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2011-0584-F
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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

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- b(1) National security classified information [(b)(1) of the FOIA]
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- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
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file

ECONOMIC EFFECTS OF HEALTH CARE REFORM

Comprehensive health care reform is a necessary element in an overall strategy to increase long-term economic growth, lower interest rates, 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: health care reform will lower business costs, raise wages, and increase opportunities for workers.

I. THE HEALTH SECURITY PLAN WILL LOWER COSTS FOR MANY BUSINESSES, FREEING UP MONEY FOR NEW JOBS, HIGHER WAGES, AND MORE INVESTMENT.

Most businesses provide health care, and the Health Security plan will lower their costs by slowing the rate of growth of health care costs, eliminating "free riders," and lowering the markup for uncompensated care. This will make it easier to hire future workers and to give wage increases to existing workers.

II. SMALL BUSINESSES WHO NOW PROVIDE COVERAGE WILL PARTICULARLY BENEFIT.

Most small businesses provide health care to their workers and have to pay up to 35% more for health care than their big business competitors. The Health Security 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. As the Wall Street Journal said, "for many small businesses, saddled with escalating health care costs, President Clinton's health care package comes as an unexpected windfall."

Accessible, reasonably priced insurance makes it easier for people to form new companies and for small business to attract and keep workers.

III. THE HEALTH SECURITY PLAN WILL REDUCE "JOB LOCK" AND INCREASE PEOPLE'S ABILITY TO FIND BETTER JOBS.

Up to 30% of people report that they are afraid to leave their current jobs because they could lose their health insurance. The guaranteed security of the Health Security plan means that people will be free to switch jobs or start a small business.

IV. THE HEALTH SECURITY PLAN WILL REDUCE "WELFARE LOCK."

One of the reasons people do not leave welfare is the loss of Medicaid benefits. Studies suggest that as many as one million of the four million welfare recipients would take jobs if they were guaranteed health care.

V. HEALTH CARE REFORM WILL "LEVEL THE PLAYING FIELD" AMONG SMALL BUSINESSES, AND BETWEEN LARGE AND SMALL BUSINESSES.

Small businesses that provide insurance currently pay more for labor than their competitors that do not insure, and pay more for insurance than their large business competitors. They also must bear the cost, in the form of higher premiums, to finance care for the uninsured.

VI. THE HEALTH SECURITY PLAN WILL INCREASE HEALTH CARE JOBS IN THE SHORT RUN AND INCREASE EFFICIENCY IN THE HEALTH CARE SECTOR IN THE LONG RUN.

By 1996, as many as 400,000 jobs will be created in the health care industry. As cost savings begin to accrue, employment growth in the health care sector will slow. Improved efficiency in the health care sector will lower the price of care to families and businesses.

VII. MINIMUM WAGE - LOOK AT REAL WORLD EVIDENCE.

Real world evidence from Harvard and Princeton studies of small businesses and restaurants shows that recent minimum wage increases did not hurt job growth, and in fact, can make it easier to hire people. Health care reform is equivalent to a small increase in the minimum wage for those firms that currently do not provide health insurance. The increase in health care costs under the Health Security plan for currently uninsured low-wage workers in small firms is equivalent to only a very modest minimum wage increase of \$.15 to \$.35 per hour.

VIII. HAWAII - LOOK AT REAL WORLD EVIDENCE.

Real world experience from Hawaii, which imposed an employer health insurance mandate in 1974, shows that from the 1970's until now, Hawaii's private non-farm employment increased by 90% (compared to 54% in the U.S.) and retail and wholesale trade employment grew by more than in the U.S.

Economic Effects of Health Care Reform

by

Robert Reich, Secretary of Labor

and

Laura D'Andrea Tyson, Chair, Council of Economic Advisers

October 6, 1993

I. Many features of the plan work to lower employer costs, increase job opportunities, and improve economic efficiency.

A. The Health Security plan lowers business spending on health insurance and thus frees up money for increased wages and salaries or for additional hiring.

1. The slower growth rate of health care costs means that aggregate business spending falls over time.

While the business sector as a whole will initially pay more for health insurance because of the expansion to universal coverage, the reduction in health care cost growth lowers premiums over time. By the end of the decade, businesses in aggregate will pay less for health care than they otherwise would have, even with the increase in coverage (Chart 1).

- By the year 2000, aggregate business spending on covered services alone will fall by \$10 billion. This is about 4 percent of baseline spending in that year. In 1989 dollars (the peak of the business cycle), this is about 3 percent of total business profits and about 6 percent of net investment in fixed, non-residential plant and equipment.

2. Many employers who currently offer health insurance will see their costs drop, freeing up resources for increased wages or additional hiring.

- Businesses that currently provide insurance pay more than true cost since providers overcharge them to make up for care to the uninsured. This "uncompensated care tax" amounts to over 10 percent of premiums. Under the Health Security plan, every business and individual must contribute something to the cost of their health care. Ending this cost shifting will lower costs for businesses that now provide insurance.
- Employers now providing insurance will benefit from spreading the costs over all workers. Currently, about 20 million workers are insured through a spouse's policy. By eliminating corporate "free riders", the Health Security plan will lower costs for many firms.
- Small businesses will see additional price reductions, since the load on their insurance premiums -- the amount by which the price exceeds the expected benefits -- will fall by up to 25 percent.

- Many currently insuring firms will receive discounts on their premiums.

3. Insuring firms can respond to cost reductions by:

- Hiring more workers.
- Raising wages of their existing workers or providing better pension or other benefits.
- Investing more in plant, equipment, education and training, and research and development.
- Increasing dividends to shareholders.
- Lowering prices, thereby leaving consumers with more income to spend on other goods.

Each of these outcomes has a stimulative effect on the economy and will increase employment. Economic research has not reached clear conclusions about how to apportion these effects. Almost all models suggest that wage increases are a likely response, but they differ about whether all of the savings will result in wage increases, or whether some of the savings will be allocated to additional investment or new hiring.

B. Small businesses benefit from other features of the plan as well.

- Small businesses, particularly those with low average wages, receive the largest discounts.
- Small businesses will see the largest reductions in their administrative costs.
- Many small businesses will benefit from the movement to community rating. Small businesses have the most variability in insurance premiums, because of the small size of their groups. This variability contributes to the difficulty small firms have in attracting and keeping highly skilled workers. If costs were independent of each group's risks, small businesses might find it easier to attract and keep workers.
- Health care reform will "level the playing field" among small businesses, and between large and small businesses.
 - Small businesses that provide insurance currently pay more for labor than their competitors that do not insure. They also must bear the cost, in the form of higher premiums, to finance care for the uninsured.

- Small businesses that insure currently pay up to 35 percent more than their large business competitors for the same set of benefits.
- Many small businesses would like to provide health insurance but cannot. According to a recent study prepared by Charles Hall of Temple University for the NFIB:
 - 64 percent of small business owners would like to provide some or better insurance for their workers;
 - When asked why they do not offer insurance, the most common reason (65 percent) is that premiums are too high.
 - 92 percent of small business owners agree that the cost of health insurance is a serious business problem.

C. The reform will result in greater health care employment in the short run and a more efficient health sector in the long run.

- By 1996, as many as 400,000 net new jobs will be created in the health sector. This net job increase consists of a significant expansion of employment of health care providers and a decrease in employment of health administrators and insurance workers. As the cost savings begin to accrue, employment in the health sector will level off. By the end of the decade, health care employment will grow more slowly, although there will be no absolute decline in the number of employees.
- As the health sector becomes more productive, the economy will be able to produce more output than it could before reform. This productivity increase will raise living standards.
- Prohibiting pre-existing condition exclusions and the ability of insurers to drop coverage will improve efficiency. While any one insurer benefits from having these screens, those excluded are ultimately covered by someone, or receive uncompensated care. The resources spent "passing the buck" are thus a loss to society.

D. Health care reform will end one reason firms discriminate among types of workers.

- Firms currently have an incentive to favor workers who have other health insurance coverage, particularly working spouses in two earner families,

part-time workers, and temporary workers. In most cases, firms can hire these workers without providing health insurance.

- The Health Security plan will eliminate incentives to hire people on the basis of their health care costs as opposed to their job qualifications.

E. By providing health care security, the Health Security plan will improve the efficiency of the economy.

1. The reduction in "job lock" will increase people's ability to find better jobs.

Up to 30% of people report that they are afraid to leave their current job due to the risk of losing health insurance. Research by Brigitte Madrian at Harvard has found that mobility rates for married men are depressed by 25 percent because of job lock. This effect impedes the ability of workers to move to jobs where they are more productive.

Reducing job lock may also affect employment. Firms may be more willing to hire qualified workers with pre-existing conditions when they cannot be charged more for them. On the other hand, some workers may decide to leave the labor force if affordable health care is no longer tied to staying at a particular job. Evidence suggests that about 350-600,000 people will decide to retire early following health care reform. The increase in voluntary retirement is likely to increase employment opportunities for younger workers.

2. Lower costs for small businesses and the self-employed may make it easier for people to form new companies.

The difficulty of self-employed workers and small businesses today in purchasing health insurance creates large disincentives for individuals to leave covered jobs to start up new businesses. Reform may thus stimulate new business formation, particularly for small businesses. There is little economic research on this subject to date.

3. Eliminating the link between welfare and health insurance will reduce "welfare lock".

One of the barriers to leaving welfare is the loss of Medicaid benefits.

Having universal insurance coverage will end this fear. A typical mother on welfare, for example, will get to keep about 10 to 15 percent more of any additional earnings as a result of health care reform.

Several studies estimate that eliminating welfare lock could have substantial employment effects among the welfare population. Robert Moffitt at Brown University and Barbara Wolfe at the University of Wisconsin suggest that as many as 1 million of the 4 million welfare recipients would take jobs if there were continuous health care benefits. Aaron Yelowitz of MIT also finds that more Medicaid recipients would work if they could keep more of their income and still receive health insurance.

II. Existing studies fail to analyze accurately the Health Security plan.

There are two commonly cited studies of the economic impacts of the President's health care reform proposal: "The Impact of a Health Insurance Mandate on Labor Costs and Employment", by June and Dave O'Neill for the Employment Policies Institute; and "The Employment Impact of Proposed Health Care Reform on Small Business", by The CONSAD Research Corporation. These studies do not adequately analyze the economic effects of the President's health care reform proposal:

A. The studies make several fundamental errors in characterizing the Health Security plan.

- They completely excluded from their analysis the discounts to small and low-wage businesses that the Health Security plan provides.

The lack of discounts -- coupled with the questionable assumption that firms cannot shift any costs to workers earning less than \$25,000 per year --- lead directly to the massively overstated claims of job loss.

- They incorrectly calculate the cost for part-time employees working 20 or more hours per week.

In the O'Neill study, employers are assumed to pay the full premium for all workers who work more than 20 hours per week. In the Health Security plan, however, employers pay a much smaller, pro-rated premium for part-time workers.

- They use a benefit package that costs much more than the Administration's package.

The O'Neill study assumes that employers pay \$5,310 per worker with a family and \$2,160 per single worker. Estimates for the Health Security plan are that employers will pay about \$2,500 per worker with a family, and about \$1,500 per single worker. The cost that employers pay for a family policy is adjusted to take into account that many families will have two adults in the labor force. In these cases, both employers will contribute to the cost of health insurance.

B. The assumption about how firms change their employment in response to cost changes is three to six times higher than most conventional estimates.

The O'Neill study assumes that firms will lay off 3% of their workforce if

compensation rises by 10%.

- Summary estimates in the economic literature, for example by Charles Brown and Allison Wellington, suggest that the responsiveness of firms to cost changes for low-wage workers is only one-sixth to one-third of the O'Neill assumption.

C. Neither study accounts for job gains from businesses whose costs fall under the reform.

D. Real world evidence suggests that mandates do not have major adverse employment effects.

1. Hawaii imposed an employer health insurance mandate in 1974. From the 1970s until now:

- Total private non-farm employment in Hawaii increased by 90 percent, compared to 54 percent in the United States as a whole.
- Retail and wholesale trade employment grew by more in Hawaii than in the United States as a whole.
- Within the health care sector, total health services employment in Hawaii grew more rapidly than it did in the United States as a whole. In contrast, health insurance employment grew less rapidly than it did in the United States as a whole.

2. The increase in health care costs for currently uninsured low-wage workers in small firms is equivalent to only a very modest minimum wage increase of \$.15 to \$.35 per hour. An increase of this magnitude will still leave the real compensation cost for minimum wage workers below its average level in the 1980s.

- Evidence by Lawrence Katz at Harvard and Alan Krueger and David Card at Princeton suggests that recent increases in the minimum wage have had minimal or even positive effects on employment.

E. These studies do not focus on the many beneficial aspects of the Health Security plan discussed in Part I.

There is no denying that some firms will pay more after reform than they did prior to reform. The vast majority of Americans, however, will benefit from the reduction in health insurance costs, the portability of coverage, the lower administrative costs, the reduction in job lock, the lower costs for small businesses and the self-employed, and the reduction in welfare lock. Any study which ignores these effects cannot be a complete analysis of the employment effects of health care reform.

III. There are many factors in the health care reform that will tend to increase employment. There are some factors that will tend to decrease employment. And there are several factors that will change the composition of employment. Overall, the net effect on employment is likely to be small. Over time, the beneficial effects on employment are likely to strengthen.

A. Existing models do not allow us to quantify the net effect on employment. Estimating these effects would require precise answers to a wide range of questions, including:

- How will individuals respond to the incentives in the plan, particularly those affecting small business formation, job mobility, welfare reduction, and retirement?
- Will firms respond to reductions in health care costs by increasing wages dollar-for-dollar, or in part by increasing employment, increasing investment, or reducing prices?
- Will decreased uncertainty in the growth of health care costs encourage firms to hire more workers or encourage more individuals to become self-employed?

There are no existing models that can address all of the relevant issues. The range of uncertainty is too great to use precise numbers. For this reason, we will not present specific estimates of the employment effects of the Health Security plan.

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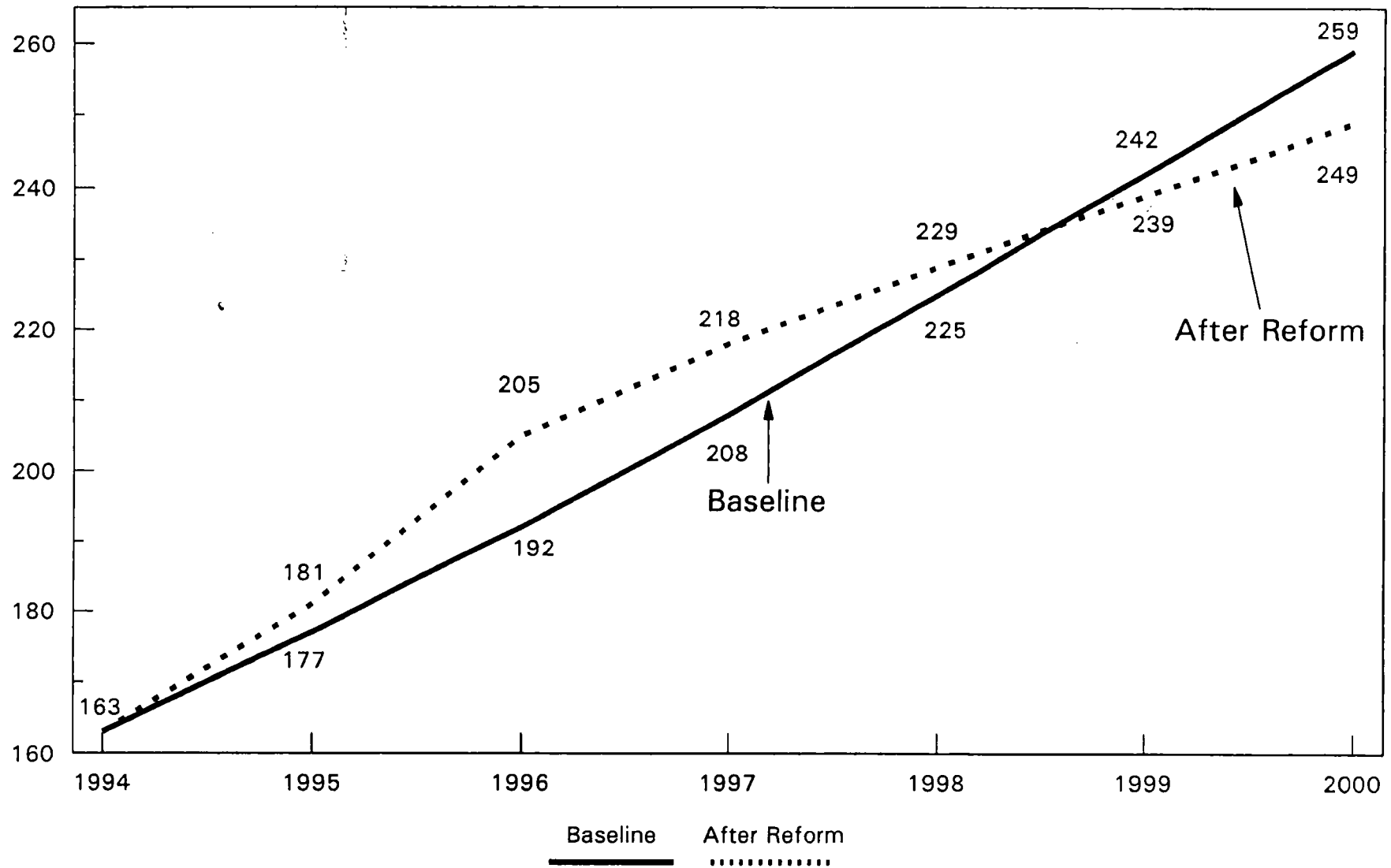
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Business Spending on Covered Services

Baseline and After Reform, 1994-2000

Billions of dollars



Notes: Preliminary estimates.

Spending after reform is for mandated services only.

"THE MANAGED COMPETITION ACT OF 1993": SOME CONCERNS

There are many components of this approach we completely agree with. Like Congressman Cooper, we believe community rating returns insurance to a community responsibility, not an exercise in profit making and risk avoidance. Like Congressman Cooper, we believe that an increased emphasis on competition will promote efficiency, reduce waste, and lower costs. And finally, like Congressman Cooper, we believe increased cost-consciousness is an important aspect of health care reform, and a necessary ingredient for cost control.

But we cannot support the Cooper bill because it does not provide health security for all Americans. We believe all Americans need and deserve health care security; this plan just doesn't provide that. We believe that comprehensive benefits should be spelled out and guaranteed; this plan doesn't provide that. We believe choice of doctor is a right; this plan considers choice a taxable luxury. We believe HMOs are one alternative; this plan believes HMOs are for everyone.

The Cooper plan must get a failing grade as it does not meet five of the six principles the President has set forth for comprehensive health reform.

- 1. It does not provide the security of a comprehensive package of benefits that can never be taken away.*
- 2. It does not provide increased choices for consumers.*
- 3. It does not provide a simpler system.*
- 4. It does not guarantee savings -- it continues the cost shift and raises the deficit.*
- 5. And it asks responsibility from no one. In fact it gives no one any reason to be responsible.*

COOPER: *"[The plan does not] compel employers to pay the health plan premiums of their employees."*

Translation: **In fact, the Cooper plan doesn't require anyone -- not employers, not individuals, not the government -- to take responsibility for health care. Therefore, it doesn't provide health care coverage for everyone and guarantees no one security.**

There are only a few ways to guarantee coverage for all Americans. One is to raise a broad-based tax, and have the government finance and deliver health care. The second is to require employers to contribute to coverage for all of their workers. The third is to require all individuals to purchase insurance for themselves. Whether it's the government, employers, individuals, or some combination... for everyone to have coverage, someone has to pay.

THE MANAGED COMPETITION ACT OF 1993

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The Cooper plan assumes that between better incentives and government help for the poor, more Americans will be covered. But individuals can still decide that health care isn't their responsibility-- it's yours and mine. They can still go without coverage, show up at the emergency room, and shift the cost to those with coverage. Employers can continue to drop workers who are costly, or not cover any of their workforce. In fact, this plan encourages employers with low wage workers to drop the coverage they now provide-- and let the government pick up their care. The result? After Cooper-style health reform, **22 million Americans will still be uncovered.** [Congressional Budget Office, July 1993]

In fact, the Cooper plan provides incentives for employers to drop coverage for many workers leading CBO to warn of 6 million newly uninsured Americans.

By providing government vouchers for low-income workers who now have coverage through the workplace, this plan could encourage some employers to drop their workers coverage, knowing the workers would be picked up by the government program. According to the Congressional Budget Office, "Enactment of the law is likely to cause a few employers to drop their health insurance plan and allow the government to assume the cost of covering their low income workers." [CBO, "*Estimates of Health Care Proposals from the 102nd Congress*," p. 52, 7/93]

COOPER: *"If an individual loses his job, he can remain in the HPPC and pay premiums himself."*

Translation: For millions, when you lose your job, you lose your coverage.

- If you lose your job, this plan does not guarantee you any protection at all.
- If you're locked into a job because you don't want to lose benefits, you're still trapped.

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COOPER:: *"A national commission will establish a uniform set of effective health benefits."*

Translation: **This plan does not even specify -- much less guarantee -- a comprehensive set of benefits, nor does it protect American families from exorbitant out-of-pocket costs.**

The Cooper proposal shifts the responsibility for defining the benefits package to a National Board -- to be determined after the legislation has passed and become law. How can the public be asked to support a bill when they don't know what health care they'll receive? The millions of Americans who want and need health care reform have made clear that health care reform must mean comprehensive benefits.

This approach does not answer a single important question about benefits:

- Which services will covered, and which will be denied?
- Are preventive services fully covered? which ones?
- How much is a family liable for in a given year?
- Is mental health care covered?
- What about lifetime limits?

No American consumer would pay up front for a new car, only to have the dealership decide later on the type of engine in the car, on the features that were included, or what kind of warrantee the car came with. There are certain things the American people have a right to know up front: guaranteed, spelled out benefits are one of them.

COOPER: *"... to discourage inflationary "Rolls Royce" health policies, which don't control costs, the bill caps tax deductibility at the cost of the lowest price AHP plan..."*

Translation: **You could be penalized if you pick your own doctor and pay a "choice tax" to belong to certain plans or see certain doctors.**

This proposal doesn't just target the "Roll Royce", it targets the family station wagon. Millions of Americans will pay new taxes for the same benefits. By trying to reward consumers for choosing tightly managed, cost-efficient plans like HMOs, the proposal punishes individuals and their employers for any other choices. If you want to continue to get health care the way you do now -- or to see the same doctor you've always seen outside of an HMO -- you get taxed.

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If you choose not to go into an HMO or HMO-type organization, you and your employer both pay new taxes on your health care premiums. HMOs are a fine alternative for many Americans, but they are not for everyone. Free choice of doctor is an American tradition, and is the only type of health care delivery in many areas of the country. The "one-size-fits-all" approach doesn't work for health care, and HMOs are not the best fit for many people who don't want to see such major change in their health care.

Under this plan:

- Those who currently have restricted choices will find their choice is still limited or more limited.
- Those who currently have a free choice of doctor will lose that choice, or pay a tax to maintain it.

COOPER: *"Employers will be allowed to deduct the cost of the most efficient health plans but not the cost of excess benefits or wasteful spending."*

Translation: **The Cooper plan encourages employers to reduce benefits by levying tax penalties on employers that give their workers comprehensive coverage.**

Does Congressman Cooper consider prescription drugs "excessive benefits"? Does he consider investments in mental health and long-term care "wasteful spending"?

Today employers can deduct the cost of any and all health benefits as a business expense. The Cooper proposal would set a "tax cap" at the lowest cost plan in the area -- a plan with benefits that are less generous than what most people have today.

So even though this plan says that "*individuals would choose*", employers would have every incentive to force their workers into only one plan -- the cheapest plan. This trend exists today...workers are increasingly locked into one plan by their employer, forcing them to give up relationships with doctors they trust.

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COOPER: *"This is financed by . . . reducing the increase in provider fees under Medicare. . . "*

Translation: **The Cooper plan worsens today's cost shifting, raising private sector costs and endangers access for Medicare beneficiaries.**

Most experts agree that there is room to slow the growth of spending in Medicare. But responsible lawmakers and senior advocates believe that there are two important conditions: first, if seniors are asked to pay more, they should get more. And second, if costs are controlled on the public side, they must be controlled on the private side.

