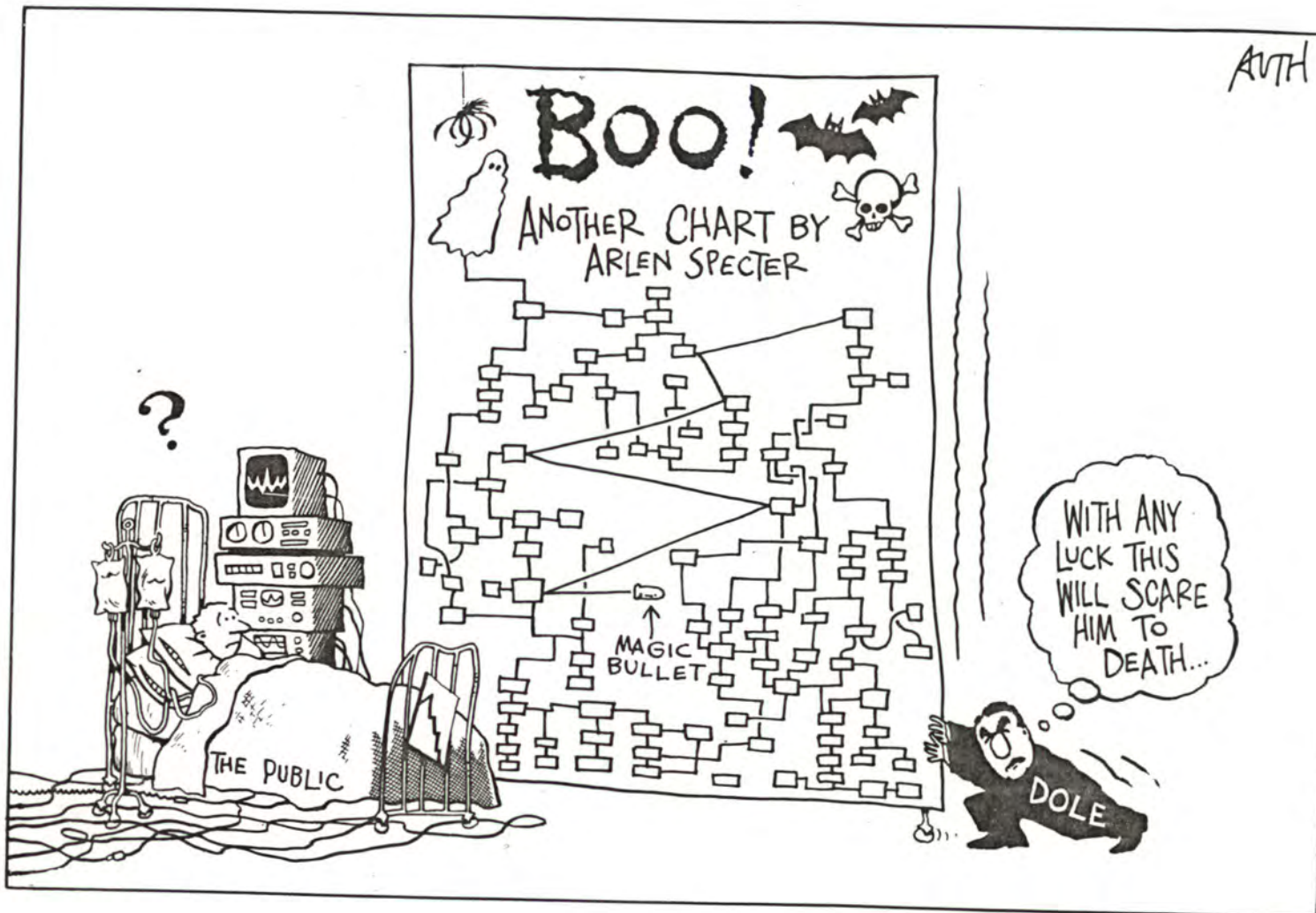
In fact, analysts predict job gains as a result of our approach. An Economic Policy Institute predicts that 258,000 manufacturing jobs will be created over the next decade as high health costs drop. There will also be health care jobs created, as we guarantee coverage for everyone, with one Brookings Institution analyst predicting 750,000 jobs created in home health care alone. Some people will certainly be doing different things -- there'll be less people processing paper and more people giving care.



