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A Conversation with Christopher C. Jennings

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* Kathy Cerminara: Good afternoon everyone. Today we have with us Christopher Jennings, one of our Goodwin Series speakers. Chris Jennings served as Senior Health Policy Advisor and Deputy Assistant for Health Policy to President Bill Clinton. As Deputy Assistant to the President for Health Policy, working out of the President's Domestic Policy Council and in conjunction with the National Economic Council, Jennings was in charge of developing the Administration's health care policy. In this capacity, beginning in 1994, he coordinated the health policy work of numerous federal agencies, including the Office of Management and Budget and the Departments of Health and Human Services, Treasury, and Labor. As the President's Senior Health Policy Advisor, Jennings advised the President on a wide variety of issues, including Medicare, Medicaid, long term care, insurance coverage expansions, and consumer protection. Recognizing his work, the National Journal in 1997 designated Mr. Jennings as one of Washington's 100 most influential individuals in the federal government.

Before his White House appointment, from 1993 to 1994, Jennings was the Senior Legislative Health Reform Advisor to the Health Care Financing Administration (HCFA), and during his tenure in this position he worked with first lady Hillary Rodham Clinton, preparing her for testimony on Capitol Hill regarding health care reform. Prior to joining the Clinton Administration, Mr. Jennings served as a committee staff member for Senators Glenn, Belcher, and Pryor. Today he is going to talk about health care policy and about what we can do, or maybe, what we should think about when we are reforming the health care system in America.

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I. INTRODUCTION

I had an extraordinary experience as Health Care Advisor to the President in the Clinton White House and I want to talk to you a little bit about what we have done. More importantly, I have been asked to talk about how we can improve the heath care system in this political world that we live in and how we can apply some of the lessons we learned to the future.

There is no question that the Clinton Administration experienced both the thrill of victory and the agony of defeat in our continuous struggle to reform and to improve the nation's health system. Beyond the record, however, I believe there were many significant lessons learned that can and should be applied to future efforts to reform health care in the United States. The most important of these are the critical steps of effectively defining the problem, establishing the goals for reform, developing viable policy, and designing a workable strategy to pass and enact legislation.

II. DEFINING THE PROBLEM; ESTABLISHING GOALS FOR REFORM

Before embarking on any major reform, one has to effectively define the problem. Without first achieving broad agreement that there is a problem that virtually all understand and determine is worth addressing, it is impossible to proceed with meaningful reforms. Although it may seem that the problems of health care in this country are universally understood, many of the examples I will subsequently share will illustrate that defining the problem can actually be one of the most complicated parts of shaping health policy.

As important as defining the problem, though, is establishing objectives for change. Just as there are many differing opinions on the flaws (and strengths) of the health care system, there are just as many perspectives on what the goals of reforms should be. By providing examples of some of the

most prominent issues in health care today, I will try to illustrate how the broadly differing views people have about the problems and desired outcomes for reform severely complicate any effort to improve the nation's health care system.

A. *The Uninsured*

The fact that more than forty million Americans lack health insurance is commonly believed to be the crux of the health care problem in this country.[1] Improving access to health coverage is generally viewed as a primary goal of health care reform. But even this seemingly obvious conclusion has not achieved a consensus status.

Opponents of reform frequently argue that there really is not a problem of access; they suggest that anyone without a preexisting condition can purchase relatively affordable health insurance. They also argue that this issue is not, nor should be, a national domestic policy priority because the problem is overstated, as anyone can go into an emergency room and receive care, regardless of insurance status.

All the arguments and research to the contrary do not sway opponents of major change.

For instance, one can cite the fact that the percentage of uninsured adults who do not receive medical care is more than three times that of privately insured Americans.[2] Or, one can point out that the uninsured are fifty to seventy percent more likely to need hospitalization for avoidable and expensive health conditions, like pneumonia and uncontrollable diabetes, than those who have private insurance.[3] The fact that children without health insurance are nearly twice as likely to forego health care for conditions like asthma or recurrent ear infections, which can lead to serious problems throughout life, does not break through either.[4]

1. Robert Mills, *Health Insurance Coverage: 2000*, at 1, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS P60-215 (2001).