This plan fails to meet both those conditions. It slows growth in Medicare spending, both by reducing rates to providers and by dramatically increasing Part B premiums for upper-income Medicare recipients. And yet it dedicates none of that money to new benefits or increased protections for seniors ... not one thin dime.

Secondly, it slows Medicare spending without controlling spending on the private side. The result? Private sector health care will continue to be threatened by ever-rising costs, as the budgeted public programs shift costs to the unbudgeted private sector. Second, as the gap between Medicare rates and private sector rates continues to widen, more doctors will choose not to see Medicare recipients, and more Medicare patients will find they have less and less choice of doctor as a result.

BUT

The Cooper plan gives seniors nothing in return.

For three out of four senior citizens, prescription drugs are the single highest out-of-pocket expense. Millions of other seniors, even those with comfortable incomes, live with the lurking fear that a serious illness could wipe out their savings by forcing them to enter a nursing home.

This plan says that many seniors will pay four times more for the same Medicare, and still be strapped with huge prescription drug bills, still have no options for long-term care unless they want to leave home and move to an institution.

We believe it is unconscionable to ask seniors to contribute to reform while their two most pressing health care concerns -- long-term care and help with prescription drugs-- are ignored.

THE MANAGED COMPETITION ACT OF 1993

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COOPER: *"... does not include price controls, nor does it include global budgets."*

Translation: **This plan does not guarantee cost control, nor does it protect individuals and families from insurance premiums that skyrocket year after year.**

Competition will go a long way to slow runaway health care spending, to be sure. But today skyrocketing health care costs are threatening American families, American businesses and the health of our economy itself. But what if competition takes too long? What if it doesn't work everywhere?

In addition, this proposal does nothing to guarantee that rising health costs will no longer wipe out our families and businesses. Controlling the increase in premiums that individuals and businesses pay is the only way to protect the private sector from being bankrupted by health care.

Under this plan:

- The practice of "cost shifting" -- squeezing down on the public side and pushing costs higher on the private side-- will continue unchanged.
- Individuals and families now unprotected from skyrocketing costs have no greater protection.
- Costs will still rise at the projected rate-- or faster: "CBO estimates that, after a few years, H.R. 5936 would leave national health expenditures only a little higher than they would otherwise be."
[CBO, *Estimates of Health Care Proposals from the 102nd Congress*, p. 58, July 1993]

COOPER: *"... the bill uses strong tax incentives ..."*

Translation: **This plan is an administrative nightmare; it might as well be called "the IRS full employment bill".**

This plan significantly expands the reach of government bureaucracies and government involvement in the workplace. It requires the IRS to determine and monitor the low-cost plan in every HPPC region, and match that against spending on health care by every employer for every

THE MANAGED COMPETITION ACT OF 1993

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employee. And this adds a tremendous new administrative burden for businesses -- particularly small businesses who now suffer tremendous administrative burdens -- by forcing them to keep on top of the "lowest cost plan" the way an investor would follow changes in the stock market.

COOPER: *"Deficit: [1995] \$14 Billion; [1996] \$22 Billion; [1997] \$17 Billion; [1998] \$12 Billion; [1999] \$5 Billion"*

Translation: **The Cooper Plan increases the deficit by \$70 billion.**

This proposal doesn't even pay for itself. In fact, the CBO/Joint Tax Committee analysis of the plan found that it increases the deficit by \$70 billion in the first 5 years alone.

COOPER: *"The states will gradually assume responsibility for long-term care, with greater flexibility to try innovative approaches."*

Translation: **The Cooper plan does not address long term care other than shifting enormous federal costs onto the states.**

The fastest growing item in most state budgets is Medicaid, outstripping state's abilities to pay for other needed services like education and public safety. And more and more of those Medicaid dollars go to the mounting costs of long-term care. As our population ages and more and more Americans live longer, these costs add increasing burden on both federal and state governments.

Today, the federal government contributes at least 50 cents of every dollar states spend on Medicaid long-term care; in some cases, up to 75 cents. The Cooper plan says that states should bear those costs completely on their own, a proposition that would bankrupt many states.

Health Care - 15 October

file

I. Pledge

Stan: make it 2 pts
this Congress
Universal

JT. Resolution

II. Senate Visits

- Teams of Adm officials
- One-on-ones

III. Launch

- Oct 25-26
- 2 day travel

IV. Materials / Book

Health Care Reform Project Statement of Principles

I _____ will support the enactment of health care reform for all Americans. My support is not tied to any particular legislative proposal, but offered in the belief and conviction that only through the bi-partisan cooperation of Congress, the Administration and all interested organizations will we succeed in enacting comprehensive health care reform without delay.

In this spirit, I offer my support for passage of federal legislation that will:

1. Assure all Americans the security that they will never again lose their health care coverage, that all Americans will be protected, and that coverage will be comprehensive and affordable.
2. Slow the growth of health care inflation and eliminate waste, fraud, and overcharge throughout the health care system.
3. Improve the quality of health care for all Americans.
4. Make the health care delivery system better serve the needs of people and communities and foster, enhance and promote the health and wellness of all Americans.
5. Simplify billing and record keeping for both patients and providers in order to concentrate health resources on patient care.
6. Protect consumers by assuring they (a) can continue to choose their health care providers, (b) are given meaningful information for making those choices, and (c) are assured of representation on key decision-making bodies.
7. Promote the coordination of patient services across the full continuum of care, including both acute and chronic illnesses.
8. Provide adequate and equitable financing to ensure an immediate and sustained financial commitment to fulfilling the promise of comprehensive reform.

Name _____
District _____

Signature _____
Date _____

Please return to the Health Care Reform Project, 2550 M St., NW Suite 250, Washington, DC 20008.

Report to the American People Outline

Letter from the President

reduced version of transmittal letter that highlights the six principles
historical background, everything that's wrong threatens everything that's right

Forward by The First Lady

review of the process, people met along the way (from testimony)

Chapter I -- What's Wrong/The Problem

what's right
what's wrong (arranged along six principles with letters/anecdotes)
cost of doing nothing

Chapter II -- The Solution/How The New System Works

walkthrough the new system/conversational
boxes on Medicare, unemployed etc. as in brochure

Chapter III -- Security

Health Security card
comprehensive benefits package
Medicare -- drugs/longterm care
retirees
access -- rural/urban

Chapter IV -- Simplicity

standardization/information
doctors
national programs

Chapter V -- Savings

philosophy -- competition/private system
cost containment
fraud

Chapter VI -- Choice/Quality

consumer-driven system
choice of doctor, plan
preventive care
workforce
malpractice
Academic Health Centers/research

Chapter VII -- Responsibility

- how we pay for reform (based on Senate Finance Committee testimony)
- individual scenarios
- business scenarios
- federal budget impact

Chapter VIII -- Conclusion

- return to principles
- contrast with alternatives
- cost of doing nothing
- historical moment

[Note: quotes from letters, validation quotes, "examples that work," and charts/graphs scattered throughout the text.]

Materials List

October 15, 1993

Materials Currently Available

MATERIAL	CONTACT	DISTRIBUTION
Health Care University	Steve Edelstein	Catherine
Congressional Briefing Book <i>Executive Summary</i> <i>Plan Summary</i> <i>Policy Summaries</i> <i>Q&A</i> <i>Benefits Package: Graphics</i> <i>Validation</i>	Steve Edelstein	Catherine
Preliminary Plan Summary	Carolyn	GPO phone # 783-3238, stock # 040-000- 00632-0, \$2.50
Policy Summaries	Christine/Steve/ Veronica	Catherine
Q&A	Jason Solomon	Jason Solomon
Breast pocket card	Catherine	Catherine
Stump speech	Lissa	Bob
Press packet	Bob	Catherine
Editorial Board mailing	Neel Latimore	Neel Latimore
Business	SBA & Commerce	Ken Stram phone # 205-6700
Veterans	VA	Leslie Sauwin phone # 523-1802
Defense	DOD	Redmond Walsh phone # 703/697- 1252
Federal Employees	OPM	Abby Block phone # 606-1000

MATERIAL	CONTACT	DISTRIBUTION
People with Disabilities	President's Committee on People with Disabilities	Dina Dorich phone # 376-6200
Health Security Card: Samples Stickers Blow-up for Speech Camera ready - B&W/ Color	Meeghan	Meeghan & DNC
Single Claim Form	Meeghan	Catherine
Charts & Graphs	Steve	Catherine

Upcoming Material

Material	Contact	Date Available
Report to America	Carolyn Gatz/ Bob Boorstin	10/27
Pamphlet	Meeghan/Sara	Week of 10/19
Video	DNC	Week of 10/19
A Physician's Guide	Arnie Epstein	Week of 10/19
Rural Health Pamphlet	Dena Puskin and Lois Quam, Office of Rural Health	Week of 10/26
Older Americans	Jennifer Smith, HHS/HCFA	Week of 10/26
African Americans	Claudia Baquet, Office of Minority Health	Week of 10/26
Hispanic	Claudia Baquet, Office of Minority Health	Week of 10/26
Women	Jennifer Smith, HHS	Week of 10/26
Financing piece	Paul Starr/ Carolyn Gatz	
Rationale Book	Paul	
New England Journal of Medicine Framework of Rationale	Paul	
Scenarios: Individual	Jen Smith & Meeghan	
Scenarios: Business	Glen Hutchins & Susan Otrin	
Comparisons with Congressional Legislative Initiatives	Chris Jennings	
Mental Health Benefits	Bob Boorstin	
"I'm Covered Now, What Does the Health Security Plan Mean to Me?"	Bob Boorstin	
Breast Pocket Cards - One for Each Pamphlet	Catherine	

Legislative Materials
October 15, 1993

Approval Process

Material	Authors	Approval Needed
Legislation	Drafting Team	OMB Process
Section-by-Section Analysis	Drafting Team	OMB Process
Revised Plan Book	Ira Magaziner, Carolyn Gatz, Policy Team	List
Report to America	Carolyn Gatz, Bob Boorstin,	List
Bob Boorstin	Message of Transmittal	List

Approval List:

Mrs. Clinton
Dave Gergen
George Stephanopoulos
Mark Gearan
Ira Magaziner
Gene Sperling
Melanne Verveer
Maggie Williams
Jeff Eller
Bob Boorstin
Nancy-Ann Min
John Podesta
Counsel's Office -- Steve Neuwirth
Kevin Thurm
Ken Thorpe
Judy Feder
Stan Greenberg
Mandy Grunwald
Kent Markus/Dick Celeste

In order to facilitate the approval process, we ask that you make comments to the author within 24 hours of receiving the material.

American Airlines

file/Health
Care

R L CRANDALL
CHAIRMAN AND PRESIDENT

September 28, 1993

The Honorable Bill Clinton
Ms. Hillary Rodham Clinton
The White House
Washington, DC 20500

Dear President and Mrs. Clinton:

Your address to Congress on the health care crisis went very well. My sincere congratulations to both of you for having moved this issue to the top of the nation's priorities.

I think you are right in believing that health care reform will be good for business. If we can stop runaway health care inflation, businesses like ours can use the dollars we save to increase capital spending and add jobs.

But there will be a more subtle benefit. For many years, American Airlines has competed against companies who, by not providing benefits for their employees and retirees, have obtained substantial cost advantages. When universal coverage becomes a reality, this practice will stop.

Five years ago, I testified before Senator Kennedy's committee in favor of mandating health care benefits. Afterwards, we were besieged with angry letters from frequent fliers and I found myself under fire from many of my business colleagues. Earlier this year I restated my views before Senator Kennedy's committee and was pleased by the completely different reaction. Today, it is widely, if quietly, recognized in the business community that we simply must have real reform; I think you have made a great contribution to encouraging that change in attitude.

A better plan will make America a better place and I want to pledge my support, and that of AMR and American, to making reform happen. We are obviously

concerned about some of the specifics of the plan, but look forward to learning more of the details and to participating in what I am certain will be a vigorous debate.

I have asked Ed Faberman and Degee Wilhelm in our Washington office to continue working with your people in this effort. Please let us know how we can help.

Very truly yours,

A large, stylized handwritten signature in black ink, consisting of several overlapping, sweeping strokes that curve upwards and to the right.

ke

GREENBERG
RESEARCH
INC



515 SECOND STREET NE
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TEL 202 547-5200
FAX 202 544-7020

file
Health Care
JT Sess

MEMORANDUM

TO: Chairman Wilhelm
Democratic National Committee

FROM: Greenberg Research

RE: Survey Research on President's Address to Congress on Health Care

DATE: September 23, 1993

Our focus group research suggests that President Clinton's health care plan was enthusiastically received by voters who viewed the speech. In this group of 50 participants (half Perot voters, half weak Clinton), there was almost unanimous support for the Clinton plan after the speech, with 42 percent somewhat in favor and 52 percent strongly in favor.

Clinton himself registered strong gains in his favorability and job approval ratings as a result of the speech. His mean favorable score jumped from 51 before the speech to 73 afterwards while his job approval moved from 62 percent approve to 82 percent approve.

These voters were reassured on a number of areas (see Table below). Most importantly, almost three quarters (72 percent) felt their family would be helped by the plan and an equal number believe the plan will preserve their right to choose a doctor. An overwhelming 86 percent believe the plan is a risk worth taking.

Still, these voters want more details about the plan and still believe that it will be paid for mainly by a tax increase (62 percent, down from 82 percent before the speech). Almost as many believe the plan will hurt the economy and jobs (44 percent) as believe it will help the economy (48 percent). A small majority (52 percent, down from 64 percent before the speech) wants Congress to take a lot more time to consider the plan.

Participants watched the entire speech and responded with an electronic dial. Clinton voters often exceeded Perot voters by an average of 15 to 20 points, usually during personal testimonies or other rhetorical flourishes.



Clinton voters, however, reacted much more intensely to the basic theme of coverage for all people and related discussions of security, including coverage for unemployed and poor people and protecting rights of seniors. We shouldn't underestimate how important this concept is to base Democratic voters.

Perot voters react to security, but mostly in the context of the individual: lose your job or switch jobs, you're covered. If you leave your job to start a small business, you're covered...pre-existing medical condition, you're covered.

Perot voters were as responsive as Clinton voters on critiques of the system itself and the other core components of the Clinton plan: simplicity, savings, choice, quality and responsibility. They were also responsive to calls for Congressional action and bipartisanship.

Perot voters actually exceeded Clinton voters in a few areas: changing unhealthy behaviors in this country (Perot around 70 and Clinton 66) and safeguarding the finest medical research in the world (Perot 66, Clinton 64).

When Clinton claims that reforms can be made without raising taxes, Perot voters lag about 15 to 20 points behind Clinton voters.

High points of the speech include:

- "...our health care is too uncertain and too expensive; too bureaucratic and too wasteful. It has too much fraud and too much greed." (Mean spike to 70)
- "...Giving every American health security -- health care that's always there - health care that can never be taken away." (Joint mean of 74, Clinton voters at 83)
- "...principles that must guide our reform of America's health care system: security; simplicity and savings; choice, quality and responsibility." (Mean spike to 66)
- "...we have to preserve and strengthen what is right with our health care system and fix what is wrong with it." (Spike to 71)
- "...causing companies a competitive disadvantage...no excuse for this kind of system and changes have to begin with Congressional action." (Joint spike to 69)



-
- "...let us keep this spirit and keep this commitment until our work is done."
(Mean spike to 67, steep Perot jump)
 - "...we cannot continue to do this...our competitiveness, economy, living standards depend on our ability to achieve savings without harming the quality of our health care." (Steep Perot rise to match Clinton voters at a mean of 67).
 - "...have to crack down on fraud and abuse in the system." (Clinton and Perot spike together to 67)
 - "...insurance companies can no longer cast people aside when they get sick."
(Joint spike from 58 to 65)
 - "...we have to change our ways if we really want to be a healthy people and have an affordable health care system." (Joint spike to 68)
 - "Ask yourself if the cost of staying on the same course isn't greater than the cost of change." (Spike to 65)
 - "I know we have differences, but we are here tonight in a spirit that is animated by the problems of those people." (Spike to 70)

The highest, strongest and sustained mean of the speech occurs during the card discussion and following statements of guaranteeing coverage, gradually going from 71 to a peak of 75:

"With this card, if you lose your job or switch jobs, you're covered.

"If you leave your job to start a small business, you're covered.

"If you are an early retiree, you're covered.

"If you or someone in your family has a preexisting medical condition, you're covered.

"And if an insurance company tries to drop you for any reason, you'll still be covered – because that will be illegal."

The actual "high point" of the speech is a spike to 77 on "and for the first time, Medicare will cover the cost of prescription drugs."

HEALTH SECURITY

PRELIMINARY PLAN SUMMARY

The Health Security plan guarantees comprehensive health benefits for all American citizens and legal residents, regardless of health or employment status. Health coverage is seamless; it continues with no lifetime limits and without interruption if Americans lose or change jobs, move from one area of the country to another, become ill or confront a family crisis.

Every American citizen will receive a Health Security Card that guarantees comprehensive benefits that can never be taken away. Fundamental principles underlie health care reform:

- The guarantee of comprehensive benefits for all Americans.
- Effective steps to control rising health care costs for consumers, business and our nation.
- Improvements in the quality of health care.
- Increased choice for consumers.
- Reductions in paperwork and a simplified system.
- Making everyone responsible for health care.

Americans and their employers are asked to take responsibility for their health coverage and, in return, they are guaranteed the security that they will always be covered under a comprehensive benefit.

The Health Security plan creates incentives for health care providers to compete on the basis of quality, service and price. It unleashes the power of the market and puts American consumers in the driver's seat. Consumers choose from whom and how they get their care.

The plan empowers each state to set up one or more "health alliances" that contract with health plans and bargain on behalf of area consumers and employers. Health plans must meet national standards for coverage, quality, and service set by the National Health Board. But each state tailors its approach to local needs and conditions.

The Health Security plan frees the health care system of much of the paperwork and regulation, allowing doctors, nurses, hospitals and other health providers to focus on providing high-quality care. It cracks down on fraud and abuse, reforms malpractice law and policy and outlaws insurance practices that hurt small businesses and imposes the first national standards for the protection of patient privacy and confidentiality in medical information and records.

CREATING SECURITY

The Health Security plan guarantees every American and legal resident health coverage that can never be taken away:

- The comprehensive benefits have no lifetime limits on medical coverage and provides a full range of medically necessary or appropriate services.
- No health plan may deny enrollment to any applicant because of health, employment or financial status, nor may it charge some patients more than others because of age, medical condition or other factors related to risk.
- All health plans must meet national quality standards and provide reliable information to consumers so they can choose their health plans and providers.
- Americans have a broad choice of health plans and providers.
- Elderly and disabled Americans receive outpatient prescription drug benefits under Medicare for the first time and expanded access to home and community-based long-term care services.
- Self-employed workers are able to deduct the full cost of their health coverage from their federal income taxes.

- Workers older than 55 who retire before they are eligible for Medicare receive comprehensive coverage for the guaranteed benefit but continue to pay only the employee share of the premium.
- New investments and loans help improve the availability and quality of health care in rural communities and inner-city neighborhoods.
- School-based and community clinics expand access to care in areas with inadequate health services.
- Financial incentives and expansion of the National Health Services Corps attract health professionals to areas with shortages of doctors and nurses.

CONTROLLING COSTS

The Health Security plan cuts the projected growth in health care costs by increasing competition in health care, reducing administrative costs and imposing budget discipline. Health plans compete to provide affordable, quality care:

- Uniform, comprehensive health benefits and reliable information about the price and performance of health plans encourage informed choices.
- Consumers may choose to pay less for lower-cost health plans or more for higher-cost plans, creating incentives for cost-conscious decisions.
- Payments to health plans are fixed, providing incentives to spend resources wisely. Payments are adjusted based on the risk characteristics of each health plan's participants.

If savings attained through competition and reductions in administrative burden fail to contain costs, limits on the rate of growth of insurance premiums provide an emergency brake -- or backstop -- to ensure that premiums remain in line with inflation.

Health reform also reduces the projected rate of growth in federal and state spending for Medicare, Medicaid, and other government programs. Resources conserved from those steps are applied to other aspects of the health care system, particularly the expansion of Medicare benefits to include prescription drugs and for new long-term care services.

The Health Security plan cracks down on providers and institutions that overcharge or engage in health care fraud. It sets tough new standards and imposes stiffer penalties that include:

- New criminal penalties for health care and for the payment of bribes or gratuities to influence the delivery of health services and coverage.
- New civil financial penalties against providers who submit false claims.
- Tighter restrictions to eliminate referral "kickbacks" in the private sector and new standards that prohibit physicians from sending their patients to get services at institutions in which they have financial interests.
- Strong accountability standards that make provider and other misconduct automatic grounds for exclusion from all health plans.

EXPANDING CHOICE

The Health Security plan guarantees consumers a choice of health plans and enhances the patient-doctor relationship.

- Alliances offer an array of competing health plans from which individuals and families choose their health coverage, expanding the range of choice for many Americans.
- Alliances must offer a traditional fee-for-service option in which every patient can see any physician he or she chooses.
- Consumers -- rather than their employers -- choose their health plan from among a menu of plans offered by alliances.
- Doctors and other health care providers also have a choice of health plans and delivery systems in which they may choose to practice medicine.
- Separate programs increase federal support for long-term care and improve the quality and reliability of private long-term care insurance.

ENHANCING QUALITY

The Health Security plan improves the quality of health care. It creates standards and guidelines for health professionals, reorienting quality assurance programs to measuring outcomes rather than regulation, increases the national commitment to medical research and promotes primary and preventive care.

- Health plans are held accountable for delivering appropriate, quality care.
- Regular surveys of consumer satisfaction are used to measure health plans.
- Regular publication of useful and easily understood information about quality and cost allows consumers to make informed choices among health plans.
- A special funding mechanism strengthens the role of academic

health centers in research, training and specialized care.

- Increased investment in research advances medical knowledge.
- Changes in Medicare rate schedules and the allocation of federal funds supporting graduate medical education provide new incentives for physicians to choose primary care as the focus of their training.
- Expanded funds for education and new federal action helps remove artificial barriers to practice that hinder nurses and other professionals.
- Investments in public health and medical research improve health protection for all Americans.

REDUCING BUREAUCRACY

The Health Security plan reduces the burden of paperwork and administration, streamlines regulatory, billing and reporting requirements and helps reduce confusion.

- A comprehensive benefits package that covers every American and legal resident reduces confusion for health care providers and consumers.
- Administrative costs caused by multiple insurance policies with different benefits and risk selection disappear.
- Standard forms for insurance claims and billing procedures simplify paperwork and reduce administrative costs.
- Administrative costs for small companies decline as those firms purchase care through regional health alliances that benefit from economies of scale.
- The plan simplifies federal regulatory requirements for Medicare, Medicaid and programs that govern clinical laboratories.

- The plan requires that health care services covered by workers' compensation and automobile insurance be delivered through an individual's health plan reducing duplication and waste.
- Malpractice reform reduces incentives for the practice of "defensive medicine," including unnecessary tests and procedures.

THE HEALTH SECURITY PLAN

COVERAGE

All American citizens and legal residents are guaranteed a nationally defined, comprehensive package of benefits and enroll in a health plan. Coverage continues without interruption regardless of a change of employer, employment status, marital status or medical condition.

Coverage goes into effect -- state by state -- beginning in 1995 and is fully implemented by 1997.

The vast majority of Americans continue to receive their health coverage at work, as they do today. All workers have a choice of health plans, each of which must be certified as meeting quality standards. Unlike today, however, all employers contribute to the purchase of health coverage for their employees, both full and part-time.

Employed individuals receive information about enrollment and health plans either at work or directly from the alliance. Small business owners and their families, employees of small business, the self-employed and the unemployed sign up for the health plan of their choice through the regional alliance office in their area.

Firms or Taft-Hartley Plans with more than 5000 employees may fulfill their obligation to provide coverage for their employees by establishing a corporate alliance or joining the regional alliances. Corporate alliances must meet federal standards for benefits, choice and quality.

Medicare beneficiaries continue to receive all current benefits and, in 1996, receive a new benefit covering outpatient prescription drugs. New long-term care programs also expand access to home and community-based care.

Those people who receive health care through the Department of Defense, the Department of Veterans Affairs and the Indian Health Service may continue to do so.

Medicaid beneficiaries receive coverage through the regional health alliance, choosing among the health plans it offers.

