Health Care file

General Principles

- Details are to be negotiated

1.) Reach universal coverage as soon as reasonable
   - 1997
   - In addtn to providing universal care
     health security really means cost control

   • savings in public + private sector
     could be realized

3) Preserve choice in health plans
   System relies on market competition

   ERs choose health plan now
   plan has EE choose health plan

4) Simplify System
   admin red tape + bureaucracy

   Responsibility for everyone in system
   ERs should contribute
   financing system to make
   it resp
   80/20 share; altho ER did pay more
   - cap amt ER can pay
   7.9% of payroll
   ↳ realize savings to cos.
   currently insuring
   1st yr - xpct 15% savings to cos.

   Certain small bus. never pd -
   many ERs feel they can't due to amnt marketplace
   ↳ capped & not > 3.5% of payroll

*) Quality
- ↑ quality ↑ care for emergencies
- access at emergency rm — most #
- primary care
- data shows no relation betw cost + quality

Consultations
- 1100 mtgs ē groups in 9 mos.
- no stone tablets — principles of how to get there & room for discussion

- met with Sen Jen + Labor Repb ldrshp in both houses
- good # of middle ground — Dem + Rep are cautiously optimistic.

Chaffee intro bill Wed ē 20 cosponsors & then they will talk ē us.
They'll go ē individual mandate — like auto insurance.
We believe better to have ER.EE cooperation.

Concern of ↑ complexity in new system
Why not build on system & simplify?

↳ Purchasing cooperative — a static orgz finance collection.
Hope that over X, there'll be a few entities

Purchasing cooperative to ↑ bargaining?

Health alliances will be at local level for 60-70% of people - near like Rochester.
- Hlth plans will compete
- Consumers choice

Adm cost for NHI Bd + Alliances is expected to be small
2½% → built into budget

Quality
- get away from micromgmt
get into TQM
-

Whats in it for me?
1) Loose jobs → you have it
2) 50% of cos. → ER choose one plan - EE chooses
3) Health Care Cost under control
then wage ↑

Timeline

- Bills introd & reported out
- Debated next yr

Insurance cos.

Experience rated
through pool

ADMINISTRATIVE SIMPLIFICATION

Today's health care system is awash in paperwork. Insurance overhead eats up a significant chunk of each health care dollar, paying for administrators, underwriters, and marketers in 1,500 private insurance companies. Doctors and hospitals spend more and more of their resources keeping up with all the paperwork, billing forms, codes, inspections and regulatory procedures imposed upon them by insurers and government programs.

How did we get here? Government and private insurers have set up elaborate rules and requirements for hospitals and doctor's offices to prove that they are not keeping patients in the hospital too long, seeing patients too often, or charging too much. To keep track of all the differences among different health plans, hospitals and physician's offices have had to hire more nurses, coders, clerks and administrators. What were once small back offices have grown into sprawling utilization review, coding, medical records and billing departments, which spend countless hours determining whether an individual has health care coverage, which insurance company is the main payer, what services are covered, what codes to use, and how much to charge. Under health reform, the "hassle factor" is reduced for both providers and patients through a number of simplification measures:

- Every American gets a health security card and every American gets coverage. Guaranteed universal coverage virtually eliminates the hassle of determining and tracking coverage.

- With the introduction of a standard, comprehensive benefit package, providers no longer go back and forth with health plans to determine the level of services covered. Under reform, the covered services do not vary from plan to plan and standard cost-sharing rules will simplify accounting for providers.

- A single standard reimbursement form and standardized reporting requirements replace the hundreds of different claims forms and requirements out there today. Electronic exchange of insurance and patient information further reduces provider costs and frustration.

- A national quality program stressing results over process removes insurance companies, utilization review firms and the government from the back offices of physicians and hosptitals. Regulation of clinical labaratory testing is focused to emphasize quality protection while reducing administrative burden.

- Coordinated inspection process replaces the multiple inspection processes that hospitals and doctor's offices undergo today.

- The Medicare programs simplifies and streamlines its reimbursement and claims processes. Specific reforms are aimed at rebuilding the trust between hospitals, doctors, patients and the government.

FYI for Mark:
Press packet for Children's Hospital event.

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: _____

Administrative Waste Statistics

- Health care administration costs exceed $100 billion each year. This amount is 20% of the total spending on health care in the United States and will grow to be one-third of the total health budget by the year 2000. (Washington Monthly 4/93)

- The average physician spends more than three and a half weeks per year filling out paper work, which is more time than the average American spends on vacation, and costs $4.5 billion each year. (Washington Monthly 4/93)

- In the current system, the number of health care administrators is increasing four times as fast as the number of doctors. (The New England Journal of Medicine)

- A typical month in one hospital's Medical Record's Department generated over 300,000 photocopies of records related solely to reimbursement issues for third party payers. (Children's National Medical Center, 1993)

Undefined
Mark Gearan
9/20/93
Revised Version

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, on average, 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 pay more than 3.9% of their income.

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.

Overview: *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 the same or more

- Most people getting insurance today -- including employees of small and large firms -- will pay the same or 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 only "bare-bones" or catastrophic coverage.

13% pay more for 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.

Worksheet for Individuals / Families

I. **Average Premiums** [preliminary estimate; not accounting for state differences]

Note: Employers pay 80% of this; Individuals/Families will pay 20% of this

Two Parent Family with Children	**$4,500 total**
Family Share:	*$900/year; $75/month*
Single Parent Family with Children	**$3,900 total**
Family Share:	*$780/year; $65/month*
Married Couple, no Children	**$4,000 total**
Couple's Share:	*$800/year; $67/month*
Individual	**$2,000 total**
Individual Share:	*$400/year; $33/month*

Low Wage: If you earn less than 150% of poverty, you will be eligible for a discount on your 20% share of the premium. If you don't work and have income less than 250% of poverty, you are eligible for a discount on your whole premium.

