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01. Memo	From Andy Card to John Sununu Re: Governor Ashcroft and the Medicaid Situation (2 pp.)	10/22/91	P/5	

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Series: Sununu, John, Files
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WHORM Cat.:
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(Document Follows)
By JJ (NLGB) on 10/28/05

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THE WHITE HOUSE
WASHINGTON

DATE: 10.22.91

TO: Gov. Sununu

FROM: ANDY CARD Andy

Gov. Ashcroft called to discuss what he called a serious problem over the medicaid situation.

He said there are a lot of states "hard pressed on this ... both sides of the isle."

"Assurances from OMB are not comforting."

"The idea of a state by state approach is not selling at all!"

Governors are even talking about making use of other loopholes, including designating "Disproportionate Share Facilities." (Gov. Ashcroft believes a couple of states are already trying this.)

The DSF loophole can only be close w/ legislation. Gov. Ashcroft believes OMB (Scully) may be interested in working with the Governors to

close the DSF loophole. The Govs would be interested if they could work something out on the current situation.

Do you want to signal to OMB to work w/ the Govs to find a solution?

(That is Gov. Ashcroft's hope!)

THE WHITE HOUSE
WASHINGTON

DATE:

TO:

FROM: ANDY CARD

BILL GRADISON
2D DISTRICT, OHIO

MARGARET TOTTEN
ADMINISTRATIVE ASSISTANT

COMMITTEES:
WAYS AND MEANS
BUDGET

Congress of the United States
House of Representatives
Washington, DC 20515

1125 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
TELEPHONE: (202) 225-3164

8010 FEDERAL OFFICE BUILDING
550 MAIN STREET
CINCINNATI, OH 45202
TELEPHONE: (513) 684-2456

June 20, 1991

Dear Colleague:

Much has been said recently about the Canadian health care system.

Attached is a copy of a letter which Dr. Bruce Bracken, a Canadian physician now practicing in Cincinnati, sent to one of his U.S. colleagues. Dr. Bracken graciously gave me permission to share his letter with you.

I think you'll find his comments to be interesting, though sobering.

Sincerely,

Bill Gradison
Representative in Congress

Attachment

University of Cincinnati
Medical Center

College of Medicine

Department of Surgery
Division of Urology

Mail Location 589
231 Bethesda Avenue
Cincinnati, Ohio 45267-0589

MAY 2 0 1991

May 14, 1991

Josef E. Fischer, M.D.
Professor and Chairman
Department of Surgery

Dear Joe:

This is a note summarizing some of my views on the Canadian health system which leads me to find consideration of its introduction into the United States almost appalling.

The main problems with the Canadian health system are that every bottleneck is 100% occupied. For this reason, CAT scanning, MRI scanning, extracorporal shockwave lithotripsy, and many other lesser testing facilities have long waiting lines. Extracorporal shockwave lithotripsy's waiting line is about 14 months in Ontario, and actually this delay makes the radiographic studies which initially demonstrated the need for ESWL out-of-date by the time the treatment is actually given.

When the Canadian hospitalization took over in 1968, both the active treatment facilities as well as the convalescent hospital occupancy became 100%. This has led to waiting lines for both of these institutions, which is the main determinant of inpatient care.

Outpatient care in Manitoba (my home province) leads to a three to four-month waiting period in order to evaluate a renal mass to see if it is benign or malignant. The waiting line in hospital means that urologists "try to get their testicular cancers in as soon as possible" and usually get these men in the hospital within two or three weeks. Other tumors and other lesser events (in the physician's mind) take longer.

Briefly, my father's experience is as follows: He is the son of the Premier of Manitoba, and a former leader of the official opposition party in Canada from 1940 until 1946. He, therefore, is relatively well connected.

He was told that in order to have a hip replacement, he would need to have a transurethral resection of the prostate. My partner evaluated his prostate and found that he had a flow rate of 32 cc/second, which would make him ineligible for any type of therapy by our standards.

He underwent a transurethral prostatectomy during which he had a 14-day in hospital convalescence using the old fashioned Kelley drip. He had a diagnosis made of prostate cancer, and when we reviewed the slides at the University of Cincinnati, fortunately we found that the pathologist had made a mistake and the tissue was, in fact, benign.

He had to wait three or four months to get his transurethral resection, and then waited another six to nine months in order to get his hip fixed. During the waiting, the patient is told that "the hospital will call when it gets a bed". The patient does not have any idea on what day of the week or even what month that this will occur. When they actually get the telephone call they are asked to come in the following day. When my father eventually did get his hip fixed, it went relatively well and his hip pain was gone. However, he did develop a fairly severe backache, which meant that he could not sit for more than a few minutes at a time. To illustrate this, a new car that he had purchased in the Spring had only gone three hundred miles six months later when his pain ultimately was improved. He was unable to drive the forty-five miles to a Summer home all Summer long. When his orthopedic surgeon recommended my father seek a pain clinic appointment, the waiting list was four months. Fortunately for him, an appointment became available three months after back pain developed. At that appointment, he had a injection of corticosteroids and his backache resolved, he was able to sit, play golf, drive his car etc. During this long time without pain control he felt very poorly and as many 77-year-olds do under such circumstances, became depressed, lost weight etc.

About two years later, his hip started to cause more trouble and he needed to have another hip prosthesis placed. He again went on the waiting list and some nine to ten months later, was admitted to the hospital to have his hip reoperated upon. This went relatively well, but due to his long wait, a back operation which needed to be done was done about two weeks after his hip was fixed. Although both operations were technically successful, they were done in an individual who was quite elderly, and clearly there was too much surgery done on him in too little time. This resulted in a prolonged postoperative convalescence with subsequent deterioration of morale etc.

At this point my father is still walking on crutches, is for all practical purposes is stable, and has had all of this happen to him even with the so called benefits of modern medical therapy.

The small percentage of Canadians that actually require major use of the hospital system are generally similarly cared for. As you know, patients die on the waiting list for cardiac surgery, and most medical conditions other than frank emergencies go on an interminable wait, which interestingly seems to be tolerable to Canadians.

It is the lack of service and the lack of quick response to patient needs that differentiates the Canadian from the American system. In our country, we can work up a renal mass in two or three days rather than three or four months, and in our country we admit patients with testicular cancer within twenty-four hours rather than within two or three weeks if the beds are not too tight. All of this costs more money, but allows the American physician to be a patient advocate rather than in Canada, the patient actually has no advocate whatsoever. If the patient wishes to have his tests or his hospitalization moved up, he is generally given the retort, well, are you more important than the other people who are waiting for that particular test.

Most Canadians do not feel that there is much they can do about their system, because it is "run by the government" in which few have a voice.

I doubt that the American mentality would permit a system such as this to occur. The major loss however, from a physician point of view, is the lack of opportunity to be a patient advocate.

If I can be of any further service in this matter, please let me know.

Sincerely yours,

Bruce

R. Bruce Bracken, M.D.
Professor and Director
Division of Urology

RBB:jf

State of South Carolina

Office of the Governor

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THE CHIEF of STAFF has seen

DATE: 8/30/91

TO: John Sununu
The White House

FROM: Governor Carroll Campbell
South Carolina

Total number of pages (including cover page) 3

Message:

State of South Carolina

Office of the Governor

CARROLL A. CAMPBELL, JR.
GOVERNOR

POST OFFICE BOX 11369
COLUMBIA 29211

August 30, 1991

The Honorable Louis W. Sullivan
Department of Health and Human Services
200 Independence Avenue, S. W.
Washington, D. C. 20201

Dear Dr. Sullivan:

I have recently studied the new regulations as proposed by HCFA eliminating the use of donated funds and provider taxes for Medicaid services. I agree with your goal of an effective Medicaid Program that finances essential health services for the disadvantaged through a solid Federal-State partnership, but it is essential that some flexibility be considered in dealing with such a large shift of funding responsibility to the states.

With federal mandates continuing to filter out of Congress, and the implementation of these new regulations, South Carolina's options for financing Medicaid costs are limited. The impact on our state budget will be disastrous. Given the current economic situation in the country, these regulations could not have come at a more inopportune time. It is essential that we recognize and address the problems of our nation's entire health care system.

While I anticipated that action would be taken to restrict growth in the Medicaid payments, I did not think that HCFA would propose the total elimination of these two revenue sources. These new regulations leave us with few options. Our state would have to completely eliminate our Medicaid drug program and community based service program for the elderly and severely limit our services to those with incomes below the poverty level. All recent initiatives related to infant mortality and teen pregnancy would also be eliminated. The effect would be catastrophic on South Carolina's health care system.

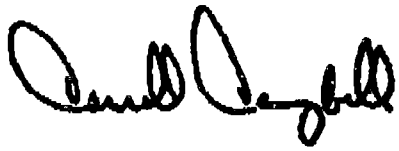
I am concerned that the HCFA staff does not understand the true fiscal impact of the regulations on the states. The effect on Medicaid programs in South Carolina alone would result in a funding loss in excess of $500,000,000 from

combined sources. The implication for program elimination and cutback is staggering.

I urge you to reconsider the regulations you signed on July 31, 1991. I cannot express how strongly I feel regarding this issue. The health care of our nation's poor elderly and poor children will suffer immeasurably.

Thank you for your consideration.

Sincerely,



Carroll A. Campbell, Jr.
Governor

cc: The Honorable John H. Sununu
The Honorable Roger B. Porter
The Honorable Richard G. Darman
The Honorable J. Strom Thormond
The Honorable Ernest F. Hollings
The Honorable Floyd D. Spence
The Honorable Butler C. Derrick, Jr.
The Honorable John M. Spratt, Jr.
The Honorable Elizabeth J. Patterson
The Honorable Robin M. Tallon, Jr.
The Honorable Arthur Ravenel, Jr.
Ms. Gail R. Wilensky

AMERICAN MEDICAL ASSOCIATION AMERICAN HOSPITAL ASSOCIATION

BLUE CROSS AND BLUE SHIELD ASSOCIATION

HEALTH INSURANCE ASSOCIATION OF AMERICA

June 24, 1991

John H. Sununu
Chief of Staff
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

THE CHIEF of STAFF has seen

Dear Governor Sununu:

We, the chief executives of the American Medical Association, the American Hospital Association, the Blue Cross and Blue Shield Association and the Health Insurance Association of America, are happy to send to you the attached document, which has evolved from a series of meetings we have held over the past year.

"National Health Care Reform: Objectives and Strategies" reflects our shared views on what should be done to solve the problems facing our nation's health care financing and delivery system. Each of our organizations has policy which amplifies and goes beyond what is contained in this statement, but we are pleased and encouraged that we share so many values and remedies.

In the very near future we will contact you regarding a meeting to discuss our views.

Sincerely,

Jack Owen
Acting President
American Hospital Association

Carl J. Schramm
President
Health Insurance Association of America

James S. Todd, M.D.
Executive Vice President
American Medical Association

Bernard R. Tresnowski
President
Blue Cross and Blue Shield Association

enclosure

NATIONAL HEALTH CARE REFORM: OBJECTIVES AND STRATEGIES

American Hospital Association
American Medical Association
Blue Cross and Blue Shield Association
Health Insurance Association of America

June 1991

NATIONAL HEALTH CARE REFORM: OBJECTIVES AND STRATEGIES

Health care in the United States is at a crossroads. American health care provides the most advanced technology, the finest hospitals, and the best trained professionals in the world, and our public-private system of coverage provides the vast majority of Americans access to that care and protection from financial hardship.

The system, however, is not free from some severe problems. The absence of coordinated incentives can result in both poor quality care and inefficient use of resources. Rigorous economic discipline is absent from health care decision making by providers, consumers, and purchasers, leading to persistent increases in costs, despite some progress in recent years. At the same time, nearly one out of six Americans -- more than 30 million people -- are without coverage for even basic medical care. Public programs for those not able to pay for their own care are underfunded and offer widely varying benefits.

The American Medical Association (AMA), the American Hospital Association (AHA), the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA) share many views on the major public policy strategies necessary to reform the health care system as we approach the next century.

Underlying these commonly held views are several shared beliefs:

- A new national health policy is needed in order to bring about change in the current conditions in the health care system.
- The health care system must be designed to meet the needs of communities and patients.
- Efforts to reform the health care system can and should build on the strengths of our employer-based and pluralistic health care delivery and financing system.
- All the major participants in the health care system -- providers, insurers, government, employers, unions, individual employees and other consumers -- contribute to the problems we face, and all will need to contribute to the solution.

Each of our four organizations develops policies which reflect the views of our own constituents, and each of us will choose our own course of action. However, we are in agreement as to the issues which must be addressed:

- **cost**
- **access**
- **quality**

The discussion which follows outlines joint objectives and strategies for reforming the system.

A. The Cost of Care

Objective:

Restrain the rate of increase in national health care expenditures.

Strategies:

1. Align the incentives guiding consumer, provider, purchaser and insurer practices, so that only appropriate care is given and in the least costly setting.

   Some current incentives foster behavior by consumers, providers, insurers and payers that can be at cross-purposes with cost management objectives. Health care financing and delivery mechanisms should be established that work together, reinforcing cost management and quality objectives while promoting access to needed care.

   For example, managed care options and cost-sharing benefits provide incentives for enrollee support of cost management programs. Similarly, provider-payer contracts, defined on the basis of clear performance criteria, can be used to establish effective incentives for cost management.

2. Develop more effective mechanisms to assess the cost and value of health care services and technologies; incorporate such information into practice parameters.

   Society must address care at the margins by establishing mechanisms for assessing the cost-effectiveness and cost benefit of new and existing technologies and practice. One objective is to identify care that is expensive but of little long-term value to patient recovery or quality of life.

   Practice parameters are educational tools which need support of the medical profession, health care institutions, payers, patients and the government. They will provide a way to guide payment decisions and help reduce unnecessary care.

   The AMA and a broad coalition of specialty societies are developing scores of parameters and moving to set up an approval process across medicine.

3. Help make low-cost insurance products available to the market by waiving state benefit mandates.

   It has been variously estimated that state benefit and provider mandates -- now numbering over 800 -- raise the

cost of premiums from 6 to over 20 percent. Large employers can avoid mandates by self-insuring. Small employers cannot always afford any coverage at all.

Recently, a number of states have waived laws that mandate certain types of expensive coverage, allowing insurers to offer small businesses and the self-employed low-cost health plans. This approach would build on that development.

4. Provide targeted public subsidies, including tax credits, so that financially vulnerable employers and employees can afford health insurance coverage.

   Special tax credits or other subsidies are needed for small businesses, for businesses in their early years of operation, and for low-income workers.

   Small businesses tend to be younger, financially less stable and employ a lower-wage work force. Thus, health benefits often represent a greater financial burden to small businesses, who are far less likely to offer them than are other employers.

   Self-employed small businesses should be helped to afford coverage by extending to them the 100 percent tax deduction that is available to other (incorporated) employers. Eleven percent of uninsured workers are self-employed, and currently receive only a 25 percent income tax deduction for the cost of health benefits.

5. Improve and streamline administrative procedures in claims processing and utilization management, to reduce the cost and complexity of compliance by providers, insurers and consumers. The eventual adoption of paperless systems is a long-term goal.

   The proliferation of administrative requirements has become a burden for many, and under some circumstances adds cost rather than saves expense.

   There are many ways to streamline and simplify the administration of health benefit plans. For example, insurers can coordinate their utilization review procedures to be more consistent with one another. They can also move to electronic mechanisms for processing claims to eliminate paperwork. Hospitals and physicians can contribute to greater administrative efficiency by developing, in cooperation with payers, more uniform billing methods and improving patient care coding.

   The recently-published "Guidelines for Health Benefits Administration - Concurrent Review and General Administrative Procedures" were developed jointly by representatives of AHA, AMA, BCBSA and HIAA, as well as

by the American Managed Care and Review Association. They were prepared to encourage greater consistency in the structure and operation of utilization review programs and to assure that such programs are implemented with minimal disruption to the delivery of medical care.

6. Modify tort law at federal or state levels to speed resolution of disputes, reduce unnecessary costs of defensive medicine and provide reasonable provision for injured patients.

During the 1980s, medical liability premiums tripled, making them by far the fastest growing component of physicians' practice expenses during that decade. These premium costs are supplemented by defensive medical practices, and the AMA estimates that together these added $21 billion to the cost of physician services in 1989.

Hospitals have also experienced substantial increases in medical liability premiums and, in some areas, have had critical operations disrupted as a result of the loss of physicians practicing in high risk specialties. Hospitals also face an increasing tendency of juries to award extraordinarily high and disproportionate punitive damage awards, which are generally uninsurable and which can threaten the financial viability of the hospital.

Medical liability litigation has had a direct and negative impact on patient access to health care; a government task force report documented 150 examples of access impairment related to professional liability premiums in 26 states.

B. Access to Care

Objective:

Provide universal access to health care services for all Americans, with clearly delineated roles for the public and private sectors.

Strategies:

7. Make available a set of benefits which cover at least inpatient and outpatient hospital, physician and diagnostic services, with reasonable cost sharing.

8. Extend Medicaid to all persons below the federal poverty level; fund the expansion through broad-based taxes. Priority should go to children.

Thirty percent of the uninsured have family incomes below the federal poverty level; another 17 percent have family incomes between one and one and a half times the poverty level. Medicaid currently covers only four out of ten poor Americans.

Raising eligibility standards will give an estimated 9.5 to 11 million uninsured Americans access to Medicaid (in addition to the 21 million now covered), while increasing Medicaid costs by only about 25 percent.

9. Establish state pools for medically uninsurable individuals where no other coverage option exists. Losses should be financed by broad-based funding.

   To date, 22 states have enacted broad-based pools for uninsurable individuals.

10. Reform the small employer market in order to guarantee readily available ongoing coverage.

    Small employers (usually defined as under 25 employees) often have difficulty securing, affording or keeping adequate coverage due to the health status of one or more employees. There are a number of mechanisms under discussion that would make coverage continuously available to all employers and their employees, including, for example, reinsurance structures (funded jointly in an equitable manner by all participants in the small employer market) which could spread the cost of enrolling people with high medical risk fairly among all insurers.

    Other proposals include establishing reasonable rules for business practices, such as assuring renewability and continuity of coverage regardless of health status, and establishing limitations on how much rates could vary for groups similar in geography, demographic composition and plan design.

11. Eliminate cost shifting to business by improving government payment rates to providers under Medicare and Medicaid.

    The Physician Payment Review Commission reports that payment rates for Medicaid vary dramatically from state to state; they are often only half of physicians' usual fees. Medicaid payments to hospitals were $4.3 billion below hospitals' actual costs in 1989.

    Because of budget cuts, Medicare is falling further and further behind in paying its appropriate share, causing both business and individuals to pay more than their share.

12. All the above strategies are intended to achieve a significant increase in the number of Americans with health care coverage. Should they not achieve this objective, an insurance coverage mandate might be considered.

13. Provide all Americans with access to affordable long-term care services, including institutional and non-institutional care.

    In order for the private market for long-term care insurance to expand, the government will have to define its own role in financing long-term care.

    Private long-term care insurance should be granted the same tax status as health insurance with regard to the premiums paid and benefits received under individual and group long-term care contracts.

C. **Quality of Care**

Objective:

Reinforce quality as an integral consideration in the delivery and financing of health care services.

Strategies:

14. Improve the mechanisms for measuring quality of care.

    Measuring the quality of medical care requires the careful evaluation of a broad range of complex technical factors. No one measure can adequately evaluate all the dimensions of medical care.

    Many quality measures have been developed, including review criteria, clinical indicators and appropriateness criteria. The use of large health databases to study health outcomes and geographic variations in utilization offer additional opportunities to measure quality of care.

