Withdrawal/Redaction Sheet
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01. Memo	From David Bates to John Sununu Re: Health Care Reform (1 pp.)	3/14/90	P/5	

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THE WHITE HOUSE

WASHINGTON

March 14, 1990

MEMORANDUM FOR GOVERNOR SUNUNU

FROM: DAVID Q. BATES

SUBJECT: Health Care Reform

This morning Connie Horner discussed with me the newspaper article on the health care reform business coalition and the timing of the Administration health care study. She was able to clarify both issues.

An article in the Washington Post noted the creation of the National Leadership Coalition for Health Care Reform, consisting of "some of the nation's largest corporations." According to the newspaper, the coalition voted in favor of pursuing some form of government sponsored national health insurance -- instead of a private market approach.

Connie reassured me that most business groups are interested in a market oriented solution to current health care delivery problems. She mentioned that Secretary Sullivan will be meeting with the business community (large corporations and small businesses) to hear their concerns, as part of the process of reviewing the health care reform studies during the coming year.

On the matter of timing of the health care review, which the President tasked to Secretary Sullivan, Connie acknowledged the reference to timing in the Sunday broadcast. She has spoken with the Secretary and assured me that they will be very careful not to say when the study will be completed, nor will they refer to an end result from the study.

cc: Dick Darman
Michael Boskin
Roger Porter

WP 3-14-90

Major Firms, Unions Join in National Health Insurance Bid

By Frank Swoboda
Washington Post Staff Writer

Some of the nation's largest corporations, including Marriott Corp., Ford Motor Co., American Telephone & Telegraph Co., Du Pont Co. and Eastman Kodak Co., have joined with a number of the nation's largest labor unions in an effort aimed at enacting some form of national health insurance.

The group, which will call itself the National Leadership Coalition for Health Care Reform, held its first meeting last Friday and immediately voted to focus its attention on government solutions to the nation's health care problems, which include rapidly rising costs, a growing pool of Americans without any health insurance and a malpractice crisis for doctors in certain specialties.

Although organized labor has long been an advocate of national health insurance, it is only in the past few years that a number of business organizations, stung by sharply rising costs of employee health insurance, have come to the conclusion that some form of government health program is necessary. The National Leadership Coalition represents the first attempt by major corporations and labor organizations to jointly formulate a unified proposal.

"We want to develop an American plan" for health care, said Peggy Rhoades, executive director of the new group. She said the coalition hoped to have a proposal for a comprehensive, "public-private" health care plan early next year when Congress is expected to begin the debate on national health insurance. "This coalition believes the health care system is in crisis . . . The problem is systemic and growing worse."

Corporations belonging to the coalition are AT&T, Ameritech, Bell Atlantic Corp., BellSouth Corp., Bethlehem Steel Corp., Du Pont, Equifax Inc., Ford, Kodak, Lincoln Telephone & Telegraph Co., Lockheed Corp., Marriott, Meredith Corp., Northern Telecom, Northwest Airlines Inc., Nynex Corp., Pacific Telesis Group, Pioneer Seed, Rubbermaid Inc., Minnesota Mining and Manufacturing Co., U.S. West and W.R. Grace & Co. The group represents some of the biggest non-union employers in the nation.

Union members include the American Federation of Teachers, the Communications Workers of America, the International Brotherhood of Electrical Workers, the International Union of Electrical Workers, the Service Employees International Union and the United Steelworkers.

Other members of the reform group include the American Association of Retired Persons, the American College of Physicians, the Association of Health Centers and the Families USA Foundation.

The AFL-CIO, which already has embarked on a major grass-roots campaign to build political support for national health insurance in the next Congress, has not yet signed on with the new group. But the unions in the coalition, particularly the SEIU, are among the most active on the issue within organized labor.

Notably absent from the group were Chrysler Corp. and American Airlines, which have been two of the biggest corporate backers of government health insurance.

Rhoades said the group was still growing. She said a number of other corporations and unions are considering joining and she soon expected to add to the membership list.

At its first working meeting last Friday, the group voted on whether to limit its considerations to private market approaches or to include government intervention as a possible solution to the problem of soaring costs. The vote was 17 to 6 in favor of exploring possible government solutions, according to a source familiar with the meeting. The only union to vote in favor of a purely market approach to medical care was the AFT, according to the source.

September 14, 1989
TO: John Sununu, White House Chief of Staff
FROM: Senator John McCain
RE: What Republicans should do on Medicare Catastrophic

The purpose of this memo is to follow-up on our telephone conversation of yesterday and your request that I outline my views on the Medicare Catastrophic Coverage Act issue, and a proposed modification of the President's position on this issue.

I. Background

In the eyes of our nation's elderly, the Medicare Catastrophic Coverage Act is itself a catastrophe and it demands attention. Defending the status quo is politically a loss, and I am certain the program will be changed. The Administration is perceived not only to be defending a highly unpopular status quo, but doing it for indefensible reasons -- i.e., the Act creates an artificial budget surplus in its first couple of years and we need these revenues, paid by seniors, to balance our budget. In short you have the worst of all worlds, because the unpopular status quo will be changed and George Bush will not be seen as being part of the solution.

The Act began as a proposal by the Reagan Administration to provide Medicare recipients, for a nominal flat fee, protection from the costs of a catastrophic illness requiring a long-term hospitalization. That was a good proposal. In fact, I sponsored it in the Senate with Bob Dole. However, Congress expanded and expanded it until it included everything from mammograms to coverage of outpatient prescription drugs. With an expansion in the benefits came the expansion in the cost; hence, the highly controversial surtax proposed by Senator Bentsen.