2. Linda Blumberg & David W. Liska, *The Uninsured in the United States: A Status Report*, THE URBAN INSTITUTE (Apr. 1996), *available at* http:/urban.org/pubs/HINSURE/uninsured.htm.

3. *Id.*

4. *Id.*

B. *Access to Coverage*

Clearly, the insurance coverage issue reflects the difficult nature of identifying health care problems and corresponding goals. Even assuming a sufficient base of bipartisan support for the general notion of policies to expand insurance, (which parenthetically, I believe there generally is), there are so many other issues. Even when policymakers advocate for all Americans having health insurance, it becomes necessary to define what that means in order to develop policy and consensus around it. Does it mean that all Americans should *have* health insurance or should they have *access* to health insurance? Access to health insurance and actually having health insurance can be two very different concepts. Universal *coverage* requires a Federal mandate; universal *access* to coverage does not necessarily require one. However, the latter is generally less efficient and more costly per person covered.

In addition, there is no broad agreement about what type and level of coverage is minimally necessary to be defined as acceptable health insurance. Does it mean comprehensive, first-dollar coverage, catastrophic stop-loss coverage, or something in between? Similarly vexing is the definition of affordability. Does affordability mean insurance premiums should not be greater than a percentage of income, or does it mean an explicit dollar amount? What are the levels of government subsidies that are necessary, desirable and/or acceptable to make health care affordable for individuals and businesses? And, most importantly, how are they to be financed?

A similar challenge is how to define and assure quality of health care. This becomes frequently something more akin to the Supreme Court's definition of pornography; you cannot define it, but you know it when you see it. And finally, how do you weigh the relative importance of each one of these essential issues? The following sampling of issues gives a sense of how complicated and controversial health care can be and why I believe it to be the most challenging domestic policy issue confronting the nation.

III. HEALTH CARE ISSUES THAT CHALLENGE THE NATION

A. *Choice*

A commonly identified health care policy problem is lack of choice. People constantly say that they want more choices in health care, but what does that mean? What should our goals be in this area? Do we want more choice of health plans? Assured choice of doctors? What about more choice

of technology and new drugs? Do we need more choice of covered benefits? If choice increases costs, do we want choice in all cases? Choice often segments the healthy from the unhealthy, making it more difficult to affordably cover the most vulnerable populations. Is that an outcome we desire? In short, the concept of choice makes for great rhetoric, but not always great policy. Rarely is there a consensus around the definition or the desired outcome.

B. *Health Care Costs*

In identifying important problems in health care, it is impossible to ignore the issue of rising health care costs. Should we care about cost growth? Do we think that health care cost containment should be a significant part of health care reform?

As the largest purchaser of health care in this country, the employer community would certainly list cost containment as a major priority in principle. But they rarely pursue it aggressively on the federal legislative front. Regardless though, should this be a major priority of any federal government health initiative? If taxpayer dollars are used for subsidizing health care, should not health care be purchased in the most cost-effective manner? If so, what is the policy that should be implemented? Should we rely on price regulation or trust that market competition governed by certain rules will do the trick? Will those who say they support cost containment strongly advocate it in the end if it means confronting health care providers and insurers directly or limiting consumer choices or benefits?

C. *Risk Selection and Insurance Reform*

When discussing the problems of the health insurance market, there is more to think about than simply constraining costs. For example, can workable and politically viable reforms be structured to assure that insurers provide affordable health coverage to all Americans, and do not discriminate against people on the basis of preexisting conditions? In a voluntary market, would these types of reforms have potentially dire consequences?

For example, what would happen if insurers enrolled every individual with a preexisting condition at the same price as healthy populations? Inevitably, people would wait until they were sick to get insurance, causing insurance prices to skyrocket, as insurers could not afford to provide health care coverage if they were only insuring sick people. However, in the absence of insurance reforms, insurers tend to develop and effectively

implement strategies to avoid high-risk, high-cost enrollees. Because of these factors, the current health insurance system encounters all sorts of risk selection problems, pointing out the need for a balanced set of insurance reforms as a major health policy goal.