15. Develop, refine and expand mechanisms used to disseminate information on quality of medical care to physicians, hospitals and other providers of health care, as well as to insurers and payers.

    Improved feedback mechanisms that provide useful information to enhance the quality of medical practice should be developed. Practice parameters and other tools to improve clinical decision making are important mechanisms to provide educational information to physicians and others. The use of practice parameters as a foundation for quality evaluation and quality improvement should be expanded.

16. Develop quality measures useful to consumers and educate them about their role in the provision of quality medical care.

    Informed decisions by consumers improve the quality of care. Quality measures that accurately inform consumers should be developed. Additional research to develop quality measures for use by consumers should be conducted. More effective mechanisms to communicate information to the public on the quality of medical care should be developed.

    Consumers should be educated about their role in the provision of quality medical care, including the appropriate utilization of health care and preventive care services.

17. Strengthen the accreditation process for the review of health care systems as a mechanism to promote quality medical care.

    Accreditation can be a valuable indicator of the quality of care provided in various patient care settings. Accreditation assures providers, consumers and payers that the quality of care in accredited patient care settings meets prescribed standards.

THE WHITE HOUSE

WASHINGTON

July 11, 1991

THE CHIEF of STAFF has seen

MEMORANDUM FOR GOVERNOR SUNUNU

FROM: DAVID M CARNEY
SPECIAL ASSISTANT TO THE PRESIDENT AND DIRECTOR, OFFICE OF POLITICAL AFFAIRS

SUBJECT: HEALTH CARE

FYI - I thought you might be interested in the attached.

PUBLIC OPINION STRATEGIES

July 8, 1991

Mr. Dave Carney
The White House
1600 Pennsylvania Avenue
Washington, D.C. 20500

Dear Dave:

On May 22, the National Health Policy Forum sponsored a seminar on "Opinion Surveys and the Policy Process: Health Care Perspectives." I spoke along with Dr. Robert J. Blendon, Chairman of the Department of Health Policy and Management at the Harvard University School of Public Health.

Since that time, I have given a similar presentation to a number of health groups around town. Given your interest in how this issue might impact the 1992 election cycle, I have enclosed a package that summarizes my presentation and shares a good portion of the data presented. (I am indebted to Dr. Blendon as I have incorporated data from his presentation as well. My further acknowledgment and thanks to Dr. Richard Wirthlin as I have also incorporated work conducted by The Wirthlin Group.)

Let me briefly summarize our perspective on the issue:

- Health care is emerging as a partisan political issue as witnessed by its use in a number of 1990 campaigns;

- Demographic trends (the aging of America) and the current realities of the health care system (people <u>are</u> paying much more for insurance coverage and care) assure the growing importance of the health care issue;

- The health care issue may or may not be an important facet of the presidential campaign, depending on the status of the economy and how it is developed by the Democrat nominee;

- The Roper data over the past twenty years does demonstrate a growing level of dissatisfaction with access to care, quality of care, and the payment system;

- Indicative of this level of dissatisfaction, growing numbers of people <u>say</u> they would support a greater federal role;

PUBLIC OPINION STRATEGIES, LP.
99 Canal Center Plaza • Alexandria, VA 22314 • (703) 836-7655 • FAX: 703-836-8117

- However, people are dramatically misreading this data if they really believe that Americans support "a Canadian-style universal government-paid health care system in the United States."

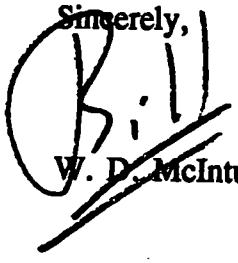
Please note however that recent data has already shown me wrong on one critical point. In a recent national survey, the Democrat party was roughly 30% ahead of the Republican party in terms of which party was best prepared to "improve health care." The Democrat margin on this question was far higher than I speculated during my presentation in late May. (Although I would like to "save face" and argue this represents an erosion for the Republican party since late May, it is more plausible that I was simply wrong at the time.)

The generic Democrat advantage on this issue has broad implications for how the two parties are likely to handle the issue. Public Opinion Strategies will be doing national research at least every two months and will continue to monitor this particular party handling question closely.

Looking ahead a bit, in July, we will start tracking a core set of health care questions that we will replicate once every six months. We will keep you posted on the results.

Please feel free to call me if I can be of any additional assistance as regards our thoughts on this topic.

Sincerely,



W. D. McInturff

Enclosure

PUBLIC OPINION STRATEGIES

NATIONAL HEALTH POLICY FORUM

May 22, 1991

Talking Points and Accompanying Materials

Materials Prepared by:

W.D. MCINTURFF

PUBLIC OPINION STRATEGIES, LP
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NATIONAL HEALTH POLICY FORUM

Talking Points/Outline: May 22, 1991

OPENING REMARKS

The health care issue is going to increase in importance as a public policy issue. A host of factors help make this case:

1. The aging of America ...

   - 1987 was a watershed year, with more people over the age of 65 years old than under the age of 13. An aging America means:

     - More concern with dependent care (how do I take care of my children and my aging parents at the same time?);

     - The need for long term health care; and

     - Increased attention to the issues of access and cost of care.

2. A "me too" issue in 1990 focus groups ...

   - A standard opening for our focus groups is to ask people "what issue or issues are of concern to you and to your family." I was especially struck in 1990 by what I like to call a "me too" response in our focus groups. One participant would tell a story about health insurance costs or being cut-off from care as a problem/concern and immediately there would be a strong chorus of "me too" stories. My own experience is whenever you have touched a "me too" issue in a focus group, something important is beginning to happen about that issue.

3. The growing use of health care as a partisan issue ...

   - In 1990, Baron Hill in Indiana and other long-shot Democrat challengers all jumped on the "Canadian health care system" rhetoric. What struck me was the relative similarity in timing and the similarity in rhetoric and campaign use about this question. Indeed, it is easy to see why Democrat challengers will continue to raise this issue:

     - It has strong appeal to their core constituency groups (African-Americans, lower income respondents, older Americans, etc.); and

     - The issue has the potential to "cut" with swing groups such as Independents and other "ticket-splitters."

4. The AMA initiative last week is to me the final evidence that indeed momentum is building for change.

   - I think the AMA has learned a lesson from the NRA ... which is to be a "player" you have to be willing to put the ante on the table. In this case, demonstrating some willingness to rethink long held positions is the necessary opening chip.

   - The point is that in my opinion the AMA initiative would not have taken place unless they were pretty convinced the train was leaving the station ... with or without them.

So, if the health care issue is going to be a bigger deal, what do people think, what are people's attitudes about different elements of the health care agenda.

1. One should not place to much stock in current data that shows that two-thirds of Americans "support a health care delivery systems built along the Canadian model." Trust me ... people have no idea what this really means and this data is incredibly "soft." In this context, "soft" means that attitudes will shift dramatically once people better understand the pros and cons of this system.

2. You need to distinguish between people's assessment of their medical care (which they think is pretty good) versus the payment system issue (which they are not happy with).

3. This issue needs an "enemy" or some sort of "bad guy" ... again, I think there is a more likely chance it will be the insurance companies and not doctors per se that would take the biggest "hit" in public esteem as this issue gets sorted out.

4. I know the big debate focuses on the 37 million Americans with no health coverage. But that means that 200 million plus people are covered. My guess is this is the time to start tracking the percentage of people whose deductibles are going through the roof or are being cut-off from selected medical care coverage. It would be my sense that "reform" is more likely as the numbers of these "disaffected" consumers rises.

Finally ... are we likely looking at a mood that generates radical or dramatic reform?

1. No.

2. The pain involved in the cure has to be less than the pain caused by the disease ... and from a public opinion standpoint, I am not at all convinced that this level of dissatisfaction exists, at least as of today.

3. Reform requires the participation of Congress. Politicians (at least most of them) tend to be: 1) cautious; 2) incrementalists; and 3) not likely to want to be the first one on their block left out on a limb.

4. Oh, and by the way, as a Republican, it is worth noting the notion that we should move to some sort of system where the federal government gets even more involved in the delivery of care makes me very nervous. In other words, what to some might be considered a "block" to "reform," is a legitimate (and strong) difference of opinion about who is best situated to help provide the solution to the current health care system.

Now, having made those points, let's look at some data ...

THIS IS NOT THE ORDER OF PRESENTATION. TO MAKE MY LIFE EASIER, I HAVE SPLIT THESE BETWEEN MY "POLITICAL" CHARTS AND THE NATIONAL HEALTH CARE DATA FROM 1990. FURTHER, LET ME HIGHLIGHT JUST A FEW ADDITIONAL KEY POINTS I MADE AFTER SHOWING THIS DATA. (In addition to this material, I also used slides from my "ten trends" presentation which places the health care issue in a broader perspective.)

"Political charts" ... (labeled set # 1):

1. 1900 ... a woman spent 17 years raising a child and 8 years taking care of an elderly parent.
   1990 ... a woman will spend 17 years raising a child and 18 years taking care of an elderly parent ...

   Trust me, "dependent care" will become a big deal.

2. Party ID data demonstrates my point about "permanent gender gap" as well as key party ID differences by age. One additional chart puts into perspective how the Democrats are focusing on "high base/high swing" precincts.

3. Party attribute chart makes the point that:

   - Dems do enjoy a probable 10% to 15% advantage on this issue, but only a relatively few people yet associate this issue with either party:

     - Democrats do not have one cohesive point of view ... and
     - Focus groups suggest that people worry even if Democrats "care" about the issue ... could they indeed actually make anything work?

TO MAKE MY LIFE EASIER, I HAVE SPLIT THESE BETWEEN MY "POLITICAL" CHARTS AND THE NATIONAL HEALTH CARE DATA FROM 1990. FURTHER, LET ME HIGHLIGHT JUST A FEW ADDITIONAL KEY POINTS I MADE AFTER SHOWING THIS DATA. (In addition to this material, I also used slides from my "ten trends" presentation which places the health care issue in a broader perspective.)

Set #2 ... health care charts:

NOTE: THIS DATA IS PROPRIETARY AND SHOULD NOT BE REPRODUCED OR USED PUBLICLY (please call Bill McInturff prior to using data).

1. Used the Connie Hoerner line that national health care would mean:

   - Efficiency of the post office;
   - Compassion of the IRS; and
   - Cost control of Pentagon purchasing.

2. Said that is was pretty clear to me based on the data that I have seen:

   - People absolutely want to be able to select their own doctor; and
   - Once people realize that optional surgery in Canada can take six months to two years, it measurably dims the enthusiasm for the Canadian system.

3. That people are nuts if they believe the data really demonstrates people would be willing to raise taxes to pay for these programs:

   - Non-political pollsters do not ask the follow-up question, "how much?" Even when the data does exist as Dr. Blendon just showed you, that so-called one-third who respond "don't know" on the "how much" question really mean not a dime. Simply put, as on the Canadian system question, you take one-third of the 66% who support this idea that's 22% ... or now you no longer can sustain majority support. And that's why this stuff would probably not be able to survive an initiative or referendum election.

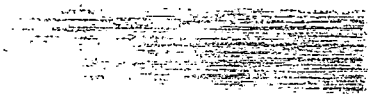
4. Why won't people support higher taxes:

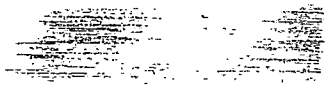
   - They do not believe the money will really be used for what it was intended for
   - They do not believe there is such a thing as a "temporary" tax or surcharge ...
   - They do not want the "camel's nose under the tent" because they believe that once a new and limited tax is started ... the dollar amounts will quickly escalate.

5. I said the report of two weeks ago that compared our 100 billion dollar "paperwork" cost versus the (roughly) 13 billion dollar tab in Canada was a potentially crucial political document as Democrats would use this for cover about where the money would come from to expand health care programs.

6. I said that the Johnson/Chandler bill was crucial as it provided a private option that Republicans should be able to comfortably talk about rhetorically.

7. On the other hand, the reason that Republicans did not want to stray into these waters is the widely held view that you can <u>not</u> "outbid" a Democrat and so accordingly, Republicans did not like to talk about this stuff.





SUMMARY POINTS

Bush was not likely to want to make health care reform an issue in the 1992 election.

1. 1988 ABC exit poll data suggests that the nine percent (9%) of the people who selected "health care" as their number one issue in the 1988 exit interview data consisted (primarily) of the following sub-groups: 1) uninsured; 2) poor; 3) blacks; and 4) Hispanics. Well, here's the same exit data in terms of what percent each of these sub-groups voted for Dukakis:

1988 EXIT INTERVIEW

Sub-group	Dukakis percentage
Uninsured	56
Poor	62
African-American	88
Hispanic	64

Hmm, doesn't seem to me that these "health care voters" are exactly the core of the Bush winning coalition.

2. Health care is not an historic fulcrum issue in deciding a presidential election. What are these "fulcrum" issues: 1) peace; 2) prosperity; and 3) personal leadership qualities. An incumbent president continues to have an enormous ability to attempt to control the agenda ... and to the extent the Bush campaign can do this, the agenda they will be pushing will probably not include a heavy dose of the health care topics.

3. It is unusual for an issue to be "slugged out" first at the presidential level ... issues normally filter up ... in other words, if health care were going to be a big deal issue in 1992, we would have seen more partisan debate on this issue in the 1990 congressional campaigns.

4. In my mind, there really is no proof yet that people can be moved from general concern to really supporting the type of radical changes being discussed.

There are though some important caveats as regards this issue in the context of a presidential campaign:

1. Hey, once there is a Democrat nominee, he or she also commands an ability to also attempt to set an agenda. If the Democrat nominee selects health care reform as a key issue (and there are a lot of reasons why they should consider this) ... the Bush campaign could well be dragged into spending much more time on this than is their likely preference.

2. The Democrats could easily focus first on cost containment issues and combine this with banging around "big insurance" companies and other interests ... this could be pretty effective.

SO HOW DO YOU MAKE HEALTH CARE A BIGGER ISSUE

1. Stop selling the 37 million people with no insurance and start also selling the xx millions of people whose deductibles are going through the roof, the yy millions whose medical bills are no longer being covered because they switched carriers, etc.

2. Do not buy the argument that folks are going to happily line up to pay more in taxes so they can wait six months for optional surgery.... that's nonsense.

3. Select an enemy ... and start demonstrating that the pain of the problem is worse than the pain of the solution.

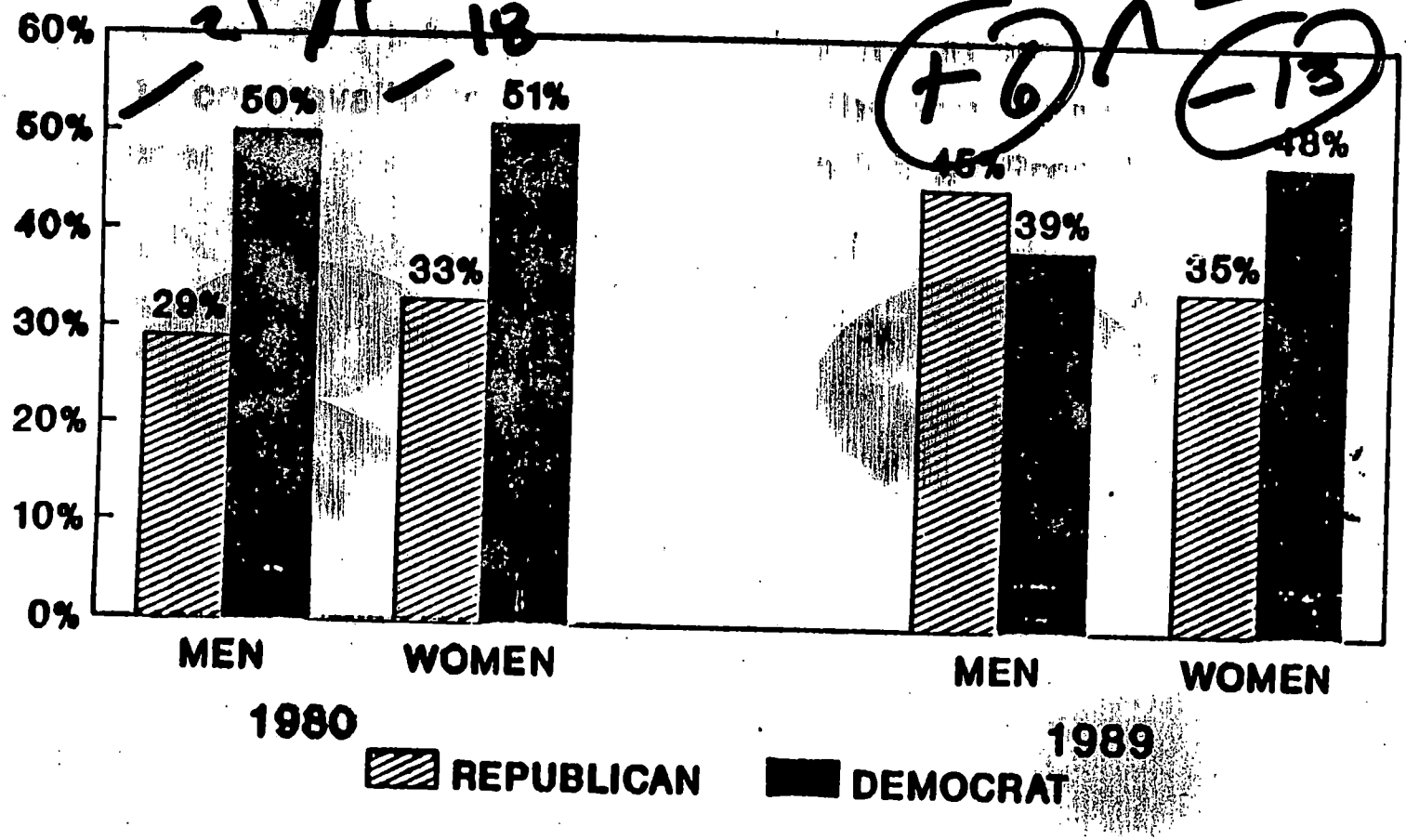
4. Stop focusing on the presidential election and start focusing on longer shot congressional and senate challengers. If people start winning upset elections and they attribute their win to the health care issue, the new Member of Congress will sell his or her colleagues and they will jump on the bandwagon.

5. See if Rod Chandler uses his own bill in his Senate campaign in Washington and with what impact ... to me, this is an important pivot to what ultimately happens on this issue (at least within the Republican caucus).