The principles of the Catastrophic Coverage Act are sound and supportable, and they do not need to be abandoned. We can still provide:

1) protection from the costs of a catastrophic illness requiring long-term hospitalization,
2) protection from spousal impoverishment,
3) and, revenue neutrality by requiring the seniors to pay to cover the costs of the program.

I have never, repeat never, proposed repealing the Act. That would be politically and substantively wrong for the President or any Republican to endorse. Repealing the benefits that are already in effect would open us up to attacks that would remind us of the 1986 COLA catastrophe. What we need to do is understand that seniors are willing to pay for benefits they want, but are rebelling at Congress telling them they must pay the costs of benefits that are not of high value to them -- such as outpatient precsription drugs, etc. Accordingly, we must adjust the Act.

Up to this point, the Administration has opposed touching the Act at all. This seems to be largely an OMB driven decision because of the fear of possible budget impacts.

II. The House Response

The House Ways and Means Committee adopted a proposal that would reduce the surtax to about half of its present level, increase deductibles under the program, raise the flat Part B premium, and push the hospitalization portion of the Act into Part A -- eventually sticking the tax payer with the burden through increased FICA obligations.

As the senior response in Congressman Rostenkowski's district suggests, this proposal was very misguided. It leaves the surtax in place, increases the burden on the low and lower middle income by raising the flat Part B premium, and waters down the benefits by increasing the program's deductibles.

III. The Senate Response

It appears that, while the Senate Finance Committee will probably stay away from an increase in the flat premium and will likely cut some of the drug benefit, they are going to leave the surtax in place and water down the value of the benefits. This will not be an acceptable solution in the eyes of the elderly.

Earlier this year, the Senate considered a proposal that I put together, which has received the endorsement of 46 seniors organization -- representing close to 20 million seniors. This proposal, which failed in June by a vote of 49-51, would preserve the long-term hospitalization, skilled nursing facility (which now has to be modified because of the new cost estimates) and spousal impoverishment provisions. It would also preserve the flat Part B premium of $4.80 per month which covers the costs of the retained benefits. It would delay the remaining provisions, including the supplemental, premium for one year to give the Congress, the Administration and the seniors the opportunity to accurately determine costs and which benefits seniors and they are willing to pay for.

IV. Conclusion

As you know John, I have encouraged, since Day One of this mess, the White House to endorse a package of changes that are responsible to the seniors complaints, provide true catastrophic protection, and are revenue neutral. Whether they have to be budget neutral is still negotiable. I hope this plea will be reconsidered. I worked closely enough with these numerous senior groups to feel confident about my suggestions.

First, the President should modify his stance in the press. Rather than continuing to focus on the budget deficit, I believe he ought to begin focusing on the emotional parts of this

issue. He would hit the right cord with the elderly by sympathizing with their catastrophic health care needs, and their concern about how significantly the Act deviated from the original catastrophic protection as the last Administration.

Second, the President ought to get behind a proposal that protects a core of the catastrophic benefits, and pays for them with the flat premium. Those benefits protected could include long-term hospitalization, spousal impoverishment and the rest of the Medicaid provisions, home health, respite, and a re-torqued skilled-nursing benefit. The flat Part B premium in the Act is sufficient to do this. And the President should support repeal of the income tax surcharge which has become the lightning rod for the seniors' complaints and the focal point of their anger.

Third, figure out a way to off-set the deficit impact, without asking the elderly to pay for it. It's a paper problem that we created, we should not subject ourselves to the arguement that we are balancing the budget on the backs of the seniors. The elderly can be asked to pay for the costs of the catastrophic benefits -- as long as they're the correct benefits. They shouldn't be asked to pay for more.

Fourth, a concerted effort out to be taken to make sure that the elderly accurately understand the revised program, and its positive attributes.

In short, I think you could, and should, sieze this as an opportunity to show the elderly which party really listens to their needs and concerns. This is an opportunity to really distance ourselves from the 1986 COLA votesm, and the Democrats have set themselves up by defending a highly unpopular program.

The above is the approach I intend to pursue here in the Senate. I believe it is politically popular with the seniors, is fiscally responsible, and will be successful in the final analysis.

I once again urge the Administration to join me in this effort rather than fighting it. I look forward to working out the details of this at you earliest convenience.

DEBBIE STEELMAN

file

Canada's Health Care System

BACKGROUND

- Canada is a primarily rural, agricultural country with 26 million persons with relatively similar socio-economic status.
- The Canadian health care system provides universal coverage for most health care. It is financed largely by general revenues provided through the treasury of the federal government and provinces (about 50-50). In some provinces, employers and/or employees (excluding the elderly and poor) pay a premium. Care, however, is free.
- Physicians are paid according to negotiated fee schedules; hospitals are paid according to negotiated budgets.

GOOD FEATURES

- It covers all its population for most health care; 80% of population is satisfied.
- It costs about 30 percent less per capita than our system and costs increase at slower rates.
- There is essentially no paperwork for patients or physicians.