# The Philadelphia Inquirer

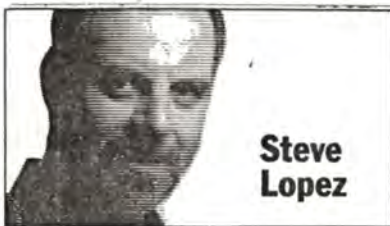
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The Philadelphia Inquirer / TONY AUTH





**Steve  
Lopez**

## *Bloody fools on health care*

To be completely honest, I wasn't focused. Whenever Sen. Bob Dole appears on my TV screen, with his Chernobyl P.R. Man smile and all that eyebrow action, my first thought is, "Damn, this guy's scary."

Then, no matter what Dole is saying, my eyes begin to glaze over.

That's exactly where I was the night Dole gave the Republican response to President Clinton's State of the Union Address. Fading, glazed. And then, on the edge of sleep, I heard Dole say something about a chart drawn up by his colleague, Sen. Arlen Specter of Philadelphia.

The idea of Bob and Arlen putting their heads together, while frightening, was at least intriguing. So I sat up and tried to focus on the chart as Dole walked over to it.

All I could make out at first was a maze of lines and boxes, and I found myself wondering if Arlen had accidentally turned in a schematic diagram of the circuitry on his toaster.

But as I looked closer, and saw dozens of little boxes all connected to a bigger box, another thought occurred. Arlen was showing us how the various chapters of the National Rifle Association pour money into his political campaigns.

But why? It didn't make sense. And then I began to catch on.

Arlen had whipped up an Eagle Scout decoder chart, ostensibly to suggest that President Clinton's health-care plan is a big hairy mess, although I'm not sure how clean a plan for 250 million people can look.

### **The GOP and little me**

After droning on awhile, Dole suddenly bent at the waist — I thought he was falling asleep, too — and waved at the bottom rows of boxes.

"You and I are down here somewhere," he said.

It was like an episode of Mr. Rogers, boys and girls. But I looked real close, and sure enough. I saw myself in the second row from the bottom, buying a bottle of Pepto-Bismol at an AM-PM Minimart. Arlen Specter was a couple of boxes over, trying to sell an NRA membership to a gunman who was holding up a drugstore.

The more I thought about it, the more I realized how much brainpower went into the chart. And so, through the Freedom of Information Act, I got a transcript of the meeting that led to its development.

Dole: I've got it. We'll use a prop.

Jesse Helms: Let's draw up a chart, like that rabitty fellow, Ross Perot.

Orrin Hatch: It's uncomfortable for me to bring up, but I think we should draw a lot of breasts and penises.

Dole: I think Jesse's choking.

Alan Simpson: I know it's odd, but I feel an attraction to Anita Hill.

Strom Thurmond: My hair doesn't look like Orange Crush, does it?

Jesse Helms: As far as I'm concerned, there is no health-care crisis.

Orrin Hatch: Let's go with that.

Dole: Fine. Does anybody actually know anything about health care?

Arlen: I was just in the hospital.

Dole: Show of hands, boys? Good. It's unanimous.

A funny people, the Republicans.

Clinton's plan may need some work — and some trimming — but that's the point. It's a plan.

### **A party without a care**

The Republicans, 12 years in power, never saw the need for one. As a result, medical fees are astronomical, 30 million people have no health insurance, and millions more struggle to pay for policies that give them few choices and many risks.

But in their defense, there's a good reason Dole and Specter are completely out of touch. Thanks to your tax dollars, they have a health plan that's so good, it's hard to imagine there could be a health-care crisis.

When Specter was ill last year, and didn't agree with the medical diagnosis, he was able to virtually order up the costly diagnostic procedure that detected a brain tumor and may have saved his life.

And now, after a career in which he's been almost invisible on health care, one of Specter's aides draws up what could just as easily be the management flow chart at a Taco Bell, and Arlen's a national hero.

I called his office and was told that 10,000 people have requested copies of the chart. Laminated, it makes a nice placemat. Or maybe people plan to enlarge it and look for themselves in the bottom rows.