SET #1

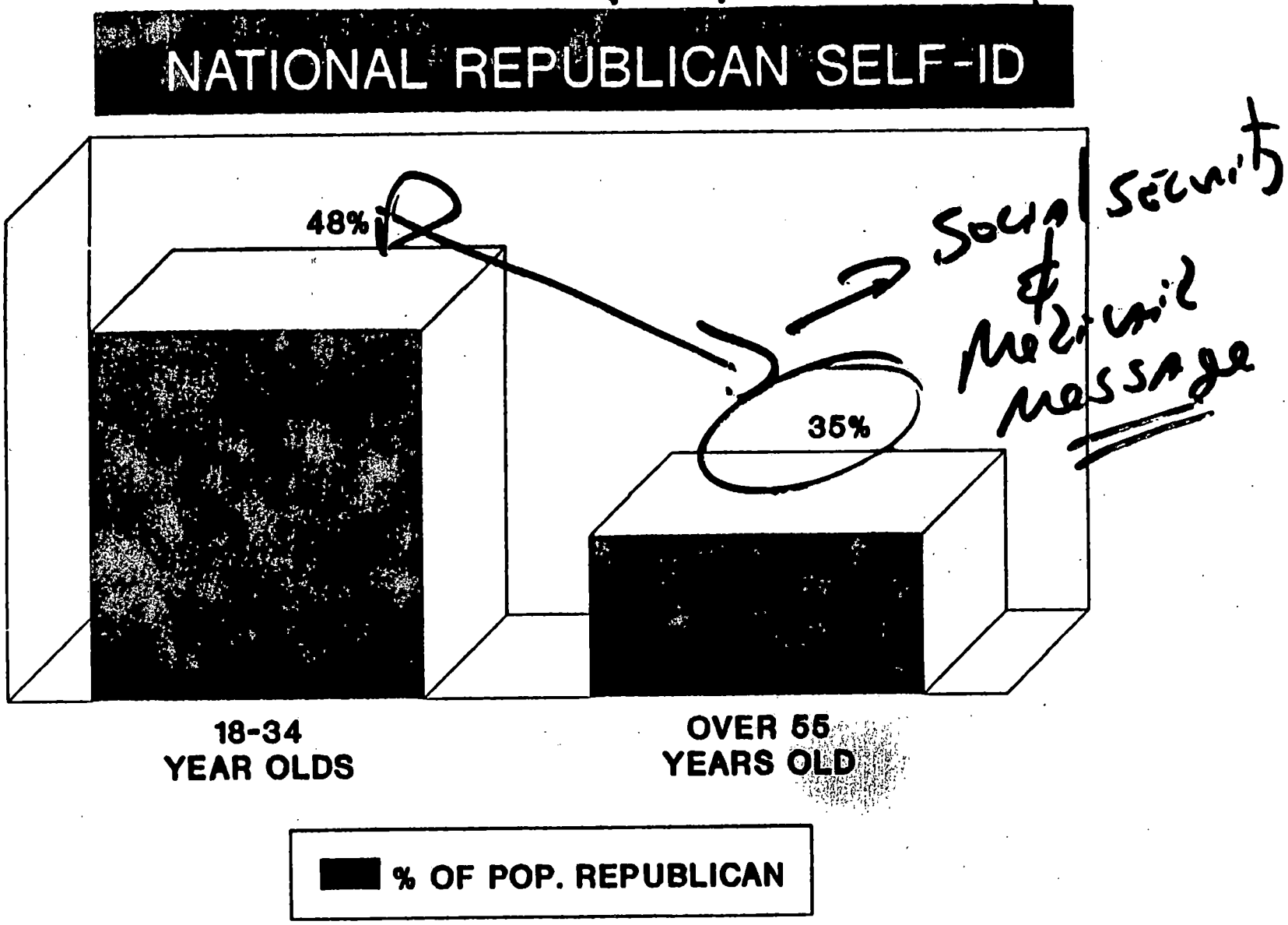
POLITICAL CHARTS

PARTISAN REALIGNMENT IN THE 1980's BY GENDER



SOURCE: WIRTHLIN GROUP SURVEYS

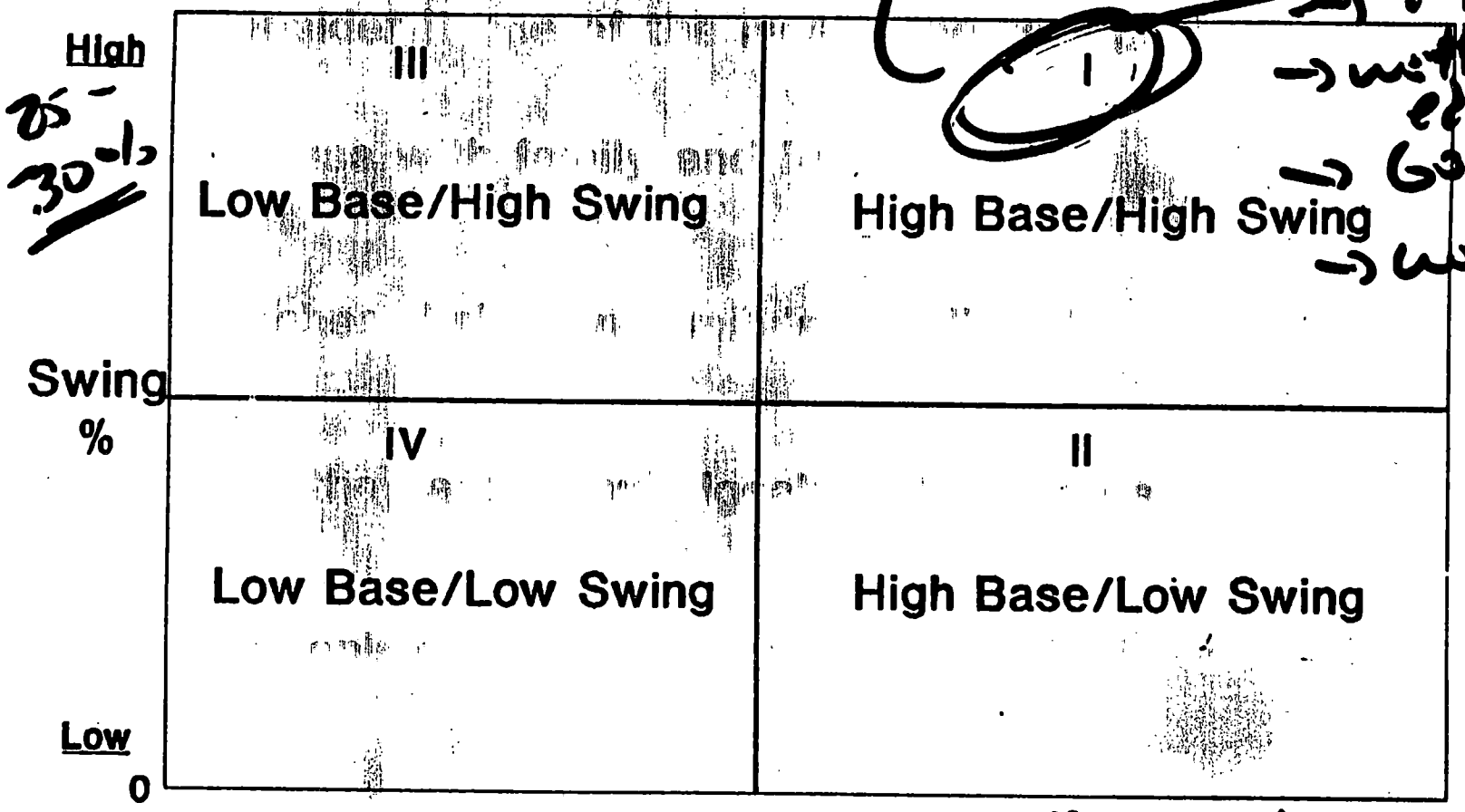
Aging of America — Why GOP lost control of the Senate



Social Security & Medicaid message

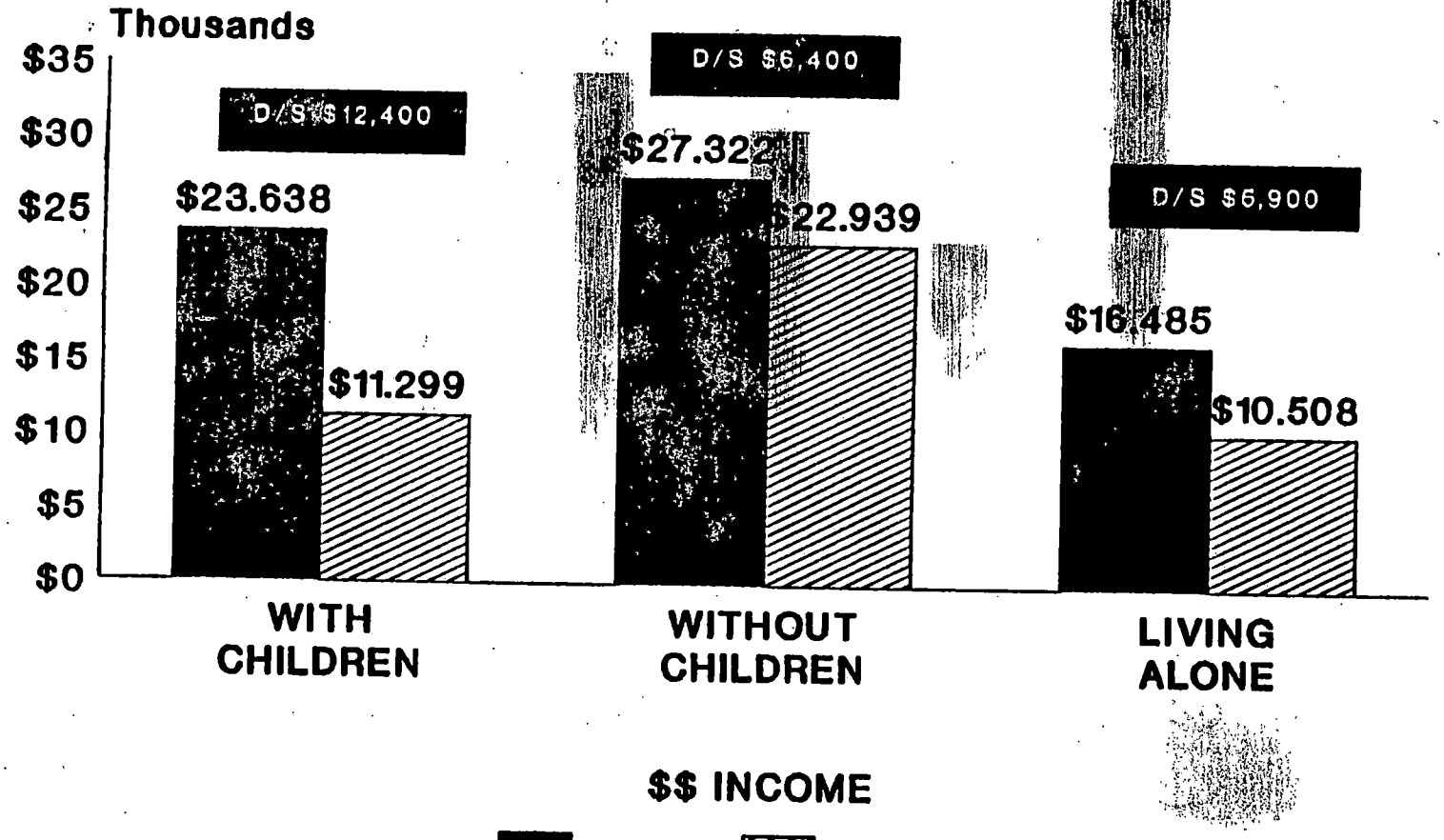
→ Albuquerque
→ Meetings

Precinct Targeting
(By Base/Swing Vote Percentage)



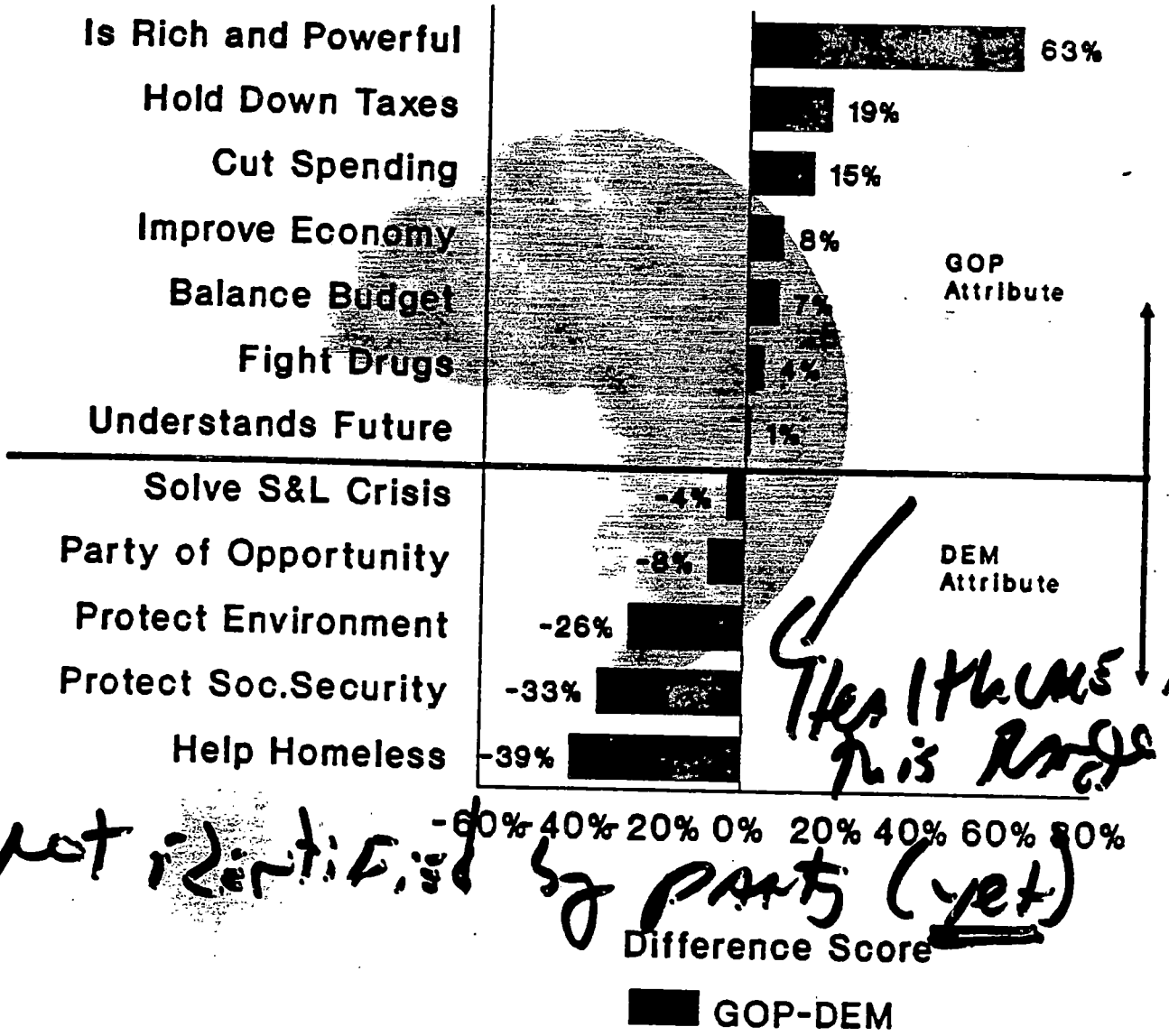
The Wirthlin Group

INCOME DISCREPENCY
MEN VS. WOMEN



WIRTHLIN GROUP SURVEYS

Rating Political Party Attributes
--Post Election Survey--



Then it's time it is Ready

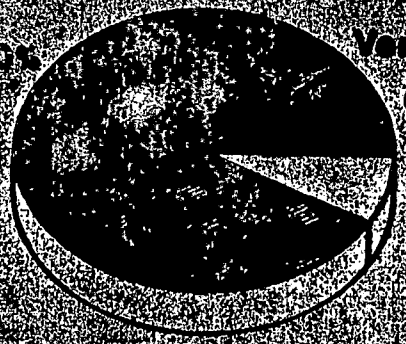
(1) Not identified by party (yet)

(2) Dem proposal not clear

(3) Dems "Care" - but can't make quit work

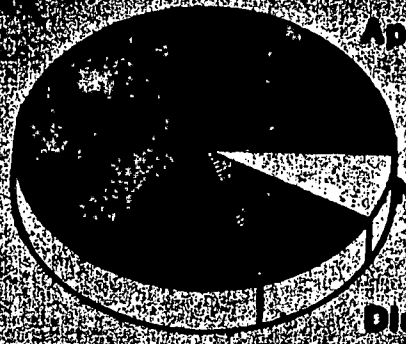
AMERICA RATES THE PRESIDENT, 1991

Has Bush done a good job making health care available to all Americans?



Source: Los Angeles Times, 1/91

Do you approve or disapprove of the way Bush is handling his job as President?



Source: CBS/NY Times, 4/91

SET # 2

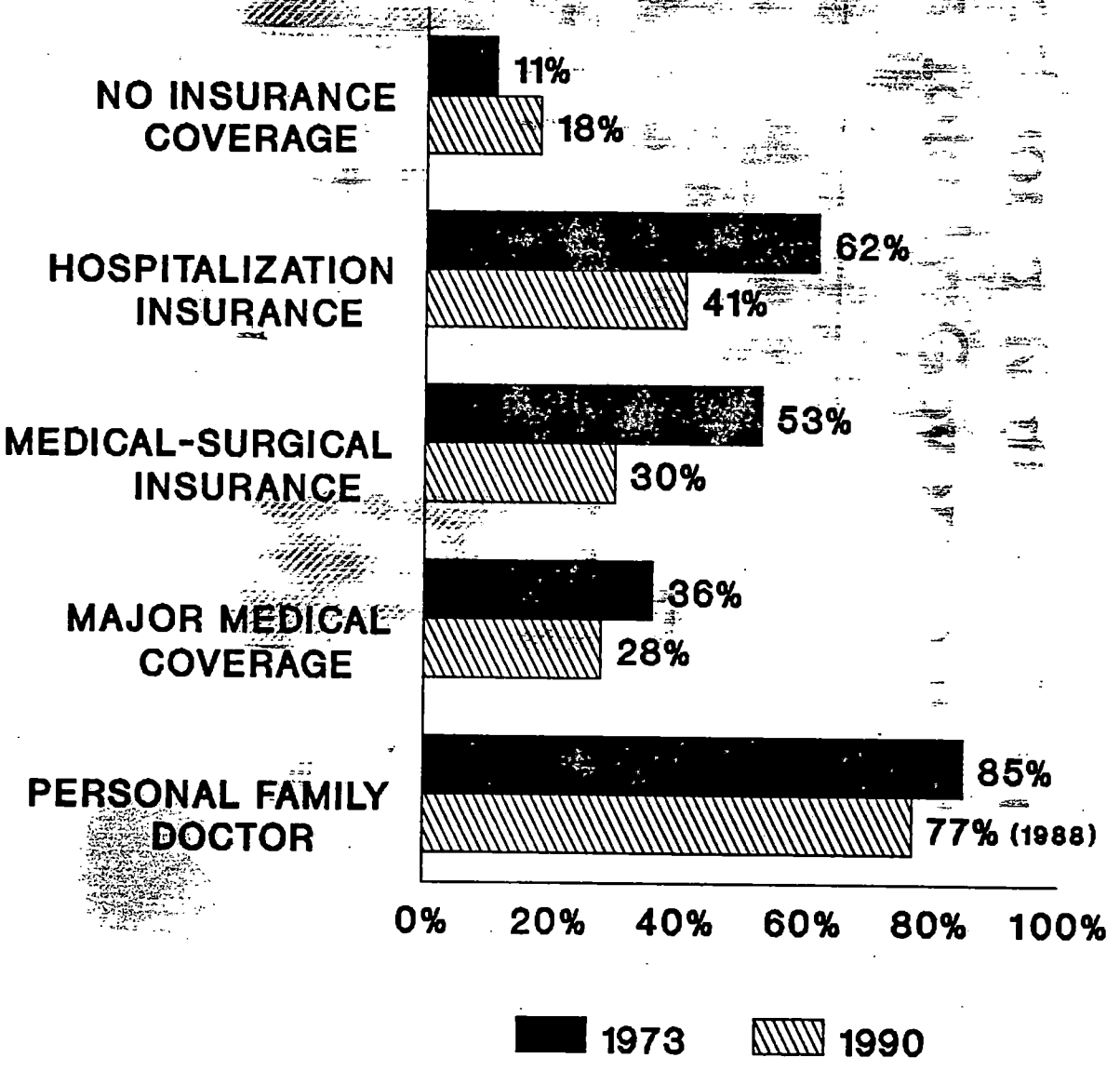
HEALTH CARE CHARTS

When Are People's Opinions Important?

