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A RETROSPECTIVE ON HEALTH REFORM
OCTOBER 1994

On any given day, almost 39 million Americans, most of them working people and their children, have no health insurance. Every month, 100,000 Americans lose insurance. Millions more stay locked into jobs they want to leave because they can't risk losing their insurance. Families find they can't get coverage for the very problems they need care for, because those illnesses have been stamped "preexisting conditions." Small businesses face health care premiums that are 35 percent higher than those of large corporations and are projected to continue to grow at double-digit rates. A full third of these small businesses that now cover their employees say they will be forced to drop their workers' insurance.

In spite of the tens of millions of Americans without insurance and the millions of others with inadequate insurance, our medical bills are growing at over twice the rate of inflation. In 1993, we spent over 14 percent of our income on health care. By the year 2004, if we do nothing, that figure is projected to jump to close to 20 percent. We spend over a third more of our income on health care than any other country. And the gap is growing, putting our companies at a competitive disadvantage in the global economy.

This is the picture candidate Clinton faced: rising health care costs swallowing up growth in workers' wages, ballooning the federal deficit and stifling the competitiveness of American industry. Economic downsizing and a sluggish economy added millions to the ranks of the uninsured, and fueled fears about losing it for those who had coverage. Candidate Clinton saw the health care issue as inextricably linked to his main campaign thrust of economic recovery, and promised to submit a health care plan within his first 100 days in office.

Other Democratic candidates offered health reform plans ranging from "single-payer", which achieved universal coverage through broad new taxes paid to the federal government to "pay-or-play", which achieved universal coverage by requiring companies that did not cover their workers to pay a tax to the federal government.

Candidate Clinton embraced a relatively new, more moderate framework, known as "managed competition." A combination of insurance and market reforms, combined with universal coverage and new government ground rules, would stimulate private sector competition and efficiency -- thus holding down health care costs. A requirement for all employers and individuals to buy health insurance with subsidies to small and low-wage companies and low-income people would guarantee private insurance to all Americans. Many conservative Democrats, including former Senator Tsongas, favored this approach.

Clinton's campaign plan, with private sector health care and increased competition as its centerpiece, would achieve four main goals:

- Provide universal health care coverage to all Americans.
- Make health care more affordable by controlling the rate of growth of health care costs so that they did not exceed the rate of growth in personal income.
- End discrimination in the health insurance market by outlawing insurance industry practices of excluding or dropping sick people and charging prohibitive rates to certain groups.
- Provide a prescription drug benefit and better home and community-based long-term care services to the elderly and disabled.

When the new President came to Washington, he was warned that he faced a serious challenge -- health reform had been attempted by seven Presidents. Seven Presidents had failed. Health reform was too big, with too many powerful vested interests. Those who profited from the status quo were tenacious, well-financed, and well-organized. Health reform was not a first-term issue.

As one old Washington hand wryly noted, health reform was a good campaign issue -- everyone's for health reform. But getting something through once in office would be a different story. The wide coalition of groups and interests who would rally behind the label "health reform" supported very different things, and uniting these groups behind a single proposal could prove next to impossible.

The goals the President laid out were, and still are, popular with the American people. Yet meeting them has not come easily. What happened?

Some say that the President and his Administration overreached -- proposing a radical, big-government, grandiose plan hatched by policy wonks with political tin ears. In fact, the President's health care plan -- true to the candidate's promise -- was comprehensive, but hardly radical. It built upon the system 90 percent of Americans now use: private sector insurance delivered through the workplace. Its primary financing mechanism -- the employer-employee mandate -- mirrored that proposed by Richard Nixon and Bob Packwood.

Why, then, was it perceived as so grandiose or over-reaching? What about the now controversial ideas like employer mandates, premium caps or large mandatory alliances? What has become conventional wisdom over the course of this debate -- that these elements were some "big government" creatures of the Health Care Task Force -- is simply not true. It is not the plan itself that was overly ambitious. Rather, it was how it was portrayed to the American people by opponents of reform.

Employer Mandates

Virtually all Democrats and moderate Republicans supported the goal of universal coverage in 1993 when the President's plan was written and presented. In fact, Senator Dole and 23 other Republican senators initially cosponsored the Chafee bill which achieved universal coverage through a mandate that individuals buy insurance.

Over the past two years of debate on health care -- in fact, over the past few decades of debate -- only a handful of ideas have been proposed that would pay for universal coverage: 1) The raising of broad-based taxes -- the single payer approach; 2) Requiring individuals to purchase insurance -- an "individual mandate"; 3) Requiring individuals and employers to share the cost of purchasing insurance -- an "employer mandate."

The single payer approach would replace today's employer-based system with broad-based income, payroll or value-added taxes, requiring at least three to four hundred billion dollars in new federal taxes per year. The government would take over paying for health care from benefits managers and insurance companies in today's market. Over 95 Democrats in the House supported a single payer bill. However, because it required raising a large broad-based tax for financing and called for the government to play a significant role in the new system, this proposal did not achieve support beyond its base.

A second approach was to mandate that all individuals buy health insurance, just as many states now mandate that all individuals buy auto insurance. The Senate Republican Task Force, chaired by Senator Chafee, used an individual mandate as its vehicle to achieve universal coverage. Many economists favor this approach -- believing that virtually all health care spending by employers comes directly out of employee wages anyway. But polling data shows that the public opposes this approach on the grounds that workers have foregone wage increases to get employer-provided health care. They feel that this approach would result in many people losing benefits they currently have.

The third approach, an employer mandate, was the approach embraced by the President during the campaign and later by his Administration. It had the advantage of building on the current system of joint employer and individual contributions. Almost 90 percent of those with private insurance today get it through their employer, with employers paying, on average, 80 percent of the cost of the premium. Spreading that responsibility across all employers and individuals -- not allowing "free riders" -- would eliminate "cost shifting" -- the extra cost families and employers with insurance today pay for those who use health care services but can't pay for their care. To ensure that this requirement was affordable, the government would subsidize insurance for low-income families and small and low-wage businesses.

An employer mandate was the least disruptive and therefore, arguably, most conservative route to universal coverage. As a result, and perhaps not surprisingly, it enjoyed the broadest support. The American Medical Association (AMA), the American Hospital Association (AHA), the Health Insurance Industry Association of America (HIAA), the Catholic Health

Association (CHA), many labor unions, the Jackson Hole Group, the National Leadership Coalition for Health Care Reform (co-chaired by former Presidents Carter and Ford), and many business groups including the Association of Private Pension and Welfare Benefits managers and even the Chamber of Commerce all publicly supported this approach. Hawaii, the state that has come closest to universal coverage, had had an employer mandate on the books for more than 20 years, and business growth had outpaced the national average. Moreover, those states most likely to provide comprehensive coverage to their citizens -- Washington and Oregon -- had also chosen this route.

In fact, the Clinton proposal for an employer mandate was very similar to a proposal made by the U.S. Chamber of Commerce and to President Nixon's 1972 health care proposal introduced by Senator Packwood.

Premium Caps

The biggest concern the American people had about health insurance was losing it; the second was its cost. Cost containment was critical to insuring that health care was affordable for businesses and families, and was essential for controlling federal spending. Virtually all comprehensive health care bills submitted by Democrats and moderate Republicans included cost containment.

But as with universal coverage, there were a limited set of options for meeting this objective.

One option was price controls -- directly setting the price for goods and services delivered in the health care sector, or setting annual ceilings on the total amount the nation would spend on health. Many traditional advocates of comprehensive reforms advocated either global national budgets, or nationally-set rates for each specific health care test and procedure. These measures had the support of some business and many labor groups. The National Leadership Coalition, co-chaired by former Presidents Carter and Ford, and including companies like Xerox and Chrysler, supported this approach.

Managed competition advocates like Senators Breaux and Boren and Representatives Cooper and Andrews proposed "tax caps" and market reforms to contain health care spending -- limits on the tax deductibility of health spending by companies. By tying the amount of deductibility to the cost of the lowest-cost health plan in an area, managed competition theory went, families and businesses would become smarter shoppers and choose lower cost health plans. Families who chose more expensive plans would be penalized by paying more, dollar-for-dollar, out of their own pockets. This new cost conscious behavior, combined with other market reforms like a standard benefits package, would constrain health care expenditures.

The President did not adopt the tax cap because it raised taxes on middle-class families and penalized many for negotiating better plans without giving them adequate time to adopt to the new environment. The President's plan encouraged consumer cost consciousness through

other measures. Employer contributions would be tied to the average cost plan in a region. Employees that chose a higher-cost plan would pay more out-of-pocket, those who chose a plan that cost less than the average would pay less. Like the managed competition approach, cost conscious behavior, combined with increased competition due to market reforms would achieve efficiencies and contain costs.

A third method of cost control was premium caps -- limiting the amount insurance premiums could be raised year after year. Bills submitted by moderate Republicans such as Senators Danforth and Kassebaum, and moderate Democrats such as Senator Bingaman and Baucus and Representatives McCurdy and Glickman included premium caps for controlling health spending.

Moderates preferred premium caps over other forms of cost containment because, unlike global budgets, premium caps cover only pre-tax health care spending. The American public could spend whatever it wanted with after-tax money. Unlike price controls, premium caps do not try to regulate every transaction in the market. Instead, they give flexibility to health plans to budget their spending within a premium. Private health plans decide the best mix and pricing of hospital, outpatient and other services, not the federal government.

Premium caps had been passed into law in Minnesota and Washington state, and had been proposed in the state of California by the state insurance commissioner. They also were supported by diverse groups including the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and the Catholic Health Association (CHA) and were supported by prominent physicians and health reform advocates such as C. Everett Koop and Jack Wennberg.

We borrowed this method of cost control directly from the Danforth/Kassebaum bill as an insurance policy on competition, both as a safeguard for family and employer affordability, as well for Congressional scoring purposes. If competition worked as predicted, insurance premiums would never reach the pre-set caps. As with employer mandates, premium caps, particularly as backstops to competition, were neither a new nor radical idea.

Large Mandatory Alliances

Perhaps no idea occasioned as much controversy as the proposal to establish large mandatory health alliances in regions around the country. These alliances pooled the purchasing of workers in firms with fewer than 5,000 employees, government employees, Medicaid beneficiaries, nonworkers and retirees. Through these pools, community rating could easily be enforced, families would have a wide array of plans to choose from, and families and businesses would have the maximum bargaining leverage to get affordable prices.

The idea for these entities, originally called purchasing cooperatives, came from the managed competition advocates at the Jackson Hole Group and the Managed Competition Act sponsored in 1992 by Representatives Cooper and Andrews. In this legislation, all firms with

fewer than 1,000 employees were required to join purchasing cooperatives. States had the option to fold in firms with up to 10,000 employees. The rationale for mandatory purchasing cooperatives was to pool employees to strengthen their bargaining leverage and to ensure an affordable community rate for health insurance.

The Administration adopted this model, choosing a firm size cutoff of 5,000 as a starting point for negotiation -- mainly because it was within the range of numbers specified in the original Cooper bill. It was also within the range adopted by Washington State which imposed mandatory community rating for firms with fewer than 7,000 employees and allowed them to join exclusive purchasing alliances.

Other Provisions

Though less in the limelight, the Health Security Act contained a number of other significant provisions -- these, too, were well within the mainstream thinking at the time. The long-term care benefit, prescription drugs for Medicare recipients, a focus on primary care, quality improvement, the creation of a health information network, administrative simplification, funding for academic health centers, rural and urban infrastructure improvements, malpractice and antitrust reforms, insurance reforms, benefit package design, public health initiatives and other aspects of the bill were all developed from recommendations in other previous legislation, from state experience, from company experience or from well established academic analysis. In fact, many of these lesser provisions are also included in Republican health reform proposals.

Complexity

While the bill's actual provisions were in the mainstream, size and complexity made it easy for critics to brand it as bureaucratic social engineering and "big government". The bill is complex -- all 1,342 pages of it. But, as the Congressional Budget Office stated:

"The Health Security Act is unique among proposals to restructure the health care system both because of its scope and its attention to detail. Some critics of the proposal maintain that it is too complex. A major reason for its complexity, however, is that the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administrations on the implementation requirements."

Health care is a very complex subject. The Congressional leadership felt it was important that the Administration's bill be detailed enough to adequately describe how a reformed system would work. When one begins to spell out what benefits are covered, how the money flows, what happens to existing government health plans like Medicare and Medicaid, the result is a lengthy bill. All major legislation are lengthy. The Crime bill passed two weeks

ago was as long as most health care bills and NAFTA legislation was literally thousands of pages. Long legislation is not a new phenomenon, nor is it limited to health care.

Yet, with health care, the length of the bill became a metaphor for the complexity people would supposedly face under a reformed system. The number of pages became a symbol of the amount of government involvement people would see in their health care. Attacking the substance of health plans by attacking their length played to the cameras. George Mitchell's eloquent presentation of his proposal did not make the evening news, but Bob Dole's antics in weighing it on a scale did.

The Administration knew that at least some conservative Republicans would attack the bill as "too bureaucratic", "too regulatory", "big government". Unfortunately, we were right.

The Administration believed, however, that introducing a skeleton bill that did not give the public and the experts an explanation of how these reforms would work would be irresponsible. In any event, a skeleton bill would undoubtedly have been attacked for being too superficial and not well-grounded.

Where are the Radical Social Engineers?

Critics of the President's initiative painted his bill as a radical document. In fact, its employer mandates were borrowed from Richard Nixon and a host of mainstream groups; its premium caps came from a bill sponsored by moderates such as Senators Danforth and Kassebaum and Congressmen such as Representatives McCurdy and Glickman and its alliances came from the bill sponsored in 1992 by Representatives Cooper and Andrews.

Those elements and the central focus of universal coverage remain popular with the public to this day. In a June Washington Post/ABC poll, universal coverage is favored by 77 percent of people and employer mandates by 72 percent. Government cost controls are favored by 75 percent of the public.

So why then, did Members who had themselves introduced these proposals later come to denounce them and press for different solutions? Why did a plan with moderate foundations and widely supported elements become viewed by many as a politically unworkable albatross?

Several reasons.... some of them within our control, many of them outside of it. Timing and unforeseen congressional events led to missed opportunities and a hardened political environment. The attacks on the complexity of the bill and misperceptions about its contents fueled people's fears about government intrusiveness. But most importantly, deep-pocketed opponents and their endless negative ads poisoned the atmosphere. Though support for the core elements of the plan remained high, much of the public came to distrust any comprehensive health reform legislation.

DELAY AND THE LOSS OF MOMENTUM

The first problem that was encountered was the loss of momentum occasioned by the need to delay the release of the President's health plan. When the President took office, he appointed a health care task force with a 100 day deadline to produce a health plan which the President could take to Congress by the end of May. Initially, the President, with advice from Congressional leaders, contemplated including the health plan in his first budget along with his economic plan. Such an approach had a number of advantages. It would not be subject to a filibuster in the Senate, thus requiring only 51 votes to pass. Tying it to his economic plan would allow the President to ask for just one vote, albeit a big and difficult one from allied Democrats. It also would ensure that the program moved quickly and did not bog down in interest group opposition.

Ultimately, this strategy proved to be impossible when the Congressional leadership determined that there was not sufficient support in the Senate to pursue it.

The Administration then intended to introduce its plan by the end of May and push for passage by the end of the year. Delaying into 1994 significantly increased the risk of having health reform politicized by the mid-term elections.

During April and May, the Health Care Task Force met 21 times to finalize decisions on the plan, with the President in attendance at numerous meetings to make the key decisions. However, after the defeat of the President's stimulus package and with mounting opposition to his economic and budget package, Congressional leaders asked that the introduction of health care be delayed until after passage of the economic package was assured. They feared that members might trade off their vote on the economic package for concessions in the health package. For example, when a Department of Treasury analysis listed a tax on wine and beer, (a tax which was never seriously considered) as a potential source of health reform financing, some privately suggested that they could not support the economic package if they knew this tax would be in the health reform package.

As the economic package stalled, the introduction of health care was delayed from early-June to late-June to mid-July to late-July and finally to late-September. Because the budget situation was tenuous as it was, the collective view was that leaked accounts of health care meetings could only disrupt the delicate balance being sought to pass the budget. At the end of May all decision meetings were suspended, both internally and with members of Congress, until after the economic package was passed.

This meant that the final group of health care decisions, originally scheduled for late-May, did not get made until just after Labor Day. The speech to the Joint Session of Congress introducing the health care plan occurred on September 22 instead of at the end of May and legislation was not submitted until late October.

This delay gave time for the opposition to organize and caused doubt among supporters. However, everyone within the Administration was unified in the belief that not passing the economic package would make it impossible to pass health care reform. Moreover, passage of the President's economic program was crucial to the country and to the presidency.

SECRECY OF THE TASK FORCE

Though the delay was inevitable, the reputation of secrecy that surrounded the health care task force was not. The formation of the President's health policy was among the most open processes ever conducted to form policy in an Administration, yet it is still widely believed, that the President's health plan was drafted in secret, behind closed doors and without the benefit of real-world views.

To meet the aggressive timetable, we established a process for making policy that was unconventional for Washington, borrowed from private sector models for conducting big projects in a short time frame. To help us flesh out the campaign framework in a way that would work effectively, we cast a wide net for participants. To establish an atmosphere of equal footing among departments and agencies and to foster interdepartmental cooperation, the decision was made to run health care out of the White House.

