NBC NEWS SPECIAL REPORT

TO YOUR HEALTH

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ANNOUNCER: The following program is being brought to you by...

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Unidentified Man #1: It's amazing that one can exceed one's lifetime earnings through medical bills. That's what it is--bills have exceeded my lifetime earnings.

Unidentified Man #2: We need to fix the system we've got, that's something we need to do.

Unidentified Woman #1: It's larger than life to be scared all the time. It's not the fear of not being insured, it's the fear of what of something happens.

Unidentified Man #3: I don't really think the government needs to be involved, but somebody's got to get involved.

Unidentified Woman #2: We are not getting the care we deserved because of money.

Unidentified Man #4: As far as they're concerned, I'm not a human being in need of medical care. It's a numbers game.

President BILL CLINTON: The medical care industry is literally drowning in paperwork.

Unidentified Woman #3: It's a never-ending job, it's like one piece of paper after another. It's constant.

Unidentified Man #5: I think anytime you get the government involved there's going to be more paperwork so I think it's not going to get any better.

Unidentified Woman #4: We're seeing too many people who are victims of the current system.

Unidentified Man #6: You wait and wait and wait.

Unidentified Man #7: Yes, is was the delay which probably cost her life. She went to her grave feeling that.

President CLINTON: When people don't have any health insurance, they still get health care, often from the most expensive place of all, the emergency room.

Unidentified Man #8: We are the department of available medicine. We're open 24 hours a day, seven days a week.

President CLINTON: Since they don't pay, who does pay? All the rest of us.

Unidentified Woman #5: What's really at stake in this health care reform debate are people.

Unidentified Man #9: You hear from different sides of which is what--I really don't know.

Unidentified Man #10: The different health care plans are confusing. That's what I find confusing because I don't understand it.

Unidentified Woman #6: I don't really understand it right now myself.

Unidentified Woman #7: I don't understand how it could ever work.

Man #7: We're all going to complain, but we also demand the care.

Unidentified Man #11: Every time the government of the United States has gotten involved in anything, the cost has never gone down. It's always gone up.

President CLINTON: With this card, you're covered.

Unidentified Man #12: It puts a bureaucrat in charge of your health.

Woman #7: The welfare program's in a mess, Medicare's in a mess, Social Security's in a mess--so why give them something else to mess up?

Unidentified Man #13: They ought to get down here and take a look at what's going on with the working people because they don't know what's going on.

Unidentified Man #14: It has the potential of destroying the American democracy.

ANNOUNCER: TO YOUR HEALTH, an NBC News special. Reporting from the Warner Theater in Washington, Tom Brokaw.

TOM BROKAW, anchor:

Good evening and welcome. And tonight we invite you to join us on a two-hour journey across some of the most challenging terrain in America--health care reform. Our destination at the end of two hours--a much clearer understanding of this very complex issue so that you can be more engaged in a debate that affects you in so many ways.

Here in the Warner Theater in Washington, we have a wide array of health care experts, more than a hundred of them, representing a wide range of interests. We also have people here tonight who have been beneficiaries of the health care system and some people who as well have been victims of it. We'll be joined as well by Senators Dole and Mitchell from Capitol Hill who are in the midst of a political debate and by Hillary

Rodham Clinton, first lady of the United States and captain of the White House health care team. I'm joined in the theater tonight by NBC's Brian Williams and by Maria Shriver. They have been reporting on this issue across the country and they will be assisting me here tonight.

And we have been talking to you trying to find out what you think about health care, what you want from it. We published 20 questions across the country today and we asked a lot of people what in fact they think of the health care system now. As you can see from this question, more than 80 percent of the American people that we surveyed say they are satisfied to very satisfied with the health care that they are getting.

TEXT:

HOW SATISFIED ARE YOU WITH THE MEDICAL CARE YOU ARE NOW RECEIVING?

A. Very Satisfied 44%

B. Somewhat Satisfied 37%

C. Somewhat Dissatisfied 10%

D. Very Dissatisfied 6%

E. Not Sure 3%

TOM BROKAW, anchor:

We'll be dealing with four issues tonight: Is the health care system broken? What do we want from it? How do we fix it? And how do we pay for it? We'll begin however with a group of people who are at the core of this debate--the millions of Americans who have no health care insurance and for that here now is NBC's Maria Shriver.

MARIA SHRIVER reporting:

Thank you, Tom.

There are at any time during the year as many as 58 million Americans who have no insurance. Those figures can go up or down during the year depending at what time you're looking at them. But one thing remains the same and that is that there are millions and millions of hard-working Americans, middle-class Americans who are either under-insured or who have no insurance. We met two families who are playing Russian roulette with their health.

It's morning in the Thoorsell household and Kathy, mother of two-year-old Starlee and seven-year-old Blaze, is hoping for the best.

Mrs. CATHI THOORSELL: Ask Starlee to help. I want you to turn this down.

SHRIVER: For Cathi and her husband, Perry, that means making it through another day without a doctor.

Mrs. THOORSELL: It's really scary to have raised two children without coverage and to worry about coverage constantly. It's more powerful than you can even imagine to worry about the costs of everything.

SHRIVER: Right now, Cathi has a temporary position at Stanford Medical Center while Perry cleans houses and businesses. They say they can't afford the nearly $7,000 it would cost to buy medical insurance for their family.

The Thoorsells are not alone. More than 30 million Americans who work have no medical insurance. They're caught between businesses which don't offer medical benefits and the sky-rocketing cost of private insurance. When you're healthy, this lack of health insurance can be merely an inconvenience. But when something goes wrong, the consequences can be overwhelming. The Thoorsells learned that firsthand when Cathi's difficult, uninsured pregnancy put them almost $30,000 in debt.

Mr. PERRY THOORSELL: I think when our son was born, that was the biggest blow getting--having a pregnancy happen when we couldn't get insurance at that point. And it put us way behind and we've never really recovered from that.

Mrs. THOORSELL: We won't be having anymore children. We thought--both of us wanted a large family, but two is large enough, and that's what we decided to do--the fear, you know, for the pregnancy would be a horrible disaster for us.

SHRIVER: They also worry that without health insurance it their children get sick they won't be able to afford medical care without going further in debt.

Mrs. THOORSELL: It's larger than life to be scared like that all the time. It's sad. I mean it's very sad that our children have to worry about, you know, about mom and dad taking care of them. The toughest fear is not being insured, it's the fear of what if something happens--that's the scary part.

SHRIVER: Three thousand miles to the east, the Reckoway family knows only too well the consequences of something happening. They thought they had done everything right--they had medical insurance when their 12-year-old son, Jeffrey, was born, but there was a catch. The family policy had a lifetime cap of $100,000 per illness. Jeffrey was born with severe respiratory and cardiac problems. And that $100,000 was used up in the first 11 months of Jeffrey's life. Today the family is more than $700,000 in debt.

Mr. JEFFREY RECKOWAY: I don't see why doctor bills are so expensive. I cost my parents a lot of money.

SHRIVER: You feel bad about that?

Mr. J. RECKOWAY: Yes.

SHRIVER: This is Jeff having his first birthday at Children's Hospital.

When he was finally able to come home, Jeffrey still needed complicated machinery and constant nursing. The Reckoways sought help from various state agencies.

Mrs. RECKOWAY: They suggested several times that we relinquish our rights to Jeffrey and make him a ward of the state, and they said that we could--we could be made his foster parents, you know, and that we could come visit him at the hospital. They also suggested that--that if Rick and I were to divorce that I would as a single parent qualify for more state aid. And we found neither of them acceptable.

SHRIVER: Do you ever think about it?

Mrs. RECKOWAY: Never.

SHRIVER: For a second?

Mrs. RECKOWAY: Never.

SHRIVER: Rick's earnings as an electrician should put the family solidly into the middle class, but the $700,000 they owe has taken their future.

Mr. RICK RECKOWAY: When you think about it, it--it's amazing that one can exceed one's lifetime earnings in medical bills. And that's what it is--bills have exceeded my lifetime earnings.

Mrs. RECKOWAY: What are you going to do? I mean you have to take care of your child. You can't put him to bed that night and say, 'Well, I'm sorry, Jeff, but you can't live tonight.' You can't do that. You want your child to survive. And that is the big thing is Jeffrey's survival.

SHRIVER: I'm here with Cathi Thoorsell and the question is, after we've just watched this piece, if you don't get this job which will give you and your family insurance, what's going to happen to you and your kids and your husband?

Mrs. THOORSELL: Well, we'll continue to be uninsured until we have access to affordable health care. We will continue to try to obtain access. It's a struggle. It's scary. And I hope a platform like this will voice a lot of Americans' opinions. I believe that we should have access and affordability.

SHRIVER: One thing that you said when we were up in Palo Alto--you said that a lot of your friends said you were crazy to actually be going on television, that it was embarrassing to you that you didn't have health insurance, and while you were embarrassed you wanted people to know that it's not always as simple as it looks. It's not always an easy choice. Tom:

BROKAW: Thank you, Maria.
TOM BROKAW, anchor:

Well, we all have lots of questions. In fact there are so many

conflicting opinions about this issue, I can't remember one in, well, 30 years of journalism that has been more difficult for us to cover on a day-to-day basis. In fact, even getting ready for this program and reporting on health care every day, I felt like I was going into a physics final without having opened a textbook. Someone who does have lots of answers, and we've got some tough questions for her tonight, is the woman who put all of this into play, Hillary Rodham Clinton. Speaking in behalf of the president, she was the head of the health care task force and she joins us tonight. First lady of the United States and the captain of the health care team.

Thank you very much for being with us.

Ms. HILLARY RODHAM CLINTON: Thank you very much, Tom.

BROKAW: Mrs. Clinton, as we go up there and sit down, I want you to know and I want the audience to know that we're not here to do the legislation. We're going to leave that to the folks that are at the other end of Pennsylvania Avenue. But we are here to have a vigorous and we hope energetic debate and an enlightened debate. The people who don't have health insurance in America, 37 million up to 58 million in the course of a year--do you think it's their inherent right to have health insurance?

Mrs. CLINTON: Yes, I do. I think that every American is entitled to guaranteed health insurance, not just because it is the right thing to do for the individuals like those we just saw in the video, but because it is the smart thing for our country to do to make sure everybody is insured and it should be a right.

BROKAW: But you're not suggesting it is some kind of a statutory right or a constitutional right?

Mrs. CLINTON: Not constitutional, but it should be statutory. The Congress is considering legislation that would guarantee health insurance to every American and that's what's called universal coverage and that should be what we have in this country because it's the right thing and the smart economics position for us to take.

BROKAW: You saw the poll that indicated that 81 percent of the Americans in this country are very satisfied or satisfied with the health care that they're now receiving. And I think that a lot of people wonder, 'Why do we have to try to turn over the whole system just to fix a part of it that's broken?'

TEXT:

Clinton Health Plan

Guaranteed health care

Requires employers to pay most costs

Creates regional "alliances" to negotiate lower insurance prices

Sets a national health budget

Mrs. CLINTON: We don't, and I think that's one of the points that really needs to be clarified in the debate. Most of us are satisfied with our doctors, our nurses, our hospitals--we have the best in the entire world. But also in that poll which was reported today it's clear that people know we could do better, that we could reform what is broken in the system, and that we could start making it more cost effective to take care of real people's problems, and we could eliminate the great insecurity that exists. Right now the only people who can be guaranteed health insurance are the very rich who can afford it for themselves or the very poor whom we pay for. Everyone of the rest of us in the middle class--we don't know that we will have the same health insurance next year at the same price covering the same services that we do this year. So that's why we need to solve the financing problems in the health care system.

BROKAW: But there are a lot of reforms underway in the private sector, in the marketplace, big corporations and even small businesses are doing it on their own. States are doing it. Why not let that proceed and keep government interference in that process at a minimum and only worry about those people who don't have health insurance and maybe expand say Medicaid to take care of that?

Mrs. CLINTON: Well, there are several reasons why. We want to make sure everybody has guaranteed insurance because as Maria said, you know, we don't know how many more people will be uninsured. The numbers have gone up in the last several years. And when I look at the people I've met around the country, the thousands I've talked to over the past year and a half, many of them did not ever think they would have the accident in their family or the illness that struck them that caused havoc with their lives. So it's very difficult to pinpoint exactly who needs to be helped. And actually if you look at what we are currently doing, we pay more than any other country but we don't guarantee health coverage, we don't take care of everybody and because we don't we end up wasting a lot of money in our system. So I want to be sure that families like the ones we just saw, they can take care of their children when they're sick, they don't have to worry about the financial aspects of it because they'll be guaranteed health insurance.

BROKAW: Cost is terrifying a lot of people. Do you know of any government program that has not exceeded the cost projections when it began?

Mrs. CLINTON: No, I don't know of any, but I think that when we talk about government programs and the proposal that the president has made, that's one of the confusions that exists. The president did not propose a government-run health care system. He proposed building on what we have that works, namely a public/private health care system where everybody would be guaranteed not government health care but private insurance where in fact the choice of doctor and hospital and other health care professionals would be guaranteed which it is not today, and where benefits would be standard that would be cost-effective and improve

things like preventive care that are often not in insurance policies today. So what the president proposed is to build on what works for the 81 percent of us who are satisfied although we are insecure, and that is getting our health insurance through the workplace, making it affordable, and making it available to everybody.

BROKAW: Mrs. Clinton, there are a lot of people in this audience tonight who have many questions for you, and one of them of course is a small business owner. They have probably the most questions at this point about the cost and what their requirements are. And NBC's Brian Williams is with one of them right now. Brian:

BRIAN WILLIAMS reporting:

Tom, we talk about middle America. The Downtowner Diner in Topeka, Kansas, is about as close to that definition as possible. Karren Friess runs that diner. We saw you in the opening segment tonight saying, 'Welfare is a mess, Social Security is a mess--why give them something else to mess up?' What are you worried about and what do you want in a health care solution?