D. *Quality*

Every American and every policymaker stresses the importance of quality health care, but no one really knows how to measure, assure, or improve it. The whole debate around a Patients' Bill of Rights illustrates this point.[5] This debate has been driven by the population of Americans that has insurance, but is dissatisfied with the product and how it is delivered. The Patients' Bill of Rights debate has clearly shown that the issue of quality cannot be ignored, particularly because the Americans who already have coverage may care more about this issue than covering the uninsured.

Long term care is also a concern. Presently, we do not provide any type of significant coverage for those people who are chronically ill of all ages, who want to stay in their home, in their communities, and want to be able to receive some sort of support for doing so.[6] When we do provide care, it is generally Medicaid.[7] We have tens of millions of Americans of all ages who are chronically ill and need to have assistance.[8] Clearly, these are issues that need attention.

As a consequence, it is critically important to define and assure quality health care. How can this be done? Is it determined by the availability of certain health care services, the ability to appeal unsatisfactory health care decisions, or is there a way to actually measure medical outcomes that can work to hold plans and health care providers accountable? And lastly, should there be penalties for health care plans or providers who provide substandard care, and if so, what should they be, and how should they be

5. Stephanie Lewis, *A Guide to the Patients' Bill of Rights Debate*, INSTITUTE FOR HEALTH CARE RES. & POL'Y, GEO. U. (Aug. 2001), *available at* http://www.kff.org/content/2001/3179/DebatePaper.pdf.

6. Democracy Compact, *Pledge to Vote*, *at* http://www.pledgetovote.com/vote/difference.html (last visited Feb. 17, 2002). The elderly vote more than any group in the country.

7. Mills, *supra* note 1, at 2.

8. *Study Says 100 Million Americans Chronically Ill*, Nov. 12, 1996, *at* http://www.diennet.com/cnnhealth.html. Study, done by researchers at the University of California in San Francisco, reveals that over 100 million people who are chronically ill in America today.

applied? Because the state of the art in the health care industry today is such that quality health care is frequently measured much more subjectively than objectively, it becomes an extremely challenging issue to address effectively and satisfactorily to all interested parties.

E. *Technology*

At the same time as the challenges of health care delivery are becoming ever more complex, the industry is in the midst of an extraordinary age of technology, with seemingly constant breakthroughs in pharmacological interventions, treatments, and diagnostic techniques.[9] These represent great opportunities to improve the quality of life and to extend the life span. Recent breakthroughs in gene therapy have perhaps the most significant implications for the future of health care.[10] Scientists have recently finished mapping the whole genome, and the implications for this knowledge in the future are beyond anything that we can imagine.[11]

But while technology produces wonderful diagnostic tools, treatments, and occasional cures, it also brings to the forefront extraordinary ethical dilemmas. For example, there are widely differing opinions about the benefits and potential harms of genetic screening. Should we know about our gene makeup and our predisposition for disease? This type of information could be very useful for insurers or employers, but would we ever want them to have access to it? Can you imagine people having access to your medical records or your genetic makeup and how that could be used or misused in the future? Should health care reform include all those issues too? How can we effectively balance the positive use of technology with its potential for abuse? And finally, does our understandable love affair with technology adequately take into account its expense and its potential for further dividing the nation between those who have access to it and those who do not?

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9. ROY PORTER, THE GREATEST BENEFIT OF MANKIND, A MEDICAL HISTORY OF HUMANITY (W.W. Noton & Co. 1997).

10. *Id.*

11. *Optical Mapping: A Complete System For Whole Genome Shotgun Mapping, available at* http://www.ornl.gov/hgmis/publicat/00santa/152.html (last visited Feb. 17, 2002). The website is provided as a service of the Human Genome Project and describes the optical mapping of the whole genome using the "shotgun mapping" approach.