BAD FEATURES

- Less access to sophisticated technology. New technologies, such as CT-scans, are two to seven times less available than in the United States.
- Queuing for certain kinds of non-emergency care, such as cardiac surgery or radiation therapy. (Wealthy and influential often are allowed to jump place in queue.)
- Appears to promote mediocrity -- access is better but care is worse.
- Characterized by conflict between government and providers (fees are 23% lower than physicians think they should be) and financial pressure on provincial and federal budgets.

WHY NOT HERE

- Would require about $300 billion in new taxes.
- System may not be transferable to a population that is 10 times larger and a provider community that has relatively more surgeons and fewer general practitioners.
- Cultural differences -- long waits for surgeries and rationing of high tech services are generally tolerated by Canadians. Americans would be less tolerant. Without such tolerance, we would never attain the 30% savings.
- The world cannot afford to give up its leader in health care technology development. (Now, the world, including Canada, "lives off" the research, development, and technological advances of U.S. medicine.)
- In the short run, moving to a Canadian system would cause tremendous disruption, essentially wiping out an entire industry (health insurance). Any savings would translate almost directly into lost jobs.
- The Canadian (or other) health care financing system will not solve many of our main health problems -- problems that are more associated with poverty and lack of education than with the American health care financing system.

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Andy Card

THE WHITE HOUSE

WASHINGTON

February 26, 1990

THE CHIEF of STAFF has seen

MEMORANDUM FOR DAVID Q. BATES

FROM: KENNETH P. YALE KY

SUBJECT: Health Policy Review

We have organized the DPC Health Policy Working Group to address the President's health policy mandate. These are very complex issues that will require close coordination between the White House and several key Cabinet agencies.

In his State of the Union message, the President asked the Secretary of HHS for a DPC review of health care cost, quality and access. This should promote a deliberative process to review the health care studies under development, such as: the "Pepper Commission" (March 1990), the "Steelman Commission" (August 1990), and the internal HHS studies (end of 1990).

During this review it will be important not to raise expectations or prematurely eliminate appropriate options. We have taken certain steps, outlined below, to begin this process.

-- Revitalize and streamline the DPC Health Policy Working Group, to make it more effective and reduce the likelihood of inappropriate information disclosures.

-- Utilize an executive strategy group, at the Deputy Secretary level, of key Working Group agencies (OPD: Roper, Treasury: McGloughlin, HHS: Horner, OMB: Diefenderfer, CEA: Schmalensee, OCA: Danzansky, and DPC: Yale) to: set the agenda of the working group, coordinate and direct issue development, and ensure the quality of materials prepared for the DPC (this was done successfully in considering the drug strategy).

-- Develop a timeline of health policy related activities.

-- Develop a general workplan, for review of issues by the DPC through 1990 and beyond.

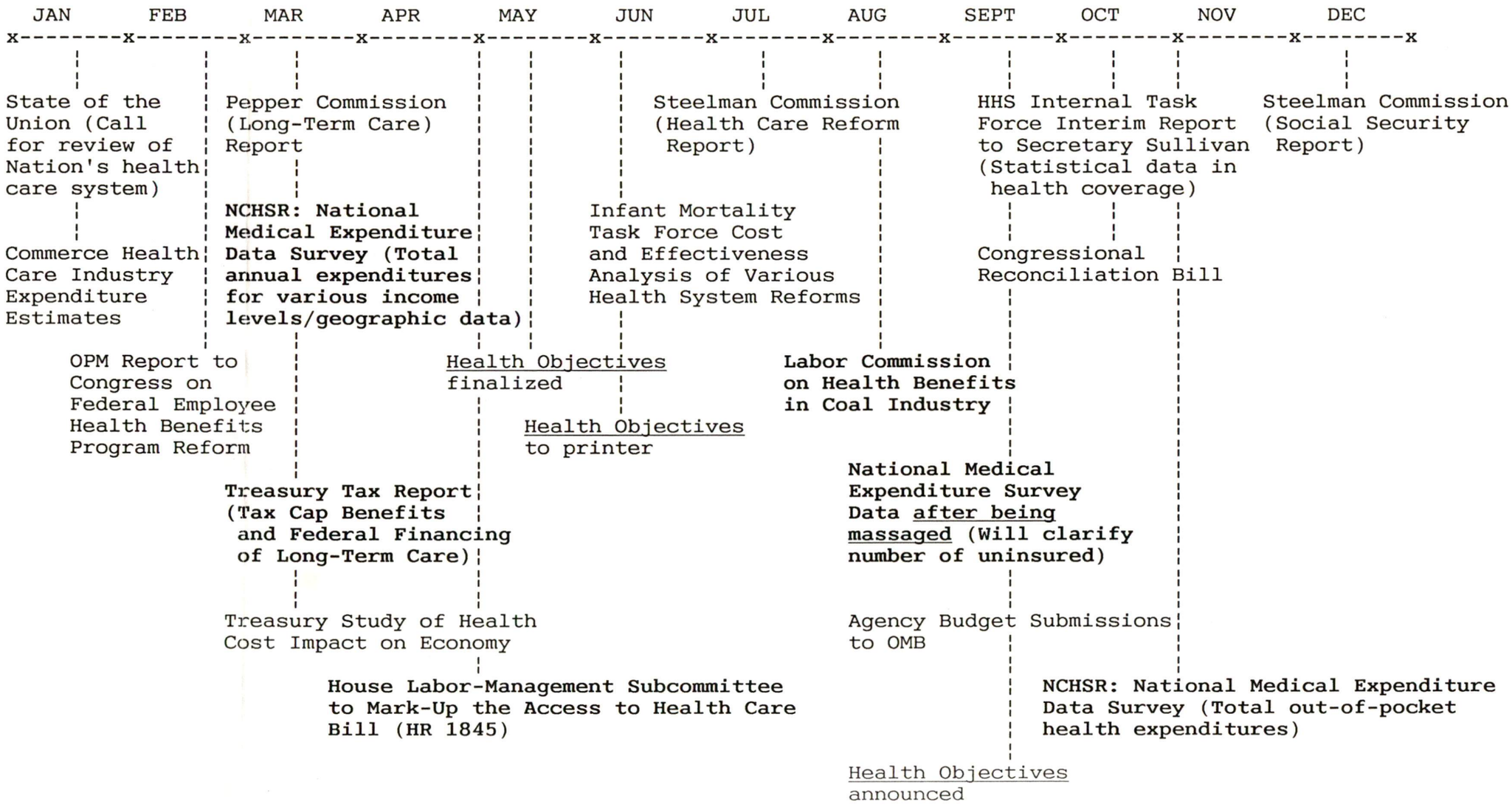
The executive strategy group has already met on several occasions to review issues needing immediate attention, and to plan for full working group meetings. The full Working Group has been revitalized, with Connie Horner as chair, and it will meet on February 28. For your information, we have attached a timeline with health related activities, which will be updated regularly. A workplan is also under development. It will require careful scrutiny.

