24. The list, submitted to committee chairman Henry Gonzalez (D-Tex.), includes seven White House officials, including Nussbaum and Chief of Staff Mack McLarty, and potential witnesses from Little Rock, including James McDougal and his wife Susan.

Fiske has urged Congress not to hold hearings on Whitewater, warning that such hearings could "pose a severe risk" to the integrity of his probe. Both Republicans and Democrats have now agreed that witnesses will not be given immunity (i.e., compelled to testify, with a promise that their testimony cannot be used against them in any subsequent criminal proceeding). But one of the consequences of this will be that many witnesses are likely to be given the standard lawyer's advice to refuse to testify unless they are given immunity.

In various interviews, Sen. Alfonse "Mr. Ethics" D'Amato (R-N.Y.) has made it clear that he hopes this is what will happen, forcing administration witnesses to publicly take the Fifth Amendment, à la the Joe McCarthy tactic of the 1950s.

Fiske met with Senate Republican leaders on March 9, but D'Amato and William Cohen (R-Me.) made it clear afterwards that they are determined to go ahead with hearings, even at the risk of impairing Fiske's investigation. The only concessions they made to Fiske were that they would not grant immunity to witnesses, and that they might be willing to delay their hearings until Fiske has completed the first phase of his investigation. On the House side, Leach refused to even meet with Fiske. "I did not want to compromise his work, and I did not want him to compromise mine," he said. Leach is still insisting on the March 24 hearings. The White House, anxious to avoid the appearance of stonewalling, will apparently not discourage officials from appearing before the committees.

Wall Street Journal accuses Fiske

Meanwhile, the *Wall Street Journal* has already accused Fiske of a coverup. In a lead editorial entitled "The Fiske Coverup," the *Journal* on March 9 accused Fiske of blocking the release of information on the death of White House aide Vincent Foster, and made it clear that it wants congressional hearings for the purpose of driving the President and the Democrats out of office. Accusing White House aides of sitting on the Foster records, *Journal* editors charged that Fiske's actions "will continue their coverup beyond the congressional election and with luck beyond the presidential one."

The *Journal* editors urged congressional leaders to insist to Fiske that they are going ahead with an investigation, even if it undercuts the independent counsel's investigation. "They should tell Mr. Fiske that they ultimately don't care whether someone goes to jail. . . . The more important responsibility is to give the public the facts it needs to judge the performance of its government; deciding whether to indict is less important than deciding to throw the rascals out."

By the end of the year, gentlemen?

Cooper health plan in the hands of the

by Linda Everett

Rep. Jim Cooper (D-Tenn.), a Rhodes Scholar who studied at Oxford, England, likes to characterize himself as a "New Democrat" who, as he told the Democratic Leadership Conference, is proud to be part of the new policy shift "away from the philosophy of entitlement and toward the philosophy of empowerment—the New Covenant." The *New Republic,* in its December endorsement of Cooper's health care reform proposal, called it a true "New Democrat alternative" to President Clinton's Health Security Act. The magazine wrote that Cooper regards medical coverage as a matter of personal responsibility, not a new entitlement. The "New Democrat," it explained, "says that once government removes the barriers that prevent its citizens from taking care of themselves, it's up to individuals to act on their own behalf."

Of course, helping millions of Americans who are wracked by the AIDS virus, or virulent, unresponsive strains of tuberculosis, or catastophic medical conditions, is a major public health issue, not a matter of people acting "on their own behalf." And maybe you're finding it hard to discern how the free market that Cooper crows about, will "empower" millions of our wretchedly impoverished families and millions more of our mentally and/or physically ill homeless people to solve their own health care problems. Yet, Cooper wants to swap the traditional, historic, but admittedly tattered covenant that this nation once proudly held in meeting the health care needs of its people on the most advanced medical levels possible, with his post-industrial "New Covenant."

Supported by Business Roundtable

Cooper's Managed Competition Act received national scrutiny in February when the Business Roundtable, an influential group of executives representing 200 of the country's largest companies, voted to support it.

