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POST HEALTH CARE SPEECH

RESEARCH

SEPTEMBER 1993

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DATE: September 26, 1993

TO: President Bill Clinton (1)
Vice-President Al Gore (2)
Hillary Rodham Clinton (3)
Mack McLarty (4)
George Stephanopoulos (5)
David Gergen (6)

FROM: Stan Greenberg (7)

RE: HEALTH CARE: THE POST-SPEECH PHASE
Repositioning

The introduction of health care and other events have put the president -- and the First Lady -- in a strong position to carry this fight forward and win. This is a new world from two months ago, with the public more positive about the country, more hopeful and more prepared to trust the president. Partisan emotions have subsided and Perot has weakened, leaving the president greater room to communicate and lead.

Nonetheless, we must step back and completely rethink our communication strategy. We have won the first battle and altered the landscape. Our strategy must reflect what people have learned, the issues they are now grappling with, the new tools and resources at our disposal and the new political realities. The main communication ideas are summarized below:

- The campaign must continue to emphasize "health care security" as the ultimate goal which keeps the debate on our terms.

- The president should concentrate, however, on explaining the plan at a personal level -- how it helps people and promotes the well-being of their families.

- The simple formulation -- preserve what's right and fix what's wrong -- is the clearest way to advance the argument.

- And rather than focus on the simplification-savings-cost nexus (as we have been doing), the president ought to focus on simplification and responsibility, which shows his motivation -- to rein-in an out-of-control system.

This memorandum reflects our post-speech and September surveys and the dial group research. They show a new political world, and we should pay attention to the learning process. Later this week, we will conduct focus groups to test new communication strategies and to advance medium-term planning for the health care initiative.

President Bill Clinton

Bill Clinton has gained steadily in popularity and standing since July. The speech had a powerful impact and helped create a large bloc of strong supporters -- now about a quarter of the electorate. But the president's standing was not created by the speech alone, thus likely represents something more enduring for the longer battle ahead.

- Clinton's thermometer has risen steadily since August 3rd, particularly through September (now at 56 degrees, 50 percent warm and 31 percent cool). The speech took it up 2 degrees but is part of a longer-term trend. That is healthier than the budget speech when all the gains came with that one event. [Graph] The president is approaching post-inauguration popularity levels.

- Clinton's image has a richness to it which, again, transcends the speech. [See the graphs, "Positive Descriptions"] The president made significant gains on being a steady leader (56 percent), on caring about people (63 percent), and on strength before the speech, particularly after RIGO and the Middle East/NAFTA. (Intense positive responses went up after the speech.) The speech itself produced gains in two of the most important areas -- keeping promises (42 percent, up 6 points) and makes me feel confident (50 percent, up 5 points) -- that, in the past, proved intractable.

- There is more positive feeling around the president: 57 percent are now "hopeful" -- a 20 point advantage over "doubtful"; in August, the advantage was only 5 points. The mood of the country is growing more optimistic -- with "wrong track" down 13 points since July. The mood today (36 percent right direction and 50 percent wrong track) resembles March.

- With the decline of partisan battle, Clinton has re-emerged as a different kind-of-Democrat: 53 percent, up 6 points after the speech. Only 39 percent describe him as a "typical Democrat," comparable to the levels apparent in April.

Spokespersons: Hillary Rodham Clinton

The campaign now has two powerful proponents of health care reform -- and we must rethink what they can best communicate in this period.

The president's job performance on health care has reached 60 percent (including 24 percent, strongly approve) -- up 8 points after the speech. A striking 57 percent describe the president as "courageous" for taking on this issue.

Positive feelings about the First Lady have moved up sharply in September, particularly after the health care address (now, 54 degrees). This is inauguration level, and puts the First Lady in a strong, credible position to communicate about the initiative. Her standing is very high with the undecided-target electorate (59 degrees) and with the weak supporters of the plan (60 degrees).

Hillary Rodham Clinton has reached this new standing largely because of gains amongst men. Here, her thermometer has risen from 43 degrees at Labor Day, to 46 degrees before the speech and to 52 degrees afterwards. That represents a jump from 31 percent with warm feelings (above 50 degrees) to 44 degrees now. She has also made gains amongst women, but particularly homemakers (warm feelings up from 29 to 48 percent). She has made a big impression on swing segments -- the largely disaffected post high school voters (up from 36 to 50 percent) and independents (from 35 to 51 percent).

The Health Care Plan

The president and First Lady have gained as leaders as the health care program was launched. The health care plan itself is another matter. The public is very supportive and hopeful but also cautious and looking anxiously for more information. At the moment, there is 2-to-1 support, and 59 percent say it is "worth the risk."

While support is positive, it is not overwhelming, as a number of unanswered questions create uncertainty and tentativeness.

- Opposition to the plan is on the defensive, with only 27 percent opposed -- down 4 points after the speech and 9 points since August. Strong opponents form only 13 percent of the electorate and are outnumbered by 2-to-1 by strong proponents. That will affect the debate at the peer group level over the next weeks and should allow the administration a fair hearing.

- Support level is modest (53 percent), largely because of the large undecided bloc -- 19 percent and undiminished by the speech. The undecided bloc, we shall see below, contains a number of segments: those uncertain how it will affect them and those (particularly non-college women) who did not watch the speech and who have very little information.

- The health care debate has lost its partisan character. Party identification is one of the weakest predictors of how people feel about the health care plan (regression analysis) which is reflected in the support across the party spectrum: 45 percent plurality support among moderate Republicans, but even 29 percent among conservative Republicans; one-third of Bush voters; and 48 percent (to only 29 percent opposed) among Perot voters. We shall see below that one-quarter of the undecided on the program are Republican women. It is clearly in our interest to preserve this tone and to make it easy for Republicans to cross this threshold.

- There is a broad consensus (68 percent) that Congress should take its time and deliberate; indeed, support for caution, over passage as soon as possible, has grown 8 points since the speech.

Communication: Successes and Failures

The initiative and address have communicated a lot about Bill and Hillary Clinton, putting them in a position to advance the plan. Trust levels are sufficiently high that 59 percent now say, "it is worth the risk" (up 9 points), even though many questions remain unanswered.

Our communication successes are most evident on promoting responsibility (up 13 points), security-coverage (up 9 points) and quality (up 7 points). Our communication is successfully communicating the values that underlie our efforts, the commitment to security and the comprehensive benefit package.

There has been moderate success on simplification (up 4 points) and maintaining choice (up 4 points) which is something of a triumph, given the predisposition to believe that government will only create more bureaucracy and place restrictions on doctors. We made little head-way on the economy or small business (up 2 points).

It is critical that we re-assess our communication on cost, savings and taxes. Despite a monumental effort by the president, we have lost ground: health reform financed by savings (down 2 points) and lower costs to the individual (down 6 points). An astonishing 70 percent believe new taxes will be required (up 4 points after the speech); and by 51 to 29 percent, people believe they will be paying higher costs. Frankly, our believability and effectiveness on security and quality runs smack into our believability on savings and cost. Health care reform, with an enhanced benefit package and coverage for all, just cannot cost less. (It is something like selling deficit reduction and new spending at the same time.)

We must carefully reassess the communication focus and priority of the president in the weeks ahead. In the section below, we suggest alternative priorities -- allowing the financing and cost issues to be addressed by the First Lady in her testimony and by a much more aggressive effort by various validators.

Communication Priorities

The president has spent most of his time in recent days talking about simplification and savings and answering a broad range of detailed questions. He should probably give his priority, instead, to three communication activities: first, keeping the plan's principal goal, health care security, before the public; second, explaining the plan at a personal level to show how people will be helped (i.e., their well-being advanced); and third, emphasizing simplification and responsibility to demonstrate his motivation and commitment to rein-in an out-of-control system.

Voters are making a basic and very personal assessment of the Clinton health care proposals. By 43 to 27 percent, people believe the proposal will be helpful to their families, though 27 percent do not know. That simple, personal and summary assessment (help or hurt your family) is the dominant determinant of how people feel about the health care program. The regression analysis sets out the statistical dominance of personal assessment.

EXPLAINING SUPPORT FOR HEALTH CARE REFORM
Regression Analysis
(61 percent of the variance)

Variable	T-Score	Significance
Very significant		
1. Help/hurt family	11.0	.000
2. Simply/bureaucracy	6.0	.000
3. Quality/decline	5.1	.000

Significant

4. Responsibility	3.8	.000

Not very significant

5. Paid with savings/tax	2.0	.044
6. Doctor choice	1.9	.054

No significance

7. Cost more/less	.3	.757
8. More/less covered	-1.8	.070

The campaign for health care reform must give its highest priority to explaining how the Clinton plan will work and how it will help people at a personal level. This is not about personal costs or systemic financing issues -- neither of which score very high in importance. This is about personal well-being. The President and First Lady must use their communication opportunities to explain the plan at a personal level. (I will explore this whole question in focus groups this week.)

The most important predictors of feeling that the plan will help or hurt at a personal level are set out below, based, again, on a regression analysis:

Variable	T-Score	Significance
1. Quality/decline	6.0	.000
2. Help/hurt economy	5.9	.000
3. Doctor choice	4.7	.000
4. Cost more/less	3.5	.001
5. Lose coverage	2.8	.005
6. More/less covered	2.5	.012
7. Paid with savings/tax	-.8	.430

To re-assure voters that the plan will help them, it is important to show that health care quality, jobs and doctor choice will be preserved. How the plan is paid for -- with savings or taxes -- is just not very important to this assessment.

We asked voters what they most wanted to know about the plan, and many mentioned cost: overall cost and where the money will come from (20 percent) and personal cost (7 percent). But that is dominated by hundreds of little questions about how the plan will affect people: need more specifics in general (15 percent) and questions about a range of micro-specifics, such as keeping one's doctor, affect on small businesses, range of coverage, affect on Medicare and more (23 percent).

We may want to recast the campaign around the simple formulation posed in the speech and radio address: preserving and strengthening what is good and fixing what is broken. That formulation addresses directly the question of personal well-being. In the dial groups, the formulation as set out below (minutes 6-8 of the speech), brought the biggest gains of all among both Clinton and Perot voters:

> This story speaks for millions of others. And from them we have learned a powerful truth. We have to preserve and strengthen what is right with the health care system, but we have got to fix what is wrong with it.

Perot voters watching the speech and hearing this paragraph moved their dials from around 50 up to 70 degrees; Clinton voters took them up from around 65 to 78.

The first regression analysis also underscores the importance of two other themes already emphasized and advanced by the president -- simplification and responsibility. In an important sense they provide the cost answer, rather than the specific discussion of personal cost and systemic financing. By emphasizing simplification and responsibility, the president shows that he is trying to rein-in a system that is out of control and bring to bear the value of responsibility.

In the 36-38 minute segment of the speech, the president delivered the responsibility message which drove both Clinton and Perot voters up on their dials. Both groups responded to the populist side: "responsibility means insurance companies should no longer be allowed to cast people aside when they get sick." The further hit on drug companies moved Clinton voters over 80 degrees on their dials. The Perot voters, however, responded alone and strongly to the personal responsibility message: "In short, responsibility should apply to anybody who abuses this system and drives up the cost for honest, hard-working citizens and undermines confidence in the honest, gifted health care providers we have."

The Swing Bloc: Targeting the Health Care Initiative

The bloc of voters who are uncertain about the Clinton plan (19 percent) include a number of segments. There is a know-nothing bloc that comprises almost half the undecided. They are undecided about the plan and do not know what affect it will have in any area, from cost to doctor choice. These voters are disproportionately Republican (53 percent), and 78 percent did not watch the president's address.

There is another bloc of uncertain voters who respond positively to at least two of the ten possible consequences of the health care plan -- e.g., lower cost, help one's family or reduce bureaucracy. These are our target-swing voters -- the people who are undecided but who are positively predisposed to the president's efforts. To increase support for the program, our efforts must reach these voters.

- The target voters are largely independents and Republicans (61 percent); three-quarters are self-described moderates or conservatives -- suggesting the importance of bi-partisanship in our efforts to expand support.

- The target voters are overwhelmingly women (66 percent), particularly non-college women (48 percent); 36 percent are homemakers or retired women. It is critical that the health care initiative move to highlight the importance of reform for women, families and children. Perhaps it is time to downplay the choice issue; perhaps it is time to organize our own bi-partisan, pro-choice/pro-life women's initiative on behalf of health care reform.

- Two-thirds of these target voters did not see the president's address. We must re-organize our communication efforts to reach non-college women. It is time to revisit day-time TV and women's work sites.

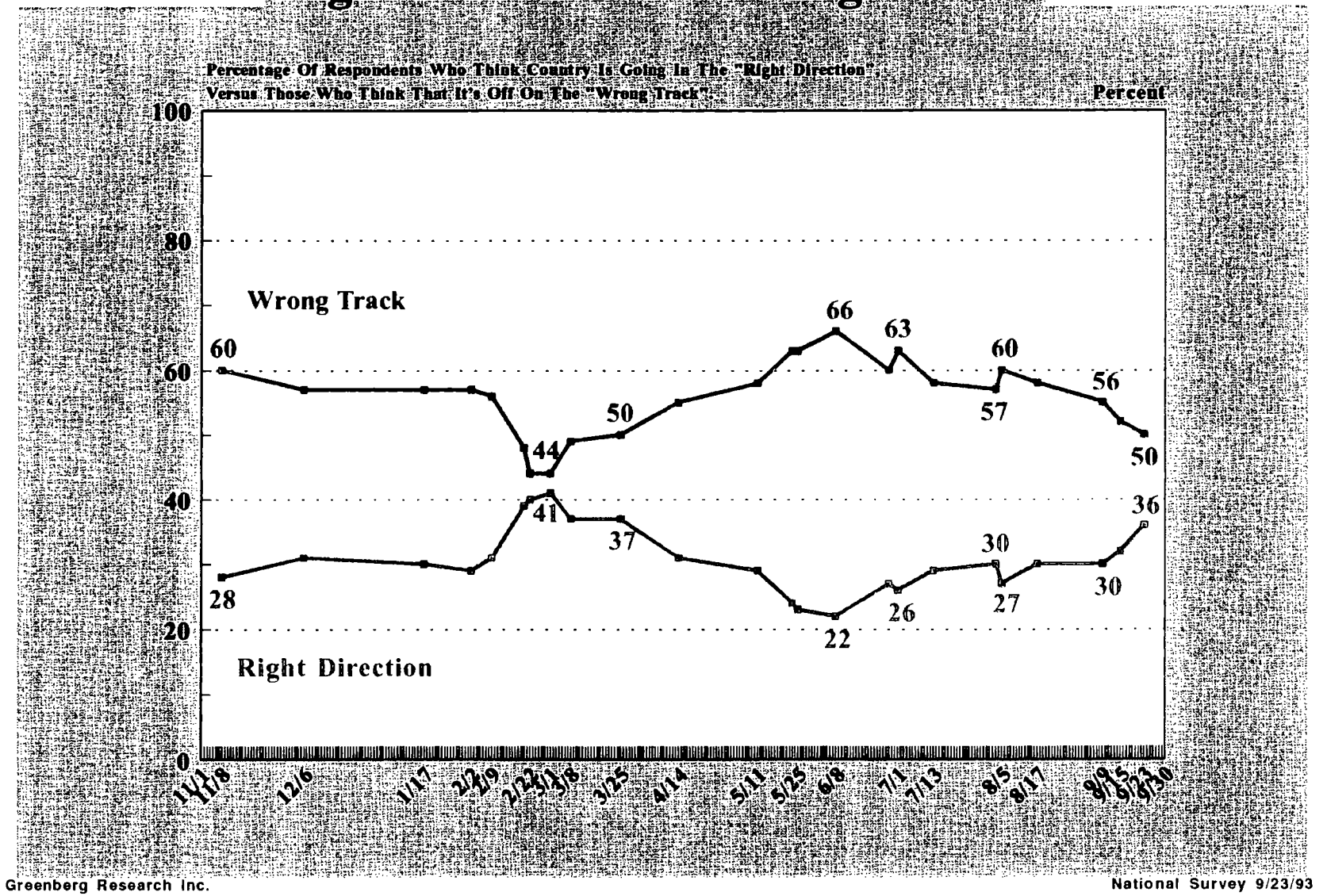
- Over a third of the targets (35 percent) are retired (men and women). We must continue to reassure seniors who make up a disproportionate share of the undecided. A quarter of the targets are in union households who are uncertain about the plan's impact on them. (In the overall sample, support for the plan dropped among union members.)

- These target voters are most pre-disposed to Clinton's efforts to advance responsibility (57 percent), maintain quality (55 percent), the right to choose (50 percent), and insurance coverage (50 percent). Their biggest uncertainty is on the personal question: will this help or hurt my family (40 percent do not know).

(This targeting exercise depends on a fairly small sample which will be enlarged once we have conducted a number of follow-up surveys on health care.)

cc: Mandy Grunwald (8)
Paul Begala (9)
James Carville
Ira Magaziner (10)
Maggie Williams (11)
Mark Gearan (12)
Roy Neel (13)
David Wilhelm (14)
Dick Celeste (15)

Right Direction Or Wrong Track?



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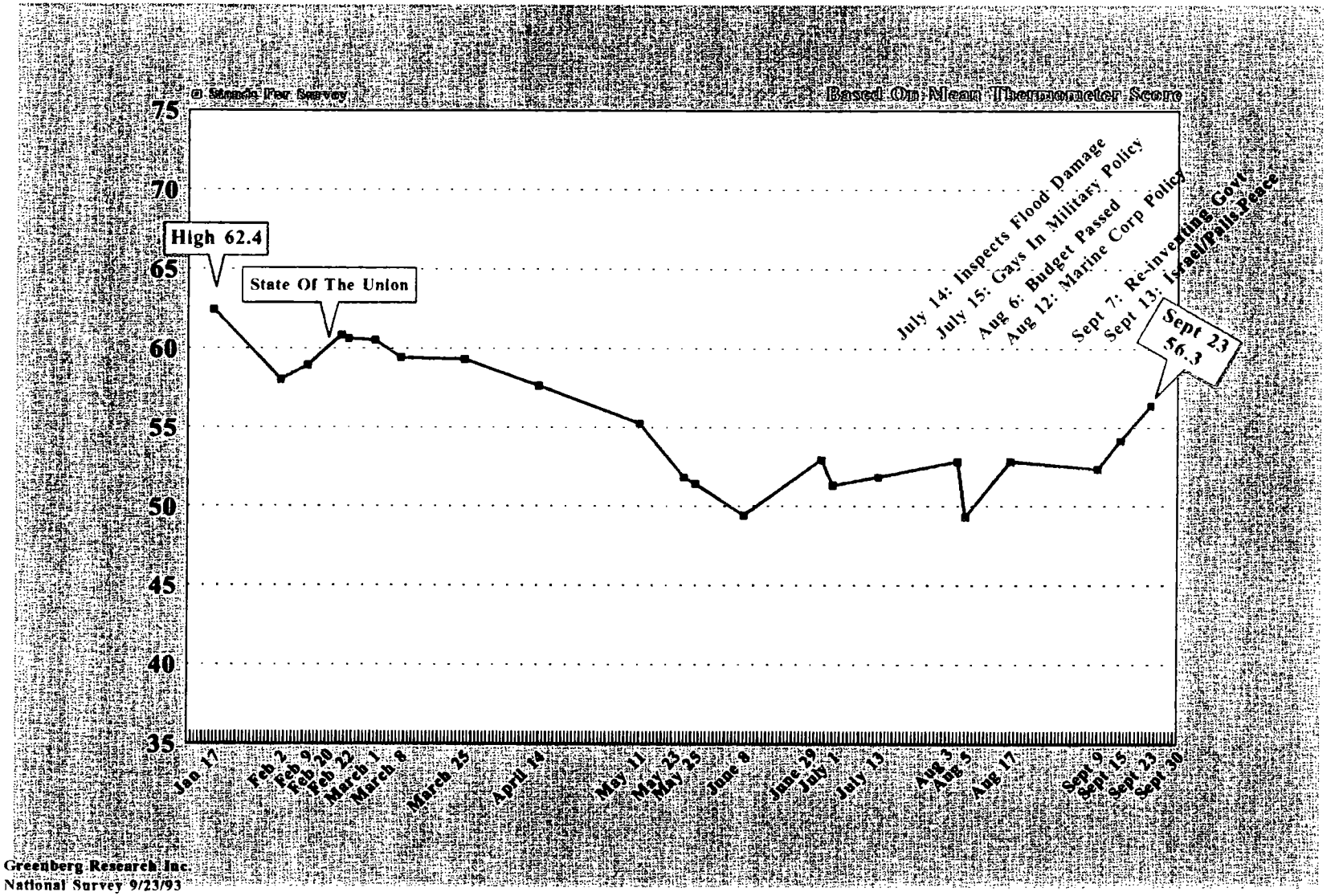
Clinton Favorability



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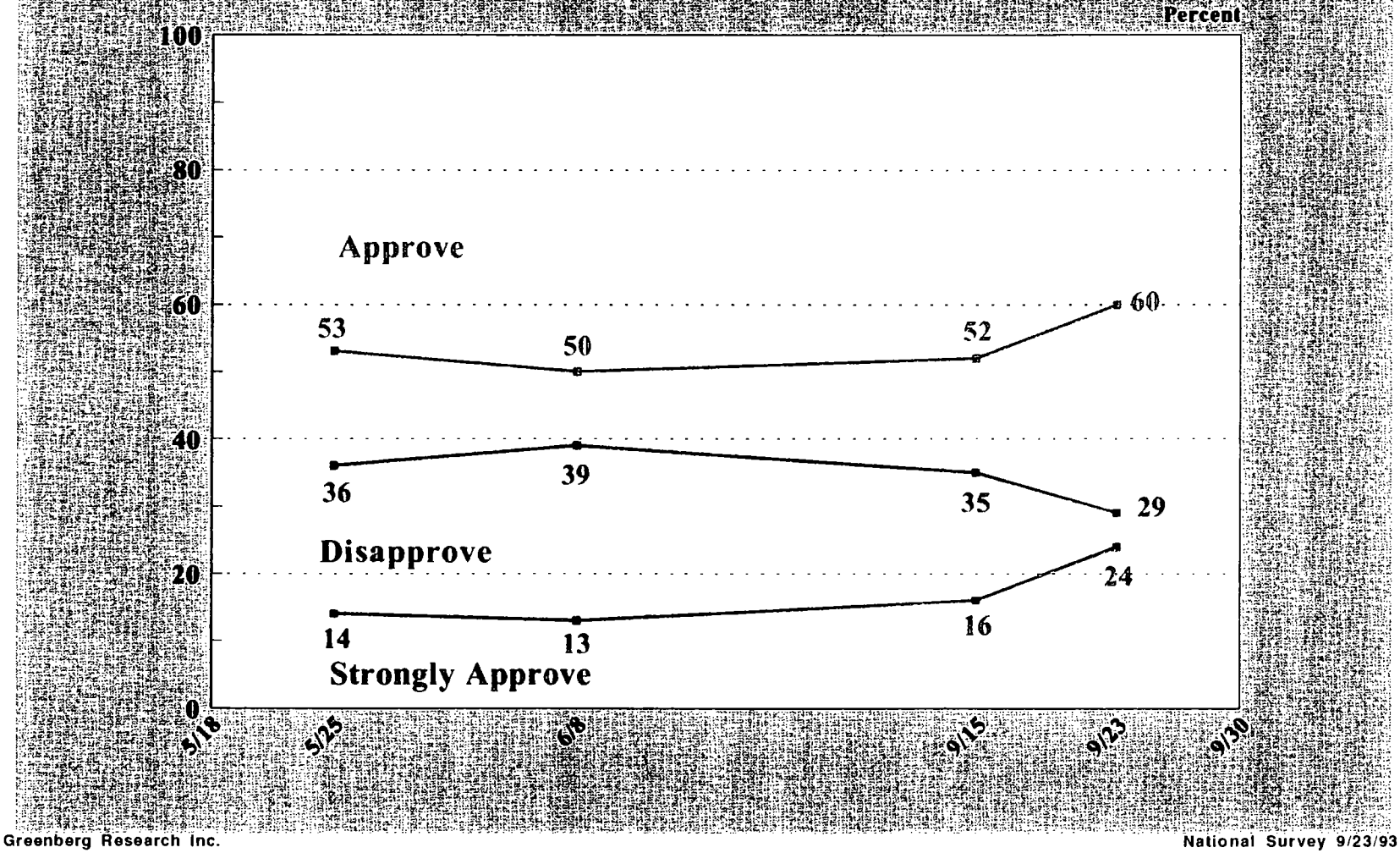
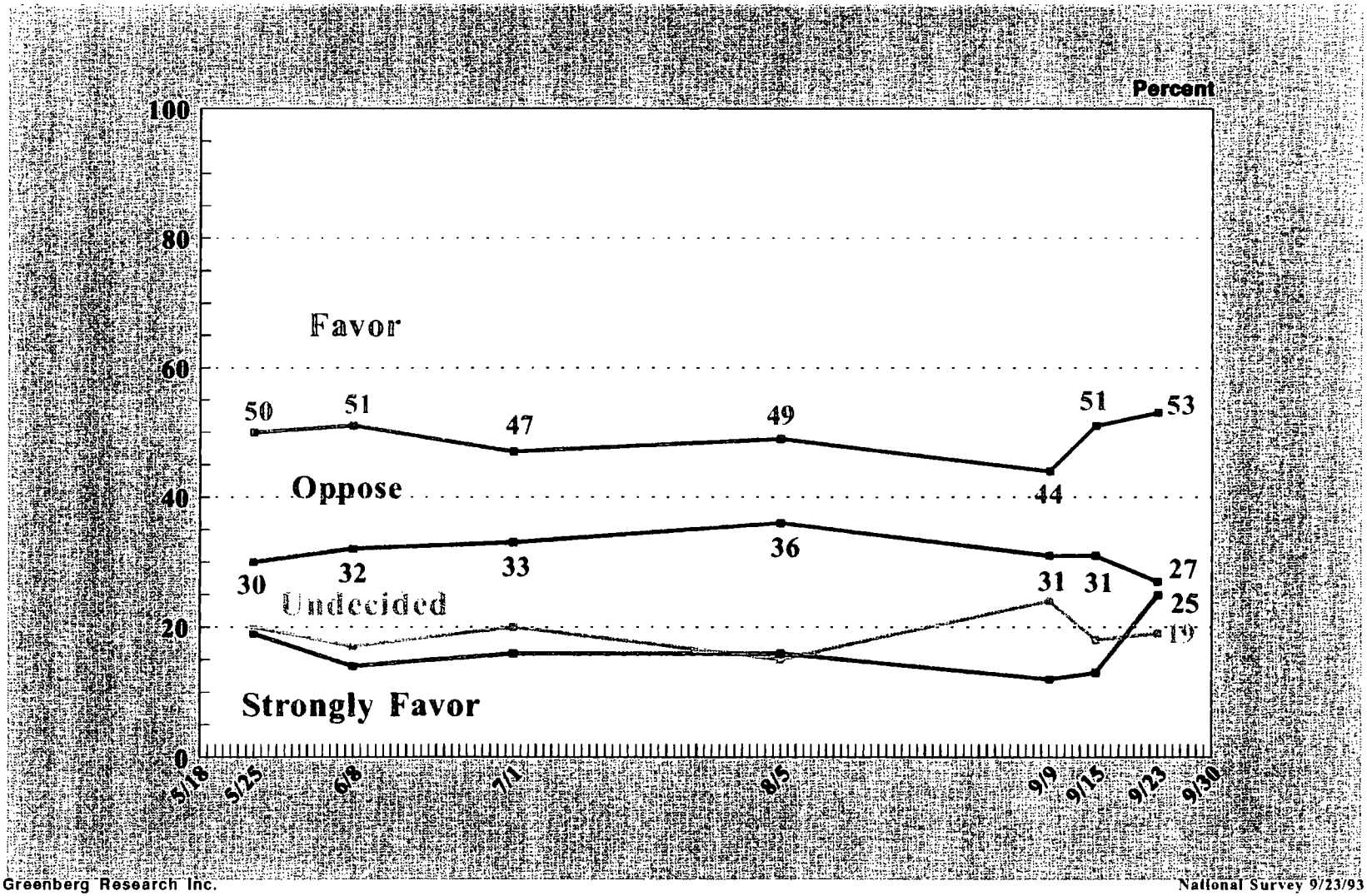
Clinton Job Approval Regarding Health Care

Do You Approve Or Disapprove Of The Way President Clinton Is Handling Health Care?



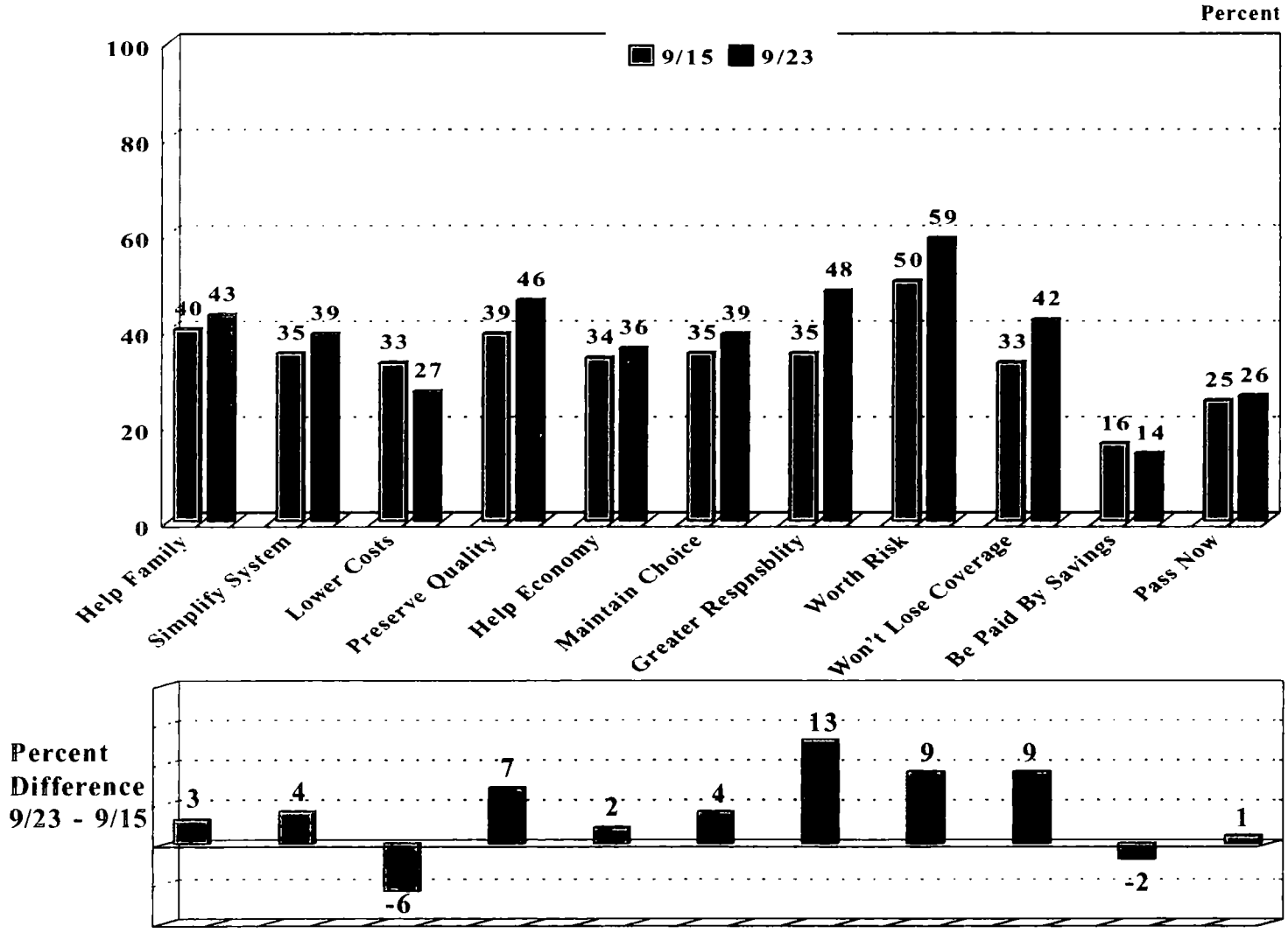
Clinton's Health Care Program

Do You Favor Or Oppose Clinton's Health Care Program?