cc: Steve Danzansky

February 26, 1990

KNOWN HEALTH EVENTS ON THE HORIZON

1990



MEMORANDUM FROM

DEBORAH STEELMAN

THE CHIEF of STAFF
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Dear Governor,

Medicare's 25th Anniversary (+ Medicaid's) is July 25. I put together some thoughts toward '92 with that in mind + hope you find them of value. I've shared this paper with Charlie Kolb, Bob Teeter + Craig Fuller also. You're doing great! Keep up the good work. Maybe we can visit sometime when I get back from the USSR. Thanks for making this.

Dori

6.14

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TEXAS ONLY

MEMORANDUM

From: Deborah Steelman

Date: June 14, 1990

Subject: Ideas for a Health Care Agenda

Confidential -- Not for Distribution

What follows are some building blocks written in an attempt to organize a political and policy development strategy on health care delivery and/or finance reform.

Many of the health care constituents have been waiting for an opportunity to reform health care financing since the early seventies. Press coverage will occur more dramatically and frequently (particularly in states with a significant portion of troubled populations (poor, black, and hispanic: California, Illinois, New York, Texas). The intensity of the crisis atmosphere in health care circles will increase accordingly.

Any strategy must define the problems most important to solve and a vision of the best solutions to those problems. At a minimum, we must be prepared for health care as a political issue prior to 1992 and as an issue on which the government will be required to act prior to 1996. A deliberate plan to control the development of the agenda on our own schedule is critical.

This will require not only discipline, but tremendous outreach to all potential supporters and opponents. This is getting tougher and tougher as many of those we would expect to count on as allies, tiring of "fighting something with nothing,"

begin to jump on various bandwagons. This category includes many of the Republican Members and most staff who have any expertise in this issue (this is most true in the Senate where Riegle and Rockefeller are making a major push for bipartisan support and getting sympathy from Chafee, Hatch, Heinz and Durenberger).

The "building blocks" that follow contain a number of questions, both political and policy. If we want to fix the problem, as opposed to sidestep it, these are questions that at some point the nation must grapple with. Therefore, I have tried to pose the questions in a way that makes it as difficult as possible not to answer them.

BACKGROUND:
DEFINITION OF THE PROBLEM

I. What is wrong with the system?

A. The system is inherently inflationary. Major factors include fee-for-service method of payment; first-dollar coverage and over-insurance resulting in higher utilization; third party payment isolates people from the consequences of their health care decisions; open-ended financing (fueled by the leniency of the tax code regarding employer sponsored health benefit plans); the multiple access to technology; various and often purposeful administrative inefficiencies.

B. The system is unbelievably wasteful. We have a glut of providers (in health care demand appears to be fueled by supply); the "health industrial complex" is gigantic; at $600 billion (of which the Feds pick up $200 billion) it is twice the size of the military industrial complex; little or no evaluation of what works and what doesn't; no evaluation of technology (like the FDA's role in drug approval); technology has become a centerpiece for marketing strategies, causing the purchase of much more machinery than is cost-effective.

C. The system is stuck in the past. The industry's gigantic infrastructure cannot change without external force; it was designed at a time we died of acute illnesses (we are now more likely to die of chronic conditions). We have a physician workforce of surgeons and internists and a paucity of geriatric clinicians or researchers. Planning doesn't work and lobbyists assure that government program funds go to areas of past need, not future ones. Also, the employee benefit system was planned in the years of little job mobility and even fewer two-earner families.

D. The system is unfair. No one knows what they can count on. Those without insurance have a great difficulty getting care and often care is obtained much later than is either cost-effective or appropriate; employers are shouldering much of obligations of government programs (Medicaid pays about $.60 of market rate and Medicare about $.80 of market rates). Health insurance, as insurance, rarely exists; it has become more a way to prepay health expenses, where at any opportunity high risk cases can be refused coverage.

E. We expect too much of the system. "Health care" cannot fix socioeconomic problems, diet problems, fitness problems, environmental problems; in fact, health care cannot fix many of the health problems we bring to it (like dying). Plus, we are a lazy people with a careless diet and a significant portion of the population whose behavior would stifle any cost containment drive no matter how draconian.

