# Withdrawal/Redaction Sheet
## Clinton Library

| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
|---|---|---|---|
| 001. memo | Chris Jennings to Hillary Clinton<br>Re: Meeting with Chairman John Dingell (2 pages) | 4/25/93 | P5 |
| 002. memo | Chris Jennings to Hillary Clinton<br>Re: Congressional Leadership Meeting (1 page) | 4/26/93 | P5 |
| 003. memo | Chris Jennings to Hillary Clinton<br>Re: House Leadership and Chairman Meeting (6 pages) | 4/27/93 | P5 |
| 004. memo w/attach. | Chris Jennings to Hillary Clinton<br>Re: Tuesday Meeting with Congressman McDermott (5 pages) | 4/28/93 | P5 |

**COLLECTION:**
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23754

**FOLDER TITLE:**
April 1993 HSA [4]

gf79

**RESTRICTION CODES**

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

**P1 National Security Classified Information [(a)(1) of the PRA]**
**P2 Relating to the appointment to Federal office [(a)(2) of the PRA]**
**P3 Release would violate a Federal statute [(a)(3) of the PRA]**
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**P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]**
**P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]**

**C. Closed in accordance with restrictions contained in donor's deed of gift.**
**PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).**
**RR. Document will be reviewed upon request.**

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

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# MEMORANDUM

To: Ira Magaziner
Judy Feder
Chris Jennings

From: Richard A. Veloz

Re: Hispanic Health Care Issues - Access for the Undocumented

Date: April 21, 1993

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**BACKGROUND**

- Access for the Hispanic Congressional Caucus is a major concern. This was expressed at the Congressional Hispanic Caucus Legislative Forum, "Beyond the Problems: Identifying Solutions to Hispanic Health Care Needs for Health Care Reform" on April 21, 1993. Access for the Caucus (18 Members of Congress) includes coverage for the undocumented. This has been further defined as coverage under the statutory language "color of law".

- I have been informed that inclusion of this language will satisfy their concerns. Currently, under this provision the undocumented are eligible for a variety of federal benefits. I and others on the Health Task Force have provided you with background information on this issue.

- This issue was also raised at the Surgeon General's National Hispanic Health Initiative Conference on April 19-20, 1993 in Los Angeles, California.

- In addition, Members of Congress and I have been contacted by press concerning this issue. Present at the hearing today were the Los Angeles Times, CNN, and I have been informed by Congress members that they have been contacted by other syndicates including USA Today.

- I have urged Members of Congress and they have agreed, to allow the Task Force to further research this issue before releasing their concerns to the press.

- **Gloria Molina, Supervisor 1st District, Los Angeles County. Clinton National Campaign Co-chair**

  She has expressed her opposition for the proposal unless the Color of Law language is included. I believe that she will back off if we include coverage for all children regardless of their citizenship status. Because of her potential influence to raise substantial opposition to passage of

the health proposal, I would recommend that we try our utmost to address her concerns. I further recommend that we wait to meet with her until we can provide her with definitive information concerning this matter.

- **Lucille Roybal-Allard, Vice President of the Hispanic Caucus**

  Her bottom line is ensuring that all individuals regardless of citizenship status should have access to all preventative/public health services.

- **National Council of la Raza (NCLR)**

- In meetings with me as well as in today's hearing, NCLR indicated that the "color of law" language should be included in the final health care proposal.

- They also feel very strongly that the proposal for a **national health ID card** not be linked with a social security number for identification purposes. They fear that U.S citizens who are of Latino decent may be denied health care because they can not produce a health ID card.

- Two years ago the Simpson/Mazzoli Immigration Bill was defeated because of a similar issue in the form of an amendment that proposed a National ID demonstration project. Once that amendment was removed, Congress had sufficient vcotes to pass the bill .

- All of the above mentioned issues have been raised by other national Hispanic organizations, including COSSMO.

**CONCLUSION**

- I recommend that this issue be discussed with civil rights/Immigration organizations such as MALDEF and others and that their assistance in drafting language suitable to all parties be obtained.

- Meetings with the Hispanic Caucus and the National Council of la Raza and others are critical prior to drafting of the final language for the National Health Care Reform.

- Furthermore, I strongly recommend that prior to this meeting counsel and advice be sought from the President's Hispanic cabinet members.

- I have been asked to meet this week with various members of the Hispanic Task Force and will proceed to set up meetings with them. Because of the urgency of this matter please feel free to call me at any time to assist in resolving the matter at hand. Tommorrow (Thursday) I will be on the "hill" in the morning and afternoon and in work group meetings at OEOB from 10:30 to 2:30 PM.

April 23, 1993

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

**TO:** CHRIS JENNINGS

**FROM:** LARRY ATKINS

**Re:** In or Out of HIPC Issue

As you prepare for meeting with APPWP on the "HIPC, in-or-out?" question, I think it would help to start with your own perspective on the question. Do you want large employers to be able to operate outside the HIPC permanently because you believe they can add value to the system (e.g. innovate, encourage entry of new AHPs, etc.), or only to minimize big business opposition to reform in the short term? If it is the former, you need a mechanism that creates favorable economics for the large employer who opts out. If it is the later, you can worry more about making the rating "fair" between various groups. I think the basic rule is that HIPCs eventually absorb everyone, unless the benefits of opting out are fairly substantial.

You asked about a "self-insurance assessment" that large employers would pay to opt out of the HIPC, and that would help finance the risk difference between the employer's population and the community. Isolating and paying for that difference without eliminating the incentives to opt out is tricky. In discussing this issue with APPWP, I think it would help to view the difference between a large employer's costs and a community rate as having three components -- these are artificial distinctions, but I think they help clarify the issues:

> Population risk -- age: employers with younger-than-average populations will want to opt out...those with older-than-average or a heavy load of retirees will want

to opt in. Is it reasonable to charge an age-based fee to the younger ones that opt out if you are also going to age-rate HIPC premiums for the older ones that opt in?

Population risk -- other factors: low income, advanced chronic illness or AIDs, disability, and other factors associated with very high health costs more likely to be associated with unemployed than employed populations. Do employers who self-insure have a responsibility to the community to help finance these "community health needs?"

Experience: some populations generate lower health care costs because they have lower "lifestyle risk" or they use health services more conservatively. This is the area of cost employers think they can control through active management. Will employers who sponsor health promotion activities or manage their own plans be allowed to benefit from the savings?

My assumption is that employers need to benefit from their own experience or there is no reason to stay out of the HIPC. At the same time, there is a case to be made for subsidizing "community health needs" (along the lines of the state high risk pools) as long as employers who opt out are not the only ones paying for this cost. Of course, this all rests on the technical question of whether it is even possible to separate the three components of health costs and set up a fair payment that compensates for one component and not the others?

Bear in mind, also, that there are two places where employers can pay community rates and lose all benefit from sponsoring their own plans -- the HIPC premium or assessments back to the HIPC, and the AHP premium.