Specter's office was nice enough to fax me my own copy. I put a magnifying glass to it — all those lines emanating from a single location, all those sharp turns and angles — and that was when it hit me.

The motorcade. The crowd. Lee Harvey Oswald. JFK.

It's Arlen's magic bullet chart.



# The New York Times

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## Health Tinkering Is Not Reform

Representative Pete Stark, the California Democrat who heads a House subcommittee on health policy, says that Congress ought to scrap the purchasing cooperatives, or alliances, that lie at the core of the Administration's health care bill. The Senate minority leader, Bob Dole, and another Republican Senator, Phil Gramm of Texas, say that Congress ought to gut the other institutional reforms proposed by the President as well — and stick to small fixes. In the next few weeks Congress will decide whether it will overhaul or merely tinker with health care.

Tinkering is not enough. To see why, imagine that Congress takes the go-slow approach and does little more than require insurance companies to make their policies *portable* (workers can keep the policy when they leave their current employer), *community rated* (the chronically ill pay the same premiums as the healthy) and *guaranteed* (insurers are required to sell to applicants regardless of preexisting medical conditions).

These small-fix insurance reforms are not enforceable if Congress leaves the current unregulated — and uncompetitive — market largely in place. The Government would find it difficult, for example, to check whether insurance companies were serving all potential applicants. Did the insurer recruit only in Scarsdale? Did the insurer answer phone calls from potential applicants in Harlem? Did the insurer tailor its benefits package so that AIDS patients would not apply?

Congress could, of course, enact 13 trillion pages of rules to stop these practices. But a more effective, less regulatory answer is to require most individuals or their employers to buy coverage through a cooperative, or alliance. The alliance, not the insurers, would then make every policy equally accessible to everyone in the region. The alliance is also positioned to transfer money from insurers who, through trickery or happenstance, do not enroll many AIDS patients to insurers who do; that is the only effective way to force insurers to serve the chronically ill.

Even the power of the alliances will probably

not stop insurers from all discrimination. So Congress will need to insist that insurers provide an identical set of health benefits — known as a standard benefits package — to every enrollee. That way policies cannot be crafted to attract only healthy applicants.

Minimal fixes would leave too many loopholes. If each of us is guaranteed the chance to buy coverage whenever we want at community rates, none of us who have a choice about coverage — who are not automatically insured through work — will buy until we get sick. That would leave only the sick to buy coverage — at what would have to be prohibitively high premiums. Under such rules, 20-something-year-old couples would wait till the wife becomes pregnant before purchasing insurance.

Advocates of small-fix reform would almost certainly have to allow insurers to exclude coverage for preexisting conditions for at least, say, nine months. But that provision would leave millions of Americans temporarily unable to get insurance and would not stop many others from gambling that they could do without insurance — knowing they could always flee to the nearest emergency room largely at public expense. The solution is to make insurance mandatory, as President Clinton proposes, so that no one, when well, can skip paying premiums.

Real portability is another fix that takes more than a flick of the legislative pen. Congress may promise workers that they can continue to buy their old policy after they change jobs; but what good is that promise if their new employer doesn't include the old plan among available health-care options? Again alliances are an answer. If people get coverage through alliances, rather than employers, they would retain access to their old plans as long as they continued to work in the same region.

Every American ought to have coverage that is portable, community-rated and guaranteed — operating through a system that is fair, dependable and free of loopholes. Alliances and a standard benefits package look like the best road to those goals. Anything less does not deserve to be called reform.



*file Wash Post  
health care*

## The Guns of February

**T**HE WHITE HOUSE "WAR ROOM," IT IS REPORTED, IS ON the health-care-reform case, getting ready to blast away, as the First Lady has just done, at any who oppose the president's plan. Critics—mostly conservative—fire some shots that appear to be well placed and some that seem to be completely misaimed. Their fire is returned from the White House, and the debate, as it is optimistically known, is on. I'm sorry to say that so far it resembles nothing so much as the outbreak of World War I—a melee of accident, error, misjudgment, malice and miscomprehension.