F. *Demographic Challenges*

Finally, in defining the problems and goals of health reform, it is important to determine if the inevitable financing and health delivery challenges associated with the retirement of the baby boom generation should be addressed. This demographic challenge is undeniable, as the population of Medicare beneficiaries will double from forty to eighty million by the year 2035.[12] Although competitive reforms over the long term may achieve some limited savings, the fact remains that if you double the population of people on Medicare, the cost will likely double as well.

Linked to the demographic challenge is the need for updating the Medicare benefit to provide for long-overdue prescription drug coverage. It makes little sense to have a Medicare benefit that does not cover prescription drugs in the twenty-first century.[13] The whole future of health care is largely reliant on pharmacological interventions, yet we do not cover an outpatient prescription drug benefit.[14] Seniors and people with disabilities care passionately about this issue because they see the extent to which their health care is pharmacologically based. They are scared of not having access to their medications, and fear, as I will note later, is an incredibly powerful motivating force.

Long-term care is also a concern. Presently, we do not provide any type of significant coverage for chronically ill individuals of any age, who want to stay in their communities, and desire to be able to receive some sort of support for doing so.[15] When we do provide care, it is generally through the welfare-oriented Medicaid program.[16] As a consequence, we have tens of millions of Americans of all ages who are chronically ill who receive no meaningful assistance.[17] While these demographic problems are undeniable, they also have great potential to be extremely expensive to address. Policymakers risk alienating a powerful constituency if they don't address these

12. Mills, *supra* note 1, at 2.

13. *See* Medicare, *Medicare Basics*, *at* http://www.medicare.gov/Basics/Eligibility.asp (last visited Feb. 17, 2002).

14. *Id.*

15. Democracy Compact, *supra* note 6.

16. Mills, *supra* note 1, at 2.

17. *Study Says 100 Million Americans Chronically Ill*, Nov. 12, 1996, *at* http://www.diennet.com/cnnhealth.html. Study, done by researchers at the University of California in San Francisco, reveals that over 100 million people who are chronically ill in America today.

issues, yet if they do take them on, they also risk weighing down any health care expansions with expensive, mostly governmental, interventions.

IV. DEVELOPING HEALTH CARE POLICY AND DESIGNING A STRATEGY FOR ENACTMENT

After effectively defining the problems in the health system that should be addressed and developing a general consensus on the goals for reform, it is necessary to design a policy that effectively achieves these goals. The importance of developing a sound policy cannot be overstated, as the policy will be forced to undergo extraordinary scrutiny by both objective policy validators and interests who oppose it. As important as the policy and the process by which it was developed is the subsequent strategy that is tapped to pass and enact such reform. My following comments address both of these essential components of a successful effort to reform the health care system.

A. *Overall Policy Approach*

Even before developing explicit policy, it is essential to determine whether the approach to health care reform will be comprehensive or incremental in nature. There are advantages and disadvantages to both. Obviously, a comprehensive approach requires a great deal of political capital and is much more difficult to develop and to advocate. However, a comprehensive approach can also much more efficiently expand coverage to a greater number of Americans and can do so while addressing the broad range of financing, insurance reform, quality assurance, and cost containment policies which are directly and indirectly impacted by any health reform. Conversely, a more targeted approach to health reform has the advantage of being easier to achieve consensus around and doing so with less political risk and capital expenditure. The downside, of course, is that while such incremental initiatives are more likely to be enacted into law, they almost inevitably cost more per individual assisted and are frequently more likely to incur unintended consequences.

B. *The Policy Development Process*

Developing viable policy—from both a structural and political perspective—is certainly one of the greatest challenges facing anyone advocating

health reform. It must be developed in a manner that a broad-based coalition of internal and external policy validators will conclude is workable. To the extent the policy design fails to work from either a financing or health care delivery perspective, the policymaker advocating it will almost inevitably receive merciless and devastating criticism that threatens the very survival of the proposal.