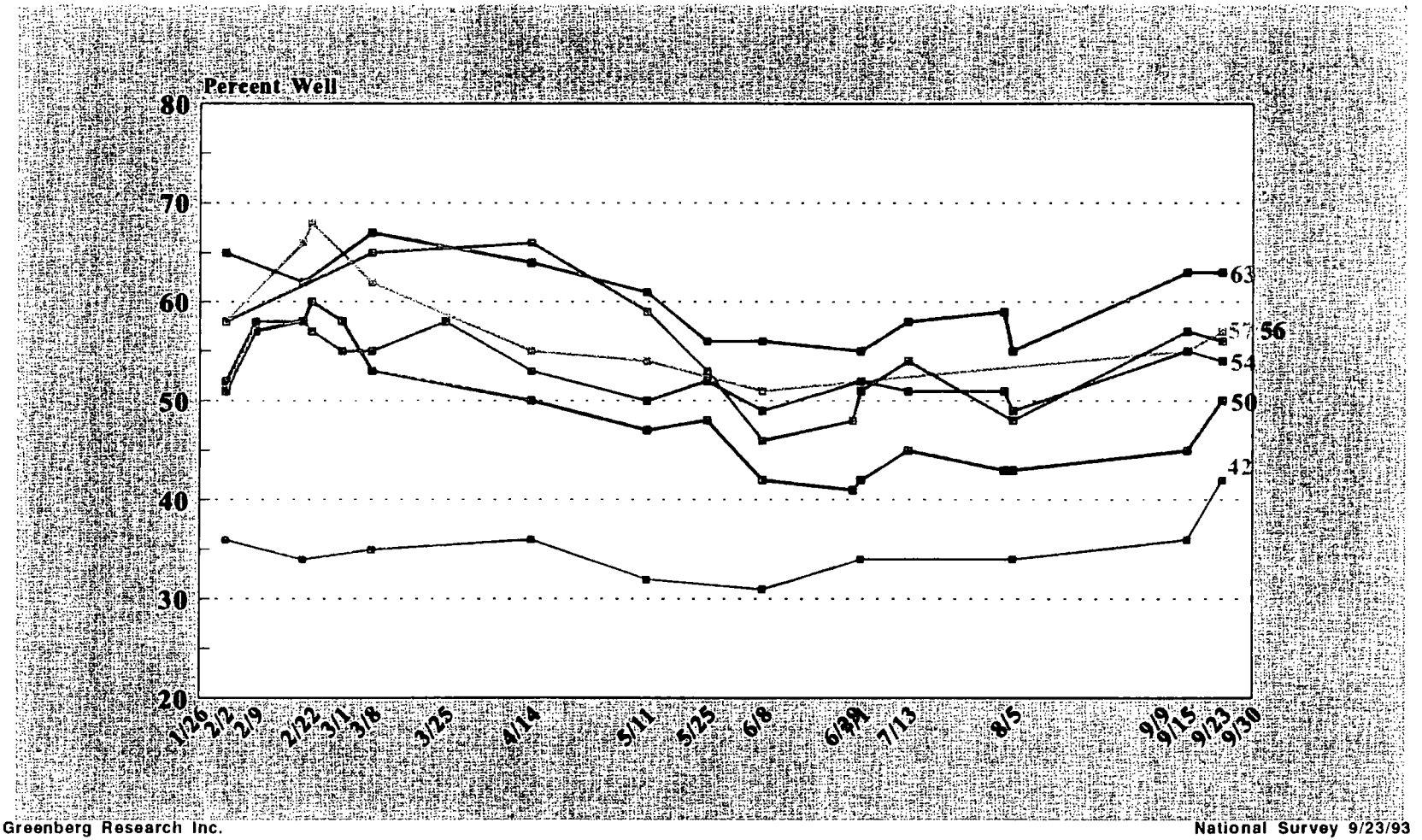
Proposal Impact

Do You Think Clinton's Health Care Program Will/Is/Means...?

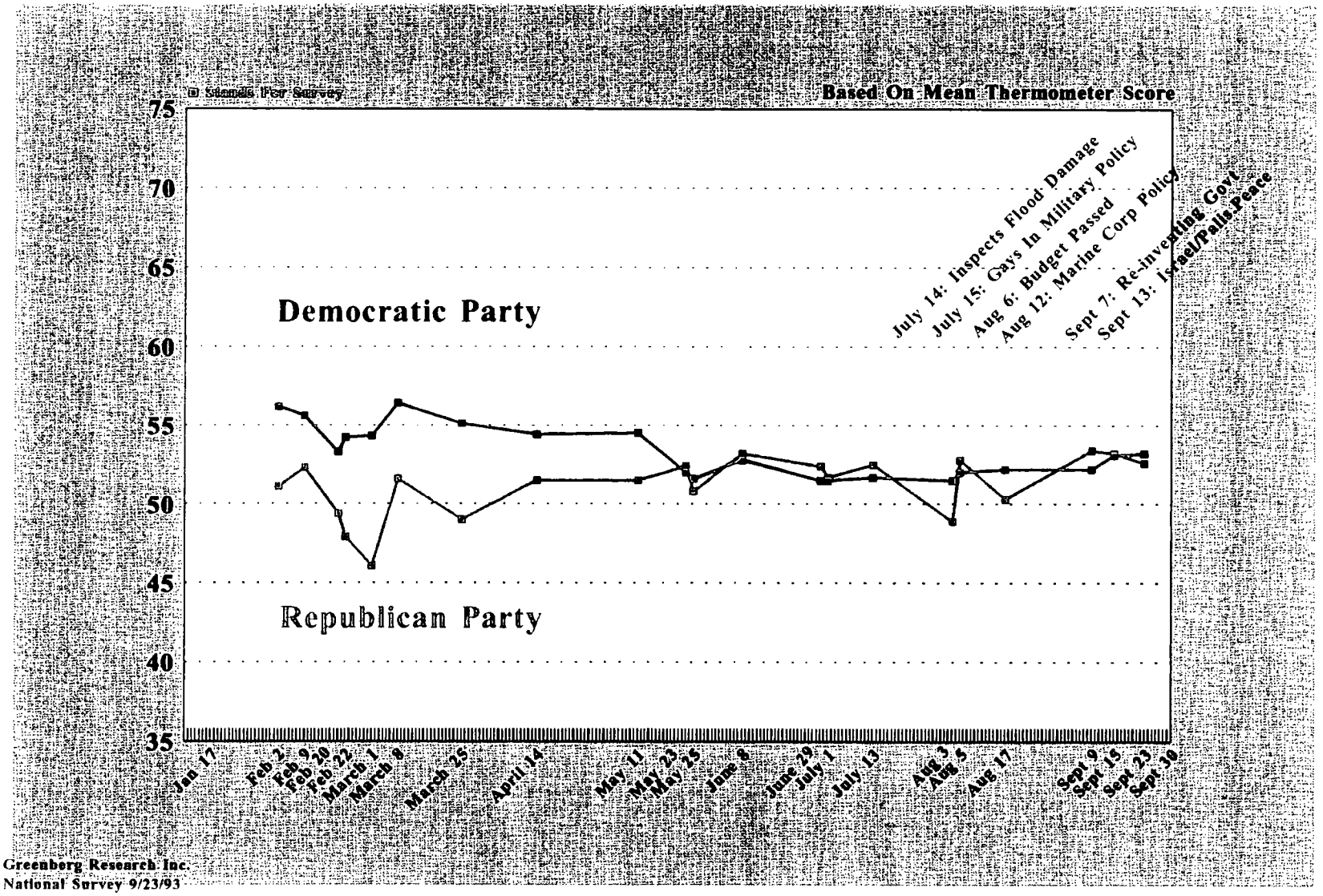


Positive Descriptions

Does The Word/Phrase Describe Clinton Well?



Democrat/Republican Favorability



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HIGHLIGHTS

THE HEALTH CARE ADDRESS

September 22, 1993

The core message of the address produced a powerful response at a number of points:

- "Preserve and strengthen" what is "right" and "fix" what is "wrong" produces a strong response from both Perot and Clinton voters -- the first major lift of the speech. **[Minutes 6-8]**

- "With this card" -- followed by the sequence, "you're covered." This produces one of the steepest responses by Perot voters which takes them up to the level of Clinton voters for the first time. **[Minutes 14-16]**

- Responsibility, led by the critique of insurance companies -- "responsibility means insurance companies should no longer be allowed to cast people aside when they get sick" -- pushes up both Clinton and Perot voters. With the "drug companies," Clinton voters go even higher. Perot voters respond strongly to individual responsibility, "anybody who abuses the system." **[Minutes 36-38]**

- Preventive care -- "a broad range ...,including regular check-ups and well-baby visits" -- pushes both Clinton and Perot voters up steeply. **[Minutes 16-18]**

The Clinton voters, listening to the address, respond uniquely to a number of elements in the speech, distinguishing them from the Perot voters:

- Clinton voters respond more immediately to the health security message -- "giving every American health security that can never be taken away." **[Minutes 2-4]**

- Clinton voters respond to the comprehensive benefit package and the listing of benefits: "hospital care, doctor visits. ..."**[Minutes 14-16]**

- Clinton voters respond strongly to "teenagers" with "automatic weapons"; Perot voters respond, though not nearly as strongly. **[Minutes 36-38]**

Perot voters seem drawn, in particular, to action-oriented segments of the speech:

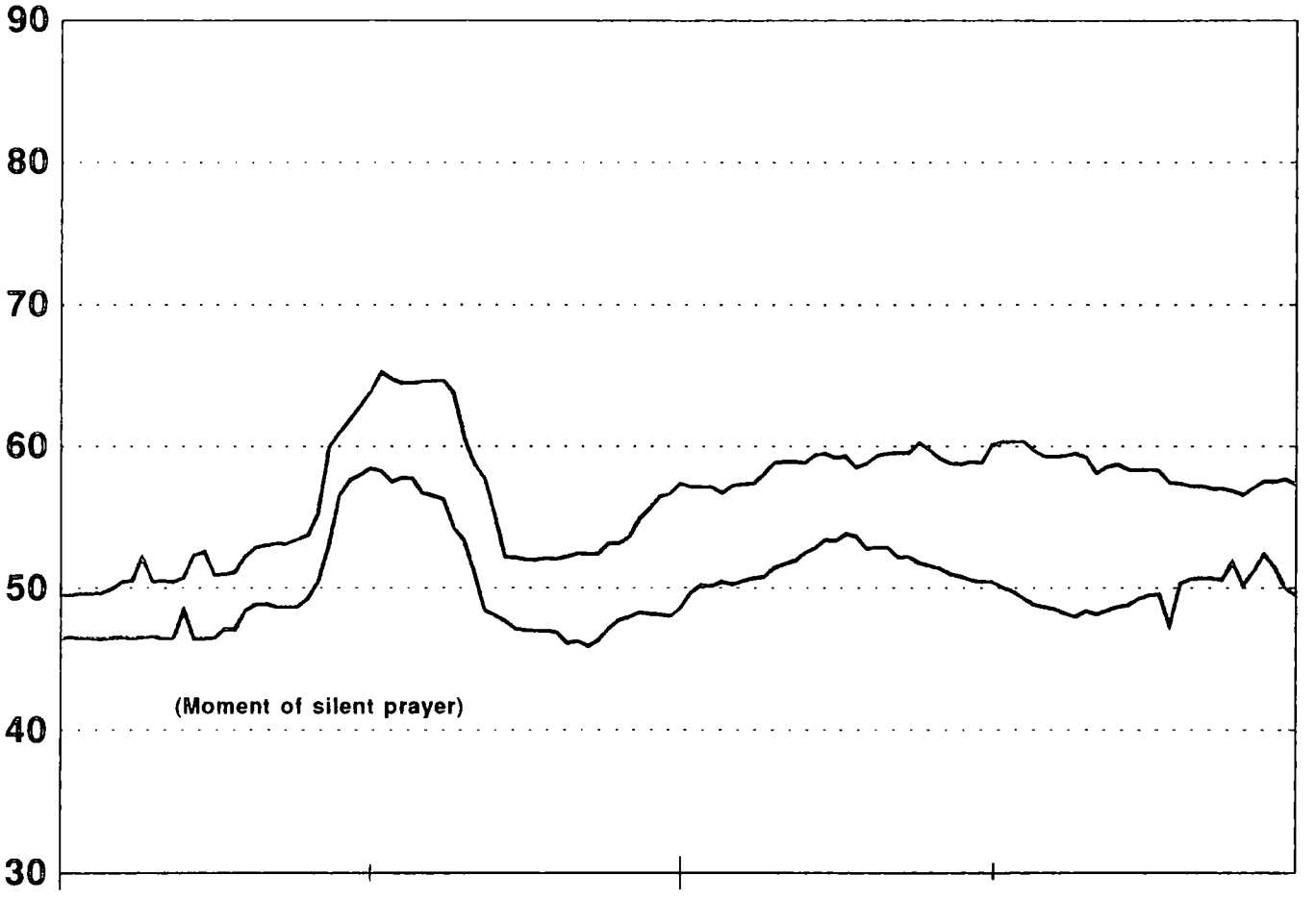
- Health care system is "broken" and "it is time to fix it." **[Minutes 2-4]**
- We "must fix this system, and it has to begin with congressional action." **[Minutes 8-10]**
- "Let us keep this commitment until the job is done." **[Minutes 12-14]**
- The nation cannot be "powerless to confront this crisis." **[Minutes 48-50]**

Perot voters also respond to the fraud and abuse segment which is no great surprise. **[Minutes 2-4]** There are other areas of response that are perhaps less predictable:

- Perot voters respond positively to helping seniors and protecting Medicare. **[Minutes 16-18]**
- There is some response among Perot voters to enhancing America's competitiveness. **[Minutes 24-26]**

Clinton Health Care Speech

9/22/93 0-2 Minutes



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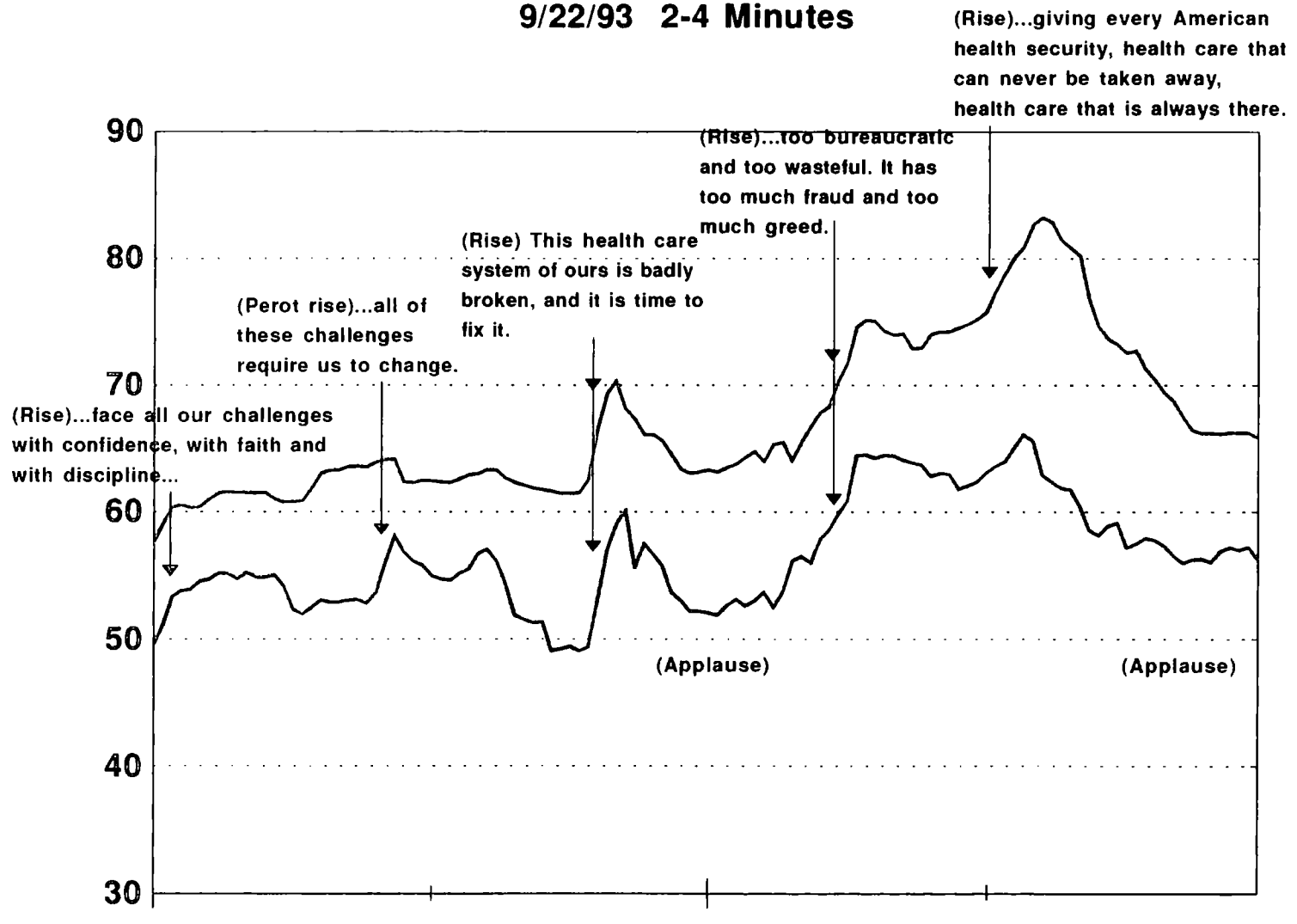
Clinton Health Care Speech

9/22/93 2-4 Minutes



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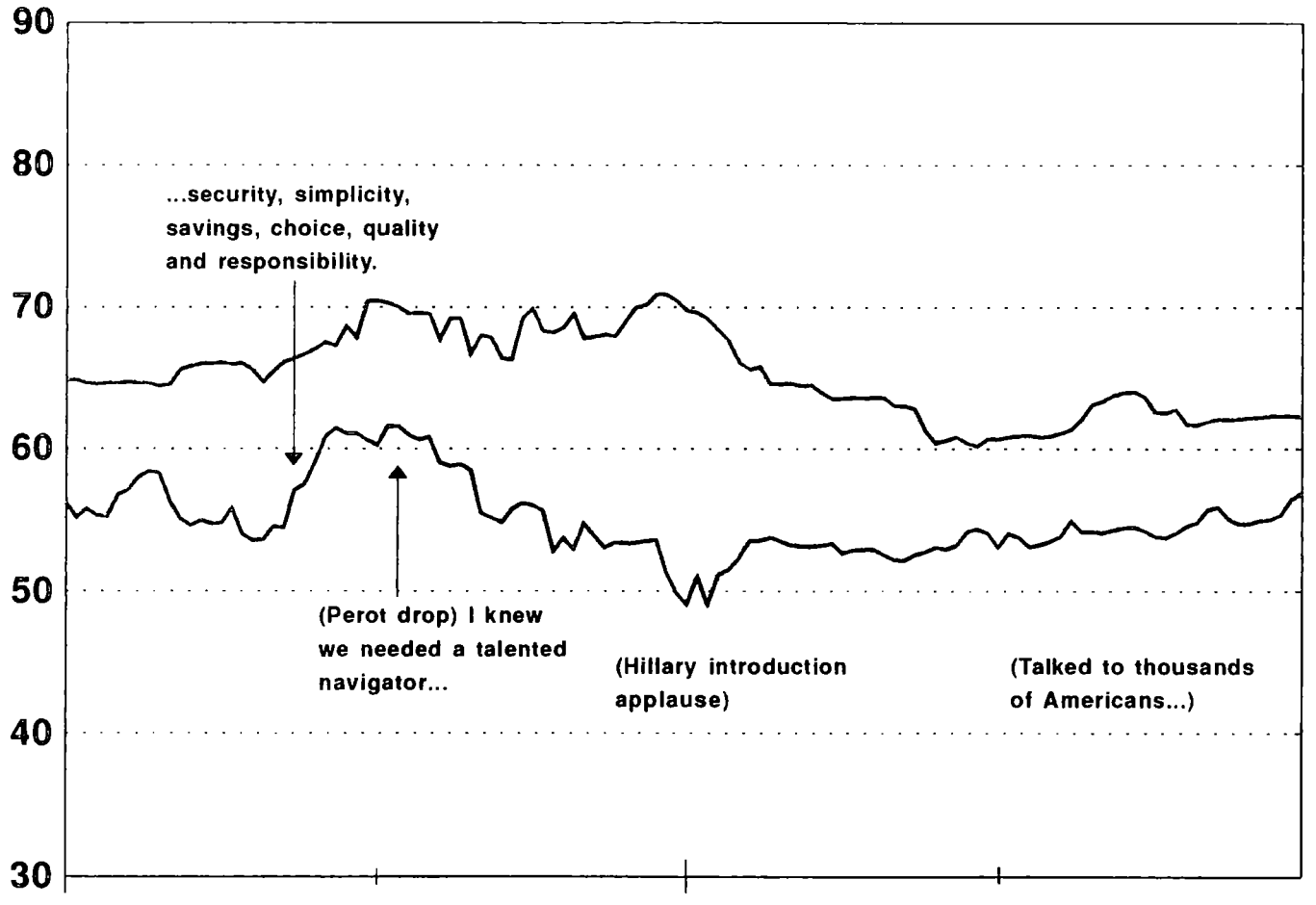
Clinton Health Care Speech

9/22/93 4-6 Minutes



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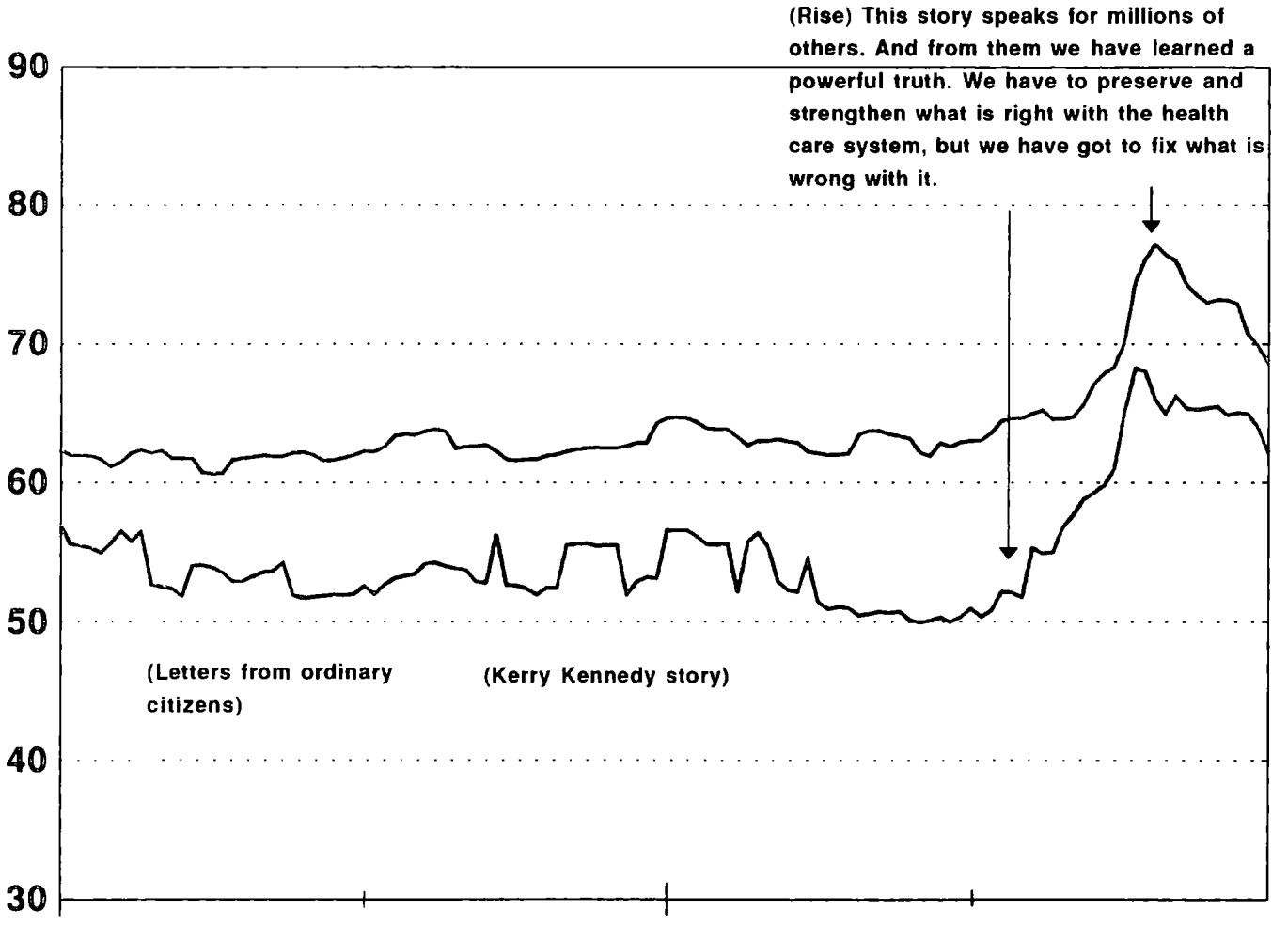
Clinton Health Care Speech

9/22/93 6-8 Minutes



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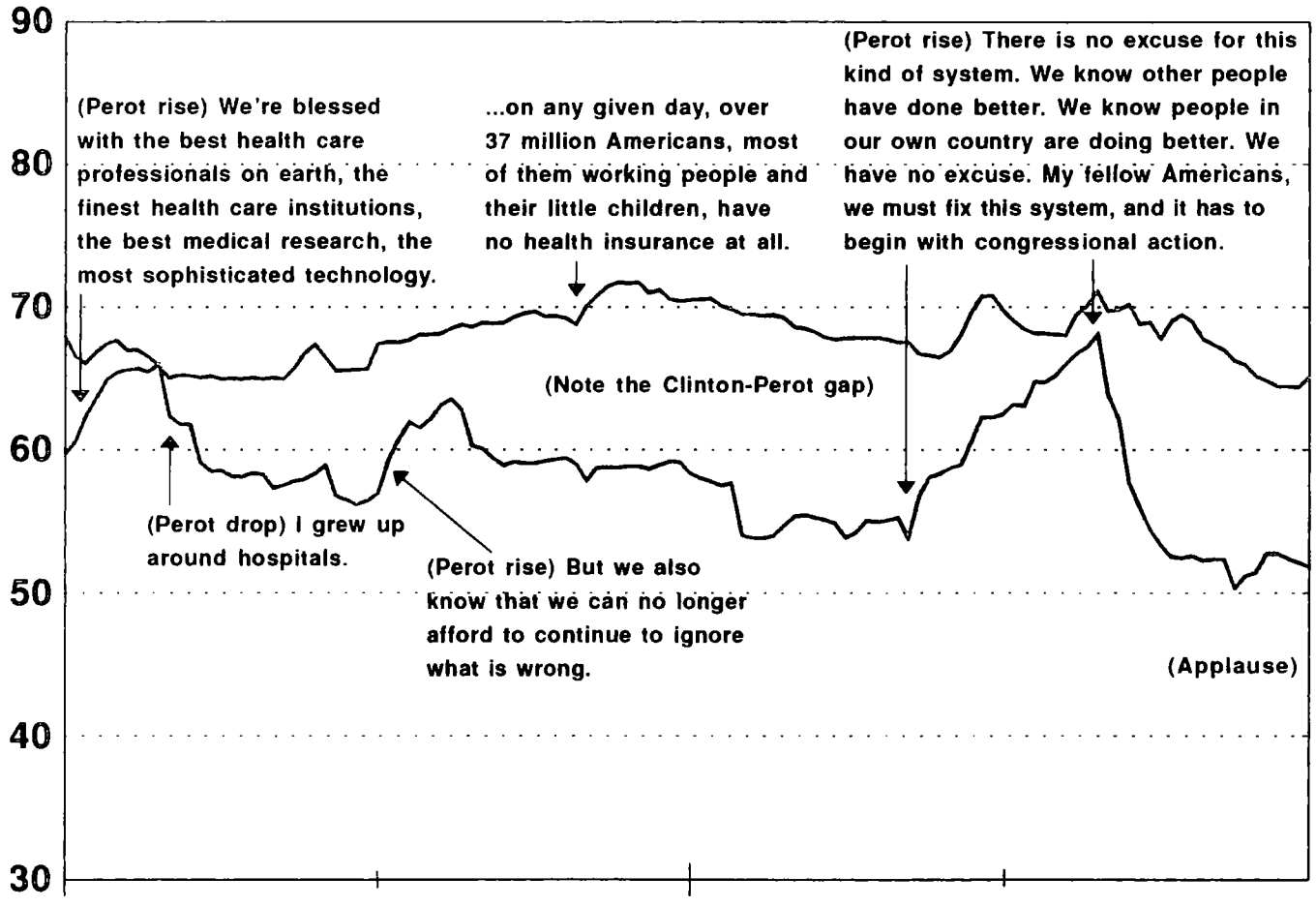
Clinton Health Care Speech