BENEFITS

The health benefits guaranteed to all Americans contain no lifetime limits on coverage, and provide a comprehensive package of medical services delivered in hospitals, clinics, professional offices and other sites. One uniform, comprehensive benefit package replaces hundreds of different insurance products in the market today.

When medically necessary or appropriate, covered services include hospital care, emergency services, preventive care, mental health and substance-abuse services, family planning, pregnancy-related care, hospice care, home health and extended-care services following an acute illness, ambulance services, outpatient laboratory and diagnostic services, prescription drugs and biologicals, outpatient rehabilitation, durable medical equipment, vision and hearing care, periodic medical checkups and preventive dental services for children.

The plan includes coverage for a full range of preventive screening and care often not covered in traditional health insurance policies. Covered preventive care includes well-baby checkups and immunizations for children, periodic physical examinations, routine laboratory work and screening tests, with no charge to the patient.

Additional benefits, including preventive dental care for adults and a more comprehensive mental health and substance-abuse benefit, are phased into the nationally guaranteed benefits by the year 2001.

Individuals or employers who wish to purchase benefits beyond the nationally guaranteed package may do so.

All individuals in a health plan pay the same premium for the nationally guaranteed comprehensive benefits regardless of health status, age, place of residence or employment status. Health plans are prohibited from discriminating based on existing medical conditions and other individual characteristics.

Medicare beneficiaries continue to receive all current benefits and, in 1996, receive a new benefit covering outpatient prescription drugs. Financial support for long-term care also expands.

COST-SHARING

Health plans adopt one of three standard cost-sharing arrangements:

- **Low cost-sharing:** This follows the existing model for integrated health plans, such as health maintenance organizations. Consumers pay \$10 co-payments for outpatient and professional services and do not make additional co-payments for inpatient services, preventive services, or home health care following an acute illness.

To obtain care from providers outside the network, plans may offer a point-of-service option that allows patients to visit any doctor, including those who may not belong to the patient's plan.
- **Higher cost-sharing:** Following the existing model for fee-for-service plans, consumers may choose to see any provider. Individuals pay \$200 annual deductibles before coverage begins; families pay a \$400 deductible. Consumers pay 20 percent co-insurance after meeting the deductible. No individual pays more than \$1500, and no family pays more than \$3000. Consumers are not charged for preventive services included in the benefits package.
- **Combination:** Following the existing model for preferred provider organizations, consumers pay low cost-sharing (\$10 co-payments) when seeing physicians and other professionals in the provider network and higher cost sharing (20 percent co-insurance) when they consult providers who are not participants in the network. Preventive services are provided without charge.

CHOICE OF HEALTH PLANS

The Health Security plan allows individuals, rather than employers, to choose their health plans on the basis of quality and price. Today, only half of employed individuals have a choice of health plans. For the rest, employers choose their health plans, locking individuals and families into a system of care delivery and determining how much they pay out of pocket.

Because the Health Security plan requires that alliances provide at least one traditional fee-for-service plan, it preserves consumers' ability to choose their own doctors and other health providers -- an option that is not available to many today.

Likewise, doctors and other health providers may choose to participate in as many or as few of an alliance's health plans as they want.

Individuals whose employers provide more generous benefits than the nationally defined comprehensive benefits may continue those benefits at their current level without any change in coverage or cost.

SUPPLEMENTAL INSURANCE

Health plans may offer standardized supplemental insurance policies to cover cost-sharing or health benefits above and beyond the comprehensive benefits package. Employers may contribute to purchase supplemental coverage for their employees. Health plans that adopt the high-cost sharing option must offer their participants the opportunity to purchase supplemental insurance policies that cover cost sharing.

Supplemental insurance policies may not duplicate coverage of any services provided under the nationally guaranteed comprehensive benefit package.

LONG-TERM CARE

Existing nursing home coverage under Medicaid continues. Disabled Americans of all ages gain access to a wider variety of home and community-based support services, making it possible to continue to live at home. The Health Security plan also provides the following expansions and improvements in coverage for long-term care:

- Improvements in Medicaid coverage for institutional care expand eligibility for nursing home coverage. The amount of income and assets Medicaid beneficiaries may retain increase to \$12,000 and the \$30-a-month living allowance rises to \$100.
- The establishment of national standards improves the quality and reliability of private long-term care insurance, while tax preferences encourages its purchase.

- Tax incentives also support the efforts of people with disabilities to work, covering 50 percent of their costs for personal assistance and other necessary support.

MEDICARE

Medicare recipients experience no change in how and where they obtain health care or their existing benefits. In 1996, Medicare benefits expand to include coverage for prescription drugs under the Medicare Part B policy.

Medicare continues as a federally run program for individuals over age 65. Once the new health care system is in place, individuals have the option of enrolling in Medicare or remaining in their health plan when they turn 65.

Medicare beneficiaries have a broader range of choice through the expansion of managed care plans.

As the alliance system is fully implemented, states may provide Medicare benefits through alliances, provided the interests of Medicare beneficiaries and the Federal Treasury are safeguarded, and there is no reduction in benefits.

MEDICAID

Medicaid recipients under the age of 65 who are not eligible for cash assistance either through Aid to Families with Dependent Children or Supplemental Security Income no longer enroll in Medicaid. They choose a health plan through their area alliance, with 80 percent of the premium covered by employer contributions if they are employed, or premium discounts if they are unemployed and have low incomes.

Medicaid continues to pay the cost of health insurance for recipients of AFDC and SSI, who also pick a plan offered by the regional alliance. They may choose any plan priced at or below the weighted-average premium without making additional payments.

Like other members of the alliance, former Medicaid recipients with incomes below 150 percent of poverty are eligible for discounts to cover a portion of the cost of co-payments and deductibles if no plan with low cost sharing is available at or below the average premium. Health plans receive the same payment for Medicaid recipients as for other participants, reducing any stigma associated with obtaining coverage through Medicaid.

To pay for services covered in the comprehensive benefits to families that receive Aid to Families with Dependent Children and Supplemental Security Income payments, Medicaid pays health plans a fixed rate for each participant. Payments from the alliance to health plans are risk adjusted.

Medicaid coverage for other services, including nursing home coverage and special services for the severely disabled and supplemental services, continue as a public program.

RETIREES

Americans who retire before age 65 and were employed for at least the amount of time used as a standard to qualify for Social Security purchase health coverage through their regional alliance and pay only the employee share of the premium for their health plan. The federal government pays the 80 percent employer share.

Although they may choose to pay more, employers whose retirement plans cover health insurance premiums for retired workers are responsible for paying only the employee's share, or 20 percent of the average premium.

CONTROLLING COSTS: MARKETPLACE REFORMS

The Health Security plan controls rising costs and improves the quality of health care by enlisting the power of a competitive market and empowering consumers to make choices that suit their needs.

Reform reduces administrative costs and frees up resources to improve quality and access for all Americans. The Health Security plan:

- Changes incentives in the insurance market so that health plans compete on the basis of quality, service and cost -- not risk selection.

Reform requires health plans to accept all applicants, and it forbids them from dropping anyone from coverage or charging some consumers more than others on the basis of age, gender, or health status or any personal characteristic.

- Empowers consumers to make more cost-conscious decisions by choosing among health plans on the basis of price and quality.

Consumers reap the savings from enrolling in a health plan that delivers the guaranteed benefits for a lower premium. If they prefer a plan that costs more, they pay the difference.

- Promotes the development of health plans that give consumers better value for their money.

In the current system, doctors and hospitals get paid extra for each service they perform. Under reform, health plans become accountable for both quality and price. The incentives change from "doing more" to giving consumers better value.

- Improves information about quality of care.

The program calls for regular monitoring of access, consumer satisfaction and the appropriateness and effectiveness of care. Consumers receive annual performance reports on health plans.

The Health Security plan also expands research related to the effectiveness of medical treatments and courses of care, fosters the development of practice guidelines and provides other information to help doctors, nurses and other professionals deliver more effective care.

- Creates standard reimbursement forms and requirements that simplify the business side of health care.

With some 1,200 different payers of health costs, hospitals, clinics and doctors contend with thousands of forms, conflicting regulations and inspections by a variety of federal, state, local and private agencies. The plan creates standard reimbursement rules and inspection procedures that streamline the system, reducing administrative overhead for providers.

- Lowers administrative costs for small groups and individuals as firms with fewer than 5,000 employees and the self employed join alliances, consolidating administration and purchasing tasks.

These groups currently pay as much as 30-40 percent of premiums to support administrative overhead, compared to 5-7 percent for large firms.

ENFORCEABLE CAP: THE BACK-STOP FOR COST CONTAINMENT

While ample evidence demonstrates that competition and increased efficiency control costs, the Health Security plan builds in a back-up measure to control health care costs: an enforceable cap.

The cap is met through capping the growth in insurance premiums paid by individuals and businesses to cover the guaranteed benefits. The Health Security plan guarantees comprehensive benefits and limits the rate of growth in premiums paid by employers and consumers for these benefits. By the end of the decade, insurance premiums are held to the rate of inflation.

Those limits are reasonable and achievable, given reforms that enhance competition in the health insurance market, simplify the system and reduce administrative costs, expand consumer choice and strengthen the negotiating power of employers and consumers through health alliances.

The projected rate of growth in federal and state spending for Medicaid is similarly limited, with coverage for Medicaid recipients provided through regional alliances. Specific reforms hold Medicare to comparable, but slightly higher, limits.

Health insurance premiums pay for coverage in the new system, just as health insurance premiums pay for coverage today. The Health Security plan limits how fast the cost of those premiums increase.

Alliance premium targets are based on the current level of health care spending in each area. They, therefore, vary substantially from alliance to alliance. The National Health Board appoints a commission to explore methods to reduce these variations over time.

In each regional health alliance, health plans bid each year to provide the guaranteed benefits, and alliances negotiate with them over premium levels. Premiums vary from plan to plan.

If the *average* premium across all plans is less than the alliance's premium target -- that is, if premiums, on average, are increasing consistent with inflation -- then no enforcement is triggered.

If the average premium across all plans exceeds the alliance's premium target, the premium, the cap prevents premiums from rising beyond the target. In that case, plans whose proposed premium increases exceed the allowed rate of growth are required to accept lower premiums. The plan must adjust its payment rates to providers or accept lower profits to make up the difference.

CORPORATE ALLIANCES

Large employers that form corporate alliances are expected to comply with the same limits on premium increases as regional alliances. If premiums in a corporate alliance exceed the allowed rate of growth during two of any three years, the Department of Labor may require the corporation to purchase coverage through regional alliances.

STRUCTURE OF THE NEW SYSTEM

A new national framework organizes the market for health coverage; the federal government, states and alliances divide responsibilities as follows:

Federal Government: Sets the basic framework for the system • Defines guaranteed benefits package • Determines caps on growth in insurance premiums • Reforms insurance system • Establishes quality standards
States: Implement health care reform within federal framework • Establish alliance(s) • Certify health plans • Monitor quality and availability of care • Implement insurance reform
Alliances: Serve as purchasing agent for employers and consumers • Solicit competitive bids from health plans • Distribute consumer information materials • Collect premiums and pay health plans

NATIONAL FRAMEWORK

The new framework for health security includes these components:

- An independent **National Health Board** acts as the board of directors for the health care system, setting national standards and overseeing implementation of reform.
- **States** establish alliances and qualify health plans. Tailoring the system to local needs, states may create a single-payer system by establishing only one alliance and negotiating directly with providers.
- Regional and corporate **alliances** bring together consumers and employers, acting as their advocates in negotiations with competing health plans over service and price.
- Competing **health plans** deliver health services covered in the guaranteed comprehensive benefit. Each alliance offers a menu of plans, including a traditional fee-for-service arrangement, preferred provider organizations and health maintenance organizations.

FEDERAL RESPONSIBILITIES AND NATIONAL HEALTH BOARD

The National Health Board consists of seven members appointed by the President with the advice and consent of the Senate. The National Health Board assumes certain responsibilities for administering the new health care system, while existing federal agencies assume others. The Board:

- Sets national standards for state plans and ensures access to health care for all Americans.
- Interprets and updates the comprehensive benefits and recommends to the President and Congress changes in the health care system.
- Establishes a new performance-based quality management program and develops valid measures of health outcomes to be used in annual performance reports for health plans.

- Develops and implements standards for a national health information system, using a public-private network to support quality improvement and collects enrollment data and comparative information about cost.
- Implements the safety net of the national health budget.

STATE RESPONSIBILITIES

States ensure that all eligible individuals enroll in a regional or corporate alliance and have access to a health plan that delivers the guaranteed comprehensive benefit. Each state must implement plans approved by the National Health Board by January 1, 1997.

States may begin to implement the new system as early as January 1, 1995. Implementation involves adopting federal standards and establish health alliances.

Within the broad federal guidelines, states exercise flexibility in the design and governance of regional health alliances. States have the option to implement a single-payer system.

States certify health plans, much as they license health providers and insurance companies today. They determine mechanisms for evaluating the quality of health plans, their financial stability and capacity to deliver the guaranteed benefits, as well as compliance with prohibitions against discrimination based on race, ethnicity, gender, income and health status.

Only certified plans may offer health coverage through alliances. In the case of areas where no health plan forms, the state must assure that at least one health plan is available to cover every eligible individual.

HEALTH ALLIANCES

Each state creates one or more regional alliances that organize a menu of health plans, negotiate premiums and enroll individuals in plans. Within broad federal parameters, states exercise flexibility in the design and governance of regional alliances.

The vast majority of people continue to choose their health care coverage through their employers, who provide information on area health plans available through the alliance. The following groups obtain health coverage through regional alliances:

- Employees in firms with fewer than 5000 employees
- Employees of federal, state and local governments
- Individuals who are self-employed
- Part-time workers
- Retirees not yet eligible for Medicare
- Individuals who are not employed.

Health alliances consolidate the purchasing power of individuals, small- and medium-size businesses to secure the best health coverage for the lowest price. Alliances organize and streamline the fragmented insurance system, replacing health insurance brokers, agents and underwriters with consumer-run organizations focused on providing access, service, quality and affordable care.

Alliances drive the competitive forces that make the new system work for consumers and employers. Their mission is to:

- Bargain with health plans on behalf of consumers, business and purchasers of health care services.
- Negotiate premiums and coverage and ensure the delivery of high-quality care while controlling costs.
- Assure that all residents in the area enroll in health plans that provide the guaranteed comprehensive benefits.

Where inadequate services exist, alliances may organize health providers or use financial incentives to encourage health plans to expand.

Alliances operate as non-profit corporations, independent state agencies or agencies of the executive branch of the state. The board of each alliance includes an even number of consumer and employer representatives but may not include health providers and others who profit from the industry. Each alliance also forms an advisory board composed of health care professionals and providers who practice in its health plans.

Alliances hold an annual open enrollment period during which they offer consumers a menu of health plans, including at least one traditional fee-for-service plan.

Alliances negotiate rates for premiums with each health plan and collect premium contributions. Alliances pay health plans a fixed premium for each individual or family that enrolls, adjusting the total payments to plans to reflect the health status of that plan's participants.

CORPORATE ALLIANCES

Firms employing more than 5000 workers, Taft-Hartley plans and rural cooperatives are eligible to organize corporate alliances, although they may also choose to purchase coverage through regional alliances. Corporate alliances resemble the operation of large employers' benefit departments, arranging premiums and the delivery of services.

Corporate alliances provide health benefits to their employees either through a self-funded employee benefit plan or through contracts with health plans. They operate under the same rules as regional alliances except that the population served is limited to company employees and their dependents. Each corporate alliance contracts with at least one fee-for-service plan and offers at least two other health plans.

The U.S. Department of Labor monitors the operation of corporate alliances, fulfilling the same role that it assumes under the Employee Retirement Income Security Act of 1974 (ERISA).

Organizations eligible to form corporate alliances may exercise a one-time option to have individual establishments with fewer than 100 employees join regional alliances at community rates. Large corporations also periodically have the option to join regional alliances at a risk-adjusted rate, which gradually declines to the community rate.

A new chapter in ERISA establishes fiduciary and enforcement requirements for employers and other sponsoring health benefit plans in corporate alliances.

HEALTH PLANS

Competing health plans provide medical services guaranteed in the comprehensive benefits, delivering them through fee-for-service networks, preferred provider organizations and health maintenance organizations. Health plans may not:

- Deny enrollment to any person based on individual characteristics, health status or anticipated need for health care.
- Terminate, restrict or limit coverage for the comprehensive benefit package for any reason.
- Cancel coverage for any eligible individual until that individual is enrolled in another health plan.

COMMUNITY RATING

Health plans offer coverage at the same rates for all participants, regardless of age, health or other personal characteristics. Alliances adjust payments to health plans to account for the level of risk among individuals enrolled in each plan.

IMPROVING HEALTH SERVICES

The Health Security plan seeks to remove financial and non-financial barriers that limit care for Americans who live in urban centers, rural communities and those who suffer from certain illnesses. Because a disproportionate number of residents of rural communities and urban centers lack health coverage today, universal coverage will bring major new health resources into those communities.

The plan improves access specifically for Americans who live in rural areas through initiatives to:

- Develop communications links between rural health professionals and academic health centers.
- Create incentives to expand community-based networks of health providers and plans, such as long-term contracts for health plans in rural areas and federal loan guarantees for capital improvements.
- Attract health professionals to rural areas through the expansion of the National Health Service Corps, tax incentives to encourage practice in rural areas, and changes that increase compensation for primary care physicians who serve Medicare beneficiaries.
- Expand the rural public health system, including support for transportation, outreach, case management, translation, health education, nutrition, social support, child care and home visiting services.

The Health Security plan makes federal grants and loans available in underserved urban communities for capital investment. The government further supports the efforts of traditional health care providers, such as community-based clinics, to adapt to the new system through designation as essential community providers.

Essential community providers receive special protection: For five years, health plans are required to reimburse these providers for services. At the end of that period, health plans must either demonstrate their capacity to provide access for all participants -- including residents of underserved areas -- or continue contracting with essential providers.

Federal block grants that support community health centers, family planning clinics, health care for homeless families and maternal and child health programs continue. New initiatives include funding for school-based clinics.

TRANSITION

STATE IMPLEMENTATION

States begin implementation of the new system as early as January 1, 1995. Most states come into the system in 1996; the rest are required to begin implementation by 1997.

At the time of state implementation, federal discounts for small, low-wage employers and low-income individuals and families become available. States that expedite implementation receive financial incentives including special start-up funds, and early access to federal funding for discounts.

Organizations eligible to establish corporate alliances must begin providing the guaranteed benefit package by January 1, 1997.

INSURANCE REFORM

To reduce the potential for disruption during transition, interim insurance reform imposes new rules including:

- Prohibitions against dropping consumers from coverage.
- Prohibitions against profiteering.
- Prohibitions against reducing coverage.
- Creation of a national risk pool to assure access to coverage during the transition.
- Assurance of portability of coverage

FINANCING HEALTH COVERAGE IN THE PRIVATE MARKET

The Health Security plan caps employer contributions for insurance premiums as a percent of payroll. The cost of providing health coverage declines for most firms that currently provide insurance.

- The plan eliminates the \$25 billion that employers pay each year to cover the cost for uninsured patients.
- In the current system, many employers pay the entire premium for family policies, while the employer of a worker's spouse makes no contribution. Under reform, both employers share the cost for families in which two spouses work.
- In the current system, health insurance premiums for many employers total more than 10 percent of payroll. Under reform, premiums paid by employers purchasing through regional alliances are capped at 7.9 percent of payroll.

Businesses that employ fewer than 50 workers receive additional discounts on their insurance premiums, reducing their contributions to between 3.5 percent and 7.9 percent of payroll.

- Under reform, employers in regional alliances pay community rates that do not vary according to the age, gender or health status of their workers.

Employer obligations for insurance premiums are calculated based on the average premium among health plans in their area. As competition among health plans -- backed up by national caps on premium increases -- brings the rate of growth in health costs under control, the projected rate of growth in health costs declines throughout the business sector.

EMPLOYER PAYMENTS

- Employers pay 80 percent of the average premium in the alliance toward the cost of the policy chosen by the employee, which depends on the employee's family status.

For employees with a spouse, the employer contribution is reduced to reflect the contributions on behalf of dual wage earners in the alliance region.

- For part-time workers, employers pay a pro-rata share of the 80 percent employer contribution based on the number of hours worked.

CONSUMER PAYMENTS

Working Individuals and Families: Individuals and families in which at least one person works pay a maximum of 20 percent of the premium to enroll in the average-cost health plan in their area.

- Those who choose a lower-cost plan pay less than the 20 percent average.
- Those who choose a more expensive plan pay more, as they do today.
- Employers who currently pay 100 percent of the premium for their employees may continue to do so.

Working individuals and families may have their share of the premium deducted from their paychecks or write a check to the local health alliance.

Consumers pay premiums based on the type of policy they need to purchase:

- Two parent family with children.
- Couple.
- Single parent family.
- Single individual.

Individuals and families with incomes below 150 percent of the federal poverty level -- \$21,525 for a family of four -- are eligible for discounts on the employee's share of the premium.

Part-Time Workers: Part-time workers are responsible for the 20 percent employee share of the premium, and workers with incomes below 150 percent of the poverty level receive discounts.

The number of hours an employee works determines how much of the employer share of the premium is paid by the employer and how much by the worker. For example, an employer would pay 40 percent of the premium for someone who works half-time. The worker is responsible for the remaining 40 percent of the premium, with discounts provided on a sliding-scale basis.

A part-time worker with more than one job receives contributions from more than one employer toward the employer's share of the premium.

Unemployed Individuals: Unemployed individuals and families are responsible for the 20 percent employee share of the premium and receive a discount if their incomes are below 150 percent of the poverty level. They also are responsible for what would be the employer's share of the premium but receive discounts on a sliding-scale basis to help cover the cost.

Self-employed Individuals: The self-employed worker pays the 20 percent employee share of the premium and receives a discount if his or her income is below 150 percent of the poverty level. Self-employed workers also are responsible for the 80 percent employer share and receive the same discounts as small employers. They may deduct from their taxes 100 percent of their health care premiums.

TAX DEDUCTIBILITY

Employer contributions toward the premium and toward cost sharing related to the nationally guaranteed comprehensive benefit -- as well as for additional benefits phased in by the year 2001 -- are fully tax deductible and not counted as taxable income for employees.

Tax preferences continue for benefits in excess of the nationally guaranteed benefit package offered as of January 1, 1993, for ten years after enactment of health reform.

THE HEALTH SECURITY PROPOSAL

HOW IT WILL AFFECT DOCTORS

Preserving the Doctor - Patient Relationship

The personal relationship between doctor and patient is the cornerstone of patient care. Yet under the present system, that relationship is undermined by insurance regulations that force employees to quit their family doctor when their insurance, through a job loss or change, is altered. The Health Security proposal protects the right of Americans to choose their doctor and stay with that person, regardless. Doctors will be able to order for their patients the tests they need and the medications they require, without fear that they are causing economic hardship.

An End to the Paperwork 'Hassle Factor':

Filling out confusing forms and picking through the details of varying benefit packages can be a frustrating and overwhelming experience for doctors' clerical staffs. The Health Security Act of 1993 will reduce the "hassle factor." With the institution of standard benefit packages, doctors will no longer have to wade through fine print to find out if a procedure is covered. Under reform, a standard form for all payers and common coding system will replace the bureaucratic nightmare of multiple claims forms and codes.

Malpractice Reform:

The Health Security proposal is a bold attempt to finally overhaul the medical malpractice system. Attorneys' fees will be limited, and patients wishing to file claims will be required to first make their case in an out-of-court setting before going to court (alternative dispute resolution).

Streamlining Regulation:

Quality assurance programs run by the government have relied too often on external checks, forms and process manuals, and on the punishment of providers. Through reform, these programs will be retooled to set and enforce performance standards, not detailed process standards.

Doctors' Incomes:

Historically, doctors have been well paid and this will not change under health reform. What is likely to occur is a closing of the gap between the incomes of specialists and primary care physicians -- as the demand for primary care physicians grows.

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

September 20, 1993

**PRESIDENT CLINTON TO DISCUSS HEALTH SECURITY ACT TODAY
WITH MORE THAN 100 DOCTORS**

Washington D.C. -- President Clinton, First Lady Hillary Rodham Clinton, Vice President Al Gore and Mrs. Gore will meet with more than 100 doctors in the East Room today, including former Surgeon General Dr. C. Everett Koop and Dr. Thomas Berry Brazelton, to discuss the Administration's Health Security Act. Many of the doctors participating in the breakfast meeting have been involved with the policy development of the Health Security Act. The names of those doctors participating in this event are attached.

