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MSA DEMONSTRATION: RESEARCH SUGGESTS CONTROLS NEEDED TO PREVENT ADVERSE AFFECT ON INSURANCE MARKET

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Overview

Health insurance reform legislation is stalled largely because of controversy over whether tax-advantaged Medical Savings Accounts should be permitted.[1] A potential compromise would allow a "demonstration" to test and evaluate the effects of MSAs before Congress considers whether to make them permanent. Senator Kassebaum and other Senate Republicans have proposed a broad demonstration that would allow MSAs to be used during the demonstration period by employees of smaller businesses (those with up to 50 employees) and by self-employed persons.

There continues to be considerable disagreement about whether it is possible to conduct a safe and effective demonstration project — one that will provide information about the effect of MSAs on workers, employers, and insurers while not creating widespread irreparable harm to any of those participants or to the insurance market as a whole. Although many issues remain outstanding, two types of issues affecting the design of the demonstration are particularly thorny:

- The extent to which the demonstration design should include relatively stringent limits on deductible amounts, coinsurance requirements, and total out-of-pocket expenses for the high-deductible insurance plans used in conjunction with MSAs; and

- The size and scope of the population permitted to use MSAs during the demonstration period.[2]

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[1] Medical Savings Accounts are tax-advantaged personal savings accounts that may be used by persons covered by high-deductible health insurance policies. Funds in the MSAs may be used to pay for a wide range of health care expenditures, including types of expenditures not covered by the insurance policy. MSAs are included in H.R. 3103, the Health Coverage Availability and Affordability Act of 1996, that the House passed on March 28, 1996. Medical Savings Accounts were not included in the Senate version of the legislation that passed on April 23.

[2] This paper focuses on design issues that would directly affect the insurance market. A number of other design issues remain outstanding. For example, as the legislation stands, the tax treatment of MSA funds

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The issues of demonstration design are important because there is a strong potential for widespread use of MSAs to result in a division of the health insurance market — known as "adverse selection"— that could drive up the cost and curtail the availability of conventional insurance. Adverse selection would occur if young, healthy people with low medical costs were to become concentrated in one type of insurance plan, in this case the MSA plans. MSAs would be attractive to such people because the MSA legislation allows participants to retain unspent health care dollars in their own accounts. People with low health care costs could accumulate tax-free investment earnings on those funds and eventually use them as retirement savings or (in some circumstances) for other purposes.

Because the younger, healthier people choosing MSA plans would no longer participate in conventional insurance, conventional, low-deductible insurance would be left covering those who are less healthy and have higher medical costs. As a result, the cost of conventional insurance would increase; the premiums for it would reflect the higher average medical expenses of the pool of people remaining in conventional insurance. According to the American Academy of Actuaries, a disproportionate share of these would be older employees and pregnant women.

Recent research suggests that the premiums for coverage under a conventional health insurance policy could nearly double or even increase as much a four-fold, depending on the degree of adverse selection MSAs trigger in the insurance market. At those increased premiums, it is likely that significant numbers of employers would be unwilling to offer their employees conventional insurance and that this decline in the market for conventional insurance would lead some insurers to cease selling it. If this degree of adverse selection in the insurance market were to occur on a broad scale during a demonstration period, the disruptions to the insurance market might not be readily reversible if Congress subsequently decided not to continue the MSA experiment.

The available research suggests that the probability and degree of adverse selection would be related to the two critical issues of demonstration design identified above: the types of high-deductible insurance plans permitted to be used with MSAs and the number of people permitted to participate in the experiment.

- The degree of adverse selection and cost increases for conventional insurance appears to be related to the difference in the risk of out-of-pocket costs consumers would bear under an MSA plan as compared with the risk of such costs under conventional insurance. Healthier workers

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[2] (...continued)
used for non-medical purposes is too lenient to prevent use of MSA accounts as tax sheltered means of accumulating savings for a variety of purposes.

would be more likely than less healthy workers to accept an insurance policy under which they might have to pay a few thousand dollars of health care costs from their own funds if they became very sick, because healthy workers would judge that the probability of their actually having to incur such costs is low. But among less healthy workers, the greater the probability that their out-of-pocket costs under an MSA could significantly exceed such costs under conventional insurance, the more likely they would be to stick with conventional insurance. The research finds that the difference in potential out-of-pocket costs under the two types of insurance does not have to be exceptionally large to trigger this type of division of the health insurance market by health status. When workers covered by high-deductible insurance/MSA plans risk incurring annual out-of-pocket costs that are just $1,000 more than the potential out-of-pocket costs under conventional plans, the research finds substantial adverse selection.

- Both the House MSA legislation and the Kassebaum compromise could trigger extreme adverse selection. The Kassebaum proposal allows insurance deductibles to be as high as $5,000 for individuals and $7,500 for families, while the House bill puts no limits on deductibles. In addition, while conventional insurance typically limits the out-of-pocket costs an individual must pay to $1,000 or $2,000 over the course of a year, consumers could be liable for *unlimited* out-of-pocket costs under either the House bill or the Kassebaum compromise. Given the research findings that differences of this magnitude trigger adverse selection, it is critical that the demonstration design put strict limits on both the deductible amounts and the total out-of-pocket costs consumers can incur under the high-deductible insurance policies used with MSAs.

- The effect of adverse selection on the insurance market also depends on the proportion of all insured people who would choose to enroll in the plan that is the most financially advantageous to them, given their expected health status. Since in any given year most people are healthy and few are sick, up to 80 percent of all people could benefit financially in the short run by choosing an MSA plan. While the Kassebaum compromise makes as many as 40 million workers eligible to use MSAs — that is the number of individuals who are self employed or work in a business employing fewer than 50 people — the potential for adverse selection argues for keeping the scope of the experiment far smaller than that until the effects of MSAs on health insurance markets and people who rely on health insurance coverage can be carefully evaluated.

The research cited above on adverse selection, which includes work by RAND, the Urban Institute, and the American Academy of Actuaries, was conducted through computer simulations of the health insurance market. Some MSA proponents believe that intermediating factors, such as the extent to which choices concerning which types of health insurance are purchased are made by employers rather than individuals, will prevent the degree of adverse selection found in the research from occurring in the real world. They may or may not turn out to be correct. But allowing a large-scale test without adequate safeguards and limits on the high-deductible insurance plans used with MSAs is comparable to playing Russian roulette with the health insurance market. Without appropriate limits, substantial and perhaps irreversible harm to insurance markets and to less-healthy segments of the population could result from the process of "demonstrating" and "evaluating" the MSA approach.

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Potential Damage to Insurance Market Relates to Design Issues

Adverse selection in the health insurance market takes place when healthy and less healthy segments of the population become segregated in different types of insurance plans. If healthier people choose high-deductible insurance with MSAs, the pool of people covered by comprehensive health insurance will tend to be sicker on average than it would be without MSAs. And if the pool of people who are conventionally insured incurs higher-than-average health care costs because some of the healthier people are no longer in the pool, the premiums for conventional insurance will rise. MSAs pose a strong risk of triggering this type of effect.

Young, healthy people who anticipate having low health care costs in the near future would likely choose to participate in MSA plans. They would do so because the MSA legislation allows participants to retain unspent health care dollars in their own accounts. Thus, people with low health care costs can accumulate tax free earnings on those funds and use them as retirement savings or for a wide variety of other purposes.[3] On the other hand, older and less healthy people who judge they are likely to incur health care costs would be better off financially if they remained covered by conventional health insurance, which generally has lower deductible amounts and relatively low caps on out-of-pocket expenditures. As a result, the pool of workers covered by conventional insurance could incur far higher average health care costs than the larger pool of workers who now are covered by such insurance. To accommodate

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[3] Under the legislation, a 10 percent penalty applies to withdrawals prior to age 59 ½ for purposes other than medical expenses. Those negotiating a demonstration project reportedly have considered a 15 percent penalty for non-medical withdrawals prior to age 65. Even with the high penalty, however, some taxpayers could gain financially by saving for non-medical purposes through an MSA (which exempts employer deposits from income and FICA taxes and allows interest to compound free of tax) rather than through an investment taxed under normal provisions of current law.

those higher average health care costs, the premiums charged for conventional fee-for-service insurance policies would have to increase dramatically. (See appendix for illustration of how the division of the insurance market could affect premiums.)

If such a division of the insurance market and the resulting increase in the cost of conventional insurance — the process known as "adverse selection" — were to take place on a widespread basis during an MSA demonstration period, it could become difficult to reverse those conditions at a later date. Experts point out that many employers would not be willing to pay the sharply higher premiums for conventional insurance that adverse selection is likely to trigger. Some employers would no longer offer conventional insurance to employees, and some insurance companies probably would cease selling such insurance. If Congress subsequently decided, based on the results of the demonstration project, that allowing tax-advantaged MSAs is not sound public policy and discontinued them, it is unclear whether or how the market would recover. Participants in the demonstration might no longer have the option to buy conventional insurance coverage at an affordable price.