Here are my thoughts on a line of questioning to probe this issue with large employers, presupposing a HIPC and a provision for large employers to opt out. I am not sure where you will get with APPWP because I am not sure how much thinking they have done on this issue -- but I think this will clarify the choices for them:

A. Age Adjustment

1) Who should cover their retirees?
   a) should large employers who opt out be required to vest those already retired, and keep them in their own health plan? Given a standard benefit, should vesting permit the employer to raise cost sharing to the standard benefit level?
   b) should large employers have any obligation to future retirees or should they be free to give them cash and send them to the HIPC?
   c) when they send them to the HIPC, should the employer's retirees get a community rate or an age-adjusted rate? Should they be rated on any health factors other than age? Should a person of the same age buying from the HIPC as an individual pay the same age-rated premium?

2) if retirees are able to benefit from a community rate, should an employer with a young population who opts out be required to pay a community rate -- either by making a payment back to the HIPC or by paying a community rate to the AHP?

B. Community Health Needs

1) If the HIPC, by definition, attracts a higher risk population than the average in the community (disabled, early retirees, low-income), is it fair to subsidize this risk only through the HIPC premium paid by small business and individuals?

2) Assuming there will be some subsidy for very high risk cases (i.e. that they will not be charged a premium commensurate with their risk), is it reasonable to finance this through an equitable assessment on all employers (in and out of the HIPC)? If not, how should it be financed?

3) Assuming it can be done technically, is it reasonable to charge a fee to employers who opt out of the HIPC that would pay for their portion of this cost?

C. Experience

1) Assuming adjustments are made to the HIPC for age and for "community health needs", do large employers need to be able to negotiate their own experience-rated premiums with the AHPs? Is this likely to help them or hurt them (or make no difference at all), given the HIPC's role in negotiating with AHPs.

2) What is the value to large employers of managing their own plans, given a standard benefit and some adjustment for age and community needs?

3) Could large employers get to the same point if they purchased through the HIPC with an experience-rated premium? What are the problems with this approach?

I expect large employers who prefer to opt out of the HIPC to want to benefit from the age profile and experience of their own populations -- with some employers perhaps willing to help underwrite some of the high risk cases in the community. An age adjustment to offset any age advantage they have from opting out would be perceived as eliminating much of the total benefit from opting out, or at least leaving them in a situation where the benefits of managing their own plans barely matched the added costs.

Retirees are a very complex issue for large employers, as you know. With the exception of those with older populations and high retiree ratios who want to dump into the HIPC, most large companies are taking or planning to take a one-time charge for FAS106, and probably prefer to manage their own retirees. Although some will convert the promise to cash (or a defined contribution) and let their retirees buy coverage.

I also expect large employers to be uncomfortable with any fee for opting out of the HIPC, preferring a broad tax mechanism to a specific tax on health benefit plans for financing the high risk or the underserved (although a tax on health benefits is less of a problem if all employers have to provide health coverage). If so, you should throw the question of paying for "community health needs" back to them to come up with a way to do it.

DRAFT

**OVERVIEW OF HEALTH REFORM:**

ALL AMERICANS ARE GUARANTEED:

- COMPREHENSIVE BENEFITS
- SECURITY AND PORTABILITY OF COVERAGE
- CHOICE OF PLANS AND PROVIDERS
- HIGH QUALITY CARE

FEDERAL GOVERNMENT WILL:

- DEFINE BENEFITS
- DEVELOP QUALITY, ACCESS, INSURANCE STANDARDS
- REFORM MALPRACTICE
- ESTABLISH FRAMEWORK FOR STATE-RUN SYSTEMS
- SET BUDGETS

STATES WILL:

- SET UP ALLIANCE TO REPLACE FRAGMENTED INSURANCE MARKET
- GUARANTEE AFFORDABLE COVERAGE THROUGHOUT STATE
- ENFORCE QUALITY, ACCESS AND INSURANCE STANDARDS
- ENFORCE BUDGETS

HEALTH ALLIANCES WILL:

- ENSURE AVAILABILITY OF VARIETY OF HEALTH PLANS
- NEGOTIATE PREMIUMS WITH HEALTH PLANS
- MANAGE ENROLLMENT
- PROVIDE CONSUMER EDUCATION AND PROTECTION

HEALTH PLANS WILL:

- ACCEPT ALL APPLICANTS AT COMMUNITY RATE
- PROVIDE GUARANTEED BENEFITS WITHIN AGREED-UPON RATE

[redacted] [redacted]

DRAFT

## ADDRESSING THE PROBLEMS: THE WORK TEAM PROPOSALS

| PROBLEM | SOLUTION |
|---|---|
| LACK OF SECURITY | • ALL AMERICANS ARE INSURED<br>• INSURANCE CANNOT BE DENIED OR TAKEN AWAY REGARDLESS OF HEALTH STATUS<br>• BENEFITS AT A COMPARABLE LEVEL CONTINUE REGARDLESS OF EMPLOYMENT OR INCOME STATUS<br>• ALL AMERICANS AND THEIR EMPLOYERS PAY INTO THE SYSTEM AT THE SAME RATE REGARDLESS OF THEIR HEALTH STATUS |
| CONSUMER CONFUSION | • GREATER CHOICE OF PLANS FOR MANY AMERICANS<br>• SIMPLE UNDERSTANDABLE BENEFITS PACKAGE<br>• ONE COVERAGE PACKAGE FOR A FAMILY<br>• NO COVERAGE BATTLES AMONG INSURERS<br>• GUARANTEED ACCESS TO PLANS<br>• CONSUMER COMPLAINT MECHANISM IN PLANS AND ALLIANCE<br>• SIMPLE REIMBURSEMENT AND CLAIMS FORMS<br>• PUBLISHED QUALITY INFORMATION |

DRAFT

## ADDRESSING THE PROBLEMS: THE WORK TEAM PROPOSALS (CONT'D)

| PROBLEM | SOLUTION |
|---|---|
| PROVIDER HASSLE | • STANDARD REIMBURSEMENT AND ENCOUNTER FORM<br>• SIMPLIFICATION OF REGULATIONS |
| HIGH ADMINISTRATIVE COSTS | • ELIMINATION OF INSURANCE UNDERWRITING AND MULTIPLE RISK PRODUCTS<br>• SIMPLIFICATION OF CLAIMS AND REIMBURSEMENT<br>– MOVE TOWARDS CAPITATED PAYMENT SYSTEMS<br>– SIMPLE UNIVERSAL CLAIMS AND REIMBURSEMENT FORMS DRIVEN BY UNIVERSAL ENCOUNTER FORMS<br>• ELIMINATION OF DUAL COVERAGE AND COVERAGE DETERMINATION PRACTICES<br>• SIMPLIFICATION OF PRODUCT REDUCES NEED FOR AGENT TO ASSIST CONSUMERS<br>• REDUCTION IN COSTS OF SMALL GROUP ADMINISTRATION<br>• REDUCTION IN REGULATORY REQUIREMENTS -- FORM FILLING<br>• REDUCTION IN MALPRACTICE PREMIUMS<br>• REDUCTION IN TIME SPENT BY PROVIDERS AND INSURERS INVESTIGATING OR DEBATING REIMBURSABILITY |