The health care working groups included an extraordinary group of people, many of whom had extensive careers on the front lines of the health care system. Serious consultations and reviews included hundreds of others from all walks of life. Practicing physicians, nurses, social workers, hospital administrators, benefits consultants and managers, consumers, businessmen, actuaries and accountants, health lawyers and others were involved in extensive work associated with the task force.

We met with more than 1,100 different interest groups, had daily meetings with members of Congress, and involved more than 120 Congressional staffers on the working groups. Outside experts were consulted, and made presentations to the working groups regularly.

Representatives from the National Governors Association participated on the working groups and officials from associations of state legislatures, counties and cities were included as well.

Between February 20, 1993 and April 18, 1994, the First Lady held a series of 23 public hearings and town meetings across the country.

Also by May, review groups composed of health care providers, consumers, auditors, actuaries, hospital and insurance administrators and lawyers reviewed and responded to ideas presented by the working groups. The working groups incorporated their comments and met their deadlines. The whole process resulted in an amazing amount of work being completed in a very short time period.

Yet despite this unprecedented level of consultation and involvement, the widely held perception is one of secrecy. The main reason has to do with the way we dealt with the press -- or in this case, didn't deal with the press.

First of all, we had a lot of work to do and a very limited time in which to get it done. And, we thought that, like the economic package, NAFTA, reinventing government and welfare reform, there would be plenty of time to educate the public and brief the press about the plan after internal deliberations were completed. We miscalculated.

While a few cursory press briefings were held, the press was, by and large, excluded from the deliberations of the task force and the ongoing efforts of the working groups. This caused three serious problems from which we never recovered:

1. Many members of the press rightly resented their exclusion from the process. Many of the reporters covering health care had waited 12 years to cover this story, and now that moment in history had arrived, they were being kept out.
2. Reporters meeting daily deadlines for health care stories were forced to rely on leaked information, often provided by people who were not directly involved or wanted to influence the outcome of policy deliberations. This led to negative and distorted coverage.
3. We had undertaken an enormous task and were using an unconventional process to complete it. Both the importance of the task, how it was being worked on, and who were involved should have been better communicated and explained. In short, we missed an opportunity for the press to be educated about our deliberations and about the health care issues which could provide a context for their reporting later.

THE COMMUNICATIONS CHALLENGE

We always knew that communication would be essential to the success of the health care initiative. A special operation called the delivery room was established in late-May to prepare the groundwork for introducing health care to the nation. The operation was diverted at the end of June until mid-August toward fighting for passage of the economic program. It resumed operations again in late-August.

We also knew that the first six weeks would be crucial in defining the debate. We had to educate the American public on what was in our plan before opponents mis-characterized it. During the summer of 1993 there were intensive discussions in the White House about scheduling the President's three major initiatives for the fall: health care reform, NAFTA and reinventing government. A decision was made to introduce reinventing government for a week just after Labor Day. The President would spend a day in September to introduce NAFTA. NAFTA would quietly proceed through Congress until a major public offensive would be launched in November, a few weeks before the vote. Five solid weeks of the

President's time would be devoted to health care, beginning just before the President's Joint Session health care speech on September 22.

Open to all Members of Congress, a "Health Care University" took place on September 20 and 21. Over 40 experts, including the First Lady, briefed Members of Congress on health reform and the President's plan. Attended by both Democrats and Republicans, the university garnered Republican praise. House Minority Leader Bob Michel called it "very, very productive and unique...on this issue, we can definitely work together."

The following day, September 22, President Clinton delivered his long-awaited health care reform speech to the Joint Sessions of Congress. In his speech, the President repeated the goals for health reform, themes that had become so familiar: security, savings, quality, simplicity, choice, and responsibility. These principles would need to be there in the end, but the President invited the American people and the Congress to carefully review, question and critique the details.

His speech was a hit. According to USA Today, "Lawmakers of both parties praised Clinton for tackling the issue and his persuasive, determined tone." The Boston Globe reported that "Clinton went out of his way to find common ground with Republican lawmakers...citing both former President Richard M. Nixon and Reagan-era surgeon general C. Everett Koop as inspiration for elements of his plan."

During the week following the speech, White House officials and Cabinet Secretaries fanned out across the country in a series of meetings, speeches and interviews. The fall campaign had started off successfully. In a Washington Post-ABC News poll taken on September 23, 56 percent of Americans said they approved of Clinton's health plan.

According to the New York Times the President's plan was "alive on arrival". That universal coverage would be achieved -- that all Americans would have health care that was always there -- was a given. Democrats and Republicans alike realized early on that they had better jump on the universal coverage bandwagon. It was widely believed that any bill the Congress passed would have to get to universal coverage.

The Clinton plan would serve as a framework for Congress' efforts -- the Committees would work through the details -- how generous the benefits package, when universal coverage would be achieved, the exact mix of taxes and spending cuts. Universal coverage was not in question.

However, beginning in October; opponents of reform -- insurers, the NFIB, restaurants, for-profit hospitals stepped up their attacks, mounted their advertising campaigns, began coordinated grass roots lobbying efforts -- all aimed at bringing down the Clinton plan. Supporters of reform -- the AARP, the AFL-CIO, many provider groups and businesses and others -- also shared the view that universal coverage was inevitable. The inevitability motivated opponents to focus their attacks; it had the opposite impact on our supporters. Believing that

universal coverage was a foregone conclusion, our supporters spent their time trying to improve the bill in small ways important to their constituencies.]

Even those with different approaches used the Clinton plan as the basis for comparison -- Representative Cooper termed his own plan "Clinton Lite", a "second cousin" of the Clinton plan. Senator Chafee spoke on Sunday talk shows of the "similarities in our approaches", and his optimism about achieving consensus. The Wall Street Journal and the New York Times ran articles about possible minor modifications to the President's plan to get to a final deal.

The President's appearances were followed by a successful week of testimony in Congress by the First Lady. Hillary Clinton spent the week testifying before the House Ways and Means Committee, the House Energy and Commerce Committee, the Senate Finance Committee, and the Senate Labor and Human Resources Committee. Responding to a series of challenging, often antagonistic questions, the First Lady impressed legislators with her savvy and expertise. Representative Dan Rostenkowski told his fellow committee members that "if there was any doubt about whether the President should have appointed her, there's no doubt about it any longer.

Her mere appearance on Capitol Hill was unusual: she is the third First Lady, preceded by Eleanor Roosevelt and Rosalyn Carter, to ever testify before a congressional committee. The uniqueness of her testimony especially intrigued the media. The Washington Post proclaimed that "overnight, Hillary Clinton's activism updated the First Lady's role to one that many women believe more accurately reflects the status of women in America today." The New York Times announced "the end of the era in which Presidential wives pretended to know less than they did and to be advising less than they were."

The New York Times described the Clinton's "elegant tango on health care, keeping control of the debate defining the details before opponents can."

Meetings with doctors, including a supportive C. Everett Koop, the Health Care University, the President's September 22 speech, his town hall meeting in Tampa, and the First Lady's testimony before the Congress were all met positively by the Congress and across the country. At last, the White House was coasting on the previously elusive momentum that was so vital to the success of health care reform.

However, such clear sailing was short-lived. A series of foreign policy crises commanded the attention of the President and the media, and combined with NAFTA, prevented the President from concentrating on health policy until mid-December. On October 3rd, twelve American soldiers were killed and fifteen wounded in skirmishes with supporters of General Aidid in Somalia. The President learned of this on the plane to California, where he was scheduled to kick off a month of health care events. This foreign policy crisis curtailed the California trip and led to the cancellation of subsequent Presidential health events.

Four days later, the President announced that he would send 1,700 reinforcement troops to Somalia. The international crises continued: on October 11th, Haitian demonstrators prevented American and Canadian peacekeeping troops from landing in Port-au-Prince, and on October 19th, the United Nations resumed its oil and arms embargo against Haiti.

What was supposed to be four weeks of the President's time in October devoted to health care was whittled down to one day -- the event in late-October, when the President took his bill to the Congress.

In this void, opponents of health reform were very active. Newspapers were filled with stories critical of the health plan generated by one interest group or another. The HIAA funnelled \$10 million in a negative television advertising campaign, and their unanswered attacks proliferated and filled the airwaves. Other opposition groups initiated a series of direct-mail campaigns that reached the homes of thousands of Americans, warning them of the evils of the Clinton health care plan.

While every major legislative battle, including every previous attempt at health reform, has met with opposition, nowhere in the history of this country is there a precedent for the level of misinformation spread during the health debate, nor for the amount of money spent to spread it. Newsweek estimates that "interest groups spent at least \$300 million to defeat health care...much of which was spent on blatantly untrue advertisements designed to scare the public." (Newsweek, 9/19/94) The Annenberg Public Policy Center studied this phenomenon and concluded that the health care debate has generated "the largest, most sustained advertising campaign to shape a public policy decision in the history of the Republic." [The Role of Advertising in the Health Care Reform Debate, The Annenberg Public Policy Center, 7/25/94]

The first of three studies conducted by Annenberg concluded that "an unprecedented amount of money (\$50 million) had been committed to produce, air and print an unprecedented amount of ads whose prime purpose was influencing reporters and legislators rather than the public as a whole. (This conclusion was deduced from the fact that the ads were concentrated in New York and D.C..) Focusing on the lawmaker and pundit audiences paid off, as those who make the laws, those who report on it, and those who offer commentary all began to fear that they would no longer be able to see their own doctor.

And according to Annenberg, the press did not help to clarify fact from fiction: the press coverage of the ads had focused not on their fairness or accuracy but on "describing them and mapping their strategies." [The Role of Advertising in the Health Care Reform Debate, The Annenberg Public Policy Center, 7/25/94]

The study also indicated that the majority of the ads had opposed rather than favored some facet of reform with more ads explicitly objecting to the Clinton plan than supporting it. This study analyzed 198 ads -- 125 print and 73 broadcast and found 28 percent and 59 percent, respectively, to be misleading. Moreover, these ads were found to reflect the claims made

by their sponsors and/or to invite negative inferences rather than just misstate facts. A large percentage of the ads were also found to "impugn the good will and integrity of those on the other side of the issue." And finally it was found that the "most histrionic and demonstrably false assertions occur...in direct mail addressed to older Americans."

Not only were the ads negative, they were scary. Health care is an extremely personal issue, one people connect with more deeply and directly than something like trade policy or deficit reduction. Even those supportive of a major overhaul were also anxious about losing what they themselves had, so ad campaigns took direct aim at exploiting the sense that people would lose everything they now knew and liked about their health insurance. *"The ads are more likely to provoke anxiety than to provide reassurance. Fear is the primary motivator in ads on all sides."* [The Role of Advertising in the Health Care Reform Debate, The Annenberg Public Policy Center, 7/25/94]

The Wall Street Journal published an article titled "Truth Lands in Intensive Care Unit", which detailed some of the worst fearmongering hitting the airwaves. The article began: The baby's scream is anguished, the mother's voice desperate. "Please," she pleads into the phone, as she seeks help for her sick child.

"We're sorry, the government health care center is now closed," says the recording at the other end of the line. "However, if this is an emergency, you may call 1-800-Government." Her baby still wailing, she tries it, only to be greeted by another recording: "We're sorry, all health care representatives are busy now. Please stay on the line and our first available.."

"Why did they let the government take over?" she asks plaintively. "I need my family doctor back."

The only problem with the radio spot, produced by a Washington-based group called Americans for Tax Reform, is that it isn't true." (WSJ, April 29, 1994)

Yet these kinds of threats -- government take over...losing your doctor....paying more and getting less....were raised over and over by opponents. According to the Annenberg study, the focus of anti-Clinton plan ads was 1) increased taxation; 2) rationing; 3) big bureaucracy/government control; 4) diminished choice of plan/doctor; 5) massive job loss.

The opposition mustered by the leaders of the National Federation of Independent Businesses, the Health Insurance Industry Association of America, The Alliance for Managed Competition (The Big 5 Insurers), The Pharmaceutical Manufacturers Association, and the for Profit Hospitals was tenacious, well organized, well financed and effective. This combined with the efforts of the Republican National Committee and various ultra conservative organizations who were responsible for some of the most misleading scare attacks have led to a seemingly intractable belief that health reform is synonymous with 1)government takeover of the health care system. (In fact, the Health Security Act preserved a private system). 2) Losing your

choice of doctor and being forced into one plan. (In fact, the proposal increased choice for most Americans by requiring a fee-for-service plan and giving families choice, not their employers. 3) Bankrupting the country. (In fact, premium caps limited the growth of health care costs to below where they would be without reform. 4) Big government and bureaucracy. (Compared to the current system, it streamlined things).

In late-December, the Administration made an effort to reinvigorate the political and communications effort. But no sooner did this effort kick off than the Whitewater and Arkansas trooper allegations sprung up. The attacks were venomous and personal, and they took aim at the core ingredient needed for public support of reform, trust in the President and First Lady. To diminish public trust in the reformers was to effectively raise fears about reform -- as Rush Limbaugh so boldly put it in his appearance on Nightline: "Whitewater is about health care."

Misconceptions about the President's plan had by this point become widely accepted and many ordinary Americans reacted with a mixture of fear and anger over what they were sure we proposed to do to their health care. At town hall meetings, angry people would state their vociferous opposition to the Clinton plan, waving mailings that claimed that the plan would have the government taking over and running all the hospitals in the country. Another favorite mischaracterization was that people would not be permitted to see their own doctor outside the health plan approved by the government, and that if they did so, they could be fined and their doctors could go to jail. This of course was ridiculous. The Wall Street Journal article detailing the false advertising touched on this, too. It said:

"Another of the big canards about the Clinton plan is that people face "5 years in jail if you buy extra health care", as the American Council for Health Reform puts it in a direct-mail package it has sent out to millions of people....But in fact, while there is an anti-bribery provision in the Clinton proposal, the bill explicitly says that people are free to purchase "any health care services" they want out of their own pockets. "I don't see anybody going to jail on a liver transplant rap," says John Sheils, a vice president at health consulting firm Lewin-VHI, Inc. "They're trying to scare little old ladies."(WSJ, April 29, 1994)

Yet this particular charge was repeated by Washington pundits, magazine and newspaper columnists and at almost every town hall meeting I attended.

Public Support

The opponents were successful. Despite high and consistent support for all the major elements of the Administration's proposal, support for anything labelled the Clinton Plan declined dramatically since September of 1993. This was best captured in a Wall Street Journal article that was titled "Many Don't Realize It's the Clinton Plan They Like". The Clinton plan, when described without the label was viewed favorable by 76 percent of those surveyed, versus 48 percent for the original Chafee plan, 42 percent for the Gramm plan, 34 percent for

the Cooper bill and 30 percent for the McDermott bill.

Consistently, when labels are removed from plans and their essence is described to the public in polls or focus groups, the Clinton plan wins far and away the most support as delivering what Americans want in the way they want.

PARTISAN GRIDLOCK

Finally, the battering taken by the plan itself led Republican leaders to conclude that they could effectively stonewall on health care and hand the President a major political defeat.

While Rep. Gingrich had been urging and enforcing an obstructionist path in the House from the beginning, Senator Dole went back and forth, alternatively speaking constructively about achieving universal coverage, the President's bottom line, and at other times declaring that there was no health care crisis and that we should do nothing.

During the late spring, Republicans made a decision not to give the President any victories, for if they did not, they could potentially gain significantly at the mid-term elections. In a June 7 memo, Republican strategist Bill Kristol urged republicans to reject a bill, even a watered down bill, that would allow the President to honor his veto pledge, since it would "protect the President's 'read my lips' pledge on health care." By July, Kristol's advice was: *"Republicans should hold off on health care negotiations until Mr. Clinton eats his words."* *"The appropriate Republican response is to take the noble road of opposing any alternative that Democrats offer and insist on starting over in '95. We should send them to the voters empty-handed."*

That strategy even spilled over to the politically safest of issues, crime fighting. All but two Republican Senators voted for the crime bill in the Spring, and then they tried to kill it in August. The tone in the Senate turned very partisan.

In response, the Administration concluded that the only way for a bill to have a chance at achieving sufficient support would be to publicly declare the President's bill dead. In that way, the Congress could develop a bill that was disassociated from the interest group attacks on the President's plan and design an initiative that moved closer toward Republican proposals to achieve universal coverage. Despite these actions, the Republicans continued to back away.

If this debate has taught us anything, it is that there are no easy answers for solving this problem. Nobody has yet found the silver bullet -- and everybody's looked. No bill, not the Cooper bill, Chafee bill, the Dole bill, the Michel bill, or the so-called "Mainstream" proposal has achieved the support needed to build a consensus.

So, where do we go from here? The problems which health reform is designed to address will not go away by themselves. People will continue to lose coverage. Costs will continue to rise faster than people's incomes, stealing away their living standards. Bureaucracy will increase and choice will diminish. The problem will not go away.

The final pages in this chapter of legislative history are yet to be written. The American people want comprehensive health reform. They want universal coverage, they believe that shared responsibility between employers and individuals is the best way to finance it and they believe that in health care, the government must play a role to contain costs.

