WITHDRAWAL SHEET
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
1. Credit Card	Hanns Kuttner personal credit card (1 pp.)	n.d.	P-6, F-6

COLLECTION	Bush Presidential Records Office of Policy Development Johannes Kuttner Files
FILE LOCATION	Health Care Reform - Clinton - 3/92, 9/92 Plans [OA/ID 06968]

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]
- **P-1 National Security Classified Information [(a)(1) of the PRA]**
- **P-2 Relating to the appointment to Federal office [(a)(2) of the PRA]**
- **P-3 Release would violate a Federal statute [(a)(3) of the PRA]**
- **P-4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]**
- **P-5 Release would disclose confidential advise between the President and his advisors, or between such advisors [a)(5) of the PRA]**
- **P-6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]**

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- **F-8 Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]**
- **F-9 Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]**

ERNST & YOUNG

Hans-

Good speech - I like your use of Rumm - See you back in D.C.!

Carolyn

Prepared by	Index No.
Date	

HANS

99
150

1, 2, 3, 4, 5, 6, 7

-Kellogg - Ec. Econ.
(Ken Athen → Fitz Smith)

Terry Kellogg

- walking through CDF plan which he calls "regulated competition"
  - local monopolies (insurers ē exclusivity)
  - near community rating.

Predictions

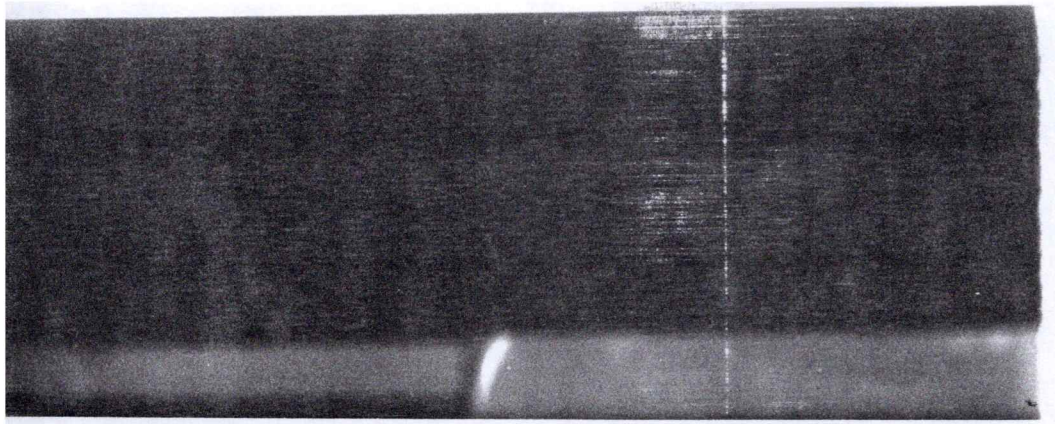
- consolidation.
  → S&P changing rating
  - carriers ē low/poor risks, poor cap → could be toast guy.
- mandatory offer
  → risk pool would not significantly improve.
- Guaranteed issue
  - easy to circumvent
- No real improve
  → always been an insurer ē continuous open enrollment for employers ē 3 or more employees.
- Better sit to survive.
- Reduced # of purchasers

[CRT ISSUE — coop size ≥ 100+ → reduce decisionmaking by 95%
where line is drawn.) — would become customer service rather than marketing.

- Coops - politicize decision.

Carol Herrmann

Cert ē



seeking missiles, emphasizing instead laser-armed satellites and ground-based interceptor missiles, for which much research and development will be done in Huntsville. The local angle obviously has some importance to Shelby, who promised early to "put Alabama's needs at the top of my priority list," and ballyhooed initiatives like keeping a Texas landfill from being dumped in Alabama and making Mobile a Navy homeport.

In 1992, Shelby hopes to break the political jinx on this seat which, before his election in 1986, had five occupants in eight years. He has certainly shown himself adept at eking out majorities from diverse constituencies. He won a House seat in 1978 by winning the critical runoff with the support of white conservatives against a black candidate; despite the large number of blacks in his district, he voted against the Voting Rights Act extension and the Martin Luther King holiday. In 1986, he got liberal Don Siegelman to drop out of the primary and, with 51% in a five-candidate field, barely avoided a runoff. In the general election, his TV ads attacked Republican incumbent Jeremiah Denton—a Vietnam POW for eight years who blinked out "torture" in Morse code when he was interviewed on TV—not only for voting to cut social security but for faking invoices to raise campaign money, voting to raise his pay while cutting veterans' benefits, and owning two Mercedes. Shelby won by less than 7,000 votes. For 1992, the key question is whether he will attract serious opposition,but he probably will be reelected easily.

Presidential politics. In national politics, Alabama is on the verge of becoming irrelevant. Whites vote overwhelmingly for the Republicans (or for Jesse Jackson's strongest opponent in the Democratic primary) and blacks vote overwhelmingly for Jackson in the primary and the Democrat in the general. After the 1988 conventions, neither presidential nominee touched down in Alabama, which had to be content with two visits from Dan Quayle. The state's Republican preference is underlined by the low turnout in Democratic presidential primaries—less than half that in the seriously contested 1982 and 1986 gubernatorial races.

Congressional districting. Alabama's congressional district boundaries haven't been changed much since the mid-1960s. But for the 1990s, it might be possible to create a black-majority (and national Democratic) district joining the Black Belt with Montgomery and black sections of the Birmingham area. There's an incentive for Republicans and blacks to back such a plan; the casualty would probably be 2d District Republican Bill Dickinson, but Republicans might figure he's a goner anyway since he was reelected in 1990, after 26 years in office, with only 51% of the vote. Democrats' success in foiling Republican hopes in the 3d and 5th Districts in 1989 and 1990 means that this will likely be a heavily Democratic delegation for many years.

The People: Pop. 1990: 4,040,587 (Pop. 1980: 3,893,888, up 3.8% 1980–90 and 13.1% 1970–80). 1.6% of U.S. total, 22d largest. Median age: 33.0 years. 12.9% 65 years and over. 73.6% White, 25.3% Black. Households: 57.0% married couple families; 70.5% owner occupied housing; median house value: $53,700; median monthly rent: $229. 6.8% Unemployment. Voting age pop. (1990): 2,981,799. Registered voters (1990): 2,375,444; no party registration.

1990 Share of Federal Tax Burden: $12,603,000,000; 1.21% of U.S. total, 25th largest.

1990 Share of Federal Expenditures

	Total		Non-Defense		Defense	
Total Expend	$17,261m	(1.72%)	$13,333m	(1.72%)	$3,928m	(1.74%)
St/Lcl Grants	2,101m	(1.56%)	2,095m	(1.56%)	6m	(3.28%)
Salary/Wages	2,756m	(1.89%)	1,276m	(1.66%)	1,480m	(2.14%)
Paymnts to Indiv	8,589m	(1.73%)	8,080m	(1.70%)	509m	(2.40%)
Procurement	3,388m	(1.80%)	1,466m	(2.75%)	1,922m	(1.42%)
Research/Other	426m	(1.14%)	416m	(1.17%)	10m	(3.64%)

Political Lineup: Governor, Harold Guy Hunt (R); Lt. Gov., Jim Folsom, Jr. (D); Secy. of State, Billy Joe Camp (D); Atty. Gen., Jimmy Evans (D); Treasurer, George C. Wallace III (D); Auditor, Terry Ellis (D); State Senate, 35 (28 D, 7 R); State House of Representatives, 105 (82 D, 23 R). Senators, Howell T. Heflin (D) and Richard C. Shelby (D). Representatives, 7 (5 D and 2 R).

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THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 1
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

ASAM
American Society of
Addiction Medicine

708/332-1018

- Guarantee private coverage for nonworkers, starting with nonworking pregnant women and children.

- Dedicate federal savings from cost controls to paying for expansions in coverage.

Governor Clinton said that he would put his plan before Congress in the first hundred days of his administration.

"I have a plan for fundamental change and real reform," said Governor Clinton. "George Bush has a last minute political proposal."

"Mr. Bush has done next to nothing to solve the health care crisis," Clinton added. "I will make sure health care costs don't rise faster than your income. He won't. I will take on irresponsible drug companies and insurance companies. He won't."

George Bush's inaction has let health care costs climb to $800 billion in 1992. They now add $1,230 to the price of an American car. Over the next five years, they'll account for more than half the growth of the federal deficit.

The health care reform plan Clinton detailed today is central to Putting People First, Governor Clinton's national economic strategy for America.

-30-

[Please see the detailed summary of the plan that follows.]

Clinton Gore

FOR IMMEDIATE RELEASE
September 24, 1992

CONTACT: George Stephanopoulos
(501)/399-3900

Controlling Costs and Guaranteeing Care for All
The Clinton/Gore Health Care Plan

Governor Bill Clinton today detailed his health care reform plan and laid out the fundamental differences between his comprehensive plan and George Bush's piecemeal approach to the health care crisis.

"We'll never revive our economy or cope with the deficit until we get health care costs under control," said Clinton.

The Clinton/Gore plan will tightly contain costs so that they rise no faster than wages, saving Americans $700 billion by the end of the decade. The plan will also guarantee coverage for all Americans, and preserve the private health system's quality and choice. Highlights of the plan include –

Controlling costs:

- Pence in national health costs by setting a national health budget to limit what consumers pay for health coverage.

- Take on the insurance companies to restore competition, driving costs below the budget and protecting consumers. We will ban "pre-existing condition" exclusions, require policies to offer full benefits, and set up purchasing groups that give individuals and companies real buying power and make insurers compete for their business.

- Stop drug price gouging by ending special tax breaks for companies that raise drug prices faster than inflation.

- Take other steps to control costs: reform medical malpractice laws, reduce duplicative technology and streamline paperwork.

Covering all Americans:

- Require employers to insure their workers, either directly or through a purchasing group; phase in requirements, with small businesses coming last, and provide tax credits to protect businesses.

• more •

Clinton 3/92 Plan

Mamms -
FYI.
L.

BILL CLINTO

National Health

THE HEALTH CARE SQUEEZE ON THE FORGOTTEN MIDDLE CLASS

We are the only advanced nation in the world that doesn't provide health care to all its citizens and doesn't effectively control costs. America spends 30% more of its GNP than our major competitors, puts more pressure on business, and relegates more people to the ranks of the uninsured, who get care that is too late, too expensive, and paid for by the rest of us. Every day America spends twice as much on health -- $2 billion -- as we did for a day of Desert Storm. Also, by many measures from infant mortality to heart disease to life expectancy, we aren't the healthiest country in the world.

For a decade, the Reagan and Bush administrations have ignored the needs of middle-class families and let health care costs soar out of control. In 1980, when Reagan-Bush first took office, national health care expenditures totaled $249 billion or 9.1 percent of our economy. In 1991, they totaled $738 billion or about 13 percent of the economy.

In 1980, 12.5 percent of Americans under 65 were not covered by health insurance. Today, over 16 percent are not covered and many more are only partially covered.

In 1980, total spending by federal and state governments on health care totaled $105 billion. Today it totals almost $300 billion.

Today, health care costs are the number one cause of personal bankruptcies, the number one cause of business bankruptcies and the number one cause of labor disputes in the nation. Health insurance costs add more than $700 to the cost of every car produced in the United States and corporate health insurance spending is equal to more than 100 percent of all company after-tax profits.

Despite a relentless focus on controlling costs over the past decade, American health care costs are much higher and rising much faster than in other nations. If present trends continue,

we will be spending over 17% of GNP on health at the end of the decade, enough to consume the peace dividend and make it impossible to be fully competitive in the global economy.

Today, millions of people live with gnawing fears that their coverage will be canceled, their out-of-pocket costs will go through the roof, their employer will no longer be able to afford insurance, or they won't be able to change jobs without losing their health insurance because of a family member's illness.