DRAFT

## ADDRESSING THE PROBLEMS: THE WORK TEAM PROPOSALS (CONT'D)

| PROBLEM | SOLUTION |
|---|---|
| UNNECESSARY TESTS AND PROCEDURES | • BUDGETED/CAPITATED SYSTEMS DISCOURAGE UNNECESSARY UTILIZATION AND INTENSITY OF SERVICE BY PROVIDERS<br><br>• GATEKEEPERS (IN HMOs OR PPOs), SOME USE OF COPAYS IN FEE FOR SERVICE PLANS AND PRICE COMPETITION WILL DISCOURAGE UNNECESSARY CONSUMER USAGE<br><br>• NATIONAL TECHNOLOGY ASSESSMENT AND BETTER INFORMATION ON PRACTICE PATTERN DIFFERENCES AND EFFECTIVENESS OF TREATMENT WILL ENHANCE COST CONSCIOUS/HIGH QUALITY PRACTICE<br><br>• BUDGETED/CAPITATED SYSTEMS ENCOURAGE MORE PRUDENT USE OF TECHNOLOGY AND MORE COST EFFECTIVE CAPITAL INVESTMENT<br><br>• MALPRACTICE REFORMS WILL CUT THE COSTS OF MALPRACTICE INSURANCE AND DEFENSIVE MEDICINE |
| UNDERSERVED POPULATIONS | • UNIVERSAL COVERAGE<br><br>• INCREASED INVESTMENTS IN INFRASTRUCTURE IN POOR URBAN AND RURAL AREAS AND IN PUBLIC HEALTH<br><br>• PREVENTION OF "RED LINING" OF HEALTH ALLIANCES<br><br>• RISK ADJUSTMENT OF POOR POPULATIONS<br><br>• HEALTH ALLIANCE RESPONSIBILITY FOR BUILDING HEALTH NETWORKS WHERE NONE EXIST |

DRAFT

## ADDRESSING THE PROBLEMS: THE WORK TEAM PROPOSALS (CONT'D)

| PROBLEM | SOLUTION |
|---|---|
| INADEQUATE LONG-TERM CARE | • EXPANDED OPPORTUNITIES FOR HOME CARE AS BEGINNING OF SOCIAL INSURANCE PLAN<br>• RAISING MEDICAID SPEND DOWN LIMITS<br>• INCENTIVES/REGULATION FOR PRIVATE INSURANCE MARKET |

DRAFT

# HOW THE NEW SYSTEM MAINTAINS WHAT PEOPLE LIKE IN THE CURRENT SYSTEM

| | |
|---|---|
| MAINTAIN NEGOTIATED BENEFITS | • LARGE EMPLOYERS AND EMPLOYEES CAN MAINTAIN THEIR CURRENT PLANS AS LONG AS THEY MEET FEDERAL STANDARDS<br><br>– EMPLOYERS CAN CONTINUE TO PAY MORE GENEROUS PREMIUM SHARES AND COST-SHARING THAN NATIONALLY GUARANTEED BENEFITS PACKAGE IN A TAX SUBSIDIZED MANNER |
| MAINTAIN HIGH QUALITY SYSTEM | • QUALITY OF SYSTEM WILL IMPROVE WITH BETTER PRACTICE GUIDELINE INFORMATION, QUALITY REPORT CARD, CONSUMER SURVEYING<br><br>• QUALITY INFORMATION WILL BE MORE AVAILABLE TO CONSUMERS |
| MAINTAIN CHOICE OF DOCTOR | • BUDGETED FEE FOR SERVICE NETWORK ALLOWS ALL AMERICANS TO CHOOSE THEIR DOCTORS AS THEY CAN TODAY<br><br>• AVAILABILITY OF MULTIPLE PLANS OF DIFFERENT TYPES ALLOWS CONSUMERS GREATER CHOICE OF TYPE OF CARE THAN MANY HAVE TODAY |

Jordana:

Could you please fax this to Andrea King?

225-7414

I say [redacted] – we are MOL drafting this.

CJ

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M E M O R A N D U M

TO: Requestors for Information on Meetings with Republicans
FR: Chris Jennings
DATE: April 27, 1993

From the onset of the Administration's work on the health care reform proposal, the Health Care Task Force and its Work Groups have made a concerted effort to reach out to House and Senate Republicans for their guidance and support. We believe it is essential to have their involvement to make the package as strong as possible and to assure it prompt and necessary passage. We are therefore concerned that there is any perception that the White House, in any way, has not actively sought the advice and participation of Republicans from the beginning.

It is very important to note that the President has insisted on significant Republican involvement from the moment he established the Health Care Task Force. On January 26th, he requested that the House and Senate Democratic and Republican Leadership appoint representatives to the Task Force. Senator Dole chose himself and Representative Michel appointed Representative Dennis Hastert (R-IL) to serve on his behalf.

Since that time, Mrs. Clinton and/or Ira have attempted to hold meetings on a virtually weekly basis with House and Senate Republicans and/or their staffs. The House has chosen to send its Members to the meetings, while the Senate Health Care Task Force has chosen to send staff. The Senate Republican Task Force has suggested that more active Member-level discussions be delayed until we have a better sense about what our final proposal will be. As these decisions are made, we will reach out to these Members again. It is essential to remember, however that we have always encouraged and been open to meeting with Republican Senators.

To help clear up any misperception with regard this issue, I have attached a list of the numerous meetings that Mrs. Clinton, Ira Magaziner, Judy Feder and their designees have held with Republicans over the last two and half months. I hope you will find this information to be helfpul. Please do not hesitate to contact me with any questions at 456-2645.

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# REMARKS BY

# U.S. REP. JIM MCDERMOTT
# D-7TH WASHINGTON

# IN THE
# U.S. HOUSE OF REPRESENTATIVES
# WASHINGTON, D.C.

## Wednesday
## April 28, 1993

MR. SPEAKER: WE ARE NOW ENGAGED IN A GREAT DEBATE OVER WHAT SHAPE REFORM OF OUR NATION'S HEALTH CARE SYSTEM WILL TAKE.

TONIGHT I WANT:

* TO TALK ABOUT SOME OF THE REASONS WE NEED NATIONAL HEALTH CARE REFORM;

* TO LAY OUT SOME OF THE OPTIONS BEFORE US;

* TO EXPLAIN SOME OF THE TERMS MANY AMERICANS ARE HEARING FOR THE FIRST TIME;

* TO OUTLINE SOME OF THE FUNDAMENTAL GOALS OF ANY HEALTH CARE REFORM PACKAGE; AND FINALLY,

* TO DISCUSS THE HEALTH CARE REFORM PLAN I HAVE AUTHORED, AND WHICH HAS BEEN CO-SPONSORED BY 71 OTHER MEMBERS OF THIS BODY.