Of all the hundreds of lobbyists who came to see us, there were none representing those real Americans counting on us to solve this problem once and for all. No one represented the 58 million people who at some time during the year have no insurance; or the 80 million people who come from families who are classified as having pre-existing conditions; or the 120 million Americans whose health insurance policies include lifetime limits which means that the insurance runs out when they need it most. The President has to be their lobbyist, and he will continue to speak out and fight for their interests and the interests of all Americans who deserve comprehensive private health insurance that can never be taken away.

On any given day, almost 39 million Americans, most of them working people and their children, have no health insurance. Every month, 100,000 Americans join the rolls of the uninsured. Millions more stay locked into jobs they want to leave because they can't risk losing their insurance. Families find they can't get coverage for the very problems they need care for, because those illnesses have been stamped "preexisting conditions." Small businesses face health care premiums that are 35 percent higher than those of large corporations and are projected to continue to grow at double-digit rates. A full third of these small businesses that now cover their employees say they will be forced to drop their workers' insurance.

In spite of the tens of millions of Americans without insurance and the millions of others with inadequate insurance, our medical bills are growing at over twice the rate of inflation. In 1993, we spent over 14 percent of our income on health care. By the year 2004, if we do nothing, that figure will jump to close to 20 percent. We spend over a third more of our income on health care than any other country. And the gap is growing, putting our companies at a competitive disadvantage in the global economy.

This is the picture candidate Clinton faced: rising health care costs swallowing up growth in workers' wages, ballooning the federal deficit and stifling the competitiveness of American industry. Economic downsizing and a sluggish economy added millions to the ranks of the uninsured, and fueled fears about losing it for those who did had coverage. He saw the health care issue as inextricably linked to his main campaign thrust of economic recovery, and promised to submit a health care plan within his first 100 days in office.

Senator Kerrey and former Governor Brown were pushing for a "single-payer" health care plan -- proposing universal coverage through huge new taxes paid to the federal government. Senator Harkin advocated a pay-or-play model, which achieved universal coverage by requiring companies that did not cover their workers to pay a tax to the federal government.

Candidate Clinton embraced a relatively new, more moderate framework, known as "managed competition." A combination of insurance and market reforms, combined with universal coverage and new government ground rules, would stimulate private sector competition and efficiency -- thus holding down health care costs. A requirement for all employers and individuals to buy health insurance with subsidies to small and low-wage companies and low-income people would create a universal system. Many conservative Democrats, including the Democratic Leadership Council and former Senator Tsongas, favored this approach.

Clinton's campaign plan, with private sector health care and increased competition as its centerpiece, would achieve four main goals:

Provide universal health care coverage to all Americans

Make health care more affordable by controlling the rate of growth of health care costs so that they did not exceed the rate of growth in personal income.

End discrimination in the health insurance market by outlawing insurance industry practices of excluding or dropping sick people and charging prohibitive rates to certain groups.

Provide a prescription drug benefit and better home and community-based long-term care services to the elderly and disabled.

These goals were and still are popular with the American people. Yet meeting them has not come easily.

When the new President came to Washington, we were warned that we faced a serious challenge -- health reform had been attempted by seven Presidents. Seven Presidents had failed. Health reform was too big, with too many powerful vested interests. Those who profit from the status quo are tenacious, well-financed, and well-organized. Health reform was not a first-term issue.

And as one old Washington hand wryly noted, health reform was a good campaign issue -- everyone's for health reform. But getting something through once in office would be a different story. The wide coalition of groups and interests who rally behind the label "health reform" supported very different things, and uniting these groups behind a single proposal could prove next to impossible.

A year ago last month, the President's economic program barely passed a reluctant Congress. As a result of its passage, we are experiencing steady economic growth. Over four million jobs have been created since the President took office. The deficit has been slashed, and, for the first time since Harry Truman was President, we'll have three years of declining deficits in a row. Yet, the President's popularity rating is low and major health reform is now viewed as an uphill struggle.

What happened? Conventional wisdom is that the President and his Administration overreached -- proposing a radical, big-government, grandiose plan hatched by policy wonks with political tin ears.

In fact, the President's health care plan -- true to the candidate's promise -- was comprehensive, but hardly radical. It built upon the system 90 percent of Americans now use: private sector insurance delivered through the workplace. Its main provisions mirrored those proposed by the likes of Richard Nixon and Bob Packwood.

Why, then, was it perceived as so grandiose or over-reaching? What about these now controversial ideas like employer mandates, premium caps or large mandatory alliances? What has become conventional wisdom over the course of this debate -- that these elements were some "big government" creatures of the First Lady's Health Care Task Force is simply not true. It is not the plan itself that was overly ambitious. Rather, it was how it was portrayed to the American people by opponents of reform.

Employer Mandates

Virtually all Democrats and moderate Republicans supported the goal of universal coverage in 1993 when the President's plan was written and presented. In fact, Senator Dole and 23 other Republican senators initially cosponsored the Chafee bill which achieved universal coverage through a mandate that individuals buy insurance.

Over the past two years of debate on health care -- in fact, over the past few decades of debate -- only a handful of ideas have been proposed that would pay for universal coverage: 1) The raising of broad-based taxes -- the single payer approach; 2) Requiring individuals to purchase insurance -- an "individual mandate"; 3) Requiring individuals and employers to share the cost of purchasing insurance -- an "employer mandate."

The single payer approach would replace today's employer-based system with broad-based income, payroll or value-added taxes, requiring at least three to four hundred billion dollars in new federal taxes per year. The government would take over paying for health care from benefits managers and insurance companies in today's market. Over 95 Democrats in the House supported a single payer bill. Because it required raising so much in new taxes and called for the government to play a large role in the new system, this proposal had limited support.

A second approach was to mandate that all individuals buy health insurance, just as many states now mandate that all individuals buy auto insurance. The Senate Republican Task Force, chaired by Senator Chafee, had an individual mandate as its vehicle to achieve universal coverage. Many economists favor this approach -- believing that virtually, all health care spending by employers comes directly out of employee wages anyway. But polling data shows that the public opposes this approach on the grounds that workers have foregone wage increases to get employer-provided health care. They feel that this approach would result in many people losing benefits they currently have. In addition, if individuals were mandated to buy insurance, it would have to be affordable. Because health insurance premiums are so expensive, the federal government would have to ensure adequate subsidies to help defray some of the cost for families. Paying for these subsidies means raising significant new taxes. And, well over half of the population would then be receiving subsidies, requiring a huge new administrative bureaucracy.

The third approach, a so-called employer mandate, was the approach embraced by the President during the campaign and later by his Administration. It had the advantage of building on the current system of joint employer and individual contributions. Almost 90 percent of those with private insurance today get it through their employer, with employers paying, on average, 80 percent of the cost of the premium. Spreading that responsibility across all employers and individuals -- not allowing "free riders" -- would eliminate "cost shifting" -- the extra cost families and employers with insurance today pay for those who use health care services but can't pay for their care. To ensure that this requirement was affordable, the government would subsidize insurance for low-income families and small and low-wage busi-

nesses.

This was the most conservative route to universal coverage, and enjoyed the broadest support. The American Medical Association (AMA), the American Hospital Association (AHA), the Health Insurance Industry Association of America (HIAA), the Catholic Health Association (CHA), many Labor Unions, the Jackson Hole Group, the National Leadership Coalition for Health Care Reform (co-chaired by former Presidents Carter and Ford), and many business groups including the Association of Private Pension and Welfare Benefits managers and even the Chamber of Commerce all publicly supported this approach.

Hawaii, the state that had come closest to universal coverage, had had an employer mandate on the books for more than 20 years, and business growth had outpaced the national average. Washington, Oregon, and other states were following Hawaii's lead.

In fact, the Clinton task force proposal for employer mandates was very similar to a proposal made by the U.S. Chamber of Commerce and to President Nixon's 1972 health care proposal introduced by Senator Packwood, today's ranking Republican member of the Senate Finance Committee.

Premium Caps

The biggest concern the American people had about health insurance was losing it; the second was its cost. Cost containment was critical to insuring that health care was affordable for businesses and families, and was essential for controlling federal spending. Virtually all comprehensive health care bills submitted by Democrats and moderate Republicans included cost containment.

But as with universal coverage, there were a limited set of options for meeting this objective.

One option was price controls -- directly setting the price for goods and services delivered in the health care sector, or setting annual ceilings on the total amount the nation would spend on health. Liberal bills included either global national budgets, or nationally-set rates for each specific health care test and procedure. These measures had the support of some business and many labor groups. The National Leadership Coalition, co-chaired by former Presidents Carter and Ford, and including companies like Xerox and Chrysler, supported this approach.

Managed competition advocates like Senators Breaux and Boren and Representatives Cooper and Andrews proposed "tax caps" to contain health care spending -- limits on the tax deductibility of health spending by companies. By tying the amount of deductibility to the cost of the lowest-cost health plan in an area, managed competition theory went, families and businesses would become smarter shoppers and choose lower cost health plans. Families that chose more expensive plans would be penalized by paying more, dollar-for-dollar, out of their own pockets. This new cost conscious behavior, combined with other market reforms

like a standard benefits package, would constrain health care expenditures.

We did not adopt the tax cap because it raised taxes on middle-class families. But we did encourage consumer cost consciousness through other measures. Employer contributions would be tied to the average cost plan in a region. Employees that chose a higher-cost plan would pay more out-of-pocket, those who chose a plan that cost less than the average would pay less. Like the managed competition approach, cost conscious behavior, combined with increased competition due to market reforms would achieve efficiencies and contain costs.

A third method of cost control was premium caps -- limiting the amount insurance premiums could be raised year after year. Bills submitted by moderate Republicans such as Senators Danforth and Kassebaum, and moderate Democrats such as Senator Bingaman and Baucus and Representatives McCurdy and Glickman included premium caps for controlling health spending.

Moderates preferred premium caps over other forms of cost containment because, unlike global budgets, premium caps cover only pre-tax health care spending. The American public could spend whatever it wanted with after-tax money. Unlike price controls, premium caps do not try to regulate every transaction in the market. Instead, they give flexibility to health plans to budget their spending within a premium. Private health plans decide the best mix and pricing of hospital, outpatient and other services, not government bureaucrats.

Premium caps had been passed into law in Minnesota and Washington state, and had been proposed in the state of California by the state insurance commissioner. They also were supported by diverse groups including the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), and the Catholic Health Association (CHA) and were supported by prominent physicians and health reform advocates such as C. Everett Koop and Jack Wennberg.

We borrowed this method of cost control directly from the Danforth/Kassebaum bill as an insurance policy on competition, both as a safeguard for family and employer affordability, as well for Congressional scoring purposes. If competition worked as predicted, insurance premiums would never reach the pre-set caps. As with employer mandates, premium caps, particularly as backstops to competition, were neither a new nor radical idea.

Large Mandatory Alliances

Perhaps no idea occasioned as much controversy as the proposal to establish large mandatory health alliances in regions around the country. These alliances pooled the purchasing of workers in firms with fewer than 5,000 employees, government employees, Medicaid beneficiaries, nonworkers and retirees. Through these pools, community rating could easily be enforced, families would have a wide array of plans to choose from, and families and businesses would have the maximum bargaining leverage to get affordable prices.

The idea for these entities, originally called purchasing cooperatives, came from the managed competition advocates at the Jackson Hole Group and the Managed Competition Act sponsored in 1992 by Representatives Cooper and Andrews and Senators Boren and Breaux. In this legislation, all firms with fewer than 1,000 employees, all government employees, all Medicaid recipients and all nonworkers were required to join purchasing cooperatives. States had the option to fold in firms with up to 10,000 employees. The rationale for mandatory purchasing cooperatives was to prevent firms with young healthy people from opting out and leaving only sicker, older people in the pools. Having the pool dominated by costly populations would defeat the purpose by making the community rate unaffordable.

The Administration adopted this model, choosing a firm size cutoff of 5,000 as a starting point for negotiation -- mainly because it was in the range of numbers specified in the original Cooper/Breaux/Boren bill. It was also in the range adopted by Washington State which imposed mandatory community rating for firms with fewer than 7,000 employees and allowed them to join exclusive purchasing alliances.

Other Provisions

Though less in the limelight, the Health Security Act contained a number of other significant provisions -- these, too, were well within the mainstream thinking at the time. The long-term care benefit, prescription drugs for Medicare recipients, a focus on primary care, quality improvement, the creation of a health information network, funding for academic health centers, rural and urban infrastructure improvements, malpractice and antitrust reforms, insurance reforms, benefit package design, public health initiative and other aspects of the bill were all developed from recommendations in other previous legislation, from state experience, from company experience or from well established academic analysis. In fact, many of these lesser provisions are also included in Republican health reform proposals.

Complexity

While the bill's actual provisions were in the mainstream, size and complexity made it easy for critics to brand it as bureaucratic social engineering and "big government". The bill is complex -- all 1,342 pages of it. But, as the Congressional Budget Office stated:

"The Health Security Act is unique among proposals to restructure the health care system both because of its scope and its attention to detail. Some critics of the proposal maintain that it is too complex. A major reason for its complexity, however, is that the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administrations on the implementation requirements."

Did the bill really have to be 1,342 pages? Only if we wanted it to work, which we did. Couldn't we have written a shorter skeleton bill? Only if we were willing to leave the actual

details of the plan to government regulators, which we weren't.

Health care is a very complex subject, and, like most major pieces of legislation, a bill to reform the health care system is never going to make for beach reading. The Congressional leadership requested a fully fleshed out bill that would be the basis for committee deliberations. When you begin to spell out what benefits are covered, how the money flows, what happens to existing government health plans like Medicare and Medicaid, you find yourself with a long bill. Senator Mitchell's bill is longer than our original one. The Senate Finance Committee bill which does a lot less than ours was over 1,100 pages. Even Senator Dole's bill, which no one thinks does a whole lot, takes over 650 pages to do it. The Crime bill passed two weeks ago was as long as most health care bills and NAFTA legislation was literally thousands of pages. Long legislation is not a new phenomenon, nor is it limited to health care.

Yet, for some reason, with health care, the length of the bill became a metaphor for the complexity people would supposedly face under a reformed system. The number of pages became a symbol of the amount of government involvement people would see in their health care. Attacking the substance of health plans by attacking their length played to the cameras. George Mitchell's eloquent presentation of his proposal did not make the evening news, but Bob Dole's antics in weighing it on a scale did.

We knew conservative Republicans would attack the bill as "too bureaucratic", "too regulatory", "big government". We weren't disappointed. The attacks came fast and furious.

But, we believed that introducing a skeleton bill that did not give the public and the experts an explanation of how these reforms would work would be irresponsible. In any event, if we had laid out a skeleton bill, we would undoubtedly have been attacked for being too superficial and not well-grounded.

Where are the Radical Social Engineers?

Critics of the President's initiative painted his bill as a radical document. In fact, its employer mandates were borrowed from Richard Nixon and a host of mainstream groups; its premium caps came from a bill sponsored by moderates such as Senators Danforth and Kassebaum and Congressmen such as Representatives McCurdy and Glickman and its large mandatory alliances came from the bill sponsored in 1992 by Senators Breaux and Boren and Representatives Cooper and Andrews.

Those elements and the central focus of universal coverage remain popular with the public to this day. In a recent Washington Post/ABC poll, universal coverage is favored by 77 percent of people and employer mandates by 72 percent. Government cost controls are favored by 75 percent of the public.

So why then, did Members who had themselves introduced these proposals later come to denounce them and press for different solutions? Why did a plan with moderate foundations and widely supported elements become viewed by many as a politically unworkable albatross?

Several reasons.... some of them within our control, many of them outside of it. Timing and unforeseen congressional events led to missed opportunities and a hardened political environment. The complexity of the bill and misperceptions about the process fueled people's fears about government intrusiveness. But most importantly, deep-pocketed opponents and their endless negative ads, heaped upon a President beleaguered by orchestrated personal attacks and other divisive legislative battles, poisoned the atmosphere. Though support for the core elements of the plan remained high, much of the public came to distrust any reform with the label "Clinton plan".

DELAY AND THE LOSS OF MOMENTUM

The first problem we encountered was the loss of momentum occasioned by the need to delay the release of the President's health plan. When the President took office, he appointed a health care task force with a 100 day deadline to produce a health plan which the President could take to Congress by the end of May. Initially, the President, with advice from Congressional leaders contemplated including the health plan in his first budget along with his economic plan. This had a number of advantages. It would not be subject to a filibuster in the Senate, thus requiring only 51 votes to pass. Tying it to his economic plan would allow the President to ask for just one vote, albeit a big and difficult one from allied Democrats. It would ensure that the program moved quickly and did not bog down in interest group opposition.

This strategy proved to be impossible when as a parliamentary matter, Senator Byrd and others felt that it would not be appropriate.

We then intended to introduce our plan by the end of May and push for passage by the end of the year. We knew that delaying into 1994 raised the risk of having health reform politicized by the midterm elections.

During April and May, the Health Care Task Force met 21 times to finalize decisions on the plan with the President in attendance at numerous meetings to make the key decisions. However, after the defeat of the President's stimulus package and with mounting opposition to his economic and budget package, Congressional leaders asked that the introduction of health care be delayed until after passage of the economic package was assured. They feared that members might trade off their vote on the economic package for concessions in the health package. For example, when a Department of Treasury analysis listed a tax on wine and beer, (a tax which was never seriously considered) as a potential source of health reform financing, the whole California delegation sent a letter of complaint, and some privately threatened to withhold support for the economic package.