II. What's right with the system?

A. The system provides the best care in the world for those who have full knowledgeable and financial access to it.

B. Free access to the market assures that we have the best technology, the brightest doctors, the best support systems and the least inconvenience to patients.

C. Our research capacity advances the world. No country holds a candle to our contribution to the body of health science.

BACKGROUND: THE POLITICS OF THE PROBLEM

I. Any solution, or partial solution, will sting one or more of ten organized constituencies:

1) Labor

2) Big business

3) Small business

4) Hospitals

5) Physicians

6) Consumers/taxpayers

7) Federal government budgeteers

8) State governments

9) Insurance

10) The elderly

II. The problems are old; our health care system "has reached a state of crisis" (according to the advocates) dating all the way back to the 1800's. All the public knows is that they want to see their own doctor, when they want him, and do resent the cost increases.

III. The solutions are arcane and complex, suitable only for jargon-weighted discussion among academicians. Advocates have developed a few glib phrases ("mandated health benefits" or "national health insurance") whose opponents quickly move to a discussion that would glaze the eyes of even the most determined listener. Consequently, as a nation, we have never answered any previous "health care crisis" with a national solution. Why should this change now?

IV. No solution will fix all the problems and all solutions will cause other problems. Most solutions also appear to defy reason by requiring more money for a health care system that is already more expensive than in any other nation on earth.

V. Priorities are difficult to agree on. Each of the constituencies disagree on what is most important to address first; priorities even among individual constituencies differ tremendously (due, for example, to specialization, employment history, age).

NEXT STEPS:
THE BAD, THE UGLY AND THE GOOD

I. (THE BAD) Drive home in concrete terms why there is no consensus on the problems, let alone the solutions. Identify each problem area (infant mortality, closing trauma centers, the disenfranchised) and expose the many "problems" contained within those simple phrases. Each has causes ranging from socioeconomic and educational factors, to finance and lack of leadership. Choosing, for example, to rectify our dismal performance regarding infant mortality with a national health care finance reform is (almost) a non sequitur.

II. (MORE BAD) Discuss in layman's terms the choices we face. Which risks are best worth taking? This is the only way to see if people's vague anxiety and business/government cost concerns can be focused toward a solution. The answers to these questions, I believe, will tend to support leadership in a direction different than that espoused by Senators

Rockefeller and Kennedy and are the only way to begin to develop a political constituency for acceptable reform options.

A. Choice:

1) Do we want collective decision-making (under a national or state system of rules, or by requiring a specific role for all employers) or should we promote individual decision-making and individual choice (requiring all individuals to insure and expecting individuals to play a larger role in sustaining their own health and choosing treatments)?

2) Are we willing to enact and enforce a mandatory system?

3) Do we want standardization of benefits or should we continue to allow different plans and benefits in different states, different government programs and different employer plans?

B. Cost:

1) Are willing to tolerate any expansion of costs while the system is restructured or while we expand access?

2) Which of the current payors do we want to protect most from cost increases: government, employers, or people?

3) Is there a limit to health care expenses the people will accept? Is intentional rationing -- based on age, cost-effectiveness, or any other criteria -- a direction we must pursue? Do we live in a country where transplants are available only to those who can afford them?

C. What is the most important thing to do -- lower costs or improve coverage? Despite the fact that cost containment could be much less problematic with universal coverage, the fact is that for the near term, cost containment and improving access may be diametrically opposed agendas. The health industry lobbyists, as well as insurance and business certainly think so.

Can we say that either one is a priority over the other? If cost containment is our priority, what does that mean? What do we risk if we put a total lid on

expenditures? What do we risk if we decide to explicitly ration, for some populations or for all? What do we risk with technology assessment? What do we risk if we decide to explicitly ration? If access for the disenfranchised is our priority, what do we risk by doubling the size of the Medicaid program? What do we risk by requiring all employers to provide coverage? What if we believe cost and improved coverage are equally important?

III. (THE UGLY) Expose the difficulties of reform.

A. Resistance to change: a veritable morass of sacred cows.

1) Any $600 billion industry has huge vested interests who care only in the status quo or better.

2) The diversity of the industry creates many pockets of absolute authority and self-interest that multiplies the industry's resistance to change (hospitals, doctors, allied health professions, unions, an entire university structure, government administrative systems, government delivery systems, employer-based insurance, the lab industry, the pharmaceutical industry, the home care, nursing home, and home health aid industry, insurers and claims processors, the producers of medical devices and technology, etc.).

3) The emotional, personal nature of the ultimate service provide a sharp political tool for both the beneficiaries involved and the specific interests in the industry.

4) Infrastructure changes are always the hardest. When will we be willing to modify in any real way any of this infrastructure? How will we determine, politically and collectively, what we are willing to change?

a) For example, should we restrict hospitals services or growth; restrict the number of physicians or their income potential; eliminate or radically reform the insurance industry; regulate new technology's access to the market; change the tax benefits that has produced the alliance of business, union, providers and insurance?

IV. (MORE UGLY) State what changes we as a society are in fact considering when the buzzwords of reform are thrown around, and what they may mean for the way we get our health care.

A. Providers

Does government have a cost containment role beyond the established government role in Medicare/Medicaid? If so, that means regulation and limiting choice.