- Consider it one of the most important problems
- Discuss with family and friends
- Touches their own family's life directly
- Feel they are knowledgeable about issue
- Feel opinion will not change with more information

Gallup and Yankelovich, Skelley and White

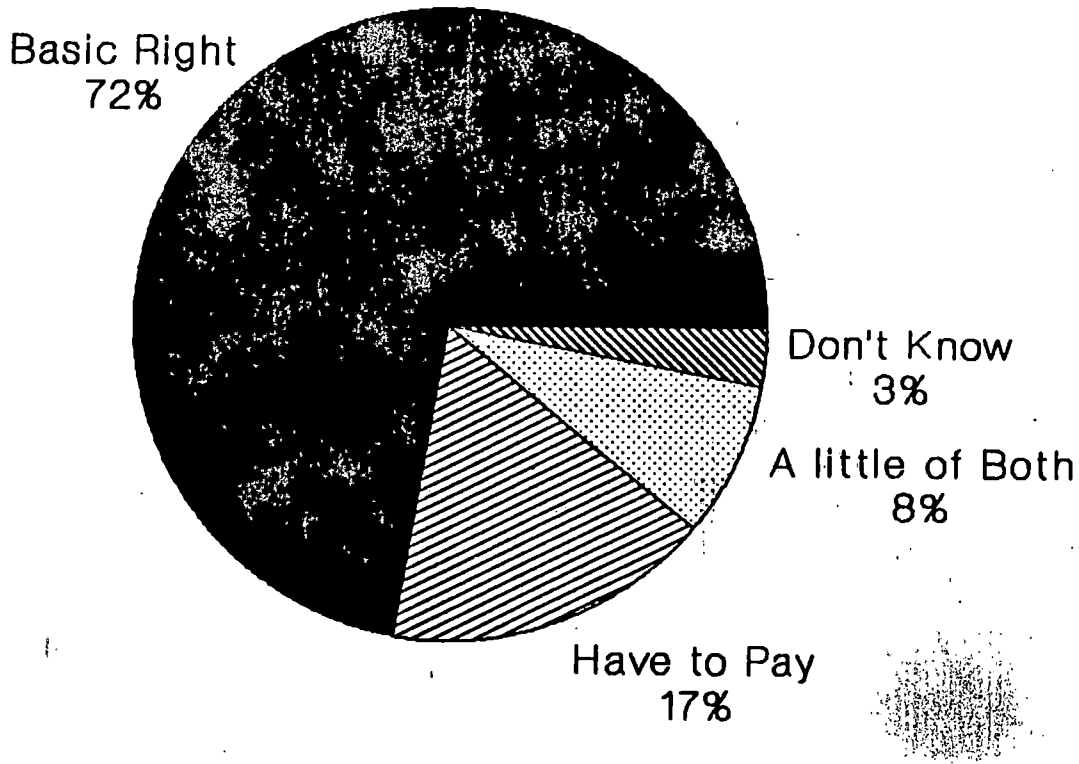
STATUS OF AMERICANS' HEALTH CARE 1973 vs. 1990



ROPER DATA

Attitudes toward health care

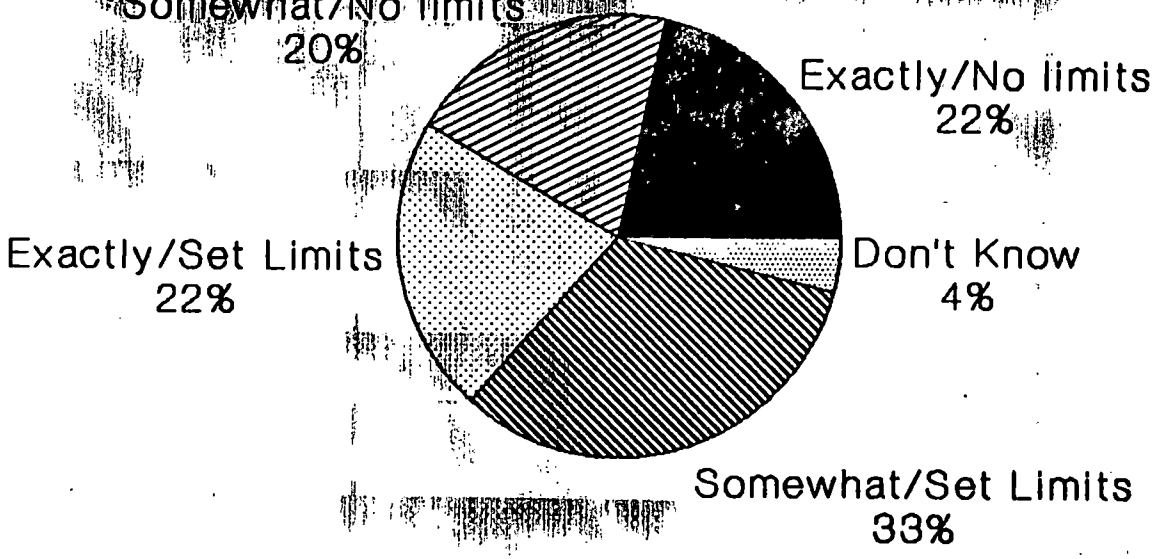
...would you say that healthcare is a basic human right which everyone should be given regardless of their ability to pay OR do you think each person should have to pay for the healthcare he or she receives?



National Survey of 1000 adults-1990

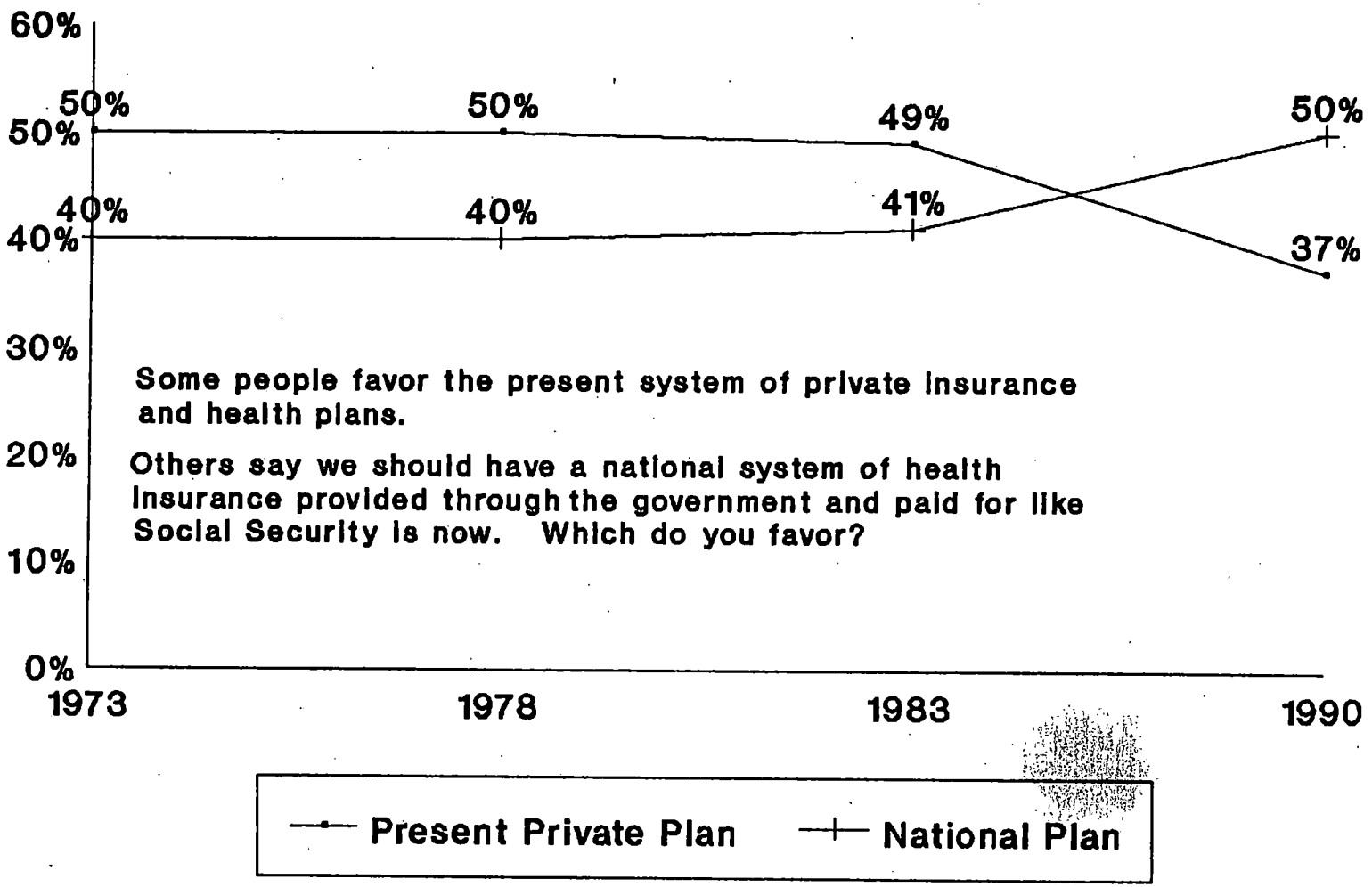
Some people believe that when it comes to healthcare, there should be no limits in our country. No stone should go unturned or dollar held back if it has a chance of making someone better or extending their life.

Other people believe that when it comes to healthcare just like every thing else, there are limits. Our country can't afford everything they want or even what physicians or hospitals may want to provide. How about you?