MR. SPEAKER, AMERICANS ARE DEMANDING FUNDAMENTAL HEALTH CARE REFORM BECAUSE THE COSTS OF HEALTH INSURANCE AND MEDICAL CARE ARE OVERWHELMING AMERICAN FAMILIES AND OVERWHELMING THE NATION.

CURRENTLY, HEALTH CARE COSTS INCREASE AT THE RATE OF 11% A YEAR. EVERY AMERICAN FAMILY HAS FELT THE IMPACT OF THAT FACT.

THE NUMBER OF DAYS THE AVERAGE AMERICAN MUST WORK JUST TO PAY HEALTH CARE EXPENSES HAS INCREASED
FROM 30 DAYS IN 1980 TO 44 DAYS IN 1991.

LET ME REPEAT THAT. IN 1991, THE AVERAGE AMERICAN WORKED 44 DAYS A YEAR JUST TO PAY HEALTH CARE EXPENSES.

IF OUR CURRENT SYSTEM IS LEFT UNCHECKED, BY THE YEAR 2002, THE AVERAGE AMERICAN WILL WORK 64 DAYS JUST TO PAY HEALTH CARE EXPENSES.

ALL SIDES IN THE HEALTH CARE DEBATE AGREE THAT 37 MILLION AMERICANS ARE WITHOUT HEALTH INSURANCE OF ANY KIND TODAY AND THAT ANOTHER 100,000 LOSE THEIR HEALTH INSURANCE EVERY MONTH.

ANOTHER ALMOST 40 MILLION ARE DANGEROUSLY UNDERINSURED. BOTH GROUPS ARE JUST A SINGLE SERIOUS ACCIDENT, A SINGLE SERIOUS ILLNESS, OR A SINGLE ACT OF GOD AWAY FROM A LIFETIME OF FINANCIAL RUIN.

INDEED, INABILITY TO PAY MEDICAL BILLS IS ONE OF THE MAJOR CAUSES OF PERSONAL BANKRUPTCY IN THE UNITED STATES TODAY.

MOST OF THESE PEOPLE ARE HARD WORKING AMERICANS WHOSE EMPLOYERS PROVIDE LITTLE OR NO INSURANCE.

WHAT'S MORE, THERE IS A NEW ECONOMIC TREND IN THIS COUNTRY THAT MAKES CLEAR THAT THE CURRENT SYSTEM -- LEFT UNREFORMED -- WILL ONLY GET WORSE, NOT BETTER.

OF THE 200,00 NEW JOBS CREATED IN THE LAST THREE MONTHS, THE OVERWHELMING MAJORITY WERE PART-TIME JOBS.

THE VAST MAJORITY OF THESE PART TIME JOBS OFFER NO HEALTH INSURANCE BENEFITS AT ALL.

EVEN THE HEALTH REFORM PROPOSALS WHICH WOULD REQUIRE EMPLOYERS TO PROVIDE HEALTH INSURANCE DO NOT EXTEND THAT MANDATE TO PART-TIME WORKERS.

IF WE CONTINUE TO ALLOW HEALTH INSURANCE TO BE TIED TO EMPLOYMENT; AND IF WE RELY ON A HEALTH REFORM "SOLUTION" WHICH REQUIRES EMPLOYERS TO PROVIDE INSURANCE; IT IS CLEAR BUSINESSES WILL JUST HIRE MORE PART TIME WORKERS, IN ORDER TO AVOID THE COSTS OF EXTENDING HEALTH INSURANCE COVERAGE TO FULL TIME WORKERS.

WHAT HAPPENS TO PEOPLE WHO DON'T HAVE HEALTH INSURANCE WHEN THEY GET SICK OR INJURED UNDER THE PRESENT SYSTEM?

THEY DON'T JUST DISAPPEAR. THEY GET MEDICAL CARE. THEY JUST GET IT VERY EXPENSIVELY -- IN HOSPITAL EMERGENCY ROOMS -- VERY INEFFICIENTLY, AND TOO LATE, AFTER THEIR MINOR CONDITION HAS BECOME A SERIOUS ILLNESS.

WHO PAYS FOR THIS CARE? EVERYONE WHO HAS PRIVATE HEALTH INSURANCE. THE COST OF GIVING CARE TO THE UNINSURED IS SHIFTED TO THE BILL OF THE INSURED PATIENT.

THAT'S ANOTHER REASON THE CURRENT SYSTEM -- LEFT UNREFORMED -- ISN'T GOING TO FIX ITSELF.

AS THE COST OF TREATING MORE AND MORE UNINSURED AMERICANS IS SHIFTED TO THOSE WHO DO HAVE INSURANCE, PREMIUMS COSTS GO UP EVEN FURTHER.

MORE AND MORE PEOPLE FIND THEMSELVES PRICED OUT OF THE INSURANCE MARKET AND THE SPIRAL CONTINUES.

OF COURSE THE TAXPAYER ALSO PAYS FOR MUCH OF THIS CARE.

IT IS NOT CHEAPER TO HAVE PEOPLE GO WITHOUT INSURANCE.

IT COSTS ALL OF US MORE.

THE CONGRESSIONAL BUDGET OFFICE (CBO) FOUND THAT IF WE HAD A NATIONAL HEALTH INSURANCE SYSTEM IN EFFECT IN 1991 THAT COVERED EVERYONE, WE WOULD HAVE REDUCED -- REDUCED -- NATIONAL HEALTH EXPENDITURES BY ABOUT 14 BILLION DOLLARS IN THAT YEAR.

WE MUST BREAK THE LINK BETWEEN HEALTH INSURANCE AND EMPLOYMENT.

ACCESS TO HEALTH CARE IS A FUNDAMENTAL ELEMENT OF FREEDOM ITSELF, A BASIC COMPONENT OF WHAT IT MEANS TO LIVE IN A DEMOCRACY.

IT SHOULD BE A FUNDAMENTAL RIGHT OF CITIZENSHIP.

IT IS CLEAR THAT A FEDERALLY-FINANCED SYSTEM OF HEALTH INSURANCE IS:

* BETTER FOR BUSINESS;
* BETTER FOR WORKERS;
* BETTER FOR THE ECONOMY AS A WHOLE;
* AND CERTAINLY BETTER FOR PEOPLE WHO NEED HEALTH CARE -- ALL OF US.

ON MARCH 3, I INTRODUCED THE AMERICAN HEALTH SECURITY ACT.

IT IS A PLAN TO PROVIDE HEALTH INSURANCE TO ALL AMERICANS:

* REGARDLESS OF THEIR CURRENT HEALTH;

* REGARDLESS OF WHETHER THEY HAVE A PRE-EXISTING CONDITION;

* AND REGARDLESS OF WHERE THEY WORK OR WHERE THEY LIVE.