As the economic package stalled, the introduction of health care was delayed from early-June to late-June to mid-July to late-July and finally to late-September. The budget situation was tenuous as it was, the collective view was that leaked accounts of health care meetings could only disrupt the delicate balance being sought to pass the budget. At the end of May we suspended all decision meetings, both internally and with members of Congress, until after the economic package was passed.

This meant that the final group of health care decisions, originally scheduled for late-May, did not get made until just after Labor Day. The speech to the Joint Session of Congress introducing the health care plan occurred on September 22 instead of at the end of May and legislation was not submitted until late October.

This delay gave time for the opposition to organize and caused doubt among supporters about our resolve. While those of us working on the health care initiative were dispirited, we agreed with the need to delay. Passage of the President's economic program was crucial to the country and to the presidency. Without a complete focus on it, the President's whole agenda, including health care would be potentially jeopardized.

SECRECY OF THE TASK FORCE

Though the delay was inevitable, the reputation of secrecy that surrounded the health care task force was not. The formation of the President's health policy was among the most open processes ever conducted to form policy in an Administration, yet it is still widely believed, in the court of public opinion, that the President's health plan was drafted in secret, behind closed doors and without the benefit of real-world views.

To meet the aggressive timetable, we established a process for making policy that was unconventional for Washington, borrowed from private sector models for conducting big projects in a short time frame. To help us flesh out the campaign framework in a way that would work effectively, we cast a wide net for participants. To establish an atmosphere of equal footing among departments and agencies and to foster interdepartmental cooperation, the decision was made to run health care out of the White House.

The health care working groups included an extraordinary group of people, many of whom had extensive careers on the front lines of the health care system. Serious consultations and reviews included hundreds of others from all walks of life. Practicing physicians, nurses, social workers, hospital administrators, benefits consultants and managers, consumers, businessmen, actuaries and accountants, health lawyers and others were involved in extensive work associated with the task force.

Most people took unpaid leaves from their jobs, left their homes and families for three months, and worked literally around the clock to meet the deadline. That would have been trying under any circumstances. It was extremely difficult in a three-week old Administration still unsure how to reserve rooms, get people cleared through security to get into the

building, and fill out forms.

We met with more than 1,100 different interest groups, had daily meetings with members of Congress, and involved more than 120 Congressional staffers on the working groups. Outside experts were consulted, and made presentations to the working groups regularly. The White House complex has probably not seen so much traffic, before or since. In fact, no one would be more surprised to hear that the process was secretive than the security guards at the White House, who no doubt still have nightmares about the lines of people flowing in the door saying: "I'm here for a meeting on health care."

Representatives from the National Governors Association participated on the working groups and officials from associations of state legislatures, counties and cities were included as well.

Between February 20, 1993 and April 18, 1994, the First Lady held a series of 23 public hearings and town meetings across the country.

Also by May, review groups composed of health care providers, consumers, auditors, actuaries, hospital and insurance administrators and lawyers reviewed and responded to ideas presented by the working groups. The working groups incorporated their comments and met their deadlines. The whole process resulted in an amazing amount of work being completed in a very short time period.

Yet despite this unprecedented level of consultation and involvement, the widely held perception is one of secrecy. The main reason, I think, has to do with the way we dealt with the press -- or in this case, didn't deal with the press. While a few cursory briefings were held, the press was by and large excluded from the deliberations of the task force and the ongoing efforts of the working groups. This caused three serious problems from which we never recovered:

1. Many members of the press rightly resented their exclusion from the process. Many of the reporters covering health care had waited 12 years to cover this story, and now that moment in history had arrived, they were being kept out.
2. Reporters meeting daily deadlines for health care stories were forced to rely on leaked information, often provided by people who were not directly involved or wanted to influence the outcome of policy deliberations. This led to negative and distorted coverage.
3. We had undertaken an enormous task and were using an unconventional process to complete it. Both the importance of the task, how it was being worked on, and who were involved should have been better communicated and explained. In short, we missed an opportunity for the press to be educated about our deliberations and about the health care issues which could provide a context for their reporting later.

Hindsight is always 20/20, but there was really no good reason for doing this. The rationale of our communications team was that we were simply forming an administration position preparatory to a full scale open national discussion during the congressional process. But this reasoning was flawed. Health care was different. Decisions like filtering all press inquiries through one person and failing to give the press the names of people working on reform led to a perception of secrecy -- and engendered a sense of hostility which has been hard to recover from.

THE COMMUNICATIONS CHALLENGE

We always knew that communication would be essential to the success of the health care initiative. A special operation called the delivery room was established in late-May to prepare the groundwork for introducing health care to the nation. The operation was diverted at the end of June until mid-August toward fighting for passage of the economic program. It resumed operations again in late-August.

We also knew that the first six weeks would be crucial in defining the debate. We had to educate the American public on what was in our plan before opponents mis-characterized it. During the summer of 1993 there were intensive discussions in the White House about scheduling the President's three major initiatives for the fall: health care reform, NAFTA and reinventing government. A decision was made to introduce reinventing government for a week just after Labor Day. The President would spend a day in September to introduce NAFTA. NAFTA would quietly proceed through Congress until a major public offensive would be launched in November, a few weeks before the vote. Five solid weeks of the President's time would be devoted to health care, beginning just before the President's Joint Session health care speech on September 22.

Open to all Members of Congress, a "Health Care University" took place on September 20 and 21. Over 40 experts, including the First Lady, briefed Members of Congress on health reform and the President's plan. Attended by both Democrats and Republicans, the university garnered Republican praise. House Minority Leader Bob Michel called it "very, very productive and unique...on this issue, we can definitely work together."

The following day, September 22, President Clinton delivered his long-awaited health care reform speech to the Joint Sessions of Congress. In his speech, the President repeated the goals for health reform, themes that had become so familiar: security, savings, quality, simplicity, choice, and responsibility. These principles would need to be there in the end, but the President invited the American people and the Congress to carefully review, question and critique the details.

His speech was a hit. According to USA Today, "Lawmakers of both parties praised Clinton for tackling the issue and his persuasive, determined tone." The Boston Globe reported that "Clinton went out of his way to find common ground with Republican lawmakers...citing both former President Richard M. Nixon and Reagan-era surgeon general C. Everett Koop as

inspiration for elements of his plan."

During the week following the speech, White House officials and Cabinet Secretaries fanned out across the country in a series of meetings, speeches and interviews. The fall campaign had started off successfully. In a Washington Post-ABC News poll taken on September 23, 56 percent of Americans said they approved of Clinton's health plan.

According to the New York Times the President's plan was "alive on arrival". That universal coverage would be achieved -- that all Americans would have health care that was always there -- was a given. Democrats and Republicans alike realized early on that they had better jump on the universal coverage bandwagon. It was widely believed that any bill the Congress passed would have to get to universal coverage.

The Clinton plan would serve as the foundation for Congress' efforts -- the Committees would work through the details -- how large the alliances would be, how generous the benefits package, when universal coverage would be achieved, the exact mix of taxes and spending cuts. Universal coverage was not in question.

However, beginning in October; opponents of reform -- insurers, the NFIB, restaurants, for-profit hospitals stepped up their attacks, mounted their advertising campaigns, began coordinated grass roots lobbying efforts -- all aimed at bringing down the Clinton plan. Supporters of reform -- the AARP, the AFL-CIO, many provider groups and businesses and others -- also shared the view that universal coverage was inevitable. The inevitability motivated opponents to focus their attacks; it had the opposite impact on our supporters. Believing that universal coverage was a foregone conclusion, our supporters spent their time trying to improve the bill in small ways important to their constituencies.

Even those with different approaches used the Clinton plan as the basis for comparison -- Representative Cooper termed his own plan "Clinton Lite", a "second cousin" of the Clinton plan. Senator Chafee spoke on Sunday talk shows of the "similarities in our approaches", and his optimism about achieving consensus. The Wall Street Journal and the New York Times ran articles about possible minor modifications to the President's plan to get to a final deal.

The President's appearances were followed by a successful week of testimony in Congress by the First Lady. Hillary Clinton spent the week testifying before the House Ways and Means Committee, the House Energy and Commerce Committee, the Senate Finance Committee, and the Senate Education and Labor Committee. Responding to a series of challenging, often antagonistic questions, the First Lady impressed legislators with her savvy and expertise. Representative Dan Rostenkowski, then-chair of the Ways and Means Committee, told his fellow committee members that "if there was any doubt about whether the President should have appointed her, there's no doubt about it any longer.

Her mere appearance on Capitol Hill was unusual: she is the third First Lady, preceded by Eleanor Roosevelt and Rosalyn Carter, to ever testify before a congressional committee. The uniqueness of her testimony especially intrigued the media. The Washington Post proclaimed that "overnight, Hillary Clinton's activism updated the First Lady's role to one that many women believe more accurately reflects the status of women in America today." The New York Times announced "the end of the era in which Presidential wives pretended to know less than they did and to be advising less than they were."

The New York Times described the Clinton's "elegant tango on health care, keeping control of the debate defining the details before opponents can."

Meetings with doctors, including a supportive C. Everett Koop, the Health Care University, the President's September 22 speech, his town hall meeting in Tampa, and the First Lady's testimony before the Congress were all met positively by the Congress and across the country. At last, the White House was coasting on the previously elusive momentum that was so vital to the success of health care reform.

However, such clear sailing was short-lived. A series of foreign policy crises commanded the attention of the President and the media, and combined with NAFTA, prevented the President from concentrating on health policy until mid-December. On October 3rd, twelve American soldiers were killed and fifteen wounded in skirmishes with supporters of General Aidid in Somalia. The President learned of this on the plane to California, where he was scheduled to kick off a month of health care events. This foreign policy crisis curtailed the California trip and led to the cancellation of subsequent Presidential health events.

Four days later, the President announced that he would send 1,700 reinforcement troops to Somalia. The international crises continued: on October 11th, Haitian demonstrators prevented American and Canadian peacekeeping troops from landing in Port-au-Prince, and on October 19th, the United Nations resumed its oil and arms embargo against Haiti.

What was supposed to be four weeks of the President's time in October devoted to health care was whittled down to one day -- the event in late-October, when the President took his bill to the Congress.

In this void, opponents of health reform were very active. Newspapers were filled with stories critical of the health plan generated by one interest group or another. The HIAA funnelled \$10 million in a negative television advertising campaign, and their unanswered attacks proliferated and filled the airwaves. Other opposition groups initiated a series of direct-mail campaigns that reached the homes of thousands of Americans, warning them of the evils of the Clinton health care plan.

Several studies have now documented the amount of money spent on advertising and lobbying to influence the outcome of the health care debate. While every major legislative battle, including every previous attempt at health reform, has met with opposition, nowhere in the

history of this country is there a precedent for the level of misinformation spread during the health debate, nor for the amount of money spent to spread it. The Annenberg Public Policy Center has conducted a series of studies on this phenomena, and their conclusion is summarized as follows: *The health care debate has generated "the largest, most sustained advertising campaign to shape a public policy decision in the history of the Republic.* [The Role of Advertising in the Health Care Reform Debate, The Annenberg Public Policy Center, 7/25/94]

The first of three studies conducted by Annenberg concluded that "an unprecedented amount of money (\$50 million) had been committed to produce, air and print an unprecedented amount of ads whose prime purpose was influencing reporters and legislators rather than the public as a whole. (This conclusion was deduced from the fact that the ads were concentrated in New York and D.C..) Focusing on the lawmaker and pundit audiences paid off, as those who make the laws, those who report on it, and those who offer commentary all began to fear that they would no longer be able to see their own doctor. I personally was called aside by worried television anchors, newspaper editors and others who asked if their brother the specialist was really going to have to go out of business, if they were going to have to wait in line at a clinic called the DC alliance, ...

And according to Annenberg, the press did not help to clarify fact from fiction: the press coverage of the ads had focused not on their fairness or accuracy but on "describing them and mapping their strategies." [The Role of Advertising in the Health Care Reform Debate, The Annenberg Public Policy Center, 7/25/94]

The study also indicated that the majority of the ads had opposed rather than favored some facet of reform with more ads explicitly objecting to the Clinton plan than supporting it. This study analyzed 198 ads -- 125 print and 73 broadcast and found 28 percent and 59 percent, respectively, to be misleading. Moreover, these ads were found to reflect the claims made by their sponsors and/or to invite negative inferences rather than just misstate facts. A large percentage of the ads were also found to "impugn the good will and integrity of those on the other side of the issue." And finally it was found that the "most histrionic and demonstrably false assertions occur...in direct mail addressed to older Americans."

Not only were the ads negative, they were scary. Health care is an extremely personal issue, one people connect with more deeply and directly than something like trade policy or deficit reduction. Even those supportive of a major overhaul were also anxious about losing what they themselves had, so ad campaigns took direct aim at exploiting the sense that people would lose everything they now knew and liked about their health insurance. *"The ads are more likely to provoke anxiety than to provide reassurance. Fear is the primary motivator in ads on all sides."* [The Role of Advertising in the Health Care Reform Debate, The Annenberg Public Policy Center, 7/25/94]

The Wall Street Journal published an article titled "Truth Lands in Intensive Care Unit", which detailed some of the worst fearmongering hitting the airwaves. The article began:

The baby's scream is anguished, the mother's voice desperate. "Please," she pleads into the phone, as she seeks help for her sick child.

"We're sorry, the government health care center is now closed," says the recording at the other end of the line. "However, if this is an emergency, you may call 1-800-Government." Her baby still wailing, she tries it, only to be greeted by another recording: "We're sorry, all health care representatives are busy now. Please stay on the line and our first available.."

"Why did they let the government take over?" she asks plaintively. "I need my family doctor back."

The only problem with the radio spot, produced by a Washington-based group called Americans for Tax Reform, is that it isn't true." (WSJ, April 29, 1994)

Yet these kinds of threats -- government take over...losing your doctor....paying more and getting less....were raised over and over by opponents. According to the Annenberg study, the focus of anti-Clinton plan ads was 1) increased taxation; 2) rationing; 3) big bureaucracy/government control; 4) diminished choice of plan/doctor; 5) massive job loss.

Recent studies indicate that over \$100 million has been spent on lobbying and advertising to influence health reform. And even this figure doesn't capture the direct mail and phone bank efforts financed by right wing groups, the cost of the high powered lawyers, lobbyists, paid consultants and experts who paraded nonstop into our offices and the offices of key congressional members with their insurance company or pharmaceutical company clients and sponsors in tow.

The opposition mustered by the leaders of the National Federation of Independent Businesses, the Health Insurance Industry Association of America, The Alliance for Managed Competition (The Big 5 Insurers), The Pharmaceutical Manufacturers Association, and the for Profit Hospitals was tenacious, well organized, well financed and effective. This combined with the efforts of the Republican National Committee and various ultra conservative organizations who were responsible for some of the most misleading scare attacks have led to a seemingly intractable belief that the term Clinton plan is synonymous with 1)government takeover of the health care system. (In fact, the Health Security Act preserved a private system). 2) Losing your choice of doctor and being forced into one plan. (In fact, the proposal increased choice for most Americans by requiring a fee-for-service plan and giving families choice, not their employers. 3) Bankrupting the country. (In fact, premium caps limited the growth of health care costs to below where they would be without reform. 4) Big government and bureaucracy. (Compared to the current system, it streamlined things).

In late-December, the Administration made an effort to reinvigorate the political and communications effort. But no sooner did this effort kick off than the Whitewater and Arkansas trooper allegations sprung up. The attacks were venomous and personal, and they took aim

at the core ingredient needed for public support of reform, trust in the President and First Lady. To diminish public trust in the reformers was to effectively raise fears about reform -- as Rush Limbaugh so boldly put it in his appearance on Nightline: "Whitewater is about health care."

The Administration had formally passed the health care baton to the Congress, but unforeseen events in both bodies also changed the dynamic on the Hill. Senate Majority Leader George Mitchell unexpectedly announced his plan to retire after this term. The powerful chairman of the House Ways and Means Committee, Dan Rostenkowski, was charged with criminal misconduct, and forced to resign his chairmanship. If someone had asked our strongest opponents to make a "wish list" for helping them defeat health reform, it could have read: "Undermine the trust and credibility of the President and First Lady, and knock out the two most powerful consensus builders in both houses of Congress."

Misconceptions about the President's plan had by this point become widely accepted and many ordinary Americans reacted with a mixture of fear and anger over what they were sure we proposed to do to their health care. At town hall meetings I attended, angry people would state their vociferous opposition to the Clinton plan. I would ask why they were against it. They would respond that the plan would have the government taking over and running all the hospitals in the country. I would reply that this was not what the plan said. The questioner would shout back that I was lying and wave a mailing he had received from some group asserting it. Another favorite mischaracterization was that people would not be permitted to see their own doctor outside the health plan approved by the government, and that if they did so, they could be fined and their doctors could go to jail. This of course was ridiculous. The Wall Street Journal article detailing the false advertising touched on this, too. It said:

"Another of the big canards about the Clinton plan is that people face '5 years in jail if you buy extra health care', as the American Council for Health Reform puts it in a direct-mail package it has sent out to millions of people....But in fact, while there is an anti-bribery provision in the Clinton proposal, the bill explicitly says that people are free to purchase 'any health care services' they want out of their own pockets. 'I don't see anybody going to jail on a liver transplant rap,' says John Sheils, a vice president at health consulting firm Lewin-VHI, Inc. 'They're trying to scare little old ladies.'"

