# THE LOGIC OF HEALTH CARE REFORM

## WHY AND HOW THE PRESIDENT'S PLAN WILL WORK

REVISED AND EXPANDED EDITION

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# INTRODUCTION

## TO THE PENGUIN EDITION

This has become a different book since its original publication in October 1992. The ideas are the same, but they are no longer as much my own. Nor do they belong any more to the loose network of reformers who developed similar proposals in the months leading up to the 1992 election and after. In the space of a year, the approach presented in these pages has traveled from the margins to the center of national debate. The ideas have been turned from a conceptual framework into a detailed plan, and then from a plan into legislation, presented to Congress by President Clinton.

Along the way, there have been plenty of changes in specific features of the plan, and more will undoubtedly come. This book is for people who want to understand the basic paradigm of reform proposed by the President and come to a judgment about how it will work.

Some may also be curious about how the approach adopted by the President came to influence national policy. Fragments of the story have appeared in the news media, inevitably dramatizing conflicts among personalities in the inner circles of power; book-length, behind-the-scenes accounts by journalists are on their way. Without claiming to tell the whole story, I can shed some light on the evolution of the ideas behind the policies.

### The Turn Toward a New Paradigm

As a historically minded sociologist, I am inclined to emphasize patterns of long-term development that shape

major changes in social institutions on the scale of national health reform. Deeply rooted economic and political forces are driving the reform of health insurance and health care in America. But as a participant in the process, I know (at least I think I know) that the election of Bill Clinton is the immediate reason for the emergence of a plan for universal health insurance based on "competition under a cap."

In early 1992, the news media generally presented a menu for reform of health care that had three major alternatives: a Canadian-style, single-payer system of national health insurance; the conservative approach proposed by President Bush to give tax credits for limited coverage to the poor in a modestly reformed insurance market; and play-or-pay, the proposal embraced by many large corporations and congressional Democrats, which requires employers to cover their workers or pay into a public insurance program. If a fourth possibility, managed competition, was ever mentioned, it was confused with conservative, free-market ideas (even "pure" managed competition has a lot more regulation than its advocates now generally admit). A universal health insurance plan that combined competition and a budget cap on health spending was not on the menu at all.

Getting airtime for a new approach wasn't easy. On May 6, 1992, I testified before the Senate Finance Committee, along with three economists: Karen Davis, a supporter of a single-payer approach and health care price regulation; Mark Pauly, who was close to the Bush administration; and Alain Enthoven, managed competition's chief architect. In my testimony (later incorporated into this book), I argued for universal coverage with private plans competing under a budget, and I highlighted a proposal for a publicly financed system of competing health plans introduced the previous February by John





Garamendi, California's elected Insurance Commissioner.[1] Looking back today, a reader of those hearings would realize I was describing the framework of what has since become the Clinton Health Security plan. But at the time it was just one of many ideas for reform. Major groups were not sponsoring it, national politicians were not supporting it, and the media were not spotlighting it.

Interest in this alternative model began to grow that spring and summer. A week after the Senate Finance hearing, Pennsylvania Senator Harris Wofford invited me to his office to meet Garamendi and his deputy, Walter Zelman, for a discussion about the Garamendi plan and an approach to national reform that gave the states a variety of options for carrying out universal coverage. (Garamendi had worked under Wofford three decades earlier, when Wofford was running the Peace Corps mission in Ethiopia.) We were joined by Senators Tom Daschle of South Dakota and Bob Kerrey of Nebraska and then met with a group of Washington health care reporters to discuss the Garamendi plan. Along with New Mexico Senator Jeff Bingaman, who had introduced a managed competition plan of his own, these were the members of the Senate who initially showed the most interest in an approach to universal coverage that provided for private plans competing under a budget and left a lot of flexibility to the states.