IT IS A "SINGLE-PAYER" PLAN.

THAT'S ONE OF THE TERMS YOU'LL BE HEARING MORE ABOUT AS THE HEALTH CARE REFORM DEBATE CONTINUES.

IT MEANS THAT THE FEDERAL GOVERNMENT PROVIDES THE INSURANCE TO INDIVIDUALS AND FAMILIES.

WHILE THE GOVERNMENT PROVIDES AND GUARANTEES THE INSURANCE, THE DELIVERY SYSTEM IS REMAINS AS IT IS -- PRIVATE.

INDIVIDUALS WOULD CONTINUE TO CHOOSE THEIR OWN DOCTOR AND CONTINUE TO CHOOSE THEIR OWN HOSPITAL, JUST AS THEY DO NOW.

HEALTH CARE PROVIDERS WOULD CONTINUE TO WORK FOR YOU -- THEY ARE NOT EMPLOYEES OF ANY GOVERNMENT OR OF YOUR INSURANCE COMPANY.

THE AMERICAN HEALTH SECURITY ACT, H.R. 1200, IS A UNIQUELY AMERICAN PROPOSAL DESIGNED TO MEET THE DIVERSE NEEDS OF THE AMERICAN PEOPLE.

IT RECOGNIZES THAT ONE OF THOSE NEEDS IS FOR PEOPLE TO RETAIN THE RIGHT TO MAKE THEIR OWN CHOICES ABOUT WHAT'S BEST FOR THEMSELVES AND FOR THEIR FAMILIES.

IT PROVIDES INSURANCE THAT IS FEDERALLY FINANCED, STATE ADMINISTERED, AND PRIVATELY DELIVERED.

H.R. 1200 IS A HIGHLY DECENTRALIZED SYSTEM.

IT REJECTS THE NOTION THAT ALL DECISIONS ARE BEST MADE IN WASHINGTON, D.C.

UNDER H.R. 1200, THERE IS NOT ONE GIANT BUREAUCRACY CONTROLLING HEALTH CARE.

RATHER, THE STATES ARE GIVEN TREMENDOUS DISCRETION TO DESIGN THEIR OWN SYSTEMS SO A STATE LIKE NEBRASKA DOESN'T GET "SHOE-HORNED" OR "STRAIGHT-JACKETED" INTO A PROGRAM THAT MIGHT WORK GREAT FOR NEW YORK, BUT BE AN UTTER DISASTER FOR NEBRASKA.

THIS DISCRETION IS VERY REAL.

STATES DO NOT HAVE TO APPLY TO THE FEDERAL GOVERNMENT FOR PERMISSION TO DO WHAT THEY NEED TO DO.

THEY'RE IN CHARGE OF ADMINISTERING THE PROGRAM WITHIN THEIR BORDERS, AS LONG AS THEY MEET FEDERAL STANDARDS FOR:

* GUARANTEED COVERAGE TO EVERY CITIZEN;

* COST-CONTAINMENT;

* ALLOWING PEOPLE TO CHOOSE THEIR OWN HEALTH CARE PROVIDER;

* AND ASSURING AN EVER-IMPROVING QUALITY OF CARE.

SO HOW DOES IT WORK?

THE ANSWER IS -- "VERY SIMPLY."

EVERY CITIZEN OR LEGAL RESIDENT IS ISSUED AN AMERICAN HEALTH SECURITY CARD.

YOU PRESENT THE CARD EVERY TIME YOU VISIT A HEALTH CARE PROVIDER OR PURCHASE PRESCRIPTION DRUGS.

YOUR PHARMACIST, OR DOCTOR, OR HMO, OR HOSPITAL, OR WHOMEVER YOU CHOOSE, SUBMITS THE BILL TO THE STATE HEALTH SECURITY BOARD WHO PAYS IT ON YOUR BEHALF.

THAT'S IT.

NOTHING IN THE WAY YOU CURRENTLY SEEK MEDICAL CARE HAS TO CHANGE -- UNLESS YOU WANT IT TO.

YOU DO NOT HAVE TO SWITCH PHYSICIANS OR HOSPITALS.

YOU DO NOT HAVE TO FIGURE OUT WHICH PLAN YOUR CURRENT DOCTOR IS JOINING.

YOU DO NOT HAVE TO CHOOSE AN HMO OR ANOTHER SIMILAR INSURANCE PLAN AND THEREBY FACE A DECISION ABOUT WHETHER TO LEAVE YOUR CURRENT DOCTOR.

YOU DO NOT HAVE TO MAKE DECISIONS ABOUT WHICH PLAN OFFERS YOU THE SERVICES AND BENEFITS THAT YOU ARE MOST LIKELY TO NEED IN THE COMING YEAR.

DO YOU KNOW WHAT MEDICAL CARE YOU OR YOUR FAMILY IS GOING TO NEED IN THE COMING YEAR? WOULD YOU STAKE YOUR HEALTH INSURANCE ON IT?

LETS LOOK AT "MANAGED COMPETITION" AS WE'VE HEARD IT GENERALLY DISCUSSED.

"MANAGED COMPETITION" IS ANOTHER ONE OF THOSE TERMS MANY AMERICANS ARE HEARING FOR THE FIRST TIME IN THIS DEBATE.

I'D LIKE TO DEFINE FOR YOU, TONIGHT, BUT THAT'S A LITTLE DIFFICULT TO DO.

YOU SEE, IT'S JUST A THEORY.

IT'S NEVER BEEN TRIED ANYWHERE IN THE WORLD. AND THE THEORY OF WHAT IT IS, SEEMS TO BE CHANGING ALMOST DAILY.

LET ME SAY RIGHT UP FRONT THAT WE DO NOT YET KNOW WHAT THE PRESIDENT'S PROPOSAL WILL BE.

THE EARLY INDICATIONS HAVE BEEN THAT HIS TASK FORCE IS LEANING TOWARD A SYSTEM BASED ON THE "MANAGED COMPETITION" THEORY.

BUT WE DO NOT KNOW THAT THE PRESIDENT HAS MADE THAT DECISION, OR EVEN THAT THE TASK FORCE WILL -- FOR CERTAIN -- RECOMMEND A "MANAGED COMPETITION" SYSTEM TO HIM.

BOTH LOOK LIKELY.

BUT WE DO NOT KNOW THAT.

SO LET ME TALK ABOUT "MANAGED COMPETITION" IN GENERAL TERMS.

I'LL RESERVE COMMENT ON THE PRESIDENT'S PROPOSAL UNTIL AFTER WE SEE IT.

UNDER THE "MANAGED COMPETITION" THEORY, MOST AMERICANS WOULD GET THEIR HEALTH INSURANCE FROM AN ENTITY KNOWN AS A HEALTH INSURANCE PURCHASING COOPERATIVE -- A "HIPC."