Eduardo S. Alcantar M.D.: Assistant Director Disease Control; Phoenix, AZ

William Anderson, D.O.: Southfield, MI.

David Annunziato, M.D.: Nassau County Medical Center, Board of Directors of the American Academy of Pediatrics; East Meadow, NY.

John R. Ball, M.D.: Executive Vice President of the American College of Physicians; Philadelphia, Pennsylvania.

Alan Baskin, M.D.: Health Professionals Review Group; Montvale, New Jersey.

Robert Berenson, M.D.: Health Professionals Working Group

Stanley Bergen, M.D.: President of University of Medicine and Dentistry of New Jersey; Newark, New Jersey.

Michael D. Bishop, MD: Chairman of the Government Affairs Committee for the American College of Emergency Physicians; Bloomington, Indiana.

Ronald G. Blankenbaker, MD Erlanger Medical Center, Chattanooga, Tennessee.

James Block, M.D.: President and CEO of Johns Hopkins Health System, The Johns Hopkins Hospital; Baltimore, Maryland.

David Blumenthal, M.D.: Health Professionals Review Group; Boston, Massachusetts.

Laurence Bouchard, D.O.: Naragansett, Rhode Island.

Rick Boxer, M.D.: Health Professional Review Group; Milwaukee, Wisconsin.

Thomas Berry Brazelton, M.D.: Professor of Pediatrics Emeritus at Harvard Medical School and Children's Hospital in the Children's Hospital Child Development Unit; Boston, Massachusetts.

James Bresch, MD: Northwestern University Hospital; Chicago, Illinois.

Janet Zeiler Bresch, MD: University of Illinois Eye and Ear Clinic; Chicago, Illinois.

Lonnie R. Bristow, M.D.: Chairman of the American Medical Association Board of Trustees; San Pablo, California.

Eric A. Buffong, M.D.: Jacksonville, North Carolina.

Richard O. Butcher, M.D.: El Cajon, California.

Robert Butler, M.D.: Chairman of Gerontology at Mount Sinai Hospital Medical School.

Cristine Cassel, M.D.: Board of Regents and Chief of Section of General Internal Medicine at the University of Chicago

Anna Chavelle: President of the Washington State Medical Association.

Benjamin Chu, M.D., M.H.: Health Professionals Review Group; New York City.

David K. Clawson, MD: Executive Vice Chancellor at the University of Kansas.

Clifton R. Cleaveland, M.D.: President-Elect of the American College of Physicians; Chattanooga, Tennessee.

Linda Hawes Clever, M.D.: Board of Regents and Chairman of the Department of Occupational Health at California Pacific Medical Center

Jordan J. Cohen, M.D.: Dean of the School of Medicine at the State University of New York at Stonybrook; Stonybrook, New York.

William Coleman, MD PhD: President-elect of the American Academy of Family Physicians; Scottsboro, Alabama.

Michael Collins, MD: Westwood, Massachusetts.

George D. Comerchi, M.D.: Vice-President Elect of the American Academy of Pediatrics, Desert Hills Center for Youth and Families; Tucson, Arizona.

Louis Z. Cooper, M.D.: Director of Pediatrics at St. Luke's Roosevelt Hospital Center; New York City.

Kevin Cunningham, M.D.: Health Professionals Review Group; Des Moines, Iowa.

Joseph C. Czarsty, M.D.: Treasurer for the American Academy of Pediatrics; Oakville, Connecticut.

Bob D'Alessandri, M.D.: Health Professionals Review Group; West Virginia University Health Sciences Center; Morgantown, West Virginia.

Ezra C. Davidson, Jr., M.D.: Department of Obstetrics/ Gynecology; King-Drew Medical Center; Los Angeles, California.

John Delfs, MD: Director of Geriatric Medicine and ElderCare Program at the New England Deconess Hospital; Boston, Massachusetts.

Iris Del Toro, M.D.: Group Health Cooperative of Puget Sound, Redmund, Washington.

Anthony DeSpirito, M.D.: American Academy of Pediatrics Board of Directors; Jersey Shore Medical Center; Neptune, New Jersey.

Ron Dozoretz, M.D.: Health Professionals Review Group; Norfolk, Virginia.

Steve Eckstat, D.O.: Health Professionals Review Group; Des Moines, Iowa.

E. Stephen Edwards, M.D.: Chair of the American Academy of Pediatrics Council on Government Affairs; Raleigh, North Carolina.

Joseph T. English, M.D.: Chairman of the Department of Psychiatry at St. Vincent's Hospital and Immediate Past President of American Psychiatric Association; New York City.

Philip J. Fialkow, M.D.: Vice President for Medical Affairs and Dean of the University of Washington School of Medicine; Seattle, Washington.

Kevin Fickenschier, M.D.: Health Professionals Review Group; Kalamazoo, Michigan.

Michael Fine, M.D.: Hillside Avenue Family and Community Medicine, Providence, Rhode Island.

Arthur Flemming, M.D.: Chairman of the Save our Security Coalition; Washington, D.C.

John A. Flowers, M.D.: Pine Bluff, Arkansas.

Janet Freedman, M.D.: Health Professionals Review Group; Mt. Kisco, New York.

Marsha Fretwell, M.D.: Little Compton, Rhode Island

H. Jack Geiger, M.D.: Logan Professor of Community Medicine, The City University of New York Medical School, The Sophie Davis School of Biomedical Education, New York City.

Joseph Giardano, M.D.: Professor and Chairman of the Department of Surgery at George Washington University Medical Center, Washington D.C.

Stephen Gleason, D.O.: Health Professionals Review Group, Des Moines, Iowa.

Robert Graham, M.D.: Executive Vice President of American Academy of Family Physicians, Kansas City, Missouri.

Pedro Jose Greer, M.D.: Health Professionals Review Group; Miami, Florida.

Lloyd Greig, M.D.: Beverly Hills, California.

Paul Griner, M.D.: President of the American College of Physicians and General Director of Strong Memorial Hospital; Rochester, New York.

Rolf M. Gunnar, M.D.: Chair of the Board of Regents and Director of Medical Affairs for MacNeal Hospital; Riverside, Illinois.

Ralph W. Hale (MD): Executive Director of the American College of Obstetricians and Gynecologists, Washington D.C.

Margaret Hamburg, M.D.: Commissioner, NY City Department of Health; New York City.

Ray L. Henderson, M.D.: Indianapolis, Indiana.

C. Earl Hill, M.D.: Department of Family Medicine, Baltimore, Maryland.

Hugh Hill, MD, J.D.: Health Professionals Review Group; Bethesda, Maryland.

David C. Hohn, M.D.

Richard S.(Pete) Hollis (MD): President of American College of Obstetricians and Gynecologists

John Howe, MD: President of the University of Texas Health Science Center at San Antonio.

Renee Jenkins, M.D.: Chair of the American Academy of Pediatrics Committee on Community Health Services; Howard University Hospital; Washington D.C.

Lawrence Jindra, M.D.: Health Professionals Review Working Group; Floral Park, New York.

Michael M.E. Johns, M.D.: Vice President for Medicine and Dean of the Medical Faculty at the Johns Hopkins University School of Medicine; Baltimore, Maryland.

Robert Johnson, M.D.: Chair of the American Academy of Pediatrics Committee on Careers and Opportunities and works at the New Jersey Medical School; Newark, New Jersey.

Gloria Johnson-Powell, M.D.: Member of the Health Professionals Review Group; Boston, Massachusetts.

Daniel Juarez, M.D.: Internist in San Antonio.

Robert Keller, M.D.: Executive Director of Maine Medical Assessment Foundation.

William Kelley, M.D.: Executive Vice President for the Medical Center and Dean of University of Pennsylvania School of Medicine; Philadelphia, Pennsylvania.

Luella Klein, M.D.: Health Professionals Review Group; Atlanta, Georgia.

C. Everett Koop, MD, Sc.D.: Co-Chair of the National Ready to Learn Council; Bethesda, Maryland.

Andrew Kumpuris, MD: Health Professionals Review Group, Little Rock, Arkansas.

Edward L. Langston, M.D.: Department of Family Practice Residency at Memorial Health Care System and the AAFP Board of Directors; Houston, Texas.

Leonard Lawrence, M.D.: Associate Dean for Student Affairs at the University of Texas Health Science Center at San Antonio; San Antonio, Texas.

W. David Leak, M.D.: Westerville, Ohio .

Robert Lehman, M.D.: DePaul Hospital in Norfolk, Virginia.

Jack Lewin, MD: Health Professionals Review Group; Honolulu, Hawaii.

Edward Loniewski, D.O.: Chairman of the American Osteopathic Association Council on Federal Health Programs; Redford, Michigan.

Osvaldo Lopez, M.D.: Chairman of the Department of Orthmology at the Illinois

	MAS Medical Center and President, Latino Medical Association of Chicago.
Betty A. Lowe:	Vice-President of AAP, Arkansas.
Paul A. Marks, M.D.:	President and CEO of the Memorial Sloan-Kettering Cancer Center, New York City.
Shirley Marks, M.D.:	University Park Hospital, Tyler, Texas
Walter J. McDonald, M.D.:	Associate Dean for Education School of Medicine at the Oregon Health Sciences University and Chair of the Board of Governors for the American College Physicians, Portland, Oregon.
Read McGeehee, M.D.:	St. Mary's Hospital, Richmond, Virginia.
John S. McIntyre, M.D.:	President of the American Psychiatric Association, Rochester, New York.
Robert E. McAfee, M.D.:	President-Elect of the American Medical Association, South Portland, Maine.
Morris B. Mellion, M.D.:	Immediate Past President of AAFP; Omaha, Nebraska.
Robert Michels, MD:	Dean of Cornell University Medical Center and Provost for Medical Affairs for Cornell, The New York Hospital.
James J. Mongan, M.D.:	Executive Director of the Truman Medical Center and Dean of the University of Missouri - Kansas City School of Medicine; Kansas City, Missouri.
Susana Morales, M.D.:	Assistant Clinical Professor of Medicine at Columbia University College of Physicians and Surgeons, New York City.
Jeff Morris, MD, MPH:	Health Professionals Review Group; Encinitas, California.
Thomas Nickels:	Executive Director of the American College of Emergency Physicians, Washington, D.C.
James Nuckolls, M.D.:	Blue Ridge Health Associates; Galax, Virginia.
Clyde W. Oden, O.D.:	President and CEO of Watts Health Foundation; Inglewood, California.
Gilbert Omenn, M.D.:	School of Public Health and Community Medicine at University of Washington; Seattle, Washington.
Herbert Pardes, MD:	Vice President for Health Sciences and Dean of the Faculty of Medicine at Columbia University.
Howard Pearson, M.D.:	President of AAP; New Haven, Connecticut.
Edmund Pellegrino, M.D.:	Georgetown University Hospital; Bethesda, Maryland.
Raul Perea-Henze, M.D.	
Robert Petersdorf, M.D.:	President of the American Association of Medical Colleges, Washington, D.C.
Mitchell Rabkin, M.D.:	President of Beth Israel Hospital; Boston, Massachusetts.
Irwin Redlener, M.D.:	Vice Chair of the Health Professions Review Group, New York
Neil Redlener, M.D.:	Director of the Inpatient Psychiatric Unit at the University Hospital Boston University Medical Center, Boston, Massachusetts.
Arnold Relman, M.D.:	Health Professionals Review Group
Carolina Reyes, M.D.:	Gynecologist and Obstetrician, Los Angeles, California.
Susan Reynolds, M.D.:	Health Professionals Review Group; Malibu, California
Perry Rigby, MD:	Chancellor of Louisiana State University Medical College.

Elena Rios, MD, MSPH: Health Professionals Review Group; Sacramento, California.
Carolyn B. Robinowitz, MD: Senior Deputy Medical Director at the American Psychiatric Association, Washington D.C.

Richard Rockefeller, MD: Falmouth, Maine.
Allan Rosenfield, MD: Dean of Columbia School of Public Health, New York City.
Melvin Sabshin, M.D.: Medical Director of the American Psychiatric Association, Washington, D.C.

Joe. M. Sanders, Jr, M.D.: Executive Director of AAP; Elk Grove, Illinois.
David Satcher, MD: President of Meharry Medical College; Nashville, Tennessee.
Jane Green Schaller, MD: Professor and Chairman of Pediatrics at Tufts University School of Medicine; Boston, Massachusetts.

Lawrence Scherr, MD, MACP: Health Professionals Review Group; Manhasset, New York
Howard Shapiro, M.D.: Director of Public Policy for American College of Physicians, Washington, D.C.

Steven P. Shelov, MD: Professor and Vice Chairman of Pediatrics at Einstein College of Medicine; Bronx, New York.

Kenneth Shine, MD: Health Professionals Review Group, Washington, D.C.
Aaron Shirley, MD: Project Director of the Jackson-Hinds Comprehensive Health Center; Jackson, Mississippi.

David M. Siegel, MD: Government Affairs Committee for American College of Emergency Physicians.

Ciro Valent Sumaya, M.D.: University of Texas Health Science Center; San Antonio, Texas.
Rosemarie Sweeney: Vice President for Socioeconomic Affairs and Policy Analysis for the American Academy of Family Physicians, Washington, D.C.

Eric Tangelos, MD: Rochester, Minnesota.
Gerald E. Thomson, M.D.: Chair of the Health and Public Policy Committee for the American College of Physicians, Board of Regents and Associate Dean for the College of Physicians and Surgeons at Columbia University, New York City.

James S. Todd, M.D.: Executive Vice President of the American Medical Association; Chicago, Illinois.

John P. Tooker, M.D.: Chair-elect for the Board of Governors of the American College of Physicians and Assistant Chief of Medicine at Maine Medical Center; Portland, Maine.

Al Truscott, MD: Medical Director of Group Health Cooperative of Puget Sound; Seattle, Washington.

Reed Tuckson, MD: Health Professionals Review Group; Los Angeles, CA
John M. Tudor, Jr., M.D.: President of the American Academy of Family Physicians; Salt Lake City, Utah.

David Valdez, M.D.: Memorial Medical Family Practice Center; Corpus Christi, Texas.

Yvonnecris Smith Veal, M.D.: St. Albans, New York.

Robert Waller, MD: CEO of the Mayo Clinic; Rochester, Minnesota.
Tracy Walton, Jr., MD: Washington, D.C.
James R. Weber, M.D.: Chair of the Board of Directors of the American Academy of

Family Physicians; Jacksonville, Arkansas.

Jack Wennberg, MD, MPH: Director of the Center for the Evaluative Clinical Sciences and Professor of Epidemiology at Dartmouth Medical Center; Hanover, New Hampshire.

Jerry M. Wiener, M.D.: President-elect of the American Psychiatric Association and Chairman of the Department of Psychiatry and Behavioral Science at George Washington University, Washington D.C.

Robert Williams, MD: President of the American College of Emergency Physicians; Harbor Springs, Michigan.

Stanley Yarnell, MD: Health Professionals Review Group; San Francisco, California.

Kneeland Youngblood, MD: Health Professionals Review Group; Plano, Texas.

Joseph Zanga, MD: Member of the Board of Directors of the American Academy of Pediatrics and works at the Children's Medical Center; Richmond, Virginia.

John S. Zapp, American Dental Association.

Barry Zuckerman, MD: Professor and Chairman of the Pediatrics Department at the Boston University School of Medicine; Boston, Massachusetts.

The White House
Health Care Reform Today
September 20, 1993

* Today, President Clinton and the First Lady will join more than 100 doctors to talk about the Health Security Act. Joining them and speaking will be the former Surgeon General, Dr. C. Everett Koop.

* This week, as we head towards the President's speech on Wednesday night, we'll be giving you our suggestions on how to talk about health care. The basics of how what we say centers around these six principles: Security, Savings, Simplicity ... Quality, Responsibility and Choice.

* 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.

* 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.

* While others are not drawing any lines in the sand on the details of the plan, the NFIB sure did. NFIB head Jack Faris made that clear in Friday's New York Times. He said: "We checked the Constitution, and we don't see where it gives you the right to universal health insurance." Basically, the NFIB is saying to everyone who currently does not have health care or is at risk of losing their health care to drop dead. But then again, the NFIB has been predicting the end of the world as they know it since at least 1962.

The White House
Health Care Reform Today
September 17, 1993

* A great start to the dialogue on health care. The President and the First Lady, the Vice-President and Mrs. Gore listened to people put faces to the problems of health care. They heard from 15 of the more than 700,000 who wrote to the White House about the need for health care reform. The President said:

"In the weeks and months ahead, health care will often be topic number one at dinner tables, at offices, at medical clinics, and in the halls of Congress.

If you read some of these letters as I have, the picture very quickly becomes clear. Even the millions of Americans who enjoy health care coverage are afraid it won't be there for them next month or next year. They want us to take action to give them the security that all Americans deserve."

* Former Secretary of Health, Education and Welfare in the Eisenhower Administration, Dr. Arthur Flemming has expressed his strong support for President Clinton's health care reform proposal. He said: "The President has presented us with a historic opportunity, and we must seize the moment. Let us get a plan on the books and begin to learn from experience, instead of engaging in endless rhetoric. As a former U.S. Commissioner of Aging, I am particularly enthusiastic about the plan: because this proposal will mean a straightened Medicare program -- providing greater security and expanded benefits for older Americans. Under the President's proposal, older Americans will receive all the benefits they do today. In addition, Medicare will be expanded to cover prescription drug benefits, and there will be a new long-term care program to cover home- and community-based care. Nearly all Americans will still have to pay only 25% of the total cost of the Part B benefits they receive -- including the new drug benefit. Any increase in the premium will be consistent with the increase in benefits. Only the wealthiest Americans -- those people earning \$100,000 or more -- will pay the full actuarial value of the benefits they receive. Finally, Medicare funds now being wasted to cover fraud and overcharges will be used to pay for these new benefits."

The White House
Health Care Reform Today
September 15, 1993

* Today, Republican members of the House and the Senate will release their separate plans for health reform. We are confident that, like us, the Republicans are serious about comprehensive health reform, and that there will be significant areas of agreement between their plans and ours. We look forward to engaging in the same constructive dialogue around their plan as the proponents of reform from both sides of the aisle have done with us. And we believe that in judging the different reform proposals that will be considered by the Congress in the coming months, the American people should judge them all against the same test:

- * Does the plan cover every American?
- * Does it guarantee the security that insurance is rock solid-- no dropping people, no excluding people, no lifetime limits?
- * Does it provide comprehensive benefits, including full coverage of primary and preventive care-- to all Americans?
- * Does it guarantee that costs are brought under control and kept under control, so that health care is affordable and the deficit controlled?
- * Does it guarantee that the paperwork mess that bogs down doctors and nurses and befuddles consumers is cleaned up and made simple?
- * Does it preserve and enhance the high quality of American medicine, and preserve the right to choose your own doctor?

* The Laborer's International Union yesterday got firmly behind the President's health reform plan. LIUNA President Arthur Coia said at a Laborers' health Care conference in Pittsburgh: "Laborers and their employers need health care reform. Our survival depends on it. The Clinton program insures the stability of our union

The White House

Health Care Reform Today

September 14, 1993

◆ The American Medical Association said Monday that "the moment of truth had arrived for health care reform and that doctors were cautiously optimistic about the Clinton administration's initial proposals. "The time is now to get something done," said James Todd, executive vice president of the group.

Reuters-9/13/93

◆ In the coming days, you will hear a growing drumbeat of naysayers who will predict the opposite. We have two items of note. First, a Tom Oliphant column from the *Boston Globe* dated 9/13/93. Second, the *Wall Street Journal* article headlined: "Small Business Sees Burdens Getting Lighter" from 9/13/93. Oliphant writes: "Of all the absurdities being spread around here by the status quo's shameless defenders, none is more preposterous than the false alarm that more than a million people could lose their jobs because President Clinton is trying to put small business in a regulatory vice of death. The truth is that the nearly gestated Clinton plan constitutes a luscious opportunity for a minority now at a competitive disadvantage (small businesses that offer their workers no health insurance and are thus bailed out by all taxpayers) to join the more competitive majority (those that do have health coverage)."

◆ The *Wall Street Journal* article contains strong testimonials from small business people including Jay Edward Jones from Technical Land Consultants in Youngstown Ohio. After crunching the numbers in the plan he said: "I'll take it." He compares the \$429 a month he pays for his employee's family coverage to \$420 *a year* he would pay under the plan. Anne-Marie Corner of Biosyn says: "Anything that would guarantee buying into a pool at reasonable rates would be beneficial."

◆ Yet despite all this, John Motley of the NFIB continues his litany of doom for small business. What's interesting to note though is that in the same Wall Street Journal article, Motley never talks about whether or not it would be good for his members...just that it's too "...radical." We believe his members will think different, when given an opportunity to review the plan.

The White House
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Address of President William Jefferson Clinton
Before a Joint Session of Congress
Health Care Remarks
DRAFT EIGHTY: September 22, 1993

Mr. Speaker, Mr. President, Members of Congress,
distinguished guests, my fellow Americans --

Tonight, those of us in this room, and those of you in your homes, have come together to write a new chapter in the American story.

That story started over 350 years ago when courageous people left old lands and old ways to pursue life's most basic aspirations -- to live in a place of freedom and opportunity, where they could rise to their full potential, and where their children could live a better life than they did.

It's been the same in every American generation. From the settling of the frontier to the landing on the Moon, ours has been a story of challenges defined, obstacles overcome, new horizons secured. We haven't always known exactly how we'd get there, but we have always known where we were going. This is what makes America what it is and Americans who we are.

Now we are in a time of profound change and opportunity, of dislocation and uncertainty. Our challenge is to help Americans enter this dynamic future with confidence. I want the American people to face all of our challenges with faith and discipline -- whether it's reducing the deficit, increasing investment, converting from a defense to a high-tech peacetime economy, making our streets safe or rewarding work over idleness. All these challenges require change.

If Americans are to have the courage to change they must be secure in their basic needs. And tonight I want to talk with you about one of the most essential things we can do to build that security: it is time for America to fix a health care system that is badly broken. Despite the dedication of millions of talented health care professionals, our health care is too uncertain and too expensive; too bureaucratic and too wasteful. It has too much fraud and too much greed.

This must be our most urgent priority: Giving every American health security -- health care that's always there -- health care that can never be taken away.

Fixed Principles

On this journey, as on all others, there will be rough stretches. There will be storms and there will be fog. There will be honest disagreements about how to reach our destination. After all, this is a complicated issue.

But every successful journey is guided by fixed stars. And if we can agree on some basic values and principles, we will reach that destination together. So tonight, I want to talk with you about the fixed principles that must guide our reform of

America's health care system: Security, choice, and quality; simplicity, savings and responsibility.

When I launched our nation on the journey to reform our health care system, I knew we needed a talented navigator -- someone with a rigorous mind, a steady compass, and a caring heart. Luckily, I didn't have to search very far. Because I could turn to Hillary Rodham Clinton. And I think she has done a brilliant job.

Over the past eight months, Hillary and those working with her talked to literally thousands of Americans to understand the strengths and frailties of our health care system.

They met with over 1,100 health care organizations; literally from A to Z -- from Abbotsford Clinic Community Health Center to the Zero to Three National Center for Infant Care. They talked with thousands of doctors, nurses, pharmacists, hospital administrators, insurance executives and small business owners. They talked with the uninsured and the self-insured, with union members, older Americans and advocates for children.

The First Lady consulted extensively with government leaders of both political parties, here on Capitol Hill and across the states of our country.

The Stories and the Letters

She listened to those who tend to the sick and to those who receive care. Hillary and the Task Force received and read 700,000 letters from ordinary citizens. And what they wrote -- and how bravely they spoke about their struggle -- is what calls us to action.

All of us know someone who has worked hard and played by the rules but been hurt by this system that just doesn't work. Let me tell you about just one.

Kerry Kennedy owns a small furniture franchise that employs seven people in Titusville, Florida. Like most small business owners, Kerry has poured his sweat and blood into that company. But over the last few years, the cost of insuring his seven workers skyrocketed, as did the cost of the coverage for himself, his wife, and child. This year, however, Kerry could no longer afford to provide coverage because the insurance companies had labeled two employees high risk simply because of their age. But, you know what? Those two people are Kerry's Mother and Father who built the business and now work in the store.