Why, if we insure fewer people and provide less care, are we still spending more than any other nation in the world?

We have the world's most expensive and inefficient system of financing health care. We have a health care delivery system that has few incentives to keep costs in check and many to let them explode. The cost control system itself, with its regulatory requirements, has added tens of billions to the cost of health care. We have denied access to basic health care to millions, thus insuring that when they get care it is too late, too expensive, and the costs are passed on to the rest of us. We have higher rates of teen pregnancy, drug abuse, AIDS, and violence than other countries.

THE CLINTON HEALTH CARE PLAN: A NEW COVENANT FOR CHANGE

It doesn't have to be that way. We need a new approach that will control costs, improve quality, maintain choice, and cover everybody. We don't need to lead with a tax increase that asks hard-working people who already pay too much for health care to pay even more, until every effort has been made to squeeze excess cost out of the system.

Instead, we need a plan to reform the way government and business pay for health care in this country, a plan that provides real incentives to lower costs and improve quality, increases access, and emphasizes a more educated, responsible citizenry.

Under the Clinton plan for national health insurance reform, all Americans will have affordable health care. Employers and employees will either purchase private insurance or opt to buy into a public program. The poor and the unemployed will have access through the public program, and will be asked, to the extent possible, to share some of the costs.

All Americans will be covered with a core benefit package, and no person will be cut off, canceled, denied, or forced to accept low-quality care.

There should be a New Covenant for change in health care. Americans shouldn't have to live in fear of losing health insurance when changing jobs or not being able to get insurance because of "pre-existing" health conditions. We'll bring down costs for middle-class families, maintain a choice of providers, and assure comprehensive coverage. In return, Americans

should assume the responsibility to take advantage of preventive care, take better care of themselves, and use health care services appropriately.

STEP ONE: CONTROLLING COSTS AND IMPROVING QUALITY

We can cover every American with the money we're now spending on health care by taking bold, specific steps to cut costs. We'll spend an estimated $817 billion on health care in 1992. The only way to secure national health insurance for all our people is to spell out a specific plan to bring costs down.

In the first year of a Clinton Administration, we'll take the following specific steps to cut health care costs:

1. INSURANCE REFORM

Under the current system, over 1500 different companies compete in the insurance market with 1500 sets of payment rules and 1500 bureaucracies processing 1500 sets of forms, which leads to staggering administrative costs for both companies and health care providers. We need to streamline this needlessly complicated system.

Underwriting practices that balkanize Americans into smaller and smaller risk groups must be banned in favor of broad-based community rating. Access, continuity, and renewability of coverage under a community rating system will be guaranteed.

These changes will save billions of dollars and bring stability to the system.

2. GUARANTEED BENEFITS AND LIMITED COST INCREASES

The federal government will establish a board including health care consumers, providers, and payors, and define a core benefit package that all insurers will provide. The core benefit package will include ambulatory physician care, in-patient hospital care, prescription drugs, basic mental health, and important preventive care benefits, such as pre-natal care and annual mammograms. This will guarantee uniformity between the basic public and private programs which will further reduce administrative costs and inequality of care.

The board will also establish annual health budget targets nationally and state by state, to guide expenditures in the public and private sectors, to develop an all-payor reimbursement system, and develop incentives and guidelines for global budgetary and other quality-enhancing, cost-efficient reforms.

This approach will begin to involve all parties in working together to assure that the cost of health care can't go up any faster than the average American's income is going up.

3. REDUCE BUREAUCRACY AND CONTAIN THE PAPER EXPLOSION

When Ronald Reagan took office in 1980, he pledged to control health care costs. But rather than changing the system, he focused instead on intensely regulating and monitoring it, adding layers of bureaucracy onto an already overly complex system. These actions made the system even more costly.

In the '80s, the federal government multiplied documentation requirements, administrative procedures, prior authorization processes, billing rules, coding processes, requirements for funding eligibility and review organizations to guard against hospitals, nursing homes and other health care agencies providing unnecessary care, keeping patients hospitalized for too long, seeing patients too often, or charging too much.

Those requirements have led to the creation of whole staffs and departments in hospitals, doctors' offices and home health agencies dedicated to nothing but administrative form-filling. These functions are themselves creating huge costs which have overwhelmed any potential savings.

In addition to the health care workers hired only to meet paperwork requirements, bedside caregivers -- doctors, nurses, aides, therapists -- find that their time is increasingly split between hands-on care and filling out forms.

The American Medical Association estimates that the average doctor now spends 80 hours a month -- two full work weeks -- on paperwork. Nurses in hospitals often spend almost half their time processing information and filling out forms.

Two hospitals now exist within an institution's walls. There is the hospital we know, where nurses and doctors lower temperatures, fix bones, perform surgeries, and provide care. The second hospital creates paper which documents a patient's journey through the hospital. The "paper" hospital is growing much faster than the real hospital.

The billions fueling our health care bureaucracy would be better spent on providing better care for all Americans, implementing a long-overdue emphasis on women's health, and expanding medical research to prevent and cure Alzheimer's Disease, breast cancer, heart disease, AIDS, and other diseases.

The all-payor system will virtually eliminate unnecessary paperwork by eliminating 1500 separate sets of rules and forms. Under the Clinton plan, the costly billing, coding, and utilization review functions that currently govern most provider payment systems would be replaced by a simplified, streamlined billing system. American hospitals currently devote far

too much of their total budgets to billing and administration. A system which instead decentralizes decisions, encourages higher quality, and evaluates results based on modernized information management can save billions of dollars.

4. REDUCE DRUG PRICE INCREASES

Prescription drug costs rose at three times the general rate of inflation in the 1980s. American consumers pay more for their drugs than the citizens of Canada and Europe do for the same drugs. Some drugs manufactured by American pharmaceutical companies sell for three to six times as much in the U.S. as in other countries.

A Clinton Administration will support Senator David Pryor's proposal to eliminate special tax breaks now on the books for drug companies that raise their drug prices faster than Americans' incomes go up, saving the taxpayers up to $2 billion a year, and saving consumers billions more.

We need a robust American pharmaceutical industry that will continue to lead the world in research and development. We should accelerate the FDA approval process which is adding to the cost of drugs and unnecessarily delaying their impact.

While maintaining the R&D tax credit, we should also limit the deductibility of marketing and lobbying costs for prescription drugs because the American drug industry spends more money pitching products than it spends on research and development. And we should work to ensure that American pharmaceutical companies don't charge buyers in their own country more than they charge those of other nations.

5. REDUCE BILLING FRAUD

Recent, very disturbing reports indicate that too many providers are gaming health reimbursement systems -- including Medicare and Medicaid -- to secure billions of dollars in unwarranted billing.

A Clinton Administration will reduce billing fraud by moving away from the complex billing systems that invite abuse, and by vigorously prosecuting offenders.

6. CONTROL THE UNNECESSARY SPREAD OF TECHNOLOGY

Too many hospitals in the U.S. have an incentive to purchase and utilize the latest high-tech machinery, even if it duplicates neighboring institutions. To make up those costs, hospitals

often use these diagnostic machines and high-tech surgical procedures unnecessarily -- thereby adding costs without improving health. At the other extreme, the Canadian system severely limits the distribution of high-tech equipment, resulting in unacceptable delays and standing in line for treatment.

Under the Clinton health care plan, the cost review board mentioned above will develop recommendations and incentives for more sensible capital budgets, including the shared use of technology where appropriate. We can save billions of dollars that now go to unnecessary tests and procedures.

7. DEVELOP A RATIONAL MEDICAL LIABILITY SYSTEM

Consumers and health care providers spend hundreds of millions of dollars paying higher insurance premiums to underwrite medical malpractice litigation. Even more troubling is how our current system has resulted in physicians and other health care personnel practicing "defensive medicine." This practice results in tests that are frequently unnecessary, but that are ordered to insure the provider against a malpractice suit.

Alternative dispute resolution mechanisms should be made available in every state, which can effectively and humanely address and resolve these legal challenges.

8. DISSEMINATE UPDATED MEDICAL PRACTICE GUIDELINES

Tens of millions of dollars are spent on inappropriate and/or unnecessary care. Providing updated medical practice guidelines to health care personnel to help them make the right decisions about treatment will save money and lives, and help eliminate improper care.

With practice guidelines, the quality of health care will improve, costs will decline, and better guidelines on what constitutes medical malpractice can be developed.

9. REORGANIZE THE HEALTH CARE WORKPLACE

Freed from burdensome administrative requirements and punitive quality control systems, the health care workplace will be ripe for more modern and efficient work organization.

Health care institutions will become much more efficient, because work will be reorganized around results, not reporting requirements. All parties will conform to a single, uniform information system, and tie in to a single computerized database, for the swift, efficient, and confidential exchange of patient information. Eventually, everyone will carry "smart cards" -- small microchips or magnetic strips coded with their personal medical information. Information accessed through the cards will generate huge savings through the elimination of

multiple, paper-based record-keeping systems, the reduction of unnecessary tests generated by lack of information, and quicker, more efficient transfer of patients and their records between different institutions and providers.

10. REINVENTING CARE DELIVERY: GROUP CARE HEALTH NETWORKS

In order for quality to improve and cost controls to take hold, we need to reorganize the way we provide health care in this country. Insurers, health care institutions, and individual health care providers currently operating in the system should be given strong incentives to collaborate to develop local group care models called Health Networks. These networks would not only be an important element of the private health care system, but would be able to serve those in the public program.

Each Health Network would operate under a global budget based on the population they insure and/or provide care for. Networks would negotiate fees with participating providers and institutions, and the providers and institutions that affiliate with a given network would collectively manage care delivery within the global budget.

Many private health insurance firms are already moving toward the group care concept with comprehensive health services provided under global, not fee-for-service, budgets. This kind of care is the guiding principle behind HMOs. The Health Network concept would encourage insurers and providers to develop different approaches to managing care within global budgets, emphasize the importance of primary and preventive care, and remove financial incentives for unnecessary tests and procedures. All health care consumers could choose the type of network that best suits them, and gain access to the most cost-effective providers in the most appropriate settings.

STEP TWO: GUARANTEE UNIVERSAL COVERAGE

A Clinton Administration will treat affordable, quality health care as a right, not a privilege. Universal access and cost control go hand in hand. Employers and employees will either purchase private insurance or opt to buy into a high-quality public program. The disabled and the elderly will have access to comprehensive long-term care from Medicare, including inexpensive in-home services designed to foster independence. Finally, the poor and unemployed will have access to the public program. All will be asked to share some of the costs, except for preventive and some basic primary services and with protections for those who cannot afford it. Co-payments must not be burdensome but should be sufficient to discourage overutilization and to encourage shared responsibility.

No person will be cut off, canceled, denied, or forced to accept low quality care.

1. WORKPLACE COVERAGE

Coverage through the workplace will build on the public/private partnership that is uniquely American. Government will make health care more affordable, and business will then be able to make health care available to more workers.

The average cost to business of health coverage jumped from $2,600 per employee to over $3,100 in 1990 alone. Under the existing system, the average annual premium will continue to rise, and the percentage of our workforce without any coverage will continue to increase. The measures outlined in this proposal will enable employers to have healthier, more productive workers at lower cost.

Universal coverage will end the practice of cost shifting from those who don't pay, which adds an estimated 10% to the bills of those who do, and will lead to more preventive and primary care instead of delayed emergency care, thus increasing the health of America and lowering the costs.

2. PROTECTION FOR SMALL BUSINESS

A Clinton Administration will take steps to protect small businesses from rising health care costs in a number of ways. First, the insurance premiums paid by all employers will be based on a community-based rating system rather than an experience-based rating system, and small employers will be able to buy into Health Networks that serve large numbers of people. Small businesses will not be penalized because their employee base is smaller. Just as our economic well-being counts on both small businesses and large firms to flourish in the community, insurance premiums will be based on the health needs of the community, not on the health of particular employees at one firm or another.