INSURANCE COMPANIES WOULD COMPETE TO PROVIDE THE LOWEST COST PLAN. MOST OF THESE PLANS WOULD BE FORMS OF HMOS.

IN FACT, THE ONLY WAY TO ASSURE THAT ANY PLANS ALLOWING AMERICANS TO CHOOSE THEIR OWN HEALTH CARE PROVIDER ARE OFFERED AT ALL UNDER "MANAGED COMPETITION" WOULD BE TO REQUIRE BY LAW THAT THE "HIPC" MAKE AVAILABLE AT LEAST ONE VERSION OF ITS PLAN WHICH ALLOWS AN INDIVIDUAL TO MAKE THAT CHOICE.

SO THE "HIPCs" OFFER A VARIETY OF MOSTLY HMO PLANS. UNDER THE "MANAGED COMPETITION" THEORY, YOUR EMPLOYER WILL THEN BE REQUIRED TO CONTRIBUTE A PERCENTAGE OF THE PREMIUM TO ENROLL YOU, AND YOU ALONE -- NOT YOUR SPOUSE, NOT YOUR FAMILY -- IN THE LOWEST COST HMO.

YOU PAY THE REMAINING PART OF THE PREMIUM. YOUR EMPLOYER MAY CHOOSE TO PAY ADDITIONAL PREMIUMS TO ENROLL YOU IN A BETTER HMO OR YOUR EMPLOYER MAY NOT.

YOU MAY CHOOSE TO ENROLL IN A BETTER HMO OR A FREE CHOICE PLAN BUT YOU WILL BE RESPONSIBLE FOR THE ENTIRE DIFFERENCE IN THE PREMIUM.

AND IN SELECTING THE PLAN YOU WANT, WHETHER ITS THE LOWEST COST HMO OR NOT, YOU WILL STILL HAVE TO FIGURE OUT:

* WHAT YOUR PREMIUM WILL BE;

* HOW YOUR COPAYMENTS ARE CALCULATED;

* WHETHER YOUR ULTIMATE EXPOSURE IS CAPPED AT A LEVEL YOU CAN AFFORD;

* WHETHER THE SERVICES OFFERED AND THE RANGE OF HOSPITALS AND SPECIALISTS ARE CONSISTENT WITH WHAT YOU EXPECT YOUR HEALTH STATUS TO BE IN THE COMING YEAR;

* AND WHERE YOUR CURRENT DOCTOR OR YOUR CHILDREN'S DOCTOR, OR YOUR OBSTETRICIAN IS LIKELY TO BE.

THERE ARE OTHER THINGS TO FIGURE OUT, BUT YOU GET THE IDEA, I THINK FROM THIS PARTIAL LIST.

SUPPOSE YOU ARE IN THE LOWEST COST PLAN BECAUSE THAT'S WHAT YOUR EMPLOYER OFFERS. YOU CAN'T AFFORD THE HIGHER PREMIUMS OF A BETTER PLAN, ESPECIALLY WHEN YOU HAVE TO ADD IN THE ADDITIONAL COST OF PAYING FOR YOUR FAMILY'S COVERAGE TOO.

SO YOU ARE IN THE LOWEST COST PLAN -- FOR THIS YEAR.

BUT NEXT YEAR, A DIFFERENT PLAN IS THE LOWEST COST PLAN. SO YOU HAVE TO CHANGE PLANS.

THAT MEANS YOU MAY ALSO HAVE TO CHANGE DOCTORS.

UNDER THE "MANAGED COMPETITION" SYSTEM, WHEN YOU CHANGE PLANS, YOU CHANGE DOCTORS BECAUSE YOUR DOCTOR NO LONGER WORKS FOR YOU, HE OR SHE NOW WORKS FOR "THE PLAN."

THE THIRD YEAR, LET'S SAY A DIFFERENT PLAN IS THE LOWEST COST PLAN. SO YOU CHANGE PLANS -- AND DOCTORS -- AGAIN.

SUPPOSE YOU HAVE A JOB WHERE YOUR EMPLOYER IS WILLING TO PAY AN ADDITIONAL PREMIUM FOR EXTRA BENEFITS.

WHAT HAPPENS WHEN YOU CHANGE JOBS?

YOU LOSE THOSE EXTRA BENEFITS, GET BOUNCED DOWN TO THE MINIMUM BENEFIT PACKAGE SET UP FOR UNEMPLOYED AND POOR PEOPLE, AND YOU CHANGE DOCTORS AGAIN.

SUPPOSE YOUR EMPLOYER SUPPORTS A BETTER HMO FOR YOU BUT DOES NOT PROVIDE FAMILY COVERAGE.

THEN YOU ARE IN ONE HMO AND YOUR FAMILY IS IN THE LOWEST COST HMO, WHICH IS THE ONLY ONE THAT IS SUBSIDIZED TO ENABLE UNINSURED UNEMPLOYED PEOPLE TO BUY IN TO AN INSURANCE POOL.

WHY IS THERE ALL THIS INSTABILITY AND UPHEAVAL? BECAUSE "MANAGED COMPETITION" IS A SYSTEM BASED ON COMPETITION FOR PRICE, NOT QUALITY.

THE ONLY PLAN THAT WOULD GET THE MAXIMUM EMPLOYER SUBSIDY WOULD BE THE LOWEST COST PLAN. SO ALL THE PLANS WILL COMPETE TO BE THE LOWEST COST PLAN.

THE CONSTANT SHIFTING OF PLANS AND PHYSICIANS THAT PATIENTS WILL BE FORCED TO DO IS NOT JUST PROBABLE, IT IS GUARANTEED.

MR. SPEAKER, I HAVE TO ASK THE QUESTION: DO WE REALLY NEED TO GO THROUGH ALL THIS CONFUSION AND UPHEAVAL FOR A THEORY THAT HAS NEVER BEEN TESTED ANYWHERE?

THERE IS NO WHERE ON THE FACE OF THE EARTH THAT WE CAN POINT TO AS AN EXAMPLE OF WHERE THIS HAS WORKED TO GUARANTEE UNIVERSAL COVERAGE AND TO CONTAIN COSTS.

THERE IS NO EXPERIENCE ANYWHERE IN THE WORLD THAT WE CAN LEARN FROM TO AVOID MAKING THE SAME MISTAKES OTHER COUNTRIES HAVE ALREADY MADE.

AND CERTAINLY THERE IS NO ARGUMENT OTHER THAN ONE BASED ENTIRELY ON BLIND HOPE AND WISHFUL THINKING THAT SAYS THIS APPROACH WILL IMPROVE THE QUALITY OF CARE OR EVEN ALLOW CONTINUITY OF CARE.

THE AMERICAN PEOPLE, BOTH PRIVATELY AND PUBLICLY NOW SPEND 950 BILLION DOLLARS A YEAR ON HEALTH CARE.