Ms. KARREN FRIESS: Well, I don't think it--my basic thing is I'm against employer mandates. Basic small business cannot afford to be inundated with more cost than we already have.

TEXT:

Employer Mandate: A requirement that all employers offer and pay for a portion of their workers' health coverage.

Ms. FRIESS: I--you know, I don't think that it's my obligation to insure all my employees. Nowhere does--did it ever say that insurance was a right. I already--I already furnish them with workers' compensation. Now I'm going to--you know, that covers them for eight hours a day, now I have to cover them for 24 hours a day. I don't see where the fairness is.

Mrs. CLINTON: Well, I can really understand your question. I've spent a lot of time talking to small business owners, and my father was a small business owner, and I really appreciate the bind that you often find yourself in. But what we're proposing is to do several things. One is eventually to take out your obligations under workers' comp for health care, so that we would eliminate that expense to give you the support you need financially and it would be for a very small business quite subsidized to be able to help afford the insurance for you employees. Because the problem we have now is that those folks who work for you, and I've met many, I've sat in many cafes and restaurants talking to both the employers and the employees, when they get sick, thank goodness they get to go to one of our hospitals. They do get taken care of. If they don't have any insurance then what happens is that if you have insurance on yourself and your family, your rates go up. Everybody has to pay more to take care of the people who don't pay for themselves. And the problem is that we do not have the kind of system where individuals on their own can afford that insurance for themselves. Our business system which has

really stood the test of time where the employer contributes something and the employee contributes something works for the vast majority of Americans. But it doesn't cover everybody. So we understand the financial pressure, but we also believe that we can keep the cost down once everybody is in the system. And we're going to be changing the way the insurance market operates. It wouldn't work today, I certainly guarantee you that. Because the way the insurance operates, it discriminates against small businesses like yours. You pay the load. And I don't blame you for saying, 'Wait a minute, I'm not going to get dragged into that.' But if we reform the insurance market, if everybody has to contribute, if we provide subsidies for small business, if we remove the burden on workers' comp health care cost, you're going to pay less than what a minimum wage increase has cost many businesses over the last 10 to 20 years without loss of employment. So I know that it's a difficult kind of choice, but we think we can do it in a way that will be fair and cost effective.

BROKAW: All right. Maria Shriver is with someone who represents, I think, probably the most overlooked segment of the health care delivery system. She's with a nurse here in the Warner Theater. Maria:

MARIA SHRIVER reporting:

Tom and Mrs. Clinton, I'm here with Julia Scott who is an advocate for black women's issues. And while she says she lauds Mrs. Clinton and the reform package for talking about preventive care, you're concerned that in fact there's not enough discussion about it, there's not enough in the plan for it.

Ms. JULIA SCOTT: Yes, clearly the way to keep down health costs is preventing illness and keeping people healthy. So prevention must be at the top of the health form--reform agenda. As you know, black women in particular suffer cervical cancer three times more than white women. While the rates have been going down for white women, they are increasing for black women.

Mrs. CLINTON: Well, I'm glad you raised women's health concerns because they have been overlooked and I hear it from women from one end of the country, of every race and every income group, and it is heartbreaking to meet women who have been denied the health care they need. I met a woman in New Orleans who didn't have health insurance, found a lump in her breast, went to a surgeon. He said, 'Well, if you had insurance, we'd biopsy it. But since you don't, we're just going to watch it.' I mean that happens all the time in our country. And you're right that if we have preventive health care we will not only save lives, we will save money.

BROKAW: Mrs. Clinton, you've been talking about all of the things that the bill can accomplish here, but the fact of the matter is that the Congressional Budget Office which looked at your bill and gave it a generally favorable response also said throughout it's analysis that there are so many uncertainties about the cost factor. And I think, to come back to that again, most people believe it will just continue to spiral up and up at even rates than we now have in which health care

represents 14 percent of the GNP.

Mrs. CLINTON: Well, Tom, I don't think that's what the CBO study said, but it is clear that is we do nothing we will continue to spiral. I mean we are on the road to much higher costs even though there has been some moderation in costs for the biggest of businesses and for other large purchases of health care. But what I think is really important is that we have a chance not only to guarantee security but to begin to bring costs into a more stable position than they've been.

BROKAW: One of the miracles of modern American medicine, of course, are the enormous number of highly trained specialists that we have in the system. A lot of them have great anxieties about the reform that is being talked, and NBC's Brian Williams is with one right now. Brian:

WILLIAMS: Tom, Mrs. Clinton, Dr. Robert Blabey is a surgeon in Stamford, Connecticut. It's fair to say it has been an occupation that has given you a comfortable living. It is also fair to say that you are disenchanted with medicine as ever before.

Dr. ROBERT BLABEY: Yes.

WILLIAMS: What are your concerns about the plans you see on the table?

Dr. BLABEY: My concerns about the plan is the loss of advocacy that the patient is going to have on the part of his physician. Specifically in the 27 years that I have practiced surgery, the only advocates I've known for patients have been either their physicians or members of the nursing professions. My concern with the plan for increasing the size of the health care industry, by that I mean the managed health care industry, is that when you or a member of your family is told that you have AIDS, juvenile diabetes, malignant tumor, that you will not get the kind of care that the American public has traditionally gotten and that is personalized care that they can choose on their own. I wonder what you would respond to that.

Mrs. CLINTON: Well, doctor, I think that you've talked about one of the most important problems we have which is happening right now. What bothers me is that under the current conditions, Americans are losing their right to choose their doctor or their hospital. They're being told where they can go and what kind of services they can perform. Doctors are being told by insurance company workers what they can do for their patients. I had a doctor tell me of an experience he had where he was trying to get a service for one of his patients and he was being told he couldn't do it, and he finally grabbed the phone from one of the workers in his office and said to the person on the other end, 'How much education do you have? Who are you? You don't have any clinical experience.' That's what's happening in our health care system right now. And much of what we're trying to do is to guarantee choice of doctor for the patient, not for the employer, not for the government, and to give back to doctors the right and the authority to make the kinds of decisions to advocate for their patients. But if we do nothing in the current marketplace, I can guarantee you based on everything we've seen and what doctors have told me, they will continue to lose autonomy and

authority. We think reform is the best way to guarantee that doctors are put back into the driver's seat in medicine in America.

Dr. BLABEY: Well, it might surprise that I'm not against reform. In fact I deal with what you've described every day, and this is what's frustrating. I think that if we're going to be serious about bringing affordable, basic, patient-drive health care to every American, it's only going to be through some modification of the single-payer system, and that's why... (Applause from audience)

TEXT:

Single Payer-System

A health care system (like Canada's) in which the government pays for everyone's health care.

Mrs. CLINTON: I don't disagree that the single-payer system has much to recommend it which is why in the president's plan he wants every state to have the option to become a single-payer state because, you know, if you think about it Medicare is a single-payer system. Most Americans don't recognize. Somebody comes up to me every day and says they don't want the government running health care. And I say, 'I agree with you. I don't either.' And they say they don't want the government involved. And then I say, 'Well, what about Medicare?' And oftentimes folks don't even know that Medicare is a government-financed single-payer system in which every patient has choice. And so I think you're right that we need to maximize choice and eliminate bureaucracy and paperwork. The president believes, though, that maintaining some competition and some market-driven forces will enable us to have a more efficient system, and that's what he's been pushing for. But the single-payer advocates should be able to have the option at the state level.

BROKAW: Mrs. Clinton and doctor, we're going to say that we're going to explain and talk a lot more about single payer in the course of this evening. And we're very happy that you're going to join us for the duration of the discussion. You're going to take a place here in the audience.
TOM BROKAW, anchor:

One of the most popular places, as you know, in the health care delivery system in America is the emergency room. In fact, in our poll almost half of the people said they use the emergency room because it is the most convenient. It is the most convenient but it has also become a kind of burden on the American health care system. And Brian Williams has more on that aspect of this discussion tonight.

BRIAN WILLIAMS reporting:

That's right, Tom. You cut your finger, you develop a cough, you stub your toe--whatever happened to a visit to the family doctor? Increasingly like what has happened to the American family, the equation has changed. It is more fragmented. The emergency room is primary care in many communities. We visited one of them, Long Beach, California.

Unidentified Woman #1: And how old is he?

Unidentified Woman #2: Seven.

WILLIAMS: When Danny Luna walked into the Long Beach Memorial Medical Center, he was in tears and a lot of pain.

Woman #1: Danny, sit down here, OK. Just have a seat.

WILLIAMS: Only a half hour earlier, he had fallen off a wire fence and cut his forearm down to the bone. His mother did just what thousands of parents do every day in hundreds of cities across the country--she rushed him to the emergency room of the local hospital.

Woman #1: Can you move your fingers? Can you feel this?

WILLIAMS: It is a decision that triggers the highest quality medical care in the world. But it's also the most expensive.

Woman #1: Take care of him, all right?

WILLIAMS: As Danny waited for his surgeon's verdict, he was surrounded by patients whose ailments were not emergencies--children with asthma, babies with fever from teething, women with headaches, teen-agers with sore throats, all of whom have turned to their local emergency rooms for primary care that could be provided for one-tenth the cost at a physician's office or neighborhood clinic.

Unidentified Man: I don't have a family physician. I was having fever last night, and my throat was hurting a lot, and I couldn't stand the pain today in the afternoon, so I had to come to the hospital.

Dr. DANIEL WHITCRAFT: Well, we're the department of available medicine. We're open 24 hours a day, seven days a week. Last year we had about 50,000 patient visits. I'd say about a third of them could have been treated in a different kind of facility, in a doctor's office, an urgent care center, the clinic.

WILLIAMS: The problem is that emergency rooms with all their elaborate trauma technology and highly specialized staff are also the most expensive and least efficient places to provide walk-in primary care to the public. Baby Eric was brought to the emergency room with a fever logged in by the nurse at 99 degrees, but the hospital is required by law to examine him. His mother gets assistance from the state of California from a program called Medical. She'll never see the bill and she likes the convenience.

Unidentified Woman #3:: I love it here. This is a great hospital and every time he's--there's something wrong with him they get everything done really quick, even if I'm really far away from it I'd rather come here.

Dr. WHITCRAFT: The minute they walk in the door, we're going to do a

medical screening exam. And if they have an emergency medical condition, we're going to treat them and stabilize them. If we fail to do this, if we turn them away because of lack of insurance or whatever, and don't do an adequate medical screening exam, if they turn out to have an emergency medical condition we can get sued, and it's worse than malpractice. Every time this mother comes in with her child, we tell her that it's important to establish a relationship with a primary care physician. If she's been in here with each of her children six or seven times now, I'll bet you she has 21 referrals to physicians that they either wouldn't take her on her time limit or don't take Medical.

WILLIAMS: This is the crux of the problem.

Dr. WHITCRAFT: Medicaid pays me about 17 percent of billed charges. OK if I bill a $100, I might get $17 back and that is usually less than a private physician's overhead for one patient. They can't pay their office expenses with the reimbursement they get, so frequently these Medicaid patients don't have any where else to go.

WILLIAMS: Dr. Whitcraft believes it's futile to blame the patients.

Dr. WHITCRAFT: I don't think you're ever going to make an emergency department see only emergencies, and there will be abuse, and we would like less of it and I think the only way is public education. Not turning them away at the front door.
TOM BROKAW, host:

Brian, we are joined now on the panel up here by two of the principles who are involved in the political debate, which has now reached fever pitch not too far from here on Capitol Hill. From your left is Senator Bob Dole of Kansas, who is the Senate Republican leader, George Mitchell, who is the Senate majority leader, and he's leading the effort on the president's behalf. Joining them here tonight, Barbara Otto, who is a consumer advocate, she's very much in favor of single payer plans, and another doctor who is with us tonight is Susan Toll, she's from the state of Oregon, where they've had a very controversial but quite successful plan in terms of determining who gets what in health care.

Senator Dole, you heard Mrs. Clinton say that she believes that it's the right of every American who does not have health insurance or coverage of some kind to in fact have it. Do you agree with that?

Senator BOB DOLE: Well, we're working right now in the Senate Finance Committee, and I think in a number of the areas we're looking at you will have that right, you'll have guaranteed issue, you'll also have accessibility and we think affordability, so that you--I think under most any of the plans we hope we can address that issue on insurance reforms.

BROKAW: In how long?

Sen. DOLE: Well, we're--as you say, it's at fever pitch right now on Capitol Hill, but I...

BROKAW: No, no, not about when the bill comes out...

Sen. DOLE: Oh, I see.

BROKAW: ...how long do you think before we'll be able to fold most of the country into some kind of a system in which they have universal coverage?

Sen. DOLE: Well, that's a little different question. I think it's how you're going to get there. If you have to use employer mandates, as my friend from Topeka indicated, that's going to be a problem.

TEXT:

Employer Mandate: A requirement that all employers offer and pay for a portion of their workers' health coverage.

Sen. DOLE: But we believe we can make great progress with some of the insurance reforms, small business reforms, maybe get up to 91, 92 percent, and then take another look in two or three or four years. We know there are a lot of problems out there that need to be addressed, and Congress meets every year, we can go back and look at it in a couple of years. If we haven't gotten up to where we think we should be, then we'll try something else.

BROKAW: Senator Mitchell, can you blame the small business owners for resisting the idea of mandates and having to kick in on something that they're not now having to pay for when their margins of profitability are already so small?

Senator GEORGE MITCHELL: No, of course not, but I think the important point to be made to them, in addition to those made earlier by Mrs. Clinton, is that the overall cost of health insurance will decline if reform is enacted and it will then be within their reach financially when combined with the subsidies. And I believe that most small business owners want to insure their employees, in fact they know their employees much more intimately than do large employers, but they feel they can't because of cost. If this plan is adopted it will bring it within reach to them because they're now paying 35 percent more for the same insurance that a large company is paying because of discrimination in the marketplace in the sale of insurance. I believe--and--and also, Tom, you should know that there are a very large number of small businessmen and women who insure their employees and who strongly favor reform because for them they'll get coverage at much less cost than they're now paying.