9/22/93 8-10 Minutes



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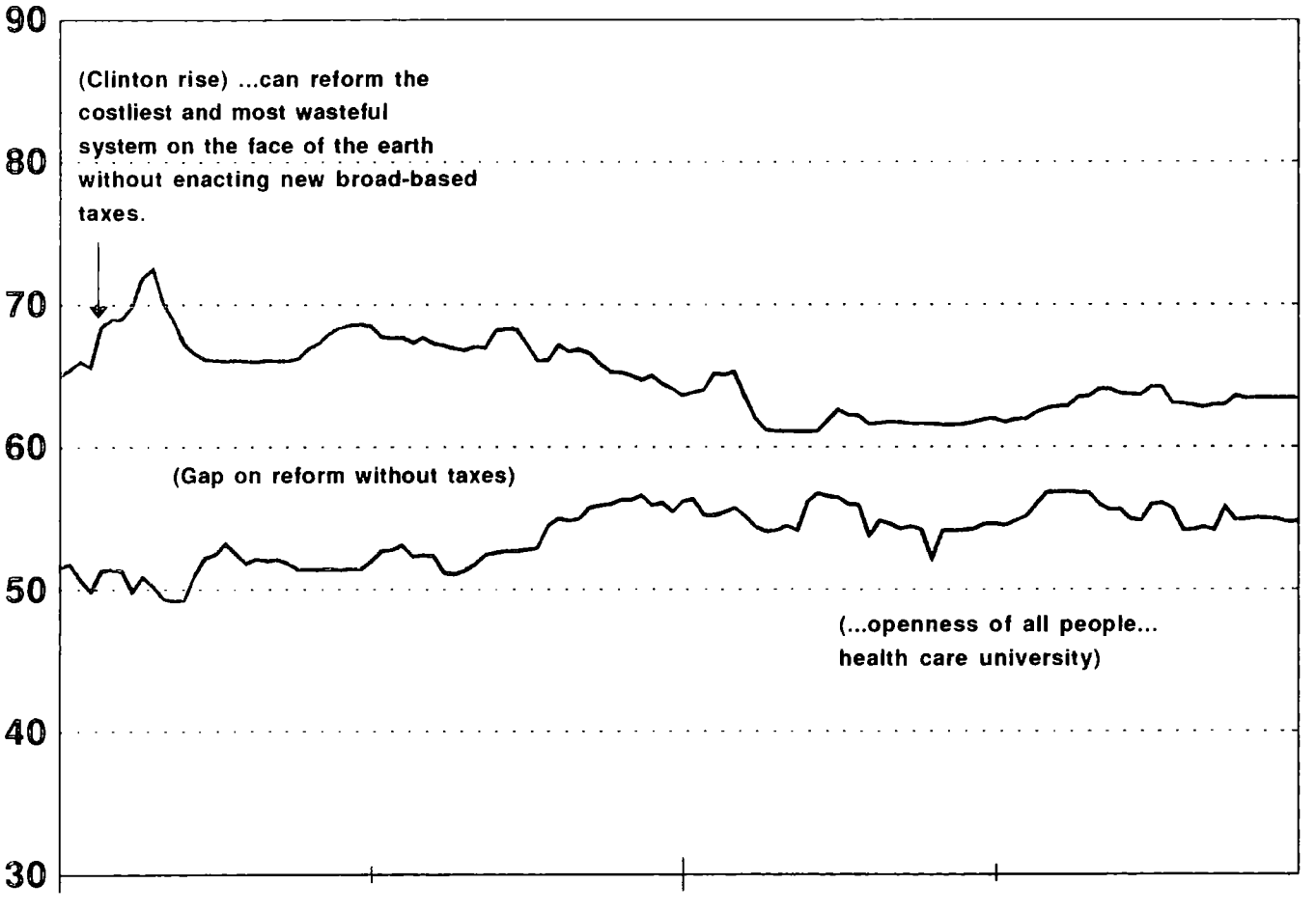
Clinton Health Care Speech

9/22/93 10-12 Minutes



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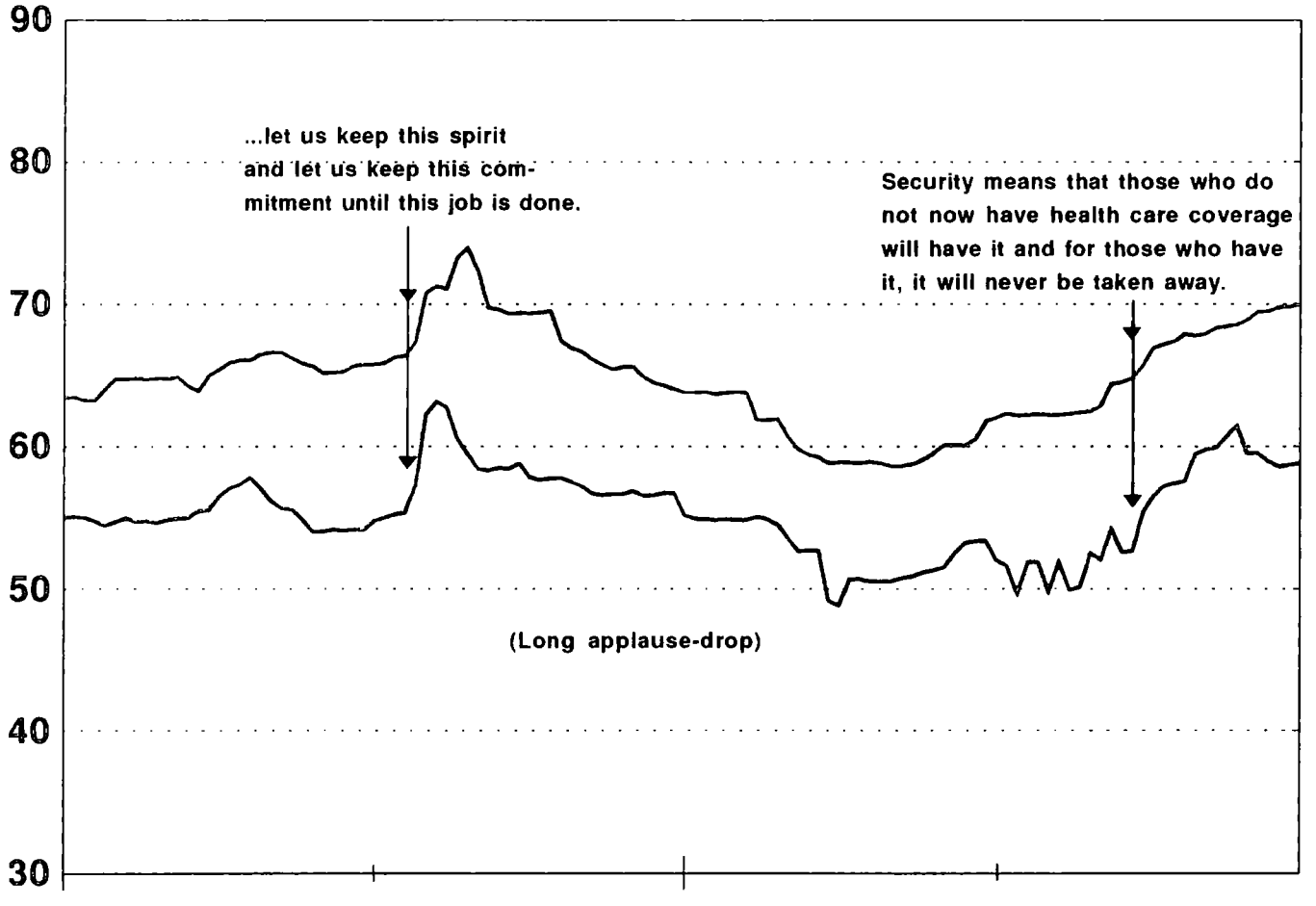
Clinton Health Care Speech

9/22/93 12-14 Minutes



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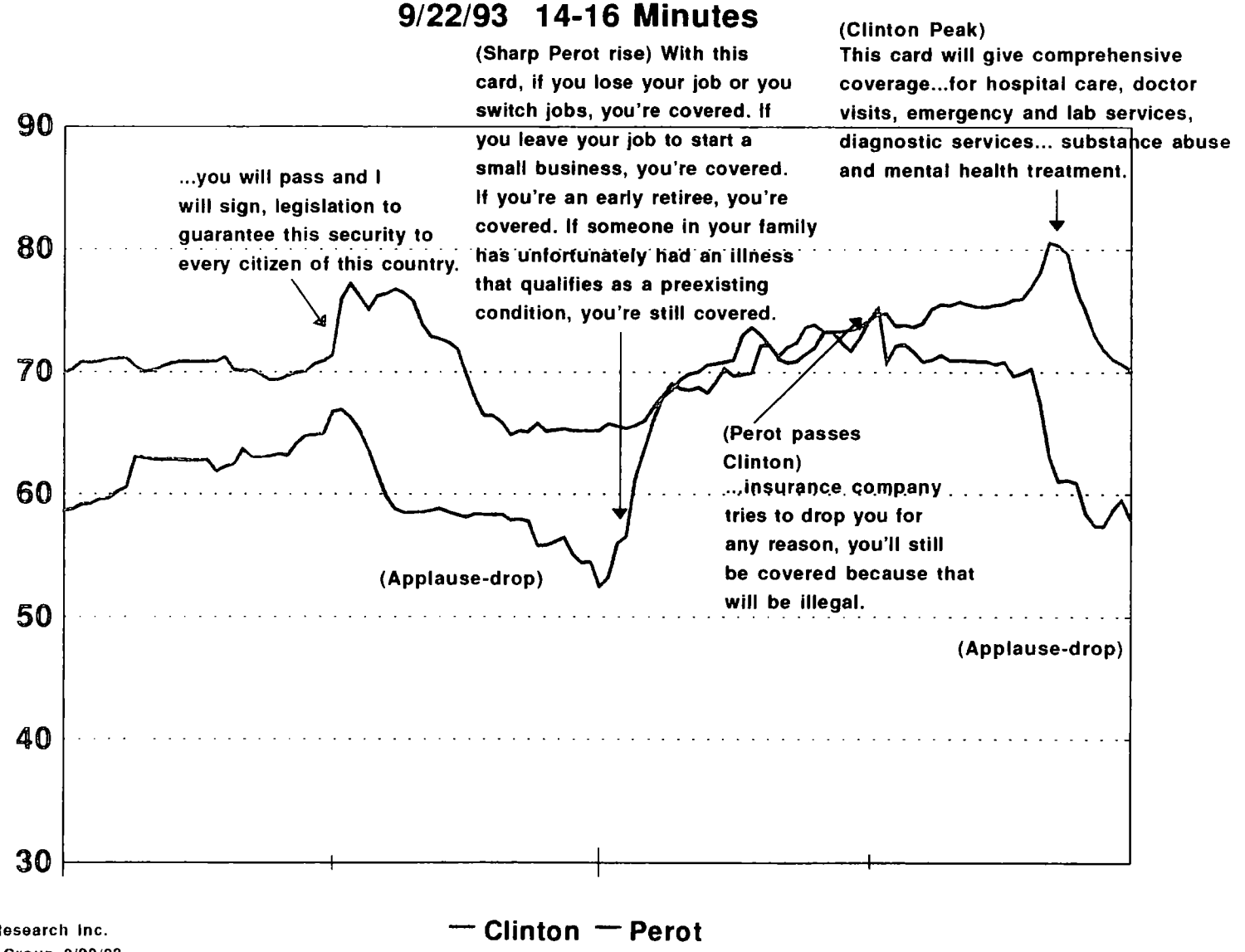
Clinton Health Care Speech

9/22/93 14-16 Minutes



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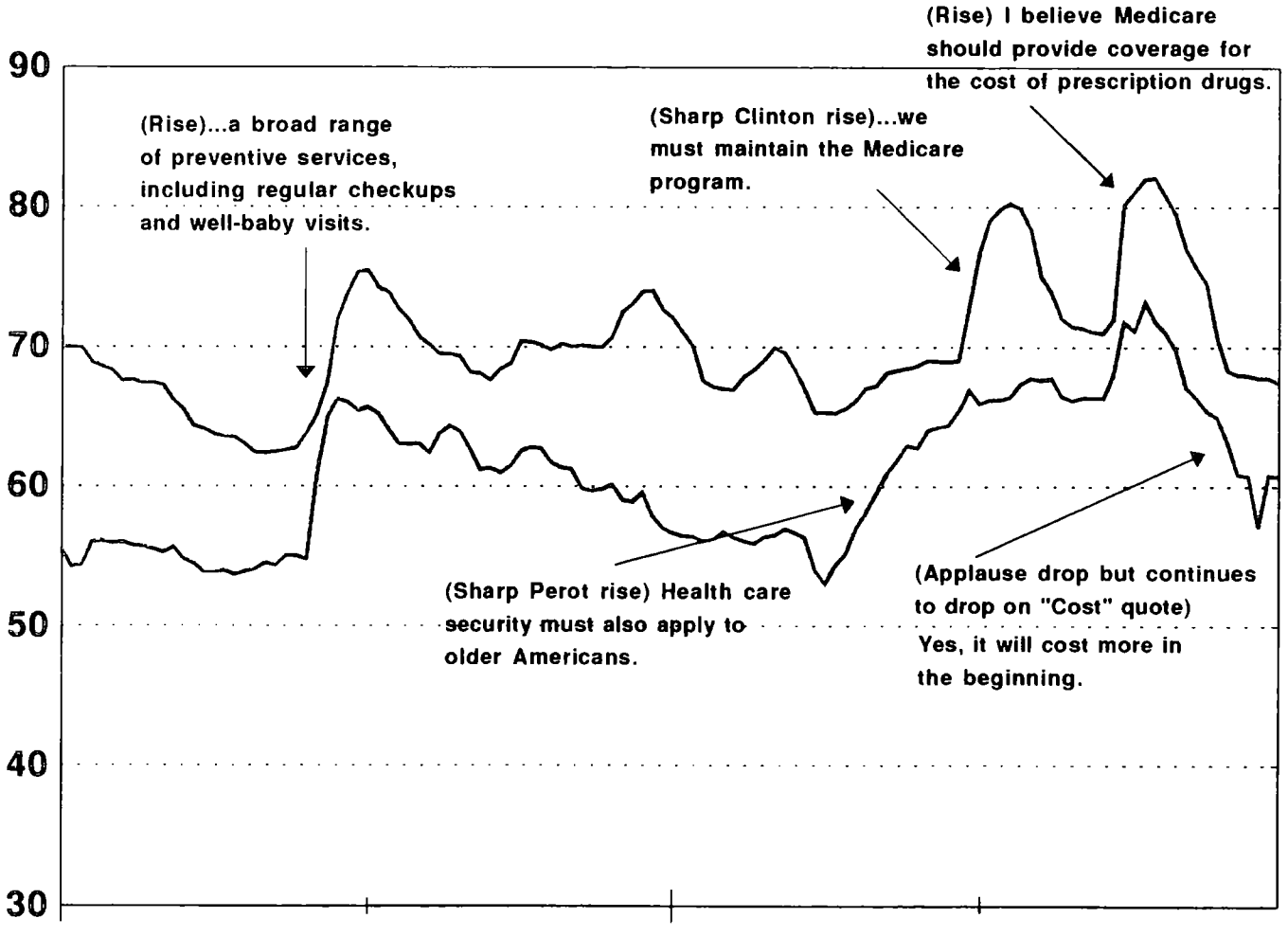
Clinton Health Care Speech

9/22/93 16-18 Minutes



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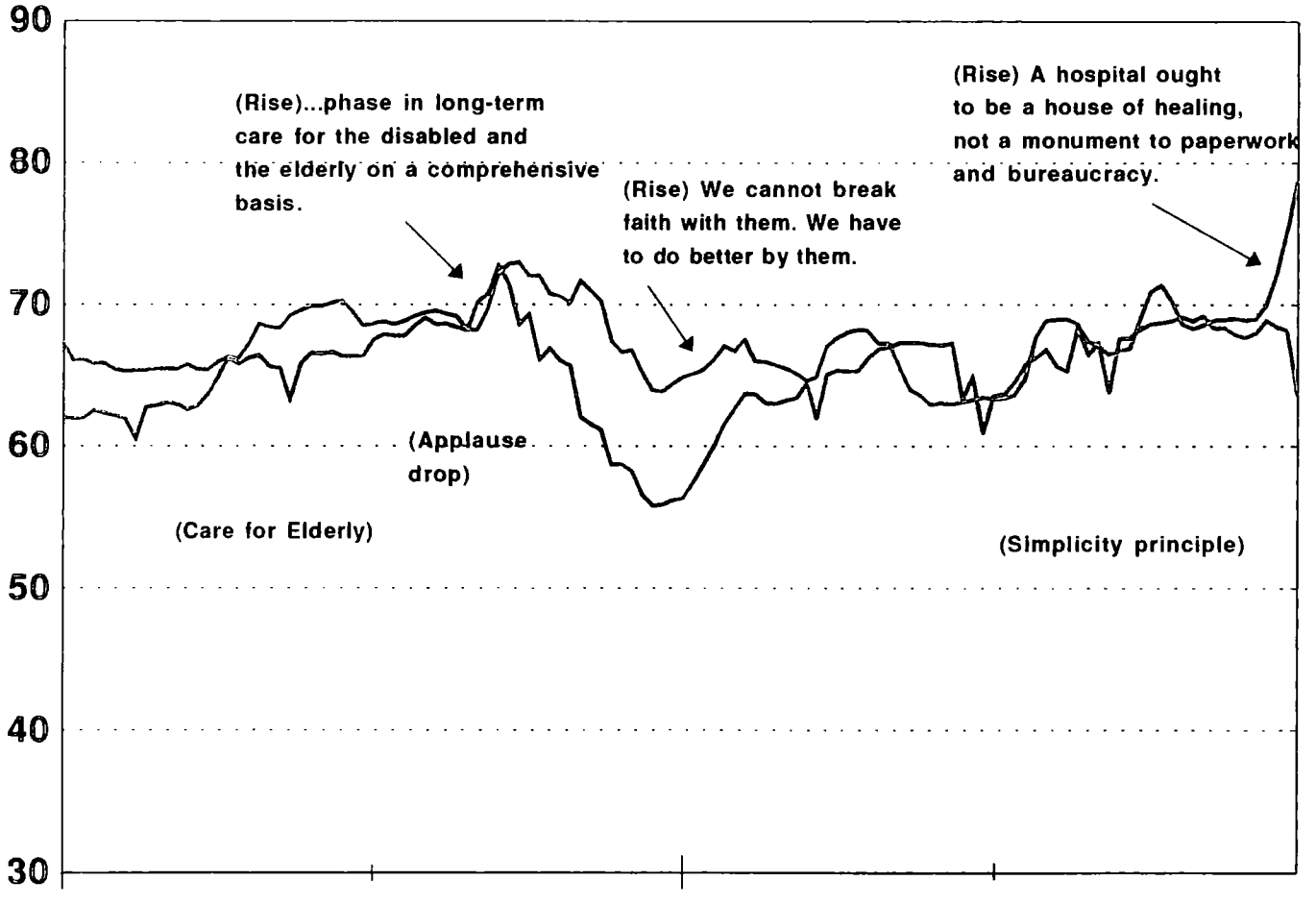
Clinton Health Care Speech

9/22/93 18-20 Minutes



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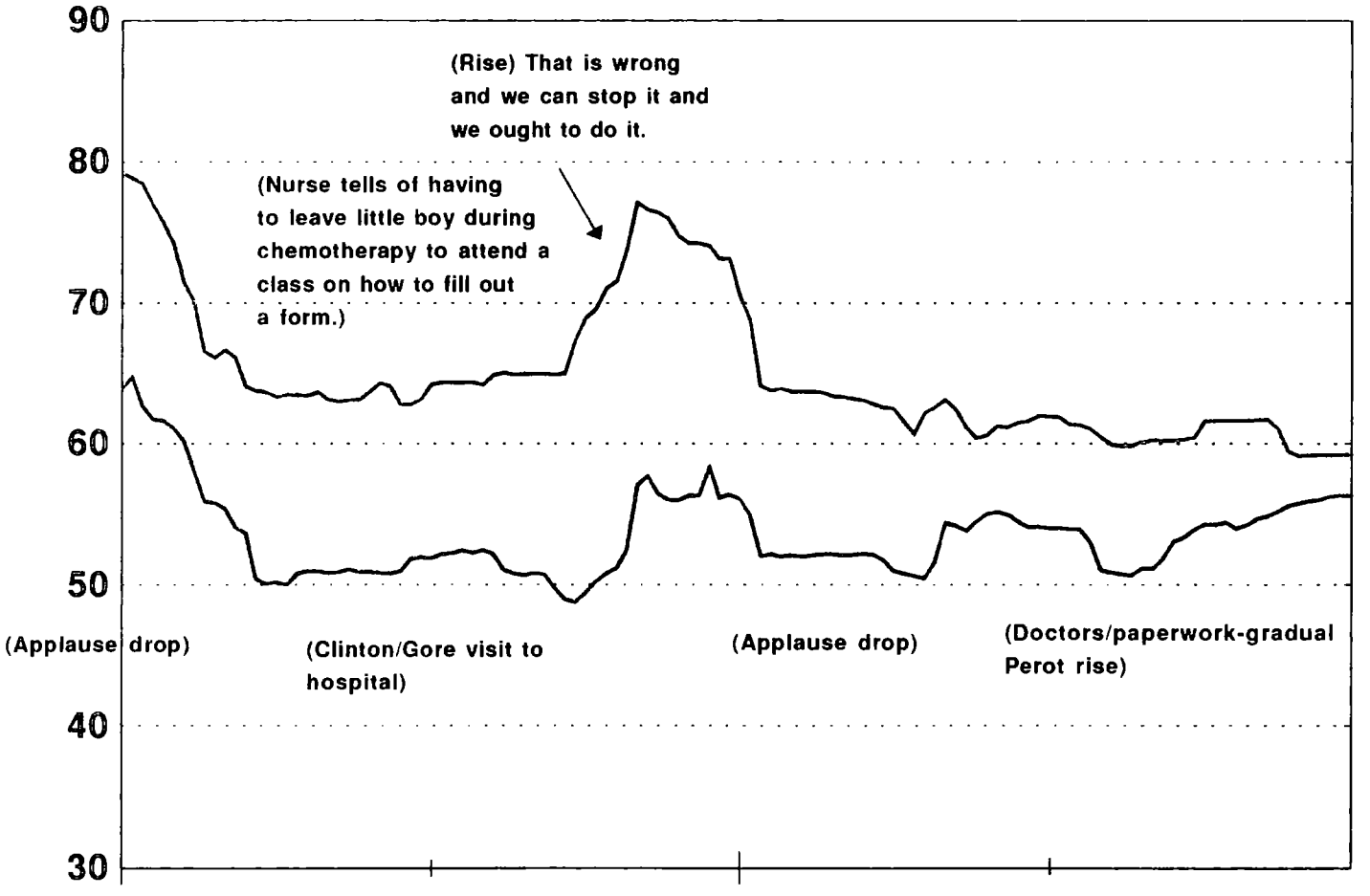
Clinton Health Care Speech

9/22/93 20-22 Minutes



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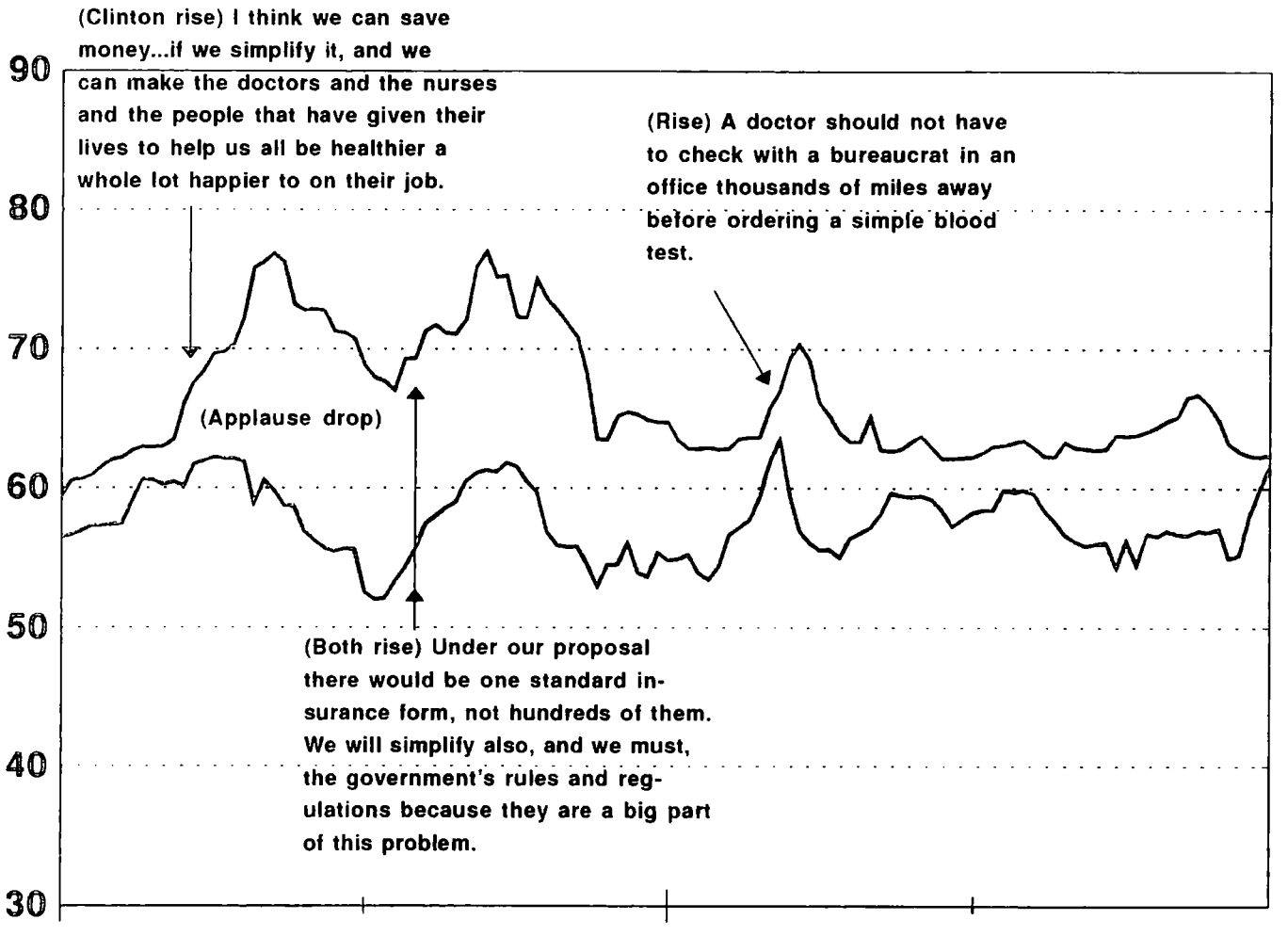
Clinton Health Care Speech

9/22/93 22-24 Minutes



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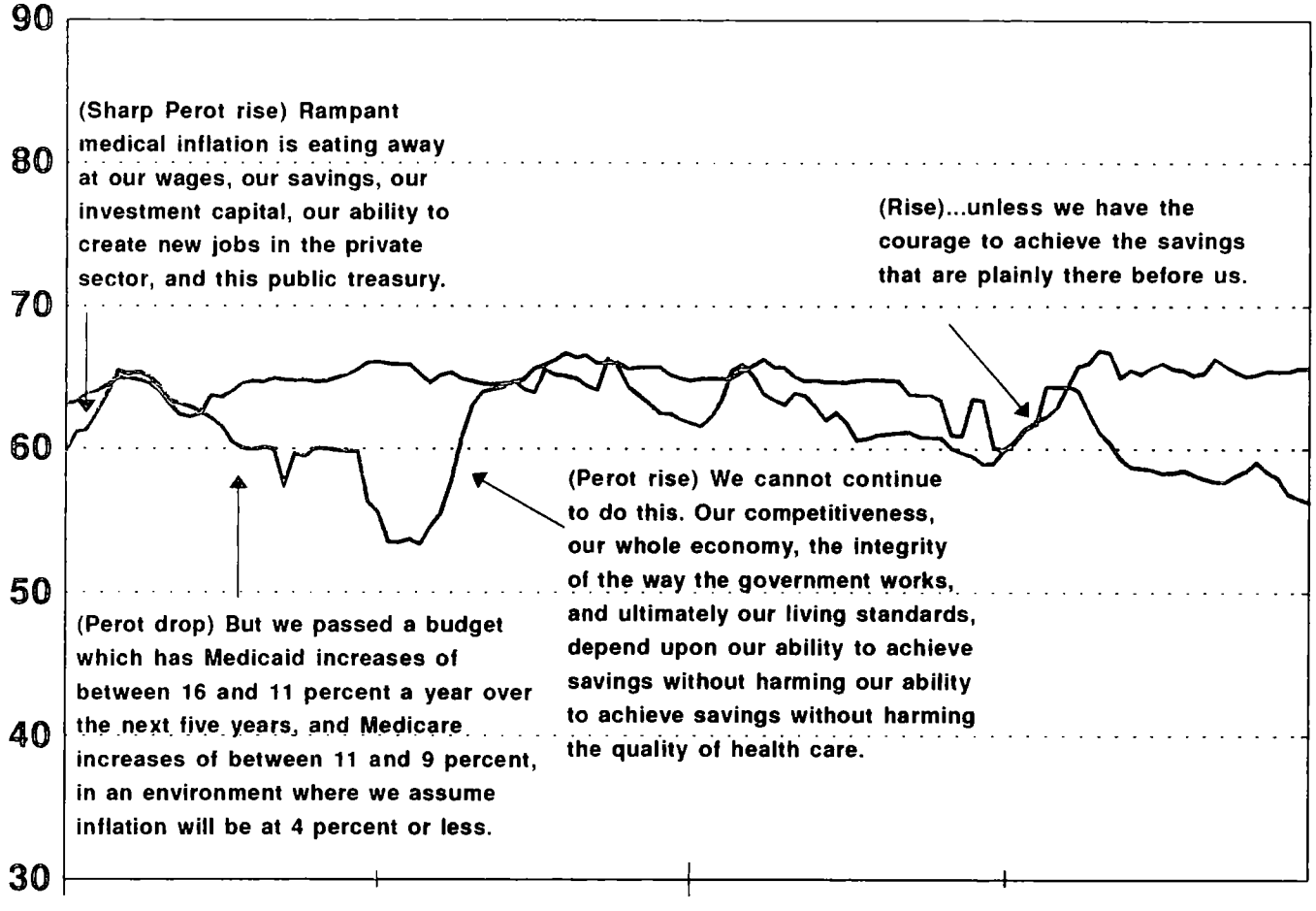
Clinton Health Care Speech