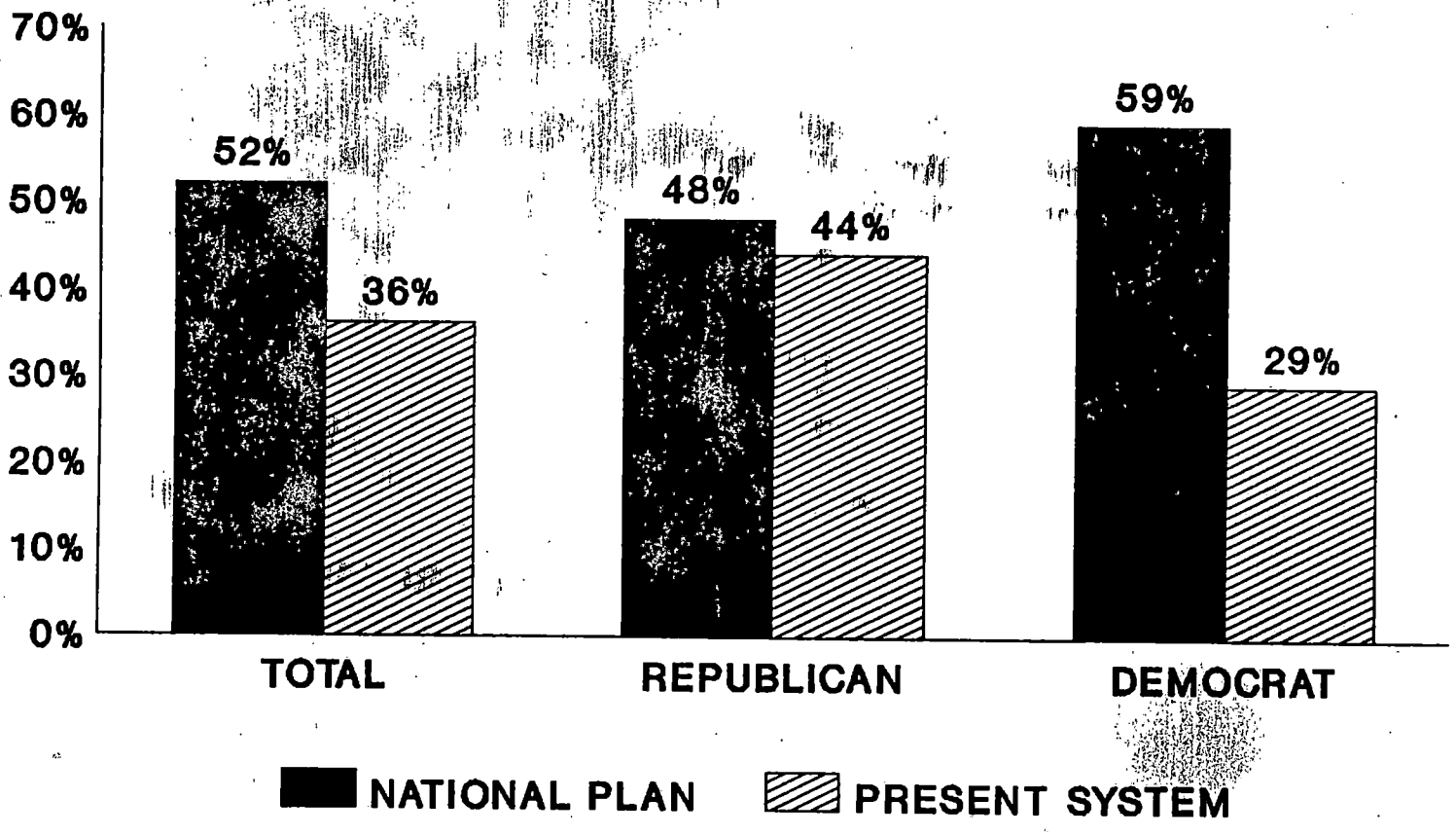
National Survey, 1000 adults - 1990

Private vs. National Health Plan



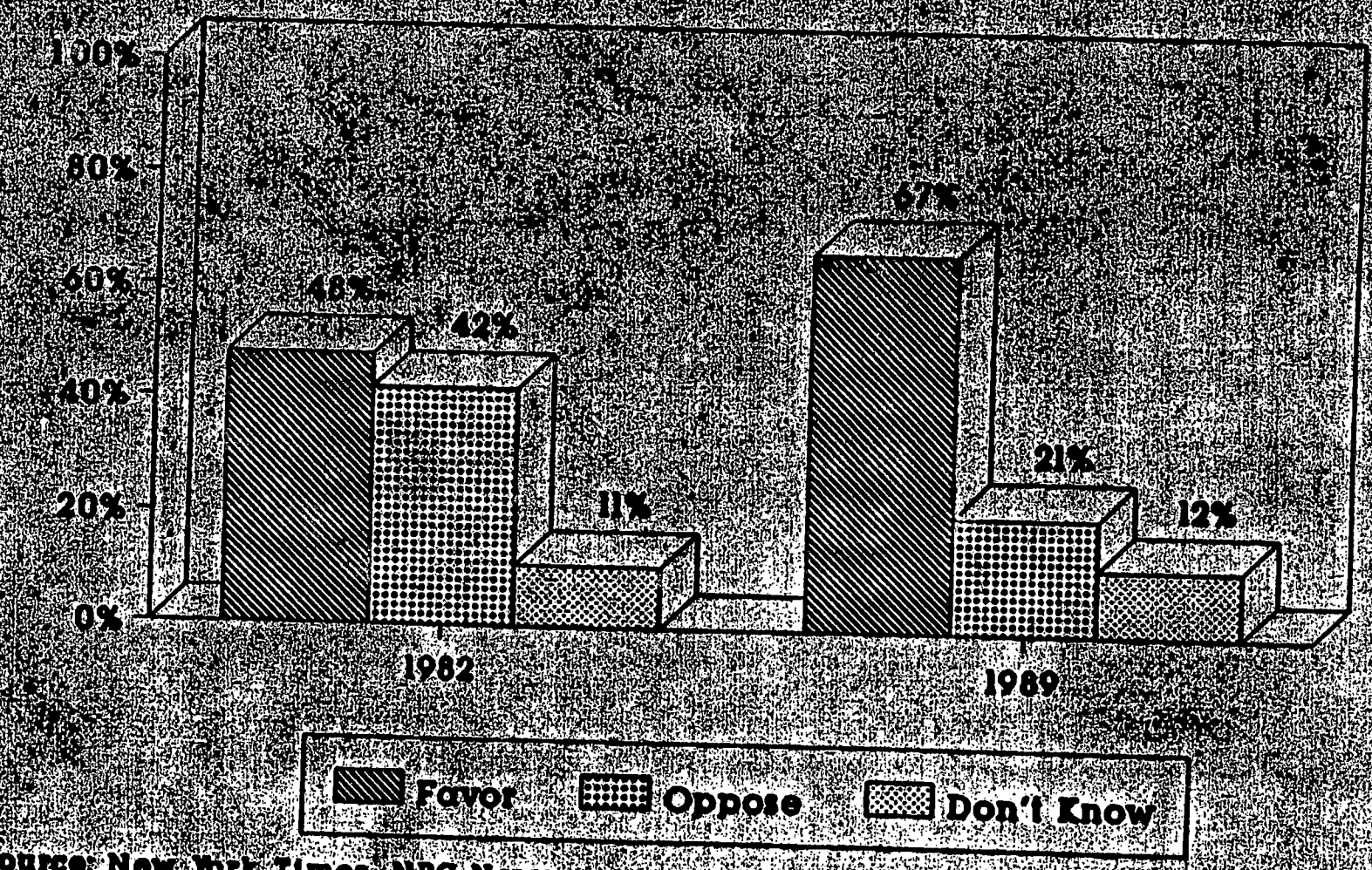
Roper Data

NATIONAL HEALTH PLAN
VS. PRESENT SYSTEM
REPUBLICAN VS. DEMOCRAT



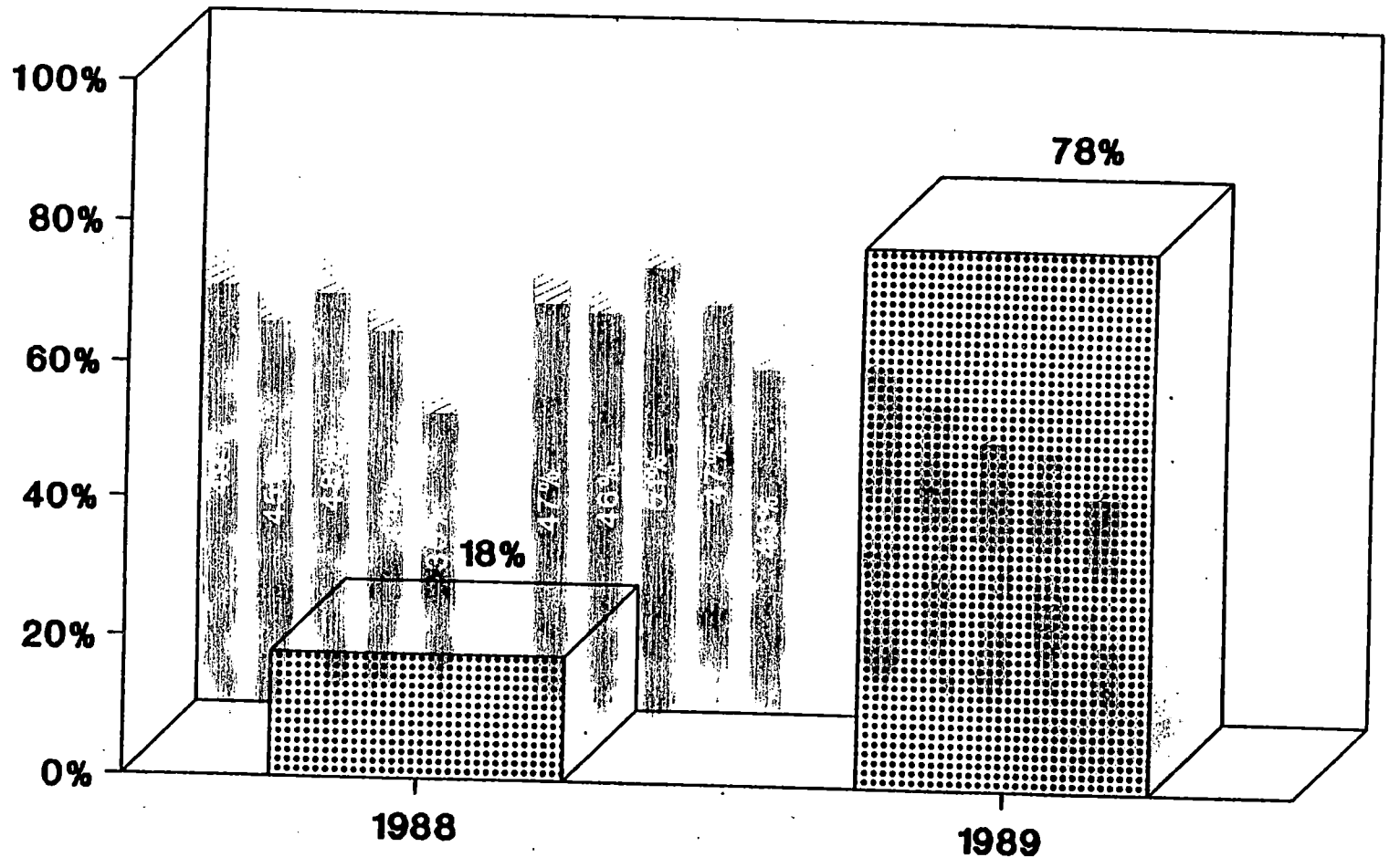
ROPER DATA

Support for a National Health Plan That is Totally Government Financed



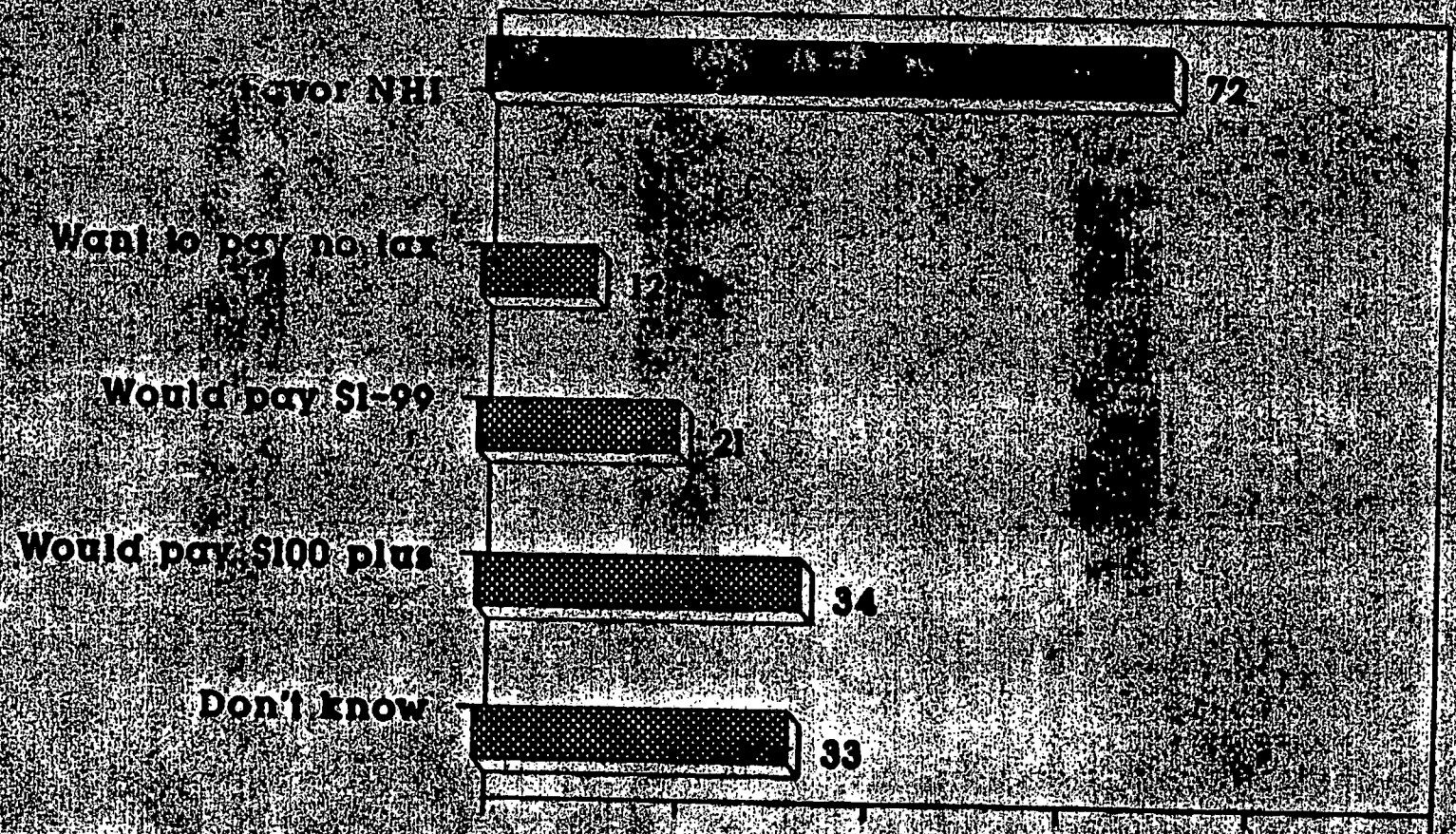
Source: New York Times, NBC News

Role of Health Benefits in Major Strikes



Source: Service Employee International Union

Support for National Health Insurance and Willingness to Pay Taxes to Fund It



Source: Los Angeles Times, 1990

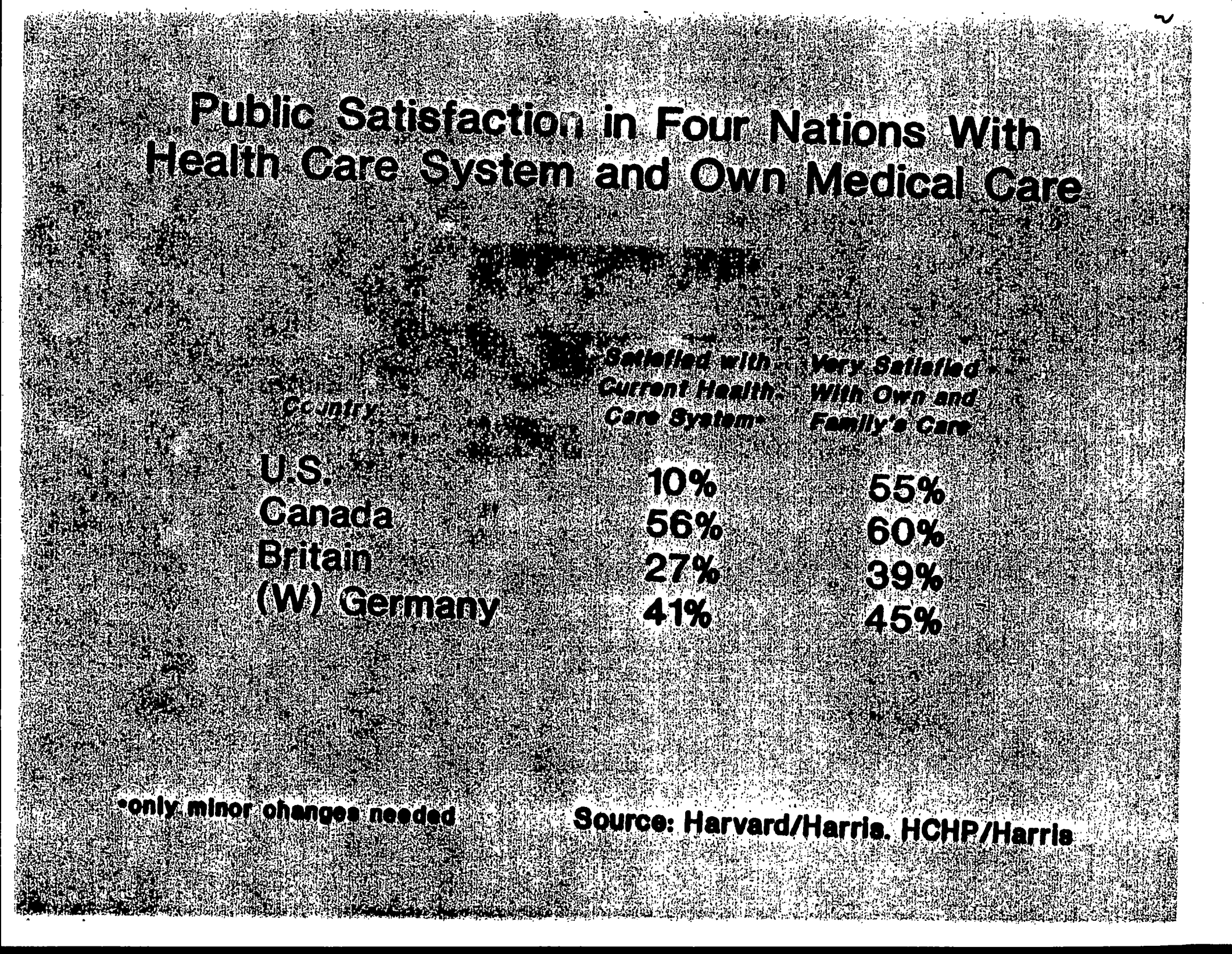
PUBLIC PREFERENCES FOR FINANCING AN NHI PROGRAM

In rank order of preference:

1. Excise taxes
2. Employer tax
3. Social Security tax
4. Premiums paid by uninsured
5. Sales tax
6. Income tax

Source: Louis Harris and Associates, 1989

Public Satisfaction in Four Nations With Health Care System and Own Medical Care

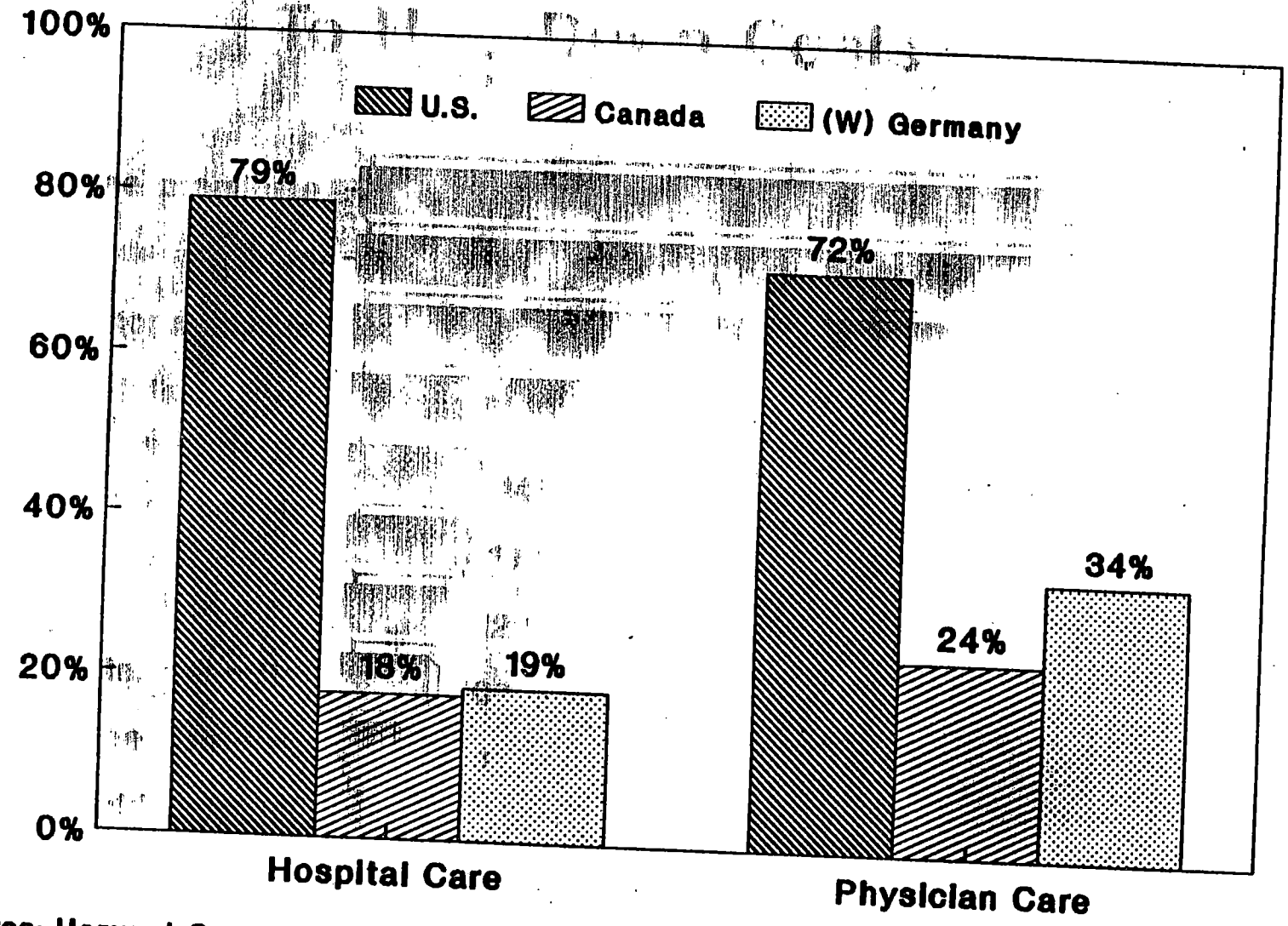


Country	Satisfied with Current Health Care System*	Very Satisfied With Own and Family's Care
U.S.	10%	55%
Canada	56%	60%
Britain	27%	39%
(W) Germany	41%	45%

*only minor changes needed

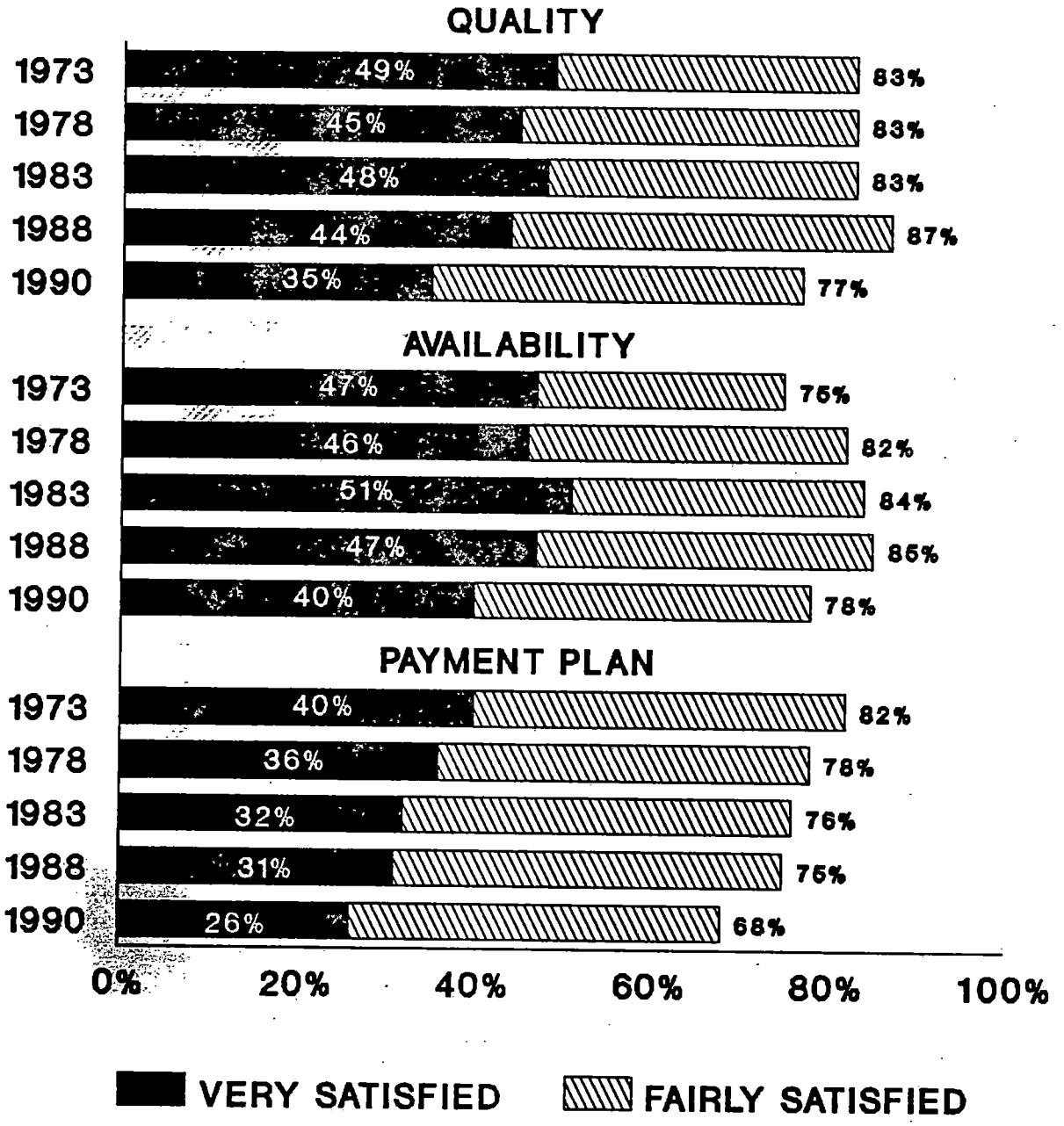
Source: Harvard/Harris, HCHP/Harris

Is Your Nation Spending Too Much?