Make no mistake, this mammoth proposition that the administration has sent up to Capitol Hill needs and invites plenty of argument. So it is not the existence of the confrontation that is troubling. Nor can you say that the Clinton administration is inept at moving tough legislation through Congress. The president had notable victories, for example, on both last year's important budget bill and the much worried-over NAFTA. But there are differences this time. For one thing, in his earlier efforts Clinton used up a certain amount of the resources available to him for barter. And, importantly, he also used up some arguments that are pretty much one-time-only appeals, such as those about having to save his presidency or not embarrass him on the eve of some large international event. Push these buttons once too often and a president looks not like a president but pitiable and easy to walk over.

But the main difference is the legislation itself. Crucial as the budget-cum-tax bill and NAFTA were, the health measure dwarfs them in several respects. Its complexity is stupendous and the impact of its intricate web of proposals extremely difficult to predict; it affects in a big way the interest of every commercial and industrial enterprise in the country, as well as the interest of every individual, and it does so on a matter about which no one can be even mildly indifferent. This one requires the best, most intelligent, most serious lobbying effort the administration can muster.

That is nowhere in sight. What has happened instead is that this gigantic book containing the program has been released to all but read through by practically none; even so some have begun to attack its provisions and others to defend them, and lines are being testily drawn about particular features that most of the combatants couldn't explain if their lives depended on it. I think that, in the first place, the administration should have put forward a less-detailed and all-inclusive product and let more be worked out in legislative language in cooperation with its allies on the Hill. Now you have this near unreadable doorstop volume that those with a particular interest, often unremittingly hostile, can mine for items and prospects that scare the daylight out of people who have no way of judging their falsity or truth.

But that part is done. What is just getting started and ought to be, as they politely say, rethought, is what appears to be a two-track lobbying effort that is singularly lacking in coherence. On one track are the president and some of his cabinet members saying most of the myriad provisions of the bill are negotiable. On the other are various

White House war-room artillery sergeants firing salvos to the effect that anyone who dares to oppose the bill is a political hack, a tool of the interests or some other Washington variation on pond scum. One track seems sometimes to give too much too soon from a bargaining point of view. The other seems mainly to give offense. Where are these tracks going? Has anyone seen the train?

Whenever Bill Clinton or any other president who has held the office since 1968 gets into a bribing or threatening posture with Congress, people mindlessly start comparing him to the great tormentor-persuader Lyndon Johnson. This is usually way off the mark. All presidents try this kind of stuff. The difference is that Johnson was exceptionally good at it, understanding the wants and weaknesses of the members better than anyone has since and being more willing to exploit them ruthlessly. By doing so he got some great things to happen. But trying this stuff without being really good at it invites more than failure; it invites reversal and rout. Unlike in the NAFTA case, Clinton doesn't have a huge component of Republicans with him this time around. He does have Democrats who have strong conflicting views among themselves on what the outcome should be. And because the financial stakes in this legislation are so high, with various industries, unions and health enterprises making out much better under one variation of the bill than another, the politics of passage are likely to be unusually complicated and intense. Clearly, then, the administration needs its best people for



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the job to be working with the Hill.

This brings up what may have been another early misstep: the decision to have the legislation created and promoted by a special White House-based ad hoc working group and commission and so forth, that existed outside the traditional buildings and venues from which such legislation comes—Treasury, Health and Human Services, Management and Budget, accountable agencies. But whether that was wise or not, it does seem to me that the White House could still get the good of its most practiced, Congress-grounded people—Secretary Bentsen, OMB Director Panetta and Deputy Director Rivlin and others—if it made them the main spear carriers in the negotiating, redrafting and lobbying effort.

War is too important to leave to the generals, the saying goes. This bill is way too important to leave to the "war room." Demonizing opponents, even those who write and behave like absolute demons, is dumb. Calling people toadies of anything is dumb. The insurance companies (some of which prosper enormously under the current Clinton bill) are not models of popularity in this country; but railing at them, while gratifying, is not a strategy. And besides, some of them are potential allies. There is a lot of wisdom (truly) on the Hill on this subject and a lot of savvy in the agencies of the administration. They can be brought together to take advantage of the opportunity Clinton has created to enact a major health reform at last. To the extent that some—surely not all—opposition is reckless and deceptive, as charged, it will not be defeated by a response in kind. What it could not withstand would be the solid, sensible, negotiated bill that could yet come out of the proceedings.