9/22/93 24-26 Minutes



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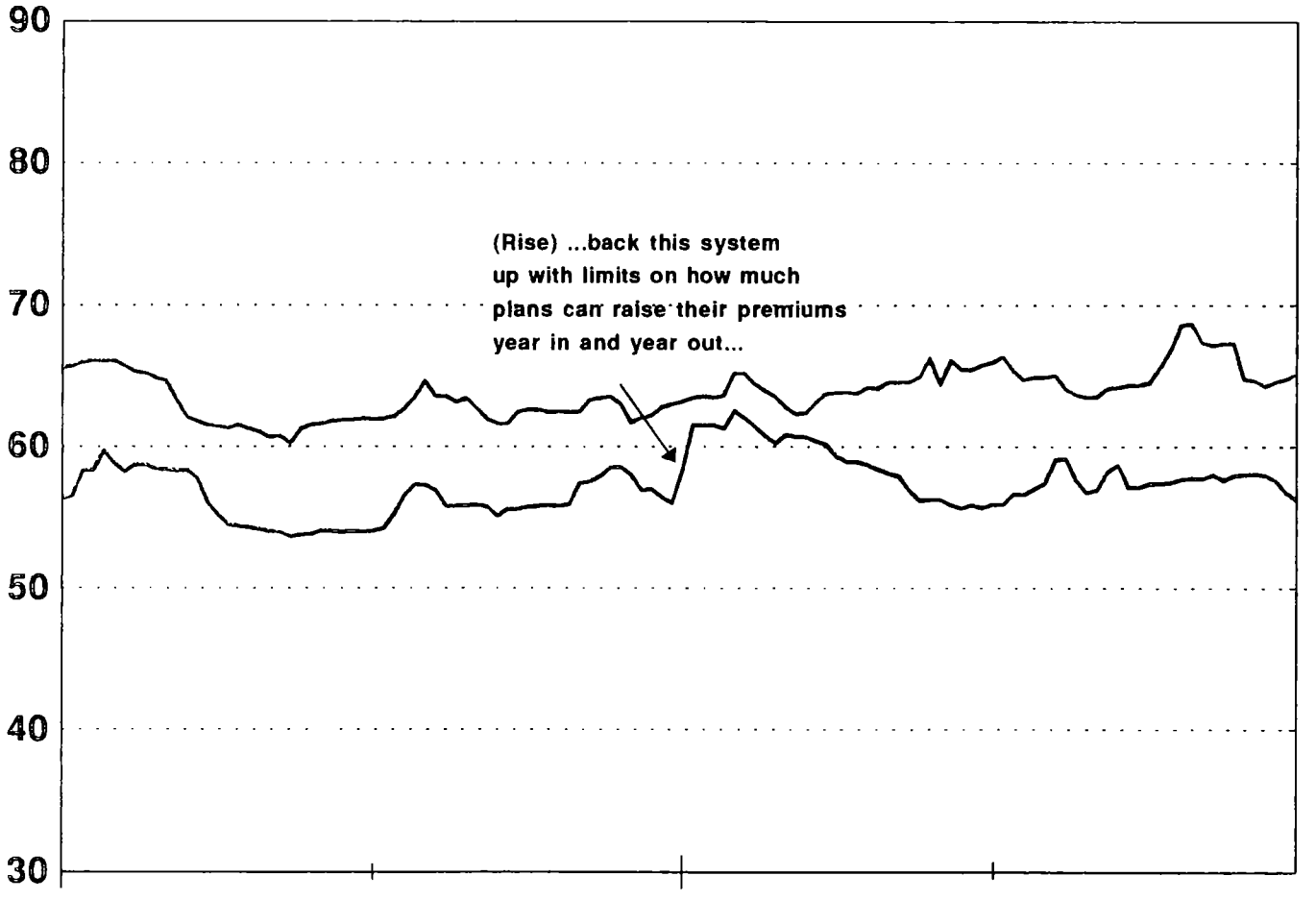
Clinton Health Care Speech

9/22/93 26-28 Minutes



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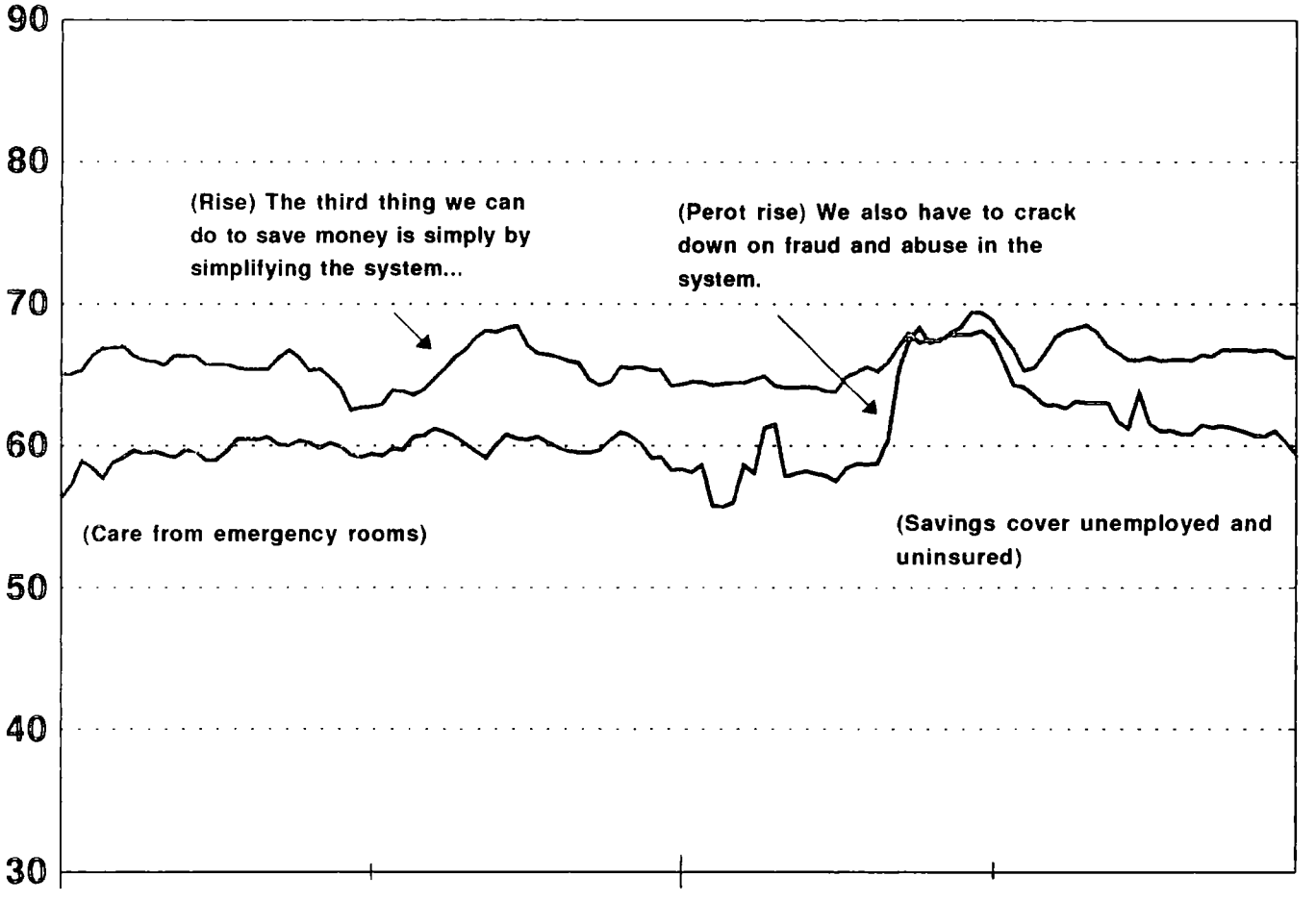
Dayton Dial Group 9/22/93

Clinton Health Care Speech

9/22/93 28-30 Minutes



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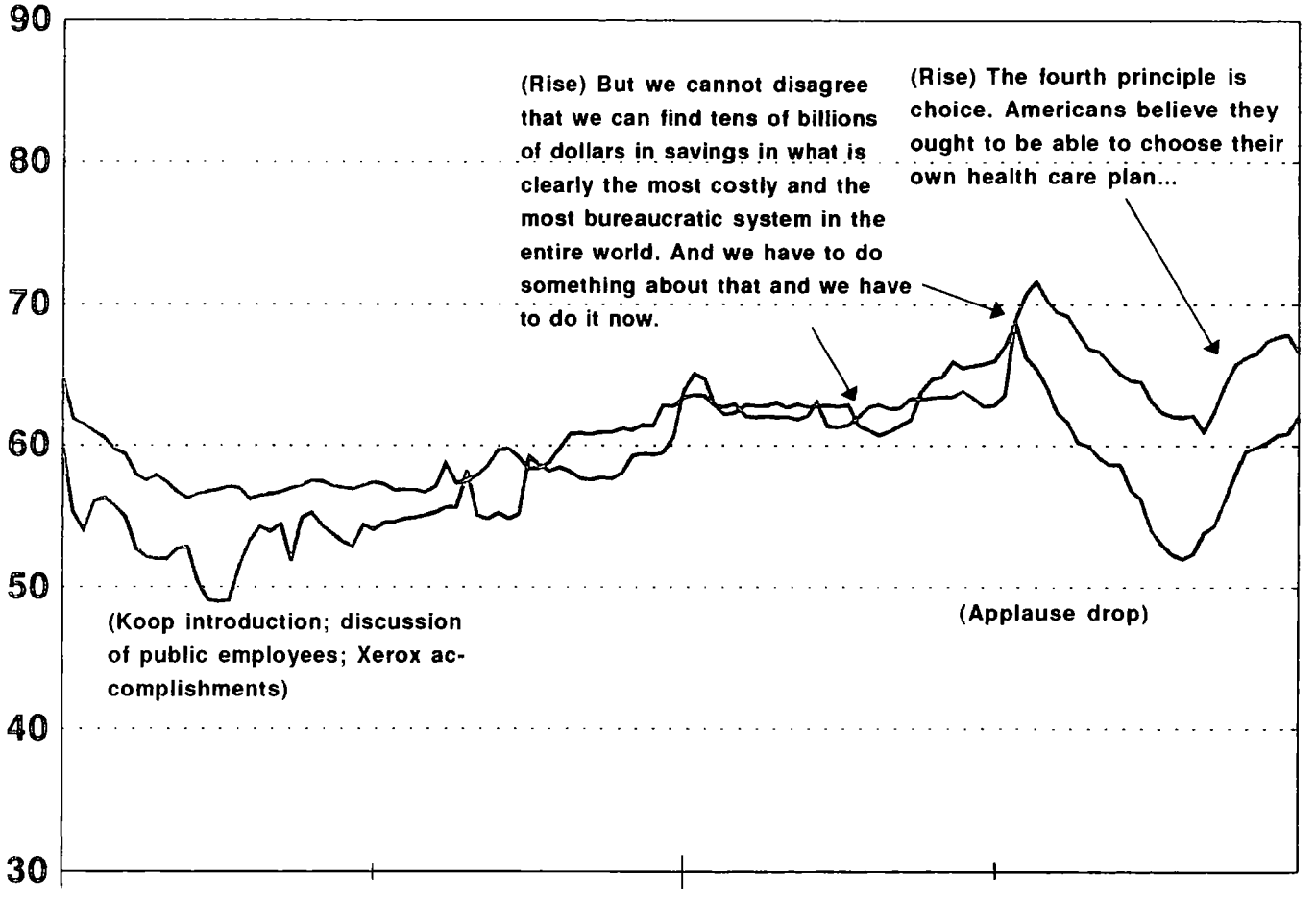
Dayton Dial Group 9/22/93

Clinton Health Care Speech

9/22/93 30-32 Minutes



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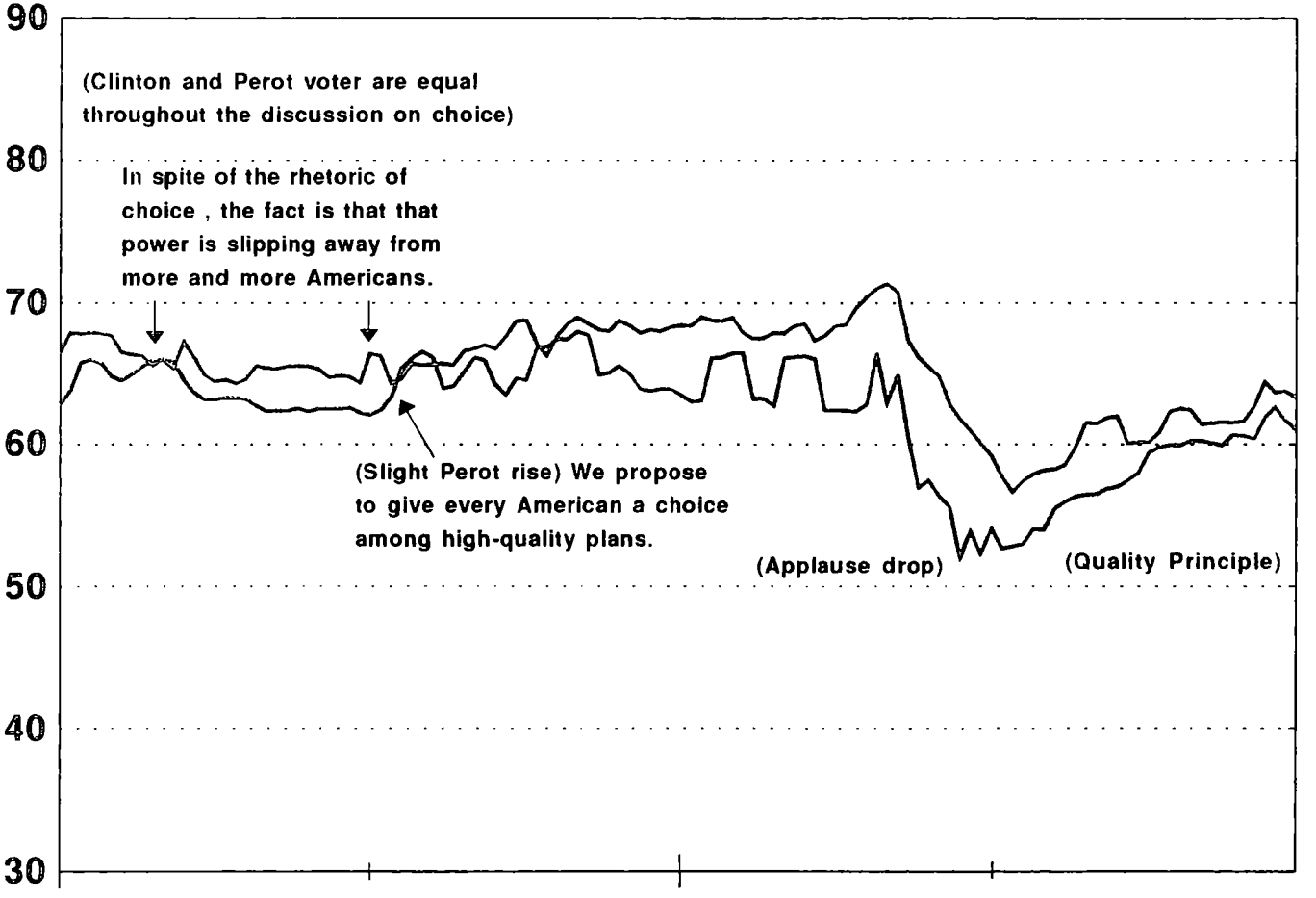
Clinton Health Care Speech

9/22/93 32-34 Minutes



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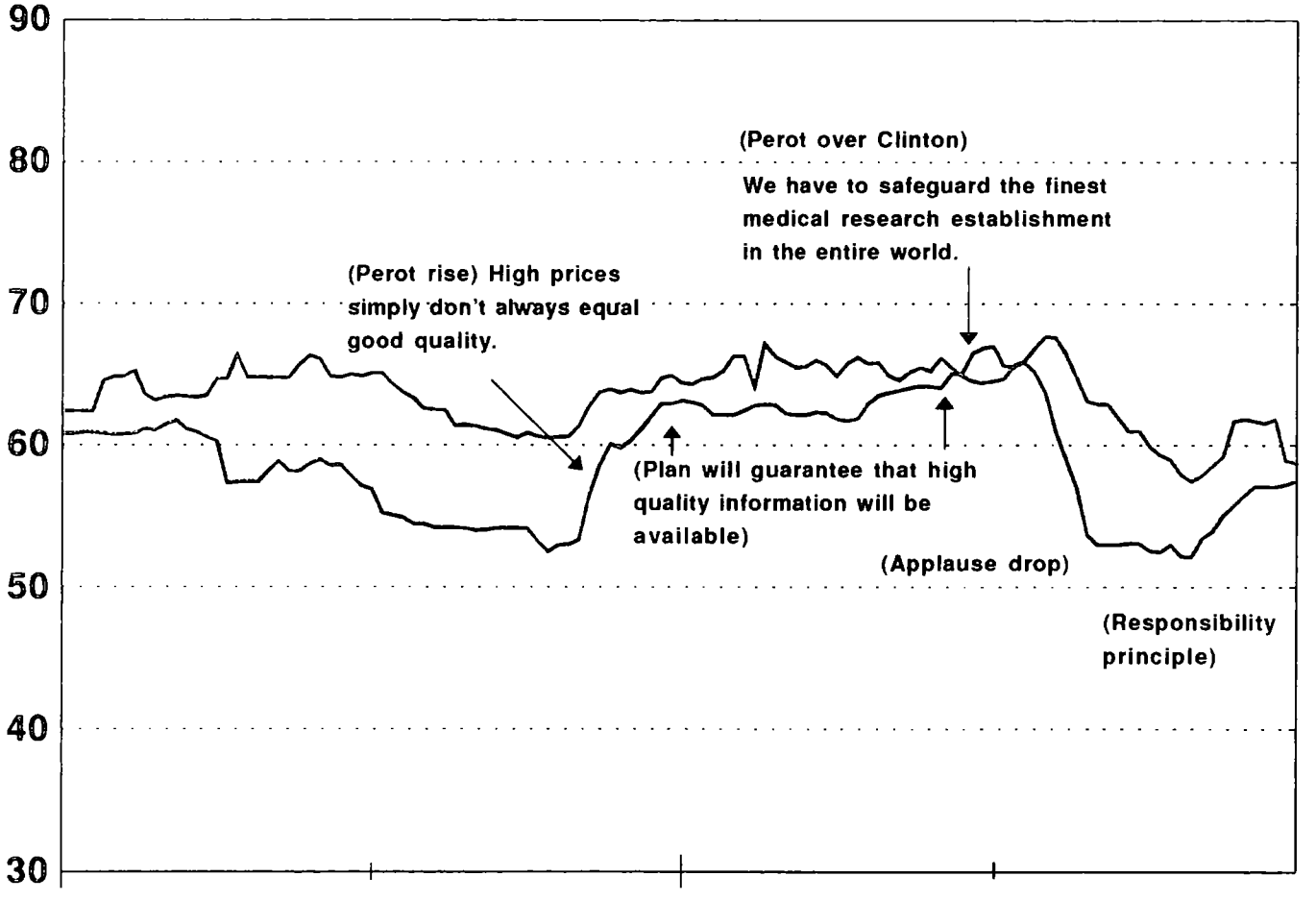
Clinton Health Care Speech

9/22/93 34-36 Minutes



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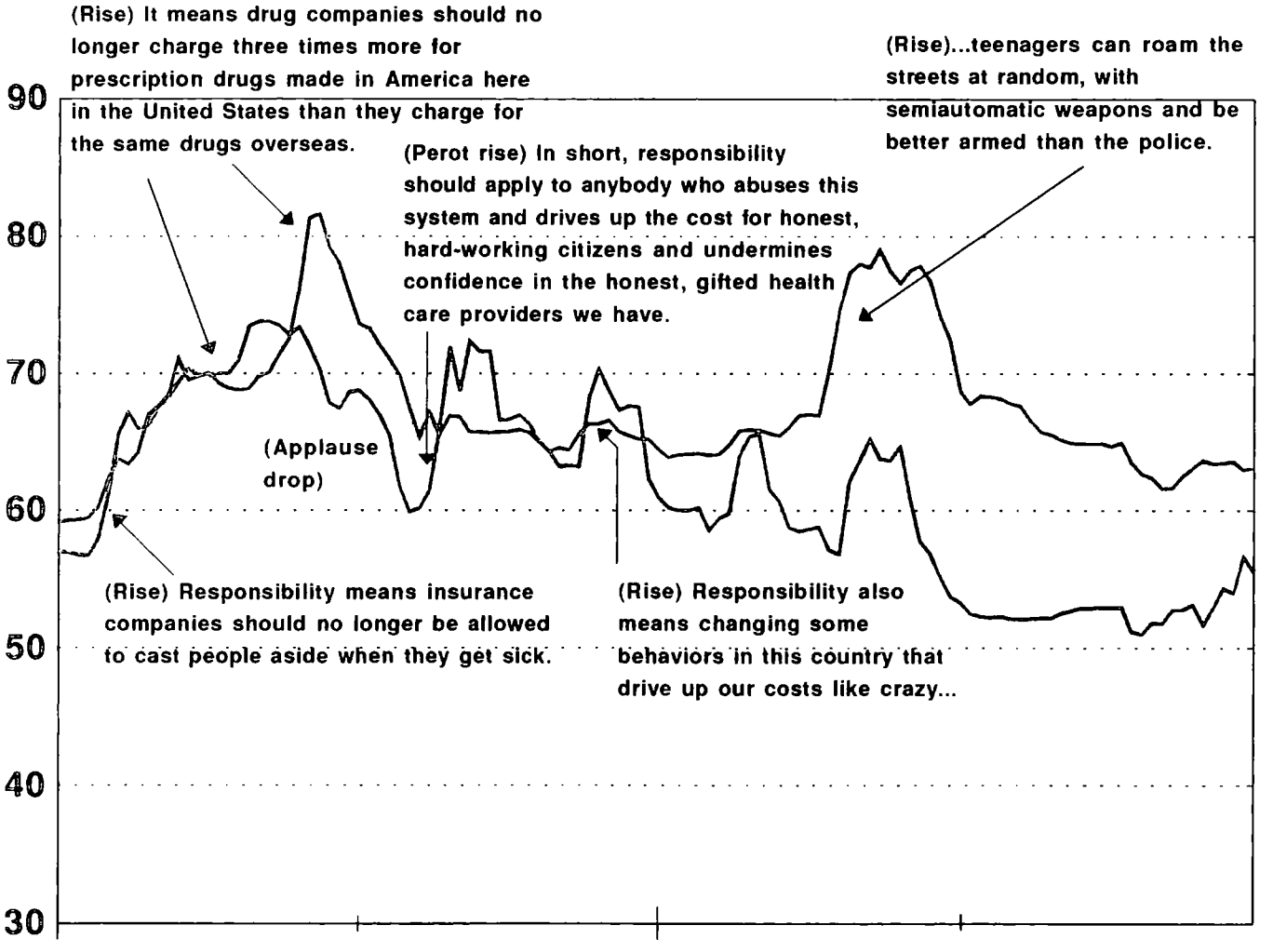
Clinton Health Care Speech

9/22/93 36-38 Minutes



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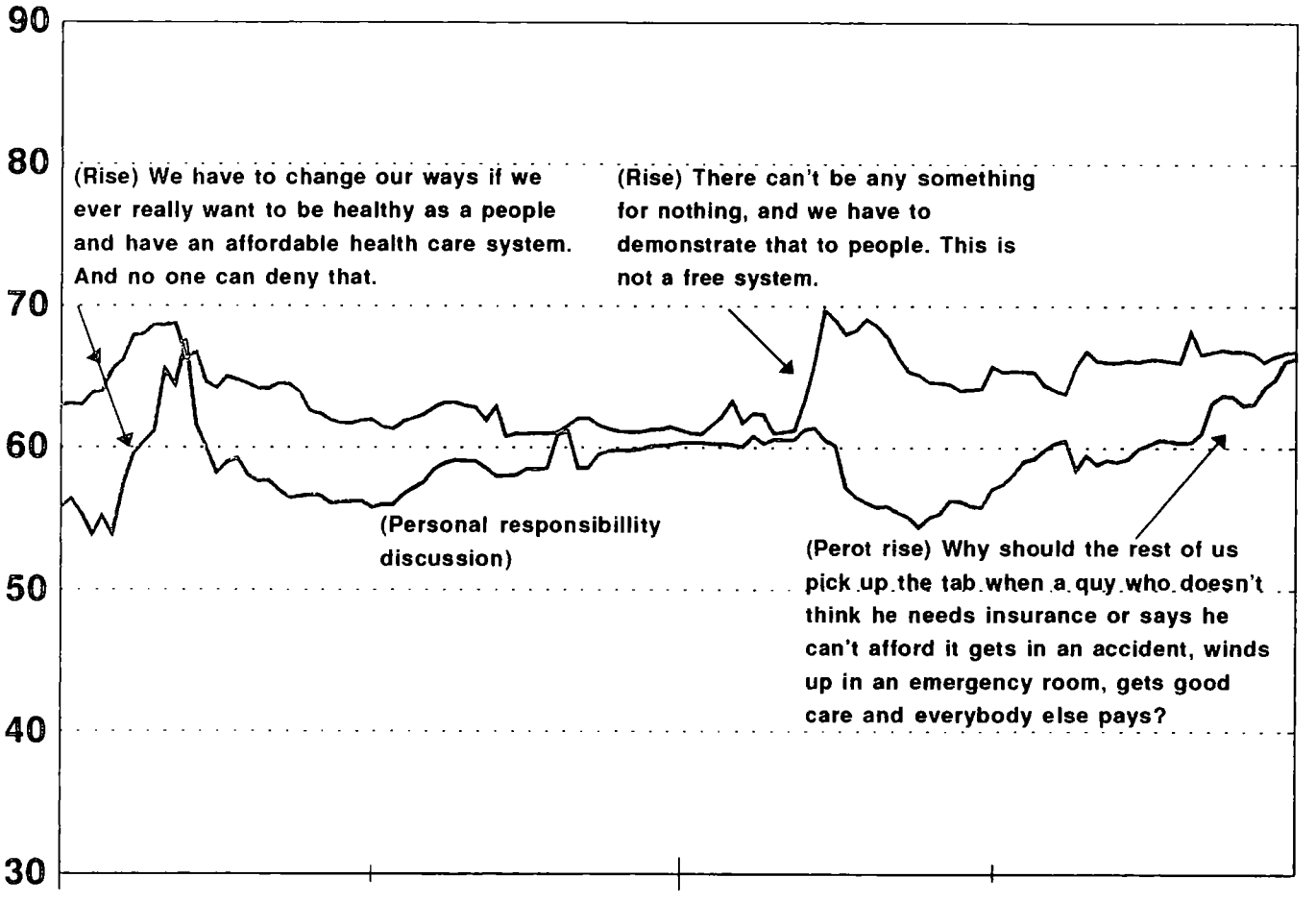
Dayton Dial Group 9/22/93

Clinton Health Care Speech

9/22/93 38-40 Minutes



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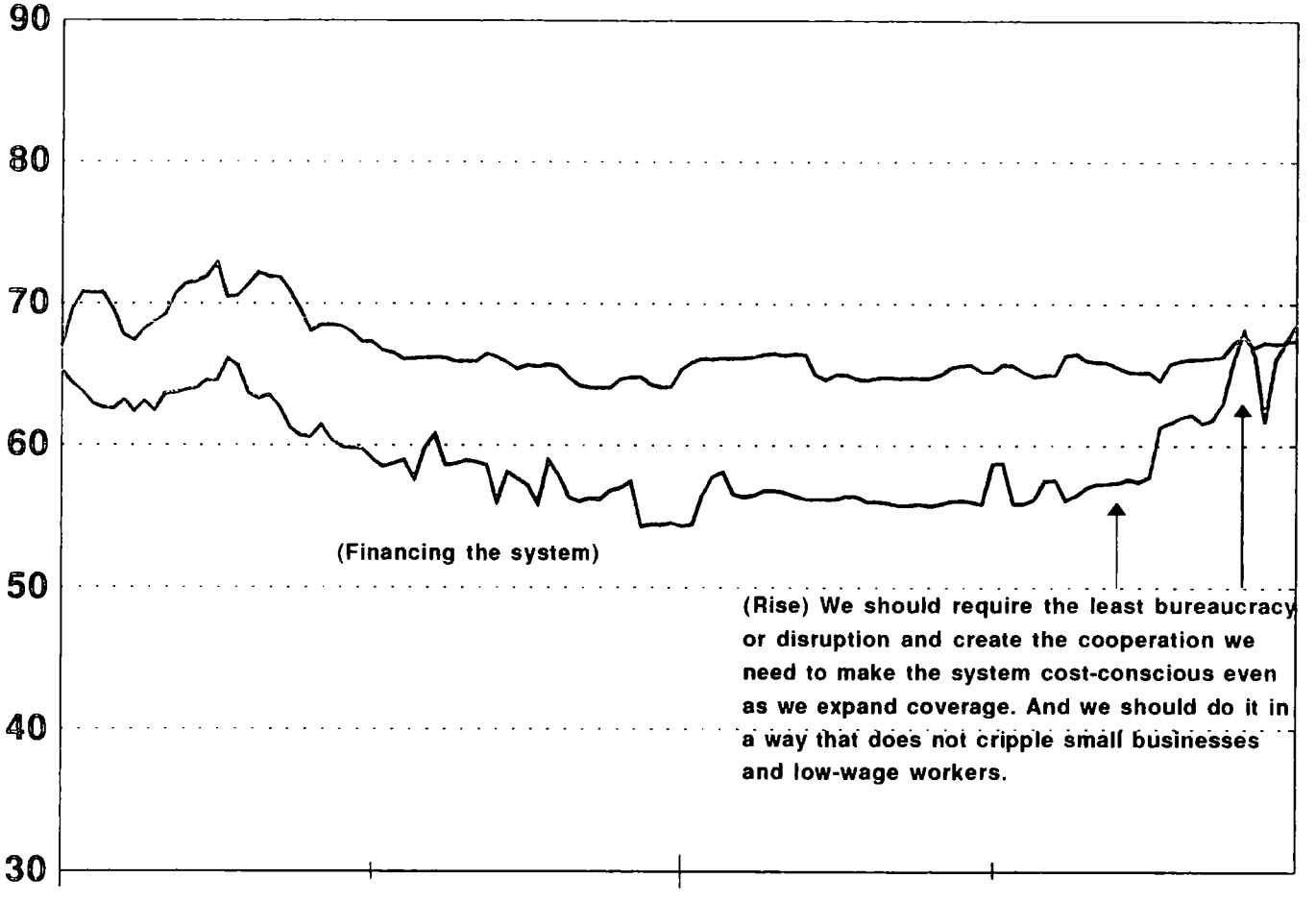
Clinton Health Care Speech