II. **Out-of-pocket costs**

It is difficult to estimate exactly how much anybody will pay in out-of-pocket costs because people's health care needs vary widely.

- Annual Out-of-Pocket Limits:
  Nobody will pay more than $1,500 dollars in out-of-pocket costs per year and no family will pay more than $3,000.

- Deductibles:
  [The amount you pay out-of-pocket until your insurance kicks in]
  Some plans -- such as HMO's and certain arrangements within networks -- will have no deductible. Fee-for-service plans and looser network arrangements will have a $200 deductible for individuals and a $400 deductible for families.

- Co-payments:
  [What the patient pays for each medical service received]
  Some plans -- such as HMO's -- will have a small ($10) co-payment per doctor visit. Others -- such as fee for service plans -- will have a 20% co-payment, up to the annual limit of $1,500 per individual and $3,000 per family.

- Lifetime Limits:
  There will be **no lifetime limit** on your insurance. Today, 60% of the plans have a limit on the total amount their insurance will cover. Many plans impose arbitrary limits the amount they'll pay for certain treatments and services.

III. Scenarios

	TODAY (Average Monthly Payment)	*REFORM (Average Monthly Payment)*	*Monthly Difference*
Two Parent Family Two children Two incomes: $55,000	$90	$75	$15 (-17%)
Two Parent Family Two children One self employed: $40,000	$90 with 25% deductibility	$75 with 100% deductibility	$15 (-17%) not including tax savings
Two Parent Family Three children Two incomes: $80,000	$90	$75	$15 (-17%)
Married Couple No children Income: $100,000	$79	$67	$12 (-15%)
Single Parent Three children Income: $20,000	$77	$65	$12 (-16%)
Single Person Income: $25,000	$28	$33	-$5 (+18%)
Uninsured Family One Income: $25,000	$0	$75	$75 --
Unemployed Family No income	$0	$0	--

IV. Companies

Employers in regional alliances will never pay more than 7.9% of their average worker wages *[sounds better than "percent of payroll"]* or 80% of the average weighted premium per worker -- whichever is less.

Companies with less than 50 employees -- with average worker wages lower than $24,000 -- are eligible for discounts on their share of the premium. This can be as low as 3.5 % of their average worker wages (i.e., for a minimum wage firm).

FINANCING HEALTH REFORM

INTRODUCTION

Questions on financing can be answered through a four-part approach.

- First, we should stress the unprecedented rigor of the process.

- Second, identify the main benefits of the plan, and the portion that is paid by the federal government. Here we should also be explicit in identifying those private employers and employees who will bear higher costs or lower compensation.

- Third, we should layout the specific sources of savings

- Fourth, there is strong back-up enforcement mechanism and evidence that these cost-savings can be achieved.

I: PROCESS: 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. 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.

II. MAJOR NEW BENEFITS WITH A FEDERAL CONTRIBUTION:

The Clinton American Health Security Act offers Americans security that they will never lose their health insurance under any circumstances. The Act provides:

1) a comprehensive benefit package for all Americans under age 65, including the 37 million who currently lack coverage;

2) a 100 percent tax deduction for premiums paid by the self-employed;

3) home- and community-based long-term care benefits;

4) Medicare coverage of prescription drugs; and

5) initiatives to improve the quality of care, access for the underserved, public health, and research.

Benefits of this magnitude do not come without costs. This paper will explain the nature of the benefits, the sources of the funds, and the reasons why reform will make the great majority of Americans better off -- even if a minority of employers and individuals will now, for the first time, have to accept responsibility for paying for health coverage.

An appendix will describe the methods used in generating the Administration's estimates.

1. SECURITY AND COMPREHENSIVE COVERAGE FOR ALL AMERICANS.

With the adoption of the Clinton plan, Americans will never again fear losing their health coverage if they lose their jobs or paying exorbitant premiums if a member of their family gets seriously ill.

Americans will pay for coverage when they work. Premium costs will be covered by subsidies when they are unemployed or out of the workforce, unless they have non-wage income.

The major costs to government come from two purposes:

- capping the premium obligations of employers, especially small businesses, at a fixed percent of payroll; and

- discounted premiums for the unemployed, early retirees, and low-income individuals and families to make health coverage affordable for everyone.

Who Bears Responsibility: Comprehensive coverage for all, including those presently uninsured or underinsured, generates an additional $68 billion in new health care spending through the economy as a whole. These added expenditures are divided among government, households and employers.

Households: Individuals who currently do not have any insurance will pay more. But they will get a major benefit, health security, at a low and affordable price, with the opportunity to pay little or nothing if they choose a lower-cost plan. Those who cannot afford to pay will benefit from discounts.

Employers: While the majority of employers who now cover their workers will see their costs go down, employers that provide no or inadequate health insurance will pay more. Many of these employers provide little coverage because of the excessive cost for small firms in the current market due to high administrative costs, rating practices (a single worker's illness can cause rates to skyrocket), and small firms' lack of bargaining power. Today, the inability of small firms to offer good coverage limits their ability to attract and retain workers. After reform, they will no longer be at a disadvantage.

Still, some small employers would prefer not to cover their workers. The Administration believes that everyone must accept responsibility and that employers who do not pay for coverage end up shifting costs to other employers. Today, employers that do insure are indirectly charged for the unpaid hospital bills left by their competitors' employees. After reform, this burden will be lifted from them.

It is vital to put the costs in proportion. A small business with average wages of $10,000 a year that provided no insurance would now be able to provide comprehensive health coverage to their employees for $350 per worker--less than $1 a day. This is a tremendous bargain. In fact, rather than being a crushing burden, the 3.5 percent cost is less than the average cost-of-living adjustment for a worker for a single year.

The affordability of premiums is also due to community rating (that is, equal premiums regardless of personal characteristics). Employers will now no longer fear that their premiums will rise if they employ a worker who has a family member with a serious medical problem, nor will their rates be influenced by the age or other personal characteristics of their employees. Community rating

will, however, lead to higher premium costs for some younger, healthier workers.