Goals of Reform Could Be Undermined

Adverse selection — and the resulting increase in premiums and limits on availability of conventional insurance — could substantially undermine the goals of the health insurance reforms contained in the proposed legislation. One purpose of the legislation is to help workers with "preexisting conditions," which often result in exclusion from coverage when a worker begins a job, changes jobs, or loses coverage under a spouse's policy. The legislation effectively curtails such exclusions for group insurance policies. But if a worker with a chronic health problem gains only the right to be covered by a high-deductible policy with an MSA — because that is the only option his or her employer offers — the worker may have to expend thousands of dollars out-of-pocket before insurance begins to pay a portion of health care costs. That situation would not fulfill the broader intent of this legislation. But if employers cannot afford to cover their employees with comprehensive insurance because adverse selection has driven up its cost, a high-deductible plan with an MSA may become the only available choice.

The two issues identified above — the risk of out-of-pocket expenses to which MSA users are exposed and the number of people who could use MSAs during the demonstration period — are important determinants of whether a division of insurance coverage between more healthy and less healthy workers would take place and whether such a division would be widespread enough to increase substantially the price and decrease the availability of conventional health insurance.

Research Indicates That Adverse Selection Occurs at Relatively Low Deductible Levels and Out-of-Pocket Caps

The levels of deductibles, coinsurance, and risk of out-of-pocket expenses allowed under the MSA legislation pose a high probability of triggering adverse selection in the insurance market, according to research that has simulated the effects of

MSAs. Adverse effects on the market for conventional fee-for-service insurance policies have been found in three separate studies by non-partisan organizations: RAND (which has been widely misinterpreted as reaching the opposite conclusion), the Urban Institute, and the American Academy of Actuaries.[4]

Each of these studies analyzed an insurance market initially offering both high-deductible plans in conjunction with MSAs and conventional low-deductible fee-for-service insurance. In these studies, each consumer was allowed to choose — within certain limits, depending on the study — the plan providing the best financial advantage for his or her health and income status. Premium savings from purchasing high-deductible rather than conventional insurance were assumed to be deposited in the consumer's MSA account. Those deposits, however, are likely to fall short of the annual deductible amounts under those insurance plans. For example, the American Academy of Actuaries showed premium savings of $1,033 as a result of buying a plan with a $3,000 deductible and a $4,000 cap on out-of-pocket expenditures rather than buying a conventional plan with a $200 deductible and a $1,000 cap on out-of-pocket expenditures. The risk of out-of-pocket expenditures increased by $3,000 but $1,033 would have been deposited in the MSA. Thus users of such MSA plans still would face a substantial risk of paying for medical costs with their own funds.

In comparing the high-deductible MSAs plans to conventional insurance, the studies considered three key differences between the two types of insurance. The differences the studies examined were: 1) the deductible amount below which the consumer pays all health care costs; 2) the coinsurance or cost sharing required once the deductible amount has been expended; and 3) the maximum out-of-pocket health care expenses the consumer can incur, above which the insurance pays all expenses.[5]

One of the key findings across all of these studies is that adverse selection will occur even when the insurance policies used with MSAs have relatively low deductible amounts. The selection will occur because less healthy people would face a high probability of paying substantial amounts of medical bills before their insurance coverage begins; most would try to avoid that situation. In the research, adverse

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[4] Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *JAMA*, June 5, 1996, p. 1666-71; Len M. Nichols, et. al., *Tax-Preferred Medical Savings Accounts and Catastrophic Health Insurance Plans: A Numerical Analysis of Winners and Losers*, The Urban Institute, April 1996; and American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues*, May 1995.

[5] For example, a typical conventional insurance policy might require the holder to pay the first $200 in health care costs (the deductible) and 20 percent (the coinsurance) of costs in excess of the deductible. Most also include a maximum amount of covered medical expenses the policy holder must pay, such as $1,500 (the cap), above which the insurance pays 100 percent of expenses. The analysis focuses on the deductible amounts and out-of-pocket caps, because those parameters are the more important determinants of the cost to the consumer.

selection was found at deductible amounts of $1,000 in the Actuaries' study, $2,000 in the Urban Institute study, and $2,500 in the RAND study (all amounts apply to single individuals).[6] By contrast, the MSA legislation that passed the House of Representatives requires a *minimum* deductible of $1,500, and *no limits* are placed on the maximum deductible amount. The MSA demonstration proposed by Senator Kassebaum also requires the insurance used with MSAs to have a minimum deductible of $1,500; it limits the deductible amount for single individuals to $5,000. Thus, it is likely that many insurance plans offered with MSAs would have deductible amounts in the range of for which the studies found adverse selection occurs. (See Table 1)

Furthermore, all of the studies assumed consumer protections that are unlikely to occur in the real-world market for MSA plans. The studies assumed that consumers using high-deductible insurance plans in conjunction with MSAs would be protected by caps placed on the maximum amount of out-of-pocket costs they could incur. The out-of-pocket maximums assumed in the studies all were very low relative to conditions likely to prevail in the market; the Actuaries and the Urban Institute assumed a $2,000 cap on out-of-pocket costs for individuals while RAND assumed a $2,500 cap. *Yet neither the House legislation nor the Kassebaum proposal requires insurers to put any cap on out-of-pocket costs a consumer could incur under the high-deductible policies.* The Kassebaum plan explicitly says that insurers can require workers to pay 30 percent of all costs above the deductible amount.

Table 1
Comparison of Circumstances of Adverse Selection Findings to MSA Proposals

	Deductible for Individuals	Out-of-Pocket Maximum for Individuals
Studies Showing Adverse Selection		
RAND	$2,500	$2,500
Urban Institute	$2,000	$2,000
Actuaries	$1,000	$2,000
MSA Proposals		
HR 3103	at least $1,500, no maximum	No limit on out-of-pocket expenses
Kassebaum Compromise	$1,500 to $5,000	No limit on out-of-pocket expenses

[6] The studies did not all include analysis for family plans, but it is generally accepted that there is little difference in the behavior of markets for individual plans and family plans.

Caps on out-of-pocket costs appear to be particularly important in determining whether adverse selection will occur because the cap is the ultimate determinant of the amount of medical costs a person with serious health problems would have to bear in any year. The higher the cap on the high deductible plan relative to the conventional plan, the less likely it is that a person anticipating potential health problems would be willing to use an MSA plan. The evidence from the research suggests that adverse selection can be triggered by relatively modest differences in out-of-pocket cost risks.

In the three studies, there was only one scenario under which adverse selection did not occur. The RAND study considered one scenario in which the out-of-pocket cost cap for individual participants was set at an identical level of $1,500 for both the high-deductible plan and the conventional plan. One would not expect to find much difference in the plans chosen by people with differing health statuses under this scenario, because the out-of-pocket risk of using the MSA/high-deductible plan not only was relatively low at $1,500 a year but also was no different from the $1,500 risk an individual would assume by using conventional insurance. Not surprisingly, RAND found little or no division of the insurance market in this case.

This RAND scenario has been widely been misreported and misinterpreted as "proving" that adverse selection will not occur. That interpretation is extremely misleading. In another RAND scenario much more representative of conditions likely to prevail in the market under the proposed legislation, a large degree of adverse selection was found.

Table 2
Differences in Caps on Out-of-Pocket Cost Between High-Deductible and Conventional Insurance in Three Studies

	Conventional Insurance	High-Deductible Insurance Used With MSAs	Difference	Study Found Adverse Selection?
RAND Scenario I	$1,500	$1,500	0	No
RAND Scenario II	$1,500	$2,500	$1,000	Yes
Urban Institute	$1,250	$2,000	$750	Yes
Actuaries	$1,000	$2,000	$1,000	Yes

Notes: Differences are shown for individual coverage.
The American Academy of Actuaries showed various levels of deductibles and out-of-pocket maximums. This table shows the smallest difference between the high-deductible and the conventional plan.

As can be seen in Table 2, which shows the difference in the maximum out-of-pocket costs between the high-deductible and the conventional insurance plans assumed in the various studies, *all* the studies — including RAND — found adverse selection when the difference in maximum out-of-pocket costs between the two types of insurance was as low as $750 to $1,000. Based on this data, it would be reasonable to hypothesize that a division of the insurance market and adverse selection is likely to occur whenever there is a significant difference in the risk of out-of-pocket expenditures between the conventional insurance plan and the high-deductible plan used with the MSA.

For this reason, it also is reasonable to conclude that the proposals put forth by proponents of MSAs would lead to a very high degree of adverse selection. As noted, neither the House bill nor the Kassebaum compromise include *any* limits on out-of-pocket costs.

Research Indicated the Cost of Conventional Insurance Would Increase Sharply

The three studies found substantial degrees of adverse selection despite the relatively modest differences between the deductible amounts and the out-of-pockets caps in the two types of insurance assumed in those studies. If such a degree of adverse selection were to take place, it is likely that some employers, self-employed persons, or individuals could not afford to purchase conventional insurance policies.

The RAND study looked at the relative health care costs of workers who would choose high-deductible coverage with an MSA as compared to those who would choose either conventional coverage or an HMO. As noted above, the study found little difference when the cap on out-of-pocket costs was the same $1,500 in both types of plan. But for another scenario using an MSA with a $2,500 deductible plan and a $2,500 out-of-pocket expenditure cap, considerable division of the insurance market was found. RAND found that MSA users would have average annual per capita health care expenditures of only $2,840, as compared to $7,549 for the people remaining in conventional fee-for-service plans and HMOs. And when compared only to people who chose fee-for-service plans — who would have average annual per capita expenditures of $8,732 — the average medical expenses of MSA users were only one-third as high.