Other assistance to small business will include: 1) the opportunity to buy into the public program if it is less expensive; 2) eliminating barriers to small businesses that want to band together to form larger groups to purchase health insurance for more moderate prices; and 3) phasing in small employers' and new businesses' responsibility as costs can be reduced, during which time their employees will be covered by the public program with the co-pay requirements mentioned above.

STEP THREE: IMPROVE PREVENTIVE AND PRIMARY CARE

We need to expand access to the primary and preventive care that helps people stay healthy and keeps costs down. We waste money and weaken health when insurance doesn't cover regular check-ups, screenings, mammograms, immunizations, and pre-natal care.

We should provide an adequate number of primary and preventive care clinics in inner city and rural areas where health care is not readily available today. We should also increase access for children to primary health care by providing school-based clinics where needed, as a supplement to universal coverage.

The medical education system needs to do more to prepare providers to practice preventive and primary care. We need to carry out the recommendations of the National Governors Association to provide incentives for students and mid-career health professionals to serve in primary care professions in rural and underserved areas: expand the National Health Service Corps: and increase support for graduate training for mid-level health professionals, such as certified nurse-midwives and nurse practioners.

Arkansas has been a leader in preventive care. The state's Health Director, Dr. Joycelyn Elders, is nationally renowned. The state has established school clinics that emphasize preventive and primary care, attack teen pregnancy, and provide more and better pre-natal and early childhood care.

STEP FOUR: EXPAND LONG-TERM CARE

We should provide long-term care to Americans of all ages when they need it. No American should have to become impoverished to qualify for long-term health care. And no family should ever have to choose between long-term care for the grandparents and education for the kids.

We can provide more services to the elderly and the disabled by expanding Medicare to include a wide range of services to be paid for through affordable and equitable cost-sharing mechanisms and to be delivered by contracting out with case managers responsible for allocating needed services in appropriate settings.

The long-term care benefits would be phased in, starting with the area most neglected -- care in the home and community. These protections for families will be increased as we generate greater and greater savings.

The primary long-term caregivers in the United States are family members -- and predominantly women. These people don't want a replacement for their care, but they need a helping hand. In a Clinton Administration, we'll provide adequate respite care services to give short-term relief for those family members who carry this extraordinary burden.

The current system of public financing for long-term care is heavily biased in favor of institutional care, even though nursing home care is often the last resort for grandparents and their families, and targeted home care can be cheaper and more comfortable. This is especially important given the fact that the elderly are the fastest-growing group in our population, and that

more and more disabled Americans are able to live in less restrictive settings and make full contributions to society.

We need to end the current disincentives to community-based care. In a Clinton Administration, senior citizens will get to choose the kind of care that works best for them. In Arkansas, we've launched a popular pilot program called ElderChoices, which gives the elderly the right to take money previously available only for nursing home care, and spend it instead on home health care, personal care, transportation to senior centers, hiring a nurse, or attending an adult day care center.

A Clinton Administration will create a voluntary National Service Corps of young Americans who can borrow money for college and pay it back by serving their communities in any number of ways, among the most important of which will be filling the need for workers to provide long-term care.

STEP FIVE: INTENSIFY HEALTH EDUCATION

Many billions of health care dollars could be saved if the American people would change their behavior -- and without changes in behavior, even the ability of the health care system proposed here to make us healthier will not bring our health costs down to the level of our competitors.

We have unacceptably high rates of infant mortality, teen pregnancy and low-birthweight babies, drug and alcohol abuse, AIDS, and violence. Too many of us still exercise too little, and too many still smoke. We continue to damage ourselves without thought to the personal consequences and the costs to our nation in paying for problems that other nations avoid altogether through different personal behavior and use of preventive and primary care options now available.

Therefore it is essential that we strengthen our health education efforts in homes, schools, workplaces, and senior centers. The national government should support these efforts with incentives either in funds, or in manpower through the National Service Corps.

* * *

Clearly, this program fully implemented will save far more than it costs to extend comprehensive coverage to all Americans, provide for long-term care, fund more inner-city, rural, and school-based clinics, and intensify our educational efforts.

Still, there will be new costs to those businesses which have not provided coverage in the past, and government costs may exceed government savings in the first two to three years. But if the cost control and restructuring recommendations are vigorously pursued, net new spending requirements, if any, should be modest.

By containing costs and eliminating waste, and by providing a vision of change and a commitment to leadership, we can protect our families' pocketbooks while guaranteeing affordable, comprehensive, high-quality health and long-term care for all. This guarantee will be a hallmark of the Clinton Administration.

-- # # # --

NEWS RELEASE

BUSH QUAYLE 92

FOR IMMEDIATE RELEASE
Tuesday, August 4, 1992
B/Q'92 - 265

CONTACT: PRESS OFFICE
(202) 336-7099

THERE HE GOES AGAIN
-Clinton Health Plan Should Include An Ear Exam-

Washington, D.C. -- It took Arkansas Governor Bill Clinton only four days to prove Bush-Quayle's 'Clinton Record Highlights' correct. On "Good Morning America" yesterday, the Arkansas Governor said of the President's health care plan, "Instead of attacking me they ought to come up with their own plan which they haven't done because they don't want to take on the vested interests in the health care debate." (Good Morning America, August 3, 1992)

Come on, Bill, you should listen up. President Bush announced his health plan on February 6, 1992. Four pieces of legislation to implement parts of the President's plan have been introduced in the Congress and are awaiting action.

"Bill Clinton has once again proved that facts mean little to him if they get in the way of a good distortion," said Mary Matalin, Deputy Manager of the Bush-Quayle campaign.

"The Arkansas Governor will go to any length to avoid discussing the hidden payroll tax in his costly 'Pay-or-Play' proposal," she continued. "Instead of owning up to the taxes in his proposal, Governor Clinton slickly tries to change the subject and dodge the issue. Perhaps the taxes in his proposal will cover ear exams so he'll be able to hear what President Bush has said."

THE BUSH PLAN: ON THE MARK AND ON THE RECORD

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FILE

Letter: From President Bush

N.Y. Times; 8-2-92

Market-Based Health Reform Is Best

To the Editor:

As the people of this country seek reform in health care, it is reassuring to see The New York Times's editorials confirm what many already know: that market-based reforms are the best way to make radical changes in the health care system. Old-fashioned models for health care reform, including Canadian-style systems or greater taxes — direct or indirect — on today's job-producing small businesses, provide no real answers for the future.

The proposals my Administration released earlier this year include many of the elements referred to in your series of editorials. I believe we must preserve the best in today's health care system — high quality and choice — while reducing the costs and providing access to health care for all Americans. The only way to reform our system capable of accommodating the changes of the coming decades is through radical changes in the delivery of private health coverage. The proposals advanced in my program will generate this restructuring — the "managed competition" you have so heartily endorsed.

Added to the voices of millions who believe market-based reforms are indeed the best hope for real change, your voice has already enhanced the prospects for enacting these proposals. If the nation stays focused on this urgent goal — access for all in a restructured competitive health care system — we can quickly make health care reform a reality. I look forward to working with the American people to urge Congress to solve our very real health care financing problems by enacting market-based reform legislation.

GEORGE BUSH
President

Washington, July 31, 1992

N.Y. Times; 8-2-92

The Guts to Reform Health Care

Liberal Congressman Ron Wyden of Oregon is for it. The Conservative Democratic Forum is for it. So too is President Bush and, according to some advisers, Bill Clinton. *It* is "managed competition," the best plan to reform health insurance and the only one with a chance to become law.

Yet it's way too early to rejoice. Politicians say they're for managed competition, but most — including the candidates — have yet to face up to harsh realities. Patients will find their choice of physicians restricted; taxpayers will have to make do with smaller health care deductions.

President Bush — despite his hosannas to the plan in the letter below — hasn't given voters that message. Neither has Bill Clinton, who so far has offered little more than vague pieties. Until they do, talk of reform will remain empty rhetoric.

•

The fight over health care reform requires two key decisions. Will the plan provide universal, therefore expensive, coverage? And will health costs be controlled by government fiat or by tightly structured markets, the essence of managed competition?

Until recently, many Democratic leaders leaned toward price controls. What was needed, they said, was a preset cap on total health expenditures that would be enforced by setting prices for every doctor, every hospital.

What many have come to understand is that managed competition offers a better answer. Under this system, consumers would be combined into large groups and represented by sophisticated sponsors. The sponsors would negotiate with doctors and hospitals, forcing them to provide high-quality treatment at reasonable cost.

Sponsors would pay providers a fixed fee for each patient, independent of how much care the patient turned out to need, thus encouraging doctors to keep patients healthy and provide the most efficient care when they are sick. This is the method health maintenance organizations already use to control costs.

But Congress can't encourage the use of managed competition unless it tightens the tax code. Consumers won't choose sponsored plans as long as they are allowed, as under current law, to deduct the full cost of wasteful plans. Congress must limit tax deductions to the cost of well-managed sponsored plans; it must disallow higher deductions for wasteful plans.

Mr. Bush understood all this when he announced the outlines of his plan in February. His plan was smart, in places ingenious, and consistent with managed competition. But when it came to the two key decisions, Mr. Bush punted. He failed to propose universal coverage. And he didn't limit tax deductions. Mr. Clinton has also evaded tough choices. He's for universal coverage, but doesn't say how to pay for it or how to contain health care costs.

An optimist can be glad that consensus is at hand. But realists worry that there's no one with the guts to make reform happen.

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NEWS RELEASE

BUSH QUAYLE 92

FOR IMMEDIATE RELEASE
Tuesday, August 4, 1992
B/Q'92 - 265

CONTACT: PRESS OFFICE
(202) 336-7099

THERE HE GOES AGAIN
-Clinton Health Plan Should Include An Ear Exam-

Washington, D.C. -- It took Arkansas Governor Bill Clinton only four days to prove Bush-Quayle's 'Clinton Record Highlights' correct. On "Good Morning America" yesterday, the Arkansas Governor said of the President's health care plan, "Instead of attacking me they ought to come up with their own plan which they haven't done because they don't want to take on the vested interests in the health care debate." (Good Morning America, August 3, 1992)

Come on, Bill, you should listen up. President Bush announced his health plan on February 6, 1992. Four pieces of legislation to implement parts of the President's plan have been introduced in the Congress and are awaiting action.

"Bill Clinton has once again proved that facts mean little to him if they get in the way of a good distortion," said Mary Matalin, Deputy Manager of the Bush-Quayle campaign.

"The Arkansas Governor will go to any length to avoid discussing the hidden payroll tax in his costly 'Pay-or-Play' proposal," she continued. "Instead of owning up to the taxes in his proposal, Governor Clinton slickly tries to change the subject and dodge the issue. Perhaps the taxes in his proposal will cover ear exams so he'll be able to hear what President Bush has said."

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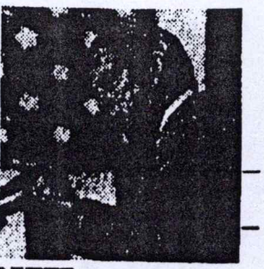
Bob Dole

NEWS FROM: U.S. SENATOR FOR KANSAS
SENATE REPUBLICAN LEADER



FOR IMMEDIATE RELEASE
AUGUST 4, 1992

CONTACT: WALT RIKER
(202) 224-5358

THE TRUTH ABOUT HEALTH CARE

CLINTON "PAY OR PLAY" PLAN

- Taxes and spending: Pay-or-play will require at least $80 billion in new taxes, and according to the Congressional Budget Office, will cost a total of $197 billion over four years.

- Jobs lost: An Office of Management and Budget study concludes that the 7 percent payroll tax required to cover pay-or-play costs would cause as many as 700,000 jobs to be lost.