9/22/93 40-42 Minutes



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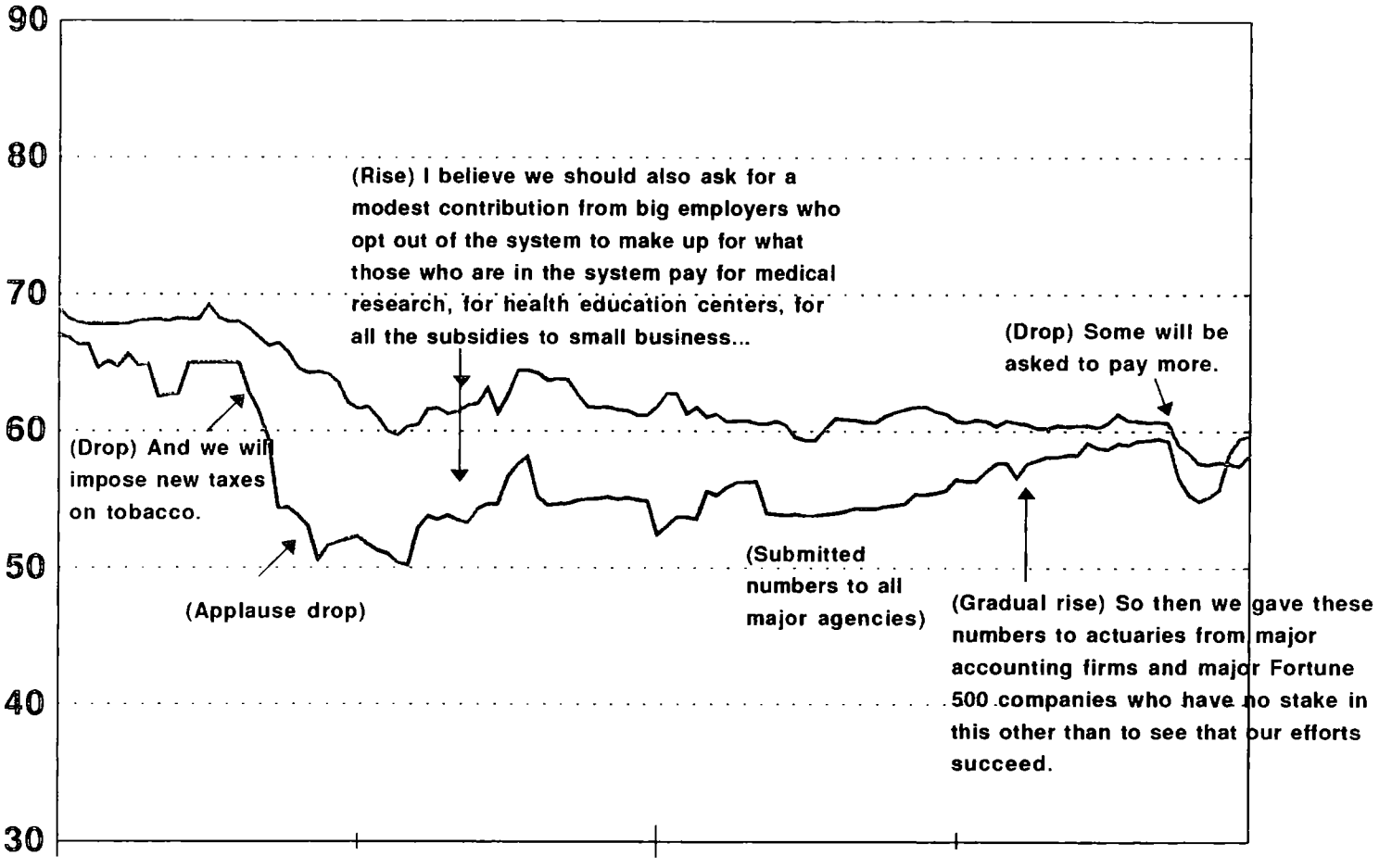
Dayton Dial Group 9/22/93

Clinton Health Care Speech

9/22/93 42-44 Minutes



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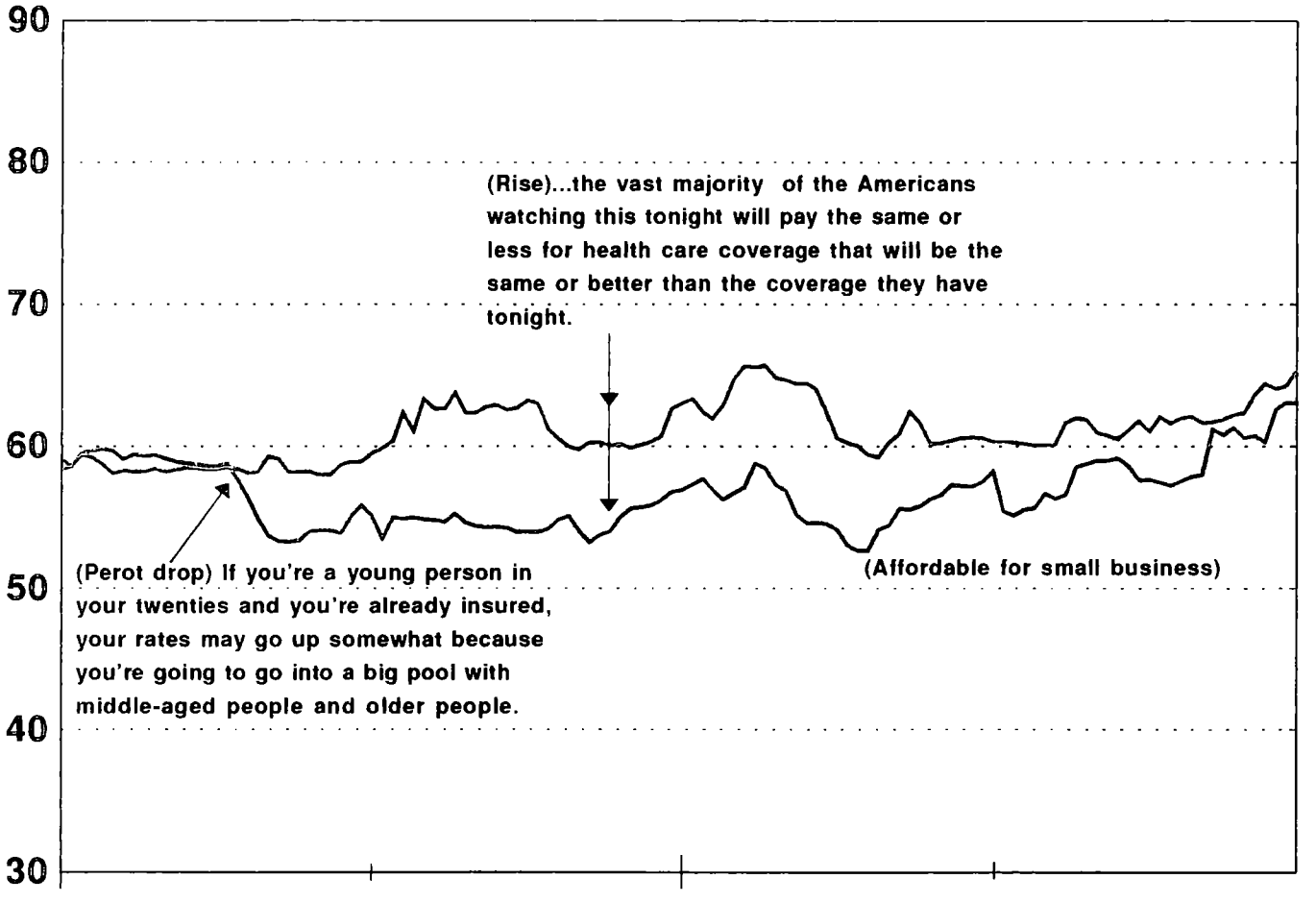
Dayton Dial Group 9/22/93

Clinton Health Care Speech

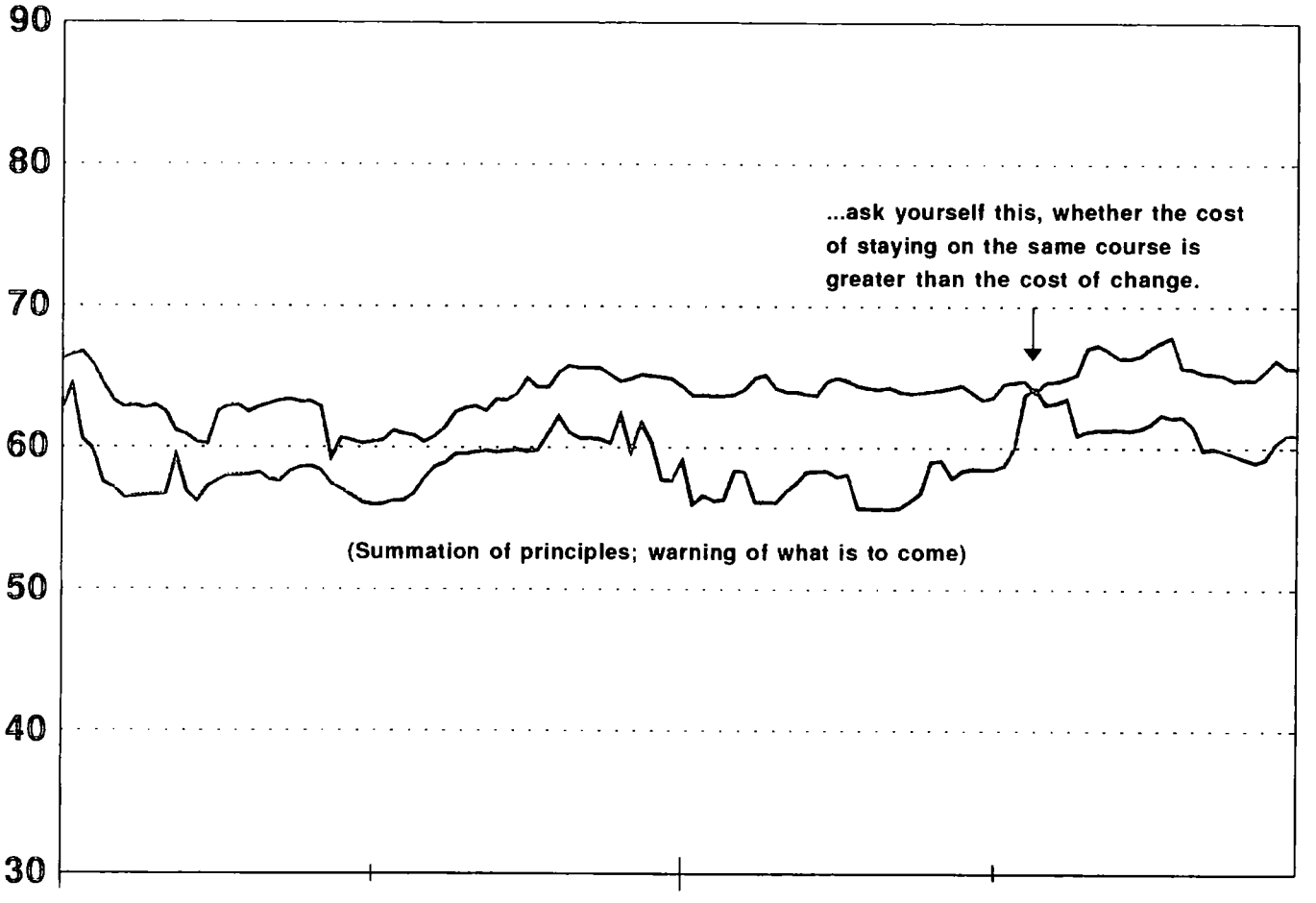
9/22/93 44-46 Minutes



Greenberg Research Inc.
Dayton Dial Group 9/22/93

Clinton Health Care Speech

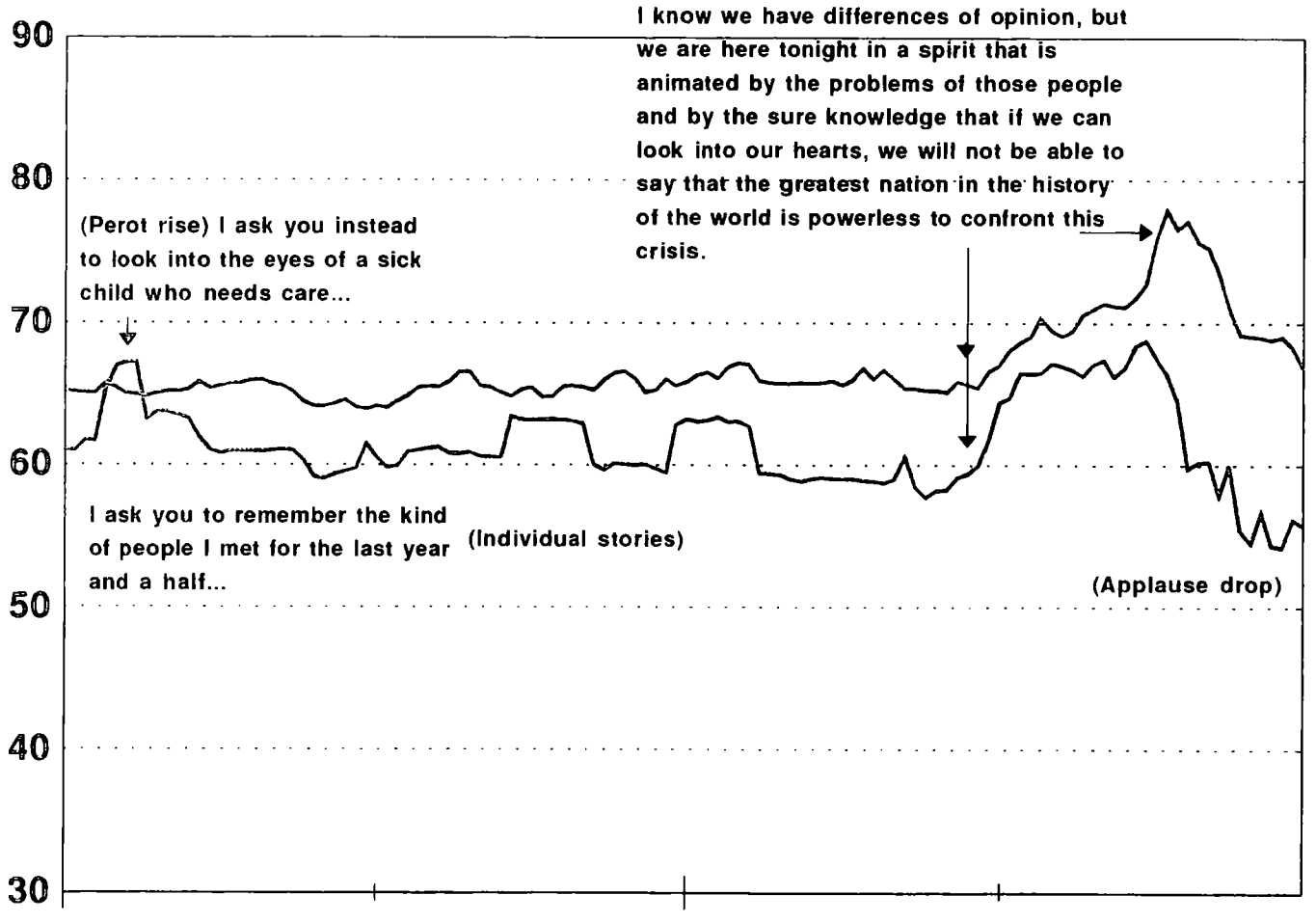
9/22/93 46-48 Minutes



Greenberg Research Inc.
Dayton Dial Group 9/22/93

Clinton Health Care Speech

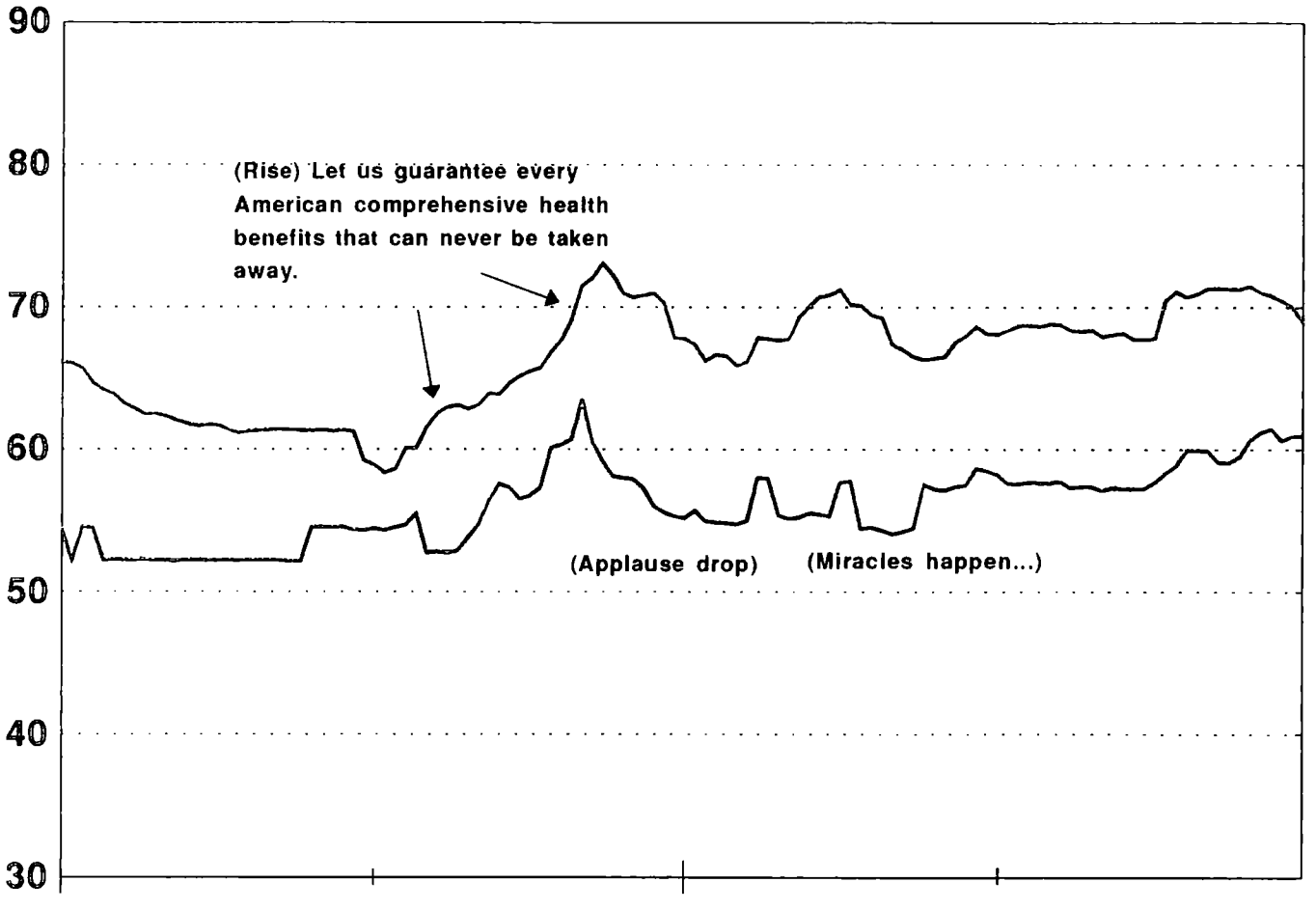
9/22/93 48-50 Minutes



Greenberg Research Inc.
Dayton Dial Group 9/22/93

Clinton Health Care Speech

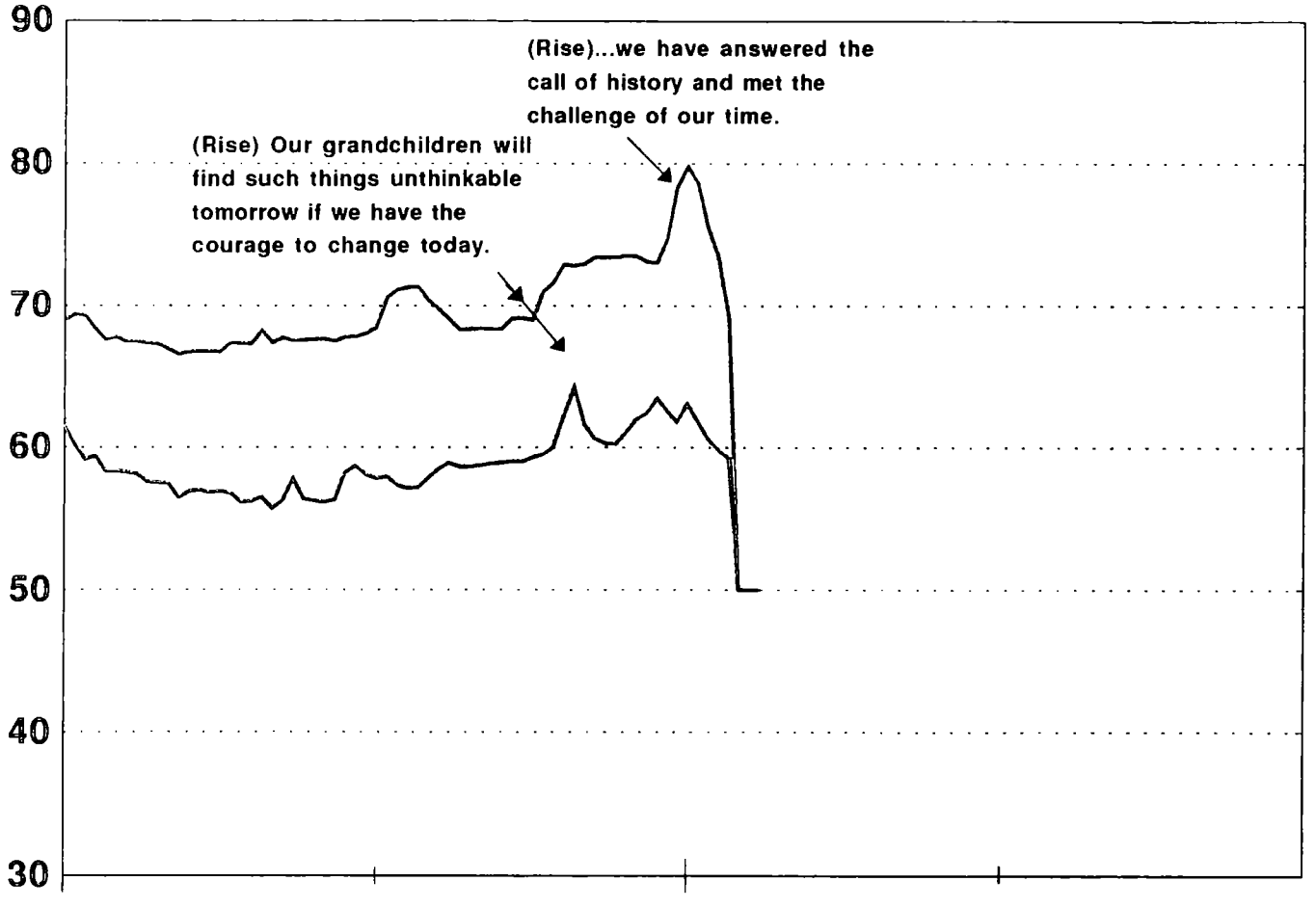
9/22/93 50-52 Minutes



Greenberg Research Inc.
Dayton Dial Group 9/22/93

Clinton Health Care Speech

9/22/93 52-54 Minutes



Greenberg Research Inc.
Dayton Dial Group 9/22/93

39. What would you most like to know about the Clinton health care plan to help you decide whether it's a good or bad idea?

0001 What is the actual cost? Realistically?

0002 Caps-limits-deducations- and what's not covered?

0003 What will happen to insurance companies and small business employers
0004 Nothing specific

0005 Let anybody but Clinton pass it

0006 Mainly worried about whether or not I will be able to choose my own doctor
0007 Nothing

0008 Where is the money going to come from?

0009 He is going up the right street and I have no questions

0010 I question how much it will cost me-I don't have insurance now-hope I can
0011 Will uninsured people get covered and how and who will pay for it
0012 How exactly it will help or hurt me and how much it's going to cost me
0013 I've heard enough about it-I don't like any part of it

0014 Will the medical research program will stay in tact?

0015 Everything-speech was only generality-no details

0016 How it's going to reflect small business

0017 Will people on medicare lose coverage or benefits?

0018 If it will change those who already have insurance to have less coverage
0019 Don't understand how its all going to go together and work out

0020 Where they get the money?

0021 The cost of it all?

0022 How we will pay for it?

0023 There shouldn't be any tax funded abortions-abortions shouldn't be in plans
0024 How will we have to pay and what is covered? Can we choose own DR and HOSP
0025 Question costs and how it will be paid for

0026 Effects on economy and the middle class tax payer

0027 He needs to answer more questions in detail

0028 How much more taxes to pay for it-all the missing cost numbers-no specifics
0029 I don't know if ti will work?

0030 Don't know

0031 How it's going to be paid for?

0032 Will this help elderly people or hurt them?

0033 How they plan to do it with doctors and medicare

0034 Question how it would help the retired?

0035 Don't know

0036 How it will effect price of insurance-will it really go down or up in end
0037 I question funding-who will pay for it?

0038 Want three different choices of medical plans-like Clinton promised
0039 Everything

0040 I know enough

0041 Question the cost-who will pay?

0042 Not sure yet

0043 How we are going to pay for it?

0044 Don't know

0045 Nothing

0046 Want more details about finances involved

0047 Question the doctors that I can choose from-can I have my own doctor?
0048 The overall cost of it?

0049 Nothing

0050 Want more information on the costs involved

0051 Question how much it's going hurt me financially

0052 Question where the savings will come from

0053 If it's percentage of cost effectiveness is high compared to what it is now
0054 How he's going to save money with his plan vs. another

0055 How it's going to effect me

0056 I want to know how it will all be implemented and how Clinton make it work
0057 With Clinton's health care plan everyone will have insurance at low cost
0058 How its going to be paid for

0059 What the overall cost will be?

0060 None-I think it's a good plan

0061 I seldom hear anything-I don't know much about health care

0062 I want to know if it will help the poor people

0063 I don't know

0064 I like to see another plan made so there will be a choice

0065 I'd like to figure out what the plan it-so are we're still in the dark
0066 We need to know where the money is going to come from for all of this
0067 Who's going to foot the bill for all of this?

0068 How will this plan of his be financed?

0069 Not really-but I do expect to be affected by tax increases to pay for it
0070 I think Clinton's health care plan definately guarantees all steady ins.
0071 His plan will insure all Americans and guarantee they will never lose ins.
0072 Do I have to change doctors?

0073 How will we pay for it?

0074 Taking care of those who are self-employed and huge bill for terminal ill
0075 What the individual costs are

0076 Don't know

0077 If Congress is going to fight what he's trying to do?

0078 How are we going to cover the cost of it

0079 Will people still have a choice of doctors and health services

under plan
0080 How much will it cost us?

0081 He should address more issues about taxing-what realisically taxes will be
0082 Will everybody go along with his plan

0083 Don't know

0084 How are we going to be taxed-want specifics on cost effectiveness
0085 What is going to happen to the old and disabled-catastrophic illesses
0086 How effect insurance companies-how effect Americans-how will be dispersed
0087 Is everyone required to have insurance-what the cost will be for it
0088 How much it will cost?

0089 What the package includes for every American

0090 Don't know

0091 Where the money is coming from and who's going to pay for it

0092 If it is going to benefit my family

0093 Want to make sure everyone gets insurance

0094 How children will be covered-cost and care

0095 How its going to effect small insurance companies

0096 Will it cover prescriptions-what percentage?

0097 It's too much of a risk for small business

0098 The enormous impact on businesses in relation to health care

0099 What the advantages per family compared to regular plan we have now
0100 What benefits and coverage for elderly and poor

0101 How it will effect elderly people especially

0102 Will there be waiting in lines

0103 Medicare part-for senior citizens-I need more specific details

0104 Want definitions-select physicians-total cost for taxpayer

0105 Re: insurance-haven't seen anything yet on specific details

0106 Can we have health care without raising any taxes

0107 He's at a stand sill right now-need more specific details of plan
0108 More or less benefits for senior citizens?

0109 What is he going to do about businesses with insurance

0110 What is going to happen to people with 2nd coverage-medicare & private
0111 I must read up on it first-an unbiased view

0112 How its really going to work

0113 I want more dsetails on plan

0114 Where's the money coming from-want specifics

0115 Nothing-I like the plan and have deceided it is what the country needs
0116 How it is really going to be funded

0117 I need to know more about how its going to effect me personally
0118 Is the cost going to be put on the tax payers

0119 He hasn't gotten everything out yet-he didn't have any specific details
0120 I like to know specifically about employer and employee costs

0121 I would like to have my medicine paid for-what percent of them will be paid
0122 Is the government going to run it or private corporations

0123 If I would be covered-people that can't affors it

0124 Don't know

0125 How we are going to pay for it

0126 Where is the money coming from to pay for it

0127 How the insurance system would work

0128 How to pay for it

0129 Need more details-more information about what areas it will cover
0130 Will it cover everything-I don't want to lose my current policy
0131 How is it going to be funded-that worries me

0132 Why he has not consulted the private health sector in developing program
0133 Will it create a new job industry

0134 Will it increase medicare costs

0135 The real cost of the program-bottom line

0136 An honest anser on the taxes-how will it be paid for

0137 Where the money is coming from-which doctor you can see-rations of care

0138 I want the ratio of overall cost vs. overal benefits

0139 How it will effect me personally

0140 I don't have a clue

0141 Can we choose our own doctors

0142 Nothing

0143 Is it going to cost our elderly-what's going to happen to them

0144 How he is going to implement it

0145 How will it actually be done

0146 Maintaining choice of doctors-who I want to go to is important

0147 How much my taxes will go up

0148 How will it effect the middle class American people

0149 Won't work out-we have to raise taxes to pay for it

0150 Re: National Health Plan-they have on like it in Canada-does it work well

DNC.Q21
September 23,1993
800 Respondents

FREQUENCY QUESTIONNAIRE

515 2nd Street NE
Washington, DC 20002

---

1. First of all, are you registered to vote at this address?

[IF YES, GO TO Q2] **[IF NO]** I'm sorry. Is there a registered voter at home I can speak to?

[REPEAT INTRODUCTION OR TERMINATE]

2. Many people weren't able to vote in November's election for president between George Bush, Bill Clinton, and Ross Perot. How about you? Were you able to vote, or for some other reason were you unable to vote?

Voted	98
Ineligible/too young	2
Did not vote	**[TERMINATE]**
Can't remember/Don't know	**[TERMINATE]**
Refused	**[TERMINATE]**

3. Generally speaking, do you think that things in this country are going in the right direction, or do you feel things have gotten pretty seriously off on the wrong track?

Right direction	36
Wrong track	50
(Don't know)	15

Now, I'd like to rate your feelings toward some people and organizations, with one hundred meaning a VERY WARM, FAVORABLE feeling; zero meaning a VERY COLD, UNFAVORABLE feeling; and fifty meaning not particularly warm or cold. You can use any number from zero to one hundred, the higher the number the more favorable your feelings are toward that person or organization. If you have no opinion or never heard of that person or organization, please say so.