To achieve success in this area, the talented policy analysts that are familiar with financing, delivery, history, and practical application of health policy must be utilized to frame the proposal. If it is an Administration proposal, contributions to the policy must come from a broad array of internal power and policy centers such as the Department of Health and Human Services, the Treasury Department, the Department of Labor, the Office of Management and Budget, the Domestic Policy Council, and the National Economic Council. This is important not only so that policymakers can benefit from various sources of expertise, but also because these departments' investment in the policy is critically important to ensure a broad-based, Administration-wide commitment to the eventual proposal released by the White House. It is also critically important to receive such validation from elite outside experts that the media and the Congress tap as resources on questions of policy.

The last policy question that must be answered is whether the proposal that is released is detailed or general in design. A detailed approach has the advantage of being able to expedite outsiders' analysis of the proposal; for example, achieving a relatively certain budget estimate from the Congressional Budget Office. If there is already broad-based support for such a policy, these details can help accelerate Congressional progress on passing the legislation. The downside, of course, is that any detailed policy exposes itself to easier scrutiny and a greater likelihood of explicit and effective criticism. As such, it frequently becomes more appealing to delay the release of underlying details to avoid such criticism.

C. *Timing and Trust in Government*

Even the best of policies will have great potential to fail if they are not proposed during a time in which the political environment is open to reform. Generally, that means that there has to be a broad-based acknowledgement that the problems in the health care delivery system are great enough to justify legislative intervention. To advocate comprehensive reform, there almost needs to be a sense of crisis. Ironically, however, there also needs to be a general trust in the government's ability to intervene in a constructive

way. Concurrent with that faith, the public must feel that they can trust the leader advocating such change. These are all necessary prerequisites, as health care is so controversial and so complex that the public must trust that the leader advocating change has their best interest in mind in order to support reform. Lastly, any policy that is promoted cannot be pursued if there are too many other policy priorities also being advocated. In order to both promote and defend a viable health policy, the advocates of that proposal must be available to dedicate a significant amount of time to it.

D. *Effective Policy Outreach and Rollout*

Beyond securing external validation from the policy elite, it is imperative to develop and implement a strategy that incorporates a broad base of validators for the initiative. It is necessary to secure the agreement of outside validators to lobby the Congress and to illustrate broad-based support from interest groups that are influential with the public, and therefore the media. In addition to proving expert support for the policy, securing interest group involvement increases the number of defenders against the inevitable opposition to the policy. To achieve this end, it is necessary to understand the priorities of key health care interest groups, such as consumer groups, health care providers, insurers, manufacturers, and state and local interests, and integrate them into both the policy and the strategy for enactment.

Unfortunately, these different interest groups rarely have a uniform vision, and you often must choose who is going to be on your side from among these different groups. It is nearly impossible to push through any health reform without the validation of the consumer groups. The provider community is often supportive of reforms that do not include significant cuts to their current reimbursement rates. The insurers and the pharmaceutical companies are often opposed to reforms that mandate significant cost containment while the business community is very focused on promoting cost containment reforms.

Along with outreach to the various interest groups, there must be a carefully designed communications strategy that is developed both for the broader public message as well as the day-to-day press coverage of the proposal. The press can play a constructive or destructive role, but they frequently play a destructive role by default, as conflict is more newsworthy than common ground. That is why I think that you will find that the best reporters are those who recognize the conflict inherent in a reform debate while simultaneously educating the public as to why such a reform is important. It is necessary that they show what benefits can emerge with the pas-

sage of a piece of legislation, as well as to fairly portray the alternative, whether that be the status quo or another piece of flawed legislation.

In order to ensure a positive media relationship, it is essential to provide sufficient and accurate information to enable the media to write knowledgeably. The media need real evidence to support the contention that any proposed solution is worth pursuing, and they are more likely to accept such information if it is validated by independent sources.

No legislation can be enacted into law unless it is passed by the Congress. Anyone who desires any legislation to be passed must understand the role and the responsibility of the Congress. There is great interest in health care on Capitol Hill, and a strong belief that their role is to be the final legislator and compromiser of any initiative. Congress reacts harshly to any hint that this authority could be undermined. As such, a well-understood knowledge of the positions of key Members and Committees of Jurisdiction, as well as a close working relationship with them, is essential. At least initially, the role of the opposing party is frequently to raise serious concerns about the proposal. Thus, policymakers' goal should not necessarily be to achieve agreement at the beginning of the legislative process, but to provide room for an acceptable compromise at the end of the process. It matters little whether the compromise is something that the opponents want or fear opposing; it matters significantly that the perception from the public is that the final agreement is bipartisan in nature.

