Although I come from Washington, DC, these days, I started life as a Pennsylvanian—and you may not know that Pennsylvania has more rural elderly residents than any other state.

Before going further, let me offer you a word about the Alliance for Health Reform. It emerged from the ashes of the Pepper Commission, for which I served as counsel. Jay Rockefeller, who chaired the Pepper Commission, agreed to collaborate with me on a non-partisan, non-profit effort to educate opinion leaders on the urgent need to address the health reform agenda. The board also includes Senator Jack Danforth (R-MO) and many who differ on what an ideal health reform plan might be, but they agree on the need to act quickly rather than wait for that ideal to arrive.

Our country stands on the brink of comprehensive, fundamental reform of its fatally flawed health care system. For the first time in a generation, we have a real chance to defuse the ticking bomb of health care costs that threatens nothing short of an economic meltdown in just a few short years.

I will not describe in detail the current health care crisis in America. Mark Waymack did a good job of that. But let me reiterate a few simple facts so we all start from the same page. It is not that most Americans do not have access to some of the most sophisticated, advanced—and expensive—health care technology available in the world.

But it is a national disgrace that 37 million Americans lack insurance coverage at any time—and more than 60 million will be without coverage sometime in the next two years.

What is more, tens of millions of Americans with coverage understand they are a pink slip or a diagnosis away from falling through the cracks.

Meanwhile, skyrocketing health care costs are eroding family income, governmental fiscal capacity and business competitiveness.

As most of you know, rural America has some special problems with health care. Non-metro areas have a higher percentage of peo-
ple without insurance, higher infant mortality rates, fewer physicians and other providers, and fewer visits to those providers.

Today I have been asked to help you focus on what the Clinton plan contains and what the major alternatives are likely to be. In short, I am supposed to function as a "Washington insider."

A few months ago, I received a fund-raising letter from Congressman Bill Archer, a Republican member of the House Ways and Means Committee. He offered me the chance to contribute $5,000 to the Republican Congressional Campaign Committee. In exchange, I would be able to attend a series of breakfast briefings by House Republicans on health care reform—conveying information without which, as a Washington insider, I would find it impossible to do my job. I chuckled and tossed the letter away.

But James Carville, the irrepressible Clinton White House advisor, got the same letter, and wrote back to Congressman Archer, "I've been called a 'stupid and pathetic country bumpkin,' . . . compared to David Koresh, . . . and blamed for a 65-point drop in the stock market. But never have I been called anything so repugnant . . . as a Washington insider."

We have a chance to make quality, affordable health care a reality for the tens of millions of Americans who now lack it—and a real chance to bring peace of mind to the majority of Americans who have coverage, but rightly fear that they, too, could lose that security any time. All Americans, in rural and urban areas, will have their lives touched by the coming reforms. So be careful who you ask for insight.

We have come a long way in health reform in a relatively short time. Health care in the 1988 presidential race, for example, was a secondary issue—less important than crime, drugs, taxes, education, abortion. In Iowa, before the 1988 caucuses, George Bush told an interviewer he would give long-term care "the attention it deserves."

But by the fall of 1991, health care became the major issue in the upset defeat of Dick Thornburgh for the Pennsylvania Senate seat. Harris Wofford told voters, "If every criminal in America has the right to a lawyer, then every working man and woman in America should have the right to see a doctor when they're sick." The political landscape has not been the same since:

* After eighteen months of meetings, Senate Republicans agreed on a reform plan and announced it three days after the Pennsylvania election.

* George Bush, whose advisors were feuding publicly about whether he ought to have a health plan before the 1992 election, had one before the New Hampshire primary.
Exit polls in New Hampshire and elsewhere showed health care as a solid #2 concern, behind the economy, in voters' minds. In the general election, health care virtually tied with deficit reduction as the second most important issue—but was a solid #2 (51-31, with education third at 18 percent) among those who voted for Bill Clinton.

Bill Clinton did not start his quest for the presidency in 1992 as the candidate most concerned about reforming the health care system. Remember, his advisers kept the campaign focused on "the economy, stupid."

But by the time President Clinton delivered his State of the Union Address, he was fixated on health care reform: "All our efforts to strengthen the economy will fail—let me say this again, I feel so strongly about this—all of our efforts to strengthen the economy will fail unless we also take this year—not next year, not five years from now, but this year—bold steps to reform our health care system."

He then designated First Lady Hillary Rodham Clinton to head his Task Force for National Health Care Reform. And while the Clinton health reform proposal, sketched in a position paper and a major speech in September, 1992, may not have changed the direction of the campaign, it has profoundly changed the debate about the shape and urgency of health reform.