Should we restrict physician, hospital and health supplier income? That means lower quality personnel, physical plant, less innovation and restricted freedom of choice for patients.

Should we directly reduce the number of providers?

Should we restrict provider's ability to buy the latest technology?

B. Insurers

Remove state regulation of insurance and either replace state with or combine with federal regulation?

Establish federal benefit package?

Reduce them to only a claims processing role?

C. People (voters)

Impose higher cost in taxes, expenses or premiums?

Restricted choice of doctors, technology or benefit plans?

Limit benefits available (not allow people to buy above a federally determined package)?

D. Business

Require all to provide coverage?

Change tax benefits on employer-sponsored insurance?

Impose a federal standard for employer-sponsored benefit plans?

E. States

Federal preemption of their authority to require coverages?

Mandate more responsibilities on them. (Medicare reimbursement levels? Continued Medicaid expansions?)

Federal takeover of insurance regulation?

V. (MORE UGLY) Help the nation set priorities and responsibilities. Throughout our history those who have favored a big role for government in health care have consistently failed.

To consider changing the role we have already established for government -- the needy and the elderly -- an overwhelming percent of the population would have to be in favor of it. On what basis would we do it? Do we prefer to retain the role we have (and live up to those responsibilities)? Or, do we believe taxpayers (or employers) must take on additional societal responsibilities? How do we assure that we live up to these responsibilities? For whom, and for what services, should government dictate? Kids? Low-income? Relief for business cost increases? Lower out-of-pockets for the middle class? Better benefits for seniors?

VI. (THE GOOD) Weave themes we can build on: equity, fairness, reasonable cost, quality in both the easy (common cold) and the difficult (cancer) times. This is what we aspire to. Terms like "universal access" do not help people understand how to get there; equity, fairness, and individual choice and responsibility do. It's the American way. Such themes also help people understand the types of changes that may be needed and provide a basis upon which to accept them. People need a road map to the important decisions. Develop a very positive and specific image of what is it we really want from our health care system.

VII. (MORE GOOD) Provide rays of hope, common sense on "what works." All health care discussions today focus only on the intractable nature of the problem, the "crisis" we are facing, and the hopelessness of changing things.

Those with the glib answers have at least latched on to the key to reform: provide a light at the end of the tunnel. We must provide light IN the tunnel. Solutions do exist today; answers are being pursued. The first and only real answers lie within each person: good health. The public

health -- i.e., personal health -- message deliverable by the President and Secretary Sullivan cannot be underestimated.

And communities are pulling together. States are the powerhouses of reform; their reforms will help show us as a nation the best way to go. Insurers are working in the states to correct the problems of affordability and availability to small business. Employers are changing their employee benefit packages to reduce costs significantly, moving toward managed care and employee incentives.

What federal actions are appropriate: the bully pulpit on prevention and fitness; its enormous investment in research, perhaps its role in setting standards. But does resolving our health care problems depend exclusively on magic answers from the Federal government?

VIII. In this context it is possible to deliver the necessary strong message regarding the pitfalls of hasty action. Counter Jay Rockefeller's "the time for study is over" with one quick reference to catastrophic and, from the above points, any of a number of tough choices upon which society must reach agreement.

In order to prove this is not a stall, but instead is a serious national dialogue, the groundwork with the public, the press, and the health care advocates must be perfect, and both the performance by the principals and the substance of our message and questions must be of the highest caliber. The quality of the "light in the tunnel" must be excellent. Talking head speeches cannot cover this ground. This will take on site visits, appropriate private briefings of the best health reporters (using places they may have already discovered) and pushing those communities and states who have positive messages into the national spotlight.

TOWARD SOLUTIONS

I. To preempt the political vulnerability (You're doing nothing. You're doing it too slow. You're studying this to death.) the outreach and public relations activities are key. These will be appropriate for the summer, but will not be enough without a clear vision for where we believe we should be going. This is the internal mission (as opposed to the external mission described above) to which the next 3 to 4 months must be exclusively and diligently dedicated. This process cannot focus only on the current options.

A. Thorough discussion of what we think is most important for the poor, the middle class, the elderly and employers.

1) Elimination of fear of either inability to get or to afford the needed health care.

2) Vastly improved access for the poor.

3) Reasonable cost for the middle class.

4) Some way to protect against costs associated with any disease, whether chronic or acute, no matter when in life it may strike.

5) A better guarantee than contained in our current system of adaptability to the changes in demographics and health care needs of the future.

6) A better division of responsibilities so people know what they can count on. The states cannot continue to be in the squeeze, nor can the overlapping nature of our federal, state and private administrative and delivery systems continue.

7) Simplicity in form and substance.

8) A reduced role for employers.

B. Development of a framework that could get us there.

1) Making the safety net not a separate program, but merely an enhanced part of the total program (example: SSI and Social Security) -- easily done through either tax credits or typical national health program.

2) Eliminating the tax subsidy for employers in employer-sponsored plans to get employers out of the health benefit role altogether (it is a no-winner for them over the long haul no matter what we do).

3) Broadening the official definition of health care to match that of the common persons (to include home and long-term care); when illness/disability causes disruption in their lives and the lives of their family, they should be able to count on protection.

C. Political assessment of the best options.

1) Determine the best year (1991, 1993, 1995) and the best vehicle for action in each of those years (bully pulpit, blue ribbon panel, reconciliation, free-standing vehicle, etc.).