Yet this particular charge was repeated by Washington pundits, magazine and newspaper columnists and at almost every town hall meeting I attended.

Public Support

The opponents were successful. Despite high and consistent support for all the major elements of the Administration's proposal, support for anything labelled the Clinton Plan declined dramatically since September of 1993. This was best captured in a Wall Street Jour-

nal article that was titled "Many Don't Realize It's the Clinton Plan They Like". The Clinton plan, when described without the label was viewed favorable by 76 percent of those surveyed, versus 48 percent for the original Chafee plan, 42 percent for the Gramm plan, 34 percent for the Cooper bill and 30 percent for the McDermott bill.

Consistently, when labels are removed from plans and their essence is described to the public in polls or focus groups, the Clinton plan wins far and away the most support as delivering what Americans want in the way they want.

PARTISAN GRIDLOCK

Finally, the decline in presidential popularity and the battering taken by the plan itself led Republican leaders to conclude that they could effectively stonewall on health care and hand the President a major political defeat.

While minority-leader-in waiting Gingrich had been urging and enforcing an obstructionist path in the House from the beginning, Senator Dole went back and forth, alternatively speaking constructively about achieving universal coverage, the President's bottom line, and at other times declaring that there was no health care crisis and that we should do nothing.

During the late spring, Republicans made a decision not to give the President any victories, for if they did not, they could potentially gain significantly at the mid-term elections. In a June 7 memo, Republican strategist Bill Kristol urged republicans to reject a bill; even a watered down bill, that would allow the President to honor his veto pledge, since it would "protect the President's 'read my lips' pledge on health care." By July, Kristol's advice was: ***"Republicans should hold off on health care negotiations until Mr. Clinton eats his words."*** *"The appropriate Republican response is to take the noble road of opposing any alternative that Democrats offer and insist on starting over in '95. We should send them to the voters empty-handed."*

That strategy even spilled over to the politically safest of issues, crime fighting. All but two Republican Senators voted for the crime bill in the Spring, and then they tried to kill it in August. The tone in the Senate turned very partisan.

Even when we were willing to declare our own bill dead so that we could form a new initiative which Republicans could claim a significant stake in and even after Senator Mitchell introduced a bill which we supported which moved far in the direction of Republican proposals to achieve universal coverage, they backed away.

If this debate has taught us anything, it is that there are no easy answers for solving this problem. Nobody has yet found the silver bullet -- and believe me, everybody's looked. Legislators wanting to approach universal coverage with no heavy lifting have found that not only is it impossible, but halfway attempts make things worse rather than better, and so they fall of their own weight when analyzed closely.

No bill, not the Cooper bill, Chafee bill, the Dole bill, the Michel bill, or the so-called "Mainstream" proposal find they have either the money to do what they say or the outside support needed to build a consensus.

So, where do we go from here? The problems which health reform is designed to address will not go away by themselves. People will continue to lose coverage. Costs will continue to rise faster than people's incomes, stealing away their living standards. Bureaucracy will increase and choice will diminish. The problem will not go away.

The final pages in this chapter of legislative history are yet to be written. Some continue to declare health reform dead, and as they run the legislative clock with their pronouncements of failure, they may just fulfill their prophecy. But it isn't over yet. As Rep. Dan Rostenkowski once noted of a previous piece of major legislation: "I went to many wakes, but never a single funeral." The budget, NAFTA, the crime bill...all faced difficult odds, discouraging vote counts, and routine death notices, yet now they are the law of the land.

Health care may meet with a different fate. It may be that the old Washington hands were right: it's just too hard to do. But we're not prepared to say that...the American people aren't prepared to say that. Health care is a real problem affecting real people, and we owe it to them to fight to the last. The President is committed to working with Senator Mitchell and others to try to achieve a path to universal coverage when the Congress reconvenes in September. The American people want comprehensive health reform. They want universal coverage, they believe that shared responsibility between employers and individuals is the best way to finance it and they believe that in health care, the government must play a role to contain costs.

Of all the hundreds of lobbyists who visited my office, there were none representing those real Americans counting on us to solve this problem once and for all. No one represented the 58 million people who at some time during the year have no insurance; or the 80 million people who come from families who are classified as having pre-existing conditions; or the 120 million Americans whose health insurance policies include lifetime limits which means that the insurance runs out when they need it most. The President has to be their lobbyist, and he will continue to speak out and fight for their interests and the interests of all Americans who deserve comprehensive private health insurance that can never be taken away.

- ① New deal with lack of committed strategy
- ② we don't admit enough fault
- ③ If you had to do it over again, what would you do differently

9/16/94

A Retrospective on Health Care Reform

④ What will happen next year

October 1994

⑤ Didn't the delay drive the

On September 22, 1993, President Clinton proposed a plan to provide health coverage to all Americans and control escalating health care costs. A little over a year later, after successfully moving health care legislation through four Congressional committees and to the floor of both Houses, health care reform failed. What happened?

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but passed

⑥ I think it

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then explain

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President Clinton - in keeping with his campaign promise to provide quality, affordable health care coverage to all Americans - put forth a plan to help solve the nation's health care problems. Building on what is good in our current health care system, he proposed universal coverage, phased in over several years, and a practical approach to rein in health care costs for American families.

⑦ Why didn't

the PNC

begin

advertising

made

consequently

other

Opponents of reform, the same interest groups that have historically opposed change, waged an all out war to defeat health care reform. While some paid lip service to the goals of reform, they spared no effort to protect the status quo. And they succeeded.

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advertising

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fight from

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⑧ Why wasn't

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Although they failed to convince the American public that the fundamental goals of universal coverage and cost containment were wrong, they succeeded in scaring and misleading the public that the bills proposed by the President and various Congressional Committees would threaten what they like about their own health care. They scared the public - confusing them about whether they would be able to see their own doctor and whether the health care system would turn into a giant government bureaucracy.

⑨ New

lead in

relying the

scene

It is interesting to note that despite the hundreds of millions of dollars spent to defeat health care reform, support for the President's goal of universal coverage remains strong. The latest NYT/CBS News poll found that an overwhelmingly majority - close to 70% - of Americans still think that it is very important that every American receives health care coverage.

Why did these special interests triumph in the face of a united President and Democratic leadership? They succeeded in classic Washington style -- a combination of massive special interest money spent on advertising, delay, distortion, and exploitation of the complexity of the Congressional process. According to Newsweek (September 19, 1994), "interest groups spent at least \$300 million - more than the Democratic and Republican 1988 and 1992 presidential nominees combined - to defeat health care. Much of this money was spent on blatantly untrue advertisements designed to scare the public..."

The heroic efforts of countless Members of Congress, led by Senator Mitchell and Congressman Gephardt, outside groups and dedicated individuals pushed health care reform further than it

has advanced in sixty years of trying under seven Presidents. Because of these efforts the public understands the importance of health reform and strongly supports efforts to fundamentally improve the current system.

Change is difficult. ^{power} In the current Washington environment. As is so often true, the forces of the status quo have the upper hand. Were mistakes made? Absolutely. Could the Administration have done a better job? Certainly. But the President, his Administration, many Members of Congress, and numerous groups and individuals fought as hard as they could to pass reform.

The biggest disappointment in the fight for health care reform is that the people who have lost the most are the tens of millions of American families who are without insurance or who live in constant risk of losing their insurance. They lost to the forces of the status quo, the special interests who have foiled efforts to change the current system for years.

These special interests fought for their right to continue to make money from the current system, and they did a good job. They won this round. But this battle is far from over. The efforts made and the lessons learned will contribute ultimately to reform of our health system. There will be a day - hopefully in the not too distant future - when the public interests are put ahead of the special interests and real health security is achieved.

Not enough
administration
plus real
efforts

+ real
national security

Myth: The Plan Was Doomed From the Beginning - It was Naive and Grandiose.

Reality: Special Interests set out to defeat anything that challenged the status quo. In fact, the President's plan was built on what works in the current system.

The special interests lined up to oppose change, to protect the status quo, as they have for sixty years. No matter what had been proposed, if it was fundamental change, the special interests would have opposed it. Individual elements of every plan proposed - whether by the President, Congressional Committees, Democrats or Republicans - were met with fervent opposition by special interests. Any approach which tried to change the status quo ran directly into the same wall of special interest opposition. *None none*

The Administration's plan was built upon what works the current system, coupled with proposals put forth by Democrats and Republicans. For example, the employer mandate simply expanded on today's system where 90% of people who currently have private insurance receive it through the workplace. It was also the same approach that President Nixon proposed two decades ago, and supported at the time by groups like the AMA, the Chamber of Commerce, the Association of Corporate Benefits Managers, the American Hospital Association, the National Coalition on Health Care Reform co-chaired by former Presidents Carter and Ford, and many other groups.

The recommendation of premium caps came straight from a bill proposed by Senators Danforth and Kassebaum and Representatives McCurdy and Glickman. They were supported by many groups, including the American College of Physicians, the Catholic Health Association and the League of Women Voters.

To enhance consumer choice and provide for community rating, the Administration proposed mandatory alliances, which were contained in the 1992 bill sponsored by Representatives Cooper and Andrews and Senators Boren and Breaux.

In many cases, these proposals have been tried and tested and are performing successfully at the state level. Employer mandates are working effectively in Hawaii, Washington and Oregon; premium caps in Washington and Minnesota. And alliances are working in models such as CalPers and the Federal Employees Health Benefits Program.

Myth: The Plan was developed in secrecy.

Reality: The Plan was developed through one of the most open and inclusive policy-making processes ever conducted.

This was one of the most open and inclusive policy-making

Too short

processes ever conducted by an Administration in terms of the full range of individuals who directly participated in providing expertise and the options considered on health care reform. The process included members of Congress and their staffs, state and local government officials, outside reviewers, health care providers, consumers etc. - to ensure diverse points of view were represented.

Myth: The Working Group process was unwieldy and chaotic, causing costly delays

Reality: Delay on introducing health care was in large part a result of other issues on the Congressional calendar.

The Administration was ready to move forward at the end of May 1993. But after the defeat of the economic stimulus package, it became clear that the introduction of health care reform should be delayed until passage of the economic plan was assured. For example, when word leaked out about a Treasury Department analysis of health care financing that included a tax on wine and beer, the California delegation sent a letter of complaint to the White House and some members privately threatened to withhold support for the economic package. Without a doubt, this unavoidable delay gave more time to the opposition to confuse and mislead the public.

Myth: The Administration was not united behind the President's plan.

Fact: During the drafting process, members of the Administration discussed various options. When the plan was introduced by the President, his Administration was fully united behind it.

The Administration was united behind health care reform. Members of this Administration worked as hard as they could to pass health reform.

*I like
Iran
better
more
united*

Like any other issue or initiative of an Administration, there were disagreements as the policy was being developed. Everyone was heard; everyone had the opportunity to make the case before the President made his decisions. Disagreements and discussions were normal and productive. They shaped the decisions that led to the President's proposal.

Everyone likes to discover and reveal differences within an Administration. There are many opinions in an Administration on any issue, as there were as health care was being developed and as it was being discussed in Congress. But more important was the commitment of the entire Administration to passing health care reform. Once the President made his decisions, the entire Administration united behind the goal of getting health care

reform passed.

Myth: Interest groups that supported universal coverage - such as the HIAA and AMA - were never brought into a coalition to support the President's goal of universal coverage.

Reality: Several groups paid lip service to health care reform and universal coverage while using every ounce of energy to maintain the status quo and defeat reform.

Judge the special interests by what they do, not what they say. It's very easy to say you are for universal coverage, and at the same time spend every resource you have to defeat any effort to enact fundamental reform.

Let's not be naive. These are very sophisticated groups that knew exactly what they were doing. They acted in what they viewed as their self-interest and they were not going to act otherwise. According to Newsweek (September 19, 1994), \$300 million was spent by interest groups to defeat reform. This type of campaign was unprecedented and effective.

*Why didn't
we
begin
mounting
efforts
earlier*

Did we know that special interests were going to attack health care reform? Of course we did. Special interests historically fought attempts to reform. We knew that it is easier to make a negative case and to scare people. Perhaps we underestimated the degree to which opponents would intentionally spread misinformation. The distortion campaign to protect the status quo was enormous - and it worked - to the detriment of the health security of the American people.

*Why didn't
we do
more
earlier
+
push*

Myth: A compromise on health care reform with Republicans was attainable, but the Administration did not reach out to Republicans.

Reality: The Administration's goal was always to work in a bipartisan fashion. Republicans were consulted throughout the process.

The Administration recognized from the very beginning that if we were to answer the call of the American people to provide for universal coverage and control health care costs, we needed to work ~~together~~ in a bipartisan fashion. From the beginning, we reached out to Republicans. We had meetings with the Senate Republican Task Force, the House Republicans and their leadership.

Twenty-three Republican Senators supported universal coverage when the President's plan was introduced. In the late spring of 1994, the Republican leadership unified its membership around a decision not to give the President any major victories. At various points the President and the Congressional leadership

offered to move closer to moderate Republicans, but they backed way. Republican resistance in the Senate to the crime bill, on Gatt and on health care during the summer all point to a desire by the Republicans to obstruct legislation that would be counted as victories for the President.

Myth: The Administration failed to capitalize on the wide public support and the fact that Democrats controlled Congress.

Reality: Throwing sand into the gears of the legislative process is easy, making it work is hard.

This was never going to be easy. Major change in our health care system does not come easily -- we have sixty years of experience to demonstrate that.

The Administration fought as hard as it could. Of course, we regret we were unable to get major reform this year. Of course, we made some mistakes, and, in hindsight, we can all point to things we should have done differently.

The general support of the public does not automatically translate into success in the face of entrenched special interests. Changing the status quo is hard; the opponents have to accomplish only one thing, to stop something. They don't have to pass an alternative. They can distort the truth; they can divert attention from the real issues; they can mislead.

Passing legislation that upsets the status quo is hard. Throwing sand into the gears of the legislative process is easy; making it work is hard. The opponents of change spent unprecedented amounts of money, \$300 million according to Newsweek, to confuse the public, to convince the public that they would lose their doctor and that the health care system would become a giant government bureaucracy.

The special interests used the tactics that are so familiar in Washington to prevent change. They confused the public; they delayed the Congressional process; they bombarded Members of Congress with their special interest pleadings; they threw up a wall of confusion between Members of Congress and public opinion on the need to reform the health system.

They succeeded in the same way that the forces of the status quo have succeeded in Washington many times in the past. They won this round; but this is not a President who gives up. Health care reform may be delayed, but it will not be defeated as long as there are millions of Americans who live in daily fear that they will have not health insurance when they get sick.

Draft.

Sept. 22, 1994.

A Retrospective on Health Care Reform
October 1994

On September 22, 1993, President Clinton proposed a plan to provide health coverage to all Americans and control escalating health care costs. A little over a year later, after successfully moving health care legislation through four Congressional committees and to the floor of both Houses, health care reform failed. What happened?

President Clinton - in keeping with his campaign promise to provide quality, affordable health care coverage to all Americans - put forth a plan to help solve the nation's health care problems. Building on what is good in our current health care system, he proposed universal coverage, phased in over several years, and a practical approach to rein in health care costs for American families.

Opponents of reform, the same interest groups that have historically opposed change, waged an all out war to defeat health care reform. While some paid lip service to the goals of reform, they spared no effort to protect the status quo. And they succeeded.

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Reality: Special Interests set out to defeat anything that challenged the status quo. In fact, the President's plan was built on what works in the current system.

The special interests lined up to oppose change, to protect the status quo, as they have for sixty years. No matter what had been proposed, if it was fundamental change, the special interests would have opposed it. Individual elements of every plan proposed - whether by the President, Congressional Committees, Democrats or Republicans - were met with fervent opposition. In essence any approach which tried to change the status quo ran directly into the same wall of special interest opposition.

The Administration's plan was built upon what works in the current system, coupled with proposals put forth by Democrats and Republicans. For example, the employer mandate simply expanded on today's system where 90% of people who currently have private insurance receive it through the workplace. It was also the same approach that President Nixon proposed two decades ago, and supported by groups like the AMA, the Chamber of Commerce, the Association of Corporate Benefits Managers, the American Hospital Association, the National Coalition on Health Care Reform co-chaired by former Presidents Carter and Ford, and many other groups.

The recommendation of premium caps came straight from a bill proposed by Senators Danforth and Kassebaum and Representatives McCurdy and Glickman. They were supported by many groups, including the American College of Physicians, the Catholic Health Association and the League of Women Voters.

To enhance consumer choice and provide for community rating, the Administration proposed mandatory alliances, which were contained in the 1992 bill sponsored by Representatives Cooper and Andrews and Senators Boren and Breaux.

In many cases, these proposals have been tried and tested and are performing successfully at the state level. Employer mandates are working effectively in Hawaii, Washington and Oregon; premium caps in Washington and Minnesota. And alliances are working in models such as CalPers and the Federal Employees Health Benefits Program.