- The Democrat health proposal would require an estimated 14% in payroll taxes from small businesses all across the country, almost twice what small business already pays in FICA taxes. Isn't this a great way to build jobs?

- Pay-or-play would consume corporate profits that could be invested in new jobs or better products. If companies do not reduce wages, pay-or-play taxes and mandates would have to consume corporate profits. In short, pay-or-play would cost businesses $49 billion a year, one-quarter of their 1991 profits.

- More government bureaucracy: Pay-or-play would result inevitably in a huge new bureaucracy to run a government health insurance system. It would also lead to rationing of care, letting bureaucrats in Washington decree the availability of different treatments and the overall quality of care.

REPUBLICAN PLAN

- **Provides secure coverage to all Americans.** "Preexisting condition" limits are eliminated when people change jobs. The fear of "job lock" -- where a worker can't move to another job without losing insurance -- is eliminated.

- **Makes insurance more affordable.** Over 95 million Americans will benefit from tax credits and deductions to offset health insurance costs.

- **Reduces red tape and administrative costs** through streamlining the current paperwork maze, and forcing all insurers, doctors and hospitals to use the same form.

- **Revolutionizes private insurance** by eliminating their ability to "cherry-pick" or cancel insurance when claims are filed. The President's plan helps small businesses and individuals afford coverage, giving them the buying power of large groups.

- **Reforms malpractice laws** to help those with legitimate malpractice claims recover damages while keeping lawyers out of the middle of medical care and reduces health costs due to "defensive" medicine. In addition it helps those with small malpractice claims, who lawyers have traditionally ignored, get a fair hearing.

- **Expands services in underserved areas.** Many areas in rural and urban America have a shortage of doctors and clinics. The President's budget expands funding to provide more care in these areas.

The Republican plan does not:

- Raise taxes or cost jobs by burdening small business with new mandates;

- Create a system of government health insurance or a huge new government bureaucracy to regulate prices and ration health care.

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Bush and Clinton plans could not be more different:

- The President in his state of the union address said, "We must make a choice. We can move toward a nationalized system ... or we can reform our own private health care system, which still gives us, for all its flaws, the best quality health care in the world."

  - The President has a plan that will reform our health care system and maintain the role of the private sector.

  - Clinton has said he supports a plan which will put more and more decisions in the hands of government.

- Second, the President has offered a comprehensive health care reform plan.

  - It is wide ranging, covering greater access to health insurance for small employers, financial help for those least able to buy insurance, reform of the malpractice system, ending expensive mandates of services that insurance must cover, and providing information so that consumers can get the best health care at the least price.

  - It is detailed. The President's plan is a published document that fills 94 pages. Clinton's thoughts have thus far only been a list -- incomplete, unexplained, and not connected.

- Of the proposals made thus far, two sharpest differences:

  - <u>How to expand access to insurance</u>? Clinton: "Pay or play" mandate on employers that will reduce the number of jobs, stifle the formation of new businesses, and decrease wages for low-income workers. The President: Provide tax credits and tax deductions to the insured so that they can buy health insurance, along with the creation of broad risk pools to make sure that poor health status does not keep insurance from being affordable.

  - <u>How to contain costs</u>? Clinton: Put decisions about how much to spend on health care in the hands of government. This is a recipe for shortages and queues. The President: Address the forces that drive costs in the system -- malpractice, excessive paperwork, and need for more cost-conscious decisions about where to get health care.

EFFECTS OF HEALTH REFORM PROPOSALS ON THE HEALTH SECTOR

	President's Comprehensive Health Reform Proposal	Play or Pay	National Health Insurance
ACCESS Coverage	Estimates: -95 million receive assistance: -25 million low income -13 million 100-150% poverty -57 million middle income; -4.9 million stay uninsured.	-Everyone receives coverage from employer or from public plan; -Urban Institute estimates (at 7% payroll tax rate): -112 million covered by public plan; -52 million switch from private to public.	Everyone receives coverage from national health insurance plan.
Insurance affordability/reforms	-Tax credits and deductions: -$1250 for individual -$2500 for couple -$3750 for family; -100% deduction for self-employed; -Premiums reduced as much as 20% for 70 million employees by: -premium bands in small group market; -health Insurance Networks for pooled small group purchasing; -extension of ERISA to HINs; -Insurance market reforms: -Guaranteed issue & renewability -Portable coverage (no pre-exist. condit. exclusions) -Group coverage for college grads.	-Tax credit (25% of costs) for certain small businesses; -100% deduction for self-employed; -Subsidy of public & private insurance premiums: -Complete subsidy of premiums for those below poverty; -Partial subsidy of premiums for 100-200% poverty; -Indiv. contrib to public plan premiums capped at % of income; -Insurance market reforms: -Guaranteed issue & renewability; -Portable coverage; -State insurance consortia; -Small-group plan must offer minimum-benefits-only option;	No premiums. All insurance financed publicly.
Provider supply	-Encouragement of primary care physicians through Medicare Graduate Medical Education (GME) payment system; -19% expansion of National Health Service Corps funds.	No provisions.	Federal government controls hospital supply because it sets and finances hospital budgets.

	President's Comprehensive Health Reform Proposal	Play or Pay	National Health Insurance
COSTS **Use of Coordinated Care**	-Private and public sector: -Pre-empt state restrictions on coordinated care; -Pre-empt state benefit mandates; -HMOs compete for new consumers; -Medicare: -Create new options, including Point-of-Service (POS), Employer POS, and Case Management; -Strengthen risk-based program by using 100% AAPCC, reforming AAPCC methodology, increasing flexibility, reforming cost contract options, and strenghtening oversight; -Medicaid: Eliminate waiver for coordinated care and require waiver for fee-for-service.	-Pre-empt state restrictions on coordinated care; -Pre-empt state benefit mandates; In HealthAmerica: -Coordinated care options in public plan; -Insurer that offers coord. care option to large groups must offer coord care option to small groups.	-No provisions and no incentives to develop or to use coordinated care; -Generally not considered necessary in centrally administered system.
Consumer Decisionmaking	-After 1 year, states publish information on average price and costs for common services; -After 5 years, states develop systems to provide comparative quality & outcomes data to consumers; -HHS develops prototype systems for gathering outcomes and quality information; -Insurance plans continue to set their own cost-sharing levels.	In HealthAmerica: Federal Board publishes data on efficiency & quality of individual providers; Cost-sharing usually consists of: -20% of premium; -20% co-payments except for preventive services; -$250/$500 deductible; -$3000 cap.	No cost sharing.
Technology Diffusion	Encourage passage of joint venture legislation S.1163.	In some proposals: -States may plan health care resource allocation; -States may set capital budgets.	Federal government plans resource allocation and sets capital budgets.

03/04/92

	President's Comprehensive Health Reform Proposal	Play or Pay	National Health Insurance
COSTS, ctd. **Defensive Medicine and Malpractice Costs**	Encourage states to: -cap non-economic damages; -eliminate joint and several liability for non-economic damages; -eliminates rules that permit double recovery; -require structured awards; -promote pre-trial alternatives; -implement new procedures to promote quality of care.	Varies by proposal. Ranges from no provisions to grants to states for tort reform.	No provisions.
Administrative Costs	Savings of $4 billion per year in 1st 4 years and $9 billion in 5th year expected from: -Small group reforms; -Electronic billing and claims using standard formats; -Computerized medical records; -Pattern-of-care review (less case-by-case review).	-Small group reforms; -Standardized billing forms; -Insurance consortia; -Focused utilization review.	Lower administrative costs with single payer.
Preventive Behavior and Use of Preventive Services	Increased funding for women and children's health promotion, primary care expansion, smoking cessation, and physical fitness & diet, including: -27% increased in Head Start and Early Childhood Development funds; -24% increase in Breast and Cervical Cancer Mortality Prevention funds; -90% increase in Childhood Lead Poisoning Prevention funds -106% increase in Tuberculosis Control.	Preventive benefits required in insurance packages.	National insurance package includes preventive benefits.

	President's Comprehensive Health Reform Proposal	Play or Pay	National Health Insurance
EFFECTS ON HEALTH PRICES Provider Rates	No new rate setting.	-A Federal board, similar to Federal Reserve Board, sets binding rates consistent with national expenditure targets; -Balance billing prohibited in many proposals. -Some State flexibility in rate-setting.	-National physician fee schedule; -Hospitals paid monthly lump sums.
Health Insurance Premiums	-Premium bands minimize variation in premiums for small groups; -Small group insurance reforms reduce premiums up to 20%; -Reduced uncompensated care reduces cost-shifting and lowers private insurance premiums.	No provisions.	Not applicable.
EFFECTS ON TOTAL HEALTH SPENDING Total Physician Spending	Reduced physician expenditures resulting from: -Medical liability reforms; -Streamlined records and billing.	-Varies by proposal: -Growth in health expenditures tied to GNP growth, or -Federal board sets expenditure targets, or -No controls on physician expenditures.	Federal government sets national physician expenditure target.
Total Hospital Spending	-Reduced hospital expenditures resulting from: -Expansion of coordinated care; -Medical liability reforms; -Streamlined records and billing; -Increased preventive behavior; -Use of primary care instead of hospital care; -Increased information available to consumers; -Disproportionate Share Hospital and Indirect Medical Education payments phased out, as tax credits reduce uncompensated care burdens.	Varies by proposal: -Growth in health expenditures tied to GNP growth, or -Federal board sets expenditure targets, or -No controls on hospital expenditures.	Federal government sets national hospital budget.
Total Savings	-$395 billion saved by 1997; -$954 billion saved by 1999.		Russo's estimate: $40 billion saved in first year.

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Harris — Updated Medicare info for AL.
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TABLE 2 -- STANDARDIZED PER CAPITA RATES OF PAYMENT FOR 1993

STATE: 01 ALABAMA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
000 AUTAUGA	$199.21	$110.80	$141.96	$88.60
020 BARBOUR	$196.37	$132.68	$158.97	$88.39
040 BLOUNT	$235.31	$120.66	$202.94	$100.65
060 BUTLER	$151.19	$101.84	$128.03	$75.64
080 CHAMBERS	$181.90	$111.10	$155.80	$82.24
100 CHILTON	$229.32	$119.23	$185.11	$89.25
120 CLARKE	$189.77	$100.01	$135.65	$62.77
140 CLEBURNE	$168.81	$102.13	$168.02	$77.55
160 COLBERT	$237.57	$113.16	$217.89	$97.38
180 COOSA	$171.96	$109.65	$120.13	$77.28
200 CRENSHAW	$164.63	$99.82	$150.43	$75.48
220 DALE	$207.35	$120.35	$164.37	$80.66
240 DE KALB	$176.84	$100.26	$166.83	$79.48
260 ESCAMBIA	$176.05	$118.72	$166.34	$92.92
280 FAYETTE	$172.13	$98.03	$142.21	$74.67
300 GENEVA	$195.40	$118.71	$148.55	$77.99
320 HALE	$184.56	$96.52	$137.35	$77.88
340 HOUSTON	$214.49	$129.51	$197.82	$96.04
360 JEFFERSON	$244.83	$137.60	$200.46	$97.96
380 LAUDERDALE	$202.40	$103.30	$177.19	$85.22
400 LEE	$165.58	$94.00	$153.97	$75.08
420 LOWNDES	$147.69	$111.52	$154.27	$74.81
440 MADISON	$210.87	$117.33	$166.62	$85.34
460 MARION	$177.27	$110.75	$172.86	$90.60
480 MOBILE	$232.95	$129.89	$194.73	$90.17
500 MONTGOMERY	$185.59	$118.94	$137.78	$79.87
520 PERRY	$170.01	$89.47	$123.49	$56.71
540 PIKE	$179.81	$114.68	$141.76	$82.32
560 RUSSELL	$168.71	$108.95	$148.15	$77.96
580 SHELBY	$288.82	$160.39	$241.52	$125.62
600 TALLADEGA	$210.04	$121.60	$174.46	$92.97
620 TUSCALOOSA	$226.16	$121.48	$177.63	$89.27
640 WASHINGTON	$189.18	$108.76	$156.73	$69.32
660 WINSTON	$202.14	$117.00	$172.11	$96.30
STATE: 02 ALASKA				
010 ALEUTIAN	$270.22	$103.38	$173.03	$97.99
030 ANGOON	$121.40	$64.74	$148.53	$87.89
050 BETHEL	$144.09	$36.72	$74.28	$22.68
070 BRISTOL BAY	$250.98	$79.05	$72.30	$32.07
090 FAIRBANKS	$244.54	$141.13	$181.44	$129.59
110 JUNEAU	$235.70	$136.88	$212.27	$94.13
130 KETCHIKAN	$188.27	$132.35	$190.78	$110.68
150 KODIAK	$284.33	$117.64	$167.73	$61.45
170 MATANUSKA	$220.40	$140.19	$194.28	$109.78
190 OUTER KETCHIKAN	$190.91	$132.84	$207.21	$113.02
210 SEWARD	$347.25	$154.09	$231.34	$108.89