Cooper claims that H.R. 3222, co-sponsored by Rep. Fred Grandy (R-Iowa), would guarantee universal access to health care (not universal coverage). The bill, sponsored in the Senate (S. 1579) by John Breaux (D-La.) and David Durenberger (R-Minn.), shares plenty of common ground

leaves care 'free market'

with President Clinton's plan. Both are based on the managed competition scheme created by the Jackson Hole, Wyoming mob of insurance company, health industry, and business executives, and cost efficiency fiends. The Wyoming-based operation is led by Paul Ellwood, who launched health maintenance organizations (HMOs) as a cost-cutting reform 20 years ago, and by Stanford health care economics professor Alain Enthoven. While the President's Health Security Act uses global budgets, employer mandates, and price controls, Cooper's is based on "pure managed competition."

Under Cooper-Grandy, individuals and small employer groups of up to 100 employees would join large purchasing pools known as health plan purchasing cooperatives (HPPCs). The HPPCs would supposedly offer a variety of plans including managed care plans and traditional fee for service, but there's no assurance of a choice of plans—that's up to market forces. In Cooper's plan, one HPPC would serve a region, usually a state. The HPPCs or purchasing pools would collect premiums and distribute them to Accountable Health Plans (AHPs) which are made up of competing cartels of insurers, hospitals, and doctors. HPPCs are supposed to equip consumers with bargaining powers to force insurers to deliver quality services at the cheapest price. But, this bill forbids HPPCs to be comprised of more than 50% of small groups, lest their bargaining power exceed levels acceptable to insurers. AHP's are to provide the basic approved benefit package but *must* require co-payments from the insured.

Cooper-Grandy guarantees that insurers cannot deny you coverage because of a preexisting condition, yet it allows insurers to refuse coverage of such conditions for the first six months of the plan. *EIR* was told that this provision is to protect insurers from bankruptcy. But what about protection for patients with *life-threatening* conditions, since studies repeatedly show that individuals in the indigent and uninsured population generally have several acute medical conditions that need immediate attention? Also, we don't know how many of the 60-80 million uninsured Americans are uninsured because they were *turned down* for having preexisting conditions.

Discriminatory ratings built in

Insurance companies are known for the infamous practice of "cherry picking"—lower premium rates are offered to relatively healthy people who are profitable insurance prospects, and no coverage or astronomical premiums face people with major medical problems. Such injustices could be alleviated by instituting "community rating" systems, whereby the risk of treating the very ill is spread over a large population.

Cooper claims H.R. 3222 does just that. But the fact is, his plan provides for a five-member National Health Board to build discriminatory ratings against older patients right into the premium rates. Cooper-Grandy premiums are not based on what one co-sponsor called the "extreme" of pure community rating, because that would fuel an "inter-generational equity problem" whereby young enrollees would be forced to carry the increased costs of coverage for an older population. The bill calls for age-adjusted ratings where premiums for groups comprised of an older work force are "significantly higher."

The national board would segregate all enrollees into premium classes, in which the premium level is based on 1) the type of plan purchased, and 2) within that type, the age of the enrollee or principal enrollee for the family. Older employees or whole families of the principal older enrollee *will pay as much as twice the costs of premiums of younger enrollees* in the same plan. And, there is no cap or restriction on how high any premium could be increased.

Employer coverage not mandated

The bill stipulates that small businesses of up to 100 employees must join a HPPC to reduce the high administrative costs and the high risk of major illness in a small group. Although large groups cannot join the HCCPs, they can self-insure and form their own AHP. Employees in both cases need only make coverage available for individuals to purchase, unlike President Clinton's plan that mandates employers purchase coverage for employees. The employer mandate is the key reason why the U.S. Chamber of Commerce (which represents 200,000 smaller companies), the National Association of Manufacturers (12,500 members), and the Business Roundtable have all said they cannot back the administration's plan, and have shifted their focus to the Breaux-Cooper bill.

Under Breaux-Cooper, the cost of an individual's insurance premium is 100% tax deductible—up to the cost of the least expensive health plan in the region. No doubt, this provision will force many people into the cheapest and most stringently enforced managed care plans. Large employers may continue to subsidize coverage for employees, but a major change is that such premiums are now tax deductible *only* up to the cost of the cheapest standard package. Any individuals or businesses that purchase plans more costly than the least expensive in the region would be subject to a

34% tax on the price difference.

Cooper is depending on this provision, aimed at forcing major companies to relinquish "wasteful Rolls-Royce" plans, to provide enough tax revenues to fund much of the overall bill. In effect, it penalizes anyone who needs more extensive coverage than the cheapest plan provides. Those with chronic health problems not only pay more for coverage with higher co-payments, they are also taxed on the price difference.