In poll after poll, the American people supported key elements of the President's plan. A June 1994 Washington Post/ABC News poll showed that 78 percent favor universal coverage, 72 percent favor an employer mandate and 75 percent favor government cost containment. In September of 1994, a New York Times/CBS News poll revealed that almost 70% of Americans still believed that every American deserves health care coverage.

Myth: The Plan was developed in secrecy.

Reality: The Plan was developed through one of the most open and inclusive policy-making processes ever conducted.

This was one of the most open and inclusive policy-making processes ever conducted by an Administration in terms of the full range of individuals who directly participated in providing expertise and the options considered on health care reform. The process included members of Congress and their staffs, state and local government officials, outside reviewers, health care providers, consumers etc. - to ensure diverse points of view were represented.

In addition, we sought outside opinions to challenge the assumptions proposed by the working group members. Audit teams critiqued and questioned assumptions and options; 14 panels of consumers shared their concerns and insights; and a health professional review group and outreach groups of doctors, nurses, public health officials etc. reviewed and commented on policy options developed by the working group.

Myth: The Working Group process was unwieldy and chaotic, causing costly delays; The plan was too complex

Reality: Delay on introducing health care was in large part a result of other issues on the Congressional calendar.

The Administration was ready to move forward at the end of May 1993. But after the defeat of the economic stimulus package, it became clear that the introduction of health care reform should be delayed until passage of the economic plan was assured.

The delay undoubtedly gave time to the opposition to organize to protect the status quo. But, passage of the economic plan was critical to the country and required the Administration's priority attention.

There is no doubt that the length of the bill, while comparable in length to other major pieces of legislation such as the crime bill and NAFTA, became a metaphor for the complexity people would supposedly face under a reformed system. The number of pages became the opponent's symbol for the amount of government involvement people would see in their health care.

The Administration believed that introducing a skeleton bill and not explaining how reforms would work would be irresponsible. And, if a skeleton bill had been introduced, we would probably have been criticized for being too superficial. The fact is that the President repeatedly stated that he laid out his goals, but was flexible on how to achieve these goals.

Health care legislation in and of itself is complex. But, as the

Director of the Congressional Budget Office stated: "the Health Security Act is unique among proposals to restructure the health care system both because of its scope and its attention to detail. Some critics of the proposal maintain that it is too complex. A major reason for the complexity, however, is that the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administration's on the implementation requirements."

Myth: The Administration was not united behind the President's plan.

Fact: During the drafting process, members of the Administration discussed various options. When the plan was introduced by the President, his Administration was fully united behind it.

The Administration was united behind health care reform. Members of this Administration worked as hard as they could to pass health reform.

Like any other issue or initiative of an Administration, there were disagreements as the policy was being developed. Everyone was heard; everyone had the opportunity to make the case before the President made his decisions. Disagreements and discussions were normal and productive. They shaped the decisions that led to the President's proposal.

Everyone likes to discover and reveal differences within an Administration. Cabinet-level officials and senior White House advisers met over 21 times during April and May and then several times again in August and September to directly participate in the formulation of the final plan. While staff-level working documents reflect a diversity of opinions and put a wide range of options on the table for consideration, this senior-level group was responsible for narrowing them and presenting recommendations to the President. Ultimately, the President made the final decisions and the entire Administration united behind the goal of getting health care reform passed.

Myth: Interest groups that supported universal coverage were never brought into a coalition to support the President's goal of universal coverage.

Reality: Several groups paid lip service to health care reform and universal coverage while using every ounce of energy to maintain the status quo and defeat reform.

Judge the special interests by what they do, not what they say. It's very easy to say you are for universal coverage, and at the same time spend every resource you have to defeat any effort to enact fundamental reform.

Let's not be naive. These are very sophisticated groups that knew exactly what they were doing. They acted in what they viewed as their self-interest and they were not going to act otherwise. According to Newsweek (September 19, 1994), \$300 million was spent by interest groups to defeat reform. This type of campaign was unprecedented and effective. While hiding under the umbrella of supporting universal coverage, they would actively attack elements that would put the nation on the road to universal coverage.

Did we know that special interests were going to attack health care reform? Of course we did. Special interests historically fought attempts to reform. We knew that it is easier to make a negative case and to scare people. Perhaps we underestimated the degree to which opponents would intentionally spread misinformation. The distortion campaign to protect the status quo was enormous - and it worked - to the detriment of the health security of the American people.

Myth: A compromise on health care reform with Republicans was attainable, but the Administration did not reach out to Republicans.

Reality: The Administration's goal was always to work in a bipartisan fashion. Republicans were consulted throughout the process.

The Administration recognized from the very beginning that if we were to answer the call of the American people to provide for universal coverage and control health care costs we needed to work together in a bipartisan fashion. From the beginning, we reached out to Republicans. We had numerous meetings with the Senate Republican and House Republican Task Force Groups and their leadership.

Twenty-three Republican Senators sponsored a bill that achieved universal coverage when the President's plan was introduced. In the late spring of 1994, the Republican leadership unified its membership around a decision not to give the President any major victories. At various points the President and the Congressional

leadership offered to move closer to moderate Republicans, but they backed away. Republican resistance in the Senate to the crime bill, on GATT and on health care during the summer all point to a desire by the Republicans to obstruct legislation that would be counted as victories for the President.

Myth: The Administration failed to capitalize on the wide public support and the fact that Democrats controlled Congress.

Reality: Throwing sand into the gears of the legislative process is easy, making it work is hard.

This was never going to be easy. Major change in our health care system does not come easily -- we have sixty years of experience to demonstrate that.

The Administration fought as hard as it could. Of course, we regret we were unable to get major reform this year. Of course, we made some mistakes, and, in hindsight, we can all point to things we should have done differently.

The general support of the public does not automatically translate into success in the face of entrenched special interests. Changing the status quo is hard; the opponents have to accomplish only one thing, to stop something. They don't have to pass an alternative. They can distort the truth; they can divert attention from the real issues; they can mislead.

Passing legislation that upsets the status quo is hard. Throwing sand into the gears of the legislative process is easy; making it work is hard. The opponents of change spent unprecedented amounts of money, \$300 million according to Newsweek, to confuse the public, to convince the public that they would lose their doctor and that the health care system would become a giant government bureaucracy.

The special interests used the tactics that are so familiar in Washington to prevent change. They confused the public; they delayed the Congressional process; they bombarded Members of Congress with their special interest pleadings; they constructed a wall of confusion between Members of Congress and public opinion on the need to reform the health system.

They succeeded in the same way that the forces of the status quo have succeeded in Washington many times in the past. They won this round; but this is not a President who gives up. Health care reform may be delayed, but it will not be defeated as long as there are millions of Americans who live in daily fear that they will lose their health insurance.

9/16/94

THE HEALTH REFORM PROCESS

For me - in you
look at this &
give me any
comments?

Press reports to date on the demise of health care have unfairly blamed the President and the Administration.

Thanks
much
Dym

The conventional wisdom surrounding health reform paints a picture that the Administration's mistakes doomed the effort from the beginning.

- *The plan was politically naive, grandiose, overreaching and big government*
- *The plan was too complex*
- *The plan was hatched in secret*
- *The policy process was unwieldy and chaotic, causing costly delays*
- *Our own economic team opposed the plan*
- *The communications strategy was unfocused and ineffective*
- *We blew the deal we could have had*

These reports are both incorrect and politically damaging. We need to quickly try to correct the record.

No single event or person led to the demise of comprehensive reform. The fact is that health care reform is tremendously difficult to accomplish, as seven Presidents and over 60 years of trying underscore. And, the challenge becomes greater as the years pass and health care consumes an ever growing share of the economy.

Ultimately, what prevented health reform from passing this year was the power of interest groups. Well-organized and monied groups interested in preserving the status quo like the Health Insurance Association of America, the National Federation of Independent Business, for-profit hospitals and a number of conservative groups spread misinformation, scared the public and put tremendous pressure on members of Congress to defeat reform. This negative campaign gave firepower to Republicans who wanted to hand the President a defeat going in to the mid-term elections. They decided in late spring to back off their commitment to universal coverage and stonewall reform.

**MISCONCEPTION #1: THE PLAN WAS POLITICALLY NAIVE, GRANDIOSE,
OVERREACHING, BIG GOVERNMENT**

Q: *The President's plan -- its premium caps, employer mandates, mandatory alliances -- was a social engineer's dream and had no chance of passing. Why did you propose such radical surgery instead of just fixing what was wrong with the current system?*

A: The President's plan built on the framework he had proposed during his campaign -- guaranteed private insurance and controlling spiralling health care costs. The American people in poll after poll supported major change and supported by overwhelming majorities the ideas the President proposed, including universal coverage, employer mandates, cost containment, tobacco tax, etc. A recent Washington Post/ABC poll (June 23-26, 1994) showed that 78 percent favor universal coverage, 72 percent favor an employer mandate, and 75 percent favor government cost containment.

When we were putting together the President's plan last year, the idea that a bill to reform the health care system would achieve universal coverage was a given. Republicans and Democrats alike supported this principle -- 23 Senate Republicans, including Senator Dole, even sponsored a bill which achieved universal coverage.

The other "liberal" ideas -- employer mandates, premium caps, mandatory alliances -- actually came from proposals made by moderate Republicans and Democrats. There are only 3 ways to get to universal coverage -- raising broad based taxes, mandating individual families to purchase insurance, or requiring employers and individuals to purchase insurance. We chose the employer mandate -- expanding the system that 90% of people with private insurance have today; the same approach President Nixon proposed two decades ago; the same approach supported at the time by groups like the AMA, the Chamber of Commerce, the Association of Corporate Benefits Managers, the American Hospital Association, the National Coalition on Health Care Reform co-chaired by former Presidents Carter and Ford and many other groups.

To control costs, we chose market reforms to stimulate competition, with premium caps as a backup in case competition didn't work to control costs. We rejected price controls as too regulatory and instead took the idea for premium caps straight from a bill proposed by Senators Danforth and Kassebaum and Representatives McCurdy and Glickman. Premium caps were supported by many mainstream groups, including the American College of Physicians, the Catholic Health Association and the League of Women Voters.

To enhance consumer choice and provide community rating, we proposed mandatory alliances, which came from the 1992 bill sponsored by Representatives Cooper and

Andrews and Senators Boren and Breaux.

In many cases, these proposals already had been tested successfully at the state level. Employer mandates are working effectively in Hawaii, Washington and Oregon; premium caps in Washington and Minnesota. And, alliances were up and working in models like CalPers and the Federal Employees Health Benefits Program.

Q: Wasn't your bill dead on arrival because it was politically naive, put together by policy wonks with tin political ears?

A: When released, the President's plan was declared "alive on arrival" by the New York Times. It was favored by the American people by a wide margin in polls and got positive reviews from moderate Republicans such as Senator Chafee who said it was a good starting point.

Only after special interests spent tens of millions of dollars to mislead the public about its contents did anything labelled "the Clinton plan" lose popularity. When the elements of the plan are described without the label, the Clinton plan is widely supported and is preferred by wide margins over other proposals. According to Wall Street Journal/NBC poll taken in March of this year, 76% thought that the Clinton plan had a great deal of, or some, appeal, compared to 48% for the Chafee plan, 34% for the Cooper plan, and 42% for the Gramm plan.

Anyone who pretends that there's an easy way to gain widespread political support for a health reform plan that achieves universal coverage is not being honest. There are no silver bullets in this debate. If there were, this would have been accomplished decades ago.

MISCONCEPTION #2: THE PLAN WAS TOO COMPLEX

Q: Why did you send up such a complicated bill? As the Los Angeles Times pointed out recently, some legislators on the Hill said that "it would have been far better to...spell out broad goals, and let Congress figure out how to get there."

A: While the bill's actual provisions were in the mainstream, size and complexity made it easy for critics to brand the bill as bureaucratic social engineering and "big government." The bill is complex -- all 1,342 pages of it. But, as the Director of the Congressional Budget Office stated: "the Health Security Act is unique among proposals to restructure the health care system both because of its scope and its attention to detail. Some critics of the proposal maintain that it is too complex. A major reason for the complexity, however, is that the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other

proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administration's on the implementation requirements."

Did the bill really have to be that long? Only if we wanted it to work, which we did. Couldn't we have written a shorter skeleton bill? Only if we were willing to leave the actual details of the plan to government regulators, which we weren't.

Health care is a very complex subject, and, like most major pieces of legislation, a bill to reform the health care system is never going to make for light beach reading. The Congressional leadership recommended a fully fleshed out bill that would be the basis for committee deliberations. When you begin to spell out what benefits are covered, how the money flows, what happens to existing government health plans like Medicare and Medicaid, you find yourself with a long bill. The Senate Finance Committee bill was over 1,100 pages and the Mitchell bill was 1,400 pages. The "Mainstream" bill runs over 1,100 pages and even Senator Dole's bill, which no one thinks does a whole lot, takes over 650 pages to do it. And, having a long bill is not unique to health care. Other major pieces of legislation that have passed this year -- the Crime bill, budget reconciliation, NAFTA -- were all almost as long or longer.

Yet, with the President's health care bill, the length of the bill became a metaphor for the complexity people would supposedly face under a reformed system. The number of pages became a symbol of the amount of government people would see in their health care.

We believed that introducing a skeleton bill that did not give the public and the experts an explanation of how these reforms would work would be irresponsible. And, if we had introduced a skeleton bill, we undoubtedly would have been attacked for being too superficial.

MISCONCEPTION #3: THE PLAN WAS HATCHED IN SECRET

Q: Why did you go to such great lengths to keep the process a secret?

A: To meet an aggressive 100-day deadline to create a health reform proposal, we established a process for making policy that was unconventional for Washington, borrowed from private sector models for conducting big projects in a short time frame.

It was one of the most open and inclusive policy-making processes ever conducted by an Administration in terms of the numbers of people who directly participated in forming the policy, the involvement of the Congress in an Administration-led initiative, the involvement of state and local government officials, and the participation of outside reviewers.

We brought together the opinions and expertise of people with different points of view -- some supported a Canadian-like single payer system; others supported a more market-oriented approach. Some brought expertise in designing insurance and market reforms; others were knowledgeable in how to improve health care quality and information flow, designing benefits packages, developing long term care home- and community-based programs; still others brought their knowledge of antitrust, malpractice and ways to control health care costs.

We met with more than 1,100 different groups, held over 200 meetings with members of Congress and involved more than 120 Congressional staffers on the working group. In the Congressional Quarterly, Senator Breaux said, "The Finance Committee has had meetings with Mrs. Clinton. The leadership has met with her; there have been briefings for Republicans; briefings with her in big groups and little groups..." Senator Chafee concurred, saying, "They have made a big effort to reach out." ("Clinton Task Force all Ears On the Subject of Overhaul," Congressional Quarterly, May 22, 1993) Outside experts were consulted, and regularly presented their views to the working group. The First Lady also held public hearings and town meetings across the country.

In addition, we sought outside opinions to challenge the assumptions and the workability of the options proposed by the working group:

- 14 panels of consumers came in to share their concerns and insights and ask questions of the working group members.
- A health professional review group and outreach groups of doctors, nurses, public health officials, hospital administrators, pharmacists and others reviewed and commented on policy options developed by the working group.
- Audit teams critiqued and questioned assumptions and options, including a group of actuaries who reviewed the validity and assumptions behind the numbers, a group of administrators and health plan executives who critiqued the practicality of the recommendations, a group of attorneys who reviewed the legal ramifications, a group who reviewed the impact on minority populations.

In spite of all of this outreach and involvement, the conventional wisdom holds that the health deliberations were "cloaked in secrecy". That's in part because of the way we handled our communications with the press. First of all, we had a lot of work to do and a very limited time in which to get it done. And, we thought that, like the economic package, NAFTA, reinventing government and welfare reform, there would be plenty of time to educate the public and the press about the plan after internal deliberations were completed. We miscalculated. Even after we recognized that the image of a secretive process was taking hold in the press, the Congressional leadership and the White House was concerned about leaks from health care jeopardizing a

fragile budget process, so we continued to keep the press at arm's length.

From the outset, we should have done a better job of informing the press about the process. If we had done that, we could have avoided perceptions of secrecy, and we could have helped the news media develop a better understanding of reform as the debate evolved.

MISCONCEPTION #4: THE POLICY PROCESS WAS UNWIELDY AND CHAOTIC, CAUSING COSTLY DELAYS

Q: *The President promised to deliver his plan to the American people within 100 days of his Inauguration, yet we had to wait until October before the President actually submitted his legislation. Why was the task force five months late getting it done?*

A: We were ready to move forward at the end of May of 1993, just as the President had pledged we would do. During April and May of last year, the task force met 21 times to finalize decisions, a number of times with the President. But after the defeat of the economic stimulus package, it became clear to everyone that the introduction of health care reform should be delayed until passage of the economic package was assured. For example, when word leaked out about a Treasury Department analysis of health care financing that included a tax on wine and beer, the California delegation immediately sent a letter of complaint to the White House and some members privately threatened to withhold support for the economic package.

With the economic package stalled, the introduction of health care was delayed from early June, to late June, to mid July, to late July, and finally to late September. At the end of May, we suspended all decision meetings, both internally and with members of Congress, until after the economic package was passed.