STATE: 01 ALABAMA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
010 BALDWIN	$198.68	$115.59	$170.21	$83.69
030 BIBB	$216.54	$125.37	$165.87	$84.44
050 BULLOCK	$122.29	$93.03	$120.84	$65.33
070 CALHOUN	$202.63	$114.32	$171.05	$88.47
090 CHEROKEE	$208.31	$109.35	$211.09	$95.60
110 CHOCTAW	$195.45	$102.12	$207.20	$85.67
130 CLAY	$161.30	$86.02	$155.05	$71.58
150 COFFEE	$207.78	$122.45	$167.31	$86.23
170 CONECUH	$171.09	$108.04	$98.90	$63.94
190 COVINGTON	$188.65	$122.04	$175.59	$95.24
210 CULLMAN	$201.44	$103.34	$170.77	$83.38
230 DALLAS	$203.51	$95.27	$171.78	$89.42
250 ELMORE	$189.33	$117.51	$146.03	$82.87
270 ETOWAH	$212.08	$118.38	$173.03	$94.69
290 FRANKLIN	$217.68	$117.23	$217.47	$108.31
310 GREENE	$142.85	$89.40	$166.23	$98.22
330 HENRY	$190.75	$122.96	$180.28	$89.83
350 JACKSON	$189.01	$101.72	$158.18	$79.87
370 LAMAR	$189.09	$93.63	$173.02	$80.85
390 LAWRENCE	$209.38	$113.96	$194.73	$92.88
410 LIMESTONE	$182.13	$102.10	$145.32	$80.72
430 MACON	$130.99	$86.15	$117.00	$60.15
450 MARENGO	$183.34	$99.44	$165.58	$68.93
470 MARSHALL	$192.69	$100.20	$171.05	$85.38
490 MONROE	$176.17	$91.25	$167.55	$73.42
510 MORGAN	$223.43	$115.95	$164.57	$79.87
530 PICKENS	$228.74	$105.58	$153.96	$67.34
550 RANDOLPH	$150.52	$87.88	$132.58	$85.18
570 ST CLAIR	$233.98	$130.48	$188.50	$102.18
590 SUMTER	$173.04	$92.30	$157.85	$64.14
610 TALLAPOOSA	$166.78	$102.59	$154.36	$87.45
630 WALKER	$268.50	$154.74	$208.19	$108.99
650 WILCOX	$148.95	$78.96	$106.24	$40.84
STATE: 02 ALASKA				
020 ANCHORAGE	$248.62	$155.44	$182.26	$114.89
040 BARROW-NORTH SLO	$240.99	$82.76	$301.99	$46.29
060 BRISTOL BAY BORO	$251.55	$134.53	$224.91	$126.51
080 CORDOVA-MC CARTH	$273.29	$145.55	$169.54	$89.36
100 HAINES	$227.04	$100.41	$208.76	$126.24
120 KENAI-COOK INLET	$293.48	$143.92	$205.91	$105.54
140 KOBUK	$184.85	$57.47	$243.36	$57.48
160 KUSKOKWIN	$158.04	$66.45	$181.45	$110.08
180 NOME	$188.28	$59.72	$110.93	$47.94
200 PRINCE OF WALES	$157.35	$93.82	$197.46	$117.73
220 SITKA	$224.61	$142.35	$171.37	$116.63

244.83
137.60
382.43

185
118

Travis Bowden EVP Alabama Power Co.

Awareness 8,000 employees

Quality

Cost

- most companies exp. 2x every 5 years.
- 3,4 yrs ago: could not afford 12% upward

Δ: - Deductibles ↑
- Premiums ↑
- Restricted some of the coverages

} pushed ↑ below 12% trend line

- Began an effort to educate employees about how to access system
- Wellness program.
- → Alabama Healthcare Coalition Comm's 42 firms
  - 100,000 employees / 250k individuals
  - want to stimulate health care
- coming up ē details ~ 10 strategies they are carrying out
  - → quality measurement system
    - voluntary for B'ham area hospitals.
    - conditions: pneumonia, heart attack, infant delivery (C SECTION)
- h.c. costs - will join education in influencing location decisions.

C. Ron Cheeley BBA - GA '73. M. Insurance.

prior to Coke: Southern Services Co.

Jan 86 - introduced Purpars. 89 - Flex Benefits

Cost BA 10.3% - trend for Fortune 50.

- Choice is very impt.

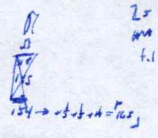
(→ 21K internationally. 4K in Atlanta.)

Toby

#2306 in FY 93. In 8 yrs: by end of cent → 23% / ahead of SSA, Dept of Defense.

5,000 → 15,000 employees. Workload 2x / # employees & 20%.

Largest health data system in the world.



H.c. employment

17.5 million by 2005

→ 2x growth as employment overall.

Medicaid

+ 35% in FY92 / + 30% over next few years

CLAIMS STDZATION: $114 billion.

∴ in 8 yrs: BILLION CLAIMS.

Pt A: 85% electronic

Pt B: 57%

Some NYU economist

→ Prices rise 2x in sectors where (something) productivity ~~costs~~ technology

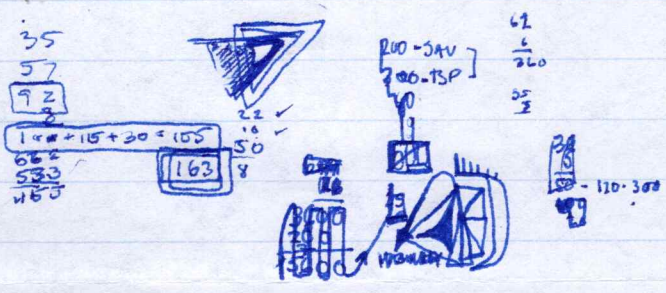
(sectors where ~~product~~ technology does not lower costs? productivity?)

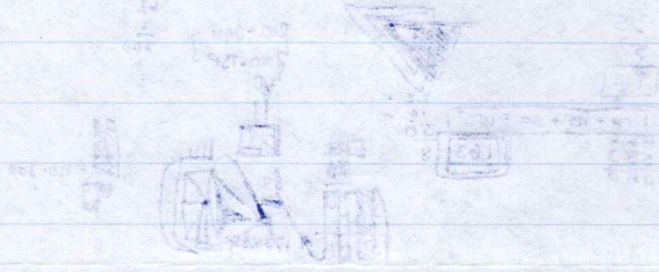
Managed care because of market failure.

Dr. Dan Johnson

- MRI v. peanut oil/iodine // X RAY

UFH: cost to HS grantees of prov Cor to employers.
Congrats to Noggles





Someone stopped by + said to the woman next to me, "He's a real Clarence Thomas. Talked about his white wife + getting picked up in a Lincoln Continental."

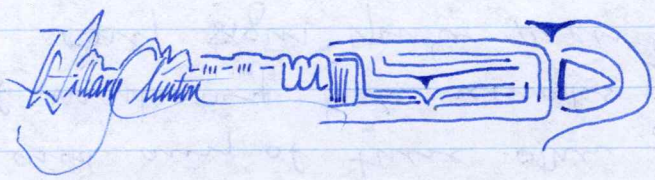
Do you have an idea of how many Alabama Medicaid recipients are SSI / over age 65 (non-nursing home) | NH - 18,000

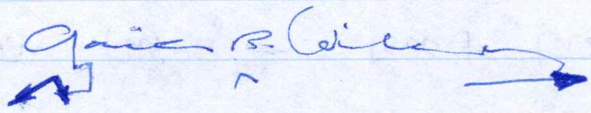
450,000 1 in every 8 Alabamians

2.

QMBS? 45,000

2
275
88
18
381





This Pru thing – isn't that who Wink works for?

Are Pru and any of these other guys thinking of marketing their networks to Medicaid agencies? Any signs you've seen?

Do you think NURSES are above / at / below average for ~~whininess~~ whininess among member groups?

If I suddenly leave the room, its because I could no longer control my urge to laugh at the malapropisms.

~~He sounds like Ross Perot.~~ Future running mate?

When I get back to DC I'm calling the NSC ~~[illegible]~~ to find out if they OK'd his travel!

I can't wait to tell Gail that Toby refers to Gail as "my predecessor"

"Scully's Last Stand"

He doubles as a prophet "All these things will come true"

Remarks

November 12, 1992

- Thank you for asking me here to discuss the President's health care plan, even though the President whose health plan I knew best lost the election nine days ago.

- I guess my feelings about being here were best summed up by Admiral Stockdale, Ross Perot's running mate, when he said during the VP debate, "Who am I? Why am I here?"

- I can't promise to be as unintentionally funny as Admiral Stockdale, but I do think that with the Bush Administration being more of an underdog than Stockdale at this point, I'm entitled to make a less serious presentation than would be the case if the election had come out otherwise.

- Here's how I want to use my time at the microphone today:

  - First, I want to dwell on the objective facts of the health care debate. [[Now those of us who find ourselves on platforms like this tend to use the same facts, but I've carefully listened to the earlier speakers and struck out the points that would be duplicative.]

- Second, I want to share with you my analysis of the historical moment at which we find ourselves and suggest what that says about where we go next.

  -- Now, this is the part where I might have talked about President Bush's plan for health care reform. Despite Saddam, not ashheap of history. But ideas of "loyal opposition" rather than those of dominant figure.

  -- Its convenient that part of the Clinton plan bears an uncanny resemblance to the Bush plan, so I won't have to throw the whole middle part of the speech.

  -- Of course, there is a lot that is very different between the two plans, and in the interest of total disclosure, I'll talk about the things that define the differences between the Bush and Clinton approaches.

-- And I'll close by turning myself into one of what the President called those "crazy pundits" and offer my candid assessment of where things might go in the coming months and years.

- There are few issues that can engender such strong emotions and heated debate, that are as complex, and affect every American in the way that health care does.

- When Americans are asked about their health care system, they like the quality of their health care services.

- However, they express serious concerns about the rising cost of care and access to that care.

- And that is what has made health care a salient issue in the political debate.

- Its the <u>cost</u> of health care that has given this issue its biggest push towards the center of public concern.

-- I'm sure that if health care didn't have the economic implications that it does, it would not be the subject of the conference we are attending today.

- Everyone has their favorite health care cost fun facts.

- Now there is a problem, and that is that you have to be a member of the League of Federal Budget Analysts to find these facts fun. But let me try them out on you anyway --

  -- Health care costs are expected to top $800 billion this year.

  -- That is over 13 percent of our Gross Domestic Product, as we've renamed "GNP," or about $2,600 for every American.