That story speaks for millions of others. And from them, we learned a powerful truth: we must preserve and strengthen what is right with our health care system and fix what is wrong with it.

This is what is right: Americans are blessed with the best health care professionals, the finest health care institutions, the most advanced research, and the most sophisticated medical technology on the face of this earth. My mother is a Nurse, and I grew up around hospitals. The first professional people I ever

knew were doctors and nurses. They represent what is right with our health care system.

But we cannot ignore what is wrong. Millions of Americans are just a pink slip away from losing their health coverage, and one serious illness away from losing their life savings. Millions more are locked into the wrong jobs, because they'd lose their coverage if they left their companies. And on any given day over 60 million of our fellow citizens, the vast majority of them children or hard working adults, have either inadequate coverage or no health insurance at all. And despite all of this, our medical bills are growing at more than twice the rate of inflation.

There are those who honestly doubt we can fix this system and expand coverage without paying more for health care. But why should that be harder to believe than the craziness of the system we've got -- a system where Americans pay more and more, but get less and less coverage with ever fewer choices? There is no excuse for that kind of system, and it's time to fix it.

The plan I am proposing will keep what is best about our health care system and fix what is wrong, based on the principles of security, choice, quality, simplicity, savings, and responsibility.

And the plan I am proposing also reforms the costliest health care system on Earth without any new broad-based taxes and without cutting the benefits older Americans receive under Medicare.

Many of the principles in my plan have already been embraced by the plans put forward by Republicans as well as Democrats. For the first time in this century, leaders of both political parties have committed themselves irrevocably to providing universal, comprehensive health care for every American.

I have been deeply moved by the spirit of this debate. We now have both Democrats and Republicans willing to say, yes, let us listen to the people, and let us act. Both sides understand the ethical imperative of solving this problem; they know it will define who we are as a people. Let me ask the Leaders of Congress -- Senators Mitchell and Dole, Speaker Foley, Congressmen Gephardt and Michel -- that we keep this spirit and keep this commitment until our work is done.

Security

The first principle of health care reform -- the most important -- must be security. This principle speaks to the human tragedies and costs that we hear about every day when Americans lack or lose health care coverage.

Security means that those who do not have health care coverage will have it and, for those who have coverage, it will never be taken away. We must achieve universal health care coverage -- coverage for all our citizens -- as soon as possible.

Under the First Lady's leadership, we looked at a number of alternatives to achieve security and universal coverage. We

considered, for example, the Canadian-style system that many Americans favor. But I simply do not believe that the answer to our health care problems is another big government program. Government needs to make the system fair, but only the private sector can make the system work.

We also explored requiring individuals to buy health insurance on their own. But that option would threaten the current employer-based insurance system that works so well, and make it very difficult to achieve coverage for every American.

We chose instead a uniquely American solution. Under our plan, every American will receive a health security card that will entitle you to a comprehensive package of benefits over the course of your lifetime that will equal benefits provided by most Fortune 500 corporations.

This card **[HOLDS UP CARD]** guarantees you a comprehensive package of benefits that can never be taken away. And let us agree on this goal tonight: Before the end of 1994, Congress will pass, and I will sign a new law to create health security for every American.

With this card, if you lose your job or switch jobs, you're covered.

If you leave your job to start a small business, you're covered.

If you are an early retiree, you're covered.

If you or someone in your family has a preexisting medical condition, you're covered.

If you get sick or a member of your family gets sick, even if it's a catastrophic illness, you're covered.

And if an insurance company tries to drop you for any reason, they'll be covered -- covered by a law that says "that's illegal."

This card will give you comprehensive coverage. You will be covered for hospital care, doctors visits, emergency and laboratory services, diagnostic services like Pap smears and mammograms, mental health and substance abuse treatment.

And our proposal will pay for regular check-ups, well-baby visits and other preventive care. It's just common sense. People will stay healthier and at lower costs. You know how your mother told you that an ounce of prevention is worth a pound of cure? Well, your mother was right.

Security must also apply to older Americans. This is something I feel very strongly about: We will maintain the Medicare program. You will see no differences in where, how, or from whom you get your care. Here's what will change: for the first time, Medicare will cover the cost of prescription drugs. And it will provide assistance in the home for the elderly and disabled who need long term care. As we proceed with health care, we must not break faith with our older Americans.

Choice

The second principle is choice. Americans believe they should be able to choose their own health care plans and their own doctor. And you know something, they're right.

But, today, under our broken health care system, their power to choose is slipping away. Now it is usually the employer -- and not the employee -- who makes the choice of what health care plan will be provided. If your employer only offers one plan, like nearly three-quarters of small and medium-sized businesses, you're stuck with that plan and the doctors it covers.

Under our plan, every American will have a choice among high quality plans. You can stay with your current doctor, join a network of doctors and hospitals, or join a Health Maintenance Organization. If you don't like your plan, every year you'll have the chance to choose a new one.

The choice will be left to you -- not your boss -- and not some bureaucrat. Under our plan, the choice will be yours.

Quality

The third principle is quality. If we reformed everything else in health care but failed to preserve and enhance the high quality of our medical care, we would have taken a step backward, not forward.

Quality is something that cannot be left to chance. When you board an airplane, you feel better knowing that plane had to meet standards designed to protect your safety. We must ask no less of our health care system.

We are not proposing that government run the health care system. We are proposing a system in which government sets standards to ensure health care quality. Our proposal will create report cards on health plans, so that consumers can choose the highest quality providers, and reward them with their business. At the same time, our plan will track quality indicators, so that doctors can make better and smarter choices about the kind of care they provide.

Our plan will guarantee that quality health care is available in even the most remote areas of our nation, linking rural doctors and hospitals with high-tech urban medical centers. And our plan will ensure quality by speeding research on effective prevention and treatment measures for cancer, AIDS, Alzheimers, heart disease and other chronic diseases. Our plan safeguards the finest medical research establishment in the world, and makes it even better.

Simplicity

The fourth principle is simplicity. Our health care system must be simpler for the patients and simpler for those who actually deliver health care: our physicians, our nurses, and our other medical professionals.

Today, we have more than fifteen hundred insurers with hundreds of different forms. They are time consuming for health care providers, expensive for health care consumers, and exasperating for anyone who has ever tried to sit down at the kitchen table and wade through the paperwork.

The medical care industry is drowning in paperwork. In the last fifteen years, hospitals have four clerical workers for every doctor just to deal with all the red tape. A hospital should be a house of healing, not a monument to bureaucracy.

A few days ago Hillary and I visited Children's Hospital in Washington, where they do wonderful, often miraculous things for very sick children.

Nurse Debbie Freiberg in the cancer unit told us that, the other day, a little boy asked her to stay at his side during his chemotherapy. But she had to tell him no. There was yet another meeting to learn how to fill out yet another form. That's so wrong.

Dr. Lillian Beard, a pediatrician, in that same hospital, said she did not get into her profession to spend time filling out forms. She became a doctor to save lives.

Under my plan, there will be one standard insurance form, not 1,500. We will simplify government rules and regulations so that a doctor doesn't have to check with a bureaucrat in an office thousands of miles away before ordering a simple blood test. And you won't have to worry about the fine print, because there won't be any fine print.

Savings

The fifth principle is that reform should produce savings in our health care system.

Today, rampant medical inflation is eating away at our wages, our savings, our investment capital, and our public treasury. It undermines America's economy, competitiveness, confidence, and living standards.

Unless every one is covered, we can never put the brakes on health care inflation. Because when people don't have insurance, they wait to see a doctor until their illness is more severe and more costly, and they often seek treatment in the most expensive settings -- like emergency rooms. And when they can't pay their bills, because aren't insured -- who do you think picks up the tab? -- we all do: through higher hospital bills and higher insurance premiums.

Unless we reform health care costs, 60 cents of every new dollar that you pay in taxes in the next five years will go to pay for health care -- without a single family being given any additional health security. Every state government and every local government will continue to cut back on everything else they must do -- from police protection to education -- to pay more for the same health care.

These rising costs are a special nightmare for America's small businesses -- the engine of entrepreneurship and job creation. Health care premiums for small businesses are 35% higher than those of large corporations, and they will keep rising at double-digit rates unless we act.

Rather than using government to set health care prices, or simply looking away as the price spiral continues, our plan relies on a third way. For the first time, we will give groups of consumers and small businesses the same bargaining clout that the biggest corporations now have. We will force plans to compete on the basis of price and quality, rather than making money by turning away people who are sick. And we will back the system up with limits on how much plans can raise their premiums. We will create what has been missing for too long: a combination of private market forces and sound public rules.

We will also save money by freeing health care providers from costly paperwork and administrative overload that now accounts for \$100 billion a year. We will crack down on the fraud and abuse that drains \$80 billion year. And we will reward people for seeking less costly preventive care to reduce more expensive emergency care down the road.

This system will work. But don't take my word for it. Ask Dr. C. Everett Koop. He says we could spend \$200 billion less every year without sacrificing the high quality of American medicine. Ask the public employees in California, who have held their premiums down by adopting this very same approach. Ask Xerox, which saved an estimated \$1,000 per worker. Ask the staff of the Mayo Clinic, who provide some of the best care in the world, while holding their cost increases to less than half the national average.

People may disagree over the numbers. But surely we can find substantial savings in the most costly and bureaucratic system in the world, and we ought to be doing something about it now.

Responsibility

The sixth and final principle is responsibility. We need to restore a sense that everyone is in this together by ensuring that everyone is part of the solution.

Responsibility must start with those who have profited from the current health care system. Responsibility means insurance companies will no longer be allowed to cast people aside when they get sick. It must also apply to laboratories that submit fraudulent bills; to lawyers who abuse the malpractice system. It means drug companies will no longer be allowed to charge three times more for prescription drugs here in the United States than they charge overseas. Responsibility must apply to anyone who abuses our system and drives up the costs for honest, hard-working citizens and health care providers.

Responsibility means changing the behavior in this country that drive up our health care costs and cause untold suffering. It's the outrageous costs of violence from far too many handguns, especially among the young. It's high rates of AIDS, smoking and

excessive drinking; it's teenage pregnancy, low-birth weight babies, and not enough vaccinations for the most vulnerable.

But let me also say this. And I hope you will listen, because it is a hard thing to hear. Responsibility in our health care system isn't about "them". It's about you. It's about me. It's about each of us.

Too many Americans have not taken responsibility for their health. Too many Americans don't pay a penny for their health care. I believe every American should be responsible for paying something. There can be no more something for nothing.

Your contribution may be as small as a ten dollar co-payment when you visit the doctor. But, why should the rest of us pick up the tab when a guy who doesn't think he needs insurance gets in an accident and winds up in the emergency room?

Reform is going to produce a better health care system for every one of us. But no one should think it's going to be a free ride. We have to pay for it. Tonight I want to tell you very plainly how we plan to do that.

Most of the money will come, as it does today, from premiums paid by employers and individuals. But under our Health Security Plan, every employer and every individual will be asked to contribute to health care. This concept was first conveyed to the Congress by President Nixon. And today a lot of people agree that it's the best approach, from the US Chamber of Commerce to the American Medical Association.

Some people call it an employer mandate, but I call it the fairest way to achieve health care coverage for all Americans. It builds on what we already have, and what already works. It includes a discount to help struggling small businesses meet the cost of covering their employees. It requires the least bureaucracy or disruption and creates the cooperation we need to make the system cost-conscious even as we expand health coverage.

Every employer should provide coverage. Three-quarters do it now. Those that pay are picking up the tab for those that do not. And that's not right.

To finance the rest of reform, we'll achieve new savings in payments to doctors and hospitals under Medicare and Medicaid and reinvest the money in long-term care and prescription drugs; recover the money that hospitals and doctors write-off today when they cover indigent patients; and increased taxes on tobacco.

These sources will cover the cost of the plan I have described to you tonight. We have subjected our numbers to the scrutiny of every major agency in our government as well as some of the most respected actuaries from private accounting firms and Fortune 500 companies.

What does all this mean for you as individuals? The vast majority of you watching tonight will pay the same or less for your health care coverage and, at the same time, get the same or better coverage than you have today.

If you currently get your health insurance through your job, under our plan you still will. And, for the first time, you will get to choose what plan you belong to.

If you're a small business owner who wants to provide health insurance to your family and your employees but can't afford to because the system is stacked against you, this plan will give you a discount that will finally make insurance affordable. And if you are already providing insurance, your rates will drop because we'll help you join with thousands of other small firms to bargain down the cost of coverage.

If you are a large employer, your health care costs will stop increasing at double digit rates, so that you will have more money to put into higher wages and new jobs.

But let's be honest. Some will be asked to pay more. For example, if you are a young person who doesn't have insurance now because you don't think you're ever going to get sick, you will be required to carry coverage. But you know what, at some point, everyone gets older, most everyone gets sick, and some of us get into accidents. That's why all of us need insurance.

These are the principles -- security, simplicity, and quality; choice, savings, and responsibility. These are the guiding stars that we must follow on our journey toward health care reform.

Conclusion

As we begin this journey, I want all Americans and every one in this Chamber to keep a few things in mind. First, over the coming months, you are going to be bombarded with scare tactics by those who profit from the current waste in our health care system. Their advertising budgets are enormous. Their arguments will be seductive. But when they tell you that we cannot afford to change the current system, I want you to stop and think: Who are they trying to protect. You or themselves?

The second thing I want you to remember is this. Our health care system is enormously complex. It makes up one-seventh of our entire economy, and reforming that system will be very tough. If it were easy, it would have been done long ago.

We won't agree on every detail, but what's more important than the details is the destination: universal coverage and comprehensive health care benefits for every American.

After all, when President Kennedy started our space program, he didn't say "we're going to launch a three-stage Saturn 5 rocket from Cape Canaveral." He simply said it was our goal to put a man on the moon and return him safely to Earth -- and the ingenuity of the American people figured out the rest.

We have delayed reforming our health care system for sixty years, and that delay is killing us. Even in the time it has taken me to give this speech, _____ families have lost their health care. _____ families. This is why we have to act.

But when we act, those of us in this Chamber, and those of you at home tonight, will have accomplished something historic -- **we will have written that new chapter in America's story, and guaranteed every American comprehensive health benefits that can never be taken away. Ever.**

Some people have said that it would be a miracle if we passed health care reform. But, my fellow Americans, I believe we live in a time when miracles happen.

Just a few days ago, we saw a simple handshake shatter decades of deadlock in the Middle East. We have seen walls crumble from Berlin to South Africa. Now it is our turn to strike a blow for freedom -- the freedom for Americans to live without fear of their own nation's health care system.

God gives each of us a short time on this planet. But I believe he gives us world enough time to make a difference. And at this moment in our history, we have been given the opportunity of a lifetime -- to do something so important and so bold that future generations of Americans will look back and thank us.

It's hard to believe that once there was a time -- even in this century -- when retirement was nearly synonymous with poverty, and older Americans died in the street. That is unthinkable today because over a half century ago Americans had the courage to change. We created a Social Security System that ensures that no American will be forgotten in their later years.

I believe that forty years from now, our grandchildren will also find it unthinkable that there was a time in our country when hardworking American families lost their homes and savings simply because their child fell ill, or lost their health coverage when they changed jobs. Yet, our grandchildren will only find such things unthinkable tomorrow, if we have the courage to change today.

This is our chance. This is our journey. And, when our work is done, we will know that we have answered the call of history and met the challenge of our times.

Thank you. And God bless America.

THE WHITE HOUSE
WASHINGTON

*file: Health Care
St. Session*

September 23, 1993

MEMORANDUM FOR MACK MCLARTY
CHIEF OF STAFF

DAVID GERGEN
COUNSELOR TO THE PRESIDENT

MARK GEARAN
ASSISTANT TO THE PRESIDENT FOR
COMMUNICATIONS

MAGGIE WILLIAMS
ASSISTANT TO THE PRESIDENT AND CHIEF OF STAFF
TO THE FIRST LADY

FROM: DAVID WATKINS *D. Watkins*
ASSISTANT TO THE PRESIDENT
FOR MANAGEMENT AND ADMINISTRATION

SUBJECT: Health Care Speech Teleprompter

The attached fact sheet outlines the facts and actions surrounding the teleprompter problem of September 22, 1993.

Corrective actions currently on-going within the White House Communications Agency are outlined.

FACT SHEET
HEALTH CARE SPEECH TELEPROMPTER
September 23, 1993

PROBLEM

The wrong speech was displayed on the teleprompter at the beginning of the POTUS address on September 22, 1993.

FACTS/DISCUSSION

1. A technician loaded a test speech into the teleprompter to check set-up at the Capitol (Health Care Speech was not available).

2. The test speech was the February 17th speech on the State of the Union.

3. This speech remained in the teleprompter memory following testing at the Capitol.

4. The Teleprompter Operator rehearsed with the POTUS at the White House during set-up at the Capitol. Later, he arrived in the Motorcade with POTUS.

5. The Health Care Speech was given to the Teleprompter Operator upon arrival at the Capitol.

6. Procedures call for the operator to clear the computer memory of previous text prior to loading a new speech. This did not happen.

7. The Teleprompter Operator loaded the Health Care Speech onto the Teleprompter. Changes were subsequently made to the Health Care Speech at the teleprompter position.

8. When these changes were saved, the State of the Union Speech (February 17th) in the computer memory was automatically placed in front of the Health Care Speech.

9. The Teleprompter Operator then repositioned to the beginning of the in-memory speech for POTUS delivery. It was not evident to the operator that an incorrect speech was displayed for POTUS use.

10. Once advised of the problem, appropriate action was taken and the Teleprompter Operator caught up to POTUS delivery.

FACT SHEET
HEALTH CARE SPEECH TELEPROMPTER

CONCLUSION

Based on the above facts, this incident could have been avoided had the test speech been cleared before loading the Health Care Speech.

CORRECTIVE ACTIONS

1. The event operator has been removed from POTUS teleprompter support.
2. All POTUS Teleprompter Operators will receive remedial training immediately.
3. Clearly marked test patterns vice previously given speeches will be used for tests.
4. All computer hard drives will be cleared of previously given speeches.

Prepared by: Colonel Thomas Hawes
Commander, White House
Communications Agency
(202) 757-5530
September 23, 1993

GREENBERG
RESEARCH
INC



Health Care

515 SECOND STREET NE
WASHINGTON DC 20002
TEL 202 547-5200
FAX 202 544-7020

Date: March 11, 1994

To: Hillary Rodham Clinton
The Health Care Team
The DNC

From: Stan Greenberg
Mandy Grunwald

RE: THE TV CAMPAIGN FOR HEALTH CARE

We are at a critical juncture in the health care campaign -- a moment when large scale TV advertising will prove critical if we are to sustain support and advance the health care initiative. Voters are uncertain and increasingly frustrated after hearing six months of attacks from the insurance industry and from Republicans. Support has dropped just as the congressional committee mark-up phase begins. The distractions of Whitewater make it even more imperative that we take decisive and bold action to reshape the environment for health care.

The opponents of health care reform have used TV to move opinion nationally and in target markets. The supporters have used it to hold press conferences while barely communicating with the American people. But now the health care campaign must communicate directly, and that means an immediate 10-week advertising campaign in excess of 10 million dollars.

The media campaign will have a number of purposes:

- to keep health care reform at the top of the agenda as other forces try to distract the country,
- to build morale, confidence and hopefulness in an environment of growing cynicism,
- to mobilize activists and the public to pressure their elected representatives, particularly those on key committees,
- to provide critical information about the Clinton health care plan to reassure and reduce uncertainty,
- to make the case for the employer mandate, the central tool for financing universal coverage.



TV Campaign for Health Care

The media campaign will be directed at the DC market, key House and Senate members, and the public at large, particularly senior citizens.

Part One: National Audience/Focus on Seniors

Every public and private poll continues to show that the American people support the key elements of the President's plan. They simply have no idea that those elements are in the President's plan. The national advertising will be designed to bridge that gap.

The national media campaign should focus on the basic description of the plan and the key information that reassures voters:

- guarantees private insurance
- Medicare protected
- choice of plan and doctor
- the outlawing of unfair insurance practices

People need to understand how reform will work: most people will get insurance at work where they do now; small business will get a discount; the government will protect Medicare and help the unemployed.

The focus on senior citizens is critical, both in the substance of the ads and the targeting of the media buy. They are the voters most concerned about health reform, most committed to the issue, and, unfortunately, the group that has swung most strongly against the Clinton plan. (Seniors were Clinton's strongest support group in the 1992 election.) For most Americans, seniors are the symbolic center of the health care debate. If they are nervous, the country is nervous. Yet, seniors move in favor of the plan once they get credible information. We had hoped the AARP would provide that, but unfortunately they have abrogated that role and allowed support to drop sharply. This effort will have to be assumed by the DNC.

Reassurance of seniors must therefore be a critical part of the national advertising effort. That advertising will be designed as a series of ads, all of a similar format, that give people a sense that this is an official description of how the President's plan works. They will be designed to inform and reassure and will highlight footage of the President, as well as any "validation" (quotes from the AARP, etc.) that we can use. We envision three or four spots as follows:



TV Campaign for Health Care

1. Guaranteed Private Insurance/Choice. The President has proposed guaranteed private insurance for every American. Comprehensive benefits for every merican that can never be taken away. Everyone will be able to choose their own plan and their own doctor. Everyone will have the security of knowing they are covered. Everyone. Everyday. Always.
2. Older Americans. The President has proposed that Medicare be preserved and strengthened. Older Americans will still be able to choose their own doctor. But they will also gain coverage of prescription drugs and long term care. Insurance companies will no longer be allowed to charge older Americans more than younger Americans. The AARP has called this "the best blueprint for reform."
3. Real Insurance Reform: The President has proposed real insurance reform to eliminate fine print and lower costs. It would be illegal for insurance companies to refuse people coverage or to charge them more if they're older or have preexisting conditions. No more lifetime limits. Your benefits package will be comprehensive and coverage cannot be taken away.
4. Guaranteed Private Insurance/How It Works: The President has insisted that health reform mean that everyone be covered. Those who work would be covered at work. Small businesses would be helped with discounts. The unemployed would be covered by government. And older Americans would continue to be covered by Medicare. Everyone would be covered. Everyday. Always.

We are working on scripts for each of these ads. Similar concepts have already been tested successfully in focus groups.

The DNC media buy for these spots would balance three considerations: First, our desire to reach as many people as possible to shift public opinion; second, our need to focus on older Americans, and finally, our Congressional targeting considerations.

The budget for this effort would be ten million dollars. That would mean four weeks of television at 500 points per week in 44 markets, and four weeks of television at 375 points per week in 8 expensive markets, reaching 63% of the American people. A list of markets covered by this effort is attached. It covers 29 of the top 40 biggest markets, all of the markets with large concentrations of senior citizens, and the highest priority congressional targets, as currently defined by legislative affairs. Obviously, it can be amended as needed. (By the way, the networks will not sell advertising time for issue advertising.)



TV Campaign for Health Care

Given the point levels of this budget, we envision three spots run over a four to five week period, beginning as soon in March as fundraising would allow.

Part Two: The Employer Mandate

The Health Care Reform Project has produced, after extensive discussions, an employer mandate spot which is now airing in the Washington, DC market. Their buy is fairly light -- about 250 points a week. But our goal should be saturation on this issue during the next 10 weeks when Congress is making the real choices about financing. The reform project is committed to this approach and willing to champion the Clinton approach. The problem is funding. Labor has put in resources and may be willing to speed up its contribution, but business has not yet put in sufficient funds.

We are proposing 4 spots to make the case for the employer mandate and to dominate the DC media environment:

1. *Health Insurance at Work* This spot is on the air now, though at low point levels. This needs an immediate infusion of funds.
2. *Small Business* The Congress needs to hear the argument that the employer mandate is pro-small business. The focus will be on the "small business heroes" who pay 30 percent more for insurance than the big companies while subsidizing the small companies who insure nobody. The Clinton plan allows small business to get lower cost and discounted insurance. This spot should move into the TV rotation as soon as possible.
3. *Welfare and Work* This spot taps into some of the strongest emotions in the employer mandate issue. Welfare provides free health insurance, but work offers no guarantee of health benefits. That is wrong. The Clinton plan says work and health benefits should go hand-in-hand.
4. *Comparative: Employer versus Individual Mandate* At some point, the congressional debate will center on this choice. We want a spot that crystalizes the debate which, we know from our research, strongly favors us. People fear a system that encourages employers to dump the insurance issue on their employees.