BROKAW: But, Senator, everybody agrees that health care reform is going to cost more at the outset, and I think that the worry is that it's going to cost more than they can afford, and the fact of the matter is at this point can you sell that politically to the country?

Sen. MITCHELL: Well, I don't know if it can be sold politically to the country, that's a different question from whether it's the right thing to do. I believe it is right, I believe it can be sold because it is right. Obviously it's difficult. I also disagree that it's going to cost a lot more. The--the--you had a poll up here that said 81 percent are satisfied with health care, that doesn't mean they're satisfied with the

cost of health care. For Americans, the average family will see their costs double before the end of this century if we don't have reform. So I think it's got to be done both because it's right and because it's what the country needs.

BROKAW: We're going to keep the political rally aspects of this to an absolute minimum here, if we can, tonight, but the fact of the matter is, Senator Mitchell, that our poll also indicated to us that people care more about universal coverage and about the quality of care than they do about cost at this point. And when we asked them whether they're willing to pay more to try to get universal coverage, almost all of them said 'No,' or only a small amount more. TEXT:

WHICH OF THE FOLLOWING DO YOU THINK SHOULD BE TOP PRIORITY FOR HEALTH CARE REFORM?

A. Controlling the Cost 25%

B. Maintaining High Quality of Care 30%

C. Providing Coverage For All Americans 40%

D. Not Sure 6%

Do you think that the American people have been spoiled by the idea of entitlements and what's happened with Medicare and Medicaid and a lot of the other entitlements that have been available?

Sen. MITCHELL: No, I do not. There is--it's fashionable these days to criticize those programs. You repeated the question to Mrs. Clinton, several people said on the show 'What's the government ever done that's good or...

BROKAW: Right.

Sen. MITCHELL: ...that the cost hasn't come down?' I disagree with the premise, I think Social Security and Medicare have been spectacular successes in American life. They have lifted the elderly of our society from the poorest to one of the--one of the better cared for in our society. I think the GI Bill and civil rights and bordering rights, a lot of things the government has done has worked, and I believe, therefore, this can work. I really do believe it and I think we need it and I believe we'll do it.

BROKAW: Isn't the long view important here, Senator Dole, that if we're ever going to get health care costs under control in this country we're going to have to bite the bullet now?

Sen. DOLE: We--we'll have to bite the bullet, but under CBO estimates, if we don't do anything in the next five to 10 years the cost will be about 20 percent of GNP, if we adopted the president's plan the cost would be about 19 percent. So are we biting the bullet? I think many of us think not. But I--I also believe, as Senator Mitchell has indicated, that the government's into health care now, I get the same question Mrs.

Clinton's--go out and have town meetings, the governments and the Medicaid, Medicare, VA hospitals, public health service, and I think that's one area we need to focus on, we need to make investments in community health centers, public health service centers, because there are always going to be some people who are going to fall between the cracks. So our view is let's move on what we can do, subsidies for low income, tax credits. There's a lot of agreement in the Senate Finance Committee, and I hope we can come out of there with a bipartisan agreement.

BROKAW: Maria Shriver's with someone who needs health care right now.

MARIA SHRIVER reporting:

That's right, Tom. When Senator Dole was talking earlier there was a lot of rumbling going on in Phyllis Salowe-Kaye's section. She has a tumor growing in her head and she's angry and she said 'I don't have time to wait.'

Ms. PHYLLIS SALOWE-KAYE (Hackensack, New Jersey): I--I need to be able to know what kind of health coverage that I'm going to get that I can work with my doctors to plan to get the best care possible so that I can go where I need to go to get that care. You go to the Mayo Clinic every year for your physical...

Sen. DOLE: Well...

Ms. SALOWE-KAYE: ...I need to be able to do the same thing, I need the same health care that you get, the same health care that we pay for, and I need to make sure that what plan comes out is going to let me know what my coverage is and that I'm not going to be paying more and getting less.

SHRIVER: And you want it now.

Ms. SALOWE-KAYE: Right now.

Sen. DOLE: Well, I certainly don't disagree with that at all, in fact we discussed today in the Senate Finance Committee how we can have employers buy into the federal employees' health benefits plan. And we're also concerned about pre-existing conditions, which would take care of the problem you have, about portability, job loss. I mean I think all these areas that we agree on are going to be very helpful to people generally across America. And I don't go to Mayo's every year for a checkup, but I've had a lot of health care in my lifetime, and I know a little about affordability and accessibility. I know a lot of people who have serious problems, and we want to address those problems. I don't think it's--it's a question of addressing the problem, it's how do we do it and still preserve the best health care system and still keep the satisfied people, the 81 percent, the 200 million Americans who are pretty well satisfied with what they have to date. Let's fix the 15 percent, let's take care of your problems without doing somebody out of--of a job or--or maybe causing business problems in small business across America. I don't think we have any debate on that--any dispute on that.

BROKAW: There are so many phrases that are being kicked around here tonight, single payer, mandates, pre-existing conditions, and so on. I think it would be very helpful if right now we told you a little more about something called pre-existing conditions and the difficulty of getting coverage for that. Maria Shriver has looked into that issue for us.

SHRIVER: That's right, Tom.
MARIA SHRIVER reporting:

Imagine this: you get cancer and then you find out that your insurance company won't cover it. That's what happened to Alan Fuller. He was diagnosed with lung cancer, he had insurance, he thought he was covered, he thought he was OK, but Alan had failed to read the fine print.

Unidentified Woman: Keep a nice fist just like that, that's perfect.

SHRIVER: In mid-December of 1993 Alan Fuller was diagnosed with lung cancer.

Woman: You OK?

Mr. ALLEN FULLER: Yeah.

SHRIVER: Ten days later he and his wife, Meg, found out from their insurance company that because of a loophole in their policy Alan was not covered.

Mr. FULLER: You feel as though if you get sick, especially with something as catastrophic as cancer, that--that people will make allowances for you, that they'll be--they'll be understanding. You expect that there will be safety nets for you to depend on.

SHRIVER: There are few safety nets for Alan and an estimated 81 million Americans under the age of 65 who suffer from illnesses that were diagnosed before their medical insurance went into effect. Insurance companies call that pre-existing conditions.

Alan and Meg own a small used book store in the Georgetown section of Washington, DC. They didn't read the fine print in their policy, which, like most, demanded a 30-day waiting period before covering any illness.

So let me understand this. Had you found or had you been diagnosed with cancer 15 days later than you were, all of these bills would be paid?

Mr. FULLER: That's right--that's right. You know, we--we did buy a policy, we did invest in health insurance, you know, I took care of it. Now I think it should take care of me, but it doesn't, you know, it appears as though it's not going to.

I mean, what difference does 15 days make? It makes all the difference to us and very little difference to them.

SHRIVER: At this point, the Fullers' $30,000 worth of medical bills

accrued so far are not their biggest worry.

Mrs. MEG FULLER: It became clear to me that we were not getting the care we deserved because of money, flat out, no question in my mind. And our first visit back to the oncologist, Alan had been feeling fuzzy in his mind and didn't know if it was because of the painkillers or because it was something larger we should be worrying about, if the cancer was spreading to his brain. And so we asked the doctor and he said, 'Well, if you had insurance, we'd do an MRI just to be sure. But since you don't, we won't.'

SHRIVER: What did you say when your doctor said that to you?

Mrs. FULLER: It--it doesn't hit you when you're sitting right there.

SHRIVER: And then when you come home, it hits you.

Mrs. FULLER: And then you come home and you say 'Wait a minute, did he really say that?' Yes, he did, and he meant it.

Mr. FULLER: I mean he is, after all, the doctor and--and you're brought up to trust them and listen to them, and if he says something like that you go, 'Oh, you're right, I guess I can't afford it and I probably should go home.'

SHRIVER: Alan's oncologist, Dr. Bruce Kressel, feels caught in the middle.

Dr. BRUCE KRESSEL: When the patient lacks insurance the patient himself is really responsible for the expenses, and I can't make one phone call and say, 'Excuse me, I have a patient who doesn't have insurance, please take care of--of all his problems.'

Mr. FULLER: It's a numbers game. I'm something that figures into their business. As far as they're concerned, I'm not a human being in need of medical care. That scares me.
MARIA SHRIVER reporting:

I'm here with Meg Fuller, Alan's wife. And we should say that Alan is here tonight in the hall, but his condition has gotten so bad since we shot that piece a couple of weeks ago that he's not even able to come down here.

Meg, I know that you've had to shop around for an inexpensive form of chemotherapy and that you're convinced that that's made his situation even worse.

Mrs. MEG FULLER (Washington, DC): I have to believe that a three-week delay in treatment can't be beneficial.

SHRIVER: So you think money has dramatically affected his chances of life and death?

Mrs. FULLER: I have to say I do, yes.

SHRIVER: Tom, I think that's the big question a lot of people who have pre-existing conditions, who have insurance feel like they pay in and the system isn't there to help them when they desperately need it.

TOM BROKAW, host:

Senator Dole, the Republican Party wants to reform the insurance policies in the country and--and deal with things like pre-existing conditions.

Senator BOB DOLE: No doubt about it.

BROKAW: But the only way you can really do that, even the insurance industry agrees, is to have some kind of universal coverage, correct?

Sen. DOLE: I don't think anybody objects to anybody being covered. There are some people who will never be covered because of the illegal immigrants, you'll have people not in the workplace, and things of that kind. But it's not--I think it's how you get there.

BROKAW: Barbara Otto, you're in favor of a single-payer system.

Ms. BARBARA OTTO (Health Care Consumer Advocate): Yes. I hear these terrible stories, the first woman where the birth of their child cost so much money, the last woman talking about her husband, and I keep saying to myself, 'Single-payer from cradle to grave.' It's fair, it's simple, it works.

TEXT:

Single-Payer System: A health care system (like Canada's) in which the govt. pays for everyone's health care.

Ms. OTTO: Minor payroll tax, a progressive income tax, even the Congressional Budget Office says it's going to save us 100 billion in the first five years. A single-payer solves our problems.

BROKAW: Senator Dole, Senator Mitchell, there's no political will that is overwhelmingly in favor of single-payer on Capitol Hill. Is that a fair statement? They've got a lot of--a lot of co-sponsors up there.

Senator GEORGE MITCHELL: That is--it's a fair statement to say there's no overwhelming political will for a single-payer, but it's an incomplete statement because there's no overwhelming political will for any other particular proposal either. That--that I--I believe that the president's plan is the best one because it combines market forces with the option for states if they choose to elect a single-payer system.

Sen. DOLE: And that's true in almost every plan. I mean the states have that flexibility. So I--I don't disagree with what else Senator Mitchell said, because I don't know of any plan that has enough votes now to pass the Senate or House. That doesn't mean we haven't stopped trying.

BROKAW: But, senator, would you like the idea of a national single-payer

system, just scrap all these other plans?

Sen. DOLE: Oh, no.

BROKAW: Why not?

Sen. DOLE: No, I wouldn't like that at all.

BROKAW: Why not?

Sen. DOLE: I think it's going to lead to rationing, I think it's going to cost more. I don't...

BROKAW: We're going to have...

Sen. DOLE: We're not--we're not Canada, we're not 20 million people, we're 250 million people, and I know they say, 'Well, the plan would be different if it operates in the United States.' No, I--I think we need to preserve the best of what we have, we need to fix what needs fixing, and we need to get it done as quickly as we can. And I--I think there's enough will to do that.

Ms. OTTO: Well, with all due respect, we have rationing now. We have people who can't afford to have children, we have people who worry every day about their children getting hurt and not being able to take care of it. We have people right now who have private insurance, like my parents, a small businessman, who has insurance, pays premiums, but has a $2400 deductible. That is not meeting the needs of the people, and that is rationing, even though he has insurance.

BROKAW: Let's take a look at a single-payer system. In fact, NBC's Brian Williams looked at the system as it's being proposed in California. Brian:

BRIAN WILLIAMS reporting:

Tom, this is a hot button issue, it is on the ballot in November. At first blush, sounds very attractive, go to the doctor, receive health care, you don't get a bill. Do you pay for it? You betcha. But it has a lot of proponents, a lot of people are looking West for the answer. Unidentified Woman #1: I'd like to introduce Dr. John Rourke, who is going to--he's a gastroenterologist in private practice, and is going to give us some information about the initiative, which has qualified for the ballot.

BRIAN WILLIAMS reporting:

Welcome to the frontline in the battle that changed health care in California. It's something called a single-payer system.

Unidentified Man #1: I think that's one of the good things about a, you know, a single-payer system is it just--it says it's going to be one insurance company, everybody's in it, nobody's excluded.

WILLIAMS: At hundreds of small gatherings like this one in Berkeley, a grass roots army called Californians For Health Security is trying to convince voters that the nation's biggest state can do a better job paying for health care than the insurance companies.

Mr. GLEN SCHNEIDER (Californians For Health Security): In November, Californians will have the opportunity to vote to establish a comprehensive health care system that will cover everybody in the state for everything that's medically necessary and will guarantee health coverage from the time you're born to the time you die.

WILLIAMS: What is a single-payer system? Simply put, the government pays all the bills with your tax money. A similar plan has been at work in Canada since 1971.

Under the single-payer plan every legal state resident would be given a card entitling them to just about any kind of health care, from a checkup at the doctor's office to major surgery. The doctor or hospital gets paid by the government, you never see a bill. The money comes from a payroll tax of 2.5 percent, replacing the money people are already paying in insurance premiums, deductibles, and out-of-pocket expenses.

Critics of the single-payer initiative here in California say it would give the government too much control over health care spending. They also say it might delay some health care procedures, and that it would create an even larger health care bureaucracy.

Dr. JOE SUGARMAN (Ear, Nose & Throat Specialist): You have basically a bureaucrat who doesn't know you and doesn't know me making pivotal decisions about your care and taking the whole process out of our hands. How many days should you be in the hospital? Is that too many? Do you really need this procedure?