And you do not really need a Washington insider to get a pretty accurate look at the health plan President Clinton will present to Congress next Wednesday night. All you need is a copy of Time, Newsweek or yesterday's Wall Street Journal. But on the theory that you have been so busy at this conference you have not had a chance to read any of the popular accounts, let me hit the highlights for you.

Universal coverage. The Clinton plan would build on the existing employer-based system of coverage by requiring all employers to pay for 80 percent of the cost of a standard plan for their workers and dependents. Employees would be required to accept the coverage and pay the remaining share of the premium in the plan of their choice. Since 85 percent of the uninsured are either workers or in the family of a worker, that one step takes us roughly 85 percent of the way toward dealing with the problem of the uninsured. The unemployed and anyone else not connected with the work force would get coverage through a regional health alliance, with subsidies available for families with incomes up to 150 percent of the federal poverty line (about $21,500 for a family of four).

Those currently receiving Medicaid acute care coverage would be folded into this new plan for private coverage. Employer requirements would be phased in, as states get up and running, with all of them in place by 1997. As a cushion against the possible loss of jobs
in small businesses, the contribution of the smallest, lowest-wage firms could not exceed 3.5 percent of payroll.

Managed competition within a budget. By the time he made the major health care speech of his campaign before Merck & Co. employees in Rahway, NJ, on September 24, 1992, Bill Clinton had explicitly ruled out the “play-or-pay” approach he favored early in the campaign primaries. (In play-or-pay, employers either provide coverage for employees and dependents or pay a payroll tax toward the cost of covering them in a public insurance plan).

In Bill Clinton’s new plan, soon to be formally transmitted to Congress, employers would still face a requirement to contribute toward the cost of coverage, but there would be no tax or public coverage option (thus causing some to describe the plan as a “play or else” proposal). In a play-or-pay plan, the lower the payroll tax rate, the more employers would find it advantageous to drop coverage, pay the tax and let government handle employees’ insurance. This change has the advantage of responding to critics who saw the public plan as a stalking horse for national health insurance. The disadvantage, in the eyes of single-payer advocates, was exactly the same: They argued that by leaving insurance companies with a central role to play, Clinton’s plan would preclude true and complete reform.

States would establish one or more risk pools—called regional health alliances. Under the plan Clinton outlined, new state or regional cooperatives or pools would be set up to arrange the purchase of coverage for all residents (except Medicare beneficiaries and employees of very large enterprises). Coverage would be purchased from a selection of qualified health plans, expected to be mainly managed care networks of providers and insurers. The alliances have a size advantage that would let them negotiate lower rates from the health plans, or networks, and collect from them information that patients could use to shop among plans. Hence, the alliances would be able to “manage,” or regulate, competition for patients among the plans on the basis of quality and cost.

A standard benefits package. Every plan would offer a standard set of benefits, defined for all by a national health board. Prescription drugs would be included as would primary and preventive care and limited mental health benefits. Separately, states would be given federal funds to set up limited long-term care programs for severely disabled people of all ages and incomes, and Medicare would be expanded to include a separate prescription drug benefit. Comparisons among plans would be greatly simplified. Individuals could buy additional coverage at their own expense.

Insurance reform. Today’s practices that allow insurers to avoid covering those thought to pose a larger chance of filing claims would
be banned, and plans would be required to charge everyone in a given area the same average rate—a so-called “community rating.”

Setting the budget. A national health board would set an overall limit for spending on health care, both public and private. Those limits would be translated into “capitation fees”—in effect, premium targets, for each regional health alliance. Each year those targets would be adjusted upward by the national board. Alliances would then keep overall spending at or below the targets. The targets would be gradually brought into line with growth overall in the national economy.

States would be responsible for setting up alliances, administering subsidies for low-income people and low-wage employers, certifying health plans, and running data collection and quality improvement programs.

They could choose to establish a government-run insurance plan—these days called a “single-payer plan.”

Regional health alliances could be state agencies or nonprofit organizations, governed by employer and consumer representatives.

It is appropriate to ask how well this device will fit in rural areas. The problem with managed competition, of course, is that in rural areas there is precious little competition to manage.

When Iowa recently asked one of managed competition’s intellectual parents, Rick Kronick, to evaluate the state’s capacity to implement that strategy, he concluded it would probably work... in Des Moines. The concentration of providers and population was too low in the rest of the state to yield enough “competition” to be managed.