Government: Federal subsidies to businesses in the regional health alliances and to low-income individuals and families will enable the alliances to provide coverage at affordable rates. The caps on employer contributions ensure that no firm in the regional alliances will have to pay more than 7.9% of payroll for health insurance. Small businesses with 50 or fewer workers will have even lower caps, depending on their average wage level. If they average less than $12,000 in wages, they will not have to pay more than 3.5% of payroll. The 3.5% cap is phased-up gradually for those with higher average wages, reaching the 7.9% level at average wages of $24,000 or more.

Unsubsidized individuals and families pay the difference between the employer contribution (normally 80 percent of the average premium) and the premium of the plan they choose. For an average-cost plan, they pay 20 percent of the premium. Individuals and families with incomes below 150% of the poverty level are eligible for a subsidy to pay their 20% share.

Many of the people receiving subsidies in the regional alliances will be people formerly on Medicaid (as well as a much smaller number on Medicare). After deducting the subsidy cost being transferred from one program to another, the net cost of subsidies will be approximately $30 billion a year (or $160 billion over the period 1995 to 2000).

2. 100% SELF-EMPLOYED DEDUCTION: Currently, many self-employed people feel that they get a bad deal on health insurance because they do not receive as generous treatment under the tax laws as do employers, who can deduct all health insurance contributions. The 1993 Budget sought to partially address this by extending -- retroactively -- the 25% deduction for health care for the self-employed. The Clinton health care plan increases the self-employed deduction to 100% -- a major step -- at a cost of $9 billion over seven years.

3. MEDICARE DRUG BENEFIT: Today, Medicare beneficiaries do not receive any kind of prescription drug benefit. Under the new drug benefit, Americans eligible for Medicare will automatically enroll in the new prescription drug benefit when they enroll in Part B of Medicare, as 97 percent of eligible individuals do. Part B premiums will increase to cover 25 percent of the cost of the new benefit, the standard level of beneficiary contribution for Part B under the current program.

The new drug benefit carries a $250 annual deductible before coverage begins. Beneficiaries also pay 20 percent of the cost of each prescription; the limit for out-of-pocked costs is $1,000. The prescription drug benefit covers all drugs and biological products, including insulin, approved by the Food and Drug Administration and prescribed for medically accepted indications.

The cost of this benefit will be $72 billion over six years.

4. LONG-TERM CARE: Disabled Americans of all ages will gain access to a wider variety of home and community-based support services, making it possible for some people to continue to live at home rather than in nursing homes. In addition, people with disabilities who go to work will benefit from a tax credit covering 50 percent of their costs for personal assistance and other necessary support. Beneficiaries qualifying for nursing home coverage will also be allowed to retain more of their personal assets.

The cost of the new long-term care benefits will be $80 billion over six years.

5. PUBLIC HEALTH AND RESEARCH: The plan will strengthen the public health infrastructure, provide support for underserved rural and urban areas, and begin refocusing public health on population-based prevention instead of providing clinical services to the uninsured. Federal support for specific research priorities, including outcomes research and research on preventive services, will also be expanded. The cost will be $29 billion over six years, financed by sin taxes.

OVERALL COSTS IN NEW SPENDING: The overall cost of the program over seven years is $350 billion.

USES OF FUNDS FOR HEALTH CARE REFORM:

Long-term care	$80 billion
Medicare drug benefit	72 billion
Public health/administration	29 billion
Discounts for businesses and workers	160 billion
100% self-employed deduction	9 billion
Total for health care	$350 billion
Deficit reduction	91 billion

TOTAL HEALTH CARE & DEFICIT REDUCTION $441 billion

A NOTE ON THE $259 BILLION SHIFT: The Clinton plan has inaccurately been described as calling for $700 billion more in government health care spending. The source of this confusion is the shift of $259 billion among federal programs, which amounts to an accounting change.

Currently, under Medicaid, the federal government and the states reimburse providers. Now, rather than sending that money directly to providers, the government will send the same money to cover the same people through the regional alliances. If a company spent $1 million on employee health insurance through Insurer A, and then shifted to Insurer B, no one would see that company as spending $1 million more. The same is the case here.

In addition, more Medicare beneficiaries who work will have employer-paid insurance as their primary payer, reducing costs to the Medicare program.

II. SOURCES OF FINANCING

The sources of financing in the administration's plan raise $441 billion over the period 1994 to 2000, which not only pays for the new benefits but reduces the deficit by $91 billion. There are six major sources of financing.

MEDICARE SAVINGS:

Specific and Scorable: The $124 billion in the last draft -- or any new number based on policy changes from consultations with Congress -- will be based on the scorable savings from a long-recognized list of options for Medicare cuts, and not on generic caps or vague cost reduction claims. The cost savings will be with specific payment changes to providers, with some modest increases in co-insurance for beneficiaries.

Redirecting Medicare Spending to Increase Benefits: This proposal does not involve cutting Medicare-- it involves spending Medicare money differently, by reducing the growth in payments to providers and increasing benefits for older Americans through expanded coverage for prescription drugs, and through a new home- and community-based long-term care program. Seniors making over $100,000 may pay higher Part B premiums, but because the lion's share of savings come from lowering the growth in some provider payments, the new benefits offered to seniors will dwarf any reductions in the growth of benefits needed to get the $124 billion in savings. And what most older Americans pay -- their share of the cost of health premiums -- will actually decline as growth in the cost of Medicare comes under control, reducing annual cost increases not only for Medicare but also for Medigap policies.

Consistent with Past Positions -- Controlling Health Care Costs without Cost-shifting or Middle Class Cuts: The Medicare cuts are consistent with the President's past positions. During the campaign and the debate over the budget, the President took the position that Medicare costs were rising at too fast a rate but that for three distinct reasons comprehensive health reform was necessary to control those costs effectively and fairly.