TV Campaign for Health Care

The employer mandate campaign will cost 150 thousand dollars a week -- 1.5 million dollars for the 10 week period -- funded through the reform project.

Part Three: National CNN

The DNC should advertise on CNN, reaching a largely elite audience, from now at least until Memorial Day and the close of the committee process. CNN is one area where the HIAA has been effective, providing a continuous drumbeat of criticism to opinion leader audiences.

There are two creative approaches we are considering for this CNN effort. First, to duplicate and expand the informative series of spots that the DNC would be running nationally. After all, it is not just the broad public who are confused about how the President's health care reform would work. Elite audiences are confused as well.

The CNN series of spots could include the four ads outlined above, but also cover more specific concerns in greater detail, such as: what the plan would mean for small business, how choice would be preserved, what would be guaranteed in the comprehensive benefits package, etc. These issues would obviously mirror many of the debates proceeding on Capitol Hill.

A second creative option would be to respond more directly to the HIAA advertising (which is continuing in selected districts.) Despite the fact that the direct HIAA response ads we tested were not as powerful as other ads, they did have resonance in areas where the HIAA had advertised heavily.

We might consider a series of spots casting our own Harry and Louise who face a series of real life problems that are solved by the Clinton plan. Harry loses his job. Louise's mother can't afford prescription drugs. Harry and Louise want to be able to keep their own doctor, etc.

A series such as this could highlight the key elements in the plan through a dramatic depiction of people's real life problems, rather than just a straight informational approach.

Whichever creative direction we take, the use of CNN is an important part of our overall effort to regain support for the President's plan.

This campaign would cost about \$115,000 per week. We would begin this effort on March 28th (first available time), perhaps earlier in the Washington, DC market, and buy continuously for nine weeks at a total cost of \$1,035,000. Depending upon the creative



TV Campaign for Health Care

approach, this effort could be funded through the DNC or the Reform Project. It is likely that we would also want to consider extending it beyond Memorial Day until final passage of the bill.

Part Four: Target Districts and States

The reform project is now airing spots in 13 media markets, with print and radio in 2 additional. The buy is again quite light -- about 500 points over 9 days. These target districts need heavier buys and spots with greater capacity to mobilize public sentiment.

We are in discussion with the reform project over the design of the future campaign. The first challenge is greater resources behind the current spot which counterpoises the insurance industry to ordinary people. (See spot and DNC video). The reform project needs to produce a number of provocative spots as soon as possible to allow sustained pressure on members.

Spot One: Everyday. This spot is on the air now -- insurance industry practices versus health care reform for people.

Spot Two: Affordability. This spot will focus on the rising costs of health care and the money that the insurance industry is spending to keep the system from changing.

Spot Three: Welfare. This spot is part of the employer mandate campaign (DC market) that emphasizes that health benefits should come with work.

Spot Four: What Congress Has. This spot asks Congress to give the American people health insurance coverage at least as good as their own -- paid for by the taxpayers. (This is a powerful spot but there are strong reasons not to air it. This spot may antagonize key members as we are trying to promote committee action and may hurt the image of Congress and Democrats independent of health care.)



HEALTH CARE MESSAGE STATEMENT

This is what we are proposing to do:

First, we want to guarantee private insurance coverage to every American. Comprehensive coverage that can never be taken away. *[contrast: It isn't real reform unless everyone's covered]*

Second, we want to take power out of the hands of the insurance companies and give it to the people. We want everyone to have the right to choose their own plan and their own doctor.

Third, we believe that health care reform must be good for older Americans. Medicare will stay as it is now. Older Americans should continue to rely on Medicare and be able to choose their own doctor. But prescription drugs should also be covered and we must finally begin to cover long term care.

Fourth, we think the best way to make sure that everyone has coverage and to pay for it, is to require coverage in every workplace. That's how 90% of Americans who have insurance get it today, and that's the best way to extend coverage to the 80% of uninsured Americans who work full or part time. Discounts should be available for small businesses, and government should cover older Americans through Medicare, as well as the unemployed.

Fifth, we must have a system of coverage that everyone can depend on. It would be illegal for insurance companies to jack up your prices or drop your coverage.

Everyone will be covered. Everyone. Everyday. Always.

**HEALTH ADS
EVERY DAY
:30**

SPOT BEGINS OF WARM FOOTAGE OF DOCTORS AND NURSES WITH THEIR PATIENTS

ANNCR EVERY DAY, ALL ACROSS AMERICA, DOCTORS AND NURSES
ARE WORKING TO MAKE SICK PEOPLE WELL.

*CUT TO FOOTAGE OF FORMS BEING FILLED OUT IN INSURANCE INDUSTRY TYPE
OFFICES*

BUT EVERY DAY, INSURANCE COMPANIES ARE WORKING TO
FIND THOSE SAME SICK PEOPLE AND DROP THEIR COVERAGE,
JACK UP THEIR RATES OR DENY THEIR CLAIMS.

CUT TO FOOTAGE OF THE PRESIDENT WITH PEOPLE..GRAPHIC BULLETS

THE PRESIDENT'S HEALTH CARE PLAN WOULD MAKE THOSE
INSURANCE PRACTICES ILLEGAL...EVERYBODY WOULD
BE COVERED WITH GUARANTEED PRIVATE INSURANCE.
EVERYBODY. EVERY DAY. ALWAYS.

THE INSURANCE COMPANIES DON'T LIKE THE PRESIDENT'S
PLAN...BUT HE DIDN'T DESIGN IT FOR THEM. HE DESIGNED
IT FOR YOU.

**HEALTH ADS
SENIORS
:30**

STILL PHOTOS OF OLDER AMERICANS. (ANNOUNCER IS OLDER FEMALE)

ANNCR WHAT WILL PRESIDENT CLINTON'S HEALTH CARE REFORM MEAN
FOR OLDER AMERICANS?

- * EVERYONE WILL BE COVERED
- * MEDICARE WILL BE PROTECTED
- * PRESCRIPTION DRUGS WILL BE COVERED
- * LONG -TERM CARE WILL BE STARTED, AND
- * THE PRACTICE OF CHARGING OLDER PEOPLE MORE
THAN YOUNGER PEOPLE WILL BE STOPPED.

PRESIDENT CLINTON'S APPROACH MAKES THESE GUARANTEES TO
OLDER AMERICANS. OTHER PEOPLE ARE TRYING TO STOP HIM.

SO CALL YOUR MEMBER OF CONGRESS. TELL THEM YOU'RE AN
OLDER AMERICAN WHO IS STANDING WITH THE PRESIDENT.
BECAUSE HE'S STANDING UP FOR YOU.



CONFIDENTIAL

DETERMINED TO BE AN
ADMINISTRATIVE MARKING

INITIALS: JAM DATE: 5/9/16

2011-0584-F

Date: February 25, 1994

To: Clinton Health Care Team

From: Stan Greenberg
Mandy Grunwald

RE: HEALTH CARE COMMUNICATION

The next three months are probably the most critical in the health care reform debate. The key committees in Congress will prepare their bills and make choices that will determine the form of the final legislation. They are operating in an environment of uncertainty -- fear of making changes that will haunt them in the future (the catastrophic experience) and frustrated by the lack of direction from home.

While a majority of the public supports the president's health care reform proposal, it is surrounded by a debilitating uncertainty. Six months into the health care debate, people do not know what is in this plan. They want to believe the plan will be good, but without information, they are increasingly frustrated. Support could decline 5 or 6 points, which would seriously complicate our work in Congress.

We propose two simple goals for this period: first, reduction in uncertainty in order to maintain majority support; and second, support for the employer mandate which is the central battle in Congress.

This proposed plan of action was developed out of discussions with the health care team, particularly Bob Boorstin, David Dreyer, and Greg Lawler.

Style of Communication

To be heard in this period and to achieve our longer term goals, it is important to communicate in ways that are reassuring and that define the health care debate:



- **Confidence.** The president must be positive and optimistic about passing health care reform legislation this year. He must set the tone that allows for a positive interpretation of what is happening in Congress. The president's confidence that health care reform will happen will keep people open to his approach.
- **People.** The president must transcend the policy debate to show the public that he is promoting reform to help ordinary people (not the insurance companies). That motivation builds receptivity to reform and defines the debate in ways that help Democrats for the long term.
- **Information.** We must be explicit about our intention to provide information that people need to judge this debate. Our communications must say, "this is what Clinton has proposed" or something similarly explicit. The public is desperate for understandable and authoritative information about the Clinton health care plan.

Describing Clinton's Approach

Our goal should be consistent communication that allows people to understand where Clinton wants to take the country on health care.

We have proposed a system of guaranteed private insurance for every American. Here is how it will work:

Most people will get their insurance at work, as they do now, and all employers will now be required to provide coverage. Small businesses will get insurance at a discount. The government will protect and improve Medicare (prescription drugs and a start on long term care) and will help insure the unemployed and those in-between jobs. Everyone will contribute something, but they will have a choice of insurance plan and doctor, and insurance companies will no longer be able to drop people or jack-up rates.

The description includes a number of key elements that are central to reducing uncertainty. These points give people the most reassuring information and ought to form the elements of a communication plan.



1. Characterization. This is guaranteed private insurance for everyone.

This characterization underscores that the system is private which cuts against the fear of government messing things up.

It also reiterates our uncompromising goal that everyone is covered. Congress should never be allowed to entertain the idea that something less is possible. Our research says "everyone insured" is a "read-my-lips" promise.

2. Choice. People must have a choice of plan and doctor. They can stay with and choose their own doctor. (The president opposes forcing people into HMOs.) The choice will be in the hands of people, not the insurance companies or employers.

3. Seniors. Medicare will stay as it is now. Coverage must be protected and improved; seniors must be able to choose their doctors, as they do now. Prescription drugs will be covered and the country will finally make a start on long term care. Protecting the health of seniors must be a primary goal of health care reform.

4. Health insurance and work. The best way to organize and finance this system is to require health insurance where you work. That is where 9 of 10 Americans with private insurance get it; but 8 of 10 of those without insurance are working. Small businesses will get lower cost and discounted insurance. Requiring insurance through work is supported by the "Health Committee" of the Chamber of Commerce, the AFL-CIO, and the AMA.

5. Insurance that can never be taken away. It will be illegal for insurance companies to drop your coverage or jack-up your rates if you have a pre-existing condition or change jobs; insurance companies can no longer charge older people more than younger people. Bill Clinton designed this plan for people, not the insurance companies.

These 5 points must become a simple litany -- represented by 5 charts (to be created) or by 5 bullet statements --

- guaranteed private insurance
- choice
- Medicare protected
- health insurance at work
- health insurance -- cannot be taken away

Or by the rhetorical form (attached at the end of this memorandum).



Paid Media Strategy

To re-assure voters and to define the debate, we are proposing three TV spots -- funded in some combination by the DNC, the unions and the health care reform project.

Seniors Spot. This spot, already tested, should reassure seniors on Medicare and doctor choice and discuss enhancement (prescription drugs and long term care). Our goal is national TV aimed at seniors. Discussions are continuing with the AARP and outside groups, though the DNC may have to finance this project. (See attached script.)

Employer Mandate Spots. With the Congress focused on the funding formula, we must help create an environment more favorable to the employer mandate. We hope for a saturation buy (supported by the unions), beginning with the prototype spot already produced. It highlights the historic role of health care benefits and the work place. In fact, a saturation buy might allow 3 spots:

1. Health benefits and the job: The American way
2. To pay for health care reform: employer mandate, individual mandate or big taxes
3. Danger of an individual mandate: erosion of benefits

This media campaign should be focused on the DC market (and selective districts with sizeable union membership) over the next 4 weeks. Discussions are taking place both with the unions and the reform project.

Information Spot. This spot contrasts with the insurance industry to show Clinton's approach to health care. It is a powerful illustration of what Clinton wants to accomplish and what he cares about. The spot, entitled "Every Day," received the highest scores from 26 of 40 focus group participants. This spot was cheered by the DPC and Message Group members and clearly lifted morale.

Our goal is to air this spot in target districts and in the DC market as soon as possible. It may be necessary to fundraise particularly around this spot. (See attached script.)



The media should be used to focus the debate on the issues and information most important to supporting Clinton's approach. Some of this is tactical (to influence individual members and the committee process), but we are trying to provide information that will allow people to support the Clinton plan. We dare not allow this uncertainty to turn to opposition.

The Employer Mandate

The president's schedule over the next four weeks must lend weight to the arguments for providing insurance through work. A range of options are set out below:

Organization Endorsements: Chamber of Commerce (health committee), AFL-CIO, American Hospital Association and the AMA.

Paired Endorsements: Chairman and flight attendants (American Airlines), Iacocca and Bieber, etc.

Small Business Heroes: Small businesses providing health coverage but squeezed -- paying 35 percent more than big businesses and subsidizing small businesses that do not insure their employees.

These presidential events will be supplemented by aggressive scheduling of the economic team to make the case for the employer mandate. Some of these should be general press events, but they also need to speak to business publications and write op-eds (as Altman did today). These events should be targeted to relevant members' districts.

The selling of the employer mandate must include a considerable emphasis on helping small business -- discounted insurance and purchasing pools to help them afford insurance for their employees.

The case for the employer mandate should begin with the simple assertion: it is the best way to achieve guaranteed private insurance for everyone. That case should center on a number of themes:

- health insurance at work (building on the current system)
- helping small business
- cost shifting
- validation (AMA, etc.)
- contrast with the individual mandate



Broad Communication

Our broad communications explaining the president's approach and providing essential information should touch on a number of topics (choice, seniors, guaranteed private insurance). It is time to step on to a larger stage and use what vehicles are open to the White House. Here are a number of possibilities:

Prime Time Press Conference: A press conference would give the president the opportunity to lay out his main ideas on health care and show his determination to win their passage in Congress.

Major Media Market Days: Once a week for twelve weeks the President and First Lady go to a major media market (LA, NY, Chicago, etc.) to "teach" about his approach to health care -- meeting with editorial boards, holding a local press conference, conducting a town meeting, etc. The president, like Ross Perot, should carry his 5 charts and educate, "here's how it would work."

Secondary Media Markets -- White House press briefing on health care with principal stations and newspapers (at least once a week); (prioritize markets by target votes in Congress).

Seniors Tour: The Vice-President and Mrs. Gore (perhaps Gore, Srs., as well) should go together to a series of senior concentrations to make the case on Clinton's ideas on health care reform and to reassure about Medicare and choice.

Hawaii Day: President focussed on Hawaii health care, perhaps with First Lady in Hawaii.

Daytime Television: The President ought to use daytime television to reach older women and seniors. "Oprah" could be a multi-day opportunity.

"Letters" Events for Television: Women who faced breast cancer who lost their health insurance.

Popular Settings: The President may want to make his case for health care in informal popular settings -- bowling alley, supermarket or shopping mall -- where he can talk to seniors and older voters.

National Days of Action: Millions of doctors, nurses and pharmacists getting information to their patients on the Clinton approach to health care.



Op-Eds: Economic team on cost-shifting, physician groups on choice, etc.

President and First Lady op ed appearing in papers across the country -- perhaps reproduced as ads in local papers.

Oval Office Address: This may be difficult to get from the networks without imminent floor action in the Congress.

President goes to the Well to answer questions on health care.

Oxford Debate: Should there be universal health coverage?

Bus Trip: If we are ever going to use the bus trip again to communicate over a 3 day period, this is the moment. The president and First Lady would be seen with people and their major speeches each day would get network attention. This probably should be held to early-mid May -- right before congressional consideration.

Congressional Coordination and Support

The House and Senate leaders are anxious for the closest possible coordination on message and strategy. They want the White House to give direction and to demonstrate confidence and competence. We offer a number of basic ideas:

Close coordination with the Hill (as evident in Pat and George's work over the past month).

Coordination with the Hill leadership to encourage outside groups to do the right things.

Working with the Wise health care group and the other groupings (single payor) to launch a range of attacks --

- insurance company control, advertising and lobbying (special interests)
- individual mandate
- raids on Medicare funding
- no crisis in health care
- those who would not have insurance for everyone



We must develop a "CBO" strategy to manage Congressional events (e.g., Stark markup) to a draw. The goal is to keep the Washington community from developing a defeatist conventional wisdom.

The Congressional process can break our confidence if we do not have an agreed upon interpretation of congressional committee actions: "The Sperling Defense" -- just another step on the road to reform. Our confidence will affect the mood in Congress and the country.

The Congress needs to hear from time-to-time our absolute commitment to veto legislation that does produce guaranteed private insurance for everyone. The president's firmness will block those who would opt for lesser reforms and it will strengthen the hand of our supporters. In the focus groups, these uncertain voters became quite angry at the prospect of anything less.

Health Care

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

March 1, 1994

**DEPARTMENT OF HEALTH AND HUMAN SERVICES RELEASES STUDY
SHOWING SIGNIFICANT SAVINGS TO STATES AND TAXPAYERS UNDER
THE HEALTH SECURITY ACT**

The Department of Health and Human Services today released a study demonstrating the significant cost savings states and taxpayers will experience under the Health Security Act. States will achieve savings through the reduction of costs in three primary areas: by enrolling Medicaid beneficiaries in private health plans; through the creation of a new federal-state home and community-based long-term care program; and through reducing the rate of growth in health insurance expenditures for public employees as well as assistance in health care costs for their early retirees.

"States are clearly among the winners under the Health Security Act. These studies show that the combination of guaranteed private insurance, long term care coverage and effective cost containment under the President's plan results in considerable savings to state governments as well as to American workers and businesses in these states," said Kenneth E. Thorpe, Deputy Assistant Secretary for Health Policy and principle author of the study.

The study is supported by the findings of three independent experts: the Congressional Budget Office, the Urban Institute and the cost accounting firm of Lewin-VHI.

Information on how the plan will affect states in general is attached. State-by-state information is available upon request.

THE HEALTH SECURITY ACT WILL SAVE STATES AT LEAST \$45.8 BILLION



SAVINGS FOR THE STATES

- STATES WOULD SAVE AT LEAST \$39.5 BILLION BETWEEN 1996 AND 2000 IN EXPENDITURES FOR MEDICAID AND COMMUNITY-BASED LONG-TERM CARE
- AS EMPLOYERS, STATES WOULD SAVE \$6.3 BILLION IN 2000 ALONE

SAVINGS FOR STATES' EMPLOYERS AND EMPLOYEES

- EMPLOYERS THAT CURRENTLY OFFER INSURANCE WILL PAY \$59.5 BILLION LESS IN PREMIUM PAYMENTS IN THE YEAR 2000 THAN THEY WOULD HAVE WITHOUT COMPREHENSIVE REFORM
- WORKERS WHO ARE EMPLOYED BY FIRMS THAT CURRENTLY OFFER INSURANCE WILL PAY \$28.9 BILLION LESS IN PREMIUM PAYMENTS IN THE YEAR 2000 THAN THEY WOULD WITHOUT COMPREHENSIVE REFORM

IMPACT OF THE HEALTH SECURITY ACT ON STATES

U.S. Department of Health and Human Services
February 22, 1994

IMPACT OF THE HEALTH SECURITY ACT ON STATES

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I. SUMMARY: Impact of the Health Security Act on States

The Health Security Act will reduce the cost of insurance in states through universal coverage, cost containment, and the elimination of cost shifting.

- Employers who currently offer insurance will save an average of \$605 per worker (1.6% of payroll or \$59.5 billion in total) on premiums in the year 2000.
- Workers who are in firms that currently offer health insurance will save an average of \$293 per worker (\$28.9 billion in total) on premiums in the year 2000.
- As a purchaser of health care coverage for their employees, states will save approximately \$5.6 billion in premium payments for active employees in the year 2000 due to slower growth in overall health care costs. Additionally, states will save an estimated \$704 million through federal support of health care for early state retirees in the year 2000.

State expenditures for Medicaid and community-based long-term care are projected to decrease in the aggregate under the Health Security Act.

- Between 1996 and the year 2000, states will save an estimated \$43.6 billion in state Medicaid expenditures under the Health Security Act; an estimated \$31.9 billion represents coverage of Medicaid recipients through regional alliances, and approximately \$11.7 billion will be saved through the new community-based long-term care program. In the year 2000, state Medicaid programs will save approximately \$22.3 billion -- \$3.3 billion results from the new home and community-based long-term care program.
- When taking new state spending for the new community-based long-term care program into account, states will save, on net, nearly \$7.6 billion on community-based long-term care expenditures between 1996 and 2000 under the Health Security Act. In the year 2000 alone, states will save \$1.1 billion on community-based long-term care.
- **States will save \$39.5 billion between 1996 and 2000 under the Health Security Act, \$7.6 billion from the community-based long-term care program, and \$31.9 billion from the remaining changes in the Medicaid program.** In the year 2000, this represents \$20.1 billion, \$19.0 billion in Medicaid savings excluding home and community-based care and \$1.1 billion in savings from the home and community-based care program.

IMPACT OF THE HEALTH SECURITY ACT ON STATES: YEAR 2000

EXPENDITURE CATEGORIES	W/O REFORM	REFORM	SAVINGS
PURCHASING HEALTH COVERAGE UNDER THE HEALTH SECURITY ACT			
<i>Employers' Share of the Premiums</i>			
Total Employer Premium Payments All Firms	\$303.5 billion	\$275.5 billion	\$28.0 billion
Total Employer Premium Payments Employers Currently Offering Insurance	\$303.5 billion	\$243.9 billion	\$59.6 billion
Premium Payments as a Percent of Payroll Employers Currently Offering Insurance	8.2%	6.6%	1.6%
Premium Payments Per Worker: Employers Currently Offering Insurance	\$3,086 per worker [\$257/month]	\$2,481 per worker [\$207/month]	\$605 per worker [\$50/month]
<i>Families' and Individuals' Share of the Premiums</i>			
Total Worker Premium Payments: All Firms	\$73.6 billion	\$53.7 billion	\$19.9 billion
Total Worker Premium Payments: Workers in Firms Currently Offering Insurance	\$73.6 billion	\$44.7 billion	\$28.9 billion
Worker Premiums: Workers in Firms Currently Offering Insurance	\$748 per worker [\$62/month]	\$455 per worker [\$38/month]	\$293 per worker [\$24/month]
<i>New Federal Funds for Discounts*</i>	---	\$81.0 billion	---
<i>State Expenditures on Active State Employees</i>	\$15.8 billion	\$10.2 billion	\$5.6 billion
<i>State Expenditures on Early State Retirees</i>	\$1.3 billion	\$0.6 billion	\$0.7 billion
MEDICAID			
State Medicaid Expenditures, Including Savings from Community-Based Long-Term Care	\$123.3 billion	\$101.0 billion	\$22.3 billion
State Medicaid Expenditures, Not Including Savings from Community-Based Long-Term Care	\$123.3 billion	\$104.3 billion	\$19.0 billion
NEW LONG-TERM CARE PROGRAM			
State Community-Based Long-Term Care Expenditures	\$9.9 billion	\$8.9 billion	\$1.0 billion

* Total discounts minus states' maintenance of effort

NOTE For display purposes only, the Medicaid savings due to the new community-based long-term care program are shown in both the Medicaid and the New Long-Term Program sections. The State Community-Based Long-Term Care Expenditures section reflects changes in state-only spending for the severely disabled and state funds directed toward the new long-term care program. Numbers may not sum to totals due to rounding.

II. HEALTH SECURITY ACT: Major Policy Changes Affecting States

*The following is a brief description of some of the major policy changes under the Health Security Act that affect state expenditures.**

UNIVERSAL COVERAGE AND COST CONTAINMENT UNDER THE HEALTH SECURITY ACT

The Health Security Act guarantees all American citizens and legal residents private insurance coverage for a comprehensive package of benefits. Coverage continues with no lifetime limits regardless of a change of employer, employment status, marital status or medical condition.

The Health Security Act relies on the requirement of shared responsibility for the purchase of health coverage. It strengthens the private, employment-based system and augments it with a commitment to make the purchase of coverage affordable through discounts to small business and families.

The Health Security Act carries out the commitment to control the rising costs of health care by:

- (1) Consolidating the purchasing power of consumers so that private payers in a competitive market can slow the growth of health insurance premiums. This process is backed up by a cap on the growth of insurance premiums.
- (2) Reducing the rate of growth of the Medicare and Medicaid programs without reducing benefits or quality of care.

PREMIUMS UNDER THE HEALTH SECURITY ACT

Under the Health Security Act, health coverage is purchased in two shares: the individual or family share and the employer share. Each individual or family purchases a health plan designed to cover one of four categories by family type:

- (1) A single adult policy;
- (2) A policy covering two adults;
- (3) A policy covering a single parent with children; or
- (4) A policy covering two parents with children.