[WRITE IN NUMBER]
[DON'T KNOW = 101]
[NEVER HEARD = 102]

[READ FIRST]

4. Ross Perot **[pah-ROE]**. Give Ross Perot a rating, with 100 meaning a very warm, favorable feeling; zero meaning a very cold, unfavorable feeling; and 50 meaning not particularly warm or cold. . . . . ___48___

[ROTATE Q5-Q8]

5. Bill Clinton . . . . . ___56___

6. The Republican Party . . . . . ___53___

7.

8. The Democratic Party . . . . . ___53___

9. In the election for President last year, did you vote for **[ROTATE NAMES]** Republican George Bush, independent Ross Perot or Democrat Bill Clinton?

SEE Q10 BELOW

[IF DON'T KNOW/REFUSED IN Q9]

10. I know that the voting is by secret ballot, but I want to assure you that this survey is completely anonymous. Could you please tell me whether you voted for **[ROTATE NAMES]** Republican George Bush, independent Ross Perot or Democrat Bill Clinton?

Republican Bush	33
Democrat Clinton	43
Independent Perot	15
(Don't know/Refused)	9

11. Do you approve or disapprove of the way Bill Clinton is handling his job as president? **[FOLLOW UP]** Do you strongly or somewhat (approve/disapprove) of the way Bill Clinton is handling his job?

		Combined
Strongly approve	17	
Somewhat approve	42	**59**
Somewhat disapprove	18	
Strongly disapprove	16	**35**
(Don't know)	6	

12. From what you have seen and heard so far about Bill Clinton's policies and goals for the country, would you say that you strongly support his policies and goals, generally support them, generally oppose his policies and goals, or strongly oppose them?

		Combined
Strongly support	14	
Generally support	49	**63**
Generally oppose	21	
Strongly oppose	13	**33**
(Don't know)	4	

Now I'm going to read you a list of issues. For each one, please tell me if you approve or disapprove of the way Bill Clinton is handling this issue. **[FOLLOW UP]** Is that strongly (approve/disapprove) or somewhat (approve/disapprove)?

[ROTATE Q13-Q15]	Strong Appr	Some what Appr	Some what Disap	Str Disap	(DK)	**Total Apprv**	**Total Disapprv**
13. The economy. Do you approve or disapprove of the way Bill Clinton is handling the economy? **[FOLLOW UP]** Is that strongly (approve/disapprove) or somewhat (approve/disapprove)?	10	41	25	18	7	**51**	**42**
14. Health care	24	36	14	15	12	**60**	**29**
15. Providing strong leadership for the country	18	40	19	17	6	**58**	**36**

Now for something different. I am going to read you a list of words and phrases which people use to describe political figures. For each word or phrase, please tell me whether it describes Bill Clinton very well, well, not too well, or not well at all.

[ROTATE Q16-Q22]	Very well	Well	Not too well	Not well at all	(DK)	**Total Well**	**Total Not Well**
16. A steady leader. Does that describe Bill Clinton very well, well, not too well, or not well at all?	13	42	29	13	3	**56**	**42**
17. Cares about people like you	26	37	22	12	4	**63**	**33**
18. Strong	17	40	25	14	4	**57**	**40**
19. Makes you feel confident	15	35	28	20	3	**50**	**48**
20. Fights for the middle class	17	37	26	16	4	**54**	**42**
21. Keeps his promises	9	33	29	22	7	**42**	**51**
22. Courageous	19	37	22	15	6	**57**	**37**

23. Do you think of Bill Clinton as a typical tax and spend Democrat or do you think of him as a different kind of Democrat?

Typical tax and spend Democrat	39
Different Democrat	53
(Don't know)	8

24. Do you feel mainly hopeful or mainly doubtful about Bill Clinton?

Hopeful	57
Doubtful	37
(Both)	4
(Don't know)	3

Now, think about Bill Clinton's health care proposal. Let me ask you a number of questions:

25. Last night, Bill Clinton presented his program to change the health care system. From what you've heard, do you favor or oppose his health care proposals?

[FOLLOW UP] Is that strongly or somewhat (favor/oppose)?

		Combined
Strongly favor	25	
Somewhat favor	29	**53**
Somewhat oppose	15	
Strongly oppose	13	**27**
(Don't know)	19	

26. President Clinton gave a speech to Congress last night about his health care plan. Did you watch the President's speech live on television, or did you see part of the speech on the news, or weren't you able to see any of the President's speech?

Yes, watched live	51
Saw part of speech on news	21
Did not see any	23
(Heard on Radio)	3
(Don't know)	2

27. Do you believe Bill Clinton's health program will help or hurt your family?

Help	43
Hurt	31
(Don't know)	27

[ROTATE Q28-Q36]

28. Do you think the program will simplify the health care system or create more bureaucracy?

Simplify health care system	39
Create more bureaucracy	45
(Don't know)	16

29. Do you think the program will mean higher or lower health care costs for your family?

Higher health care costs	51
Lower health care costs	27
(Don't know)	22

30. Do you think the program will preserve the quality of health care or undermine it?

Preserve quality of care	46
Undermine quality of care	35
(Don't know)	19

31. Do you think the program will help or hurt the economy and jobs?

Help economy and jobs	36
Hurt economy and jobs	40
(Don't know)	24

32. Do you think the program will mean that more or less things will be covered by your insurance?

More things will be covered	34
Less things will be covered	41
(Don't know)	26

33. Do you think the program will maintain or limit your right to choose a doctor?

Maintain right to choose doctor	39
Limit right to choose doctor	43
(Don't know)	18

34. Do you think the program will introduce greater responsibility into the health care system or encourage more irresponsibility?

Introduce greater responsibility	48
Encourage more irresponsibility	32
(Don't know)	20

35. Do you think the program is a risk worth-taking or is it too risky?

Risk worth taking	59
Too risky	30
(Don't know)	10

36. Do you think the program will mean that you won't lose health coverage for any reason or do you think people will still lose coverage?

Won't lose coverage	42
Will still lose coverage	36
(Don't know)	22

37. Do you think the program will mainly be paid for by cost savings or do you think the program will require broad tax increases?

Mainly be paid for by cost savings	14
Require broad tax increases	70
(Don't know)	16

38. Should Congress try to pass the Clinton program as soon as possible or should it take a lot more time to consider it?

Pass program as soon as possible	26
Take more time to consider it	68
(Don't know)	6

39. What would you most like to know about the Clinton health care plan to help you decide whether it's a good or bad idea? **[PROBE FOR SPECIFICS. WRITE DOWN ANSWER VERBATIM.]**

How much is it really going to cost? / Overall cost	8
How will America pay for it? / Where will money come from?	12
How will it affect me? / Individual cost	7
Will my taxes go up? / Tax increases	3
How will it affect insurance companies?	1
How will it affect small business?	3
How will it effect the elderly? / Will those on Medicare lose benefits?	7
How will it affect the poor?	1
How will it affect the middle class?	1
How will it affect the economy?	0
What's not covered in the plan?	1
Can I keep my own doctor?	3
Where will the savings come from?	1
How will it be implemented?	4
Will everyone be required to have insurance?	1
Will it cover prescriptions?	1
Will it cover everything?	3
Will it cover abortion? (positive or neutral)	0
Will it cover abortion? (negative)	0
General positive	4
General negative	3
Need more specifics	16
Other	4
Nothing / No worries	7
Don't know	10

Finally, I would like to ask you a few questions for statistical purposes.

40. Generally speaking, do you think of yourself as a Republican, a Democrat or what?

Strong Democrat	18
Weak Democrat	20
Ind - Lean Democrat	10
Independent	9
Independent - Lean Republican	8
Weak Republican	14
Strong Republican	17
Other	2
(Don't know/Refused)	1

41. In what year were you born?

18-24	7
25-29	9
30-34	11
35-39	11
40-44	11
45-49	9
50-54	7
55-59	7
60-64	7
Over 64	19
(Don't Know/Refused)	3

42. What is the last year of schooling that you have completed?

1 - 11th grade	8
High school graduate	32
Non-college post H.S. **[E.G. TECH]**	2
Some college **[JR. COLLEGE]**	23
College graduate	22
Post-graduate school	11
(Don't know)	2

43. Thinking in political terms, would you say that you are liberal, somewhat liberal, moderate, somewhat conservative or conservative?

Liberal	14
Somewhat liberal	11
Moderate	28
Somewhat conservative	20
Conservative	22
(Don't know)	5

44. In terms of your job status, are you employed, unemployed but looking for work, retired, a student, or a homemaker?

Employed	59
Unemployed	5
Retired	24
Student	2
Homemaker	9
(Other)	1
(Don't know/refused)	1

45. Are you a member of a labor union? **[IF NO]** Is any member of your household a union member?

Yes: Respondent belongs	12
Household member	7
No member belongs	79
(Don't know/refused)	2

46. What is your race?

White	86
Black	8
Hispanic **[PUERTO RICAN, MEXICAN-AMERICAN, ETC.]**	3
(Other)	1
(Don't know/refused)	1

Gender

Male	47
Female	53

47. And what is your zip code?

And finally, strictly for verification purposes, can I have just your first name?

THANK YOU VERY MUCH FOR YOUR TIME [TERMINATE]

The Health Security Act of 1993
Press Packet

Table of Contents

THE HEALTH SECURITY ACT OF 1993
Health Care That's Always There

Every American citizen will receive a Health Security Card that guarantees you a comprehensive package of benefits that can never be taken away.

Guaranteeing comprehensive benefits that can never be taken away. Controlling health care costs for consumers, business and our nation. Improving the quality of American health care. Increasing choices for consumers. Reducing paperwork and simplifying the system. Making everyone responsible for health care. These are the principles of the Health Security Act of 1993 and they are not negotiable.

In America, rights and responsibilities go hand-in-hand. We will ask everybody to pay something, even if your contribution is small. Everyone must assume responsibility. No one should get a free ride.

Most important, we're going to offer new opportunities and new incentives for people to stay healthy – and to treat small problems before they become big ones. Our goal should be to keep people healthy, not treat them after they become sick.

What's Wrong With the Current System

The things that are wrong with our health care system are threatening everything that's right with American health care.

- Over the next two years, one out of four of us will be without health coverage at some point. Change jobs, lose your job, or move -- and your insurance company is currently allowed to drop you.
- Today's system is rigged against families and small businesses. Insurance companies pick and choose whom they cover. Then they drop you when you get sick. If you have a pre-existing condition, you usually can't get any insurance at all.
- Insurance companies charge small businesses as much as 35% more than the big guys.
- Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have almost no choice today.
- Twenty-five cents out of every dollar on a hospital bill goes to bureaucracy and paperwork -- not patient care.
- Fraud and abuse are exploding, costing us at least $80 billion a year. That's a dime of every dollar we spend on health care.
- Our nation's health costs have nearly quadrupled since 1980. Without reform, by the year 2000, one of every five dollars we spend will go to health care.

The Health Security Plan

Every American citizen and legal resident will receive a Health Security Card. Once you get your card, you can ***never*** *lose your health coverage -- no matter what. If you get sick, you're covered. If you change jobs, you're covered. If you lose your job, you're covered. If you move, you're covered. If you have the courage to start a small business, you're covered.*

Your Health Security card guarantees you a comprehensive package of benefits that can never be taken away. *The package is as comprehensive as the ones that many Fortune 500 companies offer their employees. And in critical ways -- like paying for preventive care and prescription drugs -- the package gives you more than big companies provide today.*

You will be able to choose your doctor. *Everyone will have a choice of health plans. You'll be able to follow your doctors and nurses into a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. Your boss or insurance company won't decide how or where or from whom you get your care -- you will.*

Almost everybody will be able to sign up for a health plan at work, like you do today. You'll get brochures that give you easy-to-understand information on several health plans -- which doctors and hospitals are included, an evaluation of the quality of care, a consumer satisfaction survey, and prices. If you're self-employed or unemployed, you can sign up at your area health alliance, which will be run by consumers and businesses and bargain for affordable health care for you.

The federal government will set up a national health board -- a board of directors to set standards and make sure you get the comprehensive benefits and quality care you deserve. State governments will set up health alliances give consumers and small businesses the power to buy affordable care; and the businesses with 5,000 or more employees will be allowed to operate as "corporate alliances."

Insurance companies will be required to use a single claim form to replace the thousands of different forms they have today. So when you get sick, you won't be buried in forms -- and neither will your nurse, your doctor or your hospital.

- **Security for you and your family.**
- **A comprehensive package of benefits.**
- **Health care costs that are under control.**
- **Improved quality of care.**
- **Increased choices for consumers.**
- **Less paperwork and a simpler system.**

That's what the Health Security Act is all about.

Principle #1:
Security: Giving you health care that's always there.

Over the next two years, one of every four of us will lose health coverage for some time. The Clinton plan guarantees that you will never lose your insurance -- no matter what. Here's how the plan guarantees security:

- **Makes it illegal for insurance companies to deny you coverage because of "pre-existing conditions."** The Health Security Act also makes it illegal for insurers to raise your premiums or drop you because you get sick. All health plans will be required to accept anyone who applies -- healthy or sick, young or old.

- **Guarantees coverage if you lose your job**. The proposal guarantees that you will keep your health coverage even if you lose your job, with the employer portion picked up by Federal revenues and savings. Under the current system, if you lose your job, you lose your health insurance.

- **Guarantees coverage if you switch jobs, move or start a small business.** You will always be protected -- no matter what. Today, if you switch jobs, move or start a small business, you can find yourself without health insurance -- and risk bankruptcy.

- **Provides coverage for early retirees**. The health security plan guarantees coverage for early retirees, so they don't have to worry about being without coverage after they retire and before they are covered by Medicare. Today many early retirees are losing their health benefits.

Principle #2:
Comprehensive benefits: Keeping you healthy.

All Americans will receive a Health Security card that guarantees you a benefits package that is as comprehensive as those offered by most Fortune 500 companies...and then some.

Emphasizes preventive care. The comprehensive benefits package goes beyond virtually all current insurance plans by covering a wide range of preventive services, including mammograms, Pap smears, and immunizations, **at no charge to you.** It puts a new emphasis on helping you stay healthy, rather than waiting until they get sick. Prevention saves money and improves people's health.

Includes prescription drugs. Many insurance companies and Medicare have failed to cover prescription drugs. But drug costs are breaking family budgets, forcing many older Americans to choose between food and medicine. Health insurance should cover prescription drugs. The Health Security plan does.

All Americans will be guaranteed coverage of :

- Preventive Care (i.e., screenings, physicals, immunizations, mammograms, prenatal Care; at no cost)
- Doctor Visits
- Prescription Drugs
- Hospital Services
- Emergency/Ambulance Services
- Laboratory and Diagnostic Services
- Mental Health and Substance Abuse Treatment
- Expanded Home Health Care
- Hospice Care/Outpatient Rehabilitation
- Vision and Hearing Care
- Children's Preventive Dental Care

Principle #3:
Savings: Controlling health care costs.

Here's how the Health Security Act will control health care costs:

Limits how much insurance companies can raise your premium. Insurance companies will no longer be able to raise your premiums as they please. Today, insurance companies hike your premiums -- sometimes at several times the rate of inflation -- if you get sick, if someone in your family gets sick, and for any other reason.

Introduces competition to the health care marketplace. The Health Security plan will release the chokehold that in today's system, insurance companies have on all of us -- consumers, nurses, doctors, and businesses. Reform will encourage competition -- forcing costs down as health plans compete by offering high-quality care at an affordable price.

Cracks down on fraud. The health security proposal makes health-care fraud a crime and imposes stiff penalties on those who cheat the system. It prohibits doctors from referring patients to outside facilities, like labs, which they own a piece of. It stops the kickbacks that some laboratories give doctors in an effort to get their business.

Asks the drug companies to hold down prescription drug prices. The Health Security plan asks drug companies to take responsibility for keeping prices down, without setting prices. In today's system, overcharging runs rampant --certain prescription drugs cost Americans three times more than people pay in other industrialized countries.

Reduces paperwork. All health plans will adopt a single, standard claims form by Jan. 1, 1995. Along with other measures to streamline the system and free nurses and doctors from excess bureaucracy, this will reduce paperwork, cut red tape, and save money.

Squeezes the waste out of Medicare and Medicaid. By slowing the growth of these government programs, the proposal uses funds that have been wasted on excessive charges and funnels them into comprehensive benefits. Under reform, Medicare will be expanded to

cover prescription drugs, and there will be a new long-term care program to help cover home- and community-based care. Today, Medicare and Medicaid spending keeps going up and up. But the elderly and poor aren't getting any extra benefits. Health security will change that.

Principle #4:
Quality: Making the world's best care better.

Emphasizes preventive care. The Health Security plan puts a new emphasis on preventing illness before it becomes a medical crisis. Prevention will improve the quality of care by helping people stay healthy rather than treating them after they get sick. The benefits package fully pays for a wide range of preventive services; the vast majority of today's insurance plans don't cover a penny.

Gives consumers the power to judge the quality of care. Consumers will receive quality "report cards" that provide information on the performance of health care plans and patient satisfaction. These report cards will hold health plans accountable for meeting high standards. The National Quality Program will help states share information on health plan performance.

Reforms malpractice. The President's proposal will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to use alternative forms of dispute resolution before they end up in court. This will help eliminate the "defensive medicine" that drives up costs and hurts quality -- doctors ordering extra tests because they fear lawyers looking over their shoulders.

Encourages cooperation in rural and urban areas. Rural residents will have access to the latest technology and emergency services through telecommunications links set up between local doctors and advanced networks of specialists and hospitals. In urban areas, the plan will increase investment in public hospitals and community health centers.

Provides incentives for more family doctors to practice in rural and urban areas. The health security plan will give financial breaks to doctors and nurses who work in underserved rural and urban areas. It will expand the National Health Service Corps. Two of three rural counties today do not have enough doctors and 111 rural counties have no physician at all.

Increases funding for prevention research. The National Institutes of Health (NIH) will expand research in areas like children's health, and health and wellness promotion. Preventive care keeps people healthier and saves money at the same time.

Promotes research on the effectiveness of treatments. Today, a lack of information about the most cost-effective methods of treatment often leads to expensive defensive medicine and wide variation in treatments and costs. The plan's investments in research into what treatments really work will help improve the quality of care.

Principle #5:
Choice: Preserving and increasing what you have today.

Preserves your right to choose your doctor. The proposal ensures that you can follow your doctor and his or her team to any plan they might join. Today, more and more employers are forcing their employees into plans that restrict your choice of doctor. After reform, your boss or insurance company won't choose your doctor or health plan -- you will.

Increases your choice of health plan. You will be able to choose from among all the health plans offered in your area -- no matter where you work. Only one of every three companies with fewer than 500 employees offer any choice of health plan. After reform, every employee will be able to choose a health plan.

Puts consumers in the driver's seat. The Health Security Act brings competition to health care -- unleashing the market forces that will lower costs and improve quality. Giving small businesses and consumers the power to band together in alliances will level the playing field and give them the same bargaining strength as big businesses.

Increases options for long-term care. The President's proposal will make it possible for more Americans to continue to live in their homes and communities while receiving care. Today too many families are split apart when insurance or federal programs only pay for hospital coverage. The plan will help put an end to this situation and give families the options they deserve.

Principle #6:
Simplicity: Reducing paperwork and cutting red tape.

Gives everyone a Health Security Card. The card -- with full protection for privacy and confidentiality -- will allow for electronic billing and the creation of health care information networks. This will reduce paperwork and simplify the system.

Requires insurance companies to use a single claim form. The Health Security Act will reduce the insurance company red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. All health plans will adopt a single, standard claims form by Jan. 1, 1995. It will enable doctors and nurses to spend more time taking care of you -- and less time wrestling with paper.

Eliminates fine print. Everyone will get a comprehensive benefits package -- and what you get will be spelled out in easy-to understand language. If you get sick, insurance companies won't be able to point to fine print and deny you the coverage you've paid for.

Streamlines billing reimbursement for doctors, nurses and hospitals. The comprehensive benefits package, a standard rules and codes for payment, and elimination of excessive government regulations will reduce confusion. Doctors, nurses, and hospitals will have more time to care for patients; and all of us will benefit.

20% average. Those who choose a more expensive plan will pay a little more, as they do today. Employers who currently pay 100% of health benefits may continue to do so.

Two parent family with children: Two parent families with children -- whether one or both parents work -- pay a maximum of 20% of the family premium offered by the average plan in their area. If both parents work, they choose how to pay their family's share. They can have the share deducted monthly out of either paycheck or write a check to the local alliance.

Couple: Working married couples -- whether one or both spouses work -- pay a maximum of 20 percent of the average plan premium. They can have the share deducted monthly from either paycheck or write a check to the local alliance.

Single-parent family: Working single parents with children pay a maximum of 20 % of the average plan premium for a single parent policy.

Individual: Working single people pay a maximum of 20% of the average premium for an individual policy in their area.

Part-time worker with no unearned income: Part-time workers pay a maximum of 20% of the average plan premium for their policy type in their area.

EXCEPTIONS

Exceptions are provided for: (1) the self-employed and independent contractors; (2) part-time workers who have unearned income; (3) families with incomes below 150% of the poverty level; and (4) seasonal workers.

Self-employed/independent contractors: The self-employed and individual contractors can deduct from their taxes 100% of their health care costs. As with any small business, they pay the employer share. They also pay an individual share. If a firm earns less than $24,000 a year, it is eligible for subsidies.

Part-time workers with unearned income: Part-time workers with unearned income pay a maximum of 20% of the average plan premium for their policy type -- individual, couple, two parent, or single parent family.

The number of hours someone works determines how much of the premium is paid by the employer and how much by the individual. For example, an employer would pay 40% of the premium for someone who works half-time. Payment of the remaining 40% of the premium depends on how much a person makes in unearned income, with subsidies provided on a sliding scale for those whose incomes are below 250% of the poverty level.

Families with incomes below 150% of the poverty level: Families at this level are eligible for discounted premiums and pay a maximum of 20% of the employee's share of

the average plan premium. This applies to individuals making $10,455 annually; couples with incomes of $14,145; families of three earning $17,835; and families of four with incomes of $21,525.

Seasonal workers: Seasonal workers pay a maximum of 20% of the average plan premium in the area where they reside.. Those whose incomes are 150% of the poverty level or below are eligible for discounted premiums. If they have unearned income and are not working, seasonal workers are treated the same as part-time workers.

Unemployed and non-working: Unemployed individuals and heads of household who make less than 150% of the poverty level are eligible for individual subsidies on a sliding scale. Those with unearned income pay all or part of what would normally be the employer's share of the premium.

Those whose incomes are 250% of the poverty level or less -- pensioners, for example -- are eligible for discounts on what would be the employer's share. They are not eligible for individual subsidies, and pay the normal individual share of the health premium.

THE NEED FOR REFORM
THE COST OF DOING NOTHING

The United States is a world leader in developing new medical technologies and probing the mysteries of disease through basic and clinical research. People from all over the world come to the United States for specialized training and treatment.

But the health care system, as a whole, is in deep crisis. Health care spending now consumes 14% of GDP, up from 9.1% in 1980. If nothing is done, by the year 2000, nearly 19% of America's GDP will go towards health care alone.

Some say that is acceptable, because that's what it costs to keep our population healthy. But this means accepting that rising health care costs should consume over 100% of the projected increase in wages, produce 60% of the projected growth in the federal budget, and eat away two-thirds of our projected economic growth for the rest of the decade.

But in fact, we would be spending that money without getting the security, simplicity, and value that would help bring health and expanded opportunity to all Americans.

In short, today's American health care system is insecure, costly, and bureaucratic, and it fails to provide high quality care and choices for all Americans.

A LACK OF SECURITY

- Every month, 2 million Americans lose their insurance. One out of four -- 63 million -- Americans will lose their health insurance coverage for some period during the next two years.
- 37 million Americans have no insurance and another 22 million have inadequate coverage.
- Losing or changing a job often means losing insurance. Becoming ill or living with a chronic medical condition can mean losing insurance coverage or not being able to obtain it.
- Long-term care coverage is inadequate. Many elderly and disabled Americans enter nursing homes and other institutions when they would prefer to remain at home. Families exhaust their savings trying to provide for disabled relatives.
- Many Americans in inner cities and rural areas do not have access to quality care, due to poor distribution of doctors, nurses, hospitals, clinics and support services.
- Public health services are not well integrated and coordinated with the personal care

delivery system. Many serious health problems -- such as lead poisoning and drug-resistant tuberculosis -- are handled inefficiently or not at all, and thus potentially threaten the health of the entire population.

RISING COSTS

- Rising health costs mean lower wages, higher prices for goods and services, and higher taxes. The average worker today would be earning at least $1,000 more a year if health insurance costs had not risen faster than wages over the previous 15 years.

- If the cost of health care continues at the current pace, wages will be held down by an additional $650 by the year 2000. [OMB]

- More and more Americans have had to give up insurance altogether because the premiums have become prohibitively expensive.

- Many small firms either cannot afford insurance at all in the current system, or have had to cut benefits or profits in order to provide insurance to their employees.

- Only one other industrialized country (Canada) spends more than 10% of their GDP on health care. Japan, France and Germany spend 9% of GDP or less, and their costs have not risen nearly as rapidly as ours.

QUALITY THREATENED

- No one is accountable for the performance of the health care system -- not hospitals, physicians, other providers, or health insurers.

- Quality care means promoting good health. Yet, our system waits until people are sick before it starts to work. It is biased towards specialty care and gives inadequate attention to cost-effective primary and preventive care.

- Consumers cannot compare doctors and hospitals because reliable quality information is not available to them.

- Health care providers often don't have enough information on which treatments work best and are most cost-effective.

- Health care treatment patterns vary widely without detectable effects on health status.

- Some insurers now compete to insure the healthy and avoid the sick by determining "insurability profiles". They should compete on quality, value, and service.

- The average doctor's office spends 80 hours a month pushing paper. Nurses often

have to fill out as many as 19 forms to account for one person's hospital stay. This is time that could be better spent caring for patients.

- Insurance company red tape has created a nightmare for providers -- with mountains of forms and numerous levels of review that wastes money and does nothing to improve the quality of care.

- We have the best doctors who can provide the most advanced treatments in the world. Yet people often can't get treated when they need care.

- Our medical malpractice system does little to promote quality. Fear of litigation forces providers to practice defensive medicine -- ordering inappropriate tests and procedures to protect against lawsuits. Truly negligent providers often are not disciplined, and many victims of real malpractice are not compensated for their injuries.

GROWING COMPLEXITY

- Purchasing insurance can be overwhelming for consumers. With different levels of benefits, co-payments, deductibles and a variety of limitations, trying to compare policies is confusing and objective information on quality and service is hard for consumers to find. As a result, consumers are vulnerable to unfair and abusive practices.

- Insurers have responded to rising health costs by imposing restriction on what doctors and hospitals do. A system that was complicated to begin with has become incomprehensible, even to experts. Each health insurance plan includes different exclusions and limitations. Even the terms used in health policies do not have standard definitions.

- Small business owners -- who cannot afford big benefits departments -- have to spend time and money working through the insurance maze. For firms with fewer than five workers, 40 percent of health care premiums go to pay administrative expenses.

- Administrative costs add to the cost of each hospital stay with the number of health care administrators increasing four times faster than the number of doctors.

- Health claim forms and the related paperwork are confusing for consumers, and time-consuming to fill out.

DECLINING CHOICES

- Insurance coverage for most Americans is not a matter of choice at all. In most

cases, they are limited to whatever policy their employer offers. Only 29% of companies with fewer than 500 employees offer any choice of plans.

- With a growing number of insurers using exclusions for pre-existing conditions, arbitrary cancellations and hidden benefit limitations, consumers have few choices for affordable policies that provide real protection.

THE HISTORY OF HEALTH REFORM IN THE UNITED STATES

Health care reform has been on the American agenda for nearly a century. Since the early 1900s, commissions, committees, groups and organizations have put forth proposal after proposal to overhaul the way the nation delivers and pays for medical care. Over time, the forces of opposition have shifted, somewhat, as have their arguments against change. Remarkably, the solutions to the American health care problem have been clear from nearly 75 years. What has eluded us is the political will to tackle the health care problem once and for all.

Early Attempts at Reform

A group called the American Association for Labor Legislation made the first large scale proposal for health care reform in 1915, starting a national discussion on reforming the way health care was paid for and delivered. The group put forth nine principles for reform. **Its recommendations: employers, employees and government should share in the cost of an integrated health care system; the system should focus on prevention rather than cure; and people should have protection against bankruptcy if they become disabled.**[1]

Early opposition came from insurers, who, although they didn't sell health insurance, said they hadn't been included in formulating the plan and who feared loss of business. In the wake of American involvement in World War I, opponents of national health insurance associated reform with Germany, which had begun a system of national health insurance in the late 1800s.[2]

Continued pressure from the insurance industry, coupled with anti-German sentiment, pushed national health insurance to the back burner for more than a decade.

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[1]A Chronology of Health Insurance and Health Care Financing Reform, The Alliance for Health Reform, November 1992

[2]In 1883 Germany's Prince Bismarck launched the world's first social insurance program, which included health coverage.

The Roosevelt Era

As the Great Depression took hold, more and more Americans found themselves unable to pay for needed medical care. Hospitals took the lead in sponsoring pre-paid health care plans.

In 1932, blue-ribbon commission called the Committee on the Costs of Medical Care urged comprehensive reform. **Its proposal: create a national network of community care centers to replace the fee-for-service system of individual doctors in separate practice.** Around the same time, President Roosevelt began his own push for national health insurance. His landmark social legislation, the Social Security Act, was to include provisions for national health insurance shaped largely by the committee's report. But the AMA attacked the proposal, and President Roosevelt was faced with the choice between abandoning his plans for national health insurance or risking defeat of the entire Act. FDR decided not to include the health reform provisions, vowing to fight for national health insurance in his second term. But when Congressional elections weakened the original New Deal coalition in 1938, Roosevelt abandoned her plans for reform.

During World War II, as wage and price control policies led more employers to compete for workers by offering health insurance benefits not subject to controls, Congress introduced a bill to create a national government health insurance program within Social Security. FDR pledged to make passage a top priority after the war.

The Truman Era

After the President's death in April 1945, President Truman vowed to continue FDR's fight for national health reform. In November he introduced a large scale plan. **His proposal: federal aid to build new hospitals, increased federal support for public, maternal and child health, and-- for the first time-- universal, compulsory federal health insurance.** In response to questions about the programs high costs, President Truman noted that the U.S. spent only 4 percent of its gross national product on health care and "we can afford to spend more."

For several years, President Truman fought for passage of his national health reform bill. Initially, public support was strong, but opposition brought together organized medicine, big business and the media to sway public opinion. Pieces of the plan were broken off and passed, such as the Hill-Burton Act, which in 1946 increased federal funding for new hospital construction, and federal aid for maternal and child health.

The Truman plan was re-introduced in 1948, and legislative inaction caused the President to rail against the "do-nothing Congress." The opposition was well organized and effective, labeling reform "socialism." The Cold War and anti-communist mood of the country, along with foreign upheavals distracted Americans and their leaders. The movement lost momentum, and the coalition that had pushed for reform disintegrated.