- First, without reform, cuts in Medicare would lead providers to shift costs to the privately insured and their employers, raising the premiums of small and large businesses and working families.

- Second, cutting Medicare provider payments significantly without complimentary cost-control efforts on the private sector would lead to too large a differential in Medicare and non-Medicare payment rates.

- Third, major cuts in Medicare, following the $56 billion cut in the 1993 Budget Act, would cut benefits for average middle class Medicare beneficiaries.

The President's health program avoids each one of these problems. Comprehensive cost-containment measures prevent cost-shifting to the private sector. Such measures will also tend to reduce the differential between Medicare and non-Medicare parent rates. Finally, the additional prescription drug and long-term care benefits assure middle-class Medicare beneficiaries that they come out winners.

The Clinton plan reduces the rate of growth in Medicare costs from three times the rate of inflation to twice the rate of inflation. The savings--money that would have gone largely into higher Medicare provider payments--will essentially be reinvested in the new prescription drug and long-term care benefits. A reduced rate of growth in Medicare costs will also reduce future increases in Part B premiums paid by the elderly. Thus, Medicare enrollees will benefit from cost control twice over: they will receive broader coverage, and their own premiums will rise more slowly.

Reasonable Level of Savings: The level of savings are reasonable and comparable to the savings called for in other major health reform alternatives as well as the most serious entitlement caps called for during the budget process. The $124 billion in Medicare savings is an amount comparable to the health reform alternative offered by the Senate Republicans, which propose about $100 billion in savings, and less than the savings called for by the more liberal single-payer proposals, which save more like $150 billion from Medicare, and by less than the amount the Republican budget

alternative would have likely achieved as scored by Congressional Budget Office. According to CBO, the Dole-Domenici alternative deficit reduction proposal would have cut $66 billion in Medicare and Medicaid in the third year alone -- without any offsetting Medicare benefits or mechanisms and to prevent cost-shifting. Forty-three members of the Senate voted for this proposal.

2. MEDICAID SAVINGS:

- The Clinton health care plan will save $114 by essentially folding the acute care portion of Medicaid system (everything by longterm care Medicaid) into the overall health care system.

- The savings allowed by this reform include cutting $68 billion in disproportionate share payments. These disproportionate share payments currently exist as extra payments to hospitals who bear large portion of the poor and uninsured patients. Yet, as health reform will ensure that everyone is covered -- and end the specter of hospitals being forced to bear large uncompensated care -- this often abused payout can be ended without hardship.

- The other $46 billion will be cut by giving the alliance 95% of the per capita costs for Medicaid recipients. Because this decrease in the growth of payments for Medicaid recipients will be blended in with the overall funds of each alliance, this is not a cut that can be in any way viewed as being targeted at lower-income Americans. Rather the savings come from asking the alliances simply to control costs for the new people being transferred from acute care Medicaid. Thus, as with Medicare, the savings here are specific, not speculative.

MEDICAID SAVINGS: The Clinton health care plan will save $114 billion by folding the acute-care portion of Medicaid into the overall health care system. None of this will affect Medicaid beneficiaries because after reform no patient will ever walk into a doctor's office as a Medicaid beneficiary. The acute-care portion of Medicaid will merely be a funding stream for the regional alliances, where the money will be blended with private premiums before being paid out to health plans. The funding stream will be reduced from its projected rate of growth for two reasons.

- Medicaid now pays out "disproportionate share payments" to providers that bear much of the cost of uncompensated care for the uninsured. After everyone is covered, this often abused payout can be ended without hardship, saving $68 billion in Medicaid costs over five years.

- Second, rather than growing at its projected rate as a separate program, Medicaid costs will now grow at the general rate of increase in the alliances, saving another $46 billion. One of the main sources of higher Medicaid costs has been growing enrollment, due to declining private coverage and expanded eligibility. Clearly, under universal coverage, this source of cost pressure disappears.

SAVINGS IN COSTS OF OTHER FEDERAL PROGRAMS: Other federal health costs, including health benefits for federal employees, have been rising at an unacceptable rate. After reform, federal employees will receive coverage through the alliances. The general cost-containment measures in the health alliances will lower the rate of growth in these federal costs. In addition, universal coverage will reduce projected costs of veterans' and Department of Defense health programs and at federally supported health centers (which will now be reimbursed for previously uncompensated care). These savings and offsets will amount to $47 billion over five years.

REVENUE GAINS FROM REDUCING PROJECTED INCREASES IN HEALTH COSTS: As health costs have risen in the past several decades, an increasing share of compensation has been paid out in tax-exempt health benefits and a smaller share in taxable wages. The annual cost of this tax expenditure has risen to $68 billion to the federal government [CHECK] and still more to the states. Rising health costs in the future will make the annual loss in revenue still bigger. Thus, reducing projected health costs increases federal revenue. Indeed, any process that lowers the cost of tax-free health benefits will release money for higher wages or profits, which will now be taxable. In the early years, this effect will be offset by higher health costs to employers who do not currently provide health insurance. However, over the period from 1994 to 2000, the net effect is a $51 billion increase in federal revenue.

The scoring for such savings is no different than if the government were to decide to increase the amount of income that a worker could put into a tax-free pension. In that case, the government would be making a policy change that would shift taxable income to non-taxable income, thus lessening the amount of revenues to the government. In this case, the government is making a policy change that would shift non-taxable income to taxable corporate or personal income, thus increasing revenue. By controlling the costs of comprehensive health coverage, employers, employees, and the government benefit, because lower health care costs will tend to raise wages, and higher wages will mean more government revenue.

SIN TAXES/CORPORATE ASSESSMENT: There is no final decisions made yet as to the final composition of the sin tax component of the financing. Yet, any policy option, come from a familiar list of revenue options that have been frequently scored by CBO, JTC and the OMB and will not be subject to dispute.
The current draft calls for $105 billion from these sources over seven years.

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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.

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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.