WILLIAMS: Where do you come down on this item on the California ballot, the single-payer--the notion of a single-payer system?

Mr. BILL GRADISON (Health Insurance Association Of American President): Frankly, we think that that proposal would devastate the California economy because basically what it would require is a massive increase in taxes on businesses and individuals in California because taxes would be substituted for premiums as the means of paying for health insurance for the people in that state.

Mr. MARK GEIGER: I want you guys to wear your helmets on these things, OK?

WILLIAMS: It is an emotional issue, especially for someone like Mark Geiger and his family. Last year, Geiger's wife Patty died of cancer. At first, their insurance company would not authorize a bone marrow transplant, they called the procedure experimental. By the time the company changed its mind, six weeks later, doctors said it was too late. Just months before her death, Patty Geiger took her case to Congress.

Mrs. PATTY GEIGER (June 24, 1992): I feel as if the insurance company

played with my life. Their delay may have cost me the best medical chance I had to cure this disease.

Mr. GEIGER: I'll never really know for sure whether it would have worked. But, you know, you're always hoping that it would. She certainly was hoping and she certainly felt that the delay cost her her life. She went--she went to her grave feeling that.

WILLIAMS: Supporters of the California initiative say their plan would prevent exactly that kind of situation.

Mr. SCHNEIDER: Well, she would have gotten the health care she needed when--when her doctor thought she needed it rather than have to wait. And to me that--that seems like a good deal.

WILLIAMS: So far, more than one million Californians agree, signing petitions to place the single-payer initiative on the November ballot. If it passes, the real test will come when the government takes over from the private insurance companies and the people find out if they are still in good hands.
BRIAN WILLIAMS reporting:

Glen Schneider got it on the ballot. He chairs the campaign in California and, yes, you would shoo the insurance companies out of the state of California, but the question you are always answering is, 'Are you sure you want the state of California running health care?'

Mr. GLEN SCHNEIDER (Single-Payer Referendum Organizer): Well, first of all, the state of California doesn't run health care, it would finance health care, but health care is privately delivered. So the guy who said that a bureaucrat is going to make decisions, he's describing the present insurance company system. Under this system, the doctor is free to make whatever decision the doctor and patient think is right. We get out of the doctor's office and just pay the bills.

WILLIAMS: Tom:

TOM BROKAW, host:

Thank you, Brian.

Senator Dole, were you surprised to hear that doctor say that he probably would like a variation of a single-payer system? And the California AMA, in fact, has said that they would rather have a single-payer system than have insurance companies tell them what they can do.

Senator BOB DOLE: Oh, I think there's a lot of frustration with insurance companies, and I think if doctors are looking at it from their personal standpoint they'd be better off, they'd be compensated for all the care they give. But I--I get back to the basic thing, I think we need to give people a lot of choices. Somebody asked about federal benefits, we have a lot of choices. The consumer ought to have a lot of choices. You ought to have medical savings accounts. If you want catastrophic coverage you shouldn't be forced to buy a standard package, one size

doesn't fit all, family sizes are different. And we're considering now to require a lot of Americans who already are satisfied with their coverage maybe to change their coverage and have a standard benefit package.. But, in my view, that's--there ought to be choices, it ought to be up to the consumer and not up to the government.

BROKAW: This is a dizzying and complex political as well as medical as well as economic situation. Maria Shriver is with someone who has something to say about all this.

MARIA SHRIVER reporting:

Well, I'm here with Mike Tanner, who says the single-payer discussion makes his blood boil, thinks it's nothing short of socialized medicine.

You're angry about it.

Mr. MIKE TANNER (The CATO Institute): Absolutely. I think--I think that single-payer is--is socialized medicine in the most classic sense. And the simple fact is that every government-run health care system in the world rations care. They either ration it explicitly such as in Britain, where if you're over the age of 55 you are not allowed kidney dialysis, if you have kidney failure you go home and you die. Some 1500 Britons die every year because they're denied dialysis. Or you ration it by waiting lines, such as in Canada, where you can wait two-and-a-half months for a pap smear, five months for a mammogram, and so on.

Dr. STEFFIE WOOLHANDLER (Harvard Medical School): And that is not true either.

Mr. TANNER: I want to know what--what kind of guarantees the single-payer advocates have that we won't have that sort of rationing in this country.

BROKAW: It seems to me that's right to you, Barbara Otto.

Ms. BARBARA OTTO: First of all, the--that's simply not true, what you just said. I actually just got back from Canada and have been making myself familiar with the Canadian system. And one thing I can say is that 96 percent of Canadians are satisfied with their care and in Canada no one waits more than 24 hours for emergency care. In the United States that is not true. And the other thing I'd like to tell you, sir, is that this is not socialized medicine, this is actually one of the most fiscally conservative plans. It maintains private competition between health care providers.

BROKAW: Maria?

SHRIVER: Mike was just saying that he wasn't talking about waiting for emergency procedures, but in fact he's talking about waiting if you want to have elective surgery, and people in Canada are waiting.

Mr. TANNER: That's right. Although, I will say that Canadian heart surgeons, for example, will say that the risk of dying on the waiting

list for heart surgery is eight times the risk of dying on the operating table. But primarily I'm talking about elective surgery. The type of thing that happens with Ontario last year, for example, closed its hospitals the last two years of the month of December because they ran out of money. That surgeries, elective procedures were postponed repeatedly, and many patients remained in pain.

SHRIVER: This is the kind of thing that terrifies people about single-payer.

BROKAW: I think that Brian Williams is with someone who is trying to make herself heard on that side of the room.

WILLIAMS: You might have heard her on this side of the aisle. The thunder from the right, as it were. Identify yourself and your--your chief beef with what you heard.

Ms. WOOLHANDLER: OK. I'm Steffie Woolhandler, I work at Harvard Medical School, I am a physician, and I'm a founder of a group called Physicians For National Health Program. And we do advocate a single-payer Canadian style system for the US. But I want to correct some misconceptions. First of all, Canadians actually get more care than Americans, they get more preventive care, more primary care, more days in the hospital, more routine procedures like surgery, and they even get more of some services like bone marrow transplants and lung transplants than Americans. Canadians live two years long. Now the reason they can do this is because a single-payer system does not waste money on paperwork. The average--of the average health care dollar in the US, 25 cents is going for paperwork, 25 cents on the dollar is a paperwork cost that we spend in the US to keep the private insurance industry in health care. In Canada, paper-pushing costs 11 cents on the dollar. So do the arithmetic, that means there's $100 billion a year in paper-pushing costs that you save with a single-payer, and you can use that money to provide care for people, including bone marrow transplants, which Canadians get more of than Americans.

BROKAW: Senator Mitchell, up here on the panel, has something he'd like to say.

Senator GEORGE MITCHELL: I believe that every single American ought to have the right to have the same health insurance that Senator Dole and I have.

BROKAW: Why not take the federal system, Senator Dole, and just make it the national plan? It's an awfully good system. And you get a lot of choices within it.

Sen. DOLE: Well, we're practically--we're looking at that right now, letting employers buy into this system.

BROKAW: Is that an endorsement of your part, that you would--you'd like to have that come out of the bill?

Sen. DOLE: Yeah, we would--I would support that. I think--we can't tell

people to have a system like ours and say you can't do it. But I think the bottom line is is whether we're going to give America sort of back to the people or turn it all over to the government. I think most Americans are afraid of this mountain of bureaucrats between the, you know, them and their doctor. And you say, 'Oh, that's not going to happen.' If you have global budgets and you run out of money and you're forced into an HMO, you may not be able to see the doctor of your choice. You may want an HMO, they're fine, they do good work. But we've got some tough choices. And it's not--it--I don't think it's partisan, I think it's just a question of how we can put it together and satisfy the concerns that most Americans have.

BROKAW: Senator, you were talking about the bureaucracy and the enormous weight of that. We already have that as well, and in fact we had Brian Williams take a look at what we call the paper hospital, the enormous amount of work that has to be done. Brian:

BRIAN WILLIAMS reporting:

Tom, we heard President Clinton say it at the top of this broadcast. Hospitals, health care in general drowning in paperwork, everyone involved in the field is looking for relief. If you visit a doctor or hospital, you know this. Let's visit one now.
Unidentified Woman #1: Mr. Norfleet, do you want to come with me?

BRIAN WILLIAMS reporting:

Seventy-one-year-old William Norfleet has come to Sentara Norfolk General Hospital for cardiac surgery.

Unidentified Woman #1: Do you have Medicare as your primary insurance?

Mr. WILLIAM NORFLEET: Right.

Unidentified Woman #1: Northwestern is your secondary? I have some questions that are mandatory by Medicare. Are you presently disabled, 65 years or older, or a kidney patient?

Mr. NORFLEET: No.

Unidentified Woman #1: Were you a coal miner?

Mr. NORFLEET: Oh, no.

Unidentified Woman #1: OK. I also have here the financial agreement.

Mr. NORFLEET: You want me to read all this?

Unidentified Woman #2: Feel good?

Mr. NORFLEET: I feel good.

WILLIAMS: Norfleet's arrival activates an army of bureaucrats at the hospital.

Mr. DAVID BERND (Sentara Norfolk General Hospital, Virginia): Clearly, hundreds of our employees in our hospital here in Sentara do paperwork.

Unidentified Woman #3: The first one is for cardiac catherization, and I have one more for you to sign.

Unidentified Woman #4: Could you fax me a copy of that letter.

Unidentified Woman #5: We got a denial, $90 some thousand dollars.

Unidentified Woman #6: Every time we file on, they say we need more information.

WILLIAMS: But the real mountains of waste are unseen by patients. Teams of hospital workers must document and file and analyze and defend and review every medical and accounting detail over and over again. Why is all this necessary? Largely because government and insurance company regulations designed to save money for patient care require a bureaucracy so large they end up costing much more than they could ever save.

Mr. BERND: We deal with over 500 separate insurance companies, all with different regulations, different billing procedures, different paperwork. It's incredible.

WILLIAMS: Administrator David Bernd has cut some waste in the hospital. Streamlined medical charts save nurses 90 minutes of paperwork per shift, and Bernd is spending $50 million on a new computer system.

Mr. BERND: But without outside simplification of the health-care financing system, a lot of the benefit from this investment will not be realized.

Unidentified Woman #1: Are you allergic to anything?

Mr. NORFLEET: Hmm-mm. Nothing but this ordeal here.

WILLIAMS: Mr. Norfleet's operation, an angioplasty, will clean out some clogged arteries near his heart. The unnecessary paperwork generated by Mr. Norfleet's hospitalization will cost him, his private insurance company, and taxpayers funding Medicare an enormous sum. Moment by moment, the charges mount--surgeon Dr. David Ishe, nurses, technicians, equipment, medication, and a staff to process the paperwork.

Dr. DAVID ISHE: The results are really quite satisfactory.

WILLIAMS: By the end of the first day, the hospital bill is well past $8,000. The bureaucracy works around the clock to keep up. By morning, William Norfleet is doing so well, Dr. Ishe says he'll be able to go home later in the day.

Dr. ISHE: Absolutely.

WILLIAMS: And because he's well-insured, he is spared the ordeal of

settling the bill for his 30-hour hospital stay before he goes home. What is the final amount here?

Mr. BERND: The total bill is $10,300.

WILLIAMS: And what of that amount is unnecessary paperwork?

Mr. BERND: About 20 percent of the patient's bill.

BROKAW: Which brings us to the whole area of technology, and how it not only eliminates paperwork, but how it extends lives. And what we don't have our hands around in terms of projecting cost is what's going to happen five years, 10 years, 20 years down the road as we develop more and more extraordinary medical technology. Isn't it fair to say that we just don't know where that cost curve is going, Senator Mitchell?

Senator MITCHELL: That is true. Technological innovation is one of the great successes of American medicine. It's one of the reasons why we have the best and highest quality of care in the world to those Americans who have access to it. But it's also a source of very, very rapid increase in cost. What we need is the data and the mechanism to evaluate the benefit and the cost of various technologies. We don't have that now, and it's contributing significantly to our costs. We have to keep the technological innovation, but we have to begin to assess the cost of each of those innovations.

BROKAW: Dr. Tolle here deals a lot with medical ethics. Dr. Tolle, people have said that in most countries death is inevitable. In America, we treat it as an option. And we can treat it as an option in part because we have so many wonderful machines that can extend life. And a grieving family with someone who's critically ill is going to say, "Put him on the machine. Keep him alive as long as possible." In Oregon, you're starting to deal with that question of rationing and when we make the hard decisions. Are we ready as a culture to do that, do you think?

Dr. SUSAN TOLLE (Medical Ethicist, Oregon): Well, I think we struggle a lot. The other thing is that insurance plans also have really flipped the incentives. If I'm caring for a patient who's dying, they will get superb compensation, if they're insured, for the intensive care unit, the ventilator, dialysis, everything. If they want hospice, if they want to do what Jackie Onassis did, and go home to die, they may well get no coverage at all. And even during the day or so while we arrange for the transfer to home, we need to leave the IVs in and a few things going or insurance will stop paying.

Now, we've got to make some changes about those kinds of things. Because in Oregon, that's one of the first things people said was, 'We want compassionate care, we want hospice. Those things are a priority.' But when people are actively dying, aggressive, life-sustaining treatment is less of a priority. But I think we can't afford Senator Dole's plan that he's on and that Congress is on for everybody in this country. I think we will bankrupt the country. I think we will have to come to some tough choices of saying no to some things.

BROKAW: Senator Mitchell, 57 percent of the people that we questioned said, 'You know what? We're so confused about this debate this year, we'd just as soon have the bill passed next year.' Why not continue the debate for another 12 months?