With such differential health care costs among the people in the various plans, the premiums charged for the different types of insurance would have to adjust accordingly and would need to rise sharply for conventional insurance. RAND

concluded that, "Such a large discrepancy makes adverse selection a legitimate concern."[7]

The Urban Institute study found a similar effect on health care costs and health insurance premiums. If open choice between types of plans were available and all people who could gain financially from switching to an MSA did so, the study found that the premium for a conventional policy (for a single person) would have to increase from $1,701 to $7,396 to accommodate the higher average health care costs of those remaining in conventional insurance. Under these circumstances, the study suggested, conventional insurance would cease to exist and no longer be available to the less healthy, older people who would be "losers" under MSA plans.[8]

The study conducted by the American Academy of Actuaries found that the premium for a conventional plan for a single individual would rise from $2,699 to $4,343 if individuals could select either a conventional plan or a high-deductible plan with an MSA. The actuaries' study found a smaller difference than the Urban Institute or RAND studies because the actuaries did not assume that everyone would choose the plan that yielded the most financial benefit for him or her. For example, the actuaries assumed that three-quarters (rather than all) of the individuals with no significant health care costs would choose the high deductible plan, and that half the individuals with the highest health care expenses would select the high-deductible plan with an MSA.[9]

Although each of the three studies had somewhat different assumptions and methods, each concluded that adverse selection would result in sharply increased premiums for conventional insurance. These studies suggest that the cost of conventional insurance could nearly double and possibly even increase as much as four-fold as a result of adverse selection. The extent of the cost increase would depend on factors such as the difference in the risk of out-of-pocket costs between the high-deductible insurance/MSA and the conventional insurance and the extent to which

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[7] Emmett B. Keeler, et. al., "Can Medical Savings Accounts for the Nonelderly Reduce Health Care Costs?" *JAMA*, June 5, 1996, p. 1670. The conventional plan had a $250 deductible, a 20 percent coinsurance rate above the deductible, and a cap of $1,500.

[8] These results were found for an MSA used with an insurance plan that imposed a $2,000 deductible for single policyholders and provided full coverage for all health care costs once the deductible is met. Such a plan was compared in the Urban Institute study to a conventional plan with a $250 deductible, 20 percent coinsurance, and a $1,250 cap on out-of-pocket costs.

[9] The actuaries' study suggests that the results it found are possible for plans with deductibles as low as $1,000 combined with out-of-pocket maximums of $2,000, compared to a conventional plan with a $200 deductible and a $1,000 out-of-pocket maximum. For both types of plans, cost sharing is assumed to be 20 percent up to the maximum.

people of varying health statuses choose the plan likely to provide the most financial benefit to them.

In short, the research finds a high probability that adverse selection will occur at the levels of deductibles and out-of-pocket costs permitted under the House bill or the Kassebaum compromise. It finds that this adverse selection will result in substantial premium increases for conventional insurance — increases large enough to make such insurance unaffordable and unavailable for many Americans. As the American Academy of Actuaries has noted, "The greatest savings [from MSAs] will be for the employees who have little or no health care expenditures. The greatest losses will be for the employees with substantial health care expenditures. Those with high expenditures are primarily older employees and pregnant women."[10] These findings raise the question of whether an appropriate MSA demonstration can be designed.

Implications for MSA Demonstration Design

Can a "safe" MSA demonstration be designed that both tests whether the adverse selection found in the computer model-based research will occur in the real world and also limits potentially non-reversible damage to the conventional insurance market? That is not an easy task.

One way to limit damage is to limit the scale of the experiment. If a relatively small number of companies are allowed to participate in the demonstration (perhaps several thousand), a large amount of corroborative information could be gathered and evaluated. This would allow a study of the impact of MSA policy without engendering widespread market changes. For example, information could be gathered about the health status of workers in companies that choose MSA plans as compared to workers in companies that do not choose MSAs, as well as the effect of these choices on employees. If the participating companies were concentrated in a few states, the effect of the decision of some businesses to offer MSAs would be felt throughout the market and could be measured.[11] At the same time, the limitations on the number of companies that could offer MSAs would assure that the effects of adverse selection are not severe enough to damage irreparably the small-group market for conventional insurance while the experiment is being evaluated.

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[10] American Academy of Actuaries, *Medical Savings Accounts: Cost Implications and Design Issues, May 1995*, p. 23.

[11] It is generally thought that small business would offer only one type of insurance to their employees; for that reason, it is unlikely that the effects of adverse selection would be found within a single small business.

Another way to limit damage is to require the high-deductible insurance/MSA plans to include caps on out-of-pocket expenditures that are only modestly higher than the caps typical for conventional insurance in the area. The results of the RAND study suggest that high deductibles and caps can lead to sharply delineated divisions in the health insurance market and to commensurate increases in the cost of conventional insurance, while more modest limits can dampen that effect. In addition, placing moderate limits on deductibles and out-of-pocket expenditures will afford some measure of protection during the experimental period for less healthy workers who are forced to accept a high-deductible MSA plan, either because their employer has made the change or because insurance companies are offering only MSA plans to self-employed persons in their area.

It is also important to limit the potential for MSAs to be used as a lucrative tax shelter by some people who anticipate low health care expenditures. The MSA proposals impose penalties for withdrawal of funds for purposes other than paying medical costs, but neither the 10 percent penalty in the House bill nor the 15 percent penalty proposed in the Kassebaum compromise are sufficient to prevent this type of abuse. The penalties are particularly ineffective for funds held for a significant number of years. The longer the funds are held, the more valuable the deferral of taxes and the tax-free compounding of earnings on deposits becomes. In addition, the penalties are rendered nearly meaningless if depositors earn high rates of return on funds in MSAs. Rates of return high enough to overwhelm the effect of a 10 percent or 15 percent penalty could be earned if funds are invested in a vehicle such as a mutual fund reflecting a broad index of the stock market (on average the stock market has risen approximately ten percent annually over the past decade) or if general interest rates in the economy rise substantially in the future. If the purpose of MSA funds is to pay for medical expenses, the penalties for non-medical uses should be set at levels that insure funds are preserved for that purpose.

Similarly, the MSA proposals allow withdrawals of MSA funds without penalty for any purpose after the holder has reached a certain age — 59½ in the House bill and 65 in the Kassebaum proposal. A healthy taxpayer using an MSA, who would have far more after-tax savings than if the same amount of earnings had been saved in most other ways permitted under current law, could spend those funds on an extended vacation or any other way he or she would choose once the taxpayer reached the designated age. Yet, that same person might require long-term care within the next several years and might fall back on Medicaid to pay for that care. In other words, the person could expend one tax subsidy on personal consumption and then require another tax subsidy for health care costs. To prevent this kind of abuse, penalties for non-medical use of MSA funds should apply throughout the life of the holder rather than ceasing at a particular age. The funds accumulated in the MSA could continue to be used for covering out-of-pocket costs for health services in the latter years of life, when health care costs (including out-of-pocket costs) tend to be higher.

Appendix

If healthier people choose high-deductible insurance with MSAs in the hope of keeping their unspent deposits, the pool of people covered by comprehensive health insurance will tend to be sicker on average than it would be without MSAs. And if the pool of people who are conventionally insured incurs higher average health care costs because some of the healthier people are no longer in the pool, the premiums for conventional insurance will rise.

Consider an example in which there are five people with health insurance provided by one company.[12] Together, the five people have $15,000 a year in medical expenses. The insurance company charges the group of five a premium of $14,000 a year for insurance, out of which it reimburses the group for approximately $11,000 in medical expenses. Note that in this example the result is the same whether the medical expenses of the five people are distributed as in column A or column B below. So long as the five people remain in a group, the employer would pay an average of $2,800 on behalf of each employee.

Hypothetical Distributions of Medical Expenses		
	Example A	Example B
Person 1	$3,000	$600
Person 2	3,000	600
Person 3	3,000	1,000
Person 4	3,000	6,400
Person 5	3,000	6,400
Total Medical Expenses	$15,000	$15,000

Now assume that the medical expenses are distributed as in column B and that Persons 1 through 3 chose a high-deductible plan with an MSA. The employer pays a lower average premium for each of them and also deposits $2,000 in an MSA for each of them. Of the $6,000 deposited in the MSAs, only $2,200 (the sum of the expenses for Persons 1 through 3) would be used for medical expenses. The remaining $3,800

[12] The following example is not based on actuarial analysis. The numbers used are for illustration only.

would become savings for Persons 1 through 3. (Some of that amount might or might not be used to pay medical costs in a subsequent year.)

Persons 4 and 5 did not choose a high-deductible plan because a high-deductible plan would result in higher out-of-pocket costs for them. But when the employer tries to purchase conventional insurance for a group consisting of just these two individuals who have average medical costs of $6,400 a year, the premiums exceed $6,000 per person. The employer cannot continue to offer comprehensive insurance at that price.

This simple example illustrates how MSAs disrupt the principle of insurance. MSAs make it advantageous for healthy people to leave the insurance pool, which in turn removes from the pool a substantial amount of funds currently available to help subsidize people whose medical costs exceed the premiums they pay. If MSA users remain healthier than average, they can use the excess funds in their MSAs for their retirement, or for education, vacations, or car purchases; these excess funds will *not stay in the health care system*. The result is that the price of a basic comprehensive health insurance plan will be much higher than it would be if a normal cross-section of people of varying health statuses participated in a comprehensive insurance plan.