Another factor that dampened the push for national health reform after the war was that increasing numbers of Americans had health insurance through work. Though health coverage was increasingly common through work, changes in the insurance market sowed the seeds for many of the most devastating inequities in today's health insurance market. Commercial insurance companies-- those that sold fire and home and life insurance-- entered the health insurance market, challenging the Blue Cross and Blue Shield plans that traditionally provided health insurance.

The Blues had traditionally set premiums based on a "community rating"-- spreading the health costs of an entire community evenly and fairly among all members. They also offered "open enrollment" taking all applicants who wanted to buy insurance regardless of their health status.

Commercial insurers competed by using different practices. They adopted "experience rating," basing premiums on a group's claims history, and "medical underwriting" using the age and health status of a groups' members to anticipate the risk of future claims. This change in approach to rating and underwriting practices allowed the commercial insurers to undercut the "Blues" by offering firms with young, healthy workers lower rates, a practice now known as "cherry picking". This process increasingly left the Blues and other community-rated insurers with fewer healthy members until they began to abandon community rating and play by the new rules.

Health care costs began to rise during the 1950s, making health care services increasingly inaccessible to the two groups least likely to have coverage through a job-- the poor and retirees. In 1958, legislation was introduced to help extend coverage to these groups. That movement would eventually lead to the passage of Medicare and Medicaid.

President Kennedy advanced the health reform cause in the early sixties, and the AMA again bitterly opposed what they "socialized medicine". Despite opposition from organized medicine, President Johnson signed Medicare and Medicaid into law on July 30, 1965. Medicare extended health insurance coverage to people over 65 and those with disabilities. Medicaid expanded and reorganized federal assistance to the states to care for the poor. These laws were seen as important first steps toward national health insurance for populations at most risk. Working Americans were perceived to be less vulnerable because employers provided adequate health benefits.

A shortage of doctors, nurses and other health professionals in the mid-1960s produced laws that began federal financial help for training health professionals.[3]

The Nixon Era and Beyond

Until the 1970s, health costs were not a major focus of reform. In fact, most reformers argued in favor of more on health care. A number of factors -- high rates of inflation, slow economic growth, an explosion of medical technology, an increasing number of specialized health providers and the Medicare program --pushed the total economy spent on health care increasingly higher. With the election of 1968, the push for national health insurance was revived for the fourth time. For the first time, the focus shifted from expanding services to controlling costs.

President Nixon embarked on a health reform agenda aimed at: **expanding managed care to change incentives in which "doctors and hospitals benefit most from sickness, rather than health" establishing universal coverage by requiring all employers to provide at least a minimum health benefit and establishing a federal insurance program for the working poor and unemployed. The administration's legislation all introduced by Senator Bob Packwood and Representative Wilber Mels.**

President Nixon's health reforms almost passed with bi-partisan support. The public had grown increasingly alarmed about the crisis in health care. However the oil shock of 1973, the political demise of the Ways and Means chairman, and the Watergate scandal sidetracked the issue. Major labor unions had supported of the bill withdrew, hoping to help a more expansive package with a more liberal Congress in the wake of Watergate.

Costs continued to climb for the next twenty years, with government, businesses and insurers piecemeal at reform. Lacking a unified approach, the effect on access or costs was minimal. In the absence of an overall national framework, many of the piecemeal reforms skewed the system and added to the problem: America has an excess number of hospital beds, a shortage of primary care doctors, an insurance system that specializes in avoiding risk rather than managing it. ERISA led to large companies playing by a different set of insurance rules. Reduction in Medicaid weighed on state budgets and added to the "cost-shifting" problem.

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[3] Just as the Truman's Hill-Burton Act led to a sharp increase in the number of hospitals, these laws served to greatly increase the supply of health care providers. Many now argue that the increased supply itself created increased use of doctors and hospitals, and in turn increased health care spending.

Today's Challenge

Throughout the late eighties and early 1990s, an increasing number of legislators introduced comprehensive reform proposals, and health reform rose again in the public consciousness. The approaches vary-- "play-or-pay," "single payer," "managed competition"-- but an increasing number of elected officials tried to respond to the public's deafening call: do something.

So why has nothing been done? It is not because the answers eluded us. We knew in 1915 that employers, employees and the government should contribute to the costs of health care, and that the system should focus on prevention.

We knew in 1935 that we should encourage doctors and hospitals to form networks and share responsibility for high quality, cost-effective care. President Truman proclaimed in 1946 that health care should be considered a right, not a privilege. President Nixon told the American people in 1972 that the only way to insure universal access was to ask employers to take responsibility for their workers' coverage.

It is up to President Clinton and this Congress to decide whether the 1990s will become yet another decade in which the leaders of this nation almost did something about health care. The stakes rise each time. As the problems become worse, tackling them becomes more difficult. As costs have risen higher, the cost of doing nothing has also risen. We can no longer afford to delay.

Health Security Plan

How We Pay For Health Security

Summary

To pay for health security for Americans, we're going to spend our health care dollars wisely and ask everyone to take some responsibility The old way to finance this kind of program would have been to simply raise taxes But the President rejected that route. He believes that we can spend our health care dollars smarter, eliminate waste and demand responsibility of every American.

Here how we'll pay for it.

The vast majority of the money comes from the same place it comes from today: employers and individuals. But under the health security plan, every employer and every individual will be asked to contribute to health care. Everyone takes responsibility, and everyone gets security

To finance the rest of reform, we'll:

- Achieve new savings in Medicare and Medicaid and reinvest that money in new benefits.
- Recover the money that hospitals and doctors write off today when they give care to people who can't pay for it.
- Raise sin taxes.

Taken together, those sources can finance the health security plan. And we'll also go after two big sources of savings: the paperwork that has buried our system -- estimated to cost about $100 billion each year (which we do not even count on to finance our plan) -- and health care fraud, which cheats our nation of $80 billion annually.

Approach

The Health Security plan is a uniquely American solution to an American challenge. We believe that it's time to stop raising taxes to pay for huge federal programs -- and start spending our money right and letting the market drive prices down.

Some people believe that we should have a government-run system financed by a massive tax increase. The President specifically rejected that route. He believes that we should not raise taxes on hard-working Americans when there is another, better path to pay for health care reform.

The new way builds upon our current private health care system. Most Americans today get their health care through employers -- and that will continue. But now every employer and individual will be asked to take responsibility. By spreading the responsibility and spending Federal health care dollars wisely, we can guarantee every American a comprehensive package of health benefits that can never be taken away.

Elements

• **Employer/employee responsibility.** The Health Security plan asks every employer and employee to take responsibility for health care. It replaces today's unfair system that raises prices for those who are responsible and cover their employees while giving others a free ride [Note, that Nixon's health proposal included an employer mandate and was sponsored by Packwood.]

Take, for example, the garage owner who insures his employees and the car wash proprietor down the street who doesn't. When one of the workers at the car wash ends up in the emergency room without insurance -- and gets treated -- the garage owner and his employees take the hit. That's not right, and it's got to change.

We recognize, of course, that small businesses that currently offer no health coverage could have trouble making the adjustment if there was no measure designed to help them. That's why the Health Security plan offers them discounts and caps what they have to pay.

• **Federal program savings.** The Health Security plan tries to slow the unrestrained growth of Medicare and Medicaid and reinvest the savings in new benefits: prescription drugs and long term care. Even with the savings in the plan, Medicare and Medicaid will rise at twice the rate of inflation. [Only those people earning $100,000 or more will pay higher premiums.]

• **"Uncompensated care."** Providing health security for every American will eliminate what the experts call "uncompensated care." In everyday life, it's what happens when someone who can't pay for health care or lacks insurance walks into an emergency room and is treated. The hospitals and doctors eat the cost, and pass it on to insured patients -- one of the reasons you might pay $26 for an aspirin in the hospital. The Federal government picks up its share, too. By guaranteeing comprehensive benefits that can never be taken away, the Health Security plan lets us all benefit from the money that we'll recover.

• **New revenues.** New revenues will be raised through so-called sin taxes, which require people whose health costs are higher than the rest of us to pay more for products that are health hazards. It's also possible that we'll ask the biggest corporations to pitch in a little extra to help fund the research centers and academic hospitals that support all of us.

• **Other savings.** Administrative costs and excessive paperwork drive doctors and nurses crazy -- and help drive the costs of health care through the roof. Some estimate that just managing the paper and records and billings for health care costs Americans $100 billion every year. The Health Security plan streamlines and modernizes the way health care services are paid for -- and should yield significant savings.

The Health Security plan will crack down on the explosion in health care fraud, which is cheating American taxpayers out of $80 billion a year. The plan imposes stiff, new penalties on those who game the system. Getting tough will yield new savings that can be reinvested in what Americans deserve: high quality care. And, we don't even count on these savings to pay for the Health Security plan.

COST ESTIMATES IN HEALTH CARE REFORM

UNPRECEDENTED PROCESS OF OUTSIDE REVIEW: The health care financing analysis undertaken by the administration has been rigorous. We tapped the best analytical talent inside and outside the federal government to get it done. In creating the analytical foundation for our estimates, there was an unprecedented degree of outside review of our assumptions and methodologies from nationally recognized consulting and accounting firms and from Fortune 500 companies. That's why we're so confident that our estimates are both credible and conservative.

Urban Institute modelers and a team of non-government actuaries and health economists followed the model building and estimating process throughout, and offered analysis and suggestions. They immersed themselves in the models early on, made significant contributions to the methodologies finally used, and came away impressed with the amount of analytical rigor underlying the models and with our commitment to accuracy and prudence.

UNPRECEDENTED INTERGOVERNMENTAL SCRUTINY AND COOPERATION:
In addition to the outside groups, a team of actuaries and health economists from all the branches of government that do financial analysis and cost estimating set up a working group back in February, and have been working together ever since. They have shared data and worked through assumptions and methodologies in much greater detail than has ever been done before. You know, a lot of the people involved in this effort have been working on health care numbers their whole professional life, and they'll tell you they've never been part of anything like this.

Estimating a complete health care system overhaul is obviously an immensely complex task. Reasonable people can differ about assumptions, so our team tried to consistently err on the side of conservatism.

THIS PROCESS GIVES US STRONG CONFIDENCE IN OUR NUMBERS:
The process and rigor give us strong confidence in the numbers in the current draft. The savings estimates are under continuing review by OMB, Treasury and HHS as adjustments are made to the plan based on our continuing consultation. Policy and technical adjustments will of course will be made as any major policy like this goes through the normal process of review, but we will continue to maintain the high standards we have proceeded by so far.

SCENARIOS

Summary

Listen, nobody can tell you exactly what you'll pay for health care when the program takes effect. Obviously, it will vary depending on where you live and which plan you choose.

Individuals: As a rule, most individuals and families -- in which at least one person works -- will pay a maximum of 20% of the average health plan premium in their area. Those who choose a lower cost plan -- from among the range of plans offered -- will pay a little less than the 20%. Those who choose a more expensive plan will pay a little more, as they do today. On average, nobody will more than ___% of their income. For example, a family of four that earns $40,000 will pay an average of $75 a month for their health premium.

The individual/family contribution is based on the actuarial value of the premium -- not on income level. [There are discounts, of course, for low wage or unemployed individuals/families.] So, an individual earning $30,000 per year will pay the same premium as an individual earning $300,000 per year.

Summary: *About two thirds of people will pay the same or less under reform. Of the other third, most will pay more for better benefits and a relatively small percentage -- mostly young, single and healthy -- will pay more for similar benefits.*

67% pay same or less for more

- Most people getting insurance today -- including employees of small and large firms -- will pay less for their benefits.

20% pay more for better benefits

- This includes people who have no insurance today as well as those who currently have bare-bones or catastrophic coverage.

13% pay more for the similar benefits

- The vast majority of this group are young, single, healthy individuals who today are "experience-rated" and will be "community-rated" under reform. A very small percentage are people -- of all ages and health status -- who belong to large pools of relatively healthy people..

PAYMENT SCENARIOS

As a rule, most individuals and families in which at least one person works will pay a maximum of 20% of the average health plan premium in their area. Those who choose a lower cost plan -- from among those offered in the area -- will pay a little less than the 20% average. Those who choose a more expensive plan will pay a little more, as they do today. Employers who currently pay 100% of health benefits may continue to do so.

- **Two parent family with children:** Two parent families with children -- whether one or both parents work -- pay a maximum of 20% of the family premium offered by the average plan in their area. If both parents work, they choose how to pay their family's share. They can have the share deducted monthly out of either paycheck or write a check to the local alliance.

- **Couple:** Working married couples -- whether one or both spouses work -- pay a maximum of 20 percent of the average plan premium. They can have the share deducted monthly from either paycheck or write a check to the local alliance.

- **Single-parent family:** Working single parents with children pay a maximum of 20 % of the average plan premium for a single parent policy.

- **Individual:** Working single people pay a maximum of 20% of the average premium for an individual policy in their area.

- **Part-time worker,** with no unearned income**:** Part-time workers pay a maximum of 20% of the average plan premium for their policy type in their area.

EXCEPTIONS

Exceptions are provided for: (1) the self-employed and independent contractors; (2) part-time workers who have unearned income; (3) families with incomes below 150% of the poverty level; and (4) seasonal workers.

1. **Self-employed/independent contractors:** The self-employed and individual contractors can deduct from their taxes 100% of their health care costs. As with any small business, they pay the employer share. They also pay an individual share. If a firm earns less than $24,000 a year, it is eligible for subsidies.

2. **Part-time workers with unearned income:** Part-time workers with unearned income pa a maximum of 20% of the average plan premium for their policy type -- individual, couple, two parent, or single parent family. The number of hours someone works determines how much of the premium is paid by the employer and how much by the individual. For example, an employer would pay 40% of the premium for someone who works half-time. Payment of the remaining 40% of the premium depends on how much a person makes in unearned income, with subsidies provided on a sliding scale for those whose incomes are below 250% of the poverty level.

3. **Families with incomes below 150% of the poverty level:** Families at this level are eligible for discounted premiums and pay a maximum of 20% of the employee's share of the average plan premium. This applies to individuals making $10,455 annually; couples with incomes of $14,145; families of three earning $17,835; and families of four with incomes of $21,525.

4. **Seasonal workers:** Seasonal workers pay a maximum of 20% of the average plan premium in the area where they reside.. Those whose incomes are 150% of the poverty level or below are eligible for discounted premiums. If they have unearned income and are not working, seasonal workers are treated the same as part-time workers.

Unemployed and non-working: Unemployed individuals and heads of household who make less than 150% of the poverty level are eligible for individual subsidies on a sliding scale. Those with unearned income pay all or part of what would normally be the employer's share of the premium. Those whose incomes are 250% of the poverty level or less -- pensioners, for example -- are eligible for discounts on what would be the employer's share. They are not eligible for individual subsidies, and pay the normal individual share of the health premium.

PAYMENT SCENARIOS - INDIVIDUALS AND FAMILIES

TWO WORKER FOUR PERSON FAMILY

Today Debbie Brown is a special events coordinator who lives in San Diego, California with her husband, a real estate developer, and their two children. Their combined income is slightly over $75,000 a year. Their share of their current premium is $2,940.

Reform The Browns may choose to enroll in any plan offered in their alliance area and will pay the difference between what the premium costs and the 80% share contributed by employers in the alliance. For example, plans are offered in the alliance area which cost $4,300 a year, $4,500 a year and $4,700 a year. Since 80% of the average premium is $3,600, the Browns may pay either $700, $900 or $1,100, depending on the plan in which they choose to enroll. Even if they choose the highest priced plan, they will spend $1,840 less than they do now. The Health Security Plan guarantees that there will always be a health plan available to families like the Browns for no more than 20% of the average annual premium.

SINGLE WORKER 4 PERSON FAMILY

Today Debbie and her husband decide that she should stay home with the children. Because she is no longer working, their combined annual income decreases to $39,000.

Reform Since the family premium rate is based on the average number of workers per family in the alliance, the contribution made by Mr. Brown's employer and the expenditures made by the Brown's themselves will not change despite their decision.

PART-TIME WORKER WITH PENSION

Today Marjorie Smith is a 53 year old widow living in Tampa, Florida. Immediately after her 48 year old husband died, she retained coverage under her husband's group health insurance policy through COBRA. When her COBRA policy ended, she was forced to convert her policy to an individual policy. She works 15 hours a week at the library and earns $7,500 a year. She receives $12,500 a year from her husband's pension. She has a pre-existing heart condition and

pays $6,000 a year in health insurance premiums

Reform

Because Marjorie works 15 hours a week (considered half-time), her employer is responsible for contributing half of the employer's share. She is responsible for paying the other half of the employer share out of her non-wage (pension) income only. Since her non-wage income is less than 250% of poverty, she is eligible for a government subsidy towards this share of the premium. Assuming that the average annual individual premium in the alliance area is $2,000, the library will be responsible for $800. Marjorie will be responsible for the remainder, although she will be subsidized by the government.

Marjorie also must pay the difference between the 80% share and the premium price of the plan in which she chooses to enroll. Because her combined income is greater than 150% of poverty, she is not eligible for a subsidy. If she chooses to enroll in a plan with the alliance average premium, she will pay $400 per year.

Even if Marjorie were not to receive a government subsidy for her part of the employer's share, she would be paying $1,200 a year - substantially less than the $6,000 she is currently paying.

YOUNG SINGLE WORKER

Today

Bobby Jones is a 22 year old college graduate. He works for a small record store in Washington, DC where he earns $18,000 a year. The record store does not provide health insurance for its employees. Bobby is young and healthy and has decided not to spend the money to get health insurance.

Reform

Bobby and his employer will be required to contribute toward Bobby's health insurance. Because Bobby works full-time, the record store will be responsible for paying towards his health insurance premiums. As a small business, they may be eligible for government subsidies.

Bobby will be responsible for paying the difference between the 80% employer share and the premium price for the health plan in which he chooses to enroll. He will not be eligible for a government subsidy, however, because his income exceeds 150% of poverty. If the average plan costs $2,000 a year and Bobby enrolls in it, comprehensive health benefits will cost him $400 per year.

HIGH INCOME TWO-PERSON FAMILY

Today Fred and Martha Sampson live in Chicago, Illinois. Fred earns $100,000 a year as a journalist, Martha earns $150,000 as a lawyer. They are healthy and have no children. Fred's employer currently pays 100% of their high-option premium in Blue Cross. Fred and Martha pay nothing for their health insurance.

Reform Both employers contribute to a couples policy. Fred's employer can decide to continue to pay 100% of the premium on his behalf, as well as provide a supplemental policy to cover additional benefits offered under the current policy. Martha's employer must begin to pay the contribution determined by the alliance for a couples policy. Her employer may also choose to cover her individual share, allowing the Sampson's to select a plan from the Chicago alliance without any cost to themselves.

If the average premiums for couples is $4,000 -- even if their employers decide not to cover Fred and Martha's shares -- they can enroll in an average cost plan for $800 a year.

LOW-INCOME SINGLE PARENT FAMILY

Today Rosa Fernandez is a 25 year old divorced mother of 3 in Secaucus, New Jersey. She earns $18,000 a year working full-time as a secretary. Her employer does not currently provide health insurance. Her ex-husband works as a carpenter and has an annual income of $22,000. He belongs to a union which provides health insurance to its members at an annual cost to members of $1,200. He does not currently purchase health insurance. He provides annual child support payments of $6,000 to Rosa.

Reform Rosa and her children will finally have health insurance. Because Rosa is a full-time worker, her employer pays the family premium contribution determined by the alliance. With an income less than 150% of the poverty line for a family of four ($21,525), Rosa is eligible for a subsidy from the government. After contributions from her employer and the government, Rosa pays only the remiander of the cost the plan she selects from the northern New Jersey alliance.

For example, plans are offered in the alliance area which cost $3,700 a year, $3,900 a year and $4,100 a year. Eighty percent of the average premium is $3,120. Rosa receives a subsidy from the government for the difference between her employers contribution and the cost of the lowest cost plan or

$680. Rosa can select the lowest cost plan and receive comprehensive coverage for her family at no cost to her or she can enroll in the other plans by paying $200 or $400, a year depending on which plan she chooses.

SELF-EMPLOYED SINGLE PARENT FAMILY

Today Ralph Cooper, a divorced father of two, is a free-lance artist in Ft. Worth, Texas. He works out of his home and earns $24,000. He currently purchases a family policy. Under current law, only 25% of the cost of that policy is tax deductible.

Reform Ralph will be able to deduct the entire cost of his health insurance policy. As a self employed person, he must contribute both the employer share and the employee share of a single parent with children policy, estimated to cost $3,900 on average. Self-employed people are eligible for the same caps as small businesses for the employer share of premium. Eighty percent of the premium would be $3,120. With an income of $24,000 , Ralph is eligible for a discount. His employer share is capped at 6.5% of his income or $1,560 saving him $1,560. He owes the difference between the full 80% share and the cost of the policy he selects. For the average cost plan that would his family share wold be $780 a year, making his total cost $2,340 a year.

TWO EARNER FAMILY (WITH SELF-EMPLOYED WORKER)

Today Ralph Cooper marries Kathryn White, an executive with Hewlett Packard, who earns $75,000 a year. They receive family coverage through the HP plan.

Reform Hewlett Packard may choose to operate as a corporate alliance. If they do, Ralph and Kathryn can choose one of the plans offered through the Hewlett Packard corporate alliance or any of the plans in their local regional alliance selecting the plan which best meets their families needs from either alliance.

If Ralph and Kathryn choose a corporate-sponsored plan then HP pays 80% of the average contribution for their type of policy in their corporate alliance. Ralph pays a capped premium to the regional alliance as he did previously now based on the cost of a two parent family policy. They also pay the balance of the cost of the policy of their choice.

If they choose a regional alliance plan, Ralph pays the same capped premium contribution for a family policy with assistance from the government. Hewlett Packard pays 80% of the cost a family premium in the regional alliance. Ralph and Kathryn pay the difference between 80 percent of the cost of the average family premium and the cost of the plan they choose.

Q. **Will I be able to choose my own type of health insurance? And can I buy extra insurance if I want it?**

A. Of course. You will always be able to choose your plan. Today, rising health care costs have forced businesses to limit the health plans their employees can join and sometimes the doctors they can see. That won't happen under the Health Security plan. No boss will be able to tell you what doctor to go to or what health plan to join. You'll have the choice of at least three plans -- a traditional fee-for-service plan, a network of doctors and hospitals, or an HMO.

You will always be free to purchase any additional insurance you want, although these added benefits will not be tax-deductible. The insurance industry will be monitored though to make sure you don't get ripped off by companies trying to sell you duplicate coverage.

Q. **Will anything be done to reduce and simplify all the insurance forms I have to fill out?**

A. Yes. The Health Security Act will streamline the rules, reduce the paperwork, and make the system make sense. It will do away with all the different claims forms and confusing bureaucratic rules. You will no longer get a bunch of forms in the mail -- and then cross your fingers and hope that you've filled them out right. The one, comprehensive benefits package means that you will no longer have to worry about what's covered under which policy or what you might have missed in the fine print. Most importantly, this simplification will mean that the money you pay goes to health care -- not bureaucracy.

Q. **What happens if I change jobs? Will I risk losing health insurance coverage?**

A. No. The Health Security Act will guarantee that you will never lose your insurance coverage -- even if you change jobs, lose your job, move, or start a small business. It will be illegal for insurance companies to drop you **for any reason.**

Q. **What if someone in my family has a pre-existing health condition? Will they be covered?**

A. Absolutely. Under the Health Security plan, it will be illegal to refuse to insure people just because they've been sick. Health plans will have to

accept you -- healthy or not -- and, most important, they cannot charge you more for being sick. And you'll have the security of knowing that no one can ever take your benefits away from you.

Q. **Will the quality of care my family receives be hurt under a new system?**

A. No. Health reform holds doctors and hospitals accountable for the care they give. You'll get a consumer "report card" that you can use when you choose or change health plans. It will tell you what people think of the care they have received under each health plan and will have objective measures of results to help you compare one plan to another. And if you don't like your health plan, you can change to a different plan or a new doctor.

Q. **I'm retired and on a fixed income. Will my Medicare coverage be affected?**

A. No. Older Americans who receive Medicare will continue to receive all the benefits they do today. In addition, the Medicare program will be strengthened by adding prescription drug coverage and expanded options for home and community based long term care. If you're on Medicare, you'll actually have more choices after reform. You can continue to receive care like you do today or choose among different health plans that may offer fuller benefit packages and lower payments.

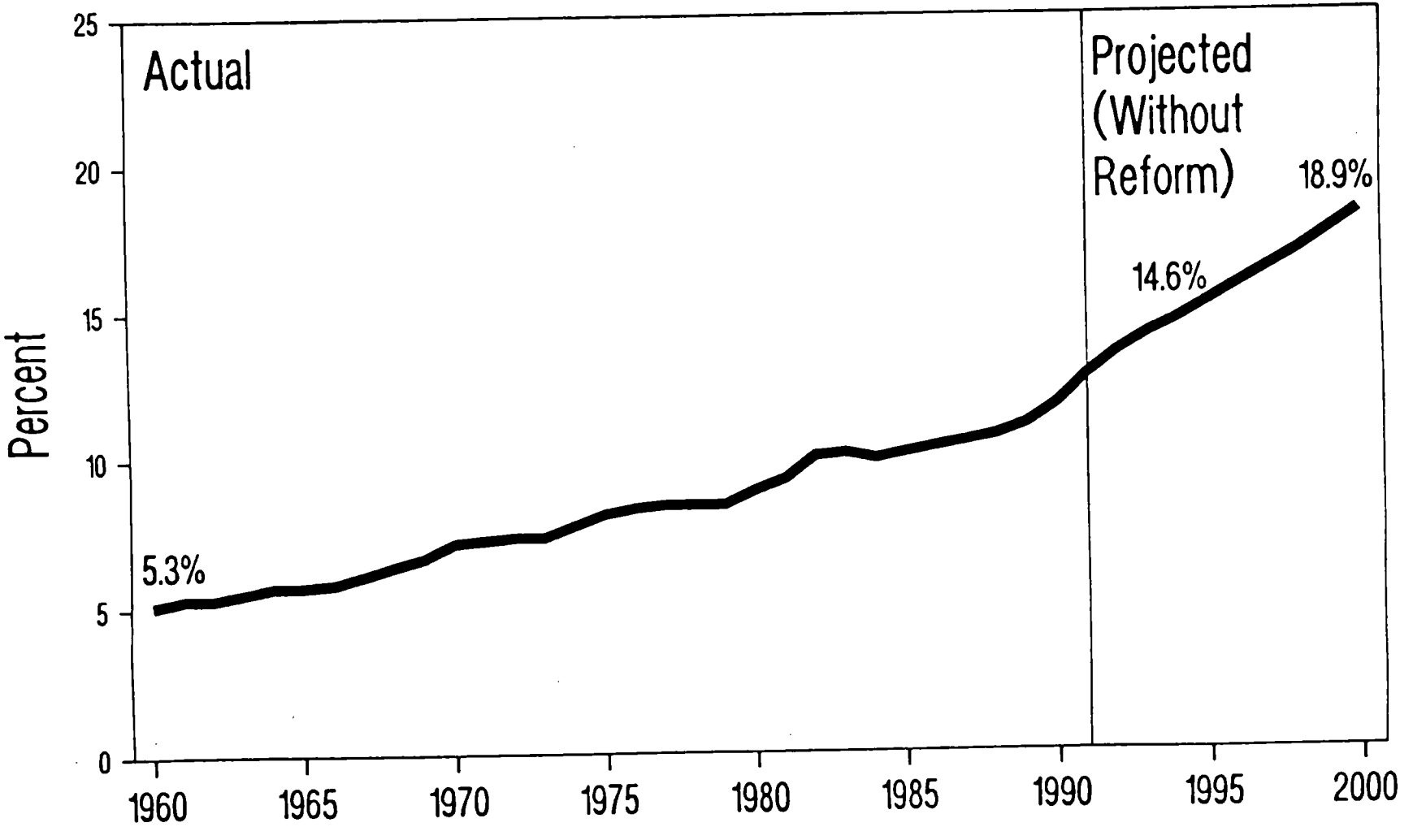
Q. **Will costs be controlled in a way that doesn't interfere with my medical care?**

A. Certainly. Costs will be controlled by eliminating the waste, fraud, and abuse in the current system -- not be cutting corners on consumers. Doctors will be in control of their professional decisions. Patients will finally be asked their opinion and will be given all the information they need to make their choices.

Q. **Will everybody in America have health insurance? And, if so, how will we pay for this?**

A. All Americans and legal residents will be guaranteed a comprehensive package of benefits that can never be taken away. Everyone -- employers and individuals -- will be asked to take responsibility for contributing something, even if its only a small amount, to the cost of their health care.

National Health Expenditures as a Percentage of Gross Domestic Product, 1960-2000



SOURCE: Congressional Budget Office

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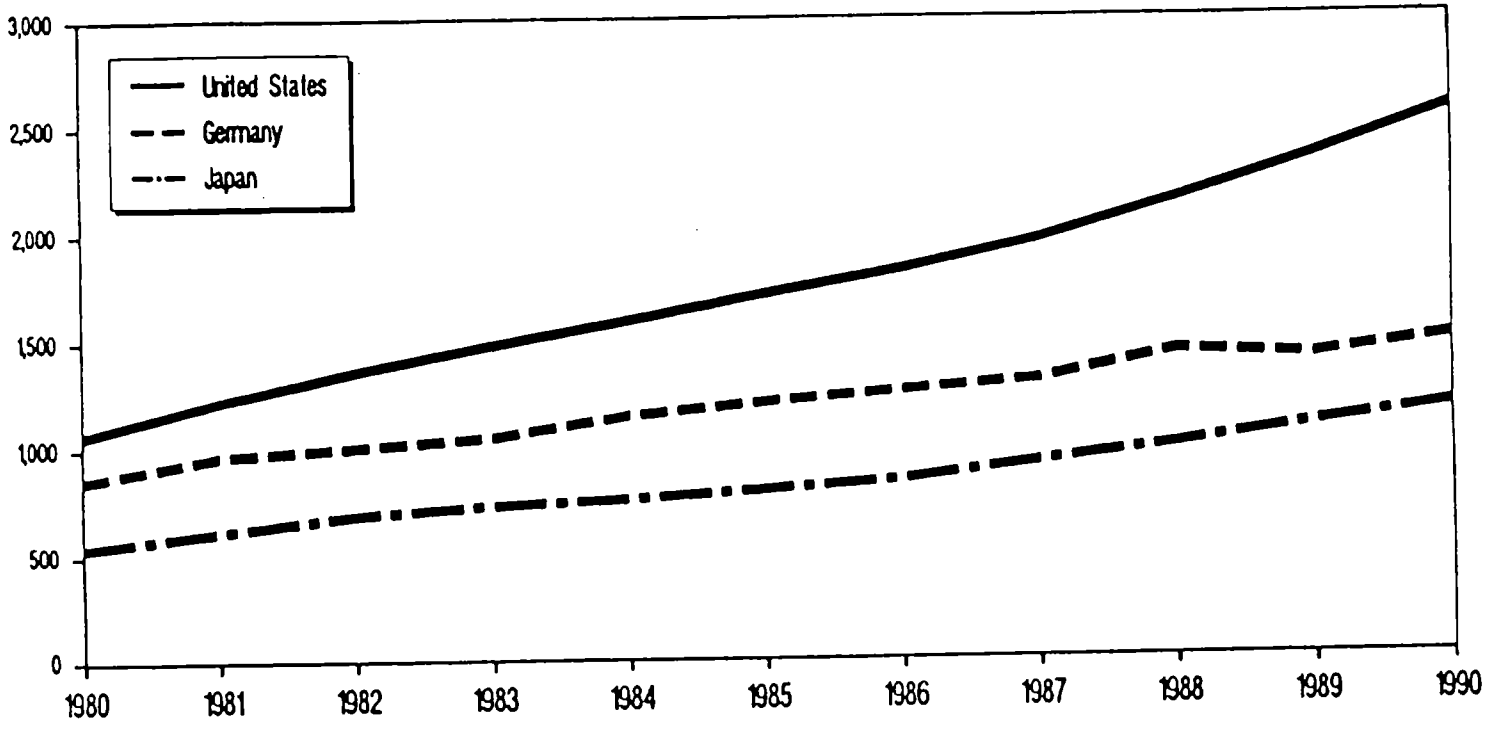
America Pays More Than Any Of Our Competitors . . .