# Precious principles of health reform

**W**inston Churchill argued that democracy is "the worst form of Government, except all those other forms that have been tried from time to time." It follows that democracies enact the worst solutions to problems, except for other grim remedies that could be employed. The outline of Bill Clinton's health reform plan fits this pattern. Congress is poised to launch major surgery on the president's proposal, removing parts like price controls for good reason. Yet lawmakers should preserve two of Clinton's key principles that are the best options among an array of unattractive choices.

First is the so-called employer mandate—the requirement that all employers contribute to their workers' health coverage. The president argues that this approach builds on the current system in which 9 out of 10 Americans with private health insurance get it through their own or a family member's employer. Yet many small firms fear the costs and distrust Clinton's pledge that government subsidies will lighten the load. Moreover, in an era of global competition, requiring firms to pay toward a fixed, generous benefits package could strip them of flexibility to manage future expenses. Fears of massive job losses are overdrawn, but there is legitimate worry about how many future jobs would be created if all firms toiled under Clinton's hefty benefits burden.

Still, there is a larger issue at stake. Employment-based health coverage is shrinking fast: In 1987, 72 percent of the work force was covered by private group health insurance, but by 1992 that number had fallen to 68 percent. What's more, roughly 75 million people are now enrolled in publicly funded health insurance, ranging from Medicare to programs for state and local workers. That's three times the number enrolled in Canada's taxpayer-funded health insurance system. America's public insurance pool could well grow to 110 million, or about 40 percent of the population, by the time most baby boomers have turned 65 and qualified for Medicare. If employer-based coverage erodes further, more galloping health outlays will be heaped onto tomorrow's taxpayers.

**Stoking innovation.** Another concern is that without a private counterweight to public plans, the nation might lose out on much critical marketplace innovation. Employer-based plans have led public systems in experimenting with arrangements like health maintenance organizations (HMOs) and ways of fostering enrollees' health. By enacting an employer mandate, policy makers would hand pri-

vate firms the task of stoking further innovation. But first, Clinton and Congress should strike a deal to phase in the mandate slowly. They could cut the share of premiums that employers must contribute to workers' coverage from 80 percent of an average-priced health plan, as Clinton proposes, to more like 50 to 70 percent. They should reject Clinton's one-size-fits-all plan in favor of a menu of options, from "catastrophic" plans with high deductibles to comprehensive packages. Finally, they should limit the tax break that makes health benefits nontaxable to workers in such a way as to encourage them to pick the best deal on coverage.

The second principle that should be preserved is universal coverage, or the guarantee that all Americans will

have health insurance. Some pundits argue that the nation can't afford insurance for the roughly 15 percent of the population that is without it at any given time. But every other large industrialized nation except South Africa has universal coverage—and the World Bank reports that in 1990 the United States, with 1 out of 20 of the world's people, spent nearly \$4 of every \$10 that the entire globe spent on health care. Meanwhile, U.S. health outlays will undoubtedly rise from 14 percent of gross domestic product now to almost 19 percent by the year 2000. Achieving universal coverage, done carefully, merely means having the political will to spread this gigantic



*'In reality, the nation can't afford to forgo universal coverage.'*

pot of health dollars among more Americans.

In reality, the nation can't afford to forgo universal coverage. Health insurance is evolving from a mechanism for simply paying doctors' and hospitals' bills into a means of managing health risks and costs. The results are dramatic: In California, where half the population is now enrolled in HMOs and other "managed care" plans, costly hospital days for every 1,000 people fell by more than a third from 1980 to 1992. To maximize savings, virtually all Americans must be enrolled in similar systems "where their incentives to stay well are matched by providers' incentives to keep them well," contends C. Duane Dauner, president of the California Association of Hospitals and Health Systems.

Let's not kid ourselves: With an aging population and booming technology, rising health outlays will be with us forever. But universal coverage, delivered through managed health systems, is the best hope for spending those dollars more efficiently. Congress should swallow its aversion to confronting people with the upfront price—new taxes—and get moving toward this fundamental goal. ■



## OPINION USA

# Health reform may cheat our sickest kids ✓

**As a parent with a child with special health-care needs, I see major gaps in the Clinton plan, as well as in other proposals.**

By Polly Arango

My son Nick is 17 years old. He attends high school, prefers Big Macs and pizza, loves to ski and swim, spends hours in his room listening to music, sometimes ignores my advice and asks me to bug off, and dreams of being a firefighter someday. He's a pretty typical teenager.