THESE NUMBERS ARE CONSERVATIVE IN THAT THEY LEAVE OUT CATEGORIES OF PROBABLE SAVINGS: All of the savings we believe are achievable through competition, through cutting bureaucracy, through cracking down on fraud, and through a new stress on prevention -- are not counted in our tables as savings estimates. Despite the evidence of lower costs in parts of the country where these reforms have taken hold, despite the fact that virtually everyone agrees that there's enough waste and bureaucracy in the system to wring out several billion dollars by streamlining paperwork, we claim no savings from these initiatives so that the credibility of our numbers and the standards of our rock-solid process will be beyond reasonable dispute.

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.

SAVINGS

Highlights:

We know this can work. There's no reason why our international competitors spend so much less than we do on health care - - yet they insure all of their people and they provide richer benefits. There's evidence out there in places that have gone to competition, that providers can and will cut their costs substantially and quickly.

California hospitals have kept their growth rates well below the national average - - 9% versus 30% over 1983-1990.

The State of Minnesota has kept its annual rates of increase 2% below statewide trends for the last two years - - primarily as individuals have chosen lower-cost plans.

Germany and Japan have been able to keep the growth in their health care costs down to GDP while ours have been growing at 9% and 10%.

The Mayo Clinic has kept its growth down to 3.9%.

Health care spending can be reined in to meet the budget caps through cutting out the waste in the current system - - streamlining administrative overhead and increasing the productivity of doctors, nurses and other health care workers.

The major cost containment mechanisms under reform come from increased efficiencies through competition. Budgeting the rate of growth in the health care premium acts as a backstop to the competition - - a commitment to downward pressure on costs that can further bolster competitive savings.

Washington State and Minnesota have recently passed health reform legislation that combine principles of managed competition with strict cost containment measures. In Minnesota, the rate of growth in health care spending must decline by at least ten percent a year for five years, beginning in 1993.

Giving incentives to providers to deliver more cost-effective care and reducing administrative costs can free up dollars to both insure all Americans and make their health care more affordable.

The reform proposal first takes cost out of the system by:

- **Changing the incentives in the insurance market to compete on**

quality and efficiency rather than avoiding high-cost patients

- **Prepaying health plans, changing the incentive from "doing more" to "doing it better"**

Under today's system, doctors get paid for each test and procedure they perform. That means, the more they do, the more they get paid. Under reform, health plans work under a fixed prepayment - - a budget that provides discipline - - changing the incentive from doing more to competing on quality and efficiency.

In Northern California, Kaiser Permanente members have 25% fewer hospital days per capita than other residents.

- **Reducing variation in practice patterns within and between communities through research and better information exchange**

Boston residents get twice as much care (costing $300 million more annually) than residents in New Haven, Connecticut. The difference in spending is not due to a difference in the quality of care patients receive.

Open-heart surgery that costs $21,000 in one Pennsylvania hospital costs as much as $84,000 in another hospital in the same state. And, the lower-cost hospital had better outcomes.

- **Streamlining administration**

Under today's system, as much as 30-40% of the premiums paid by small firms support the overhead of brokers, insurance agents and underwriters. Large firms pay significantly less for administration - - closer to 5-7% of premiums. Under reform, firms with 5,000 or fewer employees join health alliance where administrative and purchasing functions are consolidated. Economies of scale result in a lower administrative burden for the system as a whole.

A growing share of the health care dollar pays for processing paper and complying with regulations. For every one doctor hired at a hospital, there are four administrators. Under reform, a single claims form replaces the hundreds of different forms. A standardized benefits package, and standardized reimbursement rules, procedures and regulations scale back administrative overhead.

- **Making consumers cost conscious**

Under today's system, consumers often do not know how much health care costs. Employers pay their premiums; insurers pay the tab. Under

reform, consumers, not their employers, decide among health plans based on price and quality. Choosing higher-cost plans means consumers have to pay more out-of-pocket. Choosing lower-cost plans drives providers to find ways to become more efficient.

In 1988, the state of Minnesota changed its contribution from 100% of the state fee-for-service plan to 100% of the low-cost plan serving a given county. Due in large part to consumer switching, annual rates of increase have been at least 2% below statewide trends for the last two years. Estimated system savings are $23 million over the last three years, and $12 million in 1993 alone.

- **Strengthening consumer bargaining leverage**

The Health Insurance Plan of California (HIPC) received bids that were as much as 55% lower than the same plan offered by the FEHBP.

In Orlando, the 78-member Central Florida Health Care Coalition succeeded in negotiating better prices with regional hospitals that enabled the Orange County School Board to keep 20 teaching jobs it had planned to cut. The coalition persuaded hospitals to analyze why costs and quality of care differed for patients with the same illnesses. With this information, costs per hospital discharge fell 2%.

An Enforceable Budget - the Back-up Engine for Cost Control

While there is ample evidence that lower cost growth will be driven by competition and increased efficiency, the health security proposal builds in a back-up measure to cost control: an enforceable budget.

The budget is met through capping the growth in premiums individuals and businesses pay for the comprehensive benefits package, similar to the caps proposed by Kassebaum, Danforth and enacted in the State of Washington.

JOBS AND HEALTH CARE

Comprehensive health care reform is a necessary element in a compehensive economic growth strategy to bring down long-term economic growth, reduce the deficit, and create jobs. Today, the rising cost of health care is a hidden tax on employers -- hurting businesses, depressing wages, limiting job creation and threatening our competitiveness. The bottom line is this, most businesses provide health care to their workers, and health care reform will lower their health care costs -- allowing them to create jobs and increase wages.

While no one may be able to give you a precise estimate of the overall job impact, there is no question that for small businesses to manufacturers like Chrysler and US Steel, costs will be controlled and money will be freed up for job creation. The Wall Street Journal said that "for many small businesses, saddled with escalating health care costs, President Clinton's health care package comes as an unexpected windfall." Studies show that the fastest growing small businesses are the ones that provide health insurance. In addition, there will be jobs created in the health care industry, particularly for nurses and home health workers who will be providing more care.