2) Survey of Congress, both Republican and Democrat

3) Survey of constituencies

4) Polling data

D. To control schedule, the Administration must control the dialogue.

1) Coordinated speeches, appearances and publications strategy among all major Administration personnel: Sullivan, Horner, Wilensky, Gerry, Boskin, Darman, (including, to the extent possible, allies on the Hill: Hatch, Gradison, Tauke)

2) Press strategy

3) Congressional strategy

4) Strategic use of the time of President and Mrs. Bush, Vice President and Mrs. Quayle

5) Appropriate use of OMB as the "bad guy"

E. Then do the easy thing: propose the right set of solutions at the right time.

SOME ACTION ITEMS

I. JUNE

1) Perfect Secretary Sullivan's "three-minute speech" and one-liners for interviews.

2) Develop characterization of Medicare and Medicaid programs in preparation for 25th anniversary:

a) Statistics: how many served, inflation in program, budget resources, extrapolations for the future;

b) The good the program has accomplished, the bad and unintended consequences of its enactment, the choices we'll face as the program ages;

c) Accumulate the "pictures" of the program you want the media to use, both figuratively and literally.

3) Study the legislative history of the Medicaid and Medicare bills so we can remind people Medicaid was a Republican bill. Dig up Jack Kennedy and Lyndon Johnson rhetoric and quotes.

4) Decide the three main themes of the health care reform: (suggestions) personal responsibility; finance reform is not the answer to all ills; finance reform can be the solution to some problems, but only if the people are willing to support change.

5) Develop an ongoing discussion schedule with the most important Governors and their staffs and with the staff of the NGA.

6) Take fitness message beyond exercise to diet, attitude, and behavior.

II. JULY

1) Secretary Sullivan should spend the entire month illuminating the weaknesses and strengths of the Medicare and Medicaid programs, the changes underway in both, and what the future holds.

2) Site visits where innovation and/or stress in the two programs are underway.

a) Medicare: Rand (outcomes research); Harvard (physician payment reform); Florida (HMO enrollment); home health and nursing home fields, etc.

b) Medicaid: Oregon, Arizona, Illinois (prenatal care); rural areas, inner cities; competition between acute care beneficiaries (young, unmarried poor mothers) and chronic care beneficiaries (seniors). Particular stress in the hispanic community where migrant worker status precludes eligibility.

3) Background the best reporters starting early in the month.

4) Plan HCFA employee celebration and/or awards ceremony on July 30th (that's a Saturday, so may need to be on the 29th with special schedule for the Secretary on the 30th).

III. AUGUST

1) If press is desired, float some tentative options papers or proposals. Washington is dead otherwise, so they might get covered in a more thoughtful way.

2) If press is not desired, take a break like everyone else does.

IV. SEPTEMBER THROUGH NOVEMBER

1) Reevaluate policy, politics and future plans. May be an important period depending on issues that rise in the elections. Best plan is to prepare speaking and press strategy to build on the three themes developed in July, articulated in the context on the tough choices and the rays of hope mentioned in Section III.

Withdrawal/Redaction Sheet
(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
03. Memo	From David Bates to John Sununu Re: Treasury Health Care Report (1 pp.)	4/2/90	P/5	

Collection:

Record Group: Bush Presidential Records
Office: Chief of Staff, White House Office of
Series: Sununu, John, Files
Subseries: Issues Files
WHORM Cat.:
File Location: Health Care (1990)

Open on Expiration of PRA
(Document Follows)
By JP (NLGB) on 5/12/05

Date Closed:	12/9/2004	**OA/ID Number:**	29159-009
FOIA/SYS Case #:	1998-0004-F[1]	**Appeal Case #:**	
Re-review Case #:	2005-0426-S	**Appeal Disposition:**	
P-2/P-5 Review Case #:		**Disposition Date:**	
AR Case #:		**MR Case #:**	
AR Disposition:		**MR Disposition:**	
AR Disposition Date:		**MR Disposition Date:**	

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P-1 National Security Classified Information [(a)(1) of the PRA]
P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P-3 Release would violate a Federal statute [(a)(3) of the PRA]
P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P-5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
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THE WHITE HOUSE

WASHINGTON

April 2, 1990

MEMORANDUM FOR GOVERNOR SUNUNU

FROM: DAVID Q. BATES

SUBJECT: Treasury Health Care Report

Attached is a copy of Treasury's Report to the President and to the Congress entitled Financing Health and Long-Term Care. The Report was delivered Friday afternoon.

The Report was prepared in response to both a Presidential directive (from President Reagan in February 1987) and a congressional mandate (a provision of the Medicare Catastrophic Coverage Act of 1988 that was not repealed).

The Report includes general background data on current provision and financing of health and long-term care. It also includes an analysis of various tax incentives related to catastrophic illness for the nonelderly, personal savings for long-term care, and development of the private long-term care insurance market for the elderly.

The Executive Committee of the DPC Health Policy Working Group reviewed the Report to ensure consistency with the overall DPC assessment of the quality, accessibility, and cost of the nation's health care system. The Executive Committee decided to eliminate any advocacy language in the Report and to make it an academic discussion of health financing issues.

It was also decided to distance the Administration from the Report by having it signed by Assistant Secretary Ken Gideon rather than Secretary Brady; and to submit it concurrently to the DPC Health Policy Working Group so that it can be factored into the DPC review headed by HHS Under Secretary Constance Horner.

