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Response to Question from Senator Kennedy

- (a) *How do you respond to critics who say your cost estimates are not accurate, the Medicare and Medicaid cuts are too deep and harm seniors and the poor, the cost control targets you have set are so tight that they will result in rationing and lower quality care?*

Medicare

Medicare savings must be viewed in the context of overall health reform.

Without overall health policy reform we would oppose savings of this magnitude, because there would be no way to protect Medicare beneficiaries from serious risks of benefit reductions.

During the budget debate the Administration opposed an "entitlement cap" for this very reason. The cap would have forced reductions in the Medicare program -- whether or not we accomplish overall health care reform controlling private sector health care costs -- and whether or not beneficiaries could be protected.

Health care reform will protect against two factors which now make it difficult to contain Medicare costs without hurting beneficiaries: cost shifting that results from uncompensated care and price pressures arising from the difference between private and public reimbursement rates.

The health plan will not reduce Medicare spending. It will only slow the rate of growth from three times inflation to twice inflation. In the context of universal coverage and corresponding private sector cost restraint, there is no reason why this reduction in the rate of growth should harm beneficiaries.

In contrast to other proposals, the Administration only supports Medicare savings of this magnitude in the context of health reform.

43 Senators voted for the entitlement cap without a corresponding cap in private health care costs, and without any assurances about the impact on Medicare beneficiaries.

Other health care proposals call for Medicare savings comparable to or greater than ours, but fail to meet the critical test of protecting beneficiaries because they fail to provide universal coverage or to control private health care spending.

The Chafee/Dole plan, in contrast, would result in comparable Medicare savings [\$111 billion]. However, the Chafee/Dole plan would not guarantee cost controls in the private health care system and it would not guarantee universal coverage or expanded Medicare benefits.

Reform and Competition will reduce Medicare costs.

Competitive forces will reduce the cost of health care for people over 65 as well as for people under 65. With cost differentials of 300 percent between Miami and Wisconsin, there is much room for savings from competition.

Streamlined administrative procedures will reduce the costs to providers of caring for Medicare patients.

Medicare savings will be used to provide new Medicare benefits.

Savings from Medicare will be used to finance prescription drug benefits and long-term care benefits for Medicare recipients.

Medicaid and Low-income Issues

The plan is designed to *improve* the quality of care available to low income participants.

Medicaid patients today have limited choices -- their choices are limited to providers who agree to accept Medicaid reimbursement. I think we would agree that in many cases, the choices today are not what we would like them to be.

Under the health plan, all Medicaid participants will be guaranteed comprehensive coverage through plans in their regional alliance. However, low income participants will no longer bear the stigma of being in a separate health care system. Simply integrating low income people into the broader health care system will provide many with better choices than they have today.

Low income participants will not face "redlining" which would force them into plans that cover only low income people. The plan will assure that boundaries are not drawn in a discriminatory manner and that plans are open to a broad range of participants.

Essential provider provisions will further assure that assistance is targeted to underserved areas.

Rationing

We are rationing today: people who have insurance get more and better treatment than the uninsured.

By reducing waste in the system we are confident that we can assure quality while providing a comprehensive benefit.

Care decisions will be made by doctors -- if care is medically necessary it is covered.

SENATOR TED KENNEDY

c. **How will your plan assure Americans that they will always be able to choose their doctor and hospital and that their care will be of the highest quality?**

- Choice is a critical part of every doctor-patient relationship. That's why we're making sure that everyone has a choice of plan and a choice to remain with their doctor.
- If you want to stay with your doctor or hospital, you could choose the plan they signed up with. But, you'll also have a wider choice of plans -- from fee-for-service to preferred provider organizations to health maintenance organizations.
- Our doctors and hospitals deliver some of the highest-quality care in the world today. They do this in spite of the flood of paper and forms, and rules and regulations they have to wade through every time they try to treat a patient. We're stripping away the hassle in delivering care -- freeing up doctors and nurses and other health care workers to spend more time caring for their patients instead of worrying about crossing t's and dotting i's on forms for insurers.
- Patients will have an increased voice in ensuring that doctors and hospitals meet quality standards. Public accountability is one of the strongest motivators I know of to make sure that the job gets done right. That's what the report cards will do.
- Finally, we're investing more to find out what treatments really do work. Medicine is an art -- even though most people think it's a science. So much is unknown in what's practiced today, and sometimes the treatments are not always in the best interest of the patient. We need to take more of the guesswork out of medicine.

Senator Metzenbaum

2) Q. How will the President's proposal protect consumers against insurance company predatory practices, excessive administrative costs, and high prices?

A.

- Insurance companies will have to compete based on the same benefit package, and the same requirements, not only against each other but against others who form health plans.