1. HEALTH CARE IS ONE ELEMENT IN A COMPREHENSIVE ECONOMIC GROWTH AND JOBS PLAN:

Health care reform is one element in a comprehensive economic growth plan to lower the deficit, lower interest rates, and create jobs. The current system is hurting job creation, because rising health care costs have served as a hidden tax on employers leading to less job creation and less wage increases Does anyone dispute that we would have better job growth in our country if we kept costs at the level that our competitors do?

2. NEGATIVE JOB STUDIES HAVE BEEN BOGUS. THEY FAIL TO ANALYSE THE SUBSIDIES AND OTHER DETAILS OF CLINTON PLAN:

The current studies put out by the NFIB are bogus studies that do not consider the discounts provided to low-wage small businesses nor the positive effects that lowering health care costs will have on businesses that currently provide insurance.

3. THE CLINTON PLAN WILL LOWER COSTS FOR MANY BUSINESSES, LEADING TO HIGHER WAGES AND MORE NEW HIRES.

Most businesses provide health care, and we are going to lower their costs, which will make it easier for them to hire future workers and give wage increases to their existing workers.

4. SMALL BUSINESSES WHO PROVIDE COVERAGE WILL HAVE LOWER

COSTS:

Most small businesses provide health care to their workers -- paying high administrative costs and bear tremendous risk if even a single worker in their business gets sick. Small businesses pay as much as 35% more than big businesses. And it is uncontroversial that our plan will lower health care costs for these small businesses, giving these firms more money to hire more workers and pay their existing workers higher wages. So this will be a job creator for small businesses that do provide health insurance.

Listen to the lead of the Wall Street Journal on Monday. "For many small businesses, saddled with escalating health care costs, President Clinton's health care package comes as an unexpected windfall." ["*Small Business See Burden Getting Lighter*," Wall Street Journal, 9/13/93]

5. WILL HELP THE FASTEST GROWING SMALL BUSINESSES: Studies show that the fastest growing small businesses are the ones that offer health care insurance to their workers. These firms will see their costs go down under the Clinton plan. So health reform will help those firms that are creating the most jobs and growing the fastest.

6. MANUFACTURING JOBS WILL BENEFIT:
Manufacturers -- the employers that pays the highest wages to average people -- have been forced to lay off workers and that our health care reform will have a dramatic effect on lowering the costs of manufacturers and making it easier for them to compete and create new jobs. Currently, American automakers pay $1100 more per car than their competitors in Japan. Making this part of our economy stronger is especially important because it creates more exports, which is key to greater job creation.

7. INCREASED HEALTH CARE JOBS:
There will be job creation in for health care workers that serve people -- instead of pushing paper. Joshua Weiner, a health economist at the Brookings Institution, predicts that the Health Security Act will create 750,000 home health care jobs, and that overall the plan will be a job creator. (Reuters, "Health Care Reform Impact on Jobs," 9/16/93)

8. ***HAWAII – LOOK AT THE EVIDENCE:***
Since Hawaii asked all employers to provide insurance for their employees in 1974, the unemployment rate has dropped to one of the lowest in the nation (2.8% in 1991), and small business creation rates have remained high (the number of employers grew almost 200% from 1970 to 1991). In addition, only 2% of Hawaii's "rainy day" fund -- set up to assist the smallest businesses -- has been used. [The Hawaii Department of Health, June 8, 1993]

9. ***NO MORE JOB LOCK OR MEDICAID LOCK:***
People who are in jobs they want to leave but can't for fear of losing their benefits will be freed to switch jobs or start a small business, meaning more jobs and greater productivity. And tens of thousands of people on welfare will no longer have the disincentive of Medicaid benefits without the guarantee of future benefits to keep them from taking a job.

10. ***MINIMUM WAGE - LOOK AT THE EVIDENCE:***
Because we limit the amount that any small business employer would have to pay, health care reform is the equivalent to a modest increase in the minimum wage for those firms that currently do not provide health insurance. Yet, studies by economists at Harvard and Princeton show that increases in the minimum wage do not hurt job growth, and that in fact, it can make it easier to hire people. These were not abstract studies: these were real world studies of real small businesses and restaurants in Pennsylvania, Texas and New Jersey. Real studies that would again support that health care will certainly not cost jobs, and will create many new jobs in manufacturing and growing small businesses.

Health Security Plan

"If you like your insurance today..."

Summary

People who like their health insurance today have a lot to gain from the health security plan. First -- and most important -- they'll get something that no amount of money can buy in today's insurance market: security. Lose your job? You're covered. Want to change jobs? You're covered. Your child gets sick? You're coverged. You just can't guarantee that today.

People who like their health insurance today will also get increased choices , the chance to stop trading wage increases for the same health benefits, and preventive care benefits that will keep them healthy. Even those Americans who are satisfied with what they've got now have plenty to gain. And they'll probably pay less for better care.

Today

Millions of Americans have worked hard to get the solid health benefits that they enjoy today. Almost all of us have been forced to trade increases in our wages in order to maintain the same health benefits we had the year before. Or worse. And millions are locked into their jobs; they want to find better jobs but can't leave because they fear losing health insurance and not being able to get a new policy.

Even those with excellent health insurance packages live in constant fear of losing that protection. Insurance companies hold all the cards: they can drop you for almost any reason. If you move, change jobs, or get sick, your insurance can disappear over night and, if someone gets seriously ill, bankrupt your family.

Health Security

The Health Security plan gives every American -- even those who like their health insurance today -- something no amount of money can buy today: guaranteed security. All Americans will receive a Health Security Card that guarantees a comprehensive package of benefits that can never be taken away. No ifs, ands, buts or fine print. No longer will American families be asked to make significant decisions -- about where to live, work or how to care for a sick relative -- based on discriminatory insurance rules.