Senator MITCHELL: Well, personally, I'm not going to be there next year, so I'd like to get it done this year. But personal considerations aside, I believe that there is a moment in time when there is a consensus in the country that change ought to occur, although no consensus has yet formed on precisely what that change should be. And I believe that if we don't pass it this year, having nothing to do with me, it will be many, many years before it comes up again. Secondly, it takes legislation of this magnitude to be enacted a total commitment and a massive push by the president and an entire administration. We're now having that for the first time in many decades, and I don't know that going into the last two years before an election--we don't know what the outcome is going to be then...

BROKAW: Do you think we will have a bill this year?

Senator BOB DOLE: Well, I think we will have a bill. But I think the bottom line is to get it right and not set deadlines, say it has to be done by Labor Day or the end of this year. If we can pass...

BROKAW: Well, wait a minute--wait a minute. That is the question. Are we going to have it this year before the elections?

Senator DOLE: This--have a bill?

BROKAW: Yeah.

Senator DOLE: We--we could have a bill this year if we would take what we agree on. It'd be probably 20, 30 different provisions that have broad bipartisan support, so I would say yes. But I want to warn--you talk about technology. If we're going to impose price controls, as we have in the president's bill, we're going to stifle technology, experimentation, research, and development, and I think we need--need to watch things like that if we're worried about the future and--and medical care in the future.

BROKAW: Thank you all very much for being with us. We want to remind you that we are going to have a new panel in just a few moments. We're going to have a discussion here of: How do we pay for all of this? Who should be delivering it? But first, this break that includes your local stations.

TEXT

WHO DO YOU THINK WOULD DO A BETTER JOB IMPROVING HEALTH CARE: PRESIDENT CLINTON OR CONGRESS?

A. CLINTON 29% B. CONGRESS 42% C. NEITHER * 15% D. NOT SURE * 13%
TOM BROKAW, host:

We're back on TO YOUR HEALTH, our journey across the rugged terrain of American health-care reform. We want to deal now with the whole question of who pays and how much. We have been hearing a great deal tonight about that. Some people who are directly involved in the debate are with us now. We have, first of all, Margaret Jordan from Southern California Edison. She's in charge of a lot of employees out there at a big utility company, worrying about their health and welfare benefits. Herman Kane is from Godfather Pizza. You probably remember him from a spirited exchange that he had with the president of the United States about small business mandates, and how much it's going to cost small business.

Larry English is from the Cigna Health Care Company. He is a member of the so-called Jackson Hole group, a group that took a look at health-care reform for a long period of time in a very bucolic setting, I dare say. And Bill Kissick is from the University of Pennsylvania. It is fair to describe you, I think, as a medical economist, someone who is one of the original authors of Medicare, and you've been looking at the economics of your profession for some time.

We have--we've heard a lot tonight about employer mandates and how we pay for health-care reform. Godfather's is made up of a lot of small businessmen. These are individually owned franchises.

Mr. HERMAN KANE (Godfather's Pizza President): Yes.

BROKAW: You told the president they simply can't afford to have small business mandates in which they kick in for their employees' insurance.

Mr. KANE: That's right.

BROKAW: Why not?

Mr. KANE: The reason is, is because the economics of the typical restaurant in this country, which are very similar to the typical economics of many small businesses in this country, the economics simply can't absorb a major hit relative to the size of the cost of the Clinton health-care proposal. And so what would happen--let me first point out that most people--no one will disagree with the objective. No one would disagree with all of the individual cases that have been identified. But what many people have a problem with, particularly in the business sector, is how we get there. And if we take a plan as complicated as the Clinton proposal--as costly as the Clinton proposal, it would eliminate lots of jobs right away. So I believe that one of the first questions that we've got to really answer in this debate is: How much are we willing to pay in order to get there, not only today, but later?

BROKAW: But in Southern California, if you've a Godfather's pizza place, and you don't insure the employees there, there's a good chance that maybe Ms. Jordan is insuring them, because maybe a spouse works at Southern California Edison, and they, in fact, have full coverage. So you're kind of living off Southern California Edison. Is that fair?

Mr. KANE: It's not fair if you ask that question in a vacuum, but is it fair for that individual not to have a job at all? I mean, the fact of

the matter is, we have a lot of people that are working who do not have health insurance because that job comes first. I empathize with the 37 million people who do not have health insurance. But I am also concerned about eight million people who do not have jobs, and the additional people we would add to the rolls if we take the wrong approach. That is the issue that I'm raising and that is the issue with a lot of business people that I've talked with.

BROKAW: Ms. Jordan, what is your point of view on all of this?

Ms. MARGARET JORDAN: My point of view is that it is a competitive issue for big business also, and the cost-shift from these--the workers that are in companies that don't insure fully to companies like ourselves is significant.

BROKAW: Dr. Kissick is with us here. Have we gotten to the point in this country when it comes to health care and other entitlements, either through private carriers or through the government, we really expect something for nothing?

Dr. WILLIAM KISSICK (Co-Author Of Medicare, 1960's): I don't think we expect something for nothing. I think we may expect more than we think that might be appropriate for somebody else. But I think that with expenditures this year, we'll achieve $1 trillion in health and medical care before December 31 this year. That's 12 zeroes. I think we're certainly capable of providing universal access to appropriate comprehensive health care for a population of 260 million. It can be done.

BROKAW: Mr. Kane, there is somebody out in the audience who is sympathetic to your point of view, and Brian Williams is with him now.

WILLIAMS: Sal Risalvato has been a very patient man this evening, Tom, and I have finally gotten to him. He owns the Texaco Station in Riverdale, New Jersey. Four full-time employees, seven part-time?

Mr. SAL RISALVATO: Correct.

WILLIAMS: What do you need to hear for your business?

Mr. RISALVATO: Well, I'm here because small business--and we've heard this all night long--small business is very concerned about the burden that we are going to place on their backs. Small business does not have the confidence that the numbers that are being produced by the administration are going to hold up. We've used a maximum of 7.9 percent of payroll. We don't feel confident that number will stick.

We were just talking about Medicare and Medicaid. In 1965, the original projection for Medicare was a $9 billion expenditure by 1990; the actuality was $106 billion. For Medicaid, it was--the expenditure was predicted to be in 1990 $1 billion, and it ended up to be $76 billion. With these type of projections in error, how can the small business community possibly have faith in both the subsidies that the Clinton administration is proposing for small business and in the actual caps on

the percentage that we will be paying of payroll? We are going to cost millions of jobs. Estimates are in the range of one million jobs within two years.

BROKAW: Thank you, Sal. Actually, the administration will say that, in fact, they learned from the whole Medicare experience, and they've learned how to put caps on all this, and they've learned that they want to get some built-in controls.

Larry English, you're in the middle of all this as the head of Cigna Health Care, do you think that's possible?

Mr. LARRY ENGLISH (Cigna Healthcare President): Tom, we have the best health care in the world in this country, the highest quality. There's no question about it. We have the best doctors. We have the best technology. We have the most modern facilities. If we embark on a system of caps, price controls, we will have what every other country has experienced when you have those sort of things, and that is a significant deterioration in the quality of the product. We will have waiting lines, and we will have rationing. I think it's a terrible idea.

BROKAW: A lot of people believe that the insurance industry in this country is grabbing up all the power here. You're not only the carrier, but you are now organizing the networks of providers. You're in charge of the managed competition. The doctors are saying, 'We're tired of taking our orders from the companies that you own. You're buying up the doctors around the country.' Isn't that a danger to American medical care?

Mr. ENGLISH: Tom, managed competition is about increasing competition. That's what we advocate. And managed competition means that there are groups of doctors and hospitals that are organizing to compete with us. There are local and regional HMO companies that compete with us. There are national companies that compete with us. We don't have a monopoly on this business. We don't have an oligopoly in this situation. We are fighting for customers every single day. And the fascinating thing is, we're fighting for them on the basis of cost and quality. And as a consequence of that competition, we've already seen improvements in quality, and we've seen reductions in the rate of growth in cost.

BROKAW: Maria Shriver in the audience.

MARIA SHRIVER reporting:

This section is getting a lot of hissing about that over here, but I am here, and applause, I am here with Mike Thompson, who is a small business owner, who is angry about this whole debate and says, 'You know, reform is OK, but you all are talking about a takeover.'

Mr. MIKE THOMPSON (Marketing Executive, Maryland): My concern is tonight we are talking about policy by horror story. Those horror stories need to be taken care of, but we shouldn't be wiping out a current system which does a pretty good job to take care of a relatively small percentage of people who aren't covered. This evening's program--your

videotapes have been horror stories. The panels have been--have been balanced in favor of the Clinton-type health plan, that there needs to be a better discussion about ways to improve the current system and still be able to cover those who aren't employed.

Mrs. Clinton said earlier that only the large companies had savings in their health-insurance plans. Our company has a 30-percent savings in the last two years because we went out and shopped it. Our coverage is better. I pay it all for my employees--that there are changes taking place. This debate is healthy in that it has--has made the country look at how to improve the system, but I am very, very concerned that--that we are making policy by horror story. If we did that in the legal profession, we could all come up with horror stories, and we nationalize the legal profession, and we'd never get that through the Senate or the House.

I think that we are--I think we are missing a very important point in this, and that is those of us who create jobs, who sweat to make payroll every two weeks, who sweat to pay the payroll taxes, who try to figure out how to expand our businesses, are really a very small part of this discussion. People who have never had to make a payroll, people who have never owned their own homes, people who have sat in Congress for 30 and 40 years not understanding what they are creating through their regulations, are now telling me that I can absorb more costs, and that's OK, because somehow I have a pot of money sitting in my desk drawer that can pay for all this. They are not being realistic of what the impact is going to be on society if this health plan goes through as planned.

BROKAW: Let me ask you, Mr. Kane, do you believe something has to be done about health care in America.

Mr. KANE: Absolutely.

BROKAW: It's not just about the horror stories.

Mr. KANE: No, it's not just about the horror stories.

BROKAW: But what should be done, and what is the role then of small business, because, in fact, that is a reflective point of view of a lot of people out there?

Mr. KANE: Absolutely, absolutely. What needs to be done first is to define and work on the right problem. When we just share horror story after horror story after hardship case, we are getting further away from the real problem. For example...

BROKAW: Well, here's a real problem. The spending now is 14 percent of GNP.

Mr. KANE: Absolutely.

BROKAW: And it goes through every product that is produced in this country, right?

Mr. KANE: That's right.

BROKAW: So we've identified that.

Mr. KANE: We've identified the size of the problem, but we have not identified how we should go about it. Let me give you an analogy. If I have a building that has a leak in the roof, and I know that the roof is leaking, I don't blow up the building to fix the leak in the roof. That's what bothers me about a lot of the proposals that are being proposed. Small businesses are not against health-care reform. Small businesses would love to be able to cover all of their employees if they could afford it.

BROKAW: But how--how would you cover the 37 million people who do not now have health insurance? You cover them in the home office. You've got 500 employees there. They get a lot of coverage. You've got a single mother working for you in San Antonio who works long hours every day. No coverage, right?

Mr. KANE: That's right.

BROKAW: What would you do for her?

Mr. KANE: It has to begin with the individual, Tom. It's not just the responsibility that you can put on a business.

BROKAW: You're paying her--what are you paying her? Minimum wage, probably, right?

Mr. KANE: No, not necessarily. No. Minimum wage is a starting point. I mean, many of our employees--minimum wage is a starting point, but many of them make much more than minimum wage, you're right. They can't afford to buy health insurance. I can't afford to buy it for them, because I would have to eliminate many of those jobs in order to do that under the mandate.

BROKAW: How much? How much--Mrs. Clinton and the president talk about an 80-20 split originally.

Mr. KANE: Right.

BROKAW: Could you go 50-50?

Mr. KANE: I'm currently paying 75-25 for the employees that I currently cover.

BROKAW: But that's in the home office.

Mr. KANE: That's in the home office.

BROKAW: What about those people out there who are not now covered? If they paid 50 percent, would you pay the other 50 percent?

Mr. KANE: Here's the--here's the problem, Tom. I wouldn't be in

business. I would not be in business. That is the issue. It is not a matter of not wanting to pay 50-50 or 75-25...

BROKAW: You can't pay anything, you're saying?

Mr. KANE: I cannot pay anything for that large a group of people that are employed with that particular--with those kinds of skills. That's the economics of many small businesses, and that's what allows small business to try and grow and try and get to the point where they can provide benefits over time.

BROKAW: Mrs. Clinton is still in the audience tonight, and she's there with Maria Shriver now. Maria:

SHRIVER: Do you want to respond to that, Mrs. Clinton?

Mrs. CLINTON: Well, I certainly understand the concerns that Mr. Kane and the other small-business owners have expressed, but I would like to just respond to several points. I know there have been a lot of claims about studies about lost jobs. We have looked at every possible study. There are studies which say that taking the burden off of business and the general economy will create jobs. There are studies which say that jobs will be lost, but not very many.

And one of the problems that those of us who look at this have is, the minimum wage has gone up several times in the last 10 years. President Bush signed an increase of 90 cents in the minimum wage in 1989. There is no evidence that jobs were lost as a result of that. And many of those who claim that they could not afford a 15- to 30-cent-an-hour increase for health benefits, I think, are ignoring the history of the minimum wage increases, which I believe demonstrate small business is creative and smart enough to be able to do so.

But I would just end with this point. It's a sad point to end on, but every time we have looked at major health-care reform, there has been a stabilization of prices. Then if reform doesn't succeed, those prices have shot through the ceiling again. So everyone who thinks that they've had a year or two of good prices better hold onto their hats if we don't have comprehensive health-care reform that gets the prices in this system under some kind of decent control.

BROKAW: Let me ask Ms. Jordan something very quickly and then we'll get to you, Mr. Kane. Of your costs, how much do you pass along to your Southern California Edison customers? Is that going up every year?

Ms. JORDAN: Well, you know we are a regulated utility, and we can only receive in our rates--in fact, we only receive in our rates not full reimbursement for our health-care costs. Our shareholders pick up the difference. And costs in Southern California Edison are our fourth largest cost, and are fourth behind our core businesses, and it's escalating at a rate that within a year, it will be one of the core businesses. So it's a big issue for us.