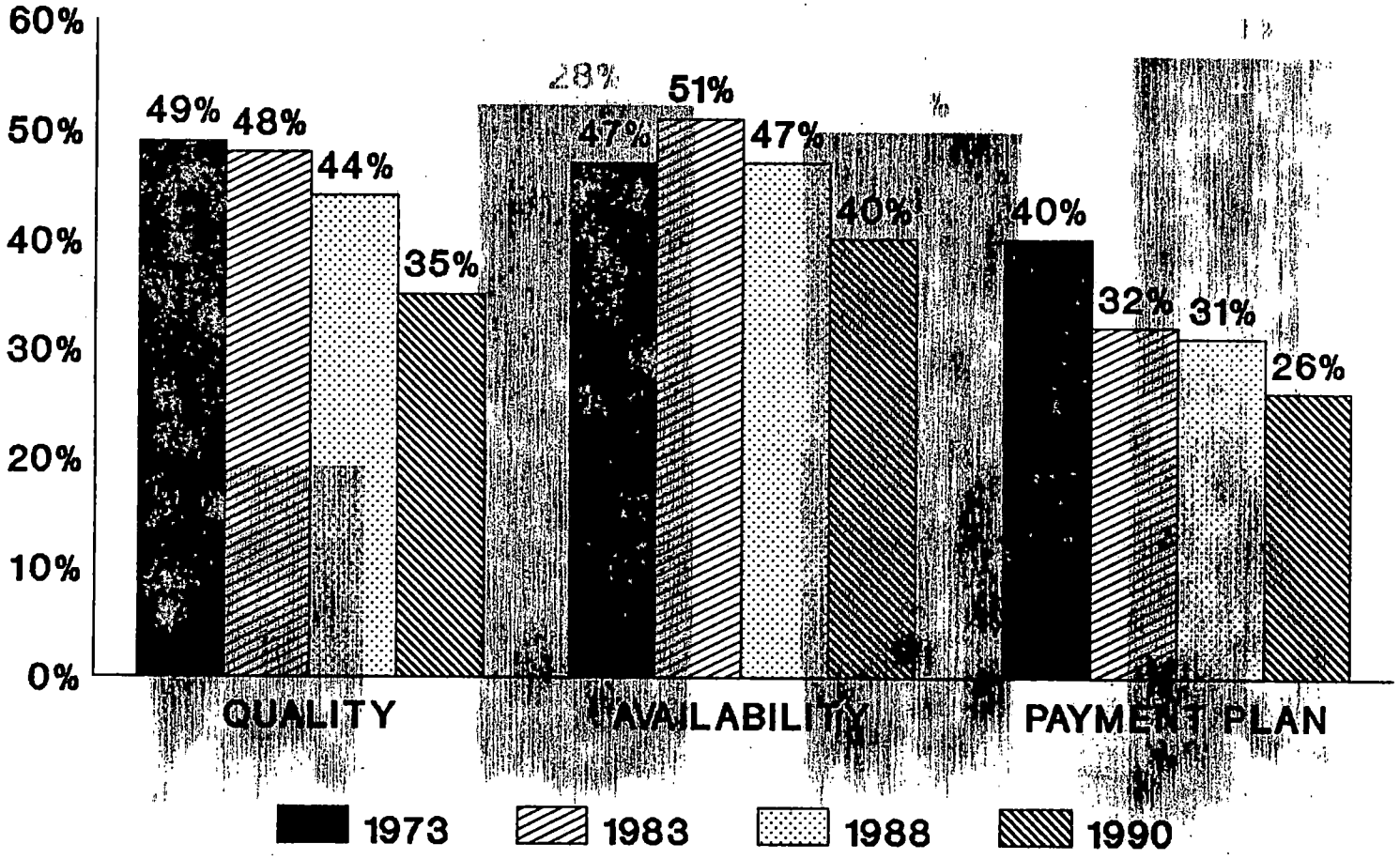
Source: Harvard Community Health Plan

PERCENT SATISFIED WITH OWN MEDICAL CARE



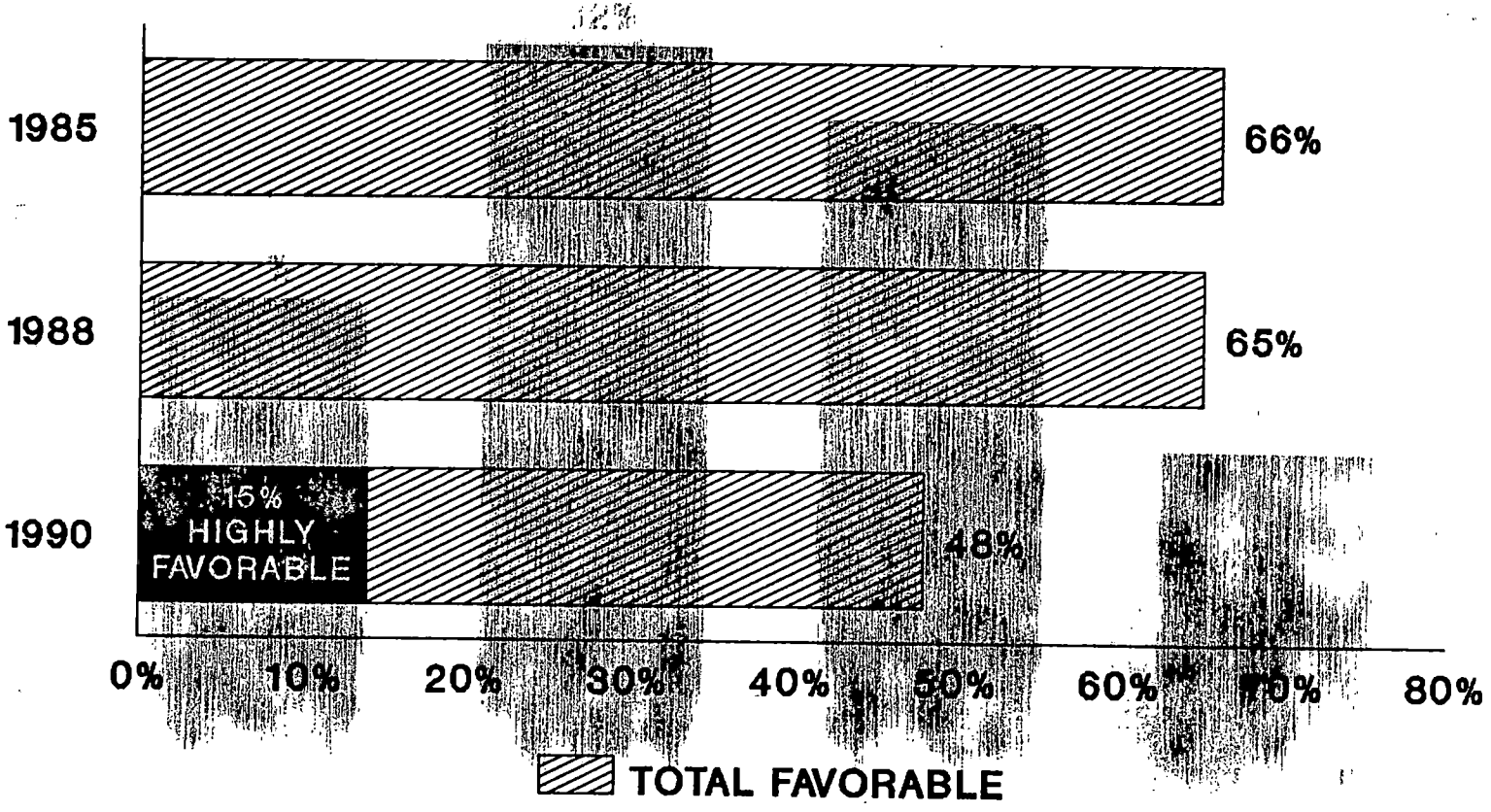
ROPER DATA

Percent Very Satisfied With Own Medical Care



Roper Data

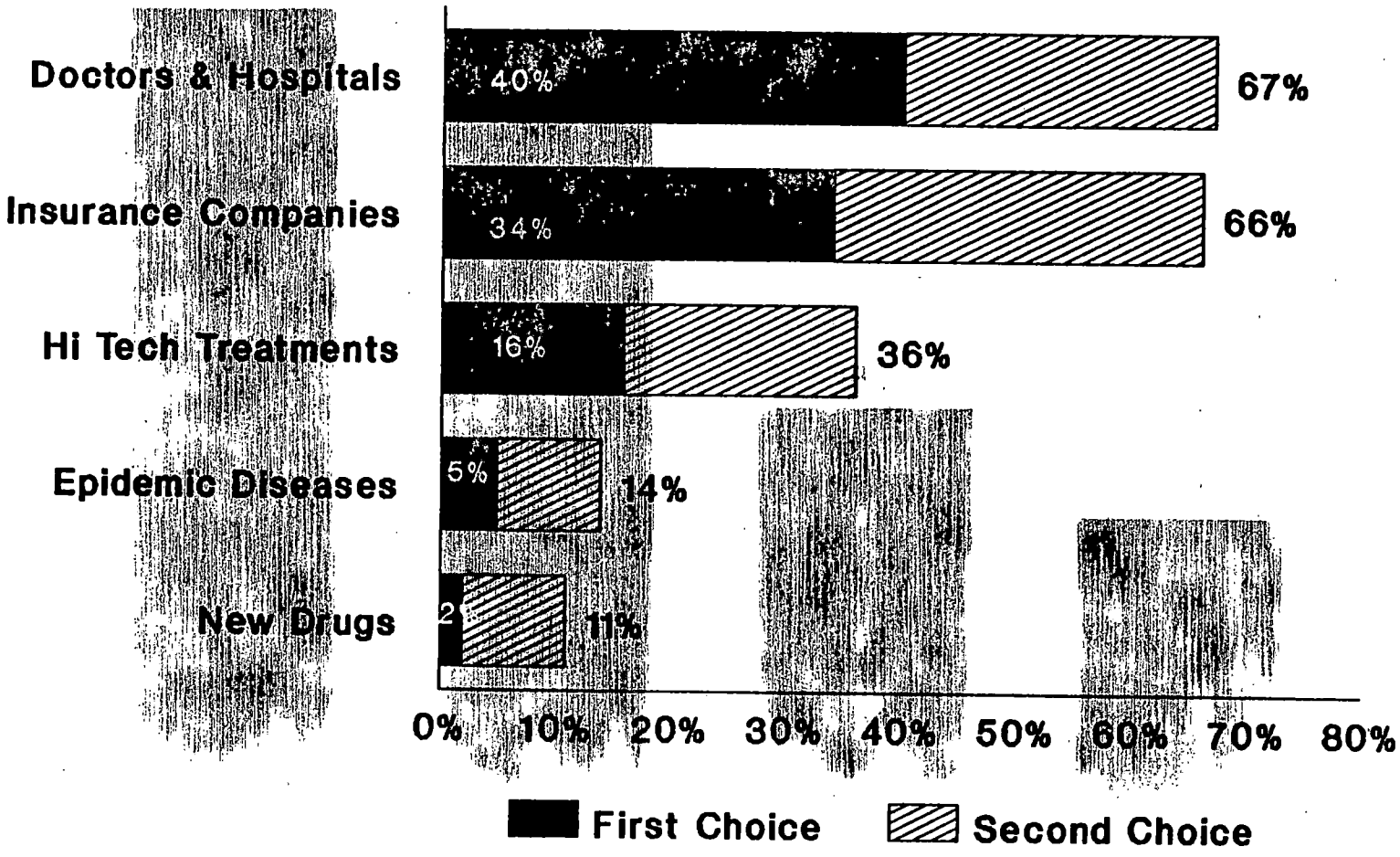
OPINION OF THE MEDICAL CARE SYSTEM
(% FAVORABLE)



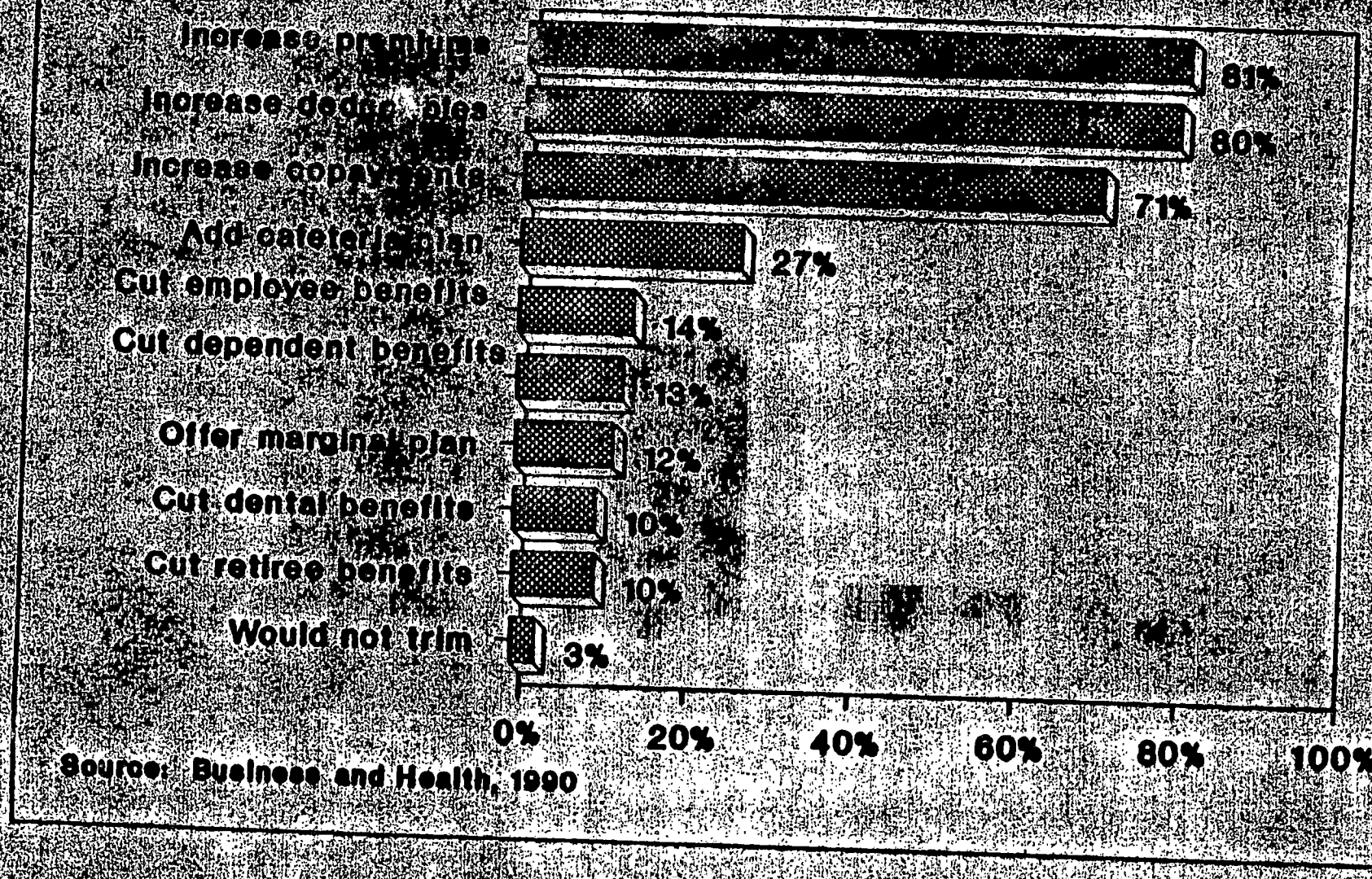
ROPER DATA

The amount of money the fed. government spends on health care has nearly doubled in the last 10 years...

Which one of the following do you believe is the single biggest reason healthcare costs have doubled...