Medicaid eliminated

Cooper-Breaux would eliminate Medicaid, freeing funds for the federal government to provide acute medical care for the needy, and for states to provide long-term care for the indigent elderly and disabled. A new federal program would pay premiums and most co-payments for people living below 200% of the poverty level; premiums are paid for those at 100% of the poverty level; and those living between 100% and 200% of the poverty level will receive a subsidy to purchase coverage. Cooper says this provides coverage for most of the country's uninsured population, but various estimates show as many as 25 million people would still lack insurance. The number of uninsured might actually be higher, since the bill uses a much lower state-adjusted poverty level for its calculations, leaving out of its count many who are too poor to cover premiums, let alone their co-payments.

There's plenty of competition in pure managed competition. Insurers compete with providers for profits; combined, they compete against the government's budget cuts, and all their varying agendas combined compete against the medical needs of you and your family and the nation. Without a strong national mandate that makes the protection and treatment of the patient primary—not profits or cost-cutting—chaos results, as is seen in Cooper's home state of Tennessee.

That state's new TennCare managed care plan for its million Medicaid enrollees added an additional half-million more uninsured people to the rolls without increasing its budget! Then Blue Cross/Blue Shield ordered 7,200 private practice physicians participating in its Preferred Provider Organization to take all TennCare patients (TennCare reimburses providers only 40% of their costs) or face the loss of their PPO practice and patients. Two patients have died as a direct result of this ongoing fiasco where about half of the doctors in the Blues' PPO plan were forced to drop out, leaving tens of thousands of patients without physicians, and the physicians without a practice.

Costs are shifted

Thus, managed care plans have a much more hazardous impact on patients then generally recognized. If AHPs can cut costs by subcontracting with a company 100 miles away to provide a costly diagnostic test, they'll do it. You, as an enrollee, are "covered" for the service, but can you afford to take a day off from work for the round trip? And if, as the Cooper plan allows, cooperating networks or monopolies in a region can cut costs by limiting the expensive medical equipment used in the state, you'll wait weeks or months for tests, as they do in Canada. AHPs can authorize that only specific hospitals in a region perform particular procedures. Frail patients would need someone to skip work to transport them to the facility, stay with them in an area hotel pending post-operative checkups, and then return them home. This is already being done in rural Texas.

Contrary to what its advocates say, there is lots of cost shifting in managed competition—the cost is shifted to you.

Treatment not guaranteed

Your ability to pay doesn't assure that you will be treated, however. Cooper's National Health Board will draw up a benefit package *after* his bill is passed. That package will be based on a list of *treatable diagnoses,* not on a list of entitlements with the amount of care covered. Neither the type of treatment needed nor the type of provider who can provide that treatment will be defined—your hospital/insurer does that. Treatment will not be based on the traditional aim of medical science—saving lives. Now it's up to the demands of the market place and the subjective concept of "futile treatment," which refers to any treatment a hospital *doesn't want to give a patient,* based on its view of what is a desirable quality of life.

A Virginia hospital decides that intermittent life-saving ventilator support to an anencephalic infant, born with an underdeveloped brain, is medically unnecessary (see *National News*); a Florida hospital calls such infants "dead"; still others call it ethically inappropriate to treat pneumonia in a cancer patient. Documented managed care horror stories abound: A heart failure patient is told to wait nearly an hour for the HMO ambulance (he dies); and, new mothers are told they only need 12-24 hours of hospital care after arduous, lengthy, and allegedly "normal" deliveries.

Cooper says Medicare will remain intact under his plan, but that's crazy. How can we assure decent treatment of older or disabled Americans who are the most vulnerable when the system itself is disabled? *EIR* was told that public hospitals, the only facilities which consistently serve the poor and homeless "will have to fend for themselves."

At a time when we need more specialization and intensified research into spinal cord injuries, Alzheimer's, and other difficult medical conditions; and at a time when 30-40% of doctors are about to leave the system due to retirement or reforms, Cooper's National Board would cut the number of specialists and doctors allowed to practice. At a time when 60 million people, many of whom desperately need acute medical treatment, will enter our health care system, Cooper says we need to slash 40% of our hospital beds.

The battle for life is certainly not "empowered" under Cooper's New Covenant, it's been put on the chopping block by the free market.