And I have to make one comment that's pertinent to the other discussion.

In talking about full coverage, we're talking about reorganizing health-care system. We're talking about organized systems of care, and that's what has to happen here. We've missed the point that to bring costs down, we also have to organize care so that there is accountability there in terms of costs and quality, so that the cost is brought down so you can afford to cover your workers and we can continue to afford to provide benefits also.

BROKAW: Mr. Kane?

Mr. KANE: That accountability with the individual has to also be restructured. I totally agree with Ms. Jordan. Secondly, the approach that we use in order to do this has to be re-examined. And, you know, the problem with the studies--and I respect, with all due respect, the studies and the analyses which suggest that the impact on my business and the impact on my industry and small business would be so much a small percentage, but the study that hasn't been done is the study of my actual profit-and-loss statement between the top line and the bottom line. That's what businesses are saying. The studies don't reflect the actual costs in terms of what we look at every day and every week.
TOM BROKAW, host:

We've been listening, not just in this hall tonight, but across the country to the debate as well. Health-care reform, as you might expect, among conservative radio commentators, it's almost topic number one these days, and Brian Williams has been listening as well. Brian:

BRIAN WILLIAMS reporting:

A lot of people waiting for this one. We have successfully found a place where the noise on health care is louder than in the District of Columbia, and it is on the radio, morning drive, evening drive--just turn the radio on. That is where the real hand-to-hand combat is taking place.

Unidentified Woman #1: I do not want socialized medicine. It's terrible.

WILLIAMS: Listen to what they're saying on talk radio.

Unidentified Man #1: We don't need the government to set up another bureaucracy as you pointed out. What we need are people to sit down and say, 'I'm responsible for myself.'

Unidentified Man #2: I don't like the president's plan, but it's certainly better than what I have now.

Unidentified Woman #2: I have always been a registered Democrat, and I voted for Bill Clinton, and I wish I'd knew in November what I know now.

WILLIAMS: It's the talk of talk radio. It can get personal, and it can get rough. Health care is what America is talking about up and down the AM dial. It's where to go to hear the thunder on the right. And most of the talk is not what the White House wants to here.

Mr. G. GORDON LIDDY: And it is I, G. Gordon, good to go, ready to launch with radio free DC, the G. Gordon Liddy Show.

WILLIAMS: G. Gordon Liddy, who served time in prison for his role in Watergate, is now heard in nearly 200 cities across the country and leads the charge against the Clinton health plan. The people who call you, what do they say?

Mr. G. GORDON LIDDY: They are frightened that they will not have the quality they have now. They are frightened that they will not be able to select their own physician. They have what they consider to be excellent personal relationships with their doctor. They want to continue to use their doctor.

WILLIAMS: After years of playing second string to television when it came to forming public opinion, talk radio is suddenly one of the best places to hear how people are thinking. There are 850 radio shows nationwide now, compared to just 200 10 years ago, and about 80 percent of the radio shows are considered conservative.

Mr. MICHAEL REAGAN: This is where we talk about the issues. Get your comments and concerns and all that is going on across this great and wonderful land.

WILLIAMS: They don't get any more conservative than Michael Reagan, son of the former president. A year ago, he was heard on five stations. Now he's up to 80.

Mr. REAGAN: Every time the government of the United States has gotten involved in anything, the cost has never gone down, it's always gone up.

WILLIAMS: Reagan says time is the real reason why people tune into talk radio.

Mr. REAGAN: When you turn on TV at night, the 19-inch or 21-inch people on paradise, you've got 30 minutes of somebody talking about all the news of the day, and maybe they can give a minute to health care, maybe they can give 20 seconds one night. You can go on talk radio with a three hour show like mine and you can talk about it for an hour, 20 minutes, 30 minutes, three hours if you wish.

Mr. MICHAEL HARRISON (Talkers Magazine Editor): I think that talk radio keeps the issue alive in terms of the voters and the public, so that it doesn't fade away as do so many other issues in America, and then the politicians strike after it no longer makes good copy in the newspapers or exciting viewing on television.

Mr. GENE BURNS: Would you say that the system that we have should simply be left alone, that it doesn't need to be fixed at all?

WILLIAMS: Syndicated radio host Gene Burns says his listeners want their government smaller, not bigger, and that fuels their opposition to the Clinton plan.

Mr. BURNS: This current plan is Medicare again. This current plan is Social Security again. This current plan is Amtrak again. This current plan is the Post Office again.

WILLIAMS: If most of the talk seems negative, that's because it is.

Mr. BURNS: And then we have people like Ted Kennedy who are talking about a right to health care. There's no such thing. No such thing. Read the framing documents...

WILLIAMS: Conservative talk show hosts attract conservative listeners--many of them retirees and well-off financially. And the Clinton health plan is their biggest target, proof that you don't need an information superhighway to interact with the rest of the country and get the message across.

Mr. LIDDY: And in '96, oh boy, we'll be playing instead of this song, "Ding Dong, the Wicked Witch is Dead."

WILLIAMS: G. Gordon Liddy. And then again, there is also television, and the unending media blitz happening on television, not to mention over the airwaves on radio.
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Mr. LIDDY: And in '96, oh, boy, we'll be playing, instead of this song, 'Ding-dong, the wicked witch is dead!'

WILLIAMS: G. Gordon Liddy.

Then, again, there is also television, and the unending media blitz happening on television, not to mention over the airwaves on radio. Richard Coorsh is with the insurance lobby and you brought us, among other things, the commercial dubbed "Harry and Louise," the American couple in a panic over the coming Clinton health-care plan that--they became cult heroes in some circles of this country.

(Footage of insurance industry commercial shown)

WILLIAMS: What--how do you see your role in this entire debate where the media are concerned?

Mr. RICHARD COORSH (Health Insurance Association Of America): Well, that's a good question. And actually, the reason the insurance industry decided to do the advertisements was because we felt that as people who have had experience in financing health care, we felt that we needed the opportunity to get across a couple of key points. And while Harry and Louise have definitely become somewhat of a cultural phenomenon, the issues that they raise and the concerns that they have about universal coverage and how best to get there are concerns shared by many Americans.

WILLIAMS: Tom:

TOM BROKAW: Thank you, Brian.

Mr. English, do you think that Harry and Louise were fair, or didn't that exaggerate, really, the debate that is going on here?

Mr. LARRY ENGLISH (Cigna Healthcare President) : Well, I don't think there's anything un-American about suggesting that maybe there is a better way and suggesting that people get more information, because this is a very complex debate. We've only been dancing around the--the issues. Look, Tom, I think we can take the best health-care system in the world, make it available to all Americans, and we can do that without the government mandates, we can do it without the bureaucrats in Washington telling the people in Connecticut how much they can spend on their health care. In fact, what we ought to do is go through each of these bills and wherever the word 'mandate' appears, we ought to strike it and insert the word 'choice,' because choice means competition. And if we enhance competition, competition has been demonstrated throughout the history of the Western world to be the best regulator of cost. So, if we enhance competition, which is what we have advocated, what the Jackson Hole Group wants to do, we will be able to pay for health-care reform without massive government intervention.

BROKAW: Thank you all very much. We're going to be back with more on TO YOUR HEALTH right after this.

TEXT:

How Much Do You Understand About The Details Of The Health Care Proposals That Are Currently Being Debated?

A: A Great Deal 7% B. A Good Amount 21% C. Only Some 42% D. Not Much At All 31%

Would You Stay In A Job Just To Keep Your Health Insurance?

A. Yes 63% B. No 32% C. Not Sure* 5%
TOM BROKAW, host:

We're back with TO YOUR HEALTH, and to help us decide tonight what we want for health care, we have assembled a new group here, some familiar

faces, if you will: Dr. Ted Koop, who was the surgeon general in the Reagan administration; Dr. Louis Sullivan, who was secretary of Health and Human Services in the Bush administration; a brand-new doctor--newly minted, if you will--Dr. Alina Lopo, who is a graduate of UCLA; and Dr. Ron Anderson, a practicing physician who also runs Parkland Memorial Hospital in Dallas, Texas.

Before we get your opinion on how we decide, let me tell you that the American people that we talked to have already made up a big a decision for themselves. They've decided that they want a lot more long-term care, and Maria Shriver has looked into that for us. Maria:

MARIA SHRIVER reporting:

That's right, Tom. There are a lot of tough choices that families have to make when it comes to health care, but perhaps the most difficult one is what to do with a loved one or an elderly parent who needs full-time, round-the-clock nursing care. Keeping that loved one at home might seem to be the best solution, but what people are finding is that the system is often stacked against them.

Reverend PANSY CHANEY (Los Angeles, California): Beebee, how are you doing, sugar?

SHRIVER: The Chaney family is facing one of the worst kinds of crisis a family can face.

Rev. CHANEY: Yeah, you were strutting then. Can't strut no more, huh?

BEEBEE: Sure can't.

Rev. CHANEY: Yeah.

My commitment was to my mother, and it was like a no-way-out, you know. I--what could I do? I couldn't abandon her. She didn't have anybody else. My mother has been there for me. I needed to be there for her.

(Singing) "Happy birthday to you..."

SHRIVER: Three years ago, when she was 81, Pansy's very active mother had a stroke. After that, nothing was the same.

Rev. CHANEY: On an average Saturday morning, it was get up, make sure Mother was physically lifted from the bed, change her clothes, change the bed, put her in the shower, dress her, medicate her, bring her back to the kitchen, fix breakfast for everyone. And by that time, she was exhausted, so it was time to put her back in the bed again.

SHRIVER: Was it nice having your mom live with you?

Rev. CHANEY: Oh, yes, I felt good. I felt, 'This is my time that I can have to help her.' Prior to her even having her stroke, she would always say, 'I never want to be a problem to anyone. Whenever I'm too old and grouchy or whatever, put me in a place.' And I said, 'Oh, Mother, you

know we're not going to ever put you in a place. I'm not going to do that.'

Beebee: I want to go home, too.

Rev. CHANEY: You want to go home, too?

Beebee: Yeah.

Rev. CHANEY: OK.

SHRIVER: But after her mother had four more strokes in three years, Pansy's choices were limited.

What kind of strain has your mother's illness put on you financially?

Rev. CHANEY: I'm broke. She had a savings when she came of $25,000. It's gone. My savings of $11,000, it's gone.

I'm going to give you this one.

SHRIVER: As a result, Pansy was forced to place her mother in a convalescent home. Because she needs skilled nursing, Medicare--the federal health-care system set up for the elderly--is paying for the first six months. After that, California's MediCal program will kick in. However, what upsets Pansy is that neither Medicare nor MediCal will provide enough money so that she can afford to care for her mother at home.

So, it's better for you financially to have your mom in a home than to try take care of her here?

Rev. CHANEY: Financially, yes. For me, emotionally, no. I'd like for her to be here.

BEEBEE: I have to remind myself, sometime, 'Myself, you had the stroke.'

Rev. CHANEY: Oh, you have to remind yourself sometime you had your stroke?

BEEBEE: Yeah.

Rev. CHANEY: Yeah.

It pulls on me emotionally. I mean, you know, it feels like your heart's breaking inside of your body.

SHRIVER: This kind of crisis touches all generations, and Pansy's 20-year-old daughter, Damien, feels it firsthand.

DAMIEN: Why did she have to place her? We could have did it. I mean, I could have got out of school and helped around the house and stuff and--I mean that those are the things that I would have went to to keep my grandmother at home.

BEEBEE: OK.

Rev. CHANEY: I love you.

BEEBEE: I love you, too.

Rev. CHANEY: OK. Give me a kiss.

SHRIVER: Do you feel you've let your mother down?

Rev. CHANEY: Yes, yes.

SHRIVER: You haven't been the daughter you wanted to be?

Rev. CHANEY: Not at all.

SHRIVER: It's an issue that is of concern to millions of Americans. And I'm here with Pansy, and, Pansy, your mother paid into Social Security; she also paid into AARP. But when she got sick, when she needed it, nothing was there for her.

Rev. CHANEY: That's correct, and that's one of the things that I would like to have answered even this evening, is that for--as a person who's approaching senior citizenry, and we pay into a system constantly, what benefits are there for us? We celebrate our youth, but it--it seems as though we are just taking our older, our elderly people, and the sick people, and throwing them away. And then another issue is, what kind of benefits--I mean, if I could bring my mom home, would the amount of money that the system is paying to that convalescent home, would they be willing to pay to me?

SHRIVER: I think that's the big question, Tom, is people want to know why they can put their parents or loved ones in a home and can't get the same money to keep them in their home.

BROKAW: Dr. Sullivan, that seems like a fair question. Why shouldn't that be possible?

Dr. LOUIS SULLIVAN (Secretary Of Health And Human Services, 1989-1993): I think that's one of many reforms that really needs to be seriously looked at. We have developed a system based around institutionalized care. That has developed to be a very expensive kind of care, and I think it is, indeed, very appropriate to look at variations, alternatives of care that not only would be less costly, but more humane. I think most elderly would rather be at home. So I would certainly support that kind of initiative.

BROKAW: Dr. Koop, do you think that we do have the wrong emphasis, even in this political debate, to say nothing of the system about where we may want to go for that kind of care?

Dr. C. EVERETT KOOP (United States Surgeon General, 1981-1989): I think this is one of those areas, Tom, where the medical delineations are not

sharp, and a social problem of our society is now pushed into the medical system. And as expanded families, extended families, have shrunk, and as more people in the home are at work, there just isn't a place to take care of elderly people.

And this is something that we imported, for example, to Japan. I just came back from Asia. It's a major problem with them, because 30 years ago they had no such thing as long-term care or a home for older people. Everybody stayed at home with an extended family. And now they're on the economic bind of having no one at home any longer to care for older people, and they are facing the same problems of high cost.

But what was just mentioned here, as an alternative, we already have done for pediatric cases. The so-called Katie Becker waivers takes Medicare money and makes it available to families to take care of their children at home. I've had a lot of experience with this. It's much more humane. It's better for the child, and it is ever so much cheaper.