Now let me tell you what it takes for Nick to be typical.

His educational assistant helps him open classroom doors and take down school assignments. My husband and I puree his hamburgers and pizza so he can eat them. Special programs on the ski slope and at the swimming pool allow Nick to have fun safely. He operates his stereo with remote-control devices. When he needs to say something, he punches his remarks into a computer and it speaks for him. And it will take a creative community effort for Nick to realize his firefighting dream.

Like about 150,000 youngsters, Nick has special health needs that seriously affect his life. Recent studies show that

there are nearly 10 million other children who have a less severe chronic health condition.

For my family, and for families who have children with any one of hundreds of challenging health conditions or disabilities, health-care reform is not just an interesting political discussion. It will determine whether we can take care of our children with special needs at home, where we will work, if we can buy a house or send our kids to college, whether we move to another state, or even if we can stay together as a family.

Like other parents, I have not waited for health-care reform to come to me. I want to know how each proposal now in Congress takes care of youngsters like Nick.

A look at the Clinton plan shows good news for most families, but major gaps for children with special health-care needs. For example, rehabilitation is provided only for conditions that result from illness or injury, so a youngster born with cerebral palsy could not receive critically important



**AT HOME:** Polly Arango, the mother of four children, including her son, Nick, at their home in Algodones, N.M.

therapies. Kids' eyeglasses are included, but hearing aids are not. The Clinton plan offers a home- and community-based long-term-care package for

people with disabilities, but it is flawed for children: Its only required services — planning and personal attendants — won't help children much; only

about 100,000 children would meet its strict eligibility criteria; and its payment structure would place an impossible financial burden on most middle-class families.

The developers of the Clinton plan believe that their Medicaid provisions will take care of these children, but careful readers of the plan disagree.

On the other hand, the Clinton plan at least spells out its benefits and mandates universal coverage. Most other plans do not define benefits, or necessarily eliminate pre-existing condition exclusions. They also leave you wondering what will happen to your child in the years before critically important services are phased in.

The proposal by Rep. Jim Cooper and Sen. John Breaux, for example, can't promise that coverage won't be lost. Sen. John Chafee's bill has subsidies for poor people but, like most plans, includes many co-payments and deductibles that can really add up quickly.

The simplest plan, by Sen. Paul Wellstone and Rep. James McDermott, offers universal coverage, choice of doctor, an acute-benefits package, eliminates pre-existing condition exclusions, and promises to come online in less than a year. But it provides few de-

tails about services for children like Nick.

Can we change any of the legislation that has been introduced? Yes. Members of Congress and the Clinton administration have approached various groups to seek their opinions about amendments. And many child advocates and disabilities activists have been working together on a special children's health program to make sure that kids like Nick don't fall through the cracks.

Why do many families like mine approach health-care reform with such intensity and healthy skepticism? It's because we know that:

1. There is a health-care crisis. Tens of thousands of families cannot purchase insurance because of their child's pre-existing condition. Thousands of parents have lost jobs because their child has driven up their employer's health-premium costs. Some working parents have been forced to separate so their child could qualify for Medicaid. And 8 million children — healthy or sick — do not have health insurance.

2. Only major reform will fix the crisis. Despite what most people think, most kids with a disability don't qualify for Medicaid. For years, insurance companies and state and federal

al policymakers created one program or another to address a specific health-care issue or population. The result is a hodgepodge of well-meaning programs with eligibility criteria that make families crazy.

3. Universal coverage will help. Then an insurance company can't turn down a child like Nick or a dad whose youngster needs multiple surgeries and follow-up therapies in order to live at home with the rest of the family.

4. Benefits packages must be broad and flexible. If benefits are neither available nor comprehensive, the consequences are costly, not only for a child but for his family and society.

My advice to families? Learn all you can about health-care reform. My family and I want to make sure the solutions fit the problem. The wrong kind of reform will send many of our kids into expensive institutions, families into bankruptcy, and all of us on a detour away from the American dream. The right kind of reform will let us be families.