Among private organizations, the Catholic Health Association had developed a proposal that was the clos-

1. Testimony before the Committee on Finance, U.S. Senate, in *Comprehensive Health Care Reform and Cost Containment*, Hearings, 102d Cong., 2d sess., May 6, 1992, pp. 36–38, 389–393. For the Garamendi plan, see John Garamendi, "California Health Care in the 21st Century: A Vision for Reform," Department of Insurance, State of California, Febrary 1992. The plan has been stymied by California Governor Pete Wilson and the state's deep recession.

est to the new model.[2] It too called for competing plans under a budget, but like the proposal that Senator Kerrey had introduced in 1991, it envisioned paying health plans a fixed amount, allowing them to compete on quality but not on price.

Meanwhile, on a separate track, Enthoven, the physician Paul Ellwood, and Lynn Etheredge, a health policy consultant, were spearheading an effort based in Jackson Hole, Wyoming, to garner support for their model of "pure" managed competition, which rejected any expenditure caps or price controls.[3] During 1992 the Jackson Hole proposals drew editorial backing from *The New York Times* and favorable attention in *Business Week, Fortune*, and elsewhere. In the House of Representatives, conservative Democrats led by Jim Cooper of Tennessee were developing a managed competition bill incorporating Jackson Hole ideas but with one crucial omission: Cooper's bill omitted a mandate on employers to pay for health insurance and consequently did not provide for universal coverage. I had no involvement with these efforts and only read the Jackson Hole papers and Cooper bill, which was introduced in September, after I had finished a first draft of this book. The distinctive contribution of the Jackson Hole Group, it then seemed to me, was its emphasis on holding health plans accountable for quality as well as cost (hence the term "accountable health plan"); however, the group's approach did not strike me as recognizing the limits of a competitive market in either controlling costs or providing access for all Americans.

2. Catholic Health Association of the United States, "Setting Relationships Right: A Working Proposal for Systemic Healthcare Reform," February 20, 1992.

3. Jackson Hole Group, "The 21st Century American Health System," Policy Documents 1–4, 1991–1992.





My interest in an approach to national health insurance that relies on competition among prepaid health plans and countervailing purchasing power to control costs dates back to the 1970s.[4] As I worked on *The Social Transformation of American Medicine*—a historical account of the formation of the medical profession and related institutions—one of my concerns was to explain the forces that had shaped the health care and insurance industries in the late nineteenth and twentieth centuries, inhibiting the development of prepaid health plans, weakening the power of the purchasers, and blocking *both* effective competition and national health insurance.[5]

After that book's publication, I moved away from specific work on health care and became more generally concerned with the relation between the public and private sectors and the revival and reframing of liberal thought. In 1989, together with the columnist Robert Kuttner and Robert B. Reich, now Secretary of Labor, I founded *The American Prospect*, a magazine devoted to recasting liberal ideas about politics and public policy. As coeditor of *The American Prospect* I came to work with some of the people who have since become prominent in the Clinton administration and became concerned about linking good policy to successful politics.[6]

4. See Paul Starr, "The Undelivered Health System," *The Public Interest* No. 42 (Winter 1976), pp. 66–85, and "Controlling Medical Costs Through Countervailing Power," *Working Papers for a New Society* 5 (Summer 1977), pp. 10–11, 97–98.

5. See especially Book One, Chapter 6, and Book Two, Chapters 1–4, in *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

6. In addition to Reich, *The American Prospect*'s writers have included Laura Tyson, chair of the Council of Economic Advisers; Alan Blinder, a member of the Council; Stanley B. Greenberg, the President's pollster; Alicia Munnell, assistant secretary of the Treasury; and Steven Kelman,

Then in 1991, as the rise in health costs and unravelling of the insurance system enlarged the constituency for health care reform, I came full-circle back to the ideas for reform I had written about fifteen years earlier.

When I distributed copies of the manuscript of *The Logic of Health Care Reform*, Reich was one of the readers. At the time, he and Ira Magaziner were playing central roles in shaping Clinton's economic program. Magaziner, a prominent business consultant, knew Reich and Clinton from their days as Rhodes scholars; he and Reich were coauthors of the 1982 book *Minding America's Business*, and they collaborated on the Clinton campaign book, *Putting People First*. Reich suggested I talk to Magaziner, who had recently been asked by Governor Clinton to do an independent review of health care reform for the presidential campaign. (Magaziner had just finished a study of health care and related services for the aged in his native Rhode Island.) In a phone conversation on July 18, Magaziner questioned me about the approach I was taking. The following Monday I sent him a copy of my manuscript, along with other materials he had asked to see. We continued to talk on and off over the next several weeks about the development of Clinton's position on health reform in the campaign's final months.