Yes, everyone will eventually have a “health security card.” But, as Dan Hawkins of the National Association of Community Health Centers points out, giving an insurance card to Americans in some areas is like giving an American Express card to a Tibetan monk: a nice gesture, but with little practical effect.

Alliances, according to the draft plan circulating, would have several tools with which to address the question of how to ensure adequate health services in rural areas.

On their own initiative, alliances will be able to create additional plans to serve rural areas, or require urban plans to serve rural alliance areas, or offer long-term contracts to plans serving rural areas.

Beyond the alliances, the Clinton plan mentions (with few specifics yet):

- Federal loan guarantees for community-based organizations in rural areas for capital improvements.
Federal grants to develop telecommunications capacity, to link rural providers with health care centers.

The National Health Service Corps would be expanded.

Tax incentives would encourage physicians and other professionals to practice in rural areas.

Supplemental services would be provided through the public health system for low-income populations—services like transportation and outreach, for example.

Academic health centers would help develop information and referral structure for special services.

And there will be a general effort to produce more primary care professionals—reforming medical education, reweighting physician compensation, and other steps.

What will all this cost? By the year 2000, about $83 billion in new federal spending:

- $30 billion in subsidies to low-income people and low-wage businesses.
- $28 billion for long-term care.
- $17 billion for the new Medicare prescription drug benefit.
- $8 billion for public health, full insurance deductibility for the self-employed, and overall administration.

The rest of the new resources would be used to reduce the federal budget deficit.

What is controversial, of course, is where to find these new resources.

In April, the Alliance for Health Reform held a forum examining the strengths and weaknesses of various new taxes. But the bruising budget battle just concluded soured completely the atmosphere for raising much new revenue. So the administration suggests that in the year 2000:

- $16 billion in “sin taxes” and a corporate surcharge for large businesses.
- $46 billion in “savings” from Medicare.
- $40 billion in “savings” from Medicaid.
- $16 billion from the effects of the mandate.
- $13 billion in other federal savings.

And here is a safe prediction: this proposal will not pass by voice vote. Some would say the 748 health interest groups in Washington will slow movement toward enactment to a stop.

There are many alternatives being offered by those groups and various lawmakers in both parties. Here is a brief listing of the major ones:

1. A less intrusive “managed competition” proposal by Representative Jim Cooper (D-TN) and other members of the Conser-
operative Democratic Forum. It contains no employer mandate and would tax the value of benefits received by employees beyond the standard package.

2. A similar proposal has been endorsed by the Senate Republican Health Task Force, headed by Senator John Chafee (R-RI).

3. An incremental plan featuring "medical savings accounts," rather like IRAs, that would encourage people to spend more sparingly a large initial amount each year, by allowing them to keep what they do not spend on health care.

4. A "single-payer," or Canadian-style plan, endorsed by almost ninety House Democrats (led by Representative Jim McDermott (D-WA) and several Senators including Paul Wellstone (D-MN)).

Already the Clinton plan has been attacked by Representative McDermott for lack of immediate cost controls, and by Senator Phil Gramm (R-TX) as simultaneously threatening fiscal disaster and destruction of the health care system as we know it.

Interest groups have been cautious in their comments. Jim Todd of the American Medical Association calls it a step in the right direction. The American Hospital Association says it is willing to discuss overall budgets. Senator Chafee has been saying sympathetic things about the Clinton plan.

What happens in Congress will unfold over the next six to twelve months, and will be complicated by the dozens of committees and subcommittees seeking to exert jurisdiction over at least part of the plan.

What is more, the attitudes of the American people, to which Congress responds, are muddy as well.

- We worry about losing insurance ourselves, and worry about those who have no coverage—but not so much that we are willing to pay much to solve that problem.
- We favor requiring employers to cover their workers—unless it means a loss in jobs.
- We want to rein in costs, but we also want the highest-tech equipment and procedures, and we want it tomorrow morning within a ten-minute drive.

As a result, the president and his allies have a tremendous selling job to do. Their strategy is clear: appeal to the uneasiness many of us have about our future coverage. The second sentence of the draft plan reads, "Americans lack security." You will hear that theme repeatedly in the next few months.

My own view is that we will have a health plan passed within the next year. There is a compelling moral case for reform and an equal-
ly compelling economic case. But the reason I am so hopeful is that the political case for reform is overwhelming. Bill Clinton’s chances for reelection would be incredibly enhanced by passage of a plan that provides peace of mind—and failure to have such a plan in place would be a serious blow to those chances. Additionally, scores of Congressional delegates have made similar commitments. I believe getting progressive, comprehensive reform is within our grasp and I intend to do all I can to bring it about. Please, help in that important venture.