*Polly Arango is one of the founders of Family Voices, a national network of families with children with special needs. For more information, call 505-867-2368.*





BY MARILYN MOON

## Health Reform and You

**Q.** *If I took federal retirement at this time and became a self-employed consultant, would I have to lose my federal employment coverage and deal with purchasing coverage for myself as a self-employed person? Or would the retirement insurance cover me even if I made quite a bit of money in self-employment?*

**A.** If you retired and became a self-employed worker, you would still benefit from federal retiree coverage, but as your own employer, you would also be required to make a contribution toward the costs of your health insurance. The proposal by President Clinton requires that both employers and individuals contribute. Normally employers pay either 80 percent of premium cost or 7.9 percent of payroll, whichever is lower. But the amount may be reduced. If your earnings were below \$24,000, your employer contributions would be limited because you would qualify for a small business subsidy. For example, if you earned \$10,000, you would have to pay only 3.5 percent of that amount, or \$350, as an employer contribution. As a federal retiree, you would be exempt from having to pay the individual's share of the premium. Thus, in this example, you would pay \$350 a year toward the cost of your premium.

**Q.** *I'm 35 years old and pregnant with my second child. My first pregnancy was completely uneventful, and I have a very healthy 4-year-old son. My doctor wants me to have amniocentesis because I'm over 35, but my insurance company will not cover it because I have no family history of problem pregnancies. The cost is \$2,000. Would the new health reform system cover such routine genetic counseling?*

**A.** All of the health reform proposals being discussed would potentially cover amniocentesis, but only if it is termed medically appropriate. Your current insurance company probably operates on a set of guidelines under which it has determined that this test is not medically necessary in your case. This is comparable to what would happen after reform under all of the plans. What is not clear, however, is exactly what the rules would be and how uniformly they would be applied. In the case of proposals like

those offered by President Clinton, Rep. Jim Cooper (D-Tenn.) and Sen. John Chafee (R-R.I.), for example, there would be multiple insurance plans competing for your business. Some might be more lenient than others. Moreover, some decisions on coverage would be made by the government. The National Health Board under the Clinton proposal and the National Health Standards Board under the Cooper proposal would make some determinations. It is not known how detailed the guidelines they would draw up would be, however.

**Q.** *In the health care debate, it seems like nothing is being said about co-payments and deductibles for Medicare. How will they change under the Clinton plan? Also many Medicare recipients have Medigap insurance to supplement the coverage. Will this still be necessary?*

**A.** Under the Clinton proposal, co-payments and deductibles now in place under Medicare would remain unchanged. Two new sets of co-payments would be added: one for laboratory services (20 percent of the costs) and one for some home health visits (10 percent on any visits that do not occur within 30 days of being discharged from the hospital). The proposal would also add a new prescription drug benefit under Medicare, the value of which would exceed the average costs of the other new co-payments. Since many Medicare beneficiaries wish to purchase protection against the co-payments and deductibles, Medigap policies would likely still be very common. The costs of such policies would, however, likely decline if they now include prescription drug coverage.

The health reform proposal that would have the largest impact on Medicare would be the single-payer plan of Rep. Jim McDermott (D-Wash.) and Sen. Paul Wellstone (D-Minn.). In that proposal, Medicare would be eliminated and the elderly and disabled would be in the same plan as everyone else. There would be no deductibles or copayments, and prescription drugs would be covered. Under the other proposals that are being discussed, Medicare would largely remain unchanged. The Cooper proposal would add some modest new preventive services, and the proposals by Chafee and by Sen. Don Nickles (R-Okla.) would each increase Medicare co-payments in ways similar to the Clinton proposal.

**D**o you have a question about President Clinton's health proposal or about the other bills in Congress? The Washington Post free telephone information service takes questions from readers about how the plan could affect them. Call POSTHASTE at 202-334-8000 on a touch-tone phone and enter category code 8500 (in Prince William County, 703-690-4110). Health economist Marilyn Moon of the Urban Institute provides answers in this column based on information from the White House, Congress and other sources. While she cannot answer all questions or give personal advice, she will answer a range of inquiries.