In candidate forums and position papers during the primaries, Clinton had already made clear his approach

director of procurement at the Office of Management and Budget. The policy-politics connection is evident in a series of articles about designing policies to meet the concerns of people who "work, pay taxes, and play by the rules" and thereby bring what Greenberg calls the "working middle class" back to the Democratic party. See Greenberg's "From Crisis to Working Majority," *The American Prospect* (Fall 1991), pp. 104–117, and my own "The Middle Class and National Health Reform," *The American Prospect* (Summer 1991), pp. 7–12.





without endorsing a specific bill in Congress. Rereading his campaign white paper on health care issued during the New Hampshire primary, I am struck by how closely the Clinton Health Security plan presented to Congress in the fall of 1993 tracks the specific points that Clinton raised as a candidate.[7]

The white paper called for universal coverage with a guaranteed benefits package, employment-based financing, cost containment in part through global budgeting, the use of health networks as an option for providing services, an emphasis on preventive and primary care, and an expansion of long-term care emphasizing care in the home. The paper does refer, however, to setting reimbursement rates for all payers and suggests that employers would have a play-or-pay choice either to cover their workers or to pay into a public program. These provisions are inconsistent with an approach that emphasizes managed competition and do not appear in the Clinton Health Security plan introduced in 1993.

A play-or-pay system poses financial risks that no government should accept. If employers have a choice about entering a public program, the employers that stay out will be those with relatively low health costs, and the public program will have a higher-risk, higher-cost enrollment. In addition, under the usual play-or-pay proposals, employers entering the public program would pay a payroll tax (estimates were running from 7 to 9 percent), while the employers outside could self-insure or pay premiums. As a result, the public program would tend to attract employers not only with above-average risks but also with below-average wages. Endemically underfinanced, the government program would almost certainly become a fiscal albatross and a

7. "Bill Clinton's American Health Care Plan," Little Rock, Ark., n.d.

source of inferior coverage. Furthermore, consumers would have no choice about whether to enroll; their employers would decide.

These objections weighed heavily with Magaziner. Still, to reject play-or-pay conspicuously in the midst of the campaign was impossible. The press would have called it a flipflop, and too many leading Democrats were committed to the approach. That summer it was unclear whether Clinton needed to pursue health policy in any greater detail; he had already said a lot. Polls indicated that the public overwhelmingly preferred him to Bush on health care. This was not a matter of support for a specific policy; the public generally trusted Democrats more than Republicans on the issue. Why become enmeshed in the details when what counted was the commitment? Besides, some argued, health care finance poses extremely complicated problems, and the heat of a campaign is not the best environment for resolving them. This was a legitimate and sensible position.

On the other hand, the press and various experts were berating Clinton for not fully specifying his plans to reform health care, and the Republicans were warming up for an attack on play-or-pay as threatening a 9 percent payroll tax and a back door to a government-run health system.

To broaden the range of views being heard in the campaign, Magaziner convened a meeting in Washington on Monday, August 10. For the first time, the campaign's Washington-based health policy advisory committee, notably including Judith Feder and Kenneth Thorpe, met with a number of people from around the country sympathetic to a managed competition approach, such as Zelman and Lois Quam, who had directed a reform effort in Minnesota. The session was chaired by Atul





Gawande, the young aide in charge of health issues in Little Rock.

The Clinton campaign was the natural place for health policy crossfertilization to take place. Clinton sought to unite more traditional liberals with "new Democrats." As director of the bipartisan Pepper Commission, an effort that sought unsuccessfully to build consensus for health care reform, Judith Feder had worked for Senator Jay Rockefeller; Atul Gawande had previously worked for Representative Cooper. A reform plan that combined the security of universal, comprehensive coverage with consumer choice and competition in the delivery of services was, in a sense, the natural byproduct of the Democratic party that Bill Clinton was trying to put back together. All along, it has been a question of the balance between the two sides of the party and the policy (and whether they could stick together!).