THERE IS NO EVIDENCE THAT THE "MANAGED COMPETITION" THEORY, AS IT IS GENERALLY UNDERSTOOD, CAN BE SUCCESSFULLY APPLIED TO AN ENTIRE NATION'S HEALTH CARE DELIVERY SYSTEM.

NONE OF THIS CONFUSION AND DISRUPTION IS REQUIRED UNDER A "SINGLE-PAYER" SYSTEM.

YOUR HEALTH INSURANCE COVERAGE IS NOT TIED TO YOUR EMPLOYER.

YOUR DOCTOR IS NOT TIED TO YOUR "PLAN".

FAMILIES CAN GET THEIR INSURANCE COVERAGE TOGETHER AND THEIR CARE FROM THE SAME PROVIDER.

IF YOU LOSE YOUR JOB OR CHANGE JOBS; GET MARRIED OR GET DIVORCED; HAVE A BABY OR LEARN YOUR KIDS NEED A SPECIALIST FOR A CATASTROPHIC OR CHRONIC PROBLEM; OR IF GRANDMA COMES TO LIVE WITH YOU, YOUR HEALTH INSURANCE COVERAGE AND YOUR ACCESS TO HEALTH CARE DOES NOT CHANGE.

YOU ARE NOT CAUGHT IN THE MAZE OF TRYING TO FIGURE OUT WHICH MEMBER OF THE FAMILY GETS WHAT, AND FROM WHOM.

THERE IS NO QUESTION THAT A "SINGLE-PAYER" PLAN WILL PROVIDE THE BEST HEALTH CARE TO THE MOST PEOPLE.

IT WILL BRING CONTINUITY AND STABILITY AND THE ABILITY TO PLAN TO A SYSTEM CURRENTLY RACKED BY FRAGMENTATION.

IT WILL BRING THE AMERICAN PEOPLE THE SECURITY WE NEED IN PLANNING OUR CHILDREN'S FUTURES -- AND OUR OWN.

THE QUESTION IS -- CAN WE AFFORD IT?

THE ANSWER IS: IT'S THE ONLY SYSTEM WE CAN AFFORD.

THE "SINGLE-PAYER" SYSTEM IS THE ONLY HEALTH CARE SYSTEM WHICH THE CONGRESSIONAL BUDGET OFFICE HAS ALREADY REVIEWED AND CONCLUDED WILL YIELD BILLIONS IN ADMINISTRATIVE -- PAPERWORK -- SAVINGS.

IN FACT, VARIOUS ESTIMATES SAY A SINGLE-PAYER SYSTEM COULD SAVE FROM 52 TO 100 BILLION DOLLARS A YEAR ON PAPERWORK ALONE.

THE WASTE CREATED BY OUR CURRENT PATCHWORK OF PRIVATE INSURANCE IS OBVIOUS WHEN YOU COMPARE THE ADMINISTRATIVE COSTS OF PRIVATE AND PUBLIC INSURANCE PROGRAMS.

IN ADDITION TO ADMINISTRATIVE SAVINGS, THE "SINGLE-PAYER" SYSTEM HAS VERIFIABLE COST-CONTAINMENT.

THE FEDERAL GOVERNMENT DEFINES THE BENEFIT PACKAGE AND PROVIDES MOST OF THE MONEY TO PAY FOR THEM.

THE STATES THEN DESIGN A PROGRAM TO ADMINISTER THE DELIVERY OF THOSE BENEFITS WITHIN THEIR OWN BORDERS.

THE QUALITY IMPROVEMENT PROVISIONS ARE PERHAPS THE BEST FEATURE OF THE BILL. FOR I FIRMLY BELIEVE THAT HEALTH CARE REFORM MUST NEVER -- NEVER -- COMPROMISE THE QUALITY OF HEALTH CARE THAT IS THE HALLMARK OF AMERICAN MEDICINE.

HOW DOES H.R. 1200 IMPROVE THE QUALITY OF MEDICINE?

FIRST, IT ELIMINATES THE INTERFERENCE BETWEEN DOCTOR AND PATIENT BY INSURANCE COMPANIES SECOND GUESSING MEDICAL DECISIONS.

WE BELIEVE WHEN SOMEONE IS SICK AND NEEDS TO GO TO THE HOSPITAL, THEY OUGHT TO CALL THEIR DOCTOR, NOT THEIR INSURANCE COMPANY.

SO IT DOES AWAY WITH ALL THOSE "PRE-CERTIFICATION" REVIEWS.

UNDER H.R. 1200, YOU WOULD NO LONGER HAVE TO CALL YOUR INSURANCE COMPANY -- WHICH KNOWS NOTHING OF THE INDIVIDUAL CASE AT HAND -- TO GET PERMISSION TO GO INTO THE HOSPITAL OR TO STAY IN THE HOSPITAL FOR A NIGHT AFTER SURGERY.

THESE POLICIES HAVE HAD DISASTROUS EFFECTS ON THE QUALITY OF CARE AND HAVE NOT WORKED TO CONTROL COSTS.

IN FACT, THEY HAVE ADDED COSTS BECAUSE YOU NEED ANOTHER LAYER OF BUREAUCRACY JUST TO HANDLE THOSE CERTIFICATIONS.

IT REPLACES THAT INTERFERENCE WITH A SYSTEM OF BROAD REVIEW OF THE WAY ALL DOCTORS PRACTICE MEDICINE.

THOSE DOCTORS WHOSE PRACTICES ARE UNUSUAL, OR ARE UNUSUALLY COSTLY, WILL BE IDENTIFIED AND TAUGHT TO DELIVER BETTER HEALTH CARE.

THIS WILL IMPROVE THE QUALITY OF CARE AMERICANS RECEIVE OVER WHAT WE HAVE TODAY.

SO, MR. SPEAKER, HOW DOES THE "SINGLE-PAYER" SYSTEM APPLY TO THE AVERAGE AMERICAN?

SUPPOSE THAT YOU ARE AN EMPLOYEE WHO HAS WORKED 15 YEARS FOR A MAJOR COMPANY AND YOU HAVE BEEN LAID OFF, MAYBE FOR SIX-MONTHS OR A YEAR, AND YOUR WIFE OR HUSBAND STAYS AT HOME TO RAISE THE FAMILY OR HAS A PART-TIME JOB THAT DOES NOT OFFER HEALTH INSURANCE.

WHAT HAPPENS UNDER A "SINGLE-PAYER" PLAN IF YOUR CHILD BREAKS A LEG DURING THOSE SIX MONTHS?

THE ANSWER IS: YOU GET YOUR CHILD'S LEG FIXED AND YOUR HEALTH INSURANCE -- INSURANCE YOU HAVE AS A RIGHT OF CITIZENSHIP -- PAYS FOR IT.

THE ANSWER IS, -- WHEN YOU WERE LAID OFF OR LOST YOUR JOB, YOUR HEALTH INSURANCE DID NOT CHANGE, BECAUSE IT IS NO LONGER TIED TO EMPLOYMENT AND DOES NOT RELY ON YOUR EMPLOYER TO PROVIDE IT.