V. APPLYING THE CLINTON ADMINISTRATION EXPERIENCE

Applying the lessons outlined previously to the experience of the Clinton Administration helps explain why it failed to achieve success in enacting the Health Security Act, but succeeded in enacting or implementing a host of targeted health care reforms in the latter part of the Administration. Regardless of the success or failure of particular policy priorities, the Administration learned the importance of making health care a presidential priority, and succeeded in laying the groundwork for the health care agenda for years to come.

Applying these lessons to the Health Security Act, one can only conclude that despite an unprecedented effort, the outcome was, in retrospect, preordained. By taking a comprehensive approach to reform, it was necessary that almost all elements of the policy and the strategy be implemented flawlessly. Unfortunately, this was not the case, as we failed in attracting and retaining both internal and external validators that were critical to the press and public evaluation of the policy. While we defined the problem and

desired outcome quite well, we promoted a policy at a time when the trust in the federal government was perhaps at its lowest. There was great dissatisfaction with, for example, the government's inability to recognize the perceived failure of the welfare system. As such, the idea that the federal government would propose and significantly regulate health care was bound to be vulnerable to fair and unfair criticisms of the proposed policy. This helps explain why President Clinton now believes that in retrospect, it might have been better to precede with welfare reform prior to pushing such an ambitious health care initiative.

There were other timing problems, however. These included the fact that the Administration had already pushed for very tough votes from the Democratic Congress on deficit reduction and trade. We also were advocating a health care initiative at a time when the President and the First Lady were being criticized (I believe unfairly and inaccurately) for a range of so-called "scandals" such as Whitewater and Travelgate. Moreover, there were foreign policy challenges, such as Haiti, that understandably distracted the President. All this combined to undermine our traditional validators within the groups and on Capitol Hill, and made it much more difficult and eventually impossible to produce a working majority in support of our policy to secure universal coverage.

These factors, along with an overwhelming lobbying assault from opponents of health care reform, served to not only undermine trust in the government, but also trust in the President. The lesson here is that the greatest motivating force in American politics is fear, not hope. Americans are frequently more vulnerable to fear tactics designed to scare them into thinking that they will lose something good than they are open to being convinced that a new policy can improve their current lot in life. Republicans, recognizing that public support for reform was diminishing and fear of it was increasing, became less and less interested in making any compromise on health care.

It is imperative to acknowledge, however, that many of these problems outlined above were self-inflicted. We produced a policy that even some of our own Administration did not support, and said so publicly. The policy released was so detailed that it made it very susceptible to effective (yet frequently unfair) criticism. Our sense of timing to promote this policy perhaps could not have been worse. And our relationships with the Hill as a consequence suffered significantly.

In contrast, subsequent health care efforts by the Clinton Administration were much more successful. They occurred subsequent to the reform of the welfare system, and were targeted reforms that addressed insurance

reforms, patient protections, children's health care, and Medicare and Medicaid modernization. They succeeded in making health care more accessible, expanding coverage, extending the life of the Medicare trust fund to historic levels, and producing the highest immunization rates and lowest infant mortality rates in the nation's history. We also set the stage for future health care debates on the Patients' Bill of Rights, expanding health insurance coverage, modernizing Medicare to include a prescription drug benefit, and reviving the public's interest in long-term care. These incremental reforms were more inefficient than broader reforms would have been. Nevertheless, such targeted reforms and successes were important perhaps at least as much because they showed that government could develop and pass workable health policy than they were comprehensive health achievements. Perhaps most important, we succeeded in making health care a presidential priority, something that I believe every subsequent President will have to emulate.