The discussion at the Washington meeting was intense, but Feder and others in the advisory group did not reject a competitive approach as long as it had a regulatory backup.[8] Under Magaziner's gentle prodding, a fragile consensus in favor of a half turn toward managed competition emerged from the Washington meeting, and the next month, a small delegation from the campaign discussed the new option with Clinton on the campaign trail in East Lansing, Michigan. Soon after, on September 24, in a speech in New Jersey and an accompanying press release from Little Rock, Clinton called for universal health coverage "privately provided, publicly guaranteed" under a system of "competition within a budget." The news media did not understand that he

8. Thorpe was also developing a combined approach to cost containment: Kenneth E. Thorpe, "The Best of Both Worlds: Merging Competition and Regulation," *Journal of American Health Policy* (July/August 1992), pp. 20–24.

was signaling an important step. "Competition within a budget" didn't register; it was not one of the familiar choices on their menu. After a skeptical *New York Times* editorial and some grief in Little Rock, the campaign issued "talking points" to clarify that Clinton did not envision price controls, and the *Times* declared victory for managed competition. During the first debate with President Bush and Ross Perot, Clinton responded to a question about health care by immediately referring to his "managed competition" plan. I wondered how many people across America had any idea what he meant.

It seems improbable that Clinton's embrace of competition had any effect on the election. Bush muffed questions about health care reform during the debates, and his campaign never aired television spots that it had prepared on health care, apparently concluding that they would only highlight an issue on which Bush did not enjoy public trust. Yet Clinton's September turn toward competition within a budget did matter a great deal after the election. It guided the work that led to the Health Security plan, presented to Congress almost exactly one year later, on September 23, 1993.

### From Paradigm to Plan (1): Getting Started

The distance between a conceptual paradigm and a detailed plan to carry it out is enormous, and many a concept has not survived the trip. If "competition under a cap" was to become a serious contender for national policy, it needed a lot more work than anyone had yet done.

Just before and after the '92 election, I tried to advance that work through a project that had grown out of the meeting with Garamendi and Zelman in May: a conference on universal health insurance and managed





competition at Princeton in late November, funded by the Robert Wood Johnson Foundation before Clinton became associated with the approach. My aim was to follow up the first edition of this book by assembling a group of policy experts who could begin answering in detail many of the hard questions that had to be confronted: What benefits would be covered? How would the new system be financed? How would the new health insurance purchasing cooperatives be organized and governed? What would be the relation between the federal government and the states? I worked closely with Zelman and several people who had advised him on the Garamendi plan, including Larry Levitt, Rick Kronick, and Linda Bergthold.

It was out of a meeting with this group in California on October 27 that a key idea emerged for financing coverage. The Garamendi plan relied primarily on a payroll tax; I had taken the same approach in the first edition of this book, while mentioning in just one paragraph that the system could also be financed by premiums. In September, Clinton had publicly ruled out a payroll tax. The alternative we discussed in California was a "capped" premium. Employers and individuals would each owe a share of the premium, with employer contributions capped as a percentage of payroll and individual contributions capped as a percentage of family income. Like play-or-pay, this approach would limit employers' liabilities to either a percentage of a premium or a flat proportion of payroll (whichever was lower), but it avoided creating a separate public program with a high-cost, low-wage population. After the California meeting, I arranged with the consulting firm Lewin-VHI to cost out the capped premium approach, according to my own primitive specifications. The Lewin numbers were, I believe, the first estimates—at least the first to be

made public—of the kind of approach to financing coverage eventually taken by the Clinton Health Security plan.[9]

Clinton's election victory and the growing recognition of his interest in the approach lent the late November conference in Princeton an air of high expectation. Many of the key congressional staff members concerned with health legislation took part; ten other participants, including six authors of papers, went on to work on the White House effort a few months later. Not all the participants who favored a competitive system, such as Enthoven, approved of budget caps; not all who favored budget caps, such as Henry Aaron, had any faith in competition. While prefiguring difficult debates to come, the discussion and the fourteen papers presented—all but two of them published in a supplement of the journal *Health Affairs* four and a half months later—began to give the model sharper definition and more credibility.[10]