While this example considers the effect of dividing the insurance pool within a single employer, these effects also could occur across employers or in the insurance market for self-employed people or individuals. Consider two insurance companies that insure small businesses. If one insurance company offers only high-deductible policies with MSAs, the premiums charged for those policies could be relatively low, reflecting both the fact that those covered by such policies would tend to be healthier than average and the fact that insurance does not kick in until the deductible is reached. If the second insurance company offers only conventional insurance, its business is likely to come from small enterprises having reasons to continue conventional insurance coverage. For example, the enterprises may employ many middle-aged to older workers or workers in their child-bearing years. But the conventional insurer in this example would be forced to charge higher premiums for such insurance than it might charge if its mix of clients was more representative. Under current laws in more than half the states, insurers are required at least partially to average — "community rate" — the differences in employee health statuses across the small businesses they insure.

In addition, experts point out that the risks of all insured groups are partially pooled internally by insurance companies even when the law does not require such pooling; insurance companies tend to compute a basic rate for, say, all small businesses and then make marginal adjustments to arrive at the premiums charged specific businesses. Under the proposed MSA legislation, these opportunities for broadly averaging health costs across businesses are likely to diminish sharply. Insurance

companies that do not specialize in providing high-deductible policies with MSAs are likely to face upward pressure on premiums, and may not be able to continue offering conventional policies at prices employers can afford.

cc Ira, Chris J, Melanne

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Observer

RUSSELL BAKER

Harry! Louise! You Lied

They told us that national health care would deprive us of the right to choose our own doctors.

So we said no to national health care.

And we found ourselves enrolled in something called an H.M.O. It gave you a list of doctors to choose from. If your doctor wasn't listed, they told you to forget him.

They told you to choose one of the doctors on the H.M.O.'s list, or else. "Or else" meant your health insurance wouldn't pay your doctor's bill.

They had deprived us of the right to choose our own doctors.

And they told us if we had national health care there would be Government bureaucrats interfering with our medical treatment.

Strangling us with red tape.

Burying us under tons of paperwork.

So we said no to national health care.

We said yes to the great insurance corporations of America, and perhaps of the entire planet now that conglomerated capital no longer recognizes national boundaries.

We said yes because we did not want Government bureaucrats interfering with our medical treatment.

Did not want to be strangled with red tape.

Didn't want to be buried under tons of paper.

So we said no to national health care and said yes to great-insurance-company health care.

And we found ourselves up to the neck bone in bureaucrats.

Not Government bureaucrats, to be sure.

That's right: The bureaucrats who occupied more and more of our lives were not Government bureaucrats. They were great-insurance-company-of-America-and-possibly-the-whole-darn-world bureaucrats.

In bureaucrats we were up to the neck bone.

The neck bone is the seat not only of the infamous pain in the neck, but also of three-day headaches, sour stomach, criminal dreams of blowing up the great insurance corporations of America, and hatred for our fellow man, though more often our fellow woman since the bureaucrats most often encountered in the typical soul-crushing struggle with a great insurance corporation of America seem to be female.

Whenever such a bureaucrat can be reached by telephone live.

By those with sufficient patience to press numbers 1 through 117 in search of a human voice.

And what was that red material so tightly wrapped around our necks? It was tape. Dreadful, terrifying red tape. But not the Government's red tape.

It was the red tape of great insurance companies, of H.M.O.'s, of various and sundry doctors and the squadrons of accountants who managed their vast files of paper.

Affidavits, certified X-rays, notarized doctors' statements, histories of previous ailments, professionally attested-to prospectuses of sicknesses likely to be incurred in futures both near and far, sworn evidence of abstinence from cigarettes, solemn oaths not to develop long-term diseases, F.B.I. records if available on drinking habits and sexual proclivities in your youth, any and all records forecasting genetic tendencies to ill health, criminal activity, out-of-body adventuring and susceptibility to kidnaping by aliens conducting experiments on humans in U.F.O.'s. Such was but a small sampling of the privately contrived nongovernmental red tape that strangled us.

Up to the neck in bureaucrats.

Paper! How thick it rose around us, how densely it filled the air. That's why we felt buried under a stifling, crushing tonnage: paper! We had said no to national health care to avoid being buried under tons of paper. And here we were. Buried.

Under tons of paper.

They told us that national health care would cost us billions in taxes. Leave it to the free market, they said, and it wouldn't cost us a cent to continue enjoying the best medicine in the world.

Provided we had private health insurance.

So we said no to national health care. We did not want to pay zillions in taxes. We did not even want to pay $1.79 in taxes, to be perfectly frank. Especially since we had health insurance, all but 30 or 40 million of us. We said the great free market should be allowed to do its work.

And that was the end of national health care. The health industry is cleaning up on Wall Street. The rest of us pray we may never get sick. □

from KRC

PRIVILEGED AND ~~CONFIDENTIAL~~

DRAFT **M E M O R A N D U M** **DRAFT**

TO: Hillary Rodham Clinton April 7, 1993
FR: Chris Jennings, Steve Ricchetti
RE: Congressional Update/Strategy for Health Reform
cc: Melanne, Howard, Distribution

Following up on the numerous initial consultations with the Hill by you, Ira and Judy (see Appendix 1 for list) and the integration of the Democratic staff into the working groups, we have developed the next stage of our legislative strategy for passing comprehensive health reform this year. This objective is achievable, but only with a strong commitment by ALL parties within the Administration to run a nation-wide campaign.

The legislative strategy is designed to counter much of the skeptical outlook that many Members of Congress currently have with regard to the prospects of action on a health reform bill in the first session of this Congress. The reasons for the Congressional perception problem are outlined in Appendix 2. Far more important than focusing on the problem, however, is taking prompt action to change the environment for legislative action.

LEGISLATIVE STRATEGY

In short, the legislative strategy that follows highlights (1) the need to finalize a health reform package that can be sold in a timely fashion, (2) the importance of close consultation on strategy and substance with the Congress before and after the legislation is unveiled, (3) the desirability of having more opportunities for the Congress to witness how committed the President is to this reform, (4) the need to target and lobby the those many Democratic and those few Republican Members who will be on the fence on this issue, and to closely coordinate this effort with the Communications team, the DNC, Intergovernmental Affairs and the Office of Public Liaison.

I. **An Expedited Decision Process Must Be Implemented**. The President must have the information he needs to make informed first-cut decisions on the structure and content of the bill. Obviously, constructive and substantive discussions with the Congress on key issues (e.g., cost containment, financing, benefits, employer responsibility, etc.) cannot take place without a much more clear sense of the direction the President is heading.

II. **Meaningful Consultation with Congress is Imperative During the Recess and Soon After their Return. Because of the enormous political implications of virtually every key policy decision that will be made, the President's thinking must be informed by the political realities in the Congress as they are perceived by Hill Leaders. In addition, to invest the Leadership into the process and to give them a sense of ownership, they must feel they have a meaningful opportunity to offer their own policy and political advice to the President before he introduces his proposal. To best achieve this, we suggest a multi-pronged strategy:**

A. As Congress Reconvenes, the President Should Re-emphasize His Commitment to Health Care. While Howard and Ira have been sending strong signals that the President desires to pass his health reform initiative this year, the doubts plaguing Members' minds can only be effectively exorcised by clear signals from the President himself. We propose informal gatherings at the White House with the House and Senate Leadership as the best way to accomplish this.

Specifically, we believe that at least four informal get-togethers hosted by the President and the First Lady should be scheduled at or around April 20th: (1) an informal meeting with the Speaker and the two Majority Leaders; (2) a dinner with the House Leadership and their most pertinent health care Chairmen (Foley, Gephardt, Bonior, Rostenkowski, Dingell, and Ford, and perhaps others); (3) a similar dinner with the Senate Leadership and their Chairmen (Mitchell, Ford, Pryor, Daschle, Moynihan, Kennedy, Rockefeller, Riegle, and perhaps Breaux); and (4) an informal meeting with the Congressional Republican Leadership. Beyond clearly illustrating the President's desire to passing reform this year, the goal of these meetings would be multifold:

* To illustrate the President's understanding of the time and work constraints we have already asked (through reconciliation, etc.) and would now be asking of the Chairmen;

* To re-energize the Leadership by asking them how to develop a realistic legislative strategy. (Although the President would have a sense of what is likely, these Members must also be invested in the timing and political strategy);

* To advise the Leadership of any new timetable for public unveiling and introduction of the President's proposal (they should not read this in the newspaper);

* To work with Committee Chairmen to help coordinate a hearing strategy before the President's bill introduction, which would establish an even more welcome political and media environment for reform; and

* To schedule a series of substantive, consultative meetings between the President and the First Lady and the Leadership, Committee Chairmen, and whomever else the Leadership designates. These meetings will give the President the political and policy advice necessary to modify his first-cut decisions in such a way that his bill will be well received on the Hill. (The third Appendix to this memo outlines a series of meetings that we should give serious consideration to holding prior to the introduction of the bill).

B. **Before the Leadership Meetings, Learn From and Reach Out to their Staff.** During the recess (and this has already started), Ira, Judy, Steve, Chris, Christine, Steve E., the Department, and others should be tapped to conduct briefings with the staff of the Leadership and other key Congressional Members.