  -- If current trends continued, health care would be over 16 percent by the year 2000.

- If these are fun facts, there is a companion set of sad facts that emerge when you apply these trends to the federal budget.

-- **The cost of federal health programs is growing rapidly.**

-- **From 1980 through the current fiscal year, the federal cost alone of the Medicaid program grew 600%.**

-- **Medicare and Medicaid, which in 1965 accounted for 0 percent of the federal budget, today account for 13 percent of the federal budget and just as many years into the future as 1965 is in the past, 27 years, they will account for almost 25 percent of the budget.**

-- **If current trends continued, we would then be at a point that after paying for health care programs**
- **for Social Security,**
- **for the national defense,**
- **and for the interest on the federal debt,**

there would be at most ten cents left on the dollar that would come into the federal Treasury.

· **Let's use a more personal take on these numbers.**

Montgomery Co. #303

-- The cost of providing the Medicare benefit package this year in Jefferson County is $382 dollars per month for someone aged 65.

-- If you were penniless and qualified for Supplemental Security Income at age 65, the maximum benefit you could receive as an individual would be $422 per month, and $633 for a couple.

-- It says something when the cost of providing health benefits is greater than that of providing minimal income protection to those in old age.

- Now despite the fact that these facts are often used to argue "Stop health spending before it stops everything else," I want to offer a different argument.

- My argument is, "Two cheers for rising health care spending."

-- Its not an all out "three cheers for health care spending" but it certainly isn't "three raspberries for health care spending" either.

-- Dr. Lacy, earlier today: questions about optimality.

→ not a result of competitive markets

- Simply put, my argument comes down to this: there is no right amount for health care spending. There is no formula that tells you when you're spending enough and when you're spending too much.

- I would argue health care should be like other areas of our capitalistic economy: the total amount spent should be the ~~amount that~~ results from summing up the ~~total amount~~ spend by 260 some million Americans living in 50 states and the District of Columbia.

  -- Its the amount that derives from decisions made by people living in new suburban developments and old country crossroads.

  -- Its sum total of decisions made by physicians treating newborns in intensive care units and you and me buying an over the counter medication when we have the flu.

  -- There's no computer program or government committee that can take the place of all these decision makers.

- **Now President-elect Clinton has argued otherwise, and we'll get to that in a bit.** During the Presidential campaign, Gov. Clinton offered a very different vision

- **I'm only offering two cheers for our health care system. Yes, there are inefficienies. Yes, the way the market for health care services functions has been different from the rest of our economy.**

- **But so far I haven't seen anything to convince me that we should do things differently in our health care system than elsewhere in our market-based economy.**

  -- **Consider** another area of our economy — **telecommunciations. Costs are rising rapidly in that sector as well. From 1980 to 1989, dollar spending for telecommunications rose from $67 to $134 billion. I don't see anyone running around and saying, "We've got to stop this proliferation of fax machines and pagers and telecommunications devices before telecommunications costs run this country into the ground."**

- **Health care is like telecommunications and other fields that grow in capability as technological boundaries move outward; both are things that**

societies want to consume more of as they prosper.

-- There is a graph.

-- US v. other advanced economies comparison: fitting the line in the OECD comparison.

- Let me move away from this issue of overall economic significance of health care to talk about the significance of health care in regional economic development.

-- If we go back to those federal budget trends, one point I did not make is what is happening to defense. Its share is shrinking. That has an effect on a state like Alabama which provides 1.21 percent of federal revenue and receives 1.74 percent of defense spending.

-- By the end of the century, federal spending on health care is likely to make a greater contribution to the Alabama economy than defense spending.

-- As you think about the regional economic significance of health care, I would encourage you to think about the potential for growth

through import replacement and export. In health care this means providing services which people now seek elsewhere and providing services which attract people from beyond your own region.

-- Already we see this in how urban and rural areas interact in the flow of health care services. Health care has shown requirements of scale that rural areas cannot provide. This means that we observe a net flow towards urban areas in this process of the health care services available becoming more specialized.

-- This phenomenon can be observed anecdotally in this way: compare the number of new rural hospitals versus the number of new urban hospitals. There has not been much rural hospital construction in the southeast since Hill-Burton funding ended in in 1974. At the same time, there are few urban hospitals that have not underdone some major construction project in the past five years.

· Its these cost-related issues that make health care an issue of pressing interest to the political system.

- **The problem in relating the two is that <u>Americans have feelings, not policy views</u> about health care.**

  -- **That's a problem for politicians, because when politicians act ahead of sufficient public understanding, they get in trouble.**

  -- **Rep. Rostenkowski, the chairman of the House Ways and Means Committee, is unlikely to forget what he experienced when seniors decided they didn't like the Medicare catastrophic health costs program. In one telling moment, an elderly constituent chased the Congressman with her cane, vowing to do great damage if she ever caught up with the scoundrel.**

  back in the Cong district in Chicago

  -- **The Congressman had twenty years and twenty feet on the angry constituent, but he's unlikely to have that advantage with health care legislation that effects all age groups.**

  -- **Believe me, we're not starting in a good place for ordinary folks to wind up appreciative of what the national government might do for them.**

  -- **Consider the results of discussions done with focus groups conducted by the Public Agenda**

Foundation. PAF is a group headed by a reformed pollster who wants consumers of polls to be mindful of the distinction between judgment and opinion. We have opinions on most things; judgment on few.

-- PAF found that most people ranked greed as the number one cost of rising health care costs: greed by insurance companies out to make excess profits; greed by malpractice lawyers who want to profit off of others' woes; greed by doctors bent on being superrich.

-- PAF did not find ordinary people offering the same reasons offered by those who call themselves health care analysts. The analysts focus on factors like an aging population, more technologies, and consumers who do not take price into account when making decisions.

-- This divergence holds the potential for legislative disaster -- for catastrophic health insurance all over again.

-- This divergence leads to the kind of views expressed by one person who attended one of the PAF focus groups. He's the guy I want to would

make the health reform debate poster child, because he said, "I want national health insurance, I just don't want the government to run it."

Part 2: Health Care and the Political System

- This brings us to where we are right now in the political life of the country.

- Unlike the 1988 election, where the American people had a choice between one candidate who said he would make health care reform a central issue in his Administration and one who said little about health, 1992 brought the American people two candidates who had distinct visions of health care reform. [[JOKE: Third candidate, who saw policy as physiology, and identified his policy as "I'm all ears."]

How same

- The Bush and Clinton plans had considerable overlap.

  -- Rhetorically, both arrived at the same place as the Clinton team made one last pass at the

settled on a plan

waffle iron in late September and came out with a plan that had the same rhetorical thrust as the President's plan, emphasizing universal coverage through private plans.

-- One specific area of agreement: insurance market reform. Both followed recommendations of the Natl Assoc of Ins Cmmrs. Sometimes the consensus items are the boring items, but these represent radical changes.

-- Insurance market reform is important for small employers. For largest employers → SELF INSURANCE

-- The NAIC recommendations would bring a new set of rules to the health insurance business. Their effect would be to shift the rules of the road akin to moving from driving on the left side of the road to the right side. Instead of making money by insuring the best risks -- those most likely to pay, least likely to have health costs -- insurers would find the way to make money in the health insurance business would be to do the best job possible in managing costs for their customers.

costs

law of large numbers means ave not much affected by one expensive case employee or dependent.

With small employers ave can be influenced.

-- The reforms that would change the rules of the road include:

Insurance → spread risk.

But incentives in the market place

- **First and foremost, requiring every insurer to take all risks, to sell insurance to everyone who wants to buy it from the insurer.**

- **Second, insurance contracts must be renewable. Current risk optimizing strategies that involve periodically dropping poor risks would be moot.**

- **Third, insurers would be required to take all members of an employee group. Individuals could not be "medically underwritten" out of their employment group.**

-- **Another important area of agreement is in the importance of automating paper-intensive processes. Certainly this is the element of reform that is most likely to be tangible the soonest to ordinary folk.**

- **What this means:**

  - **Electronic movement of information between providers and payers -- standardized formats.**

Also, ~~both plans agree on broader reforms~~;
"pre-existing conditions" clauses that ~~may~~ exclude those conditions would be ended in group health plans

Both plans feature purchasing groups
- Bush: HINS ^ voluntary. potentially multiple groups in an area; some nat'l -
- Clinton: local health networks. → higher level of integration: insurance + arrangig

- **Data embedded cards.**
  - **First, for eligibility.**
  - **Later for health information.**
- **Long-term -- electronic patient record.**

How different

- **Of course, political campaigns rarely emphasize the similarity of competing candidates' approaches.**
- **While similar in thrust -- both emphasizing universal coverage through private plans -- their differences outweigh their similarities.**
- **This is certainly true in the two divisive areas: how to assure access to insurance and how to control costs.**
- **Access**

  GB: Tax credits and, though softpedaled, a mandate that employers "arrange" for enrollment.

Clinton: Mandatory participation by employers; a new public plan for all non-working uninsured, replacing Medicaid.

→ phased in

- **Costs** → "tax credits to protect businesses"

GB: Premise – you can't substitute bureaucratic judgment for markets. You can try, but it shows no ability to hold up -- witness Nixon and wage and price controls.

Balloon analogy

Clinton: Like the Bush people, we want to let some air out of the balloon. But we are going to make the balloon fit in a box of predetermined size. If the efficiency steps don't let out enough air, then we'll force the balloon.

-- Audacious promise: health care costs ↑ not faster than incomes

-- **Depending on what form budget takes, there can be a serious threat to the health care system as we know it.**

-- **One formulation: like the latter phases of Ford and Carter inflation fighting. The function of government will be to jawbone down the cost of care.** Yes we'll have a Natl Bd, and each state will have a board... But... more like consultants

-- Another: more rigid. more regulatory.

→ Immediate conflict with one of the values Dr. Davis discussed: AUTONOMY.

→ who calls the shots.

→ who will be "Al Haig"?
- Travis Bowden + Ala Hlth Council?
- state gov official?

here in Ala:
- Ala Healthcare Council.

cooper

Predictions

- For those of you who nodded in recognition when President Bush talked about "those crazy pundits," you know the last part of the McLaughlin group is "predicitons."

- Let me make the last part of my speech some of those predictions.

- First, a "hundred days" construct doesn't fit. Have been through the process of developing a comprehensive plan and taking it through the process of writing complete legislative language, the Clinton plan would be hard pressed to make it from its current state as talking points to a legislative proposal within 100 days. If anything in the 100 days, or even the first 6 months, look for some clever ways to mark time.

- Second, if there is a mandate that employers offer benefits, it will go the way of Massachusetts' mandate. Enacted, with a lengthy phase in. But as the real hits approached, they ducked.

- **Finally, not a prediction, but a hint: watch the guy a little bit from center stage named George Mitchell, the Senate majority leader.**
  - **1991: could have had something, but he kept it from happening.**
  - **Already circulated a letter: We'll listen to you. [Not we'll push your plan.]**
  - **Could be nasty.**

- No matter who the Am people chose to be P, they were choosing a candidate who said there would be change in the health care sector.

- As a rep ~~[illegible]~~ ~~[illegible]~~ of an Admin that is preparing to head off into the sunset, I'd say: hold on – to your seat.

→ A Pres. who has talked ~~[illegible]~~ about change that challenges some of the ~~[illegible]~~ values that ~~[illegible]~~ today influence the health care system.

→ Such change means conflict.

Clinton Gore

FOR IMMEDIATE RELEASE
September 24, 1992

CONTACT: George Stephanopoulos
(501)/399-3900

Controlling Costs and Guaranteeing Care for All
The Clinton/Gore Health Care Plan

Governor Bill Clinton today detailed his health care reform plan and laid out the fundamental differences between his comprehensive plan and George Bush's piecemeal approach to the health care crisis.