The project fulfilled its purpose in a way I had not expected. Like other transition groups, the presidential transition group on health policy, led by Judith Feder, did not issue a public report. In the first half year of the new administration, the same was true for the presidential task force and working groups set up to study alternatives. As a result, there was little available for anyone to read about the approach to health care reform of the new administration. Along with *The Logic of Health*

9. John F. Sheils, Lawrence S. Lewin, and Randall A. Haught, "Potential Public Expenditures under Managed Competition," *Health Affairs* (Supplement 1993), pp. 229–242. Enthoven was the host for the California meeting, but he was not a proponent of this approach.

10. An overview, "A Bridge to Compromise: Competition Within a Budget," *Health Affairs* (Supplement 1993), pp. 7–23, which I wrote with Zelman, sums up where we stood just before the work of the new administration began.





*Care Reform* and a subsequent *American Prospect* article,[11] the papers from the Princeton conference helped to fill that vacuum, though they never had any official benediction.

Still, the Princeton papers were at a high level of generality; they left innumerable political and technical questions unresolved. They also focused on a more narrow set of issues than Clinton had addressed in his campaign. The circle of people involved was extremely limited. And the language being used was intelligible only to health policy experts. The next steps would have to move in several directions simultaneously. The new administration would have to broaden the range of issues and people involved; it would need both more complex analytical work on the policy and simpler ways to explain it. At the time, I did not understand all that needed doing. Fortunately, President Clinton turned to people who did.

## From Paradigm to Plan (2): The Presidential Phase

In early January, the President-elect asked Magaziner to organize a comprehensive reform initiative in the White House that would be chaired and led by Mrs. Clinton. Announced a few days after the inauguration, the effort took the form of a small task force composed primarily of members of the Cabinet and a supporting cast that ultimately included hundreds of people organized into more than thirty "working groups." In the last week of January, while I was in Washington to speak to a congressional breakfast meeting and a conference run by the grass-roots organization Citizen Action, Magaziner asked me to come on board as one of the working group

11. "Healthy Compromise: Universal Coverage and Managed Competition Under a Cap," *The American Prospect*, No. 12, Winter 1993, pp. 44–52.

leaders. It was "showtime" for health care reform, he said. I was there the next day for the first organizational meeting with Mrs. Clinton.

With the task force originally due to report in 100 days, the working groups and White House staff concerned with health care started off at a feverish pace, operating from daybreak until near midnight in what seemed like nonstop meetings. The group leaders had been recruited from the earlier campaign advisory committee and presidential transition team, from the network of people who had worked on the Garamendi plan and the Princeton conference, and from the various Cabinet departments concerned with health care: principally the Departments of Health and Human Services (HHS), Labor, Treasury, Veterans Affairs (VA), and Defense as well as the Office of Management and Budget (OMB) and the Council of Economic Advisers. My initial responsibility was to supervise one of the "clusters" comprising three working groups: short-term cost controls, administrative simplification, and phase-in of the new system. I also worked closely with the cluster concerned with the new system's structure.

The participants in the working groups were generally chosen for their technical knowledge, not because they were true believers. Most were regular employees of federal agencies; a small minority were "temps," as I was. (I had taken a one-semester leave and would return to Princeton in the fall.) Among the members were people representing a diversity of backgrounds and professions, including some sixty physicians. Also invited to join the groups were dozens of congressional staff (Democrats only), as well as a smaller number of people sent by governors (both Democrats and Republicans) via the National Governors Association. This breadth of participation was extraordinary. Policymaking efforts of the





executive branch do not normally include legislative staff, much less representatives of the states.

Yet in one respect, this outreach had the opposite effect from what was intended. Private interest groups protested their exclusion—there were individual doctors but no representatives of the American Medical Association—and the press was outraged that the groups at the White House met behind "closed doors." Of course, no one had seemed to mind when previous presidents developed policies behind closed doors at the White House. What president had ever done otherwise? The irony was that the very effort to include so many people had produced a deeper sense of exclusion among those who were left out, especially the press.