These briefings will serve at least four major purposes: (1) to give the Leadership (through their staff) the sense that they are being kept in the loop during the recess, (2) to establish a solid and informed foundation for Members' discussions when they return, (3) to tap into their substantial expertise and help us reach closure on a myriad of politically and technically difficult issues; and (4) to get a sense of where Members stand on them.

C. **Discuss and Align Budget Assumptions with CBO.** Robert Reischauer's assessment about how little yield <u>any</u> cost containment strategy would produce is petrifying an already scared Congress. The thinking is that CBO has the very real potential to sink an already leaking health reform ship. If our numbers come out completely different from CBO, the fears of the Congress will be realized. To head this off, the House Leadership -- working with us -- has already requested Ira's (and appropriate Administration budget number crunchers) presence at a meeting to attempt to get all parties on the same page. (Since this will be all staff, we do not believe it appropriate that Mrs. Clinton attend).

III. **<u>DEVELOP A TIMETABLE FOR CONGRESSIONAL ACTION</u>.** In conjunction with the Congressional Leadership, the development of a realistic procedural and legislative timetable is essential for a number of reasons:

* It makes the Congress focus much more intently on the work it must complete;

* It illustrates to the Congress that the White House understands the time constraints that confront the Congress; and

* It helps all other operations of the Administration (the communications, the DNC, intergovernmental affairs, and public liaison office) focus their efforts around key Congressional actions.

For the purposes of this discussion, and consistent with Howard's conversations with the Leadership, a difficult but still achievable schedule of legislative action on the President's bill could be: House passes bill in late September/early October; Senate passes bill in November or early December; Conference takes place and Houses work out differences (timing depends on differences); and the Congress passes final bill in late December or sometime early in the following year. The process boiled down to ten steps:

1. **Introduction.** The bill must originate in the House since it will have revenue implications and will likely be introduced by Majority Leader Gephardt. Senator Mitchell will introduce the President's bill in the Senate. The timeframe for this obviously depends on the President and his read of what is best for the health care bill, the stimulus package and the reconciliation bill. Having said this, the window of opportunity for Congressional consideration narrows every day we wait once the bill is ready for introduction.

2. **Bill Referral.** The Speaker will work to refer the bill to Committees for which he has previously worked out time limited reporting agreements. There could be as many as 9 Committees with some jurisdiction, but most of the work will emerge from the Ways and Means Committee, the Energy and Commerce Committee, and the Education and Labor Committee. In the Senate, it appears as though at least two Committees, Finance and Labor & Human Resources, will get titles of the bill -- with the significant preponderance going to Finance.

3. **Hearings.** The Committees are likely to hold a good 4-5 weeks of hearings. Their ability to hold and finish these hearings will depend on what other work requirements are confronting them. Given the fact that the Senate Finance Committee will in all probability still be working on the reconciliation bill, it is likely that they will -- as usual -- proceed at a somewhat slower pace.

4. **Mark-up.** The House Ways and Means Committee, like other Committees, may choose to mark-up the bill on a full Committee basis to expedite their work on the proposal. This process should be budgeted about 3-4 weeks. Under any scenario, however, Pete Stark's health Subcommittee will serve as the Committee's bill managers and will be extremely influential on the substance. (If the hearings and mark-up get overly delayed -- for whatever reason -- the Leadership may need to consider the possibility of reducing the length of the August recess; the goal here is to have the Committees at a stage where they are at least ready to finalize their mark-up soon after they return from recess). Following tradition and because the Senate will want to build on the House marked-up bill, the Finance Committee will therefore wait until at least after the House completes its Committee work before holding a formal mark-up session.

5. **House Rules Committee Mark-up.** After all the House Committees report within the timeframe allocated by the Speaker, the bill must receive a rule from the Rules Committee in order to receive floor consideration and to determine what amendments to the bill will be in order. The Leadership is likely to ask the Committee for a "modified closed rule," permitting a limited number of amendments and a limited period of time for debate. These amendments may well be limited to substitute amendments, and would likely cover the issue of abortion, taxes, possibly mandates, and others.

6. **House Vote.** House vote, assuming all else worked out, would then occur in late September/early October. Assuming passage, the bill would go to the Senate where it would be either held at the desk and placed on the calendar or referred directly to the Committee(s).

7. **Senate Mark-Up.** The Senate Committees may or may not have finished their mark-ups by the time the House passes its bill. If the Committees have not completed action, they will be pressured to do so soon. While the Labor and Human Resources Committee should have no problem pushing out a bill, a major push on the diverse collection of health care philosophies on the Finance Committee may well be needed.

8. **Senate Floor Action.** Immediately after the Committees' separate mark-ups, the Majority Leader Mitchell would likely call it up for action as soon as practical to start the debate. At that time, he would almost invariably receive an objection to his unanimous consent request to bring the bill up for consideration. A cloture vote to limit debate on the motion to proceed would ensue.

To move to the bill, the Majority Leader would have to find 60 votes. Assuming he failed on the first try, he would continue repeatedly until he (and us) successfully embarassed Members into switching their votes. (The argument would be that opponents are not even allowing consideration of health reform). Assuming that we get our first 60 vote clearance, we would then likely face a second fillibuster and cloture vote on the substance of the bill. No doubt, this floor vote will be our most difficult challenge; in order to pass the bill, we might be doing roll call cloture votes well into the late Fall and early Winter.

9. **Joint House/Senate Conference.** Depending on how different the two bills are, the conference could take a couple of weeks to several months. Since the Democrats control the conference, this would (hopefully) be an easier hurdle to clear.

10. **Vote on Final Passage.** Once again, in the Senate, you have the very real potential for another fillibuster by an unhappy Member. Should this occur, a third and final cloture petition may have to be filed and passed (60 votes) in order to get a final vote on passage. If we succeed in obtaining cloture (probably less difficult than before), we succeed in passing the historic health reform bill.

Obviously, the above mentioned "regular order" process will be difficult. Should the reconciliation bill be delayed in the Senate, there remains an outside possibility for marrying the two bills, but the 60 vote problem would still remain and such a linkage could well threaten the prospects of passing the other provisions of reconciliation this year. We are looking at alternative procedural approaches with David Dreyer and the Congressional Leadership, but it does not look like that the Senate Leadership is favorably disposed to anything other than "regular order" at this time. We will, of course, apprise you should this situation change.

IV. <u>Target the Members of Congress who are Fence Sitters</u>. There will be some Members who will want to vote for the President's proposal because it is his plan. However, for the vast majority of Members, a decision on whether to vote for health care will be based -- to an incredible degree -- on whether the Member concludes it satisfies his constituents. In order to have a chance of getting 218 votes in the House and 60 votes in the Senate, the President and the First Lady will have to lead a flawless and extensive public affairs campaign.

Most Members will need to hear from constituents they have not heard from before on the health care debate. The Member must have a perception that the general public's support for the President's proposal, in his or her district, exceeds any other "special interest" opponent's campaign.

The only way to achieve a large scale public response is through a massive public communications campaign. While this effort should be nationwide to the extent possible, it should particularly focus on a target population of Democrats we are most nervous about and Republicans we have the best opportunity to attract.

The targeting effort is now well under way. As you may recall, several weeks ago, we forwarded you a list of possible Republican Senators and vulnerable Democrats (see Appendix 4). We cross-referenced these target states with the Governors. Interestingly, 11 out of the 14 Republican Senators we targeted and 16 out of the 23 Democratic Senators come from States with Democratic Governors. We have forwarded this list to Communications, the DNC, Intergovernmental Affairs and the Office of Public Liaison. We are in the process of developing a detailed House list as well, but our preliminary analysis has led us to conclude that the target states .

In addition, the War Room is now staffed and computer equiped. We have begun a file on every Member. The files, which can be cross-tabulated, include a wide array of information on the Members (e.g. past and current positions and priorities with regard to health, information on the time and substance of your and staff meetings with the Members, key staff contact information, etc. Added to these files will be information and research being obtained by the DNC and Intergovernmental Affairs.

Lastly, as soon as the Members get back, we propose to reach out to more of the rank and file Congresspersons. Appropriate White House and HHS Department personnel will be dispersed to meet with Members or staff to share and collect information. The most important element of this strategy is that each of the targeted Members and/or their staffs will have an in-person vist from someone from the Administration working on health reform and they will all be given the opportunity to share information and advice.

Conclusion

From now until the President unveils his proposal will be a time and an opportunity to consult with and learn from the Congress. As Howard said, no matter how much we do, it will not be enough. We must go through the process, however, to ensure that the bill is well received at the time of introduction and momentum for passage of it this year is enhanced. In order to place sufficient pressure (and give them adequate cover), we will have to use our friends and resources wisely and in a very coordinated way. The Communications, Intergovernmental Affairs, the Office of the Public Liaison must worked extraordinarily closely to pool information.