The plan also:

- **Protects you if you lose your job.** Let's say your company offers you a Cadillac health plan today. That's great. But what happens if the company has to cut back and you lose your job? You lose that Cadillac plan and end up naked in the middle of the road.

• **Increases your choices.** Today only one of every three companies that employ fewer than 500 people offers employees a choice of plan. And rising health care costs and the bottom line are putting choice out of the reach of more people everyday The Health Security plan guarantees you a choice of at least three plans in every area: a traditional fee-for-service plan like many people have today, a network of doctors and hospitals, and an HMO-type plan. You -- not your boss or a benefits manager -- choose from whom and how you'll get care.

• **Helps restore lost wage increases.** The Health Security plan will give millions of American workers their first real chance for wage increases in years For two decades rising health care costs have robbed American workers of wage increases they need and deserve. If we do nothing, health costs for an insured worker will rise from 1 in 5 to 1 in 4 dollars in just seven years. By giving business the bargaining power it needs to get affordable health care and helping provide for retirees -- whose health costs are killing some big manufacturers -- the Health Security plan helps workers.

• **Guarantees preventive care.** By providing a full range of free preventive care benefits, the Health Security plan offers all but a few Americans something new: care to keep them healthy, rather than coverage for after they get sick. Preventive care benefits include such things as physicals, immunizations, mammograms and Pap smears.

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..

Worksheet for Individuals

I. **Average Premiums** [preliminary estimate; not accounting for state differences]

Two parent family with children	$4,500
Single Parent Family with Children	$3,900
Married Couple, no children	$4,000
Individual	$2,000

Low Wage: If you earn less than 150% of poverty, you will be eligible for a discount on your 20% share of the premium. If you don't work and have income less than 250% of poverty, you are eligible for a discount on the 80% (employer share) of your premium.

II. **Out-of-pocket costs**

It is difficult to estimate exactly how much any individual or family will pay in out-of-pocket costs because people's health care needs vary widely.

- Annual Out-of-Pocket Limits:
  Nobody will pay more than $1,500 dollars in out-of-pocket costs per year and no family will pay more than $3,000.

- Deductibles:
  [The amount you pay out-of-pocket until your insurance kicks in]
  Some plans -- such as HMO's and certain arrangements within networks -- will have no deductible. Fee-for-service plans and looser network arrangements will have a $200 deductible for individuals and a $400 deductible for families.

- Co-payments:
  [What the patient pays for each medical service received]
  Some plans -- such as HMO's -- will have a small ($10) co-payment per doctor visit. Others -- such as fee for service plans -- will have a 20% co-payment, up to the annual limit of $1,500 per individual and $3,000 per family.

- Lifetime Limits:
  There will be **no lifetime limit** on your insurance. Today, 60% of the plans have a limit on the total amount their insurance will cover. Many plans impose arbitrary limits on certain treatments and services, like mental health.

III. Scenarios

	TODAY (Average Monthly Payment)	*REFORM (Average Monthly Payment)*	*Monthly Difference*
Two Parent Family Two children Two incomes: $55,000	$90	$75	$15 (-17%)
Two Parent Family Two children One self employed: $40,000	$90 with 25% deductibility	$75 with 100% deductibility	$15 (-17%) not including tax savings
Two Parent Family Three children Two incomes: $80,000	$90	$75	$15 (-17%)
Married Couple No children Income: $100,000	$79	$67	$12 (-15%)
Single Parent Three children Income: $20,000	$77	$65	$12 (-16%)
Single Person Income: $25,000	$28	$33	-$5 (+18%)
Uninsured Family One Income: $25,000	$0	$75	$75 --
Unemployed Family No income	$0	$0	--

IV. Companies

Employers will never pay more than 7.9% of their average worker wages *[sounds better than "percent of payroll"]* or 80% of the average weighted premium per worker -- whichever is less.

Companies with less than 50 employees -- with average worker wages lower than $24,000 -- are eligible for discounts on their share of the premium. This can be as low as 3.5 % of their average worker wages (i.e., for a minimum wage firm).

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.

MEDICARE

SCORABLE AND SPECIFIC: The $124 billion in savings from reducing the growth of Medicare mentioned in the current draft, are based on specific, scorable policy proposals. They are not based on any vague caps or assumptions that could be subject to dispute.

REDIRECTING MEDICARE SPENDING TO INCREASE BENEFITS: This proposal does not involve cutting Medicare-- it involves spending Medicare money differently, by reducing the growth in payments to providers and increasing benefits for older Americans. The savings in Medicare will be rechanneled so that benefits for seniors will increase through expanded coverage for prescription drugs, and through a new home- and community- based long-term care program. Seniors making over $100,000 may pay higher Part B premiums, but because the lion's share of savings come from lowering the growth in some provider payments, the new benefits offered to seniors will dwarf any reductions in the growth of benefits needed to get the $124 billion in savings. And what most older Americans pay -- their share of the cost of health premiums -- will actually decline as growth in the cost of Medicare comes under control, reducing annual cost increases not only for Medicare but also for Medigap policies.

REASONABLE LEVEL OF SAVINGS: The level of savings are reasonable and comparable to the savings called for in other major health reform alternatives as well as the most serious entitlement caps called for during the budget process. The $124 billion in Medicare savings is an amount comparable to the health reform alternative offered by the Senate Republicans, which propose about $100 billion in savings, and less than the savings called for by the more liberal single-payer proposals, which save more like $150 billion from Medicare, and by less than the amount the Republican budget alternative would have likely achieved as scored by Congressional Budget Office.

THE SAVINGS ARE POLITICALLY ACHIEVABLE: The political viability of these savings have been questioned because of the controversy that normally is associated with Medicare savings. Yet, this is a different ball game. As mentioned above, this is not about reduction benefits for Medicare or shifting costs to the private sector, this is about redirecting savings to new and expanded benefits for the population these programs serve: the older Americans. As Majority Leader Mitchell has stated, if you take $8 out of a persons pocket, and put back $10, most people will think they are better off. And because it is done within the context of comprehensive health care reform, it will not shift costs to the private sector and will be part of a plan, that will increase health benefits to older Americans.