Furthermore, not much was kept secret. Any paper distributed at working group meetings quickly found its way to the news media. Memos that had no standing whatsoever as administration policy generated newspaper stories that began "The Clinton administration is considering . . ." The result was hyperbolic confusion over what the administration was going to propose.

Much of the media coverage reflected a misunderstanding of the process. During the winter and most of the spring, there was a deliberate separation of policy and politics. The members of the working groups writing memos on the pros and cons of alternative policies simply did not know which might be seriously considered. They had only the broadest political guidance, based on what the President had said in the campaign. Meanwhile, others at the White House, generally veterans of the 1992 campaign, were concerned with communications, interest group liaison, relations with Congress and the governors, and overall political strategy. Magaziner and a few others spanned the two sides of the process; eventually the pieces would come to-

gether. In fact, no final decisions could take place until the technical work on policy was joined with a broader political understanding. (A good plan for reform that could not be passed was not a good plan.) It was not the job of the working groups to make those defining judgments, nor should it have been, yet many of the people involved were frustrated by the inherently ambiguous direction they received.

At the outset, many aspects of the ultimate form of the administration's plan were uncertain. Subsequent reports in the media have suggested that the plan had already been decided on and that the entire effort was only a charade; other articles have portrayed a White House bouncing from one option to another. Neither of these views captures what really happened. There were diverse voices within the administration; the working groups included people whose views spanned the spectrum from a single-payer approach to "pure" managed competition. However, the President's statements during the campaign had effectively ruled out a tax-financed single-payer plan and pure competition.[12] From the beginning, the working group effort had a direction that was implicit in the focus on both competition and budget caps, but a wide range of alternatives remained open. The approach taken in the campaign did not, for example, rule out some short-term use of price controls until a competitive system could be organized. It did not

12. Soon after the establishment of the working groups, in an article spread across the front of its Sunday financial section, *The New York Times* described the Jackson Hole Group as Hillary Rodham Clinton's "brain trust." This claim had no factual basis. Among the leaders of the working group effort, there was only one member of the Jackson Hole Group (Thomas Pyle), and he soon left. Other articles in the *Times* have suggested that Enthoven was the "abandoned father" of reform, the "originator" of the idea later spurned. In fact, from the campaign onward, Clinton always spoke of competition





rule out allowing states the flexibility to carry out a national program through a single-payer system or all-payer rate setting. It did not resolve what to do about long-term care, mental health benefits, and many other questions. The process was open enough to allow fundamentally different alternatives to be floated and discussed—such as a value-added tax for financing—if only in the end to be shot down.

Magaziner had designed the working group effort on a model taken from his experience as a business consultant. The paradigm was a corporate restructuring or technological innovation that required thinking through innumerable options and suboptions and meshing together previously uncoordinated activities and groups into a coherent plan. The enormity of the project was evident in the organization of the working groups. Cluster 1 included groups concerned with the design of health insurance purchasing cooperatives, relations among health plans and providers, insurance market reform, budget caps, and special concerns of rural and inner-city areas. A second cluster dealt with coverage, benefits, low-income households, and Medicaid. Cluster 3 dealt with quality improvement, information systems, the health care workforce, and malpractice; a fourth cluster with the integration of current government programs: Medicare, the veterans' and military health care systems, and federal employees' health benefits. Other

"within a budget" He never embraced the Jackson Hole approach. During the campaign and development of the plan, we tried to convince the Jackson Hole Group to accept budget caps: Vast stretches of the country are unlikely to have any competition, and many areas will have no more than oligopolistic competition among a small number of plans. However, Enthoven and the others refuse to recognize these limits to their theory, and it should be no surprise that since the release of the Clinton plan they have opposed it.

clusters dealt with underserved and vulnerable populations, long-term care, and financing, and still other groups performed general analytical functions: quantitative analysis, ethical evaluation, assessment of economic impacts, and legislative drafting.

The scale of the project was astonishing even to some of us who had long advocated a comprehensive plan, and rather than being scaled back, it expanded. The initial design did not include separate groups on mental health services, the Indian Health Service, or academic health centers, and these were added. As the process unfolded, external review groups were convened, consisting of physicians, nurses, health care managers, actuaries, and others, as well as panels of consumers who had written letters to Mrs. Clinton.