"We'll never revive our economy or cope with the deficit until we get health care costs under control," said Clinton.

The Clinton/Gore plan will tightly contain costs so that they rise no faster than wages, saving Americans $700 billion by the end of the decade. The plan will also guarantee coverage for all Americans, and preserve the private health system's quality and choice. Highlights of the plan include –

Controlling costs:

- Fence in national health costs by setting a national health budget to limit what consumers pay for health coverage.
- Take on the insurance companies to restore competition, driving costs below the budget and protecting consumers. We will ban "pre-existing condition" exclusions, require policies to offer full benefits, and set up purchasing groups that give individuals and companies real buying power and make insurers compete for their business.
- Stop drug price gouging by ending special tax breaks for companies that raise drug prices faster than inflation.
- Take other steps to control costs: reform medical malpractice laws, reduce duplicative technology and streamline paperwork.

Covering all Americans:

- Require employers to insure their workers, either directly or through a purchasing group; phase in requirements, with small businesses coming last, and provide tax credits to protect businesses.

- more -

- Guarantee private coverage for nonworkers, starting with nonworking pregnant women and children.

- Dedicate federal savings from cost controls to paying for expansions in coverage.

Governor Clinton said that he would put his plan before Congress in the first hundred days of his administration.

"I have a plan for fundamental change and real reform," said Governor Clinton. "George Bush has a last minute political proposal."

"Mr. Bush has done next to nothing to solve the health care crisis," Clinton added. "I will make sure health care costs don't rise faster than your income. He won't. I will take on irresponsible drug companies and insurance companies. He won't."

George Bush's inaction has let health care costs climb to $800 billion in 1992. They now add $1,230 to the price of an American car. Over the next five years, they'll account for more than half the growth of the federal deficit.

The health care reform plan Clinton detailed today is central to Putting People First, Governor Clinton's national economic strategy for America.

-30-

[Please see the detailed summary of the plan that follows.]

SUMMARY OF THE CLINTON/GORE PLAN FOR AFFORDABLE, QUALITY HEALTH CARE

America has the finest health care in the world, but it costs too much and leaves millions without coverage.

The Clinton/Gore plan calls for fundamental change. It will make sure that no American is bankrupted by illness, ensure that all Americans have affordable, high quality health coverage, and create a health care system that is much simpler and more secure than the one today.

To make a health care system that works, the Clinton/Gore plan meets three goals:

1. Cost control so that health care costs do not increase faster than Americans' wages.

2. Guaranteed universal coverage. Every American will be guaranteed affordable, quality coverage.

3. Preserves what's best in our system. Quality private care and personal choice of the world's best doctors and hospitals.

COST CONTROL: RESTORING COMPETITION WITHIN A BUDGET

It's time to get health care costs under control. Because of Republican inaction, we will spend $809 billion on health care this year, and we'll waste as much as $200 billion of that on a bloated bureaucracy and unnecessary tests and services. Only the insurance companies benefit. They have written the rules to prevent real competition and rational planning, and they profit mainly by avoiding "risk" -- the people who need help most.

The Clinton/Gore plan will improve quality, expand choice, and control costs through a strategy of competition within a budget. This strategy is supported by leading consumer groups, including the American College of Physicians, the American Academy of Family Physicians, the American Nurses Association, and businesses from Bethlehem Steel to Xerox that belong to the National Leadership Coalition on Health Care.

The Clinton/Gore plan will further cut costs by eliminating drug price gouging, cutting bureaucracy and fraud, and reforming medical malpractice laws. We will also protect consumers by making sure insurers end their discriminatory practices and turn no one away. These are the specific steps:

• Set a National Health Budget -- an overall limit on costs.

It is time that we decide as a nation how much we want to spend on health care. The Clinton/Gore plan will establish a national health care board made up of consumers, providers, business, labor and government. Together, they will set national and state health care budgets to limit public and private health care costs.

> The budget and managed care networks: Consumers will have access to a variety of local health networks -- organized systems of insurers, hospitals, clinics and doctors. These managed care networks will receive a fixed amount of money (a "capitation fee") for meeting a consumer's full health needs. States will set an upper limit on these "capitation fees" so as to meet the budget. By limiting their total spending without interfering with their practices, the budget creates incentives for hospitals, clinics and doctors to reduce bureaucracy, eliminate duplicative technology, and stop waste.

> The budget and other insurers: For services covered by other (non-managed care) insurers, states will establish fee schedules applicable to all payers in order to meet the global budget targets.

> The budget and Medicare: We will protect Medicare benefits for the elderly. Our fundamental reforms will reduce bureaucracy and unnecessary care, generating savings for Medicare and the private sector. Medicare payments to providers, like non-managed care insurance payments, will be subject to budgetary limits.

- Set new rules for insurance companies – to create competition.

The Clinton/Gore plan will fundamentally change the rules for insurance companies. We will ban the anti-competitive practices that increase red tape and force up prices. We will restore consumer choice, end job lock, and give businesses greater bargaining power. These steps will restore real competition, drive costs below budget limits and ensure that health costs rise no faster than Americans' wages.

We will make insurance companies play by a new set of rules:

> Open enrollment. We will ban "pre-existing condition" exclusions. Insurers will have to take all comers, freeing workers locked into their jobs because they fear losing their insurance.

> Equitable pricing. Insurers will have to use "community rates," which stop insurers from charging consumers more based on such factors as size of employer, health condition or gender.

> Comprehensive benefits package. We will require insurers to offer a comprehensive benefits package, as detailed by the National Health Care Board. This package will cover the preventive and primary care Americans need to stay healthy – including pre-natal care, well-child care, mammograms and routine health screenings. It will also include full protection in case of illness – including physician visits, hospital care, prescription drugs, and basic mental health care – and allow consumers to choose where to receive care.

> Purchasing groups to drive competition. We will establish publicly-sponsored purchasing groups that band together small businesses and individuals to buy private coverage. Health networks will have to compete – at lower costs, with more choices and higher quality -- to win the business of the companies and individuals in these groups.

- Eliminate drug price gouging.

To protect American consumers and bring down prescription drug prices, the Clinton/Gore plan will eliminate special tax breaks for pharmaceutical companies that raise their drug prices faster than the rate of inflation. We must stop drug companies from charging more in the United States than they do in other advanced nations.

- Reduce paperwork and fraud.

To control costs and trim the "paper hospital," the Clinton/Gore plan will replace expensive and complex financial forms and accounting procedures. We will implement a single claims form, standardized billing codes, electronic processing, and other steps that will reduce the

paperwork now consuming as much as 80 hours a month of a physician's time. We will also crack down on billing fraud and remove incentives that invite abuse.

- **Reform medical malpractice law.**

We will reform medical malpractice laws to reduce the cost of "defensive medicine" -- doctors' practice of ordering unnecessary tests to protect themselves against malpractice lawsuits. We will make alternative dispute resolution mechanisms available in every state -- mechanisms that take disputes out of the court system and effectively and fairly address the concerns of patients and physicians. We will also encourage the development of medical practice guidelines to eliminate improper care and to help physicians defend against charges of negligence.

- **Reduce duplicative technology.**

To reduce the proliferation of duplicative technology, the National Health Board will develop recommendations and incentives for the shared use of new forms of technology.

UNIVERSAL COVERAGE: PRIVATELY PROVIDED, PUBLICLY GUARANTEED

The Clinton/Gore health reform plan will guarantee coverage for all Americans by building on our system of coverage through employment. All workers and their families will receive coverage through the workplace. Government will guarantee coverage for nonworkers.

- **Guaranteed coverage for working families.**

  > **Affordable coverage.** The Clinton/Gore plan to control costs will make sure health benefits are affordable for employers and employees.

  > **Employer responsibilities.** 85% of workers and their families get coverage through jobs. We will make sure that all do. We will require companies to insure their employees, and provide tax credits to offset costs for companies that need help.

  > **Employer options.** Employers will purchase benefits directly from insurers or through the publicly sponsored purchasing groups.

  > **Protection for business.** The Clinton/Gore plan will provide assistance to make sure that small businesses and their workers are not jeopardized by the new responsibilities. We will take a number of steps in addition to the small group market reforms already described:

  -- Provide assistance through tax credits to protect businesses.

  -- Phase in employer requirements with the smallest businesses coming in last. We will not throw businesses into today's broken health insurance system.

  -- Require employees to pay a share of the costs of new health benefits.

  -- Raise the health insurance tax deduction for the self-employed from 25% to 100%.

- **Guaranteed coverage for nonworkers.**

The Clinton/Gore plan guarantees nonworkers and their families private coverage through the publicly sponsored purchasing groups. They will pay a sliding scale premium based on income. We will fold Medicaid into this program for private coverage.

- **Savings dedicated to expanding coverage.**

We will dedicate federal savings from cost controls to expanding coverage to all. Once universal coverage is achieved, savings will be used to reduce the deficit.

OTHER STEPS FOR NATIONAL HEALTH REFORM

- **Expand Health Education and Demand Personal Responsibility**

The Clinton/Gore plan gives Americans the ability to help themselves. We will make an intensive health education effort in the workplace and in schools to educate Americans about behavior that causes ill health and high costs. We will make sure adequate information for finding high quality, cost-effective coverage is available. The right to affordable health care must be accompanied by the responsibility to maintain our own health and to use the system wisely.

- **Expand School-based, Rural and Urban Health Clinics**

Simply providing health insurance coverage is not enough. Too many Americans in underserved rural and urban communities, and too many school children across the country, lack access to the health care they need, even when they have excellent insurance coverage.

The Clinton/Gore plan will expand the number of community health clinics in rural and inner-city areas. In Arkansas, school-based clinics have been highly effective in reaching children and families on issues like teen pregnancy and early childhood care. We want to see these clinics expanded across the country.

We will expand the National Health Service Corps which pays for the education of health care professionals in return for service in underserved communities. And we will carry out the recommendations of the National Governors' Association to provide incentives for students and mid-career health professionals to serve in primary care professions in underserved areas.

- **Emphasize Preventive and Primary Care**

Failure to obtain preventive and primary care -- such as prenatal care, immunizations, check-ups, and routine screenings -- is costing billions of dollars in avoidable health care. The Clinton/Gore plan will guarantee preventive coverage for all Americans. We will also reform our medical education system to prepare more physicians to practice preventive and primary care. We will expand support for graduate training for mid-level health professionals, such as certified nurse-midwives and nurse practitioners.

- **Expand long-term care**

No Americans should have to impoverish themselves to qualify for long-term health care, and no family should have to choose between long-term care for grandparents and education for their children.

We can provide more services to the elderly and disabled by expanding Medicare. We will phase in long-term care benefits, starting with diversified coverage of home-based and community-based care. In Arkansas, we've launched a popular pilot program called ElderChoices, which gives the elderly the right to take money previously available only for nursing home care and spend it instead on home health care, personal care, transportation to senior centers, nurses' services, or attendance at an adult day care center.

Clinton-Gore '92

Talking Points

The Daily Line for Newsmakers

Thursday, September 24, 1992

THE BUSH RECORD: A HEALTH CARE NIGHTMARE

BUSH DID NOTHING WHILE COSTS EXPLODED, MILLIONS LOST INSURANCE

• Since 1980, health care costs have tripled, going from $2500 to $7500 for an American family. [Health Care Financing Administration, Office of the Actuary]

• Annual national health care spending increased from $249 billion in 1980 to more than $800 billion today. [HCFA, Office of the Actuary]

• In 1990, 35 million Americans were uninsured. Each month under George Bush, 100,000 people have lost their insurance. Most of them are workers who lose their jobs or benefits. [Current Population Reports, Bureau of the Census]

BUSH WATCHED WHILE COSTS HIT BUSINESSES, WORKERS, ECONOMY

• For the first time in American history, health care costs now exceed business after-tax profits. [Health Care Finance Review, Winter 1991]

• 1 million jobs have been lost since 1980 due to rising health care spending for business -- 200,000 under Bush alone. [K.E. Thorpe, UNC Working Paper, 8/31/92]

• Health benefits consume 8% of payroll today. By the end of the decade, they will cost as much as 20%, if nothing is done. [Karen Davis, Commonwealth Fund]

•Health care costs are hurting American competitiveness. They add $1230 to the price of cars built in America [Chrysler Corp.]