CONSISTENT WITH PAST POSITIONS: During the budget process, President Clinton stressed the need to stop the spiraling rise of health care costs, but stressed that it had to be within the context of health care reform so that reductions did not lead to hidden tax on premiums by shifting costs to the private sector or lead to reduction in benefits to middle class Americans. These reduction in the growth of Medicare will increase benefits and not shift costs due to the new heath care reform and back-up control mechanisms.

QUESTIONS AND ANSWERS

Bureaucracy
Controlling Costs/Providing Quality Care
Doctor Choice
Rationing
Abortion
Rural
Veterans
Alliances

Q: Isn't this just creating more government bureaucracy and regulation?

A No, it's today's system that's weighed down by bureaucracy and regulation. When the President and Vice-President visited a hospital here in Washington, they saw piles of forms that are eating up doctors' and nurses' time -- time that could be better spent with patients. In hospitals today, the number of administrators is increasing four times faster than the number of doctors.

The President specifically rejected a government-run system, opting instead for a system based on what we have today. His reform proposal will free doctors from the avalanche of paperwork, and streamline the system. It will create a single claims form, and it will reduce regulation of doctors and hospitals to cut the unnecessary paperwork for doctors and patients.

Q: What makes you think you can control costs and still provide quality care?

A: There's a lot of waste in today's system. There's no doubt we can do better. Look at Germany, for example. In 1990, the United States spent 99 percent more per capita on health than Germany. Germany spent just 8.1% of GDP on health care, while the United States spent 12.4%. But Germany has a lower infant mortality rate and slightly longer life expectancies for both males and females than the United States. So we're not getting good value for our health care dollar.

Q: Are people going to have the right to choose their doctor?

A: Yes. **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 employer or insurance company won't decide how or where or from whom you get your care -- you will.

Q: When you force everyone into HMOs as a part of your plan, aren't you going to be "rationing" care?

A: First of all, let me emphasize that we are going to preserve and expand choice in the

health care system. Everyone will be able to choose their doctor. No one will be forced into anything -- there will be a traditional fee-for-service option in every region of the country. As today, it is likely to be a little more expensive than some other plans. But everyone will be able to choose from a variety of health plans -- which is something that most people can't do today. Today, only 1 in 3 companies with fewer than 500 employees offer any choice of plan. So we will see increased choice.

And we're going to maintain the finest quality of care in the world. We're going to guarantee everyone comprehensive benefits, including preventive care, so that we keep people healthy instead of waiting until they get sick. When opponents of the plan talk about "rationing," they're just trying to scare the American people.

Q: Does the plan cover abortion?

A: The comprehensive insurance package covers pregnancy-related services. Though abortion, like other types of surgery, is not specifically mentioned, most plans will cover it -- as they do now. Plans will cover abortions, as all procedures, when a doctor believes it is appropriate or necessary. Abortion coverage is not mandated, and a conscience clause allows doctors and health institutions, like a Catholic hospital, to exclude abortion coverage for moral or religious reasons.

What is new in this health plan is coverage for preventive care, including family planning, which should reduce the number of abortions which is our common goal.

Q: How are you going to help people in rural areas get care?

A: Right now, two-thirds of rural counties do not have enough doctors. It's no wonder. Rural doctors provide more charity care than any doctors in the country, and they often get paid late. In many cases, rural doctors can't even take a day off because there isn't another doctor for miles around.

The plan will include incentives for doctors to practice in rural areas. Specifically, it will expand the National Health Service Corps and their loan repayment program, increase incentives for medical schools to train more primary care doctors, and give states flexibility to develop programs that are more responsive to rural needs.

The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. By sharing skills through technologies like interactive video, it will give rural residents access to the kind of care once available only at major medical centers. And it will use nurse practitioners and other health profesionals to increase the availability of care.

In addition, the Clinton plan will give rural residents the bargaining power they need to get affordable coverage and access to high-quality care.

Q: What's going to happen to the Veterans' health system?

A: The VA health system will remain intact. And veterans will receive all the benefits they do today. The VA health system will also be able to organize their hospitals and clinics into health plans that will compete with other plans to enroll veterans.

Q: Don't the boards of the health alliances offer plenty of opportunities for political corruption?

A. No. First of all, the plan has very strict rules preventing anyone associated with the health care industry from serving on the board of an alliance. Only representatives of the employers and consumers who receive coverage through the alliance can serve on the board. The board and the alliance will be held accountable, with all its workings in full, public view. If any problems were to develop, there would be a powerful constituency -- everyone who gets health care in that region -- with an interest in solving the problem immediately.

The alliance's responsibilties are limited. It acts as a purchasing agent -- and makes sure health plans meet certain standards. It cannot reject any health plan which meets the standards specified in the law; it must accept all qualified plans.

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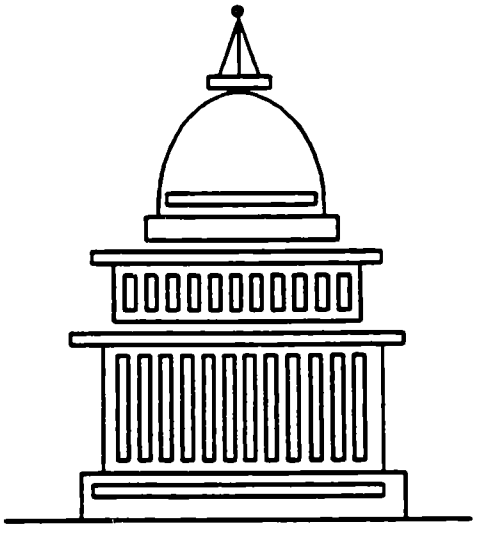
CONGRESSIONAL HEALTH CARE WORKSHOPS



SEPTEMBER 1993