According to Magaziner's design, the working groups were initially to go through a "broadening" process to ensure that all relevant issues and options were considered; then a "narrowing" phase to reduce the alternatives to a manageable set for decision making; and, finally, auditing and criticism by contrarians and other independent reviewers. To ensure progress along this route, there was a schedule of "tollgates"—checkpoints when periodic reports were due and the groups would report back on the status of their work.

The tollgates will long be engraved in the memory of the hundreds who took part in them. They generally took place in the ornate Indian Treaty Room at the top of the Old Executive Office Building overlooking the White House and stretched on for entire days, even through one weekend. The members of each cluster, the largest of which included well over a hundred people, would file into the room, and Magaziner and several others of us who worked for him sat on folding chairs at tables arranged in a large rectangle to hear the presenta-





tions and ask questions. The tollgates were marathon seminars, often technical and inconclusive, but the grandeur of the setting and the size of the meetings gave them a theatrical quality.

In February and March, the tollgates produced a great deal of high-quality analysis, pushing farther ahead than either the presidential transition or Princeton conference. Both larger principles and smaller details gradually came into focus as the groups worked methodically through the issues. As winter turned to spring, however, events beyond anyone's control created a stop-and-go pattern. Lawsuits over Mrs. Clinton's role in the task force (which was ultimately upheld by the courts) complicated the process. In March, the plan began to take shape through meetings with the President, Mrs. Clinton, and members of the Cabinet. Then the illness and death of Mrs. Clinton's father slowed progress. Later, task force meetings on the health plan stopped entirely because distorted leaks and rumors about financing threatened to disrupt passage of the President's budget in Congress.

At the end of May, the legal existence of the task force came to an end; by that time, the members of the working groups had dispersed. Magaziner continued to be in charge of developing the plan and was supported by the White House political strategy and communications team; a small policy group with offices at the White House; a cross-cutting "quantitative analysis" and budget group drawn from HHS, Treasury, the Council of Economic Advisers, and OMB; and the drafting group responsible for writing the legislation. A number of people overlapped or floated among more than one of these groups at various times, and the focal point of de facto policy making shifted. For example, during much of the spring, the quantitative analysis group was central, as al-

ternative policies were analyzed for their effects on health premiums, government budgets, and the private sector.

Although there was an earlier version that never leaked, it was only at the end of May that the policy group began to write the reform plan in detail. The *Wall Street Journal* reported that I was responsible for writing the plan. This was not the case. (The confusion about my role arose because I had spent much of April and May writing an early draft of what was later issued, in a very different form, as *Health Security: The President's Report to the American People.*) Astonishingly, the policy group was able to work through the summer on the plan, known internally as the "policy book," without premature disclosures. Final decisions made at meetings at the end of August and beginning of September were incorporated in revisions written the following weekend. It was only when the policy book was sent to the Congress for consultations the next week that it finally leaked. Although never intended for public release (it includes little explanation of any policy), this preliminary draft of the plan is the version that first appeared in print and continues, as I write, to be the one most widely distributed.

How and why President Clinton made key decisions about the plan is a story that will have to wait. A time will come for a full history when there is a full history to be told. I can say this: The strength of conviction about health care reform that the American people heard in the President's voice when he spoke to the Congress the evening of September 23, 1993, I had heard before in meetings at the White House. I do not believe there was any historical imperative that *required* Bill Clinton to commit himself to comprehensive health care reform. This was a choice of conviction: He believes in it.





And so do those of us who threw ourselves into the reform effort. One day during the spring, as part of a series of meetings required of all the top policy staff, I was asked to spend an afternoon with about a dozen citizens who had written letters to Mrs. Clinton about their difficulties with the health care system. Their experiences were not unusual, though they spoke eloquently about them. Like millions of other Americans, they were facing big medical bills, struggling to take care of aging parents, trying to get insurers to cover preexisting conditions. They reminded us why we were there. Whether the policies we recommended were the right solutions to their problems, others will have to judge. But the interests we tried to serve, let no one doubt, were theirs.