VI. LIKELY HEALTH CARE POLICY REFORMS IN THE BUSH ADMINISTRATION

Now, in Washington, we have a Republican administration and a Republican Congress. Health care has not been their number one priority to this point. Instead, they have focused on other issues, such as tax cuts, defense, spending issues, and education (not necessarily in that order).[18] Health care traditionally is not an issue that people often associate with the Republican Party. People have been skeptical of their commitment, and they feel that a lot of special interest groups are closer to them than they are to the Democratic Party.

I think, however, that President Bush took a page from President Clinton in the election. A lot of Republicans in the early 1990s were angry that President Clinton talked so much about crime and welfare reform, traditionally issues associated with Republican priorities. In fact, early in his first term, President Clinton spent a lot of time and resources to illustrate his commitment to these areas. He wanted to give the public a sense that he was not only committed to traditionally Democratic issues, but with any issues that frustrated the American people. These actions gave him common ground with the center of the American public. President Bush has made some early efforts to associate him with health policy reform, and has proposed an interim solution he calls the "Helping Hand" solution to the pre-

18. Republican Liberty Caucus, *at* http://www.rlc.org (last visited Feb. 17, 2002).

scription drug benefit problem.[19] This program is designed to help low income people obtain health care and prescription drug benefits.[20]

Most Americans do not really focus on elections until election cycles. There are strong Democrats and strong Republicans, but the people in the middle are the ones who, in the end, influence elected politicians. So I anticipate that President Bush will continue to do what he has already done to a certain extent, both in the campaign and now, which is to acknowledge that President Clinton raised very real health care issues that need to be addressed and that there is an unfinished agenda that the American public wants very strongly to get done.

VII. CONCLUSION

I always say that health care is the sex, drugs, and rock and roll of the domestic policy scene. It is the fun issue. It has everything: it is complex, it is emotional, it is special interest laden, it is money laden, it is full of politics, and it is full of policy. As maddening as it can be, it can also be the most rewarding thing one can do. I can tell you personally from having done work in health policy for so many years, that I have been privileged to meet people, whether it is parents whose children did not have health coverage, and now do, or the person who had a preexisting condition who could not get health care before the implementation of the Kennedy-Kassebaum insurance reforms,[21] and now can, to someone who is now able to take time off to care for a chronically ill spouse or parent because of the Family and Medical Leave Act,[22] or individuals with disabilities who are now able to go back to work without the fear of losing their health coverage.

When you actually get policies enacted into law and see them making a real difference in people's lives, there really is nothing like it. So I welcome young, old, and committed new people to this field. I hope you will join the cause and work towards improving the nation's health care system. As Winston Churchill said, and I'm paraphrasing, "Americans will always do the right thing, but not until they've exhausted every other option first." Since we have tried almost every course of action, I have to believe we are

19. Morton M. Kondracke, *Bush, Democrats Can Deal on Taxes, Medicare, Schools*, ROLL CALL, Jan. 4, 2001, *available at* http://www.rollcall.com/pages/columns/kondrake/oo/2001/kond0104.html.

20. *Id.*

21. *See* Press Release, *supra* note 16.

22. Family and Medical Leave Act, 29 U.S.C. 2654 (1994); 29 C.F.R. § 825 (2001).

about to get it right. With your help, I hope and expect that we will achieve the goal of assuring that every American has quality, affordable health care.

VIII. QUESTIONS AND ANSWERS

Student: I want to thank you for sharing some of the complexities of the issue, for this was a very enlightening lecture. I do not know if your definition of coverage expansion includes expansion of coverage for mental health services, or is that a totally different battle?

Mr. Jennings: I have spent a lot of time talking to Tipper Gore about those issues and we have succeeded in a number of important fields. First, we passed the Mental Health Parity Act, which mandated that there should no longer be inaccurate or discriminatory lifetime and annual caps on mental health coverage. We required, through executive order, that all federal employee health plans must have mental health parity in all benefits. The implementation of this policy proved that mental health parity in health coverage does not significantly increase health costs. This evidence may prove to be a great tool for those advocates striving to extend mental health parity to private health plans.