APPENDIX 1

SUMMARY OF CONGRESSIONAL MEETINGS
(Up to [redacted] Easter Recess)

HOUSE OF REPRESENTATIVES

Members met with:
- Democrats - 128
- Republicans - 26
- TOTAL - 154

Members Remaining:
- Democrats - 127
- Republicans - 149
- Independent - 1
- Vacancies - 4
- TOTAL - 281

Meetings with Members of the Committees of Jurisdiction:

WAYS AND MEANS

Democrats - 20 of 24

Democrats Remaining:

- Andrew Jacobs (IN)
- Harold Ford (TN)
- William Coyne (PA)
- Bill Brewster (OK)

Republicans - 4 of 14

Republicans Remaining:

- Bill Archer (TX)
- Philip Crane (IN)
- Clay Shaw (FL)
- Don Sundquist (TN)
- Jim Bunning (KY)
- Amo Houghton (NY)
- Wally Herger (CA)
- Mel Hancock (MO)
- Rick Santorum (PA)

ENERGY AND COMMERCE

Democrats - 21 of 27

Democrats Remaining:

- Philip Sharp (IN)
- Al Swift (WA)
- Ralph Hall (TX)
- Rick Boucher (VA)
- Thomas Manton (NY)
- Craig Washington (TX)

Republicans - 6 of 17

Republicans Remaining:

- Jack Fields (TX)
- Michael Oxley (OH)
- Dan Schaefer (CO)
- Joe Barton (TX)
- Fred Upton (MI)
- Cliff Stearns (FL)
- Bill Paxton (NY)
- Paul Gillmor (OH)
- Scott Klug (WI)
- Jim Greenwood (PA)
- Michael Crapo (ID)

EDUCATION AND LABOR

Democrats - 12 of 24	Republicans - 3 of 15
Democrats Remaining:	Republicans Remaining:
Bill Clay (MO)	Tom Petri (WI)
George Miller (CA)	Dick Armery (TX)
Austin Murphy (PA)	Harris Fawell (IL)
Dale Kildee (MI)	Paul Henry (MI)
Matthew Martinez (CA)	Cass Ballenger (NC)
Donald Payne (NJ)	Susan Molinari (NY)
Jolene Unsoeld (WA)	Bill Barrett (NE)
Robert Andrews (NJ)	John Boehner (OH)
Jack Reed (RI)	Randy Cunningham (CA)
Tim Roemer (IN)	Peter Hoekstra (MI)
Robert Scott (VA)	Howard McKeon (CA)
Karan English (AZ)	Dan Miller (FL)
Eni F.H. Faleomavaega (Amer. Samoa)	
Scotty Baesler (KY)	

SENATE

Members met with:		Members Remaining:	
Democrats -	45	Democrats -	12
Republicans -	20	Republicans -	23
TOTAL -	65	TOTAL -	35

Meetings with Members of the Committees of Jurisdiction:

FINANCE

Democrats - 9 of 11	Republicans - 7 of 9
Democrats Remaining:	Republicans Remaining:
David Boren (OK)	Orrin Hatch (UT)
Bill Bradley (NJ)	Malcolm Wallop (WY)

LABOR AND HUMAN RESOURCES

Democrats - 11 of 11	Republicans - 5 of 7
Democrats Remaining:	Republicans Remaining:
None	Dan Coats (IN)
	Orrin Hatch (UT)

CONGRESSIONAL MEETINGS

FEBRUARY 3, 1993

	Rep. Dick Gephardt	HRC

FEBRUARY 4, 1993

11:30 AM	Rep. Pete Stark	IM, HP
2:30 PM	Sen. George Mitchell	HRC, IM, JF
3:00 PM	Senate Democrats Sens. Mitchell, Baucus, Bingaman, Boxer, Breaux, Conrad, Daschle, Feingold, Bumpers, Harkin, Kennedy, Kerrey, Leahy, Lieberman, Metzenbaum, Mikulski, Moseley-Braun, Moynihan, Pell, Pryor, Riegle, Rockefeller, Robb, Wellstone, Wofford	HRC, IM, JF
4:00 PM	Sens. Bob Dole and John Chafee	HRC, IM, JF

FEBRUARY 10, 1993

11:30 AM	Sen. Jay Rockefeller	HRC

FEBRUARY 11, 1993

	Sen. Harris Wofford Health Reform Conference Harrisburg, PA	
3:00 PM	Sen. Mitchell's Office	IM

FEBRUARY 15, 1993

10:00 AM	Rep. Jim McDermott	IM

FEBRUARY 16, 1993

2:00 PM	House Democratic Leadership - Tom Foley, Dick Gephardt	HTC, IM, JF

	House Democrats - Andrews, Bonior, Cardin, C. Collins, Cooper, Conyers, de la Graza, Derrick, Fazio, Ford, Hoyer, E.B. Johnson, Johnston, Levin, Lewis, Matsui, McDermott, Meek, Obey, Richardson, Rose, Rostenkowski, Slattery, Slaughter, Stark, Stenholm, Strickland, Synar, Waxman, Williams, Wyden	HRC, IM, JF
4:00 PM	House Republican Leadership Bob Michel, Newt Gingrich, Dennis Hastert	HRC, IM, JF
	House Republicans - Bilirakis, Bliley, Goodling, Goss, Grandy, Gunderson, Hoke, N. Johnson, Kasich, McCrery, Moorhead, McMillen, Roberts, Roukema, Thomas, Walker	HRC, IM, JF

FEBRUARY 18, 1993

11:00 AM	Rep. Dan Rostenkowski	HRC
12:30 PM	Rep. Bill Ford	HRC
1:30 PM	Re. John Dingell	HRC

FEBRUARY 23, 1993

2:00 PM	Congressional Women's Caucus Pat Schroeder, Olympia Snowe Furse, Kaptur, Lambert, Lowey, Maloney, Mink, Morella, Slaughter, Waters	HRC
3:45 PM	Rep. Pete Stark	HRC
4:30 PM	Rep. Henry Waxman	HRC
5:15 PM	Rep. Pat Williams	HRC

FEBRUARY 24, 1993

11:00 AM	Sen. David Durenberger	HRC

11:30 AM	House Democratic Leadership and Committee Chairs Gephardt, Lewis, Richardson, Rostenkowski, Stark, Dingell, Waxman, Ford, Williams	HRC, IM, JF

FEBRUARY 25, 1993

	Sen. Jim Sasser	HRC
	Sen. and Mrs. Reigle	HRC

MARCH 2, 1993

12:00 PM	Sen. Paul Wellstone	HRC
1:00 PM	Congressional Black Caucus Clayton, Collins, Conyers, Flake, Franks, McKinney, Meek, Mfume, Moseley-Braun, Norton, Rangel, Stokes, Waters, Watt	HRC
2:00 PM	Congressional Hispanic Caucus Serrano, Roybal-Allard, Pastor, de la Graza, de Lugo, Ortiz, Richardson, Torres, Ros-Lehtinen, Becerra, Bonilla, Diaz-Balart, Guttierrez, Mendez, Romero-Barcelo, Tejeda, Velazquez, Underwood	HRC

MARCH 4, 1993

	Senators Breaux and Johnston, Rep. Jefferson Louisiana Trip	HRC
	DPC Mitchell, Daschle, Akaka, Baucus, Bingaman, Boxer, Bryan, Campbell, Conrad, Dodd, Exon, Feingold, Feinstein, Graham, Hollings, Kennedy, Kerrey, Kerry, Lautenberg, Leahy, Lieberman, Levin, Matthews, Metzenbaum, Mikulski, Moynihan, Pell, Pryor, Reigle, Rockefeller, Sarbanes, Sasser, Simon, Wellstone, Wofford	IM, JF

MARCH 5, 1993

2:00 PM	Bob Reischauer, Director CBO	IM

MARCH 6, 1993

10:00 AM	Sen. Dianne Feinstein	IM

MARCH 9, 1993

	Rep. John Conyers	HRC
1:00 PM	Rep. Jim McDermott	HRC
2:00 PM	Chmn. John Dingell and Energy and Commerce Cmte S. Brown, Hall, Kreidler, Lambert, Lehman, Margolies-Mevzinsky, Markey, Pallone, Richardson, Schenk, Slattery, Studds, Tauzin, Townes, Waxman	HRC
2:00 PM	Sen. Jeffords	IM

MARCH 10, 1993

3:00 PM	Republican Task Force Dole, Chafee, Bond, Burns, Cohen, Craig, Danforth, Gregg, Kassebaum, Mack, Murkowski, Nickles, Packwood, Roth, Simpson, Stevens, Thurmond	HRC

MARCH 11, 1993

11:00 AM	Rep. Ron Wyden	HRC
1:00 PM	Sen. Edward Kennedy	IM
2:00 PM	Senate Women's Caucus Mikulski, Kassebaum, Boxer, Feinstein, Moseley-Braun, Murray	HRC
3:30 PM	Veterans Issues Sen. Jay Rockefeller, Rep. Sonny Montgomery, Rep. Roy Rowland	HRC

3:30 PM	Gephardt, Rostenkowski, Stark, Dingell, Waxman, Ford, Willians	IM, JF
5:00 PM	Sen. Daniel Patrick Moynihan	HRC
5:30 PM	House Republicans Bliley, Gingrich, Goss, Hastert, Johnson, Thomas	IM

MARCH 12, 1993

	Sen. Bob Graham, Rep. Sam Gibbons RWJ Forum - Tampa, FL	HRC
1:45 PM	Senate Republican Staff	IM

MARCH 15, 1993

	Sen. Tom Harkin, Sen. Charles Grassley, Rep. Neil Smith RWJ Forum - Des Moines, IA	HRC
	Finance Committee Staff - Lawrence O'Donnell, Staff Dir.	CJ, KP, SR