*Note: This analysis includes the major ways that states will be affected by the Health Security Act; other sectors that will be affected, such as hospitals and local governments, are not described in this report.

Employers' Share of the Premiums

Generally, employers pay 80 percent of the weighted average premium calculated on a per worker basis within a regional alliance for the appropriate family type policy.¹ Additionally, an employer may choose to pay part or all of the family share of the premium.

Employers' premium payments within regional alliances are capped. At full implementation, employers purchasing coverage through regional alliances will pay no more than 7.9 percent of payroll for health coverage for their workers. Businesses with fewer than 75 workers receive discounts that cap their payments to a sliding scale (3.5% to 7.9% of payroll) based on size and average wage.

Families' and Individuals' Share of the Premiums

The family or individual pays the difference between the employer share and the actual premium of the health plan in which they choose to enroll. Those who choose to enroll in a lower-cost plan will pay lower premiums than those who choose higher-cost plans.

For families and individuals, as well as employers, premium payments are capped. Families with an annual income of \$40,000 or less pay no more than 3.9 percent of their income toward their share of the premium. Those with incomes below 150 percent of poverty receive discounts toward their share of the premium.

MEDICAID UNDER THE HEALTH SECURITY ACT

Under the Health Security Act, Medicaid recipients under the age of 65 enter the alliance system to obtain the guaranteed comprehensive benefit package.

People not on cash assistance who now receive Medicaid choose their health plan and may qualify for discounts based on income, like other eligible individuals and families. States contribute toward discounts for their residents by maintaining current Medicaid spending efforts for this population.

Individuals who qualify for cash assistance (Aid to Families with Dependent Children or Supplemental Security Income) also choose their own health plans through regional alliances. The federal and state governments make premium payments for these individuals based on current state and federal Medicaid expenditures.

¹ The weighted average premium is the average of the accepted bids for all health plans in the alliance, weighted to reflect enrollment of eligible individuals among the plans.

For low-income children under the age of 19, a new program is created to provide services currently offered under Medicaid but not included in the comprehensive benefits package, such as hearing aids and non-emergency transportation. States maintain current spending for children receiving cash assistance.

State expenditures on Medicaid will decrease under the Health Security Act for several reasons

- **Coverage of current cash eligible Medicaid recipients through regional alliances:** Acute care spending for cash eligible Medicaid recipients decreases because of their inclusion in regional alliances, where costs will not grow as rapidly as under the current system. States pay a premium for these services that is based on 95 percent of current expenditures for this population. In addition to this reduction in expenditures, states no longer make disproportionate share payments for their cash-eligible populations.
- **Coverage of current non-cash eligible Medicaid recipients through regional alliances and the new program for children's supplemental services:** Expenditures for non-cash eligible Medicaid recipients, like those for cash eligibles, are reduced due to their inclusion in regional alliances. Although the states make maintenance of effort (MOE) payments based on current expenditures for acute care services and disproportionate share for this population, these payments will not grow as rapidly as under the current system. Additionally, the federal government assumes the costs of supplemental services for Medicaid eligible children. Because the MOE payments for cash eligible children's supplemental services will grow at a slower rate than do current expenditures for these services, states achieve savings.

NEW LONG-TERM CARE PROGRAM UNDER THE HEALTH SECURITY ACT

The Health Security Act creates a new home and community-based long-term care program for individuals with severe disabilities regardless of income or age. The program is financed by:

- **Federal Government:** New federal funds are allotted to states based on a formula that includes the number of persons with severe disabilities among other factors. Additionally, current federal Medicaid expenditures for these services for the severely disabled will be used to fund the new program to the extent that current Medicaid eligibles are served in the program. The federal share of public costs ranges from 78 to 95 percent when fully phased in.

- **States:** State spending for the new program will be matched by the federal government at a rate substantially higher than that of the current Medicaid program. Part of the state funds will come from the transfer of Medicaid expenditures for community-based long-term care for the severely disabled. At the most, states will pay between 5 and 22 percent of the public program costs.
- **Individuals:** Participants whose income is greater than 150 percent of the federal poverty level will contribute based on their income

States have the flexibility to organize services to meet their populations' diverse needs; at a minimum, states must provide personal assistance to eligible individuals needing assistance with activities of daily living. States have the option to continue to provide community-based long-term care services under the state Medicaid program.

PUBLIC HEALTH INITIATIVES UNDER THE HEALTH SECURITY ACT

The Public Health Initiatives under the Health Security Act will provide states and communities with new funds to create partnerships among government, alliances health care providers, and communities that will:

- Enhance the capability of communities to protect the health of their populations and to address high-priority local health problems;
- Increase the number of minorities in health professions, support graduate nurse training initiatives, and expand training projects for primary care physicians and physician assistants;
- Assure access to essential health services for all Americans, particularly low-income, isolated, hard-to-reach populations; and
- Provide the knowledge and information systems necessary to prevent disease and provide medical care more appropriately and efficiently

Due to universal coverage under the Health Security Act, most personal health services now provided the Public Health Service will be paid for by insurance

III. BACKGROUND: States and Health Reform

Over the past decade, state governments, residents, and employers have faced rapid increases in the already high health care costs.

- Between 1980 and 1991, spending in states for hospital care, physician services, and prescription drug purchases in retail outlets rose at an average annual rate of 10.5 percent (1)
- In 1993, states spent more on health care than on tax-financed higher education. (2)
- Between 1988 and 1990, the average annual growth in Medicaid expenditures was 15.7 percent (3), and it is expected that state Medicaid spending will nearly triple between 1990 and 1995. (4)

United States - Health Care Environment	STATISTICS
Percentage of Population Covered by Medicaid (1991) (5)	10.6%
Medicaid Payments per Recipient (1992) (6)	\$2,937
Average Annual Growth in Medicaid Expenditures (1988-1990) (3)	15.7%
Infant Mortality Rate per 1000 Live Births (1991) (7)	8.9

States have taken several steps to control the rise in health care costs and to increase access to health care for its residents. (8,9)

- Almost all states have initiated or enacted measures to improve access and contain costs. (8)
 - Fourteen states have enacted or proposed legislation designed to provide universal coverage for all state residents. (8)
 - Twelve states have enacted or proposed legislation designed to contain costs through managed competition or purchasing pools. (8)
 - Forty-seven states have enacted or proposed small group insurance reform, eighteen states have enacted or proposed insurance reform for individuals. (8)

- Examples of state health reform initiatives include
 - Expanding access to health care for targeted population groups, such as pregnant women or children, through public sector, private sector, or a mixture of both, interventions. This often includes expanding Medicaid eligibility for coverage and services beyond Medicaid's traditional income restrictions. (8)
 - Small group and individual market reforms including guaranteed issue and renewal, limits on pre-existing condition exclusions, rating restrictions and benefit mandates. (8)
 - Containing costs through the use of managed competition or purchasing pools, provider rate setting, insurer premium caps, and global budgets. (8)

Acting alone, states are hampered in their efforts to control the growth of health care costs. The Health Security Act will enable states to control the growth of health care expenditures and assure access to care for its residents.

- Universal coverage, achieved through a federal/state partnership, will reduce the burden on state and municipal programs and providers that today help finance and deliver services to the uninsured and under-insured.
- Federal grants will help states provide special assistance to underserved rural and urban areas. States will be able to strengthen and improve essential public health efforts.
- The Health Security Act will control the increase in health care costs by introducing greater competition into the health care delivery system.

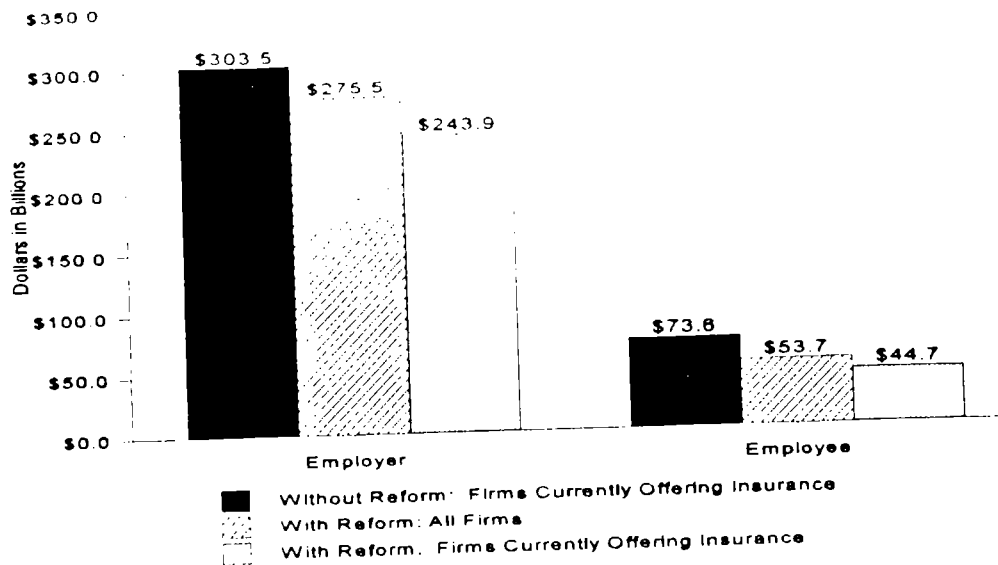
NOTES AND SOURCES

- (1) Health Care Financing Administration, as published in Levit, et al., Health Affairs, Fall 1993.
- (2) National Association of State Legislatures, 1993.
- (3) Health Care Financing Administration, Office of the Actuary. Per capita data from 1992. As cited in Office of Management and Budget Health Reform Briefing Book, October, 1993.
- (4) National Association of Budget Officers, 1993.
- (5) Congressional Research Service. Medicaid Source Book, 1993 Update. Prepared for the Committee on Energy and Commerce, U.S. House of Representatives, January 1993. P. 48.
- (6) Health Care Financing Administration, as compiled by The Urban Institute, 1993. As cited in Office of Management and Budget Health Reform Briefing Book, October 1993.
- (7) Centers for Disease Control and Prevention. Monthly Vital Statistics Report, 42(2s) August 31, 1993.
- (8) Blue Cross and Blue Shield Association. State Legislative Health Care and Insurance Issues, 1993 Survey.
- (9) Office of Management and Budget Health Policy. Health Reform Briefing Book. States. October 1993.

IV. IMPACT ON THE PRIVATE SECTOR*

A. PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT

Total Annual Premium Payments: Year 2000

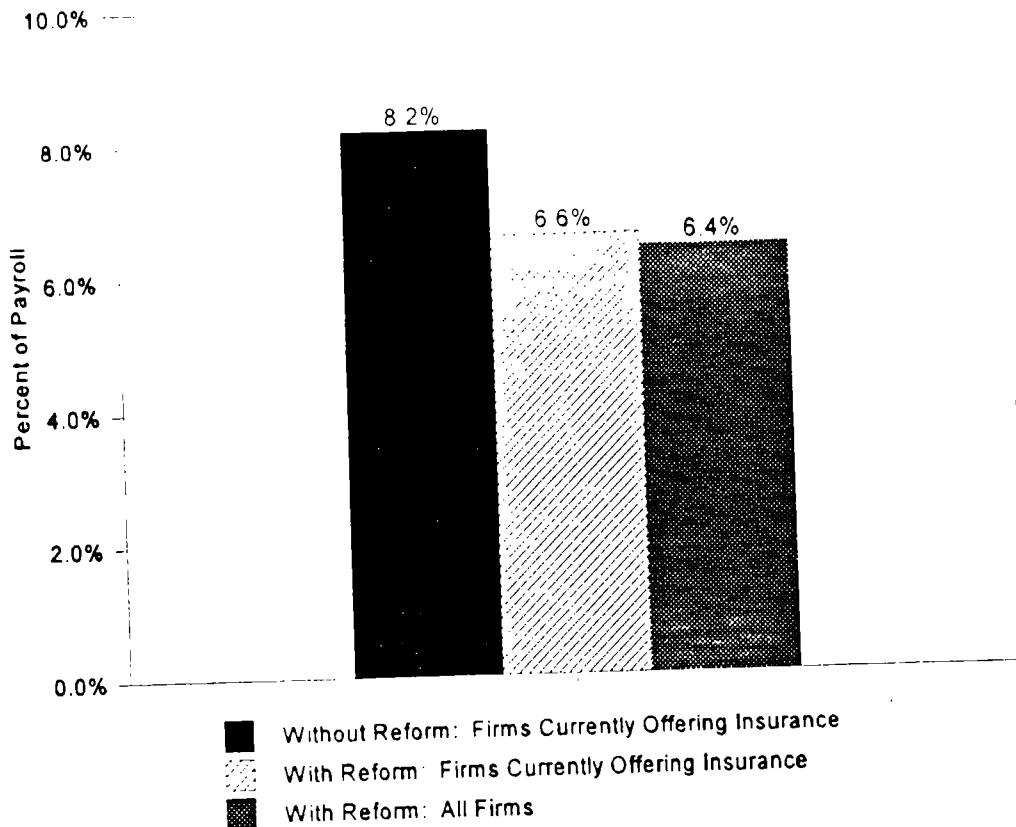


- Without reform, employers who currently offer insurance would pay an estimated total of \$303.5 billion in premiums in the year 2000. Under the Health Security Act, all firms, including those that do not currently offer insurance, will pay \$275.5 billion in premium payments for their employees. Firms that currently offer insurance to their employees will pay an estimated total of \$243.9 billion in premium payments -- \$59.5 billion less than they would pay without comprehensive reform.
- Workers who currently work in firms that offer insurance would pay an estimated total of \$73.6 billion in premium payments in the year 2000 without comprehensive reform. Under the Health Security Act, workers, including those who are not currently covered through firms offering insurance, will pay a total of \$53.7 billion in premiums in the year 2000. Employees in firms that currently offer insurance will pay an estimated total of \$44.7 billion in premiums in the year 2000, almost \$29 billion less than they would without comprehensive reform.

* The Congressional Budget Office (CBO) has produced a higher premium estimate than the Administration's. The CBO also estimates larger employer discounts. On balance, both the CBO and the Administration predict the Health Security Act will reduce business spending compared with current policy by similar amounts. (CBO, *An Analysis of the Administration's Health Proposal*, February 8, 1994, p. 54)

SOURCE: ASPE and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts

PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT **Employer Premium Payments as a Percent of Payroll: Year 2000**

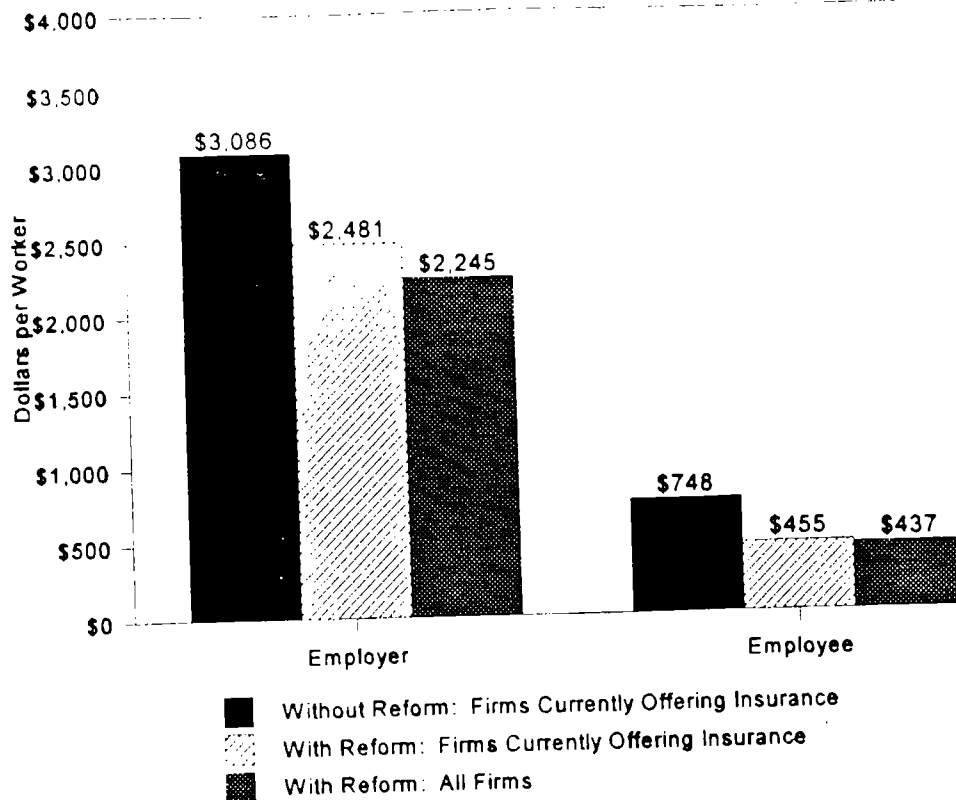


- The Health Security Act will reduce the percent of payroll that employers who currently offer health insurance will spend on premiums from 8.2 percent to 6.6 percent, a reduction of approximately 20 percent due to reforms in the Act.
- In the year 2000, all employers will spend an average of 6.4 percent of their payroll on premiums under the Health Security Act.

NOTE: Numbers may not sum to totals due to rounding.

SOURCE: ASPE and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

PREMIUM PAYMENTS UNDER THE HEALTH SECURITY ACT **Average Annual Premium Payments per Worker: Year 2000**



- For all employers, the average premium payment per worker will be an estimated \$2,245 in the year 2000 under the Health Security Act. Employers that currently offer health insurance will pay an estimated \$2,481 in premium payments for workers -- \$605 less than they would pay if there were no comprehensive reform.
- Under the Health Security Act, workers will pay an average premium share of approximately \$437 in the year 2000. Employees in firms that currently offer insurance will pay on average \$455. This is an estimated \$293 less than they would pay in premiums if there were no comprehensive reform. Savings will be even greater for those workers who currently purchase health insurance directly from insurance companies.

NOTE: Numbers may not sum to totals due to rounding

SOURCE: ASPE and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts

B. DISCOUNTS UNDER THE HEALTH SECURITY ACT

Year 2000

Qualified small and low-wage employers, low-income families, and early retirees will receive an estimated total of \$104 billion in the year 2000 for premium and out-of-pocket payment discounts under the Health Security Act.

- States' residents and businesses will receive an estimated \$81 billion in federal funds for discounts in the year 2000.
- The approximately \$23 billion remaining will come from state funds, a substitute for the \$27.8 billion that states would have paid for services for non-cash Medicaid recipients without reform.

NOTES: The gross and net discount estimates come from HCFA OACT.
Numbers may not sum to totals due to rounding.

SOURCE: ASPE, HCFA OACT, and the Urban Institute's TRIM2 Model, benchmarked to HCFA's National Health Accounts.

V. IMPACT ON THE PUBLIC SECTOR
A. STATES AS EMPLOYERS UNDER THE HEALTH SECURITY ACT

Year 2000

As purchasers of health care coverage for their employees, states will benefit from slower growth in overall health care costs

Federal support of health care for early retirees will produce large savings for state employee health benefits programs. Under the Health Security Act, the federal government will cover the 80 percent employer share of the early state retirees premiums. The state will assume the 20 percent family share.

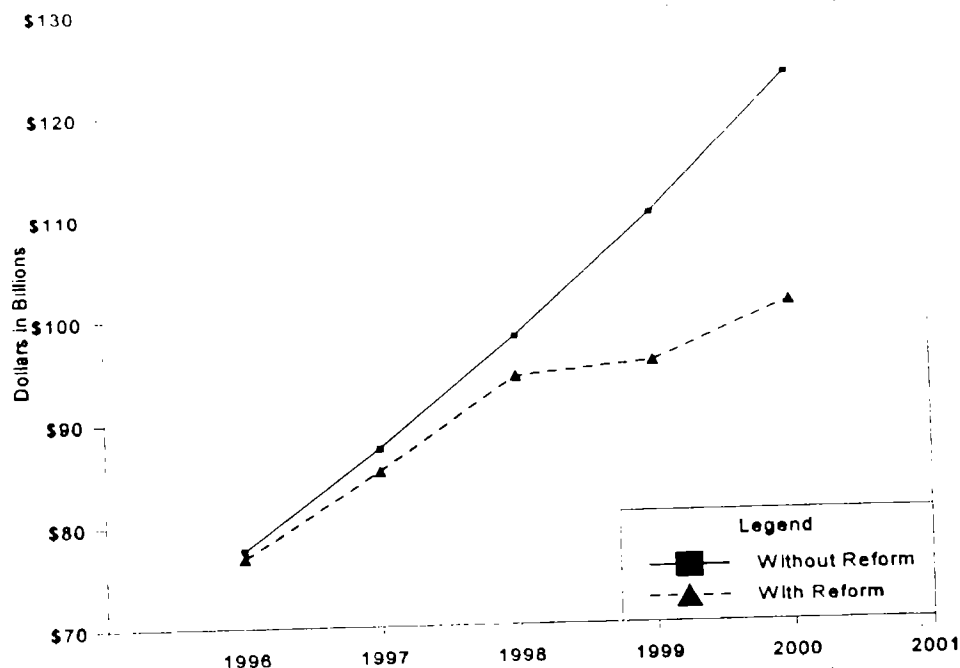
- States will spend an estimated \$10.2 billion on their active employee health benefits in the year 2000 under the Health Security Act. This represents an estimated savings of \$5.6 billion when compared to the estimated spending without reform of \$15.8 billion in the year 2000.
- States as employers will save an estimated \$704 million on its premium spending for retirees between the ages of 55 and 64 years in the year 2000.

NOTES: Estimates are based on a survey of states as employers by the Segal Company (1993), employee workforce and rates from WFEA, and reform premium estimates from The Urban Institute's TRIM2 model.
Coverage for retirees age 65 or older will not change under the Health Security Act.
Numbers may not sum to totals due to rounding.

SOURCE: ASPE

B. STATE MEDICAID SPENDING UNDER THE HEALTH SECURITY ACT

Medicaid Growth: 1996 - 2000 *



- Under the Health Security Act, states save approximately \$43.6 billion between the years 1996 and 2000. These savings will result primarily from the inclusion of Medicaid recipients in regional alliances, where health care costs will not grow as rapidly as in the current system.

NOTES:

*Estimates of the impact of the Health Security Act on all states assume that states implement reform in January of 1996, 1997, or 1998, as specified in the Act.

Please refer to the Key Assumptions listed in the Methods Paper for this report.

Assumes that

States will continue their spending on non-cash adult wrap-around services.

Sources of revenue for Medicaid disproportionate share remain and funds were used for uncompensated care.

Estimated savings will change slightly due to normal baseline revisions which accompany new economic data.

Numbers may not sum to totals due to rounding.

SOURCE: HCFA OACT, OLP and ASPE

STATE MEDICAID SPENDING UNDER THE HEALTH SECURITY ACT
Medicaid Expenditures: 1996 - 2000*

	Dollars in Billions					
	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Total
MEDICAID SPENDING WITHOUT REFORM	\$77.6	\$87.3	\$98.0	\$109.9	\$123.3	\$496.0
HEALTH SECURITY ACT SPENDING	\$76.8	\$85.1	\$94.1	\$95.4	\$101.0	\$452.3
Acute Care Medicaid	\$47.9	\$49.3	\$44.0	\$38.1	\$39.3	\$218.6
Long-Term Care Medicaid	\$27.0	\$29.3	\$32.0	\$34.9	\$38.2	\$161.3
Maintenance of Effort	\$2.0	\$6.5	\$18.1	\$22.4	\$23.4	\$122.4
CHANGE IN STATE MEDICAID SPENDING	(\$0.8)	(\$2.2)	(\$3.9)	(\$14.5)	(\$22.3)	(\$43.6)
CHANGE IN STATE MEDICAID SPENDING LESS COMMUNITY-BASED LONG-TERM CARE SAVINGS	\$0.5	(\$0.2)	(\$1.5)	(\$11.6)	(\$19.0)	(\$31.9)

- Overall, states will save an estimated \$43.6 billion on Medicaid expenditures between 1996 and 2000 under the Health Security Act. An estimated \$31.9 billion in savings results from coverage of Medicaid recipients through the regional alliances and other policy changes under the Health Security Act. The remaining \$11.7 billion in Medicaid savings results from the new community-based long-term care program **
- Medicaid spending on acute care, which includes premium payments for cash assistance recipients and wrap-around services for adults, will be an estimated \$39.3 billion in the year 2000. This will be lower than the acute care spending under the current system because of slower growth of health care costs under the Health Security Act.
- Medicaid spending on long-term care under the Health Security Act will be approximately \$38.2 billion in the year 2000. This includes coverage of institutional long-term care and continuing Medicaid community-based long-term care.
- States will contribute an estimated \$23.4 billion in the year 2000 in maintenance of effort payments that will be used for discounts for their low-income residents and small businesses.