This meant that the final group of health care decisions, originally scheduled for late May, did not get made until just after Labor Day. Once decisions were made, the health care team needed a few more weeks to refine the policy, do final number runs and draft the legislation. Then, OMB and the Treasury had to do a final scrub of the cost and revenue estimates.

The speech to the Joint Session of Congress, originally slated for the end of May, did not happen until September 22, and legislation was not submitted until late October.

This delay gave time for the opposition to organize and caused doubt among supporters as to our resolve. But, passage of the economic program was critical to the country and to the presidency. Without a complete focus on it, the President's whole agenda, including health care could have been jeopardized.

MISCONCEPTION #5: OUR OWN ECONOMIC TEAM OPPOSED THE PLAN

Q: Even the economic team opposed the plan. How could you expect to sell it to the Congress and to the American people if your own senior officials couldn't agree?

A: Health reform is fraught with controversial decisions. Like any other major issue, at times discussions put different advisers on different sides of these issues. That's to be expected. But, these differences of opinion have been widely overblown.

There was agreement on the fundamental structure of the President's package -- universal coverage with an employer mandate, managed competition backed up by premium caps, large mandatory alliances, tobacco taxes, etc.

Where people disagreed was over timing and scale of the plan. For instance, how comprehensive should the benefits package be? How stringent should the cost containment be? What year should universal coverage be achieved? How extensive should the Medicare reductions be? These issues were debated; different points of view were presented.

Cabinet-level officials and senior White House advisers met over 21 times during April and May and then several times again in August and September to directly participate in the formulation of the final plan.

While staff-level working group documents reflect a diversity of opinions and put a wide range of options on the table for consideration, this senior-level group was responsible for narrowing them and presenting recommendations to the President.

Ultimately, the President made the final decisions and the Cabinet and senior White House officials supported the plan.

Compared to the disagreements among Democrats in the Congress about the direction of health reform, and compared to the debates aired over the past year, these disagreements were minor. Like the other major initiatives this President has undertaken, these deliberations helped to sharpen the policy and to make the ultimate bill sounder.

MISCONCEPTION #6: THE COMMUNICATIONS STRATEGY WAS UNFOCUSED AND INEFFECTIVE

Q: You had to have known that interest groups were going to attack health reform. Why didn't you do anything about it?

A: Powerful special interests were perhaps the biggest single obstacle we faced. Several recent studies have documented the amount of money spent on advertising and lobbying to influence the outcome of the health care debate. Every major legislative battle -- from the New Deal to Social Security to Civil Rights -- has met with opposition. But never in the history of this country have modern technology and scare tactics combined to produce the degree and tone of misinformation that was spewed out so quickly about health care reform. And, because health care is such a personal issue, the public wanted to find out how the proposed changes would affect their own family's particular situation. The information available was largely incorrect and succeeded in both confusing and scaring the public.

Never has there been such an extraordinary amount of money spent on disseminating that misinformation. The Annenberg Public Policy Center studied this phenomenon and concluded that the health care debate has generated "the largest, most sustained advertising campaign to shape a public policy decision in the history of the Republic." Newsweek estimates that "interest groups spent at least \$300 million to defeat health care...much of which was spent on blatantly untrue advertisements designed to scare the public." (9/19/94)

If you've heard these ads, you know that not only are they negative, they're scary. The Wall Street Journal ran a story about the misinformation campaign in late April. The article began:

The baby's scream is anguished, the mother's voice desperate. "Please," she pleads into the phone as she seeks help for her sick child.

"We're sorry; the government health center is closed now" says the recording on the other end of the line. "However, if this is an emergency, you may call 1-800-GOVERNMENT." Her baby still wailing, she tries it, only to be greeted by another recording: "We're sorry, all health care representatives are busy now. Please stay on the line and our first available..."

"Why did they let the government take over?" she asks plaintively. "I need my family doctor back."

The story goes on to say: The only problem with the radio spot, produced by a Washington-based group called Americans for Tax Reform, is that it isn't true. [WSJ, 4/29/94]

Misconceptions about the President's plan abounded, fueled by these ads and direct mail campaigns. People at town hall meetings would shout their opposition to the plan because they didn't want the government taking over their hospitals (something of course not proposed in the plan). Another Wall Street Journal story said that "another of the big canards about the Clinton plan is that people face '5 years in jail if you buy extra health care.'" The story alluded to a direct mail package sent to millions of Americans by the American Council for Health Reform. The story explained that this penalty referred to an anti-bribery provision in the Clinton proposal and, in fact, the President's bill explicitly stated that people were free to purchase any health care services they wanted.

But these ads proved that it's always easier to make the negative case rather than the positive, more complicated one.

Opponents of reform distorted the President's plan into some radical, wild-eyed attempt to revamp our health system. In fact, the main elements he proposed were drawn from Republicans and Democrats alike -- most of whom could be described as political moderates. Universal coverage, employer mandates, and premium caps, while opposed by powerful interest groups, are heavily favored by most Americans, even though, as a Wall Street Journal headline noted, "Many Don't Realize It's the Clinton Plan They Like."

MISCONCEPTION #7: WE BLEW THE DEAL WE COULD HAVE HAD

Q: Why did you keep the Republicans out of health care? If they had been brought into the process earlier, you could have struck a deal that's much more comprehensive than what you're ending up with?

A: The idea that there was a deal with the Republicans if only we had acted sooner is just not true. From the beginning, we reached out to the Republicans. We had meeting after meeting with the Senate Republican Task Force, the House Republicans and their leadership. We approached Senator Chafee and the Republican task force last May to work together on a bill. Senator Chafee declined, saying that he thought it would be better for them to produce their own bill first. Then, we could sit down, compare bills and negotiate.

When our bill was introduced last September, moderate Republicans and conservative Democrats expressed optimism about being able to work out differences. On the Sunday talk shows, Senator Chafee and others spoke of the similarities between our approaches. Twenty-three Republican Senators, including Dole, supported universal coverage. In a Los Angeles Times interview in late September, Dole said "he also shares Clinton's belief that universal health care should be a non-negotiable goal of reform." (September 23, 1993) Throughout the fall, it appeared as though our

attempts to bridge the chasm between liberals on the one hand and conservative Democrats and moderate Republicans, on the other, could succeed.

We had discussions with the Congressional leadership and Committee chairs about how best to proceed. With so many committee chairs and leaders in both Houses with strong views about health reform, it would have been inappropriate and impossible to cut a deal with a handful of people. It was decided that the bill should go through the normal committee process; Senators Chafee and other Republican Congressional leaders agreed. The leadership and the Committee chairs sponsored the President's bill, and the Administration played a supportive role, providing technical assistance as requested.

Things started to fall apart in late spring, early summer of this year. Seeing the potential to capture seats at the mid-term election, the Republican leadership unified its membership around a decision not to give the President any victories. As a June 17 New York Times article reported, "Packwood cited Republican unity as a reason for going against his own preference. Packwood said that while he favored an employer mandate, he would not vote for one." The Washington Post reported the same day from the House, stating that "Rep. Fred Grandy said his 'marching orders' had been made very clear by House Minority Whip Newt Gingrich and that, reluctantly, he has agreed not to offer an amendment he had planned to introduce in Ways and Means. 'We now have a leadership that preempts policy with politics.'"

As the President's popularity slipped and public support for something called "the Clinton plan" slipped, the pressure to move toward incremental reform, away from hard votes, increased. At various points, the President and the Congressional leadership offered to move closer to the moderates by watering down the employer mandate. We offered an exemption for small firms when they said they could accept that. They backed off. We offered a "hard trigger" so that a mandate would go into effect only if market reforms didn't get to universal coverage. They backed off again. Finally, Senator Mitchell put forward his proposal -- the closest thing to a voluntary system that still could claim to achieve universal coverage -- again, they backed off. Each time we signalled compromise, they moved away.

Republican resistance in the Senate on the crime bill, on GATT and on health care during the summer all point to a desire by the Republicans to obstruct legislation that would be counted as victories for the President.

9/12/94

IRA C. MAGAZINER
REMARKS TO THE AMERICAN POLITICAL SCIENCE ASSOCIATION
NEW YORK CITY
SEPTEMBER 1, 1994

Today we find ourselves in a great -- yet still unfinished -- chapter of American political and social history. Great because for the first time in decades we are addressing one of the most intractable social and economic problems of our time -- a health care system that is out of reach for millions of Americans and too costly for our nation. Unfinished because Congress has not yet written the final words of the text.

As you know, the daily accounts we read on issues like health care reform are merely first drafts of history. Over time, those interpretations are revisited by scholars like you, who bring their own theoretical and historical perspectives to bear.

Analyzing health care reform is all the more difficult right now because the process is far from over. So my perspective, like the perspectives of other insiders and journalists and political commentators, is based on current and fluid events that can change from day to day and month to month. But hopefully I can offer some useful insights into the health care reform process that has engaged the Clinton Administration and Congress for much of the last year.

President Clinton continues to press for health care reform for the same two reasons he outlined when he ran for the Presidency: First, because the health of tens of millions of Americans -- both uninsured and insured -- was at risk and is at risk in the current system. And second, because there is no way to fully restore our economy over the long term without doing something about rising health care costs.

Every day, the health care picture gets worse. On any given day, close to 40 million Americans -- most of them working people -- lack insurance. Millions are locked in jobs they couldn't leave for fear of losing their insurance. Families can't get coverage because of "pre-existing conditions" and other forms of insurance discrimination. Small businesses face health care premiums 35 percent higher than those of large corporations -- and those premiums are projected to grow at double-digit rates.

And there is little hope of further reducing the deficit when health care expenditures consume 14 percent of our national income, and a decade from now, the figure will be closer to 20 percent. Month after month, year after year, health care costs

are further eroding our savings, our investment capital, our public treasury, our ability to create new jobs in the private sector. And we cannot take full advantage of the progress this President is making in restoring the economy if we attempt to reduce health care costs simply by chipping away at Medicare and Medicaid.

So the question President Clinton faced upon his inauguration 20 months ago was this: How do you solve a problem of this magnitude, of this complexity, of this urgency, when no President, Republican or Democrat, has managed to do it in 60 years?

Many people advised President Clinton that it was too politically risky to tackle health care reform. It couldn't be done, they said, because of the array of special interests positioned to stop it -- special interests that had spent millions and millions of dollars to stymie the efforts of Presidents Truman and Kennedy and Nixon and Carter before him.

But health care reform was simply the right thing to do socially, economically, and morally. That's why the President took on this mammoth challenge, and set in motion this historic process, regardless of the political risk. That's why he is sticking to it, and why he will keep fighting for reform until it is achieved.

Throughout the process the President's goal has been twofold: to achieve universal coverage and to control health care costs while still preserving quality. Universal coverage and cost containment sometimes are viewed as contradictory, when in fact they go hand-in-hand. Counter-intuitive as it may seem, you can't reduce the burdens on business and government and individual families until everyone is insured.

The reality is that people who don't have insurance can't pay but still get health care. They just get it when it's too late, too expensive, and often from the most expensive source of all, the emergency room. The result is that the rest of us end up footing the bill through higher hospital bills and higher insurance premiums.

The President beat the historical odds by putting health care reform on the national agenda and presenting a plan last year. Furthermore, virtually all Democrats and moderate Republicans supported the goal of universal coverage. And virtually all the comprehensive health care bills subsequently submitted by Democrats and moderate Republicans included cost containment.

There are only three ways to achieve universal coverage, all of which have been debated by politicians, economists, and policy experts for years. One is a single payer approach that would replace today's employer-based system with a broad-based income, payroll or value-added tax. It would require about three to four hundred billion dollars of new federal taxes each year, a political implausibility.

A second approach is to require all individuals to buy health insurance, the same method many states use with auto insurance today. The down side of that method is that employers might be inclined to stop covering their workers, that more and more individuals would need government subsidies to help pay for their premiums, and new taxes and a new administrative bureaucracy would result. More important, the public opposes it.

The third option -- the approach the President chose -- is to extend the system that 90 percent of insured Americans already use. The employer mandate is the least disruptive, most conservative option available. It was an option embraced by groups across the political spectrum: the American Medical Association, the Health Insurance Association of America, many labor unions, the Jackson Hole group, the Chamber of Commerce and other business groups, and the National Coalition on Health Care Reform co-chaired by former Presidents Carter and Ford.

In fact, the President's proposal for achieving universal coverage through an employer mandate was first proposed by President Nixon more than two decades ago in a bill introduced by Senator Packwood, the ranking Republican member of the Senate Finance Committee.

Cost containment is an equally important part of the President's equation. Cost containment is essential if you want families and businesses to be able to afford health care, and if you want to control federal spending.

But as with universal coverage, there are only a few ways to get costs under control.

One option is to have the government directly set the price for goods and services delivered in the health care sector, or set ceilings on the total amount the nation would spend on health care. But having the government involved in every health care transaction is way too bureaucratic.

Some advocates support the idea of "tax caps" to contain health care spending -- limits on the tax deductibility of health spending by companies. The President rejected that approach because it would raise taxes on middle-class families.

The President's plan relied on creating a more competitive market and a more cost-conscious consumer to control costs. As a back-up, the President proposed premium caps to limit the amount insurance premiums could be raised if market forces did not succeed in keeping prices down. This approach was borrowed directly from a bill put forth by Republican Senators Danforth and Kassebaum and moderate Democratic Representatives McCurdy and Glickman.

As you examine the main elements of the President's plan you will find that the bulk of ideas he proposed were gleaned from members of both parties, from liberals and conservatives and moderates alike. And in many cases, the proposals already had been tested successfully at the state level. Employer mandates are working effectively in Hawaii, Washington, and Oregon; premiums caps in Washington and Minnesota.

Perhaps no idea occasioned as much debate initially as mandatory alliances. The first barrage of negative ads came from the insurance industry, which misrepresented alliances as government take-overs of health plans that would reduce consumer choice, when in fact the opposite was true.

The idea behind alliances was to give people more choice of plans and to reduce the administrative burdens that now exist for businesses.

As someone who ran a successful small business, I can tell you that today, cost and complexity make it nearly impossible for small businesses to offer their employees a choice of plans. Alliances would have made this choice possible.

The idea for mandatory alliances came from the Jackson Hole group and from legislation sponsored in 1992 by Representatives Cooper and Andrews and Senators Boren and Breaux.

Other provisions such as the long-term care benefit, a focus on primary care, funding for academic health centers, improvements in rural and urban health care infrastructures, and some public health initiatives were also included in Republican health reform proposals.

So if you compare the President's approach to some of the options at hand, you will see that -- in case after case -- his plan was fundamentally reasonable, moderate, and in line with what most Americans wanted then and still want now.

Yet while the bill's provisions reflected the conventional solution, the size and detail of the document generated criticism from opponents that it was a bureaucratic form of social engineering and an example of "big government."

Health care reform is a very complex subject. A bill to reform the health care system is never going to make for light beach reading. Our goal in writing the legislation was to offer the American people a realistic description of how the proposed changes would work.

It's worth noting that many pieces of major legislation are as long or longer than our bill. Health care reform measures circulating on Capitol Hill range from 650 to 1,400 pages. The crime bill that passed last month was almost as long as health care legislation, and NAFTA was literally thousands of pages.

Yet the length of the President's health care reform bill became a metaphor for the complexity people would supposedly face under a reformed system. The number of pages became a symbol of the amount of government involvement people would see in their health care.

How did we arrive at the provisions of the bill?

To meet an aggressive timetable, we established a process for making policy that was unconventional for Washington, borrowed from private sector models for conducting big projects in a short time frame. We cast a wide net for participants.

To have a credible health care bill, one must address dozens of specific issues such as long-term care, mental health, malpractice, and insurance reform. So we brought together experts and practitioners in each of these areas -- both from Washington and from around the country.

We held daily meetings with members of Congress, and involved more than 120 Congressional staffers in the working groups. The First Lady also held public hearings and town meetings across the country.

By May of 1993, review groups composed of health care providers, consumers, auditors, actuaries, hospital and insurance administrators, and lawyers responded to ideas that had been proposed by different working groups.

The whole process resulted in an amazing amount of work completed in a very short amount of time. We succeeded in meeting a very tight deadline.

Has it been a flawless operation? Of course not. And while some of the problems we encountered were avoidable, others were not.

One that we couldn't avoid was the legislative calendar. We were ready to move forward at the end of May of 1993, just as the

President had pledged we would do. During April and May of last year, the task force met 21 times to finalize decisions, a number of times with the President. But after the defeat of the economic stimulus package, it became clear to everyone that the introduction of health care reform should be delayed until passage of the economic package was assured. There was concern that introducing health care might compromise support for the economic package. For example, when word leaked out -- erroneously -- about a Treasury Department analysis of health care financing that included a tax on wine and beer, the California delegation immediately sent a letter of complaint to the White House and some members privately threatened to withhold support for the economic package.

With the economic package stalled, the introduction of health care was delayed from early June, to late June, to mid July, to late July, and finally to late September. The legislation finally was submitted in late October instead of in late May. Attention was further diverted from health care because of the debate over NAFTA and the crisis in Somalia, both of which dominated the White House and Congress during the weeks after the President's bill was introduced.