Please note that one particular portion of the Report is especially likely to draw attention. This is the tax cap on employee benefits discussed as one of the financing options in Chapter 10 (p. 81). A proposal for such a tax cap included in President Reagan's FY85 Budget was controversial. If the Administration were to propose limiting the employee exclusion for the value of employer-provided health insurance, it could be perceived as support for a tax increase. The Report discusses the tax cap proposal in a neutral manner without signalling Administration support for it.

A OMB, OPD, HHS, Treasury, DPC, CEA

Withdrawal/Redaction Sheet
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Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
04. Memo	From Roger Porter to POTUS Re: Pepper Commission Report (3 pp.)	3/27/90	P/5	

Collection:

Record Group: Bush Presidential Records
Office: Chief of Staff, White House Office of
Series: Sununu, John, Files
Subseries: Issues Files
WHORM Cat.:
File Location: Health Care (1990)

Open on Expiration of PRA
(Document Follows)
By JL (NLGB) on 12/12/07

Date Closed:	12/9/2004	**OA/ID Number:**	29159-009
FOIA/SYS Case #:	1998-0004-F[1]	**Appeal Case #:**	
Re-review Case #:	2005-0426-S	**Appeal Disposition:**	
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THE WHITE HOUSE

WASHINGTON

Information

1990 APR -4 AM 9:05

March 27, 1990

MEMORANDUM FOR THE PRESIDENT

FROM: ROGER B. PORTER RBP

SUBJECT: Pepper Commission Report

This memorandum reviews the recommendations of the U.S. Bipartisan Commission on Comprehensive Health Care, also known as the Pepper Commission after its late chair, Rep. Claude Pepper. This report is one of the "health care studies now underway" you referred to in your State of the Union address. The commission unveiled its recommendations at the beginning of March, although the report writing will continue for another two months.

1. <u>The Commission called for both a new federal long-term care benefit and a program to lead towards universal health insurance</u>.

The long-term care benefit would pay for the first three months of a nursing home stay and home health care for the disabled of all ages. To encourage insurance for longer nursing home stays, long term care insurance premiums would become tax deductible. The Commission adopted this portion of its recommendation by a 11-4 vote.

The health insurance plan calls for a higher level of employer-provided insurance and a new public plan to enroll all persons not covered by employer-provided plans. Employers, beginning with those employing 100 or more employees, would be mandated to provide at least a minimum benefit package. At "full implementation" every American would be required to have health insurance. The Commission adopted these recommendations by an 8-7 vote.

In short, the Commission report offers a plan for spending the next increment of $66 billion the federal government wishes to spend on health care.

2. <u>While the Commission spoke with confidence about how to expand benefits, it offered little in the area of cost or quality</u>.

The Commission recommended a series of steps to decrease the relative cost of health insurance to small employers, compared to prices paid by large employers. But it offered little to control the cost of health care purchased by employers large or small.

The Commission proposed practice guidelines -- guidance for physicians on how best to treat a condition -- to control cost and improve quality.

3. The larger share of the federal cost -- $38.8 billion per year -- would be for a new long-term care benefit.

Any American who requires assistance to perform three out of five essential activities of daily living -- eating, dressing, moving around, using the toilet, or bathing -- would be eligible.

The benefit would pay for the first three months of nursing home stays, the majority of stays, although not of nursing home days. Home health care would also be made available to this population.

Longer nursing home stays would be paid for as they are today, through a combination of insurance, savings, and Medicaid. To still make private sources of funds more important, premiums for long-term care insurance would be made tax deductible for individuals.

4. Employers would have the primary role to increase the proportion of the population having health insurance.

All firms of 100 or more employers would be required to provide health insurance to employees and dependents or pay a payroll tax. Smaller firms would at first be encouraged to provide insurance through tax credits and subsidies for low-wage firms, reaching at the most generous a 40% credit for small firms with average wages of $18,000 or less.

After five years, if 80% or more of firms employing 25 or fewer workers do not provide health insurance, then all firms must provide health benefits.

5. Individuals who do not work for firms or who work for firms that do not provide health insurance could buy insurance from a public plan.

The public health insurance plan would begin as a voluntary program for children. After five years participation would become mandatory for all Americans not otherwise covered by health insurance.

Insurance would be priced on an income-related basis. It would replace Medicaid where its benefits overlapped with Medicaid's (e.g., hospital and doctor services). Revenue would be derived in part from the payroll tax on firms not providing health benefits and also from general revenue.

6. The basis for competition in the health insurance market would shift under the Commission's plan.

Health insurers compete on the basis of cost and risk. Because risk involves greater financial variation than the cost of health care, health insurers find greater rewards competing for the best underwriting risks rather than the cost of health care.

The Commission recommends abolishing risk-based competition through community rating. Under community rating, an insurer would have to offer the same rate classes to all purchasers of insurance. Insurers would compete to provide the most efficient, and thus least costly, health insurance package.

Reaction

Most commentators and groups that responded portray the report as either a partial or wrong answer to the right question: how to provide all Americans with health insurance. The American Medical Association has been most enthusiastic; the National Federation of Independent Business the least.

Perhaps the most apt comment came from within the Commission. Rep. Pete Stark proclaimed himself an advocate of the Commission's goals, but said the Commission's failure to say how it all would be paid for made the recommendations useless as the basis for practical action.

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THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 4
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

FINANCING HEALTH AND LONG-TERM CARE

Report to the President and to the Congress

March 1990