BROKAW: All right. Brian Williams is in our audience as well, with someone who's interested in this issue. Brian:

WILLIAMS: Tom, I'm with Tony Young, who has a question about long-term care.

Mr. TONY YOUNG (American Rehabilitation Association): There are 49 million Americans with disabilities in this country. Almost one out of every five people in this country has some sort of a disability. And as a country, we spend hundreds of billions of dollars a year maintaining people with disabilities, out of the work force, out of the community, in institutions. Taxpayers spend a lot of money doing this. Yet with rehabilitation and long-term care, we could save that money, we could put people to work, we could live in the communities and our homes where we want to. Why can't we have long-term care and medical rehabilitation in a national health program?

BROKAW: Dr. Anderson, you run a large institution. You have to deal with everybody that comes that into that institution. Most of our laws are set up that are--we want to put people in those institutions, because we know about the standards, we know about the quality, we know about the officials who are working there. Do these folks have a point here?

Dr. RON ANDERSON (Parkland Memorial Hospital, Texas): I think they have a very valid point. If you build institutions and you fund institutions, you tend to build more institutions and fund more institutions instead of fund services that made sense for the patient. I think we need to talk to patients to see what they really want, and many disabled persons and elderly persons want to live in the home. Many of them do require some continuum of care. I think there is a place for the nursing home, but there's also a place for home are, and there's a place for such innovative programs such as the Unlock Program in San Francisco, where people have care at the proper, I guess, place at the proper cost. And it's managed, if you will, along a continuum.
TOM BROKAW, host:

We have four doctors up here right now. And as you well know, the overwhelming issue in America for most people is to preserve choice. They wan go to the doctor that they want to go to, and they worry about the role of HMOs in their lives, because there will be more of them under health-care reform. Brian Williams is with somebody now who knows a good deal about HMOs. Brian:

BRIAN WILLIAMS reporting:

He certainly does, Tom. George Halvorson runs the largest HMO in Minnesota--600,000 patients.

Address two issues for me, if you will: preventive care, which is a major thrust of your operation; and how you counter the argument of choice--'I want to choose my own doctor.'

TEXT:

HMO

A health care plan that provides comprehensive care from a network of doctors at a fixed fee.

Mr. GEORGE HALVORSON (President, Healthpartners, Minnesota): Well, I think the last statement was very accurate. I think that we a sickness system in this country and not a health-care delivery system. Now we now know what causes heart disease. We know things that can be done to prevent the onset of diabetes. There are a great number of things we can do of a preventive nature. We can--we can reduce the number of pre-term births. And we don't do it because the health-care delivery system focuses on incidents of care and doesn't work as teams of providers to improve the health of the population they serve.

In our state, the choice issue has been resolved. The consumers have chosen health plans. And what we found is that when you give consumers a chance to choose between competing health plans, and they know what the quality of the plans are, and they know what the price of the plans are, and they can choose between that and an inefficient fee-for-service system, that the choices tend to work in favor of the health plans. So I think consumer choice is important, and we welcome consumer choice. What we do, though, is need--we have to give consumers choices between competing teams of providers who are focused on quality and focused on health, and get rid of the idea that what 'choice' means is picking your provider out of the Yellow Pages.

BROKAW: Dr. Alina Lopo just graduated from UCLA Medical School. You're what, 39 years old? You don't mind me giving that away, I guess.

Dr. ALINA LOPO (University Of California, Los Angeles Medical School, Class Of '94): Actually I was 43 years a couple--few days ago.

BROKAW: Now, maybe we should have stayed at 39.

Dr. LOPO: Sounded better.

BROKAW: Do you like the idea of being, as you were just described, a member of a 'competing team of providers'? Or was your idea of being a doctor someone who would have a patient population in which you would become the care provider for them?

Dr. LOPO: It was more the latter when I signed on for med school as life number two. One thing that's a little bit scary going out into the real world now is that this is changing, the game is changing, and I'm not sure that anybody is really showing us how the game--what the game--what the game is going to be like now. And the whole HMO and alphabet soup is a little bit intimidating.

BROKAW: Dr. Koop, you've been a lifetime witness to medical care in America. I think that that reflects the opinion of a lot of young doctors. It also reflects the opinion of a lot of people who depend on American health care. As you have been witness to the political debate that has been going on in this town and across the country, can you blame people for being just utterly perplexed by it?

Dr. KOOP: No, I can't be--blame them for being perplexed. I can't even blame the for being worried. I think there's a very interesting historical thing that has taken place. President Clinton, just by putting health care at the top of the national agenda, has accomplished more than all of his living predecessors put together by the promise or the threat of health-care reform. And as a result, a lot of things that are going on now that people don't like are the result of people scrambling to be in the right position when health-care reform does come. And guess who's getting blamed for that? Mr. Clinton. It's not his fault. As a matter of fact, a lot of the things in the Clinton plan would alleviate many of the concerns that people have right now because of what the market has done in this upheaval.

BROKAW: Dr. Sullivan, you don't like the Clinton plan, but do you agree with Dr. Koop's statement just now?

Dr. SULLIVAN: I think President Clinton and Mrs. Clinton certainly deserve credit for bringing this issue to the fore. I think we all are indebted to them for that. At same time, I think we need to look before we leap. We need to be sure that we first do no harm.

We have a system that is the most productive system in the world. The assumption has been that we will make changes; we will continue to enjoy the benefits that we have from our system. That's not necessarily so. A specific example is this: One of the major epidemics we confront today is the AIDS epidemic. We don't have good drugs for that, but we do have three drugs that do impair the replication of the AIDS virus. Our pharmaceutical industry has been singled out for criticism. But the American pharmaceutical industry developed not one, not two, but all three of those drugs. Think of where we would be if we did not have the incentives to encourage creativity and innovation and experimentation in our system.

BROKAW: Dr. Anderson, you're in the middle of all this, having to

deliver health care in Dallas. You deal with poor people do there. You're a practicing physician yourself. What sense of urgency do you personally feel in all of those roles about getting health care done quickly?

Dr. ANDERSON: Tom, we--we went around the state of Texas doing a health reform analysis all year, to hear town hall meetings as much as Mr. Clinton did around the country. And we heard the anxiety of the middle class, not just the poor. The poor were getting cared for at the Parklands and the Ben Taubs, but the middle class were losing insurance. They were insecure. There was enormous anxiety in small business, people who were losing employees because they couldn't afford the insurance.

So I think that the system is not fixed. I--I disagree. We have one of the best systems in the world for those who can pay, but it's based on how you pay. And I think that if you look at the ethics of this, we need to let all those other people in the system. I think we can afford to do that.

BROKAW: Should we also preserve, in reform, the traditional fee-for-service idea? Should people who are well off in America be able to buy the kind of insurance that they want and go see the specialists that they want, however much it may cost them?

Dr. KOOP: I think you have to give them that option, and the president's Health Security Act does give them that option. There is a point-of-service fee, and if you step out of your own HMO into somebody else's system, then you do have to pay 20 percent of that out of your own pocket. But there's a cap on it. So I think it would be somewhat difficult for people who don't have a financial cushion like that. But for most people, there the option is.

BROKAW: As we began the evening, we heard a voice from Topeka, from a diner, and we're going to conclude this part of the discussion by going back to that voice from Topeka. Brian:

WILLIAMS: The Downtowner Diner in Topeka. Karen Friess operates that diner. And I just wanted to make sure before we go this evening, you've heard what you came to hear. Are you any happier than when you walked in the door? And is there anything more you want to say while you have the first lady in the room?

Ms. FRIESS: Well, I have heard a lot of different things, and I think that everybody has seen that we're going to all have to work together. And I think that--I think there is a way to do it, but I think it's going to take everybody working together.

BROKAW: And will people--do you think it will take people not only working together, but spending a little more of what they have to get there as well?

Ms. FRIESS: Oh, I'm sure of that, including me.

BROKAW: Including you. And you're prepared to?

Ms. FRIESS: Yes, I am.

BROKAW: We'll be back with more, with TO YOUR HEALTH in a moment.

TEXT:

Are You Willing To Pay Higher Insurance Costs To Be Able To Choose Your Own Doctor?

A. Yes 47% B. No 49% C. Not Sure* 4%

How Important Is It To You To Have A Wide Choice Of Doctors?

A. Very Important 62% B. Somewhat Important 27% C. Somewhat Unimportant 7% D. Very Unimportant 3% E. Not Sure* 1%
TOM BROKAW, host:

As we wrap up TO YOUR HEALTH tonight, we want to return to Hillary Rodham Clinton, the first lady of the United States, one-half of the team that put health care on the national agenda. Mrs. Clinton has sat through all the discussions. She's answered questions, as well, from this audience.

You often say, as you go out to meetings like this, that if anyone has any better ideas, you're willing to listen to them, to examine them.

Mrs. HILLARY CLINTON: That's right.

BROKAW: Did you hear any better ideas here tonight?

Mrs. CLINTON: Well, what I heard which was so beneficial to me is the openness and the willingness of people to keep working toward this. You know, when my husband came with this plan, he was the first to say he only had one bottom line. That was to make sure every middle-class American, every one of us, had health security, to remove that anxiety that we've heard.

I was sitting next to the Carrs, who were here, and talking to Julie Carr and what happened to her and her husband. And it's a very typical story of thinking you're taken care of, trying to do the right thing, and then waking up one morning and finding out you're not. And what my husband said is, 'Let's figure out how to work it out.' And, you know, members of Congress are a lot of smart people. I have a great deal respect for them in both parties. If they really believe that every American ought have what they have, which is guaranteed health insurance, they can figure out how we can do it and afford to do it and deliver quality health care.

BROKAW: So what you're doing tonight is charging Congress to deliver to the country what it has for itself?

Mrs. CLINTON: That's right. I think that's only fair.

BROKAW: Mrs. Clinton, thank you very much for being with us tonight.

Mrs. Clinton, thank you very much for being with us tonight, and thank all of you in the hall here as well, and thank you at home. We hope that you have learned something in the course of this two hours about this enormously complex, but very important, issue that touches you in every conceivable way--physically, physically, emotionally, financially, politically--the whole question of what we want for health care in America. We hope that what you have heard here tonight will help you stay engaged in this debate. So on behalf of the people here, on behalf of all the people at NBC News, I personally want to thank you and tell you that as we go off air, you'll be hearing once again some of the many opinions and expressions from this evening of TO YOUR HEALTH.

(Video clips from the program are shown)

STATEMENT BY SENATOR BOB GRAHAM
JULY 28, 1994

Federalism and Health Care Reform -- A Path Almost Ignored

At this point in the national debate over health care reform, a half-dozen plans have come to the forefront. All of them seem to have obtained negative majorities. They have a common and, I believe, flawed premise. It is that the road to national health reform is a single, national, one-plan-fits-all model.

This path has taken many forms: managed competition, single-payer, employer or individual mandate, pay-or-play, Medicare expansion, market reform. The path has been trampled by detail and controversy over the means supporters use. This trampling has almost buried the broad agreement on the necessity of achieving universal coverage and cost containment.

A second path -- the path almost ignored -- is a decentralized structure, based on the principles of federalism, in which the federal government establishes objectives and states provide the specifics.

In such a system, the federal government would establish nationally agreed upon health care performance objectives, standards and goals, while giving states and communities the ability to develop localized tactics to achieve those standards. Such a structure would bring the decision-making process down to the state and community level, where health care markets are all very different.

Although several plans refer tangentially to a state role, national reform should establish a federal-state partnership as a central principle rather than an aside.

As the National Academy of Sciences's Institute of Medicine notes:

> "States are the principal governmental entity responsible for protecting the public's health in the United States. They conduct a wide range of activities in health. State health agencies collect and analyze information; conduct inspections; plan; set policies and standards; carry out national and state mandates; manage and oversee environmental, educational and personal health services; and assure access to health care for underserved residents; they are involved in resource development; and they respond to health hazards and crises."

Health care is particularly suitable to the establishment of national goals with decentralized implementation and sensitivity to local variations. States and communities within states have different health care needs based on societal factors such as:

1) The quantity and nature of health care providers. For example, Nebraska, North Dakota and South Dakota have twice the number of hospital beds per person as Alaska, New Hampshire and Hawaii.

2) Varying demographics, especially of the most health care intensive populations. For example, as a percentage of state

population, Florida, Pennsylvania, Iowa, Rhode Island and West Virginia have 50% more elderly than Alaska, Utah, Colorado and Georgia.

3) Current levels of insurance coverage. In Nevada, Oklahoma, Louisiana, Texas and Florida, approximately one-quarter of the population under 65 is uninsured. In Hawaii, Connecticut and Minnesota, less than one-tenth is uninsured.
Clearly problems in different states will require different solutions and timeframes.

For example, what would work in rural areas would not work in urban areas. The means of achieving universal coverage and access are undoubtedly different in Florida and Wyoming. Even within rural areas, the health care concerns of those along the rural sections of the U.S.-Mexico border are vastly different from the needs of ranchers in Montana.

Any successful plan must accommodate the broad diversity in this nation. Yale professors Theodore Marmor and Jerry Mashaw stated in a July 7 Los Angeles Times editorial, "Given the diversity of states, their varied experience with health care and intense local preferences, why enact a single brand of national health reform, especially if it's the poorly considered compromise that we seem to be headed toward? By moving compromise in the direction of preserving goals rather than defining means, we can allow states the further thought and experimentation that are needed for effective implementation."

Why Federalism?: Centralized System Unlikely to Work

Presently, there is insufficient field-based experience and consensus to commit the nation to a single health care model. No state, not Hawaii nor California, has had an adequately extensive or sustained experience with a managed care model. There is not an empirical base of evidence suggesting that such a model should be the centerpiece of national health care reform.