MARCH 17, 1993

	Chmn Dan Rostenkowski and Democratic Ways and Means Members Andrews, Cardin, Gibbons, Hoagland, Jefferson, Kennelly, Kopetski, Levin, Lewis, Matsui, McDermott, McNulty, Neal, Payne, Reynolds	HRC
2:00 PM	Rep. Jack Brooks	HRC

MARCH 18, 1993

7:30 AM	House Republicans Bliley, Goss, Grandy, Hastert, N. Johnson, McMillan, Thomas	IM
3:45 PM	Reps. Mike Andrews, Jim Cooper, Charles Stenholm, Lewis Payne	HRC
4:15 PM	Sen. Bob Kerrey	HRC
	Rep. Reynolds	HRC

MARCH 22, 1993

	Sen. and Mrs. Don Reigle, Rep. and Mrs. John Dingell, Sen. Carl Levin, Rep. John Conyers RWJ Hearing - Dearborne, MI	MEG, CR, DS

MARCH 23, 1993

9:15 AM	DPC Staff Meeting John Hilley, Abby Safford, Diane Dewhirst, Debra Silimeo, Greg Billings, Michael Werner, Lawrence O'Donnell, Laura Quinn, Jim Gottlieb, Larry Stein, Patricia Zell, John Ball	Begala, BB, CJ

MARCH 24, 1993

	Democratic Policy Committee Sens. Mitchell, Akaka, Baucus, Bingaman, Boxer, Bryan, Conrad, Daschle, DeConcini, Dodd, Feingold, Glenn, Graham, Hollings, Johnston, Kennedy, Kerry, Leahy, Levin, Matthews, Moseley-Braun, Reid, Wellstone, Wofford	IM, JF

MARCH 25, 1993

7:30 AM	House Republicans Bliley, Goss, Grandy, Hastert, N. Johnson, McMillan, Thomas	IM
2:00 PM	Democratic Committee Members Education & Labor, Energy & Commerce, Ways & Means Andrews, Cooper, Engel, Cardin, Lambert, Levin, McDermott, Synar, Tauzin, Pallone, Woolsey, Slattery, Rostenkowski, Dingell, Waxman, Richardson, Markey, Hall, Studds, Margolies-Mezvinsky, Kennelly, Hoyer, Fazio, Kreidler, Bryant, Klink, Sawyer	IM

MARCH 30, 1993

5:30 PM	Mainstream Forum - McCurdy, Bacchus, Browder, Carr, Cooper, Danner, Glickman, Geren, Green, Moran, Payne, Penny, Peterson, Price, Orton, Rowland, Slattery, Spratt, Tanner	IM

MARCH 31, 1993

8:00 AM	House Democratic Caucus - Barlow, Cooper, DeLauro, Derrick, Dingell, Durbin, Filner, Gephardt, Geren, Gordon, Hamilton, Hochbrueckner, Hoyer, Hughes, Inslee, D. Johnson, E.B. Johnson, Kaputr, Kennelly, Lancaster, Levin, Lewis, Lloyd, Lowey, McDermott, Moran, Obey, Olver, Pomeroy, Richardson, Romero-Barcelo, Sawyer, Shephard, Sisisky, Skaggs, Smith, Stark, Stupak, Synar, Thurman, Velazquez, Volkmer, Wise, Woolsey Ways and Means Health Sub. Stark, Levin, Cardin, McDermott, Andrews, Klezka	IM, JF

APRIL 1, 1993

7:30 AM	House Republicans Bliley, Goss, Grandy, Gunderson, Hastert, N. Johnson, McMillan, Roberts, Thomas	Quam

APPENDIX 2

APPENDIX TO HEALTH REFORM LEGISLATIVE STRATEGY

THE CONGRESSIONAL PERCEPTION PROBLEM

There are a number of reasons why the Congress, and particularly the Leadership, is apparently growing increasingly dubious about the prospects of health reform this year. Although each of the following, to various degrees, can and will go away once we have a plan and we have developed an acceptable legislative strategy with the Congressional leadership, it is useful to review the list to understand why some in the Congress and in the press are currently skeptical.

(1) **Reports of Disarray in the White House**. They are hearing and reading that the White House is in disarray around the process of developing an initiative and that a significant delay is very possible;

(2) **Cancellation of House Leadership in Meeting in Conjunction with New York Times Article Hurt**. Although last Friday's House Leadership meeting was cancelled by Majority Leader Gephardt (for fear of the consequences of another Stark outburst), there appears to be a perception that this sent another signal that health care could wait;

(3) **Skepticism that Bill Outside of Reconciliation is Possible**. The Chairman continue to strongly believe that health care outside of the reconciliation bill is virtually impossible, particularly in the Senate, and are extremely skeptical that two tax hike and benefit cut proposals can receive serious consideration in one year;

(4) **Current Senate Delay on Reconciliation is Creating Problems**. They view that the White House has an overly optimistic expectation of a completion time for the reconciliation bill (they cite Republican trouble-making, Democratic Member nervousness, and numerous politically-sensitive provisions in the bill that will be difficult to mark-up in Committee);

(5) **Fear that President isn't Assuming Enough Time for Congress.** The Committee Chairmen apparently do not believe that we fully recognize and appreciate the difficulty of the abbreviated time constraints we may be assuming for hearings and mark ups of a health reform bill. More to the point, the House Chairmen -- and particularly the Subcommittee Chairmen and their Members -- are becoming more wary that the assumed timing strategy does little other than "roll over" the Committees. Because they have yet to feel "adequately consulted" on the substance of the proposal, they are very nervous. Moreover, because our strategy assumes House passage first, the House Chairmen are also concerned that the Senate will delay so long as to practically force acceptance of the Senate version; and

(6) **Concern that CBO Numbers Will Kill Any Chances of Reform.** Recent public and private signals by CBO's Robert Reischauer about how little savings virtually any cost containment alternative can achieve over the next five plus years raises great concern that we will be forced into an all and significant tax strategy. The prospect of a major tax package on the heels of reconciliation, even for health care, frightens most Members; and

(7) **Concern that the President is not Actively Engaged.** Although you, Ira, Judy, Howard, Steve and others have sent unambiguous signals that the President is committed to getting reform done this year, the media coverage and the perception of internal squabbling is raising questions in the minds of Members and staff. Added on top to the sense that the President himself has not directly raised the health care issue since the State of the Union, the Congress is not confident it "knows" where the President now stands on this issue.

APPENDIX 4

M E M O R A N D U M

TO: Hillary Rodham Clinton March 22, 1993
FR: Chris Jennings
RE: Senate Republicans to Target as Possible Supporters and Senate Democrats to Attract and Keep on Board
cc: Legislative/Congressional Distribution List

As you know, it is now virtually certain that the President's health care proposal will require at least one 60 Member vote to have a chance of passing the Senate. (If the proposal is merged into reconciliation, 60 votes will be required to waive the Byrd rule; if it is a free standing bill, 60 votes will be required to achieve cloture on debate and to bring an end to a likely Republican fillibuster).

With the above in mind, and because we cannot count on all 57 Democrats (possibly 56 by the time of the roll call) to vote with us, we must build on and improve our ongoing efforts to attract a core group of Republicans to vote with the President on his health reform proposal. Similarly, we must attract and retain support from a fairly sizable list of Democrats who, for a variety of reasons, may be nervous about voting with us.

In an effort to pool the information we have on the target Senate Members, we convened a group including Steve Ricchetti and his staff, Melanne, Christine Heenan, HHS's Jerry Klepner, Karen Pollitz and Alan Hoffman, DNC's Celia Fischer, and Steve Edelstein and his War Room staff. (The group now meets every Friday). We found ourselves to be in significant agreement on which Senators we currently believe that the Administration and the DNC should target; I have attached a list and some cross-referencing information about this list for your use. In addition, the information we produced through this discussion will be summarized and distributed in short order.

The 14 Republicans we chose are the ever-shrinking number of Members who -- because they are viewed as moderates, have special populations to worry about, and/or are coming up on an election or retirement -- are the most likely to cross over and support us. (FYI, according to Republican staff, these Members will attempt to stick together in a block so as to strengthen their bargaining leverage IF any such minority block of Republicans forms; in other words, they plan to exert tremendous pressure on one another to block "straggler" Republican support).

The Democrats we chose are those who are historically moderate to conservative Members or who, because of their constituency or Committee assignment, are particularly sensitive to specific special interest concerns. It is important to stress that, as we are targeting these Members, we must not ignore or alienate our relatively solid progressive support base.

REPUBLICANS

	Senator	Relevant Committee Assignment
1.	Christopher Bond (MO)*	Appropriations Committee
2.	Conrad Burns (MT)* XX	Appropriations Committee
3.	John Chafee (RI) XX	**FINANCE COMMITTEE**, Health Care Task Force Chair
4.	Bill Cohen (ME) XX	Judiciary Committee
5.	Alfonse D'Amato (NY) XX	Appropriations Committee
6.	John Danforth (MO)	**FINANCE COMMITTEE**
7.	Dave Durenberger (MN) XX	**FINANCE** and Labor Committees
8.	Mark Hatfield (OR)	Appropriations Committee
9.	Jim Jeffords (VT) XX	Labor Committee
10.	Nancy Kassebaum (KS)	Labor Committee, Ranking
11.	Connie Mack (FL)* XX	Appropriations Committee
12.	Bob Packwood (OR)	**FINANCE COMMITTEE**, Ranking
13.	Bill Roth (DE)* XX	**FINANCE** & Gov. Affairs
14.	Arlen Specter (PA)* XX	Appropriations and Judiciary

* Although all will be a great challenge, these 5 Senators will be the most difficult to get on board.