There wasn't much we could do about the calendar. But we could have done things differently in terms of the press. From the outset, we should have done a better job of informing the press about the process. That way we could have avoided perceptions that the deliberations were cloaked in secrecy, and we could have helped the news media develop a better understanding of reform as the debate evolved.

These problems notwithstanding, when the plan was introduced in the fall it was greeted very enthusiastically, and in fact, it became a baseline for other approaches. Representative Cooper termed his plan "Clinton Lite," a "close cousin" of the Clinton plan. Senator Chafee spoke on Sunday talk shows about "the similarities in our approaches" and voiced optimism about achieving a consensus. The President, meanwhile, was applauded for offering a clear and persuasive enunciation of his goals to Congress and the nation. Polls showed broad support for his plan. The New York Times went as far as to term the President's bill "alive on arrival."

As the President's plan generated excitement and support for reform, interest groups who benefited from the status quo mobilized their attacks.

Powerful special interests are perhaps the biggest single obstacle we faced then and still face today as we try to move forward with reform. Several recent studies have documented the amount of money spent on advertising and lobbying to influence

the outcome of the health care debate. Every major legislative battle -- from the New Deal to Social Security to Civil Rights -- has met with opposition. But never in the history of this country have modern technology and scare tactics combined to produce the degree and tone of misinformation that was spewed out so quickly about health care reform. And never has there been such an extraordinary amount of money spent on disseminating that misinformation.

The Annenberg Public Policy Center studied this phenomenon and concluded that the health care debate has generated "the largest, most sustained advertising campaign to shape a public policy decision in the history of the Republic."

Over \$100 million has been spent overall to influence the outcome. One study found that \$50 million was spent largely to influence reporters and legislators rather than the public as a whole. And these figures don't capture direct mail and phone bank efforts financed by opponents.

Whatever your view of health care reform, if you've seen or heard the now famous -- or infamous -- ads you know that they are not only negative, they're downright scary.

In fact, they were so distorted that the Wall Street Journal ran a story about the misinformation campaign under the headline "Truth Lands In Intensive Care Unit."

The article began:

The baby's scream is anguished, the mother's voice desperate. "Please," she pleads into the phone as she seeks help for her sick child.

"We're sorry, the government health center is closed now," says the recording on the other end of the line. "However, if this is an emergency, you may call 1-800-GOVERNMENT." Her baby still wailing, she tries it, only to be greeted by another recording: "We're sorry, all health care representatives are busy now. Please stay on the line and our first available . . ."

"Why did they let the government take over?" she asks plaintively. "I need my family doctor back."

The story goes on to say: The only problem with the radio spot, produced by a Washington-based group called Americans for Tax Reform, is that it isn't true. (WSJ, 4/29/94)

Misconceptions about the President's plan were continually fueled by this type of fearmongering. At town hall meetings I

attended, angry people would shout their opposition to the Clinton plan. I'd ask why they were against it. They would talk about the government taking over and running all the hospitals. Or they would talk about how people wouldn't be allowed to see their own doctor outside the health plan approved by the government and that, if they did, the doctors could go to jail. I'd explain that this just wasn't true. But the questioner invariably would shout back that I was lying and wave a mailing he had received from some group asserting one or another of these points as fact.

The Wall Street Journal said that "another of the big canards about the Clinton plan is that people face '5 years in jail if you buy extra health care.'" The story alluded to a direct mail package sent to millions of Americans by the American Council for Health Reform. The story explained that this penalty referred to an anti-bribery provision in the Clinton proposal and, in fact, the President's bill explicitly stated that people were free to purchase any health care services they wanted.

But these ads proved that it's always easier to make the negative case rather than the positive, more complicated case.

I point out the degree of misinformation because these advertising campaigns distorted the President's plan into some radical, wild-eyed attempt to revamp our health system. In fact, as I mentioned earlier, the main elements he proposed were drawn from Republicans and Democrats alike -- most of whom could be described as political moderates. Universal coverage, employer mandates, and premium caps, while opposed by powerful interest groups, are heavily favored by most Americans -- even though, as a Wall Street Journal headline noted, "Many Don't Realize It's the Clinton Plan They Like."

In spite of the barrage from special interests, the American people have said what they want -- and they have said how they want to pay for it. And they've been very consistent in their views.

A recent Washington Post/ABC poll showed that 77 percent favor universal coverage, 72 percent favor an employer mandate, and 75 percent favor government cost controls. Even more, 80 percent, support a tobacco tax.

With that kind of support, these ideas and proposals are not going to disappear and be forgotten by the public.

Another thing worth remembering about this process is that the President never expected his plan to be the final version adopted by Congress. He has always stated very clearly that his bottom line was universal coverage but he knew his plan would be

rewritten. In fact, two House committees and one Senate committee wrote their own bills, which were similar to the President's. This was all part of the legislative process the President envisioned.

So where are we today, nearly 20 months after the process began?

We are on the path to restoring the economy and fulfilling the President's broader agenda. And ultimately history will show that this was a time of great ferment and energy when a courageous President didn't dodge a difficult issue, but instead launched a process to solve the health care problem once and for all.

We have made extraordinary progress in the fight for the health security of the American people and the fight goes on. The Congressional Leadership has made certain that health care will be first on the agenda when they return to Washington. As was proven with passage of the Crime Bill, special interests do not always succeed in undermining the interest of the American people. And we must continue to make sure that the voices of reason are heard over the shouts of fear and confusion. That's why we will not walk away from the fight to provide security for the American people.

Thank you.

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Harold - There are
Draft talking
points on the
health reform
process/documents

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THE HEALTH REFORM PROCESS

One of the first actions of the President when he took office was to establish a Cabinet-level task force to assist him in developing health reform legislation. The 12-member task force, chaired by the First Lady, had a mission to devise a workable health reform plan in 100 days based on the framework laid out by the President during the campaign -- to guarantee private insurance to all Americans and bring spiralling health care costs under control.

To meet an aggressive timetable, we established a process for making policy that was unconventional for Washington, borrowed from private sector models for conducting big projects in a short time frame. Coming up with a credible health care bill means addressing dozens of specific issues. We brought together a working group of experts and practitioners in areas ranging from long-term care to mental health, and malpractice to insurance reform to prepare a wide breadth of policy options for consideration by the task force and the President.

The working group, which disbanded on May 31, 1993, developed preliminary policy options which were presented to the cabinet-level Task Force for its consideration and subsequent recommendations to the President. The ultimate decisions on the administration's health care proposal were made by the President, advised by the Task Force.

OPENNESS OF THE PROCESS

The process was one of the most open and inclusive policy-making processes, incorporating opinions from practitioners, experts and consumers from a broad range of disciplines and from all across the country.

The Center for Public Integrity, a Washington non-profit ethics watchdog said:

"Based on meetings and accessibility, it is difficult to imagine a more open, inclusive, decision-making process for a major public policy issue in Washington." ("Well-Healed: Inside Lobbying for Health Care Reform", 1994, p. 26)

We cast a wide net for participants. The working group brought together the opinions and expertise of people with different points of view -- some supported a Canadian-like single payer system; others supported a more market-oriented approach. Some members brought expertise in designing insurance and market reforms; others were knowledgeable in how to improve health care quality and information flow, designing benefits packages, developing long term care home- and community-based programs; still others brought their knowledge of antitrust, malpractice and ways to control health care costs.

We held daily meetings with members of Congress and involved more than 120 Congressional staffers on the working group. Outside experts were consulted, and regularly presented their views to the working group. The First Lady also held public hearings and town meetings across the country.

In addition, we sought outside opinions to challenge the assumptions and the workability of the options proposed by the working group:

- 14 panels of consumers came in to share their concerns and insights and ask questions of the working group members.
- A health professional review group and outreach groups of doctors, nurses, public health officials, hospital administrators, pharmacists and others reviewed and commented on policy options developed by the working group.
- Audit teams critiqued and questioned assumptions and options, including a group of actuaries who reviewed the validity and assumptions behind the numbers, a group of administrators and health plan executives who critiqued the practicality of the recommendations, a group of attorneys who reviewed the legal ramifications, a group who reviewed the impact on minority populations.

September 6, 1994

THE HEALTH REFORM PROCESS MISCONCEPTIONS IN THE CONVENTIONAL WISDOM

PRESIDENT'S PLAN WAS POLITICALLY NAIVE, GRANDIOSE, OVERREACHING, BIG GOVERNMENT

Q: The President's plan -- its premium caps, employer mandates, mandatory alliances -- was a social engineer's dream and had no chance for passing. Why did you propose such radical surgery instead of just fixing what was wrong with the current system?

A: The President's plan built on the framework he had proposed during the campaign. The American people in poll after poll support major change and support by overwhelming majorities the ideas the President proposed, including universal coverage, employer mandates, cost containment, tobacco tax, etc.

You forget that these ideas -- employer mandates, premium caps, mandatory alliances -- came from mainstream proposals. There are only 3 ways to get to universal coverage -- raising broad based taxes, mandating individual families to purchase insurance, or requiring employers and individuals to purchase insurance. We chose the employer mandate -- expanding the system that 90% of people with private insurance have today; the same approach President Nixon proposed two decades ago; the same approach supported at the time by groups like the AMA, the Chamber of Commerce, the Association of Corporate Benefits Managers, the American Hospital Association and many other groups.

To control costs, we chose market reforms to stimulate competition, with premium caps as a backup in case competition didn't work to control costs. We rejected price controls as too regulatory and instead took the idea for premium caps straight from a bill proposed by Senators Danforth and Kassebaum and Representatives McCurdy and Glickman. Premium caps were supported by many mainstream groups, including the American College of Physicians, the Catholic Health Association and the League of Women Voters.

To enhance consumer choice and provide community rating, we proposed mandatory alliances, which came from the 1992 bill sponsored by Representatives Cooper and Andrews and Senators Boren and Breaux.

In many cases, these proposals already had been tested successfully at the state level. Employer mandates are working effectively in Hawaii, Washington and Oregon; premium caps in Washington and Minnesota.

COMPLEXITY KILLED IT

Q: Why did you send up such a complicated bill? As the Los Angeles Times pointed out recently, some legislators on the Hill said that "it would have been far better to...spell out broad goals, and let Congress figure out how to get there."

A: The President has consistently focused on the goals of health reform -- universal coverage, controlling costs, etc. From the beginning, he has been open to better ideas and new suggestions. Detailed legislation would give the American people a realistic description of how the proposed changes would work and would serve as a starting point for discussions.

Most Congressional leaders asked us to send up a detailed bill to get the process rolling. Then, the normal legislative process would work through the details. In fact, two House committees and one Senate committee wrote their own bills which were similar to the President's.

Q: Wouldn't you have been better off with a skeleton bill -- one that wasn't so detailed?

A: The President was committed to sending up a bill that worked. By laying out the details for everyone to see, people would get a clear idea of how the proposed changes would affect them. As the Director of the Congressional Budget Office stated at the time: "the Health Security Act is unique among proposals to restructure the health care system both because of its scope and its attention to detail. Some critics of the proposal maintain that it is too complex. A major reason for the complexity, however, is that the proposal outlines in legislation the steps that would actually have to be taken to accomplish its goals. No other proposal has come close to attempting this. Other health care proposals might appear equally complex if they provided the same level of detail as the Administration's on the implementation requirements."

If you look at the health reform legislation on the Hill today, you'll see that it ranges from 650 to 1,400 pages. And, that's not unique to other major pieces of legislation that have passed this year -- the Crime bill, budget reconciliation, NAFTA -- all were at least that long.

POLITICAL NAIVETE

Q: Wasn't your bill dead on arrival because it was politically naive, put together by policy wonks with tin political ears?

A: When released, the President's plan was declared "alive on arrival" by the New York Times. It was favored by the American people by a wide margin in polls and got positive reviews from moderate Republicans such as Senator Chafee who said it was a good starting point.

Only after special interests spent tens of millions of dollars to mislead the public about its contents did "the Clinton plan" lose popularity. But even now, when the elements of the plan are described without the label, the Clinton plan is widely supported and is preferred by wide margins over other proposals.

Anyone who pretends that there's an easy way to gain widespread political support for a health reform plan that achieves universal coverage is not being honest. There are no silver bullets in this debate. If there were, this would have been accomplished decades ago.

PROCESS WAS UNWIELDY, CHAOTIC

Q: Even the Administration has admitted that the working group was an "anonymous horde" and its recommendations weren't really used. Wouldn't it have made more sense to have had 20 experts consult with outside people to develop the legislation?

A: To meet an aggressive timetable, we established a process for making policy borrowed from private sector models for conducting big projects in a short time frame. The framework for reform was clearly laid out by the President during the campaign -- the charge was to develop a workable policy around that framework within 100 days. Because health care is so complex an issue, experts in one area are different from those in others. For example, mental health experts are different from antitrust experts and they are still different from experts in insurance reform. Leaders of the different issue areas acted as those "20 experts", directing the work of their teams, defining cross-cutting issues and synthesizing options.

The working group process was very fluid -- initially conceived to include about 100 representatives from within and outside the government. The working group grew over time as departments added additional staff, as gaps in expertise were filled, and as members of Congress sent over their staffs to participate.

POLICY WONKS, NO PRACTITIONERS

Q: You'd have been better off if you had involved doctors and nurses instead of lawyers and academics in crafting the proposal.

A: In fact, front-line practitioners were extensively involved in shaping and critiquing the Administration's policy. From the 68 doctors on the working group to the dozens of doctors, nurses, social workers and other practitioners on the Health Professionals Review Groups, front-line medical practitioners played a large role in preparing and analyzing the working group's policy options.

In addition, members of the task force and working groups met with the organized medical profession several times during the spring of 1993. We consulted with the American Medical Association, the American College of Physicians, the American Academy of Pediatricians, the American Academy of Family Physicians and many other physician groups and medical societies.

"Contrary to recent press reports, the American Medical Association is pleased to have received several opportunities for input on the health system reform plan being developed by the White House Task Force." (Letter from the AMA to Hillary Rodham Clinton, March 30, 1993)

DOMINATED BY SPECIAL INTERESTS

Q: The American Association of Physicians and Surgeons claims that the working group was dominated by managed care interests, specifically representatives of the Robert Wood Johnson and the Kaiser Foundation. What's your response?

A: First of all, to claim that the working group or any of its recommendations showed a leaning toward managed care interests is absurd. The membership of the working group incorporated views as diverse as single payer to those that called for a completely market-oriented system and everything in between. We explicitly excluded special interests from being members of the working group, although we conducted extensive outreach. During the time, we heard the views of over 1,100 different groups.

The President has always been committed to preserving and increasing families' choice of health plans and doctors -- that's why the Health Security Act included a requirement that everyone had to have the choice of enrolling in a fee-for-service plan. And why every plan had to offer a point-of-service option which enabled consumers to see doctors outside of the network. A group dominated by managed

care interests would not have come up with these kinds of proposals.

Q: What about the Robert Wood Johnson Foundation fellows – they clearly represent special interests, yet you classified them as government employees?

A: That's absurd. The charge that having a handful of RWJ fellows on a working group of over 500 people somehow opened the floodgates to special interests is ridiculous. It is true that we called them government employees because they follow the same rules as government employees. The RWJ fellows on the working group were employed by Members of Congress. As such, they are bound by the Senate Code of Official Conduct and are treated as employees of the U.S. Senate.

MISSED DEADLINE

Q: The President promised to deliver his plan to the American people within 100 days of his Inauguration, yet we had to wait until October before the President actually submitted his legislation. Why was the task force five months late getting it done?

A: We were ready to move forward at the end of May of 1993, just as the President had pledged we would do. During April and May of last year, the task force met 21 times to finalize decisions, a number of times with the President. But after the defeat of the economic stimulus package, it became clear to everyone that the introduction of health care reform should be delayed until passage of the economic package was assured. For example, when word leaked out about a Treasury Department analysis of health care financing that included a tax on wine and beer, the California delegation immediately sent a letter of complaint to the White House and some members privately threatened to withhold support for the economic package.

With the economic package stalled, the introduction of health care was delayed from early June, to late June, to mid July, to late July, and finally to late September. The legislation finally was submitted in late October instead of in late May.

**WORKING GROUP
DOCUMENT RELEASE/LITIGATION**

DESCRIPTION OF DOCUMENTS

Q: What documents were released today (September 7, 1994)?

A: The documents released today include documents created or received by the Administration's health reform working group, which disbanded May 31, 1993. For example, there are published reports that the working group received, briefing books and "tollgate" books which present background information and preliminary policy options on different issue areas and reports by "audit" groups that met in the late spring and summer of 1993 to review and comment on the options being developed by the working group and considered by the Task Force.

Q: Are there additional documents that exist that have not been produced?

A: The White House has released all the working group documents in the custody of the White House Office of Records Management. In coordination with the Department of Justice, the White House instructed all working group participants to submit their working group materials. Virtually all participants did so. The White House is continuing its efforts to collect additional working group materials and will make them available in the reading room.

CONTEMPT ALLEGATION

Q: Has Ira Magaziner been found in contempt of court?

A: There has been no finding of contempt by any court. The Justice Department believes that the allegations of contempt as "totally baseless". The Justice Department has further expressed its "confidence that any further proceedings will confirm this fact."

September 6, 1994