The Clinton Administration held a historic White House Conference on mental health. We released the first Surgeon General report on mental health. Tipper Gore served as a wonderful advocate for mental health, and I am confident that she will continue to work on these issues. When we passed the 1997 Balanced Budget Act we had to fight opponents of mental health parity to ensure that mental health benefits would be part of the CHIP program, which we succeeded in doing. I think that through the attention that has been focused on mental health services within the last several years, we are making real progress on these issues.

Student: On a pragmatic side, let's discuss finances. Incidents of fraud within the health care system always seem to involve big bucks. As a taxpayer, I say, okay, I am all for supporting those that need the assistance. When you design these systems, do you, at all, consider the back end? What are we going to do with those people caught abusing the system?

Mr. Jennings: That is a very good question. We have spent a lot of time over the past eight years working to control health care fraud. We spent a lot of time weeding out fraud in the Medicare program during the Clinton Administration and we did it very successfully. In the minds of many pro-

vider groups, we were too successful in this area. They feel that the Health Care Financing Administration was far too aggressive in their enforcement; they frequently felt that understandable compliance shortcomings resulting from confusing directives from Medicare were not criminal acts.

So, in order to effectively fight Medicare fraud, you have to find the right balance between strong enforcement and good communication with providers. It is true that many Americans believe that if you just cut back on the fraud, you would have all the money you need to take care of everyone. I wish that were true, but it is not. There is no question that there must be strong anti-fraud enforcement mechanisms to control fraud, and, also importantly, give yourself credibility on this issue. Americans must know that you are doing everything you can to stop fraud. But you also need to diffuse the public notion that no matter how successful you are, it will not be enough money to take care of the problems.

I must say that I am proud, however, that the Medicare actuaries and independent career analysts have concluded that the Clinton Administration's dedication to anti-fraud activities is one of the most important reasons why we significantly extended the life of the Medicare trust fund during the Administration. Additionally, I think our efforts have successfully changed provider behavior, making it much less common for providers to bill for services inappropriately.

Student: Sir, one other thing, also about financing. There is great concern about a potential recession. Realistically, what will that do for the efforts in Washington on health care?

Mr. Jennings: Well, it is interesting; sometimes in bad times you can end up having more of a focus on health care. A lot of the surveys that are most recently coming out are showing that people are concerned about job layoffs. When the job security issue gets raised, so does people's fear of losing their health care. When you lose your job you lose income, but it is much easier to replace an income source than to replace health care. People really fear losing health care.

In fact, in 1993, that was one of the driving forces for our attempt at major health care reform. The people who feared losing health care were a much more influential political force that those who were already uninsured. So, interestingly, bad times can lead to more action on big issues. Now, I do not anticipate that this recession would lead to discussions of universal health coverage, but you might make efforts to expand coverage in other ways. For example, one smaller policy that may become popular in a time of

economic downturn is subsidies for COBRA coverage. Individuals who leave or lose their jobs can opt to continue their health coverage by paying 102% of the premium their employer paid. However, many individuals cannot afford to pay these premiums, but if you can develop a six-month or year-long subsidy program for people who have lost their jobs, that stopgap period could make a real difference, in both reducing numbers of uninsured and creating a greater sense of security and trust in the government. So, in an ironic way, bad economic times can lead to positive developments.

It is interesting to note that as private sector health care expenditures have increased dramatically in recent years, we have succeeded in constraining health care spending to historic low levels. The outcome of this fact is that the large surpluses we now have are largely attributable to our success at moderating the growth of Medicare and Medicaid. I therefore believe that a strong argument can and must be made that a significant portion of federal surpluses should be dedicated to health care improvements. In the 1980s and 1990s, we always utilized health care savings to be the source of new financing for coverage improvements. While there no doubt will be an appropriate interest in dedicating some of the surplus to tax cuts, it should not be at the expense of long-overdue and needed investments in insurance coverage expansions and a new Medicare prescription drug benefit. It is my hope that the health care needs of the nation will not be bypassed by the tax cut fervor that will almost inevitably be promoted by the new President and the Republican Congress. Only time will tell.