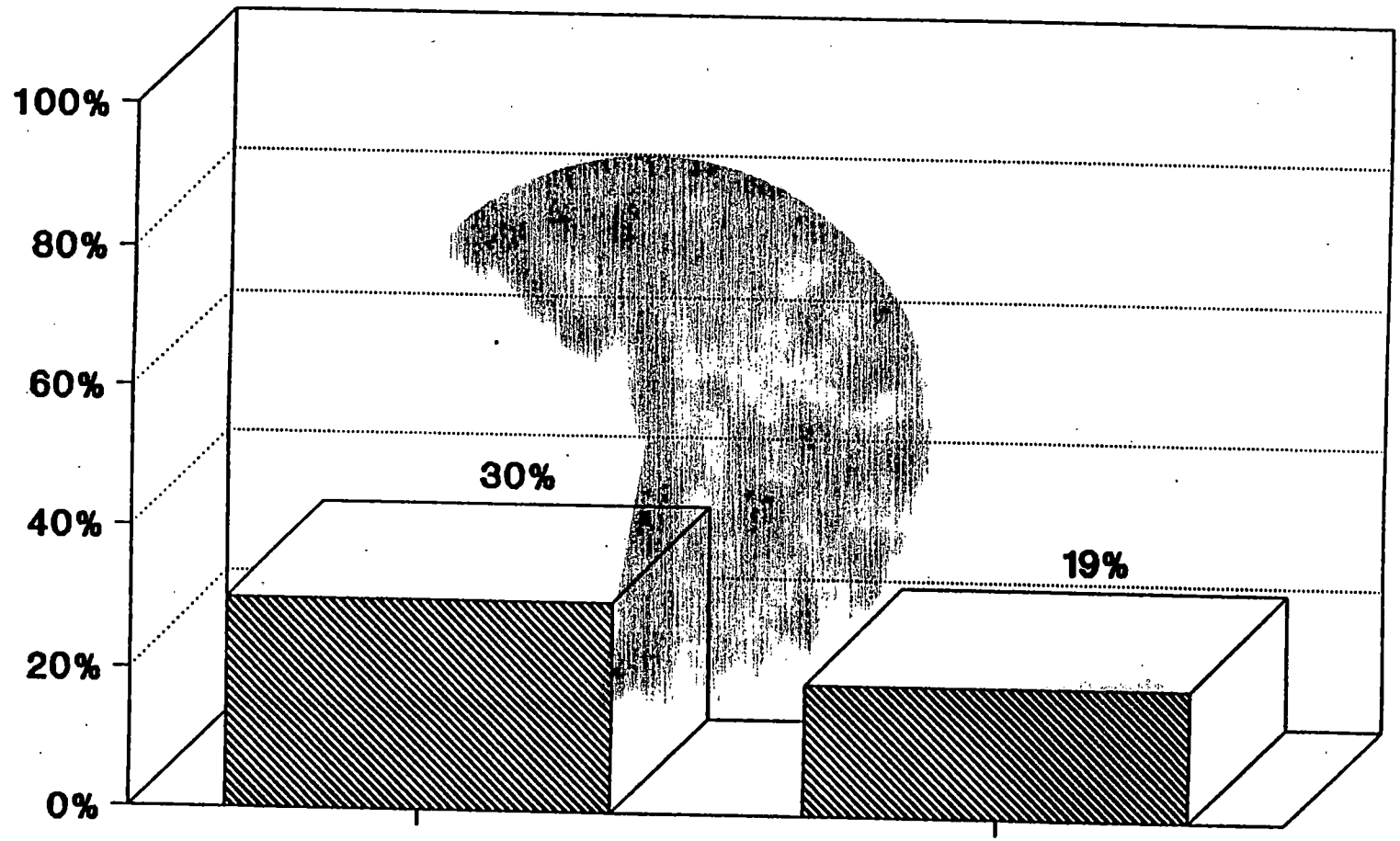


How Companies Will Trim Health Programs To Hold Down Costs



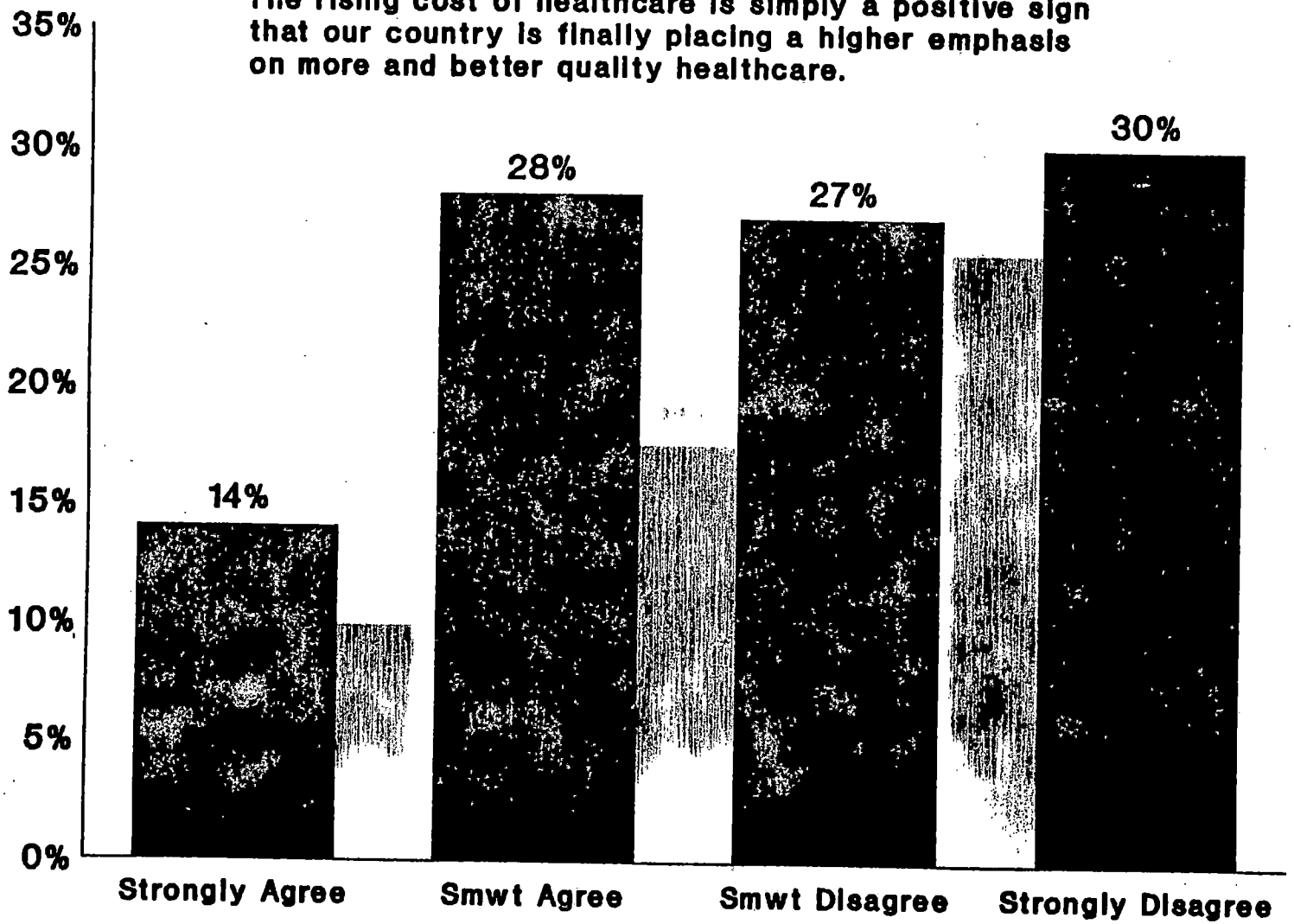
Source: Business and Health, 1990

The Health Care Issue that Concerns You the Most



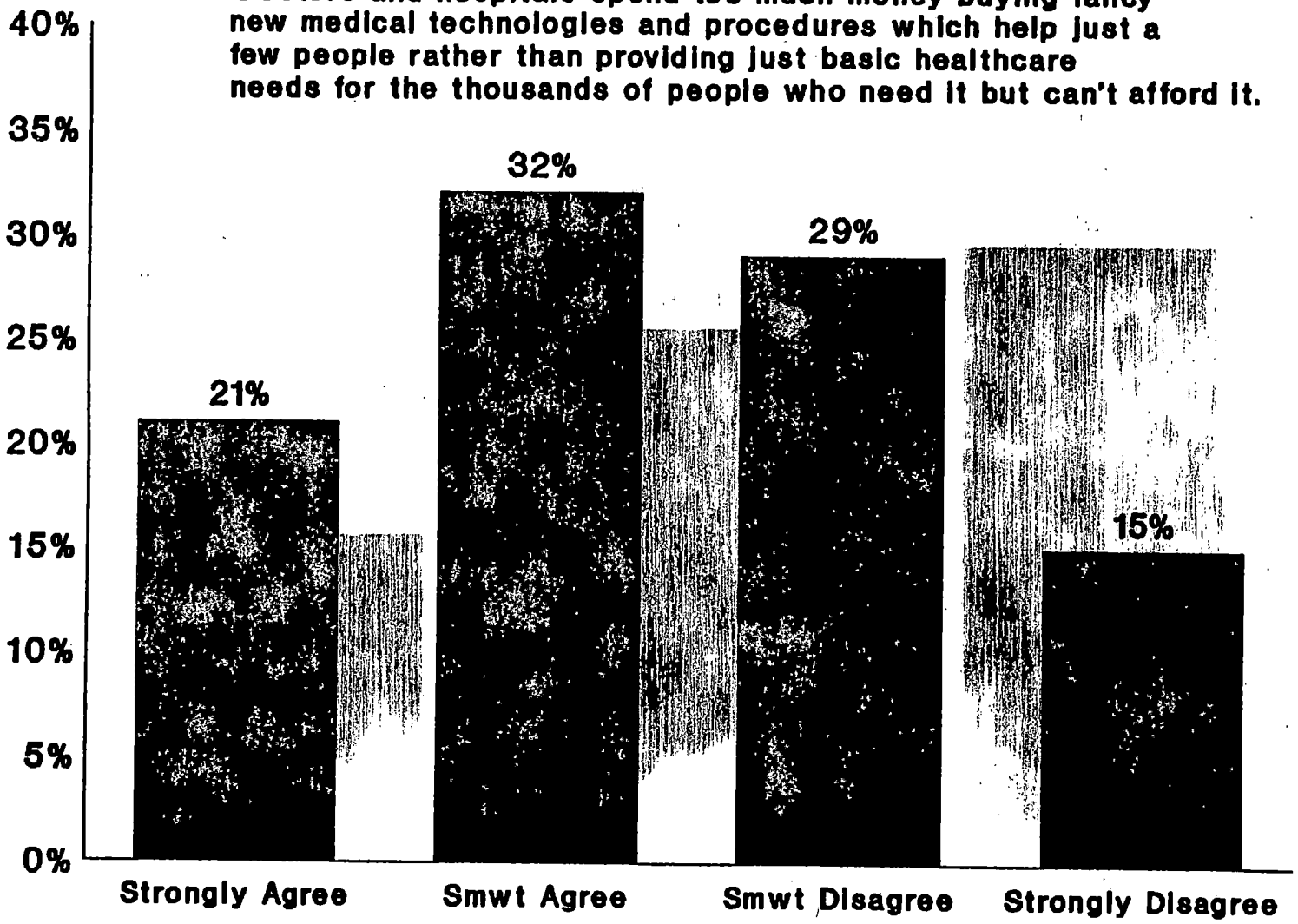
Source: Gallup, 1990

Health Care statements...



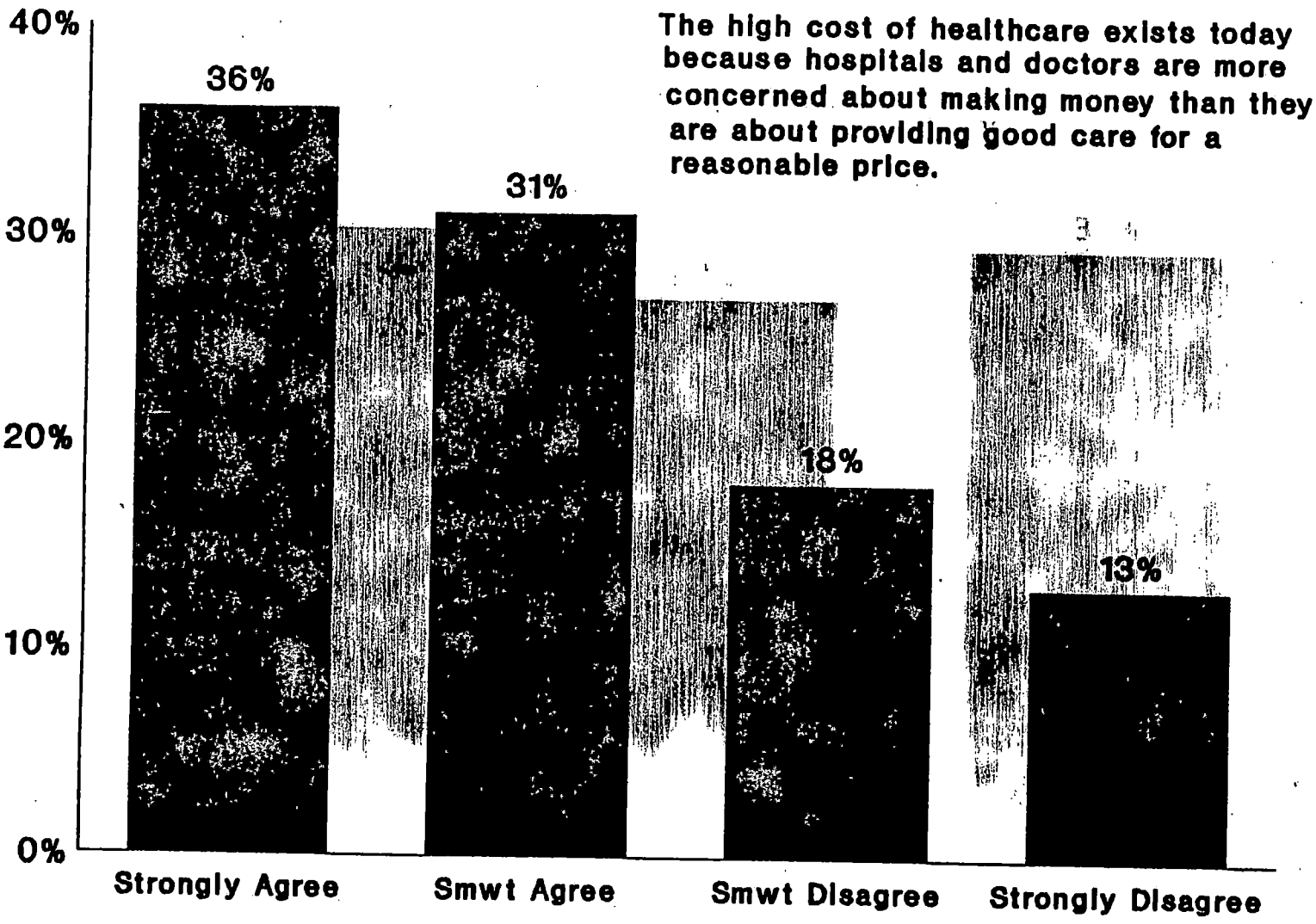
National Survey, 1000 adults - 1990

Health Care statements...



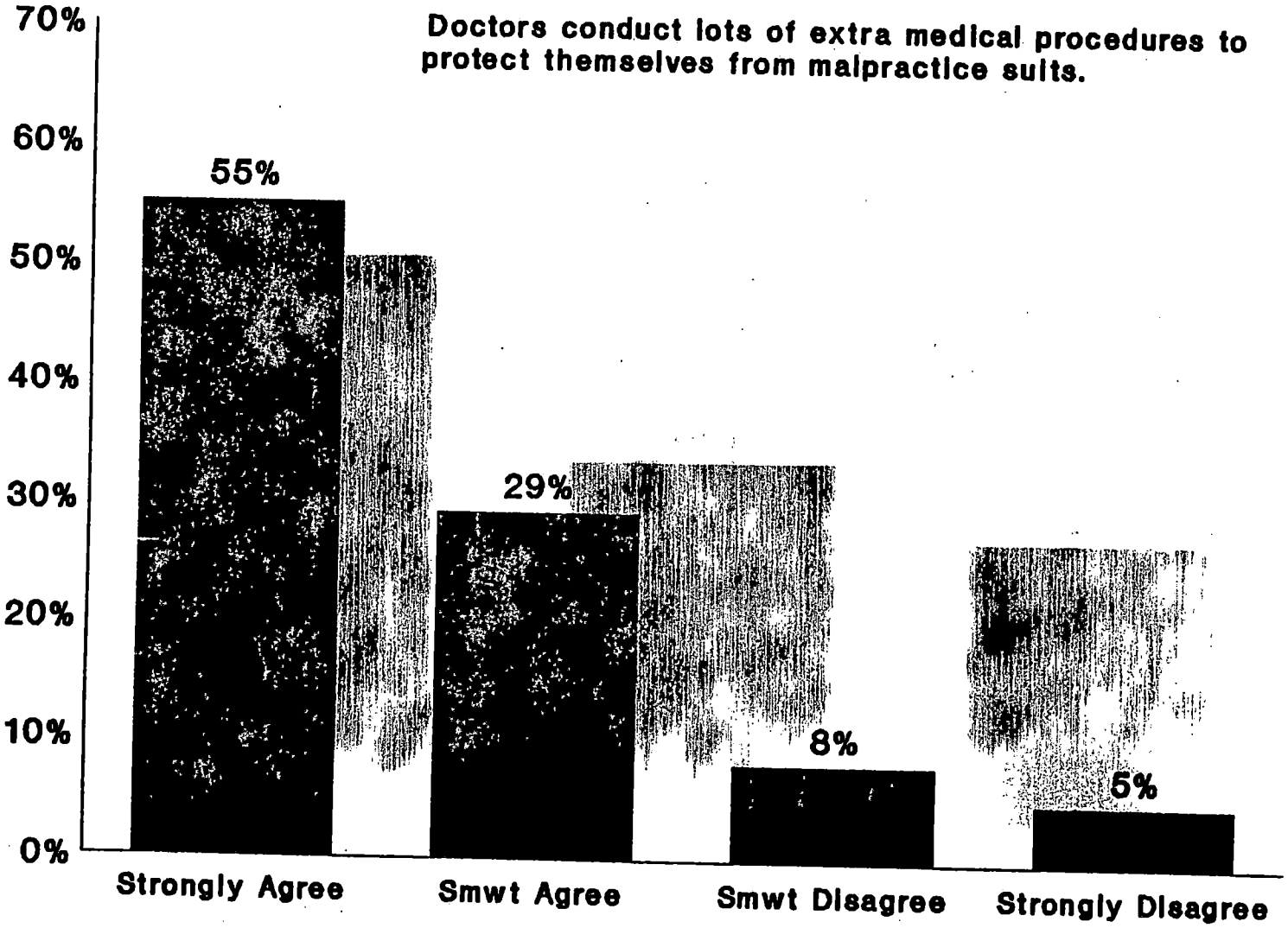
National Survey, 1000 adults - 1990

Health Care statements...



National Survey, 1000 adults - 1990

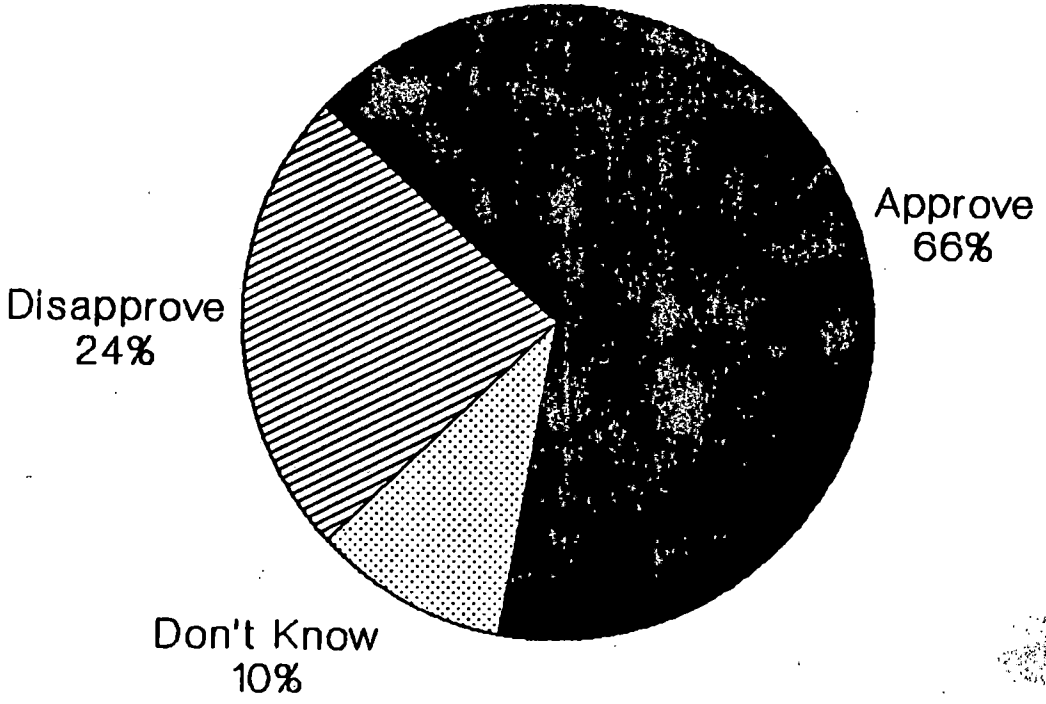
Health Care statements...



National Survey, 1000 adults - 1990

Approve/Disapprove of Canadian Health Care System

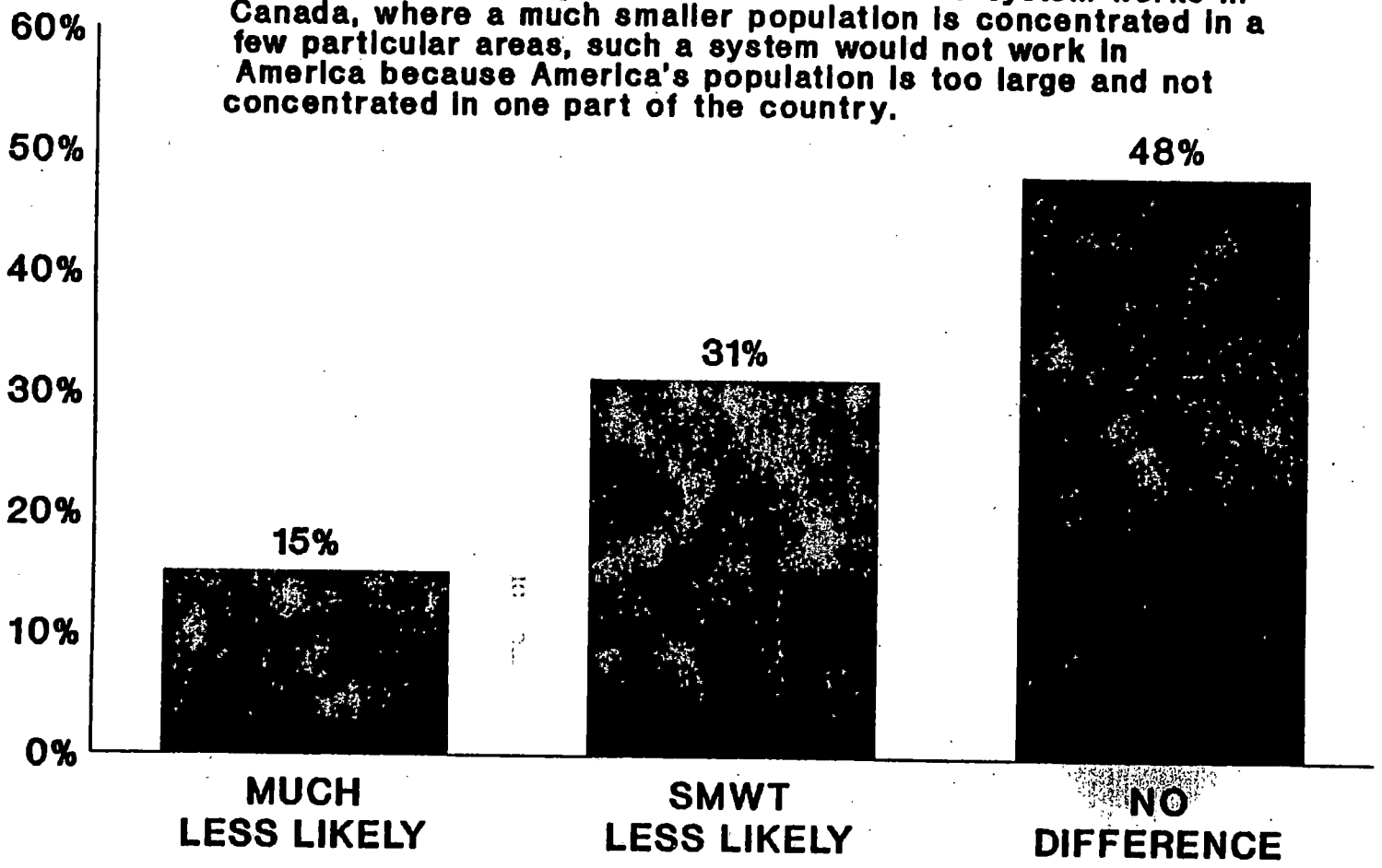
In general, do you approve or disapprove of ... a health care system like Canada's where doctors are privately employed, but the government sets rates for medical procedures and pays all medical bills for every Canadian citizen.