SO YOU CAN GO TO THE DOCTOR AND GET THAT LEG FIXED WITHOUT WORRYING ABOUT IT. AND THE HOSPITAL AND DOCTOR CAN TREAT YOU WITHOUT WORRYING ABOUT HOW TO GET SOME OTHER PART OF THE SYSTEM TO PAY YOUR BILL.

WHAT IF YOU ARE GETTING A DIVORCE OR YOUR SPOUSE DIES AND YOUR HEALTH INSURANCE ALWAYS CAME FROM YOUR SPOUSE'S EMPLOYMENT?

DO YOU LOSE YOUR HEALTH INSURANCE, TOO?

UNDER THE CURRENT SYSTEM YOU OFTEN DO. BUT UNDER THE "SINGLE PAYER" PLAN, THE ANSWER IS "NO" BECAUSE YOUR INSURANCE NOW COMES FROM THE GOVERNMENT. THE AVAILABILITY OF THAT INSURANCE DOES NOT CHANGE IF YOUR PERSONAL SITUATION CHANGES.

THE "SINGLE PAYER" PLAN -- H.R. 1200 -- IS ALSO THE BEST PLAN FOR AMERICAN BUSINESSES AND WORKERS.

BUSINESSES CAN MAKE HIRING DECISIONS ON THE BASIS OF WHAT MAKES THEIR BUSINESS MOST PRODUCTIVE, NOT ON THE BASIS OF WHAT THEY HAVE TO DO TO AVOID INCURRING EVEN GREATER HEALTH INSURANCE COSTS.

WORKERS WILL BE FREED FROM "JOB-LOCK" WHERE THEY CANNOT CHANGE JOBS BECAUSE OF THE CERTAIN KNOWLEDGE THAT IF THEY DO, THEY'LL NEVER GET HEALTH INSURANCE AGAIN BECAUSE OF A "PRE-EXISTING" CONDITION.

THE PRIVATE ECONOMY WILL GAIN TREMENDOUSLY FROM A "SINGLE-PAYER" APPROACH.

MR. SPEAKER, THE ADVANTAGES OF A "SINGLE-PAYER" PLAN LIKE H.R. 1200, I THINK ARE OBVIOUS.

BUT I KNOW THE PRESIDENT IS PREPARING HIS OWN PLAN AND I KNOW SOME OTHER MEMBERS OF THIS BODY ALSO HAVE THEIR OWN PLAN.

SO TOMORROW NIGHT I HAVE ASKED FOR TIME TO OUTLINE AND DISCUSS 12 BASIC CRITERIA I THINK MY COLLEAGUES WILL FIND HELPFUL IN EVALUATING ANY PLAN, NO MATTER WHAT ITS SOURCE.

IF A PLAN DOESN'T ~~SOLVE~~ MEET THOSE ~~PROBLEMS~~ CRITERIA, IT OUGHT TO BE REFINED OR REJECTED.

I URGE MY COLLEAGUES TO HEAR THOSE REMARKS.

TO THOSE WHO DOUBT THE ABILITY OF OUR PEOPLE TO ABSORB FUNDAMENTAL CHANGE ON SUCH A BASIC ISSUE, I SAY THIS:

WE ARE AMERICANS.

SURELY WE DO NOT NEED TO GAMBLE ON A HIGHLY DISRUPTIVE SYSTEM THAT VIRTUALLY GUARANTEES ADMINISTRATIVE CONFUSION AND SIGNIFICANT ADMINISTRATIVE COSTS.

SURELY WE CAN DESIGN A SYSTEM THAT INCLUDES THE LESSONS LEARNED FROM REAL EXPERIENCE.

SURELY WE CAN DESIGN A SYSTEM THAT BRINGS PEOPLE THE SECURITY, THE SIMPLICITY AND THE PREDICTABILITY WE DESERVE WHILE SERVING THE VALUES WE CHERISH. A SINGLE-PAYER PLAN SUCH AS THE AMERICAN HEALTH SECURITY ACT IS WHAT THIS NATION NEEDS FOR THE 21ST CENTURY.

WE SHOULD NOT ALLOW OURSELVES TO BE DIVERTED FROM WHAT WE NEED ON THE EXCUSE THAT WE ARE NOT READY.

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WE ARE AMERICANS AND WE ARE READY.

#

# Withdrawal/Redaction Marker
## Clinton Library

| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
|---|---|---|---|
| 004. memo w/attach. | Chris Jennings to Hillary Clinton<br>Re: Tuesday Meeting with Congressman McDermott (5 pages) | 4/28/93 | P5 |

**This marker identifies the original location of the withdrawn item listed above. For a complete list of items withdrawn from this folder, see the Withdrawal/Redaction Sheet at the front of the folder.**

**COLLECTION:**
Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23754

**FOLDER TITLE:**
April 1993 HSA [4]

gf79

**RESTRICTION CODES**

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

**P1 National Security Classified Information [(a)(1) of the PRA]**
**P2 Relating to the appointment to Federal office [(a)(2) of the PRA]**
**P3 Release would violate a Federal statute [(a)(3) of the PRA]**
**P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]**
**P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]**
**P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]**

**C. Closed in accordance with restrictions contained in donor's deed of gift.**
**PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).**
**RR. Document will be reviewed upon request.**

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

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

**PRIVILEGED AND ~~CONFIDENTIAL~~ MEMORANDUM**

TO: Hillary Rodham Clinton April 29, 1993
FR: Chris Jennings
RE: Teleconference Call with Congressman Valentine
cc: Melanne, Steve, Lorraine

I am told you will be making a teleconference call for the first in a series of "Citizen Meetings" with Congressman Valentine. He is extremely appreciative of your willingness to do this for him.

On April 20th, I met with Congressman Valentine to give him a sense of direction as to where the policy discussions were going and to give him the opportunity to ask questions and give advice. His District is the headquarters for a number of research hubs of the pharmaceutical industry. In addition, being from North Carolina, he is very concerned about discussions about tobacco taxes.

Although he was concerned about the direction he thought we were headed, he made it clear that he did not want to stand in the way of reform. He feels strongly that costs our totally out of control and we must get a handle on them. His message to me about the pharmaceutical firms and the tabacco farms was mostly oriented to assuring that they were treated "fairly." He was, in other words, not at all searching for any special treatment.

He is far from a detail person, but I get the sense that he has a very good "gut" sense of politics. He is also influential with the moderate to conservative wing of the Democratic party. If we actually attracted his vote, it would probably mean we were in a good position to attract other votes as well.

Lastly, he asked me to forward to you that he has been talking you up throughout his district. He believes you are one of the few people in the nation who has a chance of successfully taking on this very difficult issue. You may want to thank him for that.

Attached you will find copies of all the materials he has sent out regarding his "Citizen Meeting." I think you will find more than you need for this conversation.