XX Notably, 9 out of the 14 targeted Members have Democratic Senator counterparts and 11 out of 14 have Democratic Governors. If these Dems are on board, it will make it much more difficult for Republicans to oppose the Clinton plan.

NOTE: Seven out of the 14 are either Finance or Labor Committee Members or both (in the case of Durenberger) -- the two primary Senate health committees. Five of these Members serve on the all-important Finance Committee.

Lastly, although highly doubtful supporters, significant efforts should be made to make the following influential Members uncomfortable about engaging in active opposition: (1) Bob Dole (KS, Minority Leader, & Finance Committee Member), (2) Alan Simpson (WY, Minority Whip, Judiciary Committee), (3) Orin Hatch (UT, Finance and Judiciary Committee, Ranking Member), and (4) Pete Domenici (NM, Budget Committee Ranking Republican and Appropriations Committee).

DEMOCRATS

Senator	Relevant Committee Assignment
1. Max Baucus (MT)	Finance Committee
2. David Boren (OK) *	Finance Committee
3. Bill Bradley (NJ)	Finance Committee
4. John Breaux (LA)	Finance Committee
5. Richard Bryan (NV)	
6. Dennis DeConcini (AZ) *	Appropriations, Judiciary
7. Chris Dodd (CT)	Labor and Human Resources
8. Jim Exon (NB) *	
9. Wendell Ford (KY)	
10. Bob Graham (FL)	
11. Howell Heflin (AL) *	Judiciary Committee
12. Earnest Hollings (SC)	Appropriations Committee
13. J. Bennett Johnston (LA) *	Appropriations Committee
14. Bob Kerrey (NB)	Appropriations Committee
15. Herb Kohl (WI)	Judiciary Committee
16. Bob Krueger (TX)	
17. Frank Lautenberg (NJ)	Appropriations Committee
18. Joseph Lieberman (CT)	
19. Daniel Patrick Moynihan (NY)	Finance Committee
20. Sam Nunn (GA) *	
21. Harry Reid (NV)	Appropriations Committee
22. Charles Robb (VA)	
23. Richard Shelby (AL) *	

* Indicates the 7 Senators who probably will be the most difficult to get on board.

TOTAL STATES/MEMBERS TARGETED IN THE PRELIMINARY SENATE STRATEGY

	State	Senator(s)	Governor
1.	Alabama	Heflin and Shelby	Hunt (R)
2.	Arizona X	DeConcini	Symington (R)
3.	Connecticut	Dodd and Lieberman	Weicker (I)
4.	Delaware	Roth	Carper (D)
5.	Florida	Graham and Mack	Chiles (D)
6.	Georgia X	Nunn	Miller (D)
7.	Kansas	Dole and Kassebaum	Finney (D)
8.	Kentucky X	Ford	Jones (D)
9.	Louisiana	Breaux and Johnston	Edwards (D)
10.	Maine X	Cohen	McKernan (R)
11.	Minnesota	Durenberger	Carlson (R)
12.	Missouri	Bond and Danforth	Carnahan (D)
13.	Montana	Baucus and Burns	Raciot (R)
14.	Nebraska	Exon and Kerrey	Nelson (D)
15.	Nevada	Bryan and Reid	Miller (D)
16.	New Jersey	Bradley/Lautenberg	Florio (D)
17.	New Mexico X	Domenici	King (D)
18.	New York	D'Amato and Moynihan	Cuomo (D)
19.	Oklahoma	Boren	Walters (D)
20.	Oregon	Hatfield/Packwood	Roberts (D)
21.	Pennsylvania X	Specter	Casey (D)
22.	Rhode Island	Chafee	Sundlun (D)
23.	South Carolina X	Hollings	Campbell (R)
24.	Texas X	Krueger	Richards (D)
25.	Utah	Hatch	Leavitt (R)
26.	Vermont X	Jeffords	Dean (D)
27.	Virginia X	Robb	Wilder (D)
28.	Wisconsin X	Kohl	Thompson (R)
29.	Wyoming X	Simpson	Sullivan (D)
Total Number of Senators:		41*	20 out of 29 are Dem Govs.

* This includes the 4 additional target Republican Senators of Dole, Simpson, Hatch, and Domenici.

NOTE: If the DNC does not have the resources to target all 29 states, they should choose (generally) to eliminate first those states that have only one target Senator and whose Senator does not serve on the Finance Committee. There are 12 such states marked with an X, but my 6 lowest priorities would be Georgia, Kentucky, New Mexico, Texas, Wisconsin, and Wyoming. (I can talk about others if necessary; in addition, exceptions to the Finance and/or 2 Member rule might be Delaware, Utah, and Alabama).

(301) 652-5576

- House Bill Rule 14 – [illegible] on [illegible] calendar

- Senate Bill goes to calendar & becomes companion to H.R. bill

- Ideal is that H.R. bill gets to Senate w/o having to go to calendar.

- Committee card [illegible] reporting [illegible] deadline April 19th 20th/21st

April 24th HRC retreat Sat. morning

- Saturday morning April 24th HRC

May 18th Task Force [illegible]
22/23 [illegible] retreat

2J/24th
BC speech in May

- mandy
2

Before
- Meetings w/ members
Consultation w/ CBO

27th TV extravaganza
Thursday

- CJ | Arne | Bob – hearings
[illegible]

Republican members

Melcher-FYF

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M E M O R A N D U M

TO: Steve R. April 9, 1993
FR: Chris J.
RE: Republican Members and Staff Meetings/Contacts

Steve, as you will be able to tell by the attached list, we have been busy scheduling and holding meetings with Republican Members and staff from both Houses during the last two months. I believe the list will give Howard and you more than ample room to say that any future meetings with Republicans are simply a continuation of our past practice of consultation -- (even though the Republicans, particularly the Senate Members, have been complaining about their adequacy).

A couple last notes. I have been trying for weeks to find a way to extract Chafee and his moderates from the rest of the Republicans. The First Lady has desired to have a meeting with Senator Chafee, but has hesitated from calling to initiate one. (She does not want to appear to be going around the Minority Leader). Ira has tried too, but Chafee has repeatedly indicated he does not wish to meet with him at this time.

In addition, Senator Chafee's office (Christy Fergeson on a very confidential basis) has called to indicate that she believes their could be a constructive working relationship with at least a group of Members from the Republican Health Care Task Force. Most recently, though, she and her boss -- probably because they too fear alienating Senator Dole -- have taken the position that we should wait to have active Member-level discussions on the Senate side AFTER we have a better sense about what direction we want to go. (The reason why they are taking this position, no doubt, is that they do not have any desire to appear to be "bought off" so early in the process). Also, they still feel that having a larger number of Republicans to negotiate, at this point, places them in a much more powerful negotiating position.

Based on my numerous "off-the-record" conversations with senior staff of Chafee's office (Christy Fergeson), Danforth's office (Peter Leibold), Kassebaum's office (Andrew Patzman), and Senator Jefford's office, their is a great desire to work with us, but their is also a great fear about how it will be perceived by the rest of the Republicans. At a recent Members meeting, a comment about how "Republicans would get more than a good night's sleep if we go to bed with the Administration on health care" was made and well received by most of the Members present.

Obviously, if we have any chance of passing health care reform this year, we will have to have Republicans on board. Based on our record of meetings to date, I think we should have no problem defending a closer working relationship.

Lastly, I want to point out that, although Senate Republican Members have not been coming to meetings recently, it is not because we did not want them there. I have consistently pointed out to Shiela that our Democratic Senators are being briefed by Ira and are being done so in large numbers. Shiela always says, though, that if it is just Ira or other work group members, it will be just staff.

Hope this information is helpful. Call me up with any questions.

DATE	MEMBER(S)	MET WITH	SUBJECT
2/4	DOLE/CHAFEE	HRC/ICM/JF	process, general discussion
2/23	DURENBERGER	HRC/ICM	
3/10	Senate Republican Members Bond Burns **Chafee** Cohen Craig Danforth **Dole** Durenberger Gregg Kassebaum Mack Murkowski Nichols Packwood Roth Simpson Stevens Thurmond (others were present as well)	HRC	general discussions about process and about directions for/components of reform
3/10	JEFFORDS	ICM	
3/11	House Republican Members/Staff	ICM	
3/12	Senate Republican Staff	ICM	
3/18	House Republican Members Hastert Goss Johnson Thomas Blily McMillin	ICM	MALPRACTICE

DATE	MEMBER(S)	MET WITH	SUBJECT
3/23	Senate Republican Staff	Walter Zellman Rick Kronick Lois Quam	New System Development Governance
3/25	House Republicans Members Hastert Goss Johnson Thomas Grandy Blily McMillin	ICM	GLOBAL BUDGETS
4/1	House Republicans Members Hastert Goss Johnson Thomas Grandy Blily McMillin Roberts Gunderson	Lois Quam	RURAL HEALTH CARE
4/1	Senate Republican Staff Sheila Burke Christy Ferguson Ed Mihulski	ICM	short-term controls