•Bush's own advisory commission found that workers lost 58% of potential wage increases because employers spend it on health care costs. [Social Security Advisory Commission, Dec. 1991]

•Medicare and Medicaid have grown from 8% of the federal budget in 1980 to close to 14% today. Over the next five years, they will account for more than half the growth of the federal deficit. [CBO]

BUSH PROTECTING THE INSURANCE AND DRUG COMPANIES

• Insurance companies have given over $2 million to the Bush/Quayle re-election effort. [National Library on Money and Politics]

• Drug and health product interests have given another $1 million. [Center for Responsible Politics, National Library on Money and Politics]

• When Bush convened his 'Health Care Summit' on health care costs, Bush effectively barred groups of consumers and businesses who pay the bills. 40 representatives of health insurers and providers were invited. [Medicine and Health, 11/4/92]

Clinton-Gore '92

Talking Points

The Daily Line for Newsmakers

Thursday, September 24, 1992

THE BUSH PIECEMEAL POLITICAL HEALTH CARE NON-PLAN

* George Bush will fight for the insurance companies and the drug companies, but he'll get tough with working Americans. Bush knows that these companies give him huge contributions.

* Bush won't cut costs, he won't guarantee coverage, and he won't stop nightmare practices. Basically, he won't do anything to change what's worst in the system.

* Bush will gut Medicare and cost 2.2 million Americans their jobs. That's how he'll pay for his huge tax cut for the wealthy.

The Bush plan is nothing but politics. "Mr. Bush expressed no sense of urgency about the health care crisis until last November when the voters of Pennsylvania spoke out loud and clear for a national health plan and elected Harris Wofford to the Senate." [NYT, 8/2/92]

Bush hasn't provided details yet. George Bush has not introduced in Congress the key piece of his health plan -- his $36 billion a year health care tax credit and deduction scheme.

Bush will increase costs. The Bush proposal would increase national health expenditures by 2 percent over current levels -- $18 billion next year alone. It would increase federal tax expenditures by 39% or $36 billion a year. [R.D. Reischauer, CBO Director, Senate Finance Committee hearing, 5/6/92]

Especially when the costs benefit insurance companies. "The large inducements for insurers... would increase the already horrendous administrative costs of the current system." [Henry Aaron, Brookings, House Energy and Commerce testimony, 7/29/92]

And he'll cost jobs. "Bush's health proposals will drive up private sector costs at a loss of 1.5 million jobs in the next five years, and his economic proposals will lose another 700,000 jobs." [Kenneth E. Thorpe, UNC Working Paper, 8/31/92]

Bush will leave millions uninsured. No more than 7 million of the 37 million uninsured would be able to purchase health insurance under the Bush proposal. [Employee Benefits Research Institute]

He'll create health stamps -- welfare for health care. Bush would provide a full tax credit or voucher only for those earning less than $10,000. The value falls to just $125 for an individual earning just $15,000. Bush's proposal allows middle class families to deduct only $563 out of an average annual cost of $6,500 -- worth only about 1 month about coverage. [Dem. Policy Committee, 2/28/92; Families USA]

Bush will preserve what's worst: bad insurance practices... "[Bush's reforms] leave in place some of the worst anticompetitive features of the present failed market. They leave insurers plenty of room to defeat price competition by segmenting markets. They do not permit individual workers a choice among health plans. Moreover, they leave room for very wide variations in premiums among groups". [Alain Enthoven, New England Journal of Medicine, 9/10/92]

... and high prescription drug prices. Bush offers no proposals to contain drug prices which are increasing at triple the rate of inflation. [Families USA]

And to top it all, he'll gut Medicare and cost more jobs. In his 1992 Mid-session Review, Bush proposed raising Medicare taxes and cutting Medicare benefits by a combined total of $127 billion over the next five years, increasing the average elderly American's medical bill by $2000. [OMB] The Medicare cuts required by Bush's economic proposals would increase private sector health costs -- at a loss of 2.2 million jobs. [K.E. Thorpe, UNC Working Paper, 8/31/92]

"All the News That's Fit to Print"

The New York

TUESDAY, AUGUST 25, 1992

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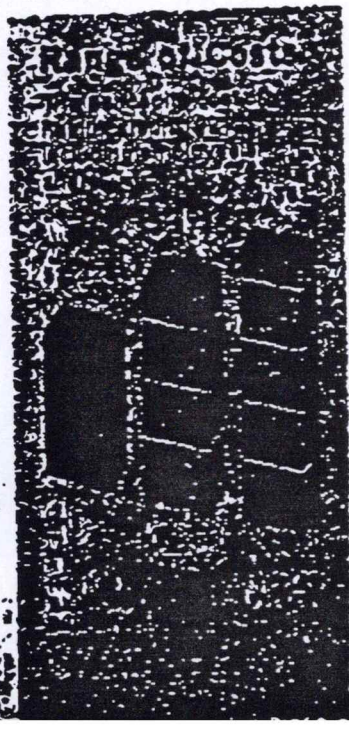
Rochester Serves as Model In Curbing Health Costs

By MILT FREUDENHEIM
Special to The New York Times

ROCHESTER — In the search for ways to slow the surge in national medical spending, policy makers and economists are paying growing attention to this prosperous industrial city of 232,000 in upstate New York.

Health-care experts say Rochester is one of the few American cities that have systems that work. Although medical costs have also been rising rapidly here in recent years, they are still at least 25 percent lower per capita than national levels. And in Rochester, only 6 percent of the population does not have insurance, according to a survey by Louis Harris & Associates, far below the 14 percent national rate.

By cooperating closely, instead of competing ferociously as they do in most cities, the doctors, the hospitals and the local businesses have kept the quality of care high, with a relatively low level of waste and unnecessary care. The General Accounting Office is preparing a report on the Rochester system for Congress.



Program Called 'a Jewel'

"Rochester is a jewel in a sea of health-care despair," said Stephen Skeete, a Toronto hospital executive who was president for four years of the Rochester Area Hospitals Corporation, a nonprofit planning and research group that the hospitals established.

The Rochester program has served the interests of the city's largest employers, including Eastman Kodak and Xerox, by holding down the growth in costly health-care benefits. But the chief beneficiaries have been the families and small businesses that would typically not have access to affordable care because they were not part of a larger group.

Under the Rochester plan, they pay the same monthly premiums for each person as Kodak and Xerox, for equal benefits. And unlike most health-care plans for small groups, no one pays more or is refused coverage because of age, sex or a previous medical condition.

Doctors and business and hospital executives around the country say one reason the Rochester system works is that local industry, vigorously led by Kodak, which has 39,500 employees here, cooperates closely.

All but a few employers buy their insurance from Rochester Area Blue Cross and an independent health-maintenance organization, instead of following the national pattern of insuring themselves in separate arrangements. This self-insuring can reduce a large company's costs at least [illegible] percent in often increases the bargain for small companies, including those that sell goods and

Rochester's Health-Care System Is Viewed as a Model for Other U.S. Cities

Continued From Page A1

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Doctors, hospitals and businesses cooperate to keep quality high.

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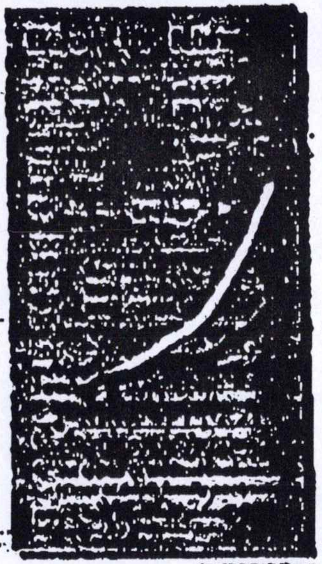

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Doctors Aid in Cost Control

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The New York Times

NEW YORK, THURSDAY, MAY 2, 1991

Seattle Showpiece of Health Care by Democracy

By TIMOTHY EGAN
Special to The New York Times

SEATTLE, May 1 — For a single monthly fee, most members of Group Health Cooperative have access to nearly unlimited medical care. If they live well, without smoking, drinking heavily or becoming overweight, they can pay even less. If they do not like the way their local clinic is being run, they can change it by voting out the management.

Group Health, medical care by democracy, is the nation's largest consumer-governed health care organization, with 470,000 members. One of every eight residents of the Puget Sound area belongs to the cooperative, which is based in Seattle.

As other health maintenance organizations have floundered, or run into financial trouble, Group Health turned a $11 million surplus last year.

'Model of the Future'

With its healthy balance sheet and growing membership, Group Health is attracting national attention. "It's my model of the future," said Dr. Arnold Relman, the former editor of The New England Journal of Medicine.

"With patients right on the board of directors monitoring them, doctors are committed to the highest quality of care," he said. "There's no incentive for doing more tests than indicated, but every incentive to do all that is indicated."

It has taken the cooperative more than 40 years to work out its kinks. The mid-1980's, as health care costs soared far beyond the rate of inflation, were particularly rough.

Group Health keeps costs down by eliminating unnecessary surgery and procedures and by stressing preventive care. "We have tried to get away from the idea that the more surgery you do, the more money you make," said Dr. Phillip M. Nudelman, the president and chief executive of Group Health.

Quality care at a reasonable price is not an impossible dream.

Avoiding Unneeded Surgery

About 30 percent of all surgery in the United States is not needed, Dr. Nudelman contends. On average, he said, the cooperative performs about 40 percent fewer cardiac operations on patients with heart disease than are done in other health systems.

Twice as many Group Health members receive flu immunization shots as the national average. There is an aggressive screening program to detect colon, skin and breast cancer at early stages. The cooperative's program for smokers who want to quit succeeds at a rate twice the national average. Counseling nurses are available 24 hours day by telephone to answer questions.

Complaints About Waiting

Doctors here insist that they do not overcharge their patients. Dr. Nudelman says any procedure that is available, including costly operations like bone marrow and organ transplants, can be had at Group Health, which has 28 medical centers and 3 hospitals in the Northwest. Cosmetic surgery is excluded.

"On a technical and service level, Group Health is as good as anybody," said Dr. Douglas Conrad, an economist at the University of Washington.

Complaints have to do with waiting periods for certain doctors and certain procedures. Group Health has more than 700 staff physicians. Members choose their own doctor, but the more popular ones can be hard to see.

The doctors are paid anywhere from $90,000 to $220,000 a year, said Dr. Nudelman, and the turnover rate is about 3 percent a year, well below the industry average.

Almost all the cooperative's revenue, which totaled $877 million last year, comes from premiums paid by consumers. In the early years most members were self-employed, jobless or could not find affordable medical insurance. Now, about 85 percent of members are on company payrolls, including large corporations like Boeing, with premiums paid by the employer.

Membership in Group Health is slightly more expensive than the local average. A 40-year-old with full coverage will pay about $160 a month, but most members pay no deductibles.

Threat of Rising Cost

The rising price of medical technology and services, though, poses a threat to Group Health's ability to provide top care at low cost. Officers wonder whether the group will always be able to afford the best and newest. But without staying on the cutting edge, it may have trouble attracting new members.

The concept of Group Health may not be easily transplanted. Group Health grew out of a Scandinavian tradition of pooling costs and talent. For this to work elsewhere, said Dr. Nudelman, "there has to be a culture willing to accept something that goes against the grain of most American health care."

The Birmingham News

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