Arguments against Canadian System

...make you much or somewhat less likely to approve of Canadian System?

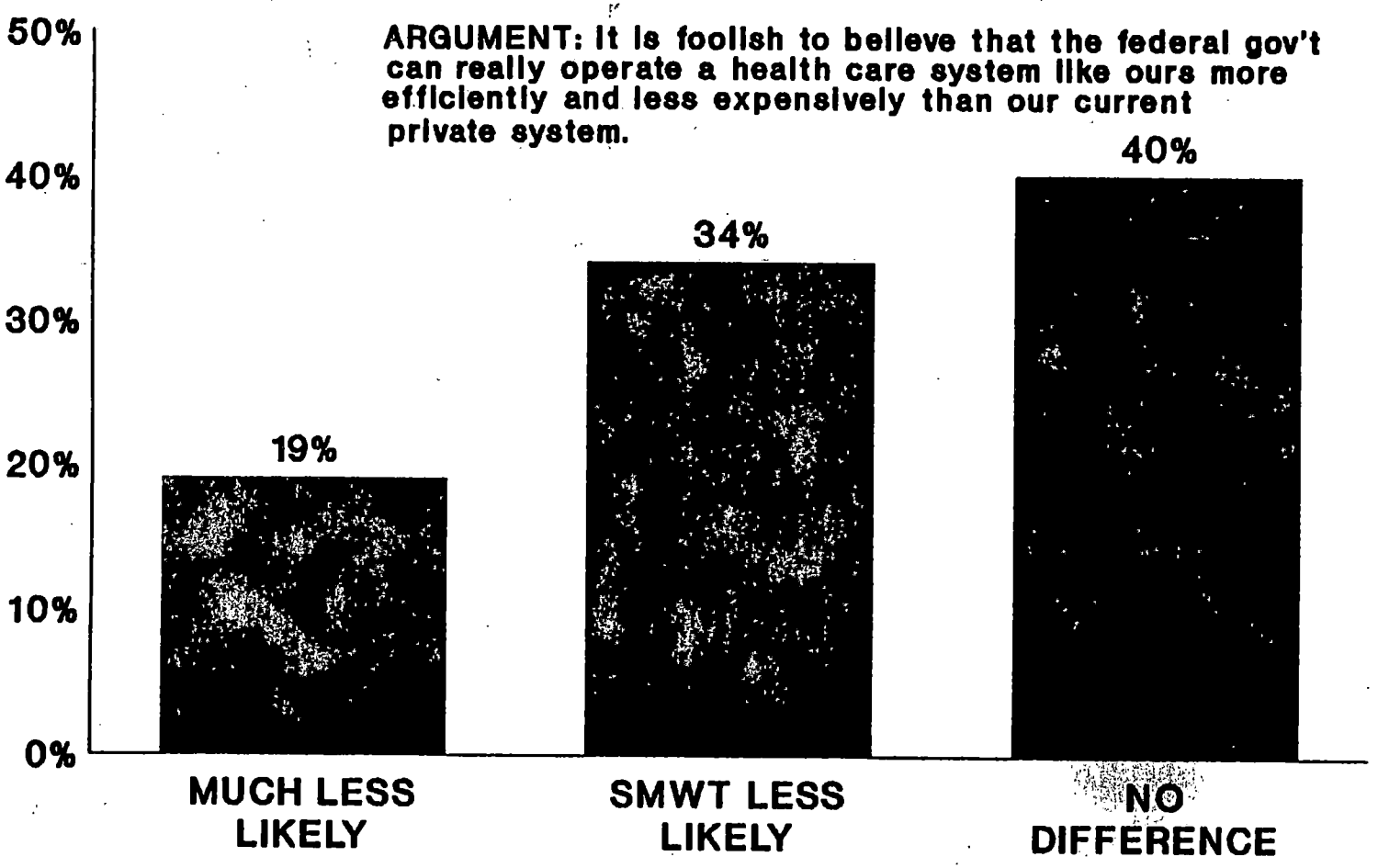
ARGUMENT: Although a national health care system works in Canada, where a much smaller population is concentrated in a few particular areas, such a system would not work in America because America's population is too large and not concentrated in one part of the country.



••Asked only of those who approve of or are unsure of Canadian System.

Arguments against Canadian System

...make you much or somewhat less likely to approve of Canadian System?



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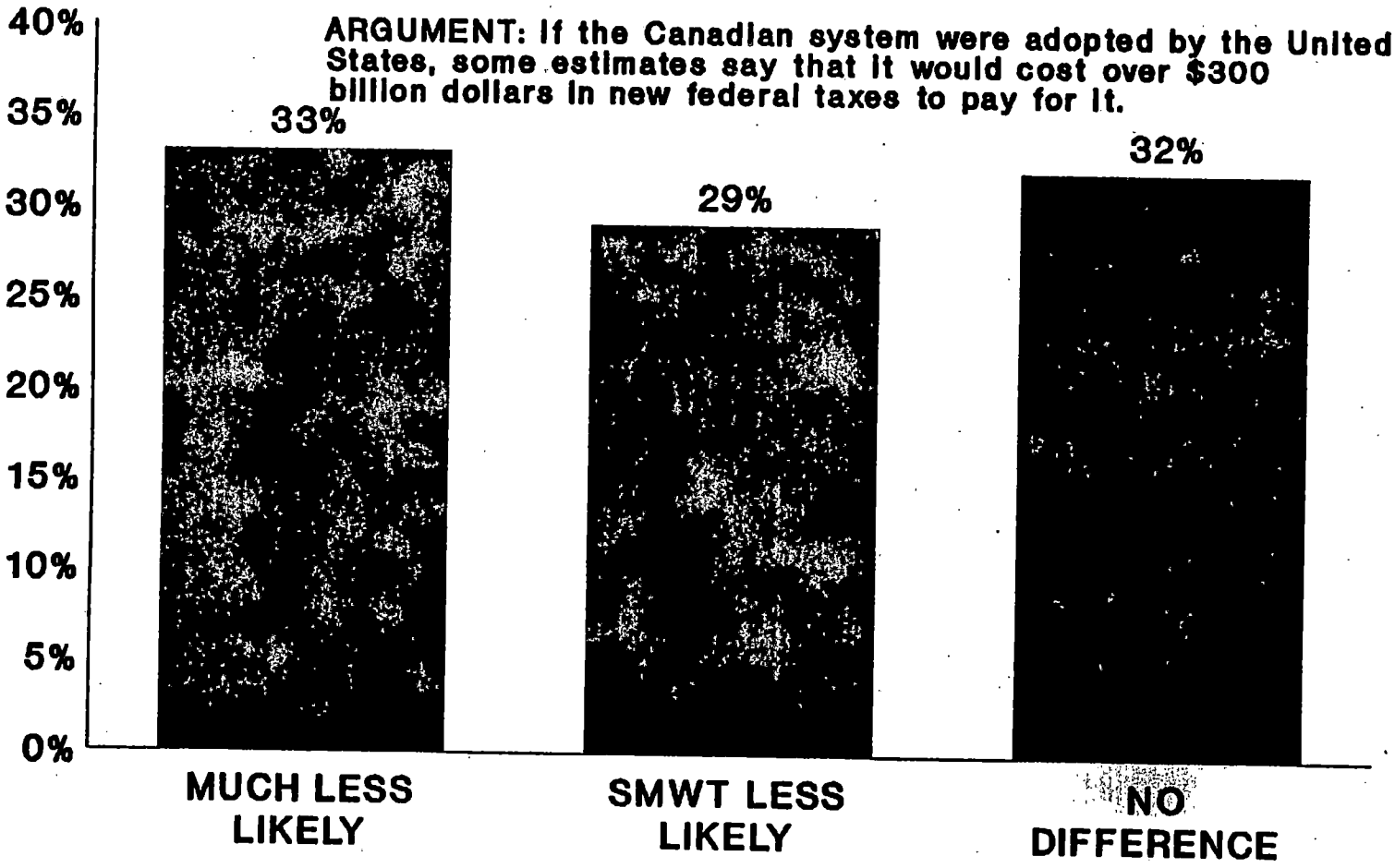
Arguments against Canadian System

...make you much or somewhat less likely to approve of Canadian System?



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Arguments against Canadian System

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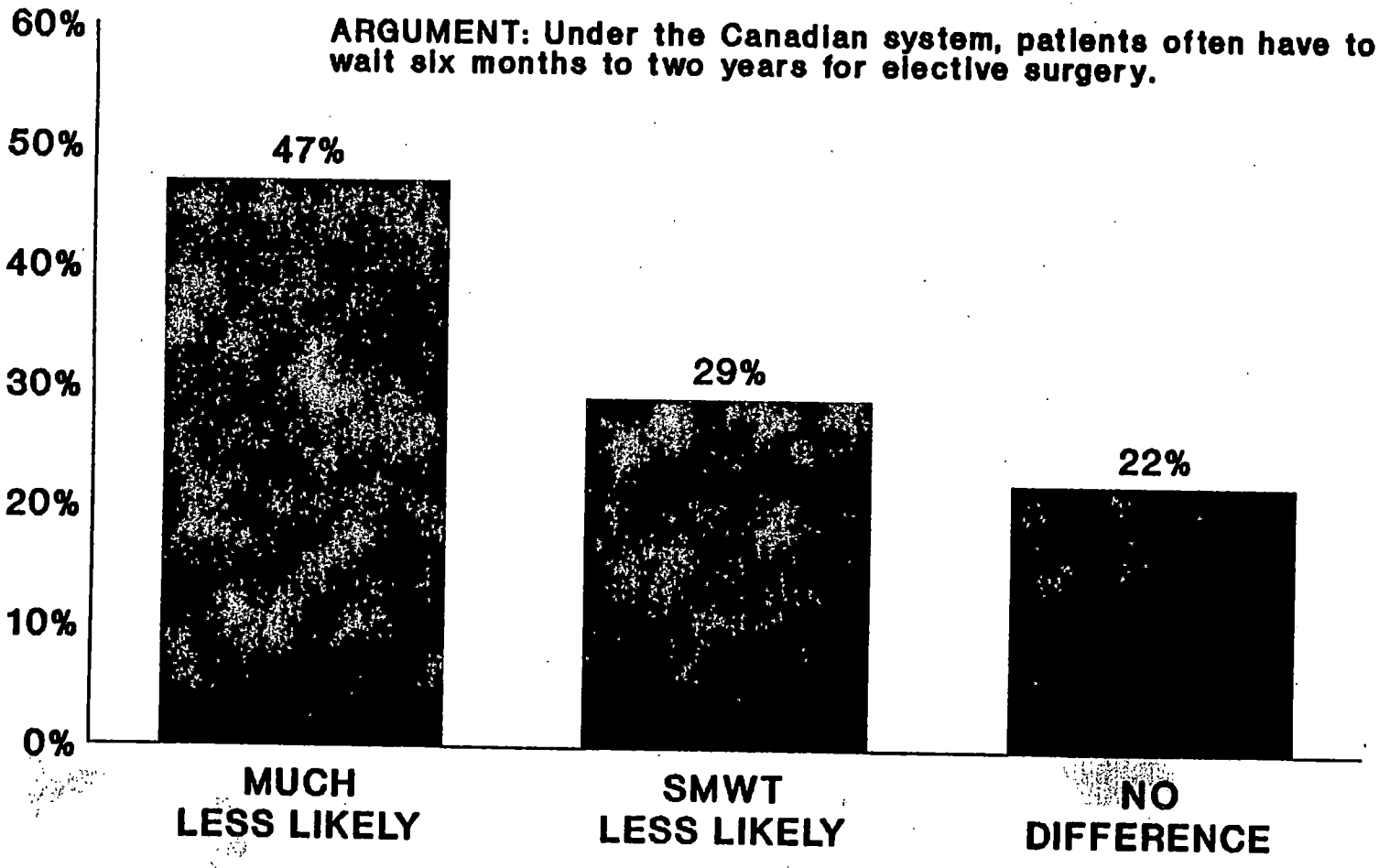

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The Association of Retired Americans

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The Association of Retired Americans

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Chairman, Advisory Board

1567 Sand Castle Road
Sanibel Island, FL 33957
813/395-1559

MISSION STATEMENT...

The Association of Retired Americans is dedicated to better living for mature Americans through benefits enhancements, communication of available resources, improved health care and health care services.

Attention Non-Chapter Members

(1) Enclose a check or money order for $30.00 made payable to The Association of Retired Americans.

(2) Mail promptly to The ARA, P. O. Box 610547, Dallas, TX 75261-0547.

Attention Chapter Members

(1) Return to Chapter for processing.

Your symbol of civic, community and personal activity.

THE ARA "ACTION GOALS"

ARA will strive to be non-partisan in all political affairs.

A C T I O N

Advocacy and active participation in governmental and legislative issues affecting mature Americans.

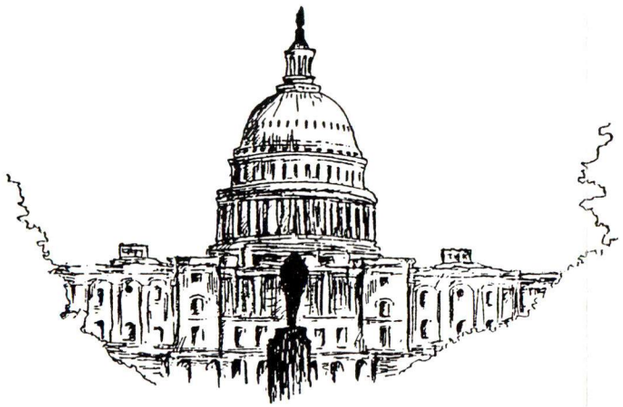
Continuous information and quality assurance on discount programs for consumer goods and services for seniors.

Timely distribution of information through *The Vintage Times* and seminar and educational programs nationwide.

Investment, insurance and health care services designed to meet the real needs of fixed-income Americans.

Opportunities for travel and recreation at discounted prices to add enjoyment to members' retirement years.

Negotiation of quality health care programs and services to promote dignity and independence for older Americans.



ARA BONUS BENEFITS

- **Save 50% at over 1,200 participating hotels nationwide** each and every night.
- **Save up to 50% on eyewear** from our list of independent network providers.
- **ARA Vintage Times subscription!** This modern publication cuts right to issues affecting you. You'll be kept informed of issues unique to the senior community.

- **Pharmaceutical Programs** with choice of mail order program for maintenance drugs or pharmacy card to present at local pharmacy for discounted prices.
- **Care Resource Line** provides air transport to the nearest appropriate medical facility on one of its medically equipped aircraft.

Your bonus benefits don't stop here...there's more.

- Travel Club
- Health Services
- Accidental Death & Dismemberment
- Legal Referral
- Moving Services
- Large Print Books
- Scholarship Program
- Discount Publications
- Hearing Service
- College Counsel
- Greens Fees Savings
- Motor Club
- Auto Rentals
- Medical I.D. Card
- Emergency Response

Full details are provided in your membership kit.

An invitation to membership

The Association of Retired Americans
P. O. Box 610547
Dallas, TX 75261-0547

Welcome!

The Association of Retired Americans is entering a new era, one of actively promoting involvement of mature Americans in governmental affairs, ARA chapter formation, and community involvement. It is with great pride and pleasure that I personally welcome you to join this progressive, innovative group.

The ARA, a membership organization founded in 1975 dedicated to the betterment of mature Americans, is open to all persons 50 years of age or older and in sympathy with the purposes and objectives of this Association as described in this brochure.

I look forward to our working together to achieve the ARA ACTION GOALS.

Sincerely,

Earl E. Heath

Earl E. Heath
President

PURPOSES AND OBJECTIVES

This Association does not contemplate pecuniary gain or profit to the members thereof, and the purposes for which this Association is formed are:

- ☆ To coordinate, plan and organize activities of public and private groups throughout the Nation involving the affairs of persons to the end that there shall be:
  - ★ Adequate community and individual activities stimulating and maintaining the interests of Retired Americans.
  - ★ Adequate public and private services maintaining and improving the health and welfare of Retired Americans.
  - ★ Adequate public and private housing to meet the needs of Retired Americans.
  - ★ Adequate dissemination of information concerning legislation, interests, problems, and affairs of Retired Americans.
- ☆ To provide and/or recommend services, products, housing, and transportation facilities to benefit and foster the meeting of needs and requirements of Retired Americans.
- ☆ To advise and assist Federal, State, County, and Municipal governmental bodies and agencies throughout the nation as to how retired Americans can assist and promote good works, support favorable legislation and promote the well being of Retired Americans.
- ☆ Advise and assist in the quality of health care programs and services for Retired Americans and to promote their dignity and independence.
- ☆ To recognize affiliated organizations with similar purposes of ARA. Such units, having objectives consistent with those of this Association, shall fulfill the needs of specialized groups in the membership.

Receipt of Membership Dues

The sum of $ _____ in payment of membership (and Chapter fees where applicable) dues in The Association of Retired Americans for one year has been received from _____ by _____ on _____, 19_____. Eight dollars of this dues is allocated to the annual subscription of *Vintage Times,* our official publication.

ASSOCIATION OF RETIRED AMERICANS
P. O. Box 610547
Dallas, TX 75261-0547

APPLICATION FOR MEMBERSHIP

In applying for membership in The Association of Retired Americans, I understand that my annual dues (and Chapter Fees when applicable) entitle myself, my spouse, and all legal dependents to the many special benefits and services available for one full year from date of receipt of this application and dues in the national offices of ARA:

NAME _____

Date of Birth _____

Address _____

City _____ State _____

Zip _____

Phone ( ) _____

Spouse's Name _____

Spouse's Date of Birth _____

Applicant's Signature _____

Solicitor _____

ARA Representative No. _____

AMOUNT RECEIVED $ _____

CHAPTER # _____ City _____
(if applicable)

Direct Inquiries to:
The Association of Retired Americans
P. O. Box 610547
Dallas, TX 75261-0547

ARA
Vintage Times
JUNE/JULY 1991
THE ASSOCIATION OF RETIRED AMERICANS

MAX FRIEDERSDORF
CHAIRMAN ARA ADVISORY BOARD

MANAGING YOUR IRA

ANNUITIES

MIDYEAR TAX CONSIDERATIONS

Vintage Times
P.O. Box 610547
Dallas, TX 75261-0547

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Withdrawal/Redaction Sheet
(George Bush Library)

Document No. and Type	Subject/Title of Document	Date	Restriction	Class.
02. Memo	From Burton Lee to John Sununu Re: AIDS (1 pp.)	6/27/91	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 1991 [2]

Open on Expiration of PRA
(Document Follows)
By _____ (NLGB) on 10/28/05

Date Closed:	1/4/2005	**OA/ID Number:**	29160-002
FOIA/SYS Case #:	1998-0004-F[2]	**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]
P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Removed as a personal record misfile.

Freedom of Information Act - [5 U.S.C. 552(b)]

(b)(1) National security classified information [(b)(1) of the FOIA]
(b)(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
(b)(3) Release would violate a Federal statute [(b)(3) of the FOIA]
(b)(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
(b)(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
(b)(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
(b)(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
(b)(9) Release would disclose geological or geophysical information

THE WHITE HOUSE

WASHINGTON

June 27, 1991

THE CHIEF of STAFF has seen

MEMORANDUM TO JOHN H. SUNUNU

FROM: BURTON J. LEE

SUBJECT: AIDS

Most pertinent to the President, in my view, is the theme that he must educate. Prevention is all we have, and will have for many years.

Issues:
1. promiscuity
2. drugs
3. fairness to our fellow Americans.