NOTES:

*Estimates of the impact of the Health Security Act on all states assumes that states implement reform in January 1, 1997 or 1998, as specified in the Act.

**Medicaid savings for community-based long-term care reported here differ from community-based long-term care savings reported in Section C because Medicaid savings do not include non-Medicaid (state-only) spending or the new program spending. Please refer to the Key Assumptions listed in the Methods Paper for this report.

Assumes states will continue their current spending level for non-cash adult wrap-around services, current state policies of revenue for Medicaid disproportionate share remain and funds are used for uncompensated care.

Long-term care includes both institutional and community-based long-term care. These estimates include offsets for the new community-based long-term care program (see next section).

Maintenance of effort payments include expenditures for alliance-covered services and disproportionate share for the non-cash population and wrap-around services for cash-eligible children.

Numbers may not sum to totals due to rounding.

SOURCE: HCFA OACT, OLP and ASPE

C. NEW LONG-TERM CARE PROGRAM UNDER THE HEALTH SECURITY ACT
State Expenditures for Community-Based Long-Term Care: 1996 - 2000

	Dollars in Millions					
	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Total
SPENDING WITHOUT REFORM	\$5,199	\$7,694	\$8,314	\$9,208	\$9,949	\$40,363
State Medicaid Spending (1)	\$3,893	\$5,856	\$6,359	\$7,154	\$7,819	\$31,081
State-Only Spending on Severely Disabled (2)	\$1,306	\$1,838	\$1,955	\$2,054	\$2,130	\$9,283
HEALTH SECURITY ACT SPENDING	\$3,764	\$5,786	\$6,601	\$7,756	\$8,870	\$32,878
New Program Spending (3)						
State Spending to Match New Federal Funds	\$869	\$1,504	\$2,106	\$2,804	\$3,551	\$11,835
State Spending to Match Medicaid Transfer	\$276	\$446	\$540	\$645	\$737	\$2,644
State Spending on Continuing Medicaid	\$2,618	\$3,836	\$3,954	\$4,306	\$4,581	\$17,297
CHANGE IN STATE SPENDING ON COMMUNITY-BASED LONG-TERM CARE	(\$1,436)	(\$1,907)	(\$1,713)	(\$1,452)	(\$1,079)	\$1,588

- States will save an estimated \$7.6 billion on community-based long-term care spending under the Health Security Act between 1996 and 2000, \$1.1 billion in the year 2000 alone.
- Without comprehensive reform, states would spend an estimated \$9.9 billion in Medicaid and non-Medicaid (state-only) funds on home health, personal health care services, and home and community-based waivers in the year 2000.
- Under the Health Security Act, federal expenditures for community-based long-term care have two sources: new federal funds and Medicaid offset amounts. States will spend an estimated \$3.6 billion in the year 2000 to match new federal funds appropriated for the new program. Additionally, states will spend approximately \$737 million to match Medicaid offset amounts.
- States will spend an estimated \$4.6 billion in the year 2000 for community-based services that continue to be offered through Medicaid.
- Total savings for states from Medicaid policy changes (\$31.9 billion) and the new community-based long-term care program (\$7.6 billion) will be an estimated \$39.5 billion between 1996 and 2000.*

NOTES

- * This assumes universal coverage in 1997. Medicaid savings will be larger if states adopt universal coverage during 1997. Please refer to the Key Assumptions listed in the Methods Paper for this report.
- (1) Projected Medicaid spending for home health, home and community-based waivers, personal care, frail elderly, and community-supported living arrangements (CSLA).
- (2) Includes estimated spending for persons who are likely to meet the eligibility criteria for the new program.
- (3) Assumes full state participation in the new program. The new program is not fully implemented until FY 2003.
- These net savings include some of the Medicaid program savings presented in Section B (State Medicaid Spending).
- The Medicaid offset estimate reflects more recent data than were available at the time that the FY 1995 Budget was prepared.
- Numbers may not sum to totals due to rounding.

SOURCE: ASPE.

Federal Expenditures for Community-Based Long-Term Care for States 1996 - 2000

	Dollars in Millions					
	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	Total
SPENDING WITHOUT REFORM (1)	\$4,787	\$7,200	\$7,818	\$8,796	\$9,613	\$38,214
HEALTH SECURITY ACT SPENDING	\$9,021	\$14,647	\$18,509	\$23,207	\$28,051	\$73,435
New Program Spending						
New Federal Funds for Program	\$4,500	\$7,800	\$11,000	\$14,700	\$18,100	\$46,100
Estimated Medicaid Transfer (2)	\$1,429	\$2,311	\$2,819	\$3,380	\$3,982	\$13,921
Federal Spending on Continuing Medicaid Community-Based Long-Term Care (3)	\$3,092	\$4,535	\$4,690	\$5,127	\$5,418	\$22,852
CHANGE IN FEDERAL SPENDING ON COMMUNITY-BASED LONG-TERM CARE	\$4,234	\$7,447	\$10,691	\$14,412	\$18,447	\$55,231

- In the absence of comprehensive reform, the federal government would spend an estimated \$9.6 billion in Medicaid funds on home health, personal health care services, and home and community-based waivers in states in the year 2000.
- Under the Health Security Act, states will receive an estimated \$18.7 billion in new federal funds in the year 2000 for the new program for persons with severe disabilities. Additionally, states will receive an estimated \$3.9 billion in federal Medicaid offset amounts to reflect Medicaid savings from the new long-term care program.
- States will receive an estimated \$5.5 billion in the year 2000 in federal Medicaid funds for community-based services that continue to be offered through Medicaid.
- Between 1996 and 2000, federal spending for home and community-based long-term care will increase by an estimated \$55.2 billion under the Health Security Act.

NOTES

Please refer to the Key Assumptions listed in the Methods Paper for this report.

(1) Projected Medicaid spending for home health, home and community-based waivers, personal care, frail elderly, and community-based supported living arrangements (CSLA).

(2) Federal Medicaid spending on persons with severe disabilities who are expected to be transferred to the new program. Assumes that no more than 75 percent of the new program's expenditures will be used for the Medicaid severely disabled program phase-in.

(3) Medicaid with federal matching funds for home and community-based long-term care continues for the non-severely disabled and the severely disabled not served through the new program.

Program is not fully implemented until FY 2003.

The Medicaid offset estimate reflects more recent data than were available at the time that the FY 1995 Budget was prepared.

Numbers may not sum to totals due to rounding.

D. PUBLIC HEALTH INITIATIVES UNDER THE HEALTH SECURITY ACT

Public Health Service Funding for States: 1997 - 2000 (Dollars in Millions)

	1997	1998	1999	2000	TOTAL
NEW PHS FUNDS	\$3,630	\$4,005	\$3,955	\$3,555	\$15,145
Health Services & Workforce Funding (1)	\$2,630	\$2,905	\$2,855	\$2,455	\$10,845
Health Research Funding (2)	\$1,000	\$1,100	\$1,100	\$1,100	\$4,300
OFFSETS	\$1,582	\$2,510	\$2,729	\$2,729	\$9,550
TOTAL FUNDS	\$2,048	\$1,495	\$1,226	\$826	\$5,595

- Between 1997 and 2000, Public Health Initiatives of the Health Security Act will provide the states and its localities with an estimated \$5.6 billion in new funds for its community health centers, training of primary care physicians, core public health functions such as immunizations and disease prevention, and health research, among other programs.
- With universal coverage, payments from health plans will replace (offset) the current Public Health funds for the personal health services, totalling approximately \$9.6 billion between 1997 and 2000.

NOTES:

It is assumed that all states will implement reform in 1997

- (1) Federal funds for Health-Related Services and Workforce are allocated to states based on the state's percentage of the population beneath the poverty level in 1992
- (2) Federal funds for Health Research are allocated to states using proportional distribution based on total FY 1993 AHRQ and NIH funds to each state
- (3) Offsets are allocated to states based on FY 1993 distribution of funds from HRSA, SAMHSA, CDC, IHS, and others

Numbers may not sum to totals due to rounding

SOURCE: OASH, PHS

CBS LETTERS EVENT

JAMES AND MARIANNE MITCHELL

Madison, Connecticut

The Mitchells, age 62, are retired and not yet eligible for Medicare. Because they have no health insurance through their previous employers, Mrs. Mitchell has gone back to work part-time to pay for health insurance. They write that the average insurance costs for people in their age group are between \$7,000 and \$10,000 a year.

This letter details the couples concerns about their reduced Social Security because:

- 1) they withdrew Social Security benefits early to get help with health insurance
- 2) Mrs. Mitchell works part time (for which they pay a penalty).

Likely question:

Will your plan reduce health insurance costs for early retirees?

Answer:

For many working Americans, retiring early can mean confronting the worst of our current insurance system. Insurers charge people more because just they are older, more because they risk getting sick, and more because they are buying insurance on their own and not as part of a big group.

We've got to return insurance to what it used to be, where everyone in a community is charged the same fair price for insurance. Under our approach, early retirees would be guaranteed private health insurance that could never be taken away. They'd have a choice of high quality, private health plans, and when they pick a plan, they'd pay the same price everyone else in that plan pays, regardless of how old they are or whether they've ever been sick.

LINDA LISH

El Dorado Hills, California

Linda is a 51 year old self-employed bookkeeper. Her husband became disabled last year and was unable to return to work. Four months later, the Blue Cross plan he had under his employer was canceled without warning.

They are caught in the middle: the "conversion policy" that Blue Cross offered them would cost approximately \$12,000 a year, far more than they can afford; and they do not qualify for MediCal (California's Medicaid program) because they have more than \$3,000 in assets.

Likely question:

How will people who lose their jobs and their insurance be treated under the Clinton plan?

Answer:

First of all, let me just say that this would not happen under our plan. This kind of thing would never happen again.

As we've traveled around the country, Hillary and I have heard so many stories like this, and it just makes you shake your head at the people who say we don't face a health care crisis in this country.

You and your husband have both worked hard to earn a living and now are at risk of losing everything you've worked for because you have no health insurance. It's just not right. You deserve the security of knowing that your health insurance can never be taken away.

Let me explain how our plan would work for you. You and your husband would pick from a wide choice of private health plans in the area of California where you live. The plans would have different doctors and would have different facilities, but they'd all cover the same set of comprehensive benefits, including good coverage for preventive care, which most plans don't include today.

Once you've picked the plan you want, you'd pay the same fair price everyone else in the plan pays -- you'd never pay more just because your husband is disabled or because you're self-employed. No one could lose their health insurance coverage when they lose their job, and no one, under any circumstances, would ever pay the crazy prices the insurance companies quoted you.

ANN HOAG

Madison, New Jersey

Ann owns a small business with one full time employee and a part-time worker (her daughter). She pays their health insurance in full, which costs her business \$12,000 a year. She is struggling to stay in business, and finds it impossible to save any money because of the high health insurance costs.

Likely question:

Under the Clinton plan, will small businesses be better able to afford insurance for their employees?

Answer:

You know, you're right what you said in your letter: small businesses get a bum rap in today's system. The small businesses that are struggling to provide some coverage to their workers -- which, by the way, is most small businesses -- pay higher prices for the same benefits, and see their prices go up much faster. Less and less of the money small businesses pay insurance companies goes to health care, and more and more of it goes to red tape and bureaucracy.

There's no doubt about it: today's health care system is stacked against small businesses.

Small businesses like yours will be big winners under our approach. Small companies will be able to band together to level the playing field and get the same good rates big businesses get. Small low-wage businesses like yours would also get discounts to help make insurance even more affordable, and rates would go up much more slowly than they have in the past.

Businesses like yours will be able to provide more benefits to their employees, and spend a lot less than you pay now.

HMO ADMINISTRATOR

CBS News chose this person, and has not released any information to us on this individual. All we know is that he will raise whether or not significant saving are achievable without putting everyone in managed care.

Likely question:

How will costs be controlled under the new system if people are allowed to opt out of HMOs and managed care systems?

Answer:

It's true HMOs can save a lot of money, but HMOs aren't for everyone. Controlling costs is certainly an important goal, one we take very seriously, but we aren't about to sacrifice the guarantee of choice.

Americans have a long-standing tradition of picking their own doctor, and I would never support a plan that would take that choice away. Our plan protects the choices people now have and creates new choices for the people now locked into only one plan.

Under our approach, every American would be guaranteed a choice of at least three plans, and at least one of those plan will be a traditional, fee-for-service plan where you go to any doctor you like. I repeat, that choice is guaranteed.

But there are a lot of ways to bring costs down without restricting people's choice. We encourage competition. We put families and small businesses in the drivers seat to give them the same bargaining power to get good prices.

We cut the red tape that is literally choking off billions each year that could be better spent on care.

We're also going to reform malpractice, crack down on fraud, and limit the amount insurance premiums can go up each year to help bring down health care costs.

COMMUNITY DOCTOR

This doctor is an African-American man, also picked by CBS, who works in a community health clinic in Southeast Washington, DC. He shares the concerns of most community health centers about their ability to stay in business under a system based on competition.

Likely question:

How will community health centers be able to survive under the new system?

Answer:

Community Health Centers have a proud tradition of reaching out and serving communities with little or no access to good medical care, and for seeing and serving all patients, regardless of their ability to pay. But many community health centers are literally struggling to keep their doors open in the wake of rising health care costs and a growing number of uninsured patients.

We need to keep community health centers at the core of health care delivery in the areas where they work well today, and our approach does that.

First and foremost our plan guarantees private insurance to all Americans, so the people who walk through your doors will carry insurance cards in their pockets that will mean payment for your center.

New community health centers will be developed, and others will be expanded or upgraded. More doctors will be available, because the plan will provide encourage medical students to become primary care doctors, and will provide incentives for health care professionals to work in underserved areas.

Our goal is to fix what's wrong while preserving what works: community health centers work, and they'll continue to play an important role under reform.

September 30, 1993

Mrs. Hillary Clinton
The White House
Washington DC 20500

Re: Health Care Reform

Dear Mrs. Clinton:

I want to voice my frustration and concern regarding health care costs for those of us who are retired, have no health insurance and are not yet eligible to receive Medicare.

The average cost of health insurance that a couple must pay out of pocket ranges from \$7,000 to \$10,000 per year! We are 62 years of age. In order to pay health insurance my wife is working part-time with no benefits. We have also taken early social security to help meet these costs.

We are being penalized by the government every way we turn:

- 1) By taking early social security our benefits are reduced.
- 2) Because my wife is working our social security benefits are further reduced if her income exceeds \$7500.
- 3) If our total yearly income exceeds \$45,000 we are further taxed -- to a greater extent than any other age category, just at a time when we must pay excessive health care insurance premiums.

One would think the government would encourage, rather than discourage those attempting to meet these costs.

We hope the proposed National Health Plan will address this problem and not penalize us even further.

Why isn't tort reform implemented? Billions of dollars could be saved for health care reform if this situation were remedied!

Sincerely,

Jim & Marianne Mitchell

James & Marianne Mitchell
57 River Edge Farms Rd.
Madison, Ct. 06443

cc: Sen. Joseph Lieberman
Sen. Christopher Dodd

203 245 0024

*Linda J. Lish**Health Reform
Multi State*

Accounting & Tax Services
(916) 933-0207 • Fax 933-2448

4993 Golden Foothill Prkwy #6
El Dorado Hills, CA 95762

September 30, 1993

Office of The First Lady
Mrs. Hilary Clinton
1600 Pennsylvania Ave. N.W.
Washington, D.C. 20500

Dear Mrs. Clinton:

My husband has been off work on disability since May 2, 1993. He is a machinist and cannot go back to work for a long time, if ever. On September 1, 93 he received a telegram from his employer stating that he was no longer a participant for medical coverage. The medical coverage is Blue Cross. He has been with his employer for 9 years - worked many long hours without breaks, even would work days straight in order to get the work out for his employer. A very loyal employee. Not once has his employer called to see how he was doing.

I spoke to several people that seemed to think that his employer couldn't do that. I inquired at the Insurance Commissioners office and was advised that Blue Cross is not governed by the Insurance Commissioners office. I called Blue Cross and was told that the contract reads that if an employee is unavailable for work for 3 months or more the employer has the right to cancel the medical coverage. They also advised that a "conversion package" was being sent out to us to convert our plan to an individual plan.

I received the plan today and have attached copies. Please note the cost of the conversion will be \$2,999/97 per quarter, that equals \$11,999.88 per year! Now, to some people this probably isn't much and they would pay, although no matter how much money I had I feel this is ludicrous! I would really like to know how they arrived at their rates. When I called them no one could answer me. Of course if we had a lot of money I guess we wouldn't have to worry about this.

Linda J. Lish

Accounting & Tax Services
(916) 933-0207 • Fax 933-2448

Page 2

In the meantime we have no medical coverage. My age is 51 and my husbands age is 58. We own a nice small home in the Sacramento Foothills, we are educated, good citizens, and good residents of our community. I am self employed in a bookkeeping and tax service. My little business is just now getting on its feet and thank God because it is keeping us "afloat" for the time being. We have absolutely no allowance for \$999.99/month for medical coverage.

I am in the process of applying for Medi Cal, but I have heard that if you have more than \$3,000 in assets, which we have, we will not be eligible.

I guess the reason why I am writing this is to "blow off steam" because I fully realize you cannot do anything about our situation. But also to show you another example of how Americas health system is so unfair to the people.

I did listen to President Clintons speech and would support the plan he wants to institute. But these plan take time to get into force and time is running out. Meanwhile, there are hundreds of thousands of persons with a similar situation as ours and probably thousands with more serious life threatening situations.

For 15 years we lived in the British Columbia, Canada interior and the medical coverage cost us \$43/month for a family of 5! We received excellent care and did not abuse the program. Hospital coverage cost us \$2.00 per day, no fee to the doctor for visits, and we had to pay full price for prescription drugs.

I would be more than happy to pay a "co pay" to the doctor or hospital and not have to lose our home and life to "medical bills".

Thank you for taking the time to read my letter.

Respectfully,

Linda J. Lish

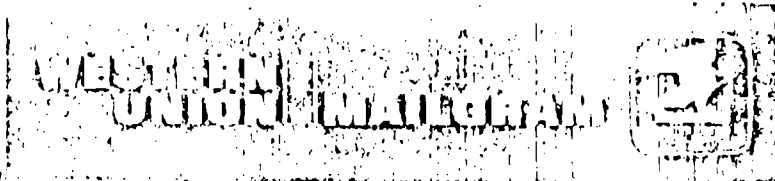
Linda J. Lish
Lawrence E. Lish
El Dorado Hills, CA

FEB-28-94 MON 14:31
WESTERN UNION
5205 HILL STREET
RENO, NV 89502

CBS WASHINGTON

FAX NO. 2026592587

P.05



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SCAA

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LAWRENCE E LISH, 9169335523
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3025 SPRINGBURN WY
EL DORADO HILLS CA 95623

THIS IS TO NOTIFY YOU AS OF TODAYS DATE, STEWART TOOL COMPANY NO
LONGER CARRIES YOU AS A PARTICIPANT FOR MEDICAL COVERAGES ON OUR
BLUE CROSS POLICY.
RESPECTFULLY,

RICHARD G STEWART

1620 EST

14959

21:09 EST

MGMCOMP

Rec'd 9/2/93

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. insurance statement	Personally Identifiable Information (1 page)	12/01/1993	b(6)

COLLECTION:

Clinton Presidential Records
Communications
Mark Gearan
OA/Box Number: 3536

FOLDER TITLE:

Health Care [Folder 3] [3]

2011-0584-F
jm1501

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

Freedom of Information Act - [5 U.S.C. 552(b)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or
financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President
and his advisors, or between such advisors [(a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of
personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed
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PRM. Personal record misfile defined in accordance with 44 U.S.C.
2201(3).

RR. Document will be reviewed upon request.

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of
an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial
information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of
personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement
purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of
financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information
concerning wells [(b)(9) of the FOIA]

Blue Cross
of California



Consumer Services Group

Mailing Address:
P.O. Box 6666
Oxnard, CA 93031-6666

Dear Member:

Although your former health plan coverage is no longer available to you, you can have continuous protection through our Group Conversion Plan. Please read the descriptive brochure carefully, so that you will understand the Group Conversion Plan benefits and other options available.

You have been billed for Major Conversion 200. If you elect to remain in this Plan, fill out the Membership Enrollment Form on the reverse side of this letter. Return to us (a) the Membership Enrollment Form, (b) your payment, and (c) the billing, so they will reach this office no later than the "payment due" date shown on the billing. Please use the enclosed envelope.

Changing Conversion Plan Options:

If you select a Conversion Plan other than the Plan you've been billed for, simply cross out the amount due on the billing and write in the correct amount. Complete the Membership Enrollment Form on the reverse side of this letter. Return to us (a) the Membership Enrollment Form, (b) your payment, and (c) the corrected billing, so they reach this office no later than the "payment due" date shown on the billing. Please use the enclosed envelope.

Alternative Coverage

If you can pass medical underwriting requirements, you may qualify for our Personal Prudent Buyer Plan[®] which costs significantly less than group conversion and provides more extensive benefits. If you think you can qualify, please phone your agent or phone us toll free at 1-800-678-6777 for more information.

To be absolutely sure of continuous coverage, you must apply and pay for the group conversion. Your coverage can be changed later if you qualify for the Personal Prudent Buyer Plan[®].

We look forward to continuing to serve you.

Cordially yours,

David L. Ludwig
Vice President, Sales
Consumer Services Group

THIS IS A SOLICITATION FOR THE ORDER OF GOODS OR SERVICES, AND YOU ARE UNDER NO OBLIGATION TO MAKE PAYMENT UNLESS YOU ACCEPT THE OFFER CONTAINED HEREIN.



ANN HOAG

Rolf's Office Machine Repair, Maintenance and Sales

Madison, New Jersey 07490

210-822-1243

She will pay \$12,000 for health insurance for her husband, herself and one full-time employee. One of her daughters works at the store part-time and requires an extra policy because she is 19. She is happy to say that she pays for her employee's health insurance in full. Health insurance is quickly becoming unaffordable for them. She very much wants to give her employee a raise, yet cannot due to high costs of health insurance.

She has changed insurance carriers, but states that "most of them don't want small businesses and the ones that do are outrageously high." She writes that: "Small business owners get a bum rap. In order to pay for health insurance, we have to raise our deductible much higher than people who work in large companies.....I hope you come up with some reforms that will help working people. People who own businesses are not rich people. Just look up and down Main Street and see how many stores are closed. Small businesses need help, especially with health insurance."



Rolf's Office Machine Repair, Maintenance and Sales

4 LINCOLN PLACE - P.O. BOX 182 - MADISON NEW JERSEY 07940 (201) 822-1243 - FAX (201) 966-9690

March 18, 1993

Ms. Hillary Rodham Clinton
The White House
Pennsylvania Avenue
Washington, D. C.

Dear Mrs. Clinton:

I wrote to President Clinton three times already, and now since you are in charge of the health insurance issue, I am writing to you.

This year we will be paying \$12,000 for health insurance. We have one full time employee and one of my daughters works here part time. We pay for our employee's insurance in full and we have to have an extra policy for my daughter since she's 19. Our health insurance is unaffordable. We have a small business here and have been struggling since 1990 to stay in business. Between taxes and this health insurance bill, we can't save very much. Sometimes I look in our business checkbook and cringe.

We have changed health insurance carriers, but most of them don't want small businesses and the ones that do are outrageously high. There should be insurance pools where small businesses or individuals can buy insurance at lower rates, just as big businesses do. Small business owners get a bum rap. We can only deduct 25% of this big health insurance bill off our income tax for our family. In order to pay for health insurance, we have to raise our deductible much higher than people who work in large companies. For all we pay, if we get sick there are big out-of-pocket expenses.

I hope you will come up with some reforms that will help working people. As I wrote to President Clinton, people who own businesses are not rich people. Just look up and down Main Street and see how many stores are closed. Small businesses need help, especially with health insurance.

Sincerely yours,

Ann Hoag
Ann Hoag