Unfortunately, the federal government's failure to provide waivers to Medicaid, Medicare and the Employee Retirement Income Security Act (ERISA) has limited states' creativity for many years. In the mid-1980's, while I was governor, Florida was unsuccessful in its attempt to receive a waiver from the federal government for a Medicaid buy-in program from the Reagan Administration.

Florida Governor Lawton Chiles was in Washington, D.C., just a few weeks ago pushing again for a federal waiver that would provide 1.1 million uninsured Floridians with health insurance. He has been met with foot-dragging and ho-humming from the Health Care Financing Administration. Why?

A New York Times article dated June 12, 1994, may provide an explanation. According to the article, Health Care Financing Administrator Bruce Vladeck warned in a June 1993 memorandum that "The waiver authority could become a way of relaxing statutory or regulatory provisions considered onerous by the states...." He added that waivers "will be used to slow down nationwide reform." After six months effort, the waiver is still not forthcoming.

The same arguments were made in 1974 when Hawaii passed its comprehensive reform bill. There was the belief that it was unncessary because there would soon be national, comprehensive reform and that Hawaii's bold initiative would frustrate national efforts. Instead, Hawaii and other states have become models for reform.

In addition, the federal government's administrative agencies are not prepared or capable of accepting the mammoth new responsibilities inherent in any unitary, and yet diverse, health care system. The Health Care Financing Administration's dismal performance in monitoring Medicare fraud (a $15-20 billion annual hemorrhage by some estimates) is a harbinger of what a unitary system could inflict upon the nation -- a train wreck with all Americans aboard.

I would further add that Congress has not been successful in recent years in confronting major, complex public problems. The savings and loan debacle, the 1986 Tax Act and catastrophic health care are all examples of how Congress has a greater interest in getting a bill passed than in truly solving problems. We may be at the point in this debate where certain compromise positions will sacrifice effectiveness and reform for a Rose Garden ceremony.

Earlier this week, I listened to one plan being proposed on the Senate floor. The Senator argued for the plan, in part, because it was the result of a series of compromises on contentious components of reform. As I listened to the compromise being discribed as a virtue, I analogized this to two aviation engineers who cannot decide on the wing-span of their plane. One says the wing-span should be 100 feet. The other says the wing-span should be 150 feet. So they compromise -- with disastrous results. They build a plane with one 50 foot wing and one 75 foot wing. Both enginners are happy, but the plane crashes. Unlike the engineers, Congress must come up with a design that works, and not one that compromises principles and threatens the health of all the passengers.

The unitary, centralized path to reform will likely result in ineffective amalgamations and compromises or a highly partisan and closely divided final enactment. The nation would be ill served by either result. A narrowly-based, partisan health care program passed this year would sow the seeds for continued destructive sniping and controversy in the years ahead, and lead to an accelerated erosion of public confidence in the federal government.

We cannot repeat the legislative failures of the eighties. The savings and loan debacle cost us $150-300 billion and was a significant factor in the most serious recession since the 1930's. A health care debacle could put millions of Americans at risk, damage the world's highest quality health care delivery system and establish another unfunded entitlement which would contribute to record deficits by the end of this decade.

Why Federalism?: It Works

There is a second path -- a federal-state partnership toward reform.

This Jeffersonian model is one that has been utilized time-and-time again. The Interstate Banking Bill, just passed by the

conference committee, provides for an interstate banking system with national standards and underlying state flexibility to recognize the diversity of communities across the nation.

Further, when it comes to health reform, states have significant experience, success and track records. They, in fact, have achieved more in the way of reform than Congress has. The Summer 1993 issue of Health Affairs documents successes at the state level in health reform from Florida, Hawaii, Maryland, Minnesota, Oregon and Washington. Significantly, these states have adopted reforms that differ in terms of scope, anticipated outcomes and process.

These variations reflect the diverse needs, ideology and stage of health care evolution in each state. So should national reform. Moving health reform to the states and closer to the people should be a central principle of a national health plan. Only then will we have real accountability and responsiveness to the needs of citizens, business and providers. Only then are we likely to have a reform which will actually deliver its promise of sustained accessibility to a high quality, affordable health care system for all Americans.

How Would This Be Accomplished?

First, the federal government should establish federal standards in those areas where uniformity is required and agreed upon. Standards that the federal government should set include:

1) Universal coverage standard;

2) Cost containment;

3) The composition of a standard benefits package;

4) Insurance reform on issues such as community rating, portability and guaranteed issuance; and,

5) A state-based public authority to assure implementation and to be accountable for these goals.

Certainly these are goals upon which the Congress, the President, the states and the American people can come to some agreement.

However, the federal government should separate the ends and goals of health reform from the means of health reform. The federal government should establish agreed-upon performance objectives to attain the five goals. However, for both political and policy reasons, the federal government should not impose uniform means by which states would achieve the performance objectives.

Rather, the federal government should set forth performance standards that are achievable, provide adequate and equitable financial assistance to states for implementation and hold states accountable for the results.

A fundamental question in determining the federal role in health care implementation should be -- does the particular proposal under consideration require uniformity in process or procedure to achieve national goals? There are a set of limited circumstances which meet

this test. These would include: Medicare, special populations such as immigrants, which impose disproportionate impacts on state and local communities, and national tax policy that creates various health care incentives. The need for national uniformity could also include the special treatment for interstate corporations similar to that received under ERISA.

However, for the vast number of issues, the answer is clearly "no". National uniformity is not required to achieve the goal of universal coverage. For example, to achieve universal coverage and cost containment, states could implement a system resembling Hawaii's, the Clinton administration's plan, managed competition without mandatory alliances, a single payer system, all-payer regulation or a combination of these proposals.

Financing a System Built on Federalism

To attain the nationally established goals, the federal government should make funding available to states in the form of a block grant based on factors such as poverty, state income, other demographics and health care costs. The federal government should utilize funding to provide rewards to states that move more quickly toward the goals of national reform, guarantee funding so long as states continued move toward those goals and possibly impose sanctions on states failing to meet the goals.

States could choose how to finance their share by virtually whatever means they wish.

Beyond that, the federal government should only provide direction and get out of the way of state reform. In fact, the states should be allowed to supplement the federal standard benefits if they so choose, but with their own, non-federal funds.

State Role in Implementation

In a decentralized or federalist system, states would have the responsibility to establish and implement programs to achieve national standards. Among other things, states should have flexibility in the following areas:

1) Organization -- states should be granted the flexibility to establish the health delivery system that best meets the geographic considerations and needs of its population;

2) Financing -- states should be responsible for any cost beyond that established as the basis for federal block grant funding, and therefore, will have a strong incentive to initiate effective cost containment systems, whether by use of market-forces, a regulated payment system or otherwise; and,

3) Regulatory approach -- states have historically and should continue to be primarily involved in the training and licensure of health care providers and have been responsible for the civil justice system, and thus, medical malpractice reform.

Moreover, states such as Hawaii, Washington, Florida, Minnesota and Oregon could maintain and build from the successful and popular

health reforms that they already have in place.

Walking the Road

What is needed is to convert the various unitary plans from explicit health reform road maps to statements of destination.

Due to the late hour of this debate, Congress should look at the objectives of the various plans and pick the proposal that best meets mutually agreed upon goals. The underlying organizational, financing and regulatory details would only be a template for states that would be applicable in the absence of a state's enactment of its own reform structure or in the wake of a failed state plan. In short, the federal template would only serve as a "safety net" for states.

States could opt-out of any federal system as long as they could demonstrate that they could meet the federally established standards that we agree upon.

This strategy is not original. In the President's "Health Security Act", states were given the option of adopting a single payer option in lieu of the purchase of private insurance through mandatory cooperatives. If states declined to use the single payer option, they would be included in the national system. My proposal suggests a similar foundation of a national system but with a broader range of options to states. Provided states meet the test of achieving universal coverage with guaranteed and affordable comprehensive benefits, they could choose from a variety of financing, organization and regulatory arrangements.

Conclusion

In the last election, Americans made it clear that health care reform is of primary importance to the nation. Health care reform is necessary not only for the 38.5 million uninsured in our nation, but also for the health of the economy.

Congress is trying to respond, but at this point, it appears that there will be one of two results: we will either fail to enact health care reform due to partisan bickering; or, we will pass a compromise that will not work, sap momentum for true reform (including stifling reform efforts at state and local levels) and further diminish the public's confidence in the federal government.

We need a path to sustained success. The well trod road of federalism is that way.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503

SPECIAL

May 16, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-2723

TO: Legislative Liaison Officer -

EOP - Review Only, See Distribution Below - ( ) - -

FROM: JANET R. FORSGREN (for) B Pellicci
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI (395-4871)
Secretary's line (for simple responses): 395-7362

SUBJECT: EOP Proposed Report RE: HR 3600, Health Security Act

DEADLINE: NOON May 18, 1994

COMMENTS: The attached speech was given by Rick Kronick at the National Managed Health Care Congress last month. The publication "Institutional Investor" (marketed to the pharmaceutical industry) wants to publish excerpts from the speech.

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

CC:
Nancy-Ann Min
Ira Magaziner
Greg Lawler
Chris Jennings
Jack Lew
Lynn Margherio
Judy Feder
Judy Whang
Jason Solomon
Meeghan Prunty

LRM #I-2723

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is **simple** (e.g., concur/no comment) we prefer that you respond by **faxing** us this response sheet. If the response is **simple** and you prefer to call, please **call the branch-wide line** shown below (NOT the analyst's line) to leave a message with a secretary.

You may **also respond** by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please **include** the LRM number shown above, and the **subject** shown below.

TO: Robert PELLICCI
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-4871
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: EOP Proposed Report RE: HR 3600, Health Security Act

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet

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THE NEW NATIONAL HEALTH CARE AGENDA

by Dr. Richard Kronick

It has often been said that health care in the United States is a paradox of excess and deprivation. We use more resources than any other country in the world to produce medical care, yet it's not clear that we produce better health for our population than our industrial trading partners. → INSERT A

Any serious proposal for health care reform must address the problem of excess and deprivation, and President Clinton's Health Security Act does so in 1,372 pages

of excruciating detail. The HSA is built around five principles: guaranteed private insurance, health benefits guaranteed at work, a guarantee that individuals will have a choice of their doctor and of their health plan, changing the rules of health insurance to end unfair insurance company practices, and preserving and strengthening the Medicare program.

Three areas have generated especially heated debate: the requirement that employers contribute to the cost of health insurance, the structure of health alliances, and premium caps.

The only way to achieve health security for all is to require that everyone who is able to makes some contribution to the financing of care. The three main options are: first, employer contribution requirements; second, individual contribution requirements — so called individual mandates; and third, a broadly based revenue such as a value-added tax.

The decision to rely primarily on an employer mandate was based on a simple consideration. Most people who are insured have that insurance paid for through contributions made by their employers. The HSA continues this practice. Besides being least disruptive, the employer mandate has the advantage that efforts by the largest employers to buy better health care for their employees will lead to improvements in the delivery system. INSERT B

It's clear, however, that employers of very low wage workers cannot afford to pay fully for their health insurance and further that part-time, self- employed and unemployed people with low incomes cannot fully pay for their insurance. The solution proposed by the HSA is a variety of subsidies, the structure of which is now being studied by Congress.

A second key judgment concerns the dreaded mandatory health alliances. What could we have been thinking of to propose creating such monsters? The answer, quite simply, is that to resolve the problems of excess, it is important to create a market for health plans that works. We wanted to use health-care resources more efficiently and organize the health care system to deliver high-quality care economically. Further, we wanted to create a market that assured consumers that they could choose their own doctor and that they, not their employer or the government, could choose their health plan. INSERT C

Unfortunately, it is not so simple to make a market work and to guarantee consumer choice. Some of us are going to be more expensive than others to take care of and health plans have strong incentives to avoid serving those of us who are going to be expensive. If a market is going to work, we must prevent health plans from prospering through favorable selection of risks and assure that the plans that prosper are those that do a good job of delivering high-quality care. INSERT D

Alliances have been criticized as monopoly purchasers and a first step toward government takeover of the health care system. This reflects a fundamental misunderstanding. Alliances are not purchasers, so they can't be monopoly purchasers. It is the consumers who are purchasers. In the Health Security Act, alliances are required to offer any plan that meets financial solvency and quality criteria with the potential exception of some very expensive plans. And this requirement prevents them from being a purchaser. Alliances are designed to structure the market for health plans in a fashion similar to the way the SEC structures the stock market.

The third issue is premium caps. I and many others, both within and outside the administration, strongly believe that a restructured market will significantly slow the rate of growth of health care expenditures. The question is, who should bear the risk if these anticipated savings do not materialize? One possible answer is to ask employers, employees and taxpayers who are required to pay for health care to bear the risk if those anticipated savings do not materialize; the other is to ask providers and health plans to do so. The Health Security Act chooses the second alternative. When Medicare and Medicaid were passed, blank checks were written to providers. The judgment in the HSA was that this would not be fair to consumers or taxpayers.

When I started teaching at University of California, San Diego five years ago, one of the lectures I inherited was called "Universal Health Insurance: Its Time is Coming". I am looking forward to the near future when I will give a new lecture titled "How Universal Health Insurance Was Enacted in 1994."

Dr. Kronick is a senior policy advisor to the Clinton White House. He is on leave from the Department of Family and Preventive Medicine at the University of California, San Diego. A longer version of this article was the keynote address at the National Managed Health Care Congress in Washington, D.C. in April.

INSERT A

At the same time, close to 40 million people at any point in time have no insurance coverage at all, and tens of millions more are just one pink slip away from losing their insurance.

INSERT B

Besides being least disruptive, requiring employer contributions will encourage the efforts made by the very largest employers to figure out how to more intelligently purchase health care.

INSERT C

We wanted to create a financing system that gives hospitals and doctors the incentives and opportunities to figure out how to use health care resources to deliver high quality, efficient care.

INSERT D

In any given year, 10% of the population accounts for 70% of health care expenditures, and health plans have strong incentives to avoid serving those of us who are going to be expensive.