Other industrialized countries provide health security for their citizens and control health care costs.



. . . With Less To Show For It

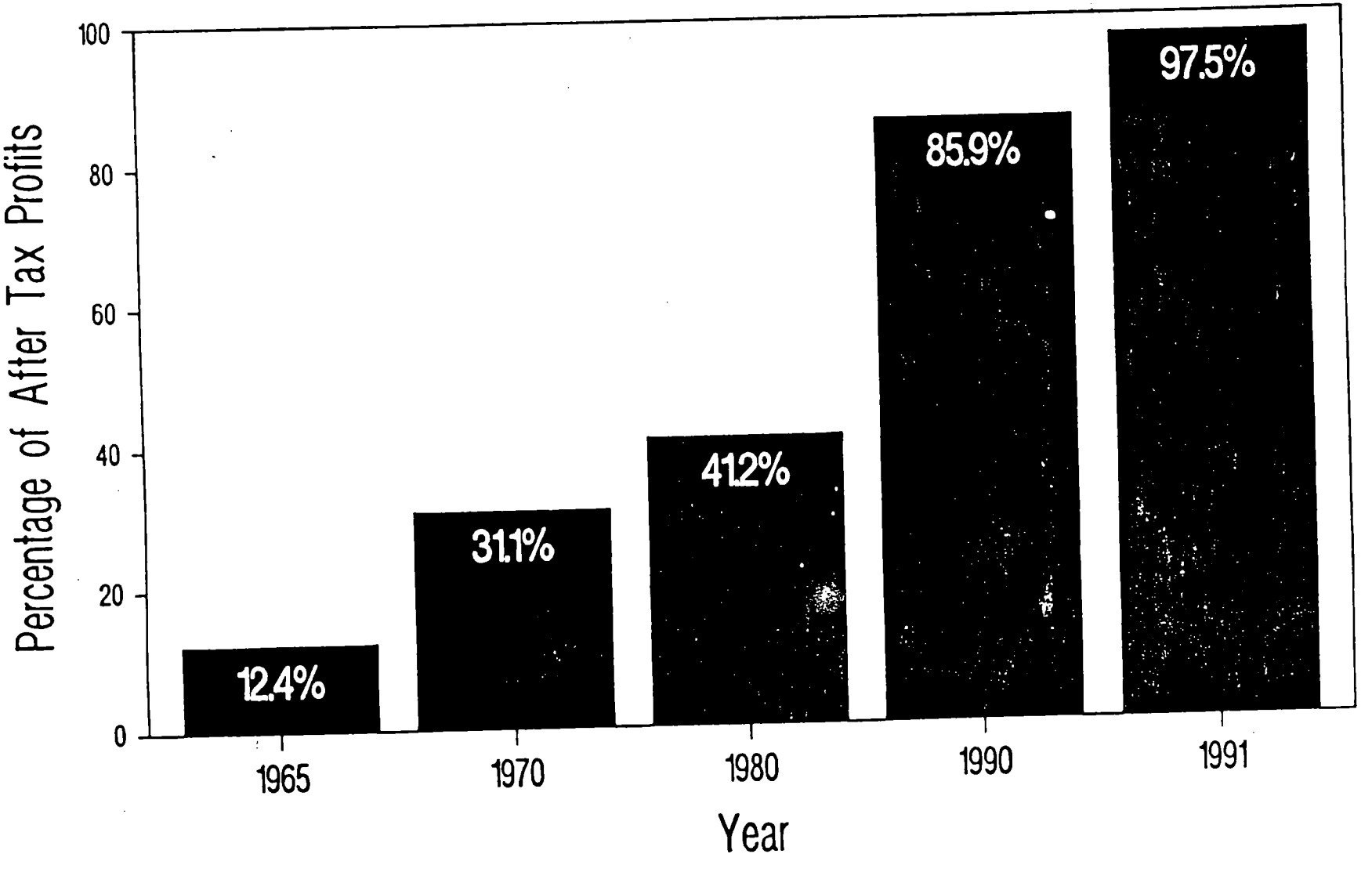
- Infant Mortality: U.S. ranks 21st out of 24
- Life Expectancy: U.S. ranks 17th for men and 16th for women

SOURCE: Per capita data; Health Care Financing Review, Summer 1992

Health Spending Is Eating Up Business Profits

Businesses' health care costs are nearly equal to their after-tax profits.

CHART 4



SOURCE: HCFA, Office of the Actuary

The Current System: Insurance Barriers

Some insurance companies engage in the following practices:

Experience rating - charging higher premiums because a person has a history or risk of illness or injury

Pre-existing condition exclusions - refusing to cover certain health conditions a person had prior to obtaining coverage

CHART 9

Cherry picking or cream skimming - offering low rates only to groups of young, healthy low-risk persons

Bait and switch - attracting customers by offering "discount" rates and then raising them substantially upon renewal

Redlining - denying coverage to people in certain industries or geographic areas perceived as high risk

No guarantee of renewal - insurance companies can drop anyone for any reason

Long-Term Care

- Today, the majority of Americans do not have adequate protection for long term care.
- The Health Security plan takes major steps towards universal access to long-term care.
  - Establishes a new home and community-based care program
  - Sets federal standards for private long-term care insurance
  - Provides tax incentives to purchase private long-term care insurance
  - Offers tax credits to enable people with disabilities to remain employed

CHART 56

Rural Telecommunications Networks

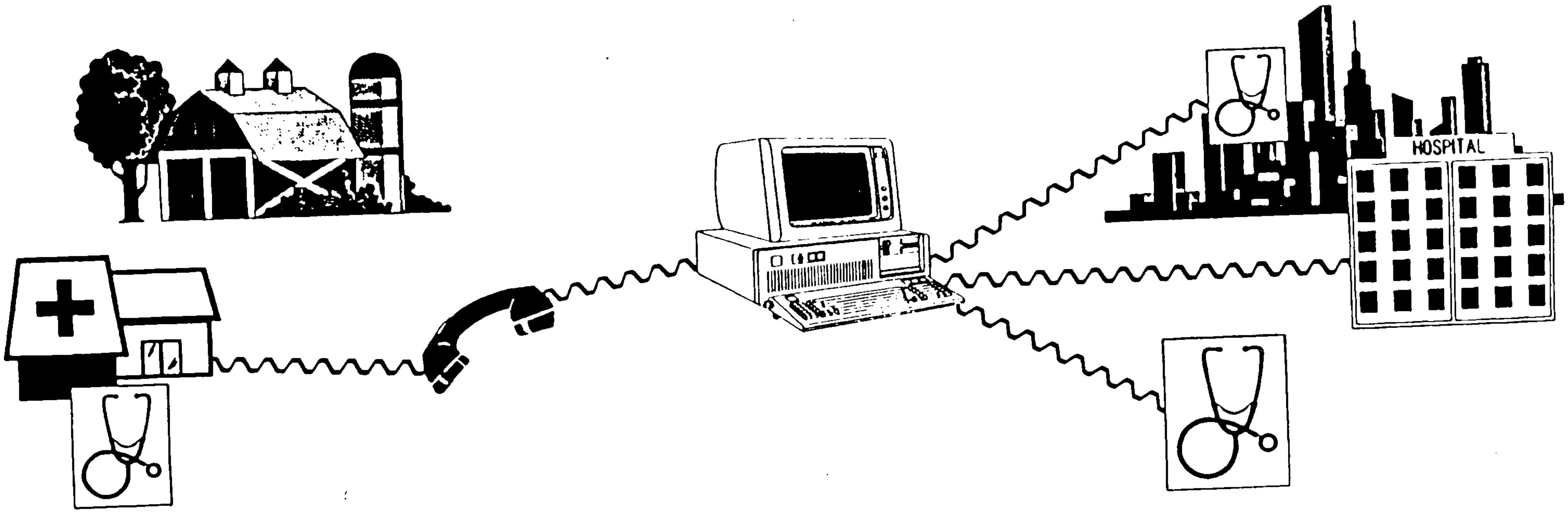
Networks assure rural residents' access to timely emergency services, specialty care, and the latest technology.

CHART 58

Doctors in rural communities

are linked by phone and computer

to the expertise of a broader network of providers



Encouraging Primary Care

- Now, only 20% of new doctors enter primary care.
- The Health Security plan will encourage more doctors to enter primary care.
  - Increases training opportunities for medical graduates entering primary care, while limiting specialty training
  - Supports training in ambulatory care settings
  - Increases availability of other primary care providers such as nurse practitioners
  - Supports training to increase the number of minority doctors and nurses

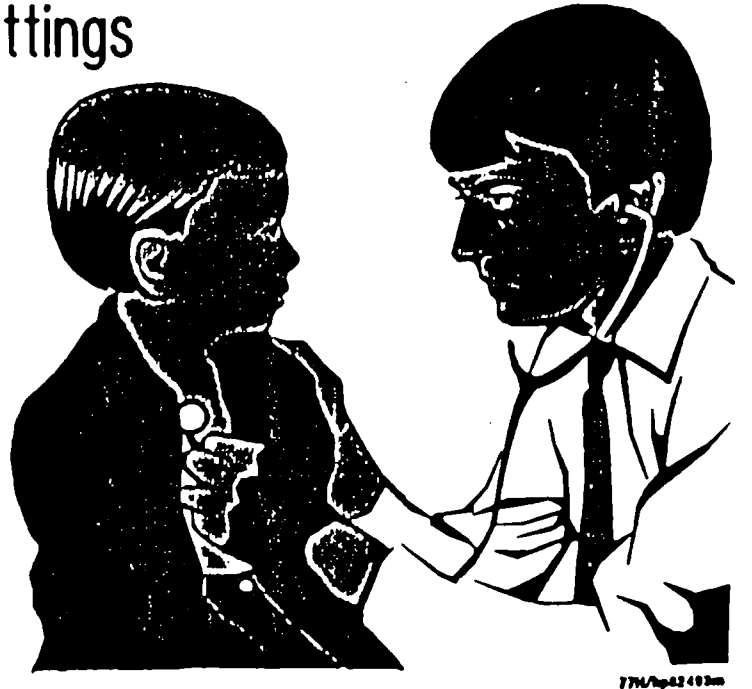


CHART 52

Academic Health Centers

- Play an important role in our health system through:
  - training our doctors, nurses and other providers
  - groundbreaking medical research
  - new technologies
  - specialized services
  - care for complex and chronically ill patients

- The Health Security plan guarantees academic health centers sufficient funding to continue these vital functions

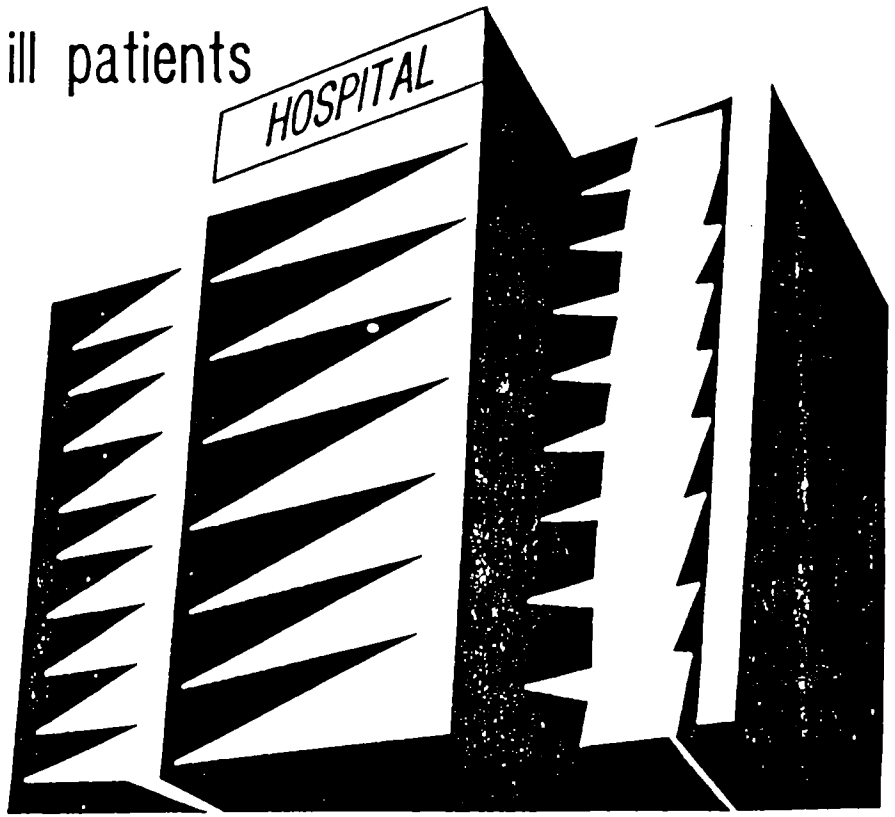


CHART 49

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The Health Security Plan: Insurance Reform

Community Rating - Health plans' premiums may only vary by family size and geographic area. Experience rating, "cherry picking," and "bait and switch" practices are outlawed.

Pre-existing condition exclusions outlawed - Plans must provide the same benefits to everyone regardless of past health.

Open Enrollment - Health plans must accept all applicants

Guaranteed Renewal - Health plans can not cancel or refuse to renew coverage.

CHART 10

How You Get Coverage: The Current System

Today's patchwork system is confusing, wasteful, and expensive - with many layers of bureaucracy between people and their doctors.

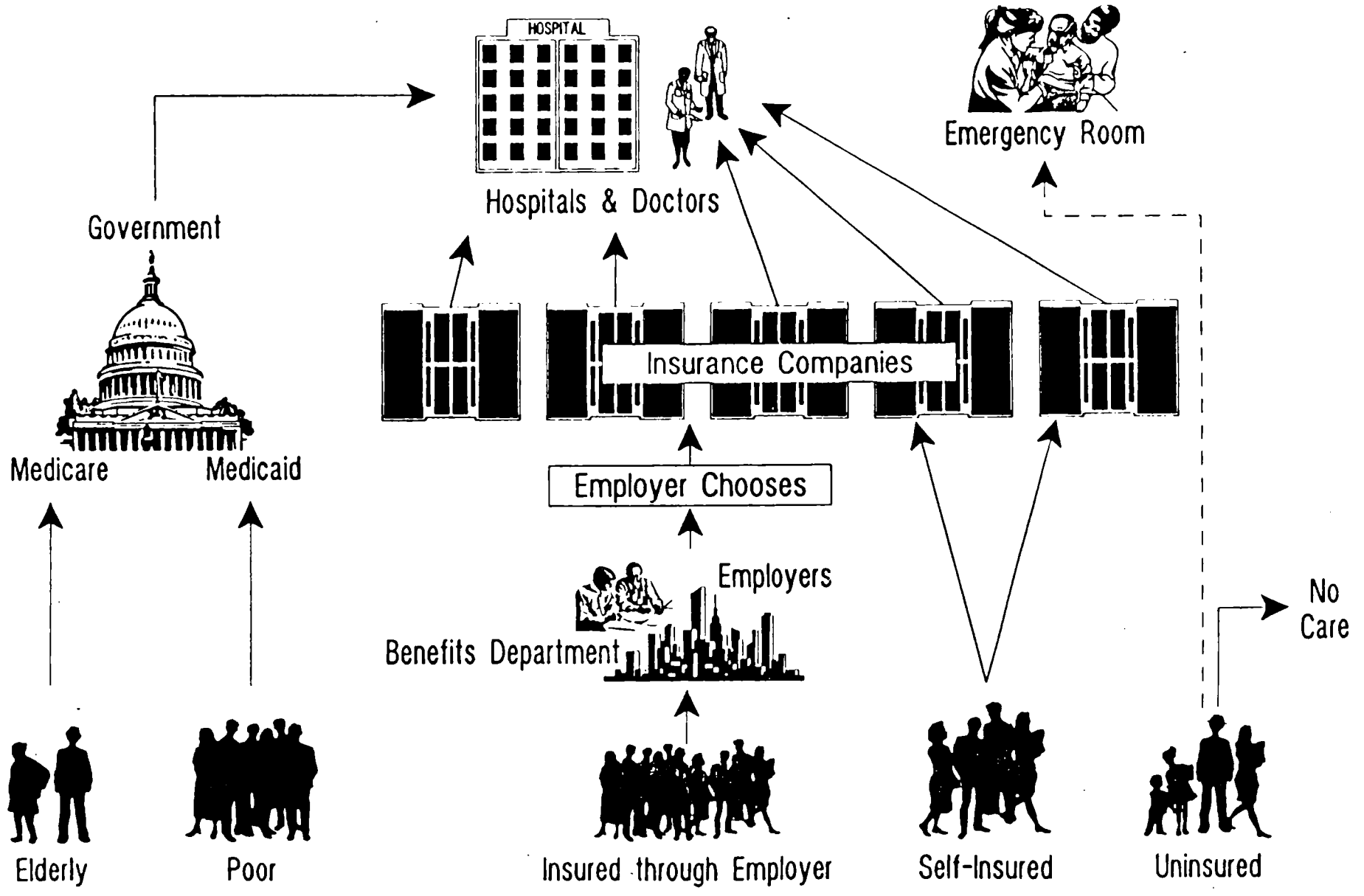

CHART 19

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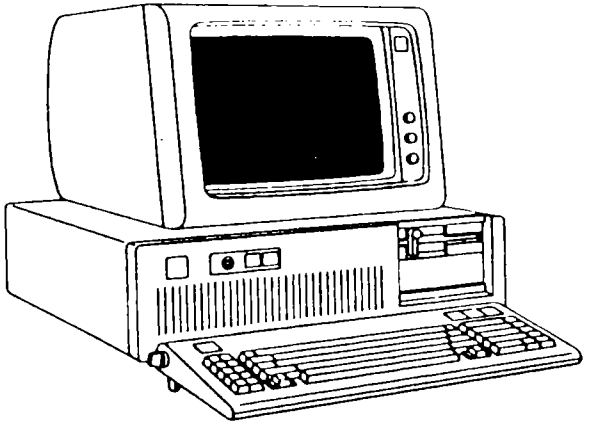
Health Security Plan: Administrative Simplification

The Health Security plan will simplify and streamline the system and lower costs. Doctors and nurses will be freed from paperwork to concentrate on delivering high-quality care.

CHART 16



A single, standardized claims form

which can be completed on the computer and transmitted automatically

to health plans

77H/hp824031

CHART 51

For Official Use Only

MEDICAL CLAIM FORM

Health Plan Information

1) Health Plan:

2) Health Plan Number:

Patient Information

1) Last Name:

2) First Name:

3) Middle Initial:

4) Patient Identification Number — —

5) Gender:

6) Patient Signature:

7) Date:

8) Release Medical Information? Yes: No:

Subscriber Information

1) Last Name:

2) First Name:

3) Middle Initial:

4) Subscriber Identification Number: — —

Treatment

1) Is need for care: a. Employment-related?

b. Auto accident-related?

c. Other accident-related?

d. Appointment?

e. Emergency?

2) Initial Diagnosis:

3) Final Diagnosis:

4) Description of Encounter:

	Dates of Service: From	Through	Place of Service:	Primary Diagnosis Code:	Procedure Code:	Units/Days of Service:	Covered Charges:	Non-covered Charges:	Co-pay Collected:	Optional Field:
a.	/ /	/ /								
b.	/ /	/ /								
c.	/ /	/ /								
d.	/ /	/ /								
e.	/ /	/ /								
f.	/ /	/ /								
5) Total:										

Health Care Provider Information

1) Name:

2) Identification Number

3) Signature:

4) Date:

Quality Report Card

Alliances collect data on the quality of all plans they offer and publish an annual "Quality Report Card" to help consumers choose among plans.

Sample Performance Measures	Plan A	Plan B	National Health Board Goal
Consumer Satisfaction			
Enrollees very satisfied with plan	85%	40%	--
Enrollees very satisfied with primary care physicain	90%	50%	--
Enrollees leaving plan last year	5%	13%	--
Access to Care			
Time to initial visit with primary care doctor	15 days	60 days	10 days
Patients with serious heart condition seeing cardiologists	30%	5%	25%
Appropriate Use of Medical Care			
Pregnant women receiving early prenatal care	70%	50%	98%
Rate of complete immunization (children age 2-5)	75%	50%	99%
Annual mammography rate (women over 50)	50%	40%	90%
Success of Medical Care			
Death rate after heart attack	6%	35%	5%
Low birthweight babies (percent of all births)	8%	10%	2%

CHART 18

What Happens to the Elderly Under the Health Security Plan?

CHART 55

Medicare

- Medicare remains a distinct and separate program, with broader choices of health plans.
- Medicare will include a new and comprehensive outpatient prescription drug benefit.
- Once alliances are operating successfully, states can seek federal approval to include all residents under one system.

Long-Term Care

- There will be a new home and community-based long-term care benefit for all Americans.

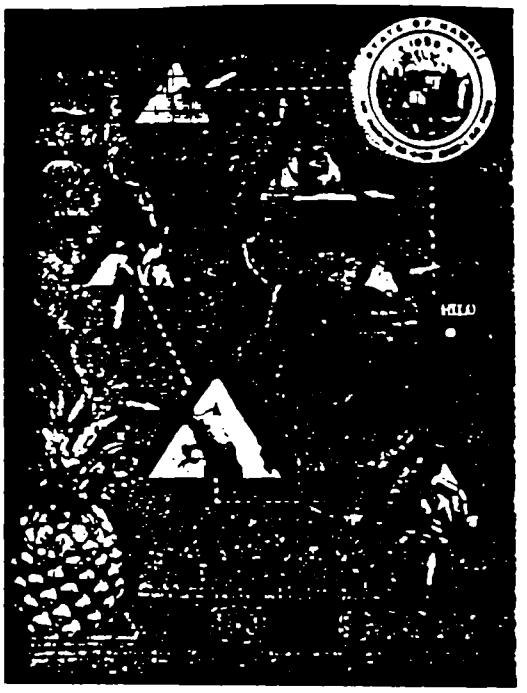
Financing

- Savings from slower Medicare cost growth finance prescription drugs and long-term care.

HAWAII: COVERAGE FOR NEARLY ALL

Hawaii likes to think of itself as the "health state." Compared to Mainland residents, Hawaiians have a higher life expectancy, spend less time in hospitals, and bear fewer babies who die during their first year of life. Hawaiians have achieved their enviable health status while spending less on medical care than the rest of the U.S. In 1988, Hawaii spent about 8 percent of its gross state product on health services; the U.S. spent about 11 percent of its gross national product.

Dr. John Lewin, director of the state health department, says that Hawaii's good fortune is the direct result of near-universal health-insurance coverage and the state's emphasis on primary and preventive care. While those factors are undoubtedly important, the genetic endowments of its ethnic populations, a warm climate, and a less-stressful lifestyle probably contribute, as well.



How it works

The cornerstone of Hawaii's health-care system is the Prepaid Health Care Act, passed in 1974. The act requires all employers to provide health-insurance coverage for their full-time workers. They don't have to cover employees' families, but most employers do, since unemployment is low and businesses must compete for workers.

The act mandates minimum coverage—120 hospital days, physicians' services, diagnostic and laboratory services, and maternity benefits. Employers can provide more coverage if they wish.

The act requires insurers to accept all employees, even those with health problems. And because everyone is covered, each insurer's "risk pool" automatically includes both the sick and the well. Insurers don't have to pad their premiums to make up for the fact that sick people are more likely to sign up for insurance, as is the case under a voluntary system. Insurers also save on administrative expenses, since they don't have to screen would-be policyholders.

Employers must pay at least half the premiums, and a worker's share is limited to 1.5 percent of his or her wages. In the beginning, workers and their employers split the cost 50-50. But as wages and premiums have risen, workers have paid a proportionately smaller share.

To assist businesses that employ fewer than eight people and that might have trouble paying, the law authorized a "premium supplementation fund." The fund has grown from the original $300,000 appropriation to $2.3-million in 18 years. "Small businesses never used it and still don't," says Mario Ramil, a Honolulu lawyer and former fund administrator. Over the years, the fund has spent only $89,000 to pay premiums, and those were owed mostly by Mainland firms that had left Hawaii.

Covering the unemployed

In 1989, with $10-million in seed money from the state legislature, Hawaii's health department established the State Health Insurance Plan (SHIP) to cover its "gap" group—people who are unemployed or who work too few hours to be covered by their employers. Most of the 15,000 Hawaiians on SHIP are poor, but not poor enough to qualify for Medicaid.

Benefits under SHIP are not as comprehensive as those provided under the Prepaid Health Care Act. They encourage primary and preventive care rather than costly inpatient hospital services. Patients are entitled to 12 physician visits each year but only five days of hospitalization. Most Hawaiians insured under SHIP must make a $5 copayment for medical services and pay a monthly premium based on their income. The state subsidizes the rest of their care.

Thanks to the Prepaid Health Care Act, SHIP, and Medicaid, only 2 percent of the population lacks some kind of health coverage, compared with about 14 percent in the continental U.S. "It doesn't occur to us that we can quit a job and not get health insurance," says Valisa Saunders, who works as a nurse. "It's not on our list of things to worry about."

Powerful payers

Much of the strength of Hawaii's health-care system stems from the negotiating power of two major insurers that cover about 70 percent of the population—the Hawaii Medical Service Association (HMSA), a Blue Cross Blue Shield organization, and Kaiser Permanente, a traditional HMO with salaried doctors working in health centers. That HMO ranked as the best Kaiser plan in the study of HMOs we reported on last month.

"We have oligopolistic insurers," says Richard Dahl, a vice president at the Bank of Hawaii, who heads the Governor's Blue Ribbon Panel looking at health-care costs. "To some, oligopoly is a dirty word, but not in this state. It provides a pretty efficient system."

Both insurers offer "community rates" to small employers, which make up about 90 percent of all business in the state. That means the insurers charge any group in a community the same rate, no matter what the health experience of a particular group of employees has been. That saves the administrative cost of tailoring individual premiums for particular groups.

Because of their large market shares, HMSA and Kaiser have been able to exert some control over health-care costs. HMSA has limited fee increases to doctors, paying only cost-of-living raises, and it has begun to eliminate the extra costs imposed by the "unbundling" of physicians' services. (Unbundling means that instead of charging one price for an appendectomy, for example, doctors

Aloha, big bucks? According to the magazine Medical Economics, the median net income for doctors in Hawaii is about $30,000 less than that of their Mainland counterparts.

Hawaii's experience with health-care reform

Drew E. Altman is president of the Henry J. Kaiser Family Foundation, which has been conducting health surveys throughout this election year.

By Drew E. Altman

EVERYBODY IS upset about health-care costs. Californians now say that after the economy, health will be the No. 2 issue on their minds when they vote for president in November, and data from a new survey shows that almost one-third of Californians are dissatisfied with their own doctors and hospitals.

Health-care experts are scouring the globe for solutions. But there is evidence to suggest that a uniquely American solution is possible.

Since 1974, Hawaii has been the only state that provides near-universal health coverage to its residents by mandating that virtually all employers provide health insurance to their employees. Those who don't qualify for coverage can be picked up by a limited program financed by the state. Hawaii claims that 95 percent of its residents have insurance coverage.

A recent survey of 1,000 Hawaiian residents by Louis Harris and Associates found that on virtually every major measure of access to health care and satisfaction with health services, Hawaii is doing about twice as well as the rest of the nation:

- Fourteen percent of all Americans were uninsured at some time during the past year; in Hawaii, 7 percent were.
- Twelve percent of Americans report that they were refused care last year because they didn't have insurance or couldn't pay; in Hawaii, 8 percent were.
- Thirteen percent of all Americans report that they needed care last year and couldn't get it – most for financial reasons; in Hawaii, the figure was 7 percent.
- Twenty-six percent of all Americans (and 29 percent of Californians) are dissatisfied with their own doctors and hospitals; in Hawaii, 12 percent are.
- Hawaii residents report paying $703 per year in out-of-pocket costs for medical bills not covered by insurance, compared with $876 nationally.

There are those who argue that Hawaii just doesn't count. It's a group of geographically remote islands, so businesses mandated to provide insurance can't easily escape to another state. Two insurers dominate the Hawaii market, unlike the hodgepodge we see in the rest of the country. Some argue that Hawaii residents (and lifestyles) are just different – the "mai tai a day keeps the doctor away" theory. The statistics, however, don't suggest that Hawaii is all that different. Key demographic indicators – from infant mortality to poverty levels – are remarkably similar in Hawaii and the mainland.

HAWAII'S SYSTEM is not perfect. It has real gaps in coverage, and does not appear to have made much progress in reining in runaway health-care costs. People in Hawaii are just as worried about paying rising medical bills as are people in the rest of the country. And since the plans employers can offer vary in coverage, many times dependents remain uninsured.

What separates Hawaii from the other plans or proposals being so hotly debated is that it has a real health system that has been serving real people for more than 17 years. It's not in West Germany and it's not in Canada; it's right here in the United States.

Hawaii's health system most closely resembles the "play-or-pay" plans currently being considered in Washington. But there are some important distinctions. Play-or-pay gives employers the option of providing insurance or paying into a public program that will do so instead. Hawaii gives employers no choice. The leading play-or-pay proposals also add a cap on health spending into the mix, a tough cost-containment measure that is needed and missing in Hawaii.

MOST BROADLY, what Hawaii says to California and the rest of the nation is that meaningful health reform can be achieved. There is no evidence, from the one state that has actually implemented major health reform, that things did anything but get better. In a field without very many success stories, that's good news.

Special to The Bee