- The current way insurance companies make money, by not insuring those who get sick, will be eliminated. Must insure those who choose the plan.

- No limitations on preexisting conditions.

- The excessive administrative costs are caused by marketing to healthy groups only -- that will be gone.

Senator Metzenbaum

D. Q. How will consumers be represented and protected?

A.

- They will run the health alliances -- one-half the members of the board must be consumers.

- They will choose the health plans they want from all the health plans in the alliance, based on quality and price.

- They will have complete and informative data on health plans and providers.

Senator Metzenbaum

Q. How will we assure that state regulations implementing Federal consumer protections are adequate?

A. • The rules about alliance representation, consumer information, quality, performance of plans, and price are all required under the law. A state must make sure they are adequate.

• Without heavy-handed federal regulation, the alliances are designed to protect consumers. They are consumer controlled to get the best health care at the best price.

• It is the forces of competition that will protect consumers; but there are safeguards. Discrimination is specifically forbidden.

• We have essential provider status for communities with particular needs, like urban and rural areas.

SENATOR HOWARD METZENBAUM

d. How will excessive drug prices be controlled?

- Prescription drug cost containment is one of the most difficult issues that we had to deal. Our goal has to find a way to contain costs while assuring adequate incentives for research and development. A number of Members believe we have been overly harsh with the drug industry and a number of others fear we have not been tough enough.
- **In the private sector**, after years of skyrocketing health care costs, health care plans -- particularly hospitals, HMOs, PPOs and other managed care plans -- have used purchasing mechanisms (such as formularies) to assure that the most appropriate and cost effective medications are prescribed and dispensed. In most cases, these techniques have been quite successful in finally containing costs.
- We will build on the success of these purchasers as we are reorienting the entire health care system towards true competition. However, like you, we remain concerned about the costs of breakthrough drugs -- medications that have no therapeutic alternatives with which purchasers can compete.
- To address this issue, as part of our National Health Board, we propose the establishment of a Breakthrough Drug Committee. This body will review new drug costs and have the authority to make public declarations about excessive drug prices. We believe this body will provide crucial information to both public and private purchasers that strengthen their bargaining hands, without regulating prices.
- **For the public sector**, by now being the largest single purchaser of prescription drugs, we believe the Medicare program should have access to a reasonable discount of between 15 and 17 percent. To protect the trust fund from an abnormally high priced new drug, the Secretary of Health and Human Services is given the discretion to negotiate with the manufacturer of the drug. If the company does not negotiate, Medicare does not have to cover the drug -- an option private sector purchasers make today. (Congress already gave her this authority earlier this year within the immunization provisions of the reconciliation bill.)

Dodd

a.

Q: How will you assure that small businesses can afford the program?

A: We have taken a number of specific steps aimed at making health care coverage affordable to even our smallest businesses.

The plan will offer significant discounts to help the small firms who are getting killed by rising costs. For the two-thirds of small businesses who can still afford to cover their workers today, this plan will very likely lower their costs.

How?

First, it will give small businesses discounts of up to 80% off of health care premiums, by capping the amount they have to pay.

Second, by pooling small businesses together to increase their bargaining clout and allow them to get the same good rates large businesses get.

Third, it will drastically reduce the administrative overhead costs that eat up nearly half of the premiums small businesses pay today. In the new system, small business contributions will go to health care, not to administrative waste.

Fourth, it will limit the amount health care premiums rise every year, protecting businesses from the huge cost increases they face year after year.

Fifth, it will increase the tax deductibility for self-employed businesses from 25% to 100%, making health care expenses fully deductible.

And finally, it will integrate the health portion of worker's compensation insurance over time, so that employers don't end up paying twice for health coverage.

Dodd

b.

Q: How will your program provide the health care children need?

A: This is a very important question, because too many children go without needed health care today:

- 30% of all children under two have not been immunized against preventable childhood disease. In many inner cities, that figure is 50%.
- One in five American children had no contact with a doctor in 1992.

This plan guarantees all American children comprehensive health care benefits, and provides unprecedented coverage of the primary and preventive services so vital to keeping children healthy.

All benefits package includes prenatal care, immunizations, regular checkups and well-baby visits, vision and hearing care, and preventive dental care for children.

Dodd

C.

Q: How do you respond to the criticism that premium caps won't work and don't get at the real cost problem?

- we don't think caps will come into effect, competition will bring prices below caps-- they are backstop
- mechanism already in place-- insurance premiums are regulated today
- easier and less regulatory than alternative approaches such as setting doctor and hospital fees
- same approach as advocated in bi-partisan legislation put forth by Kassebaum/Glickman

SENATOR PAUL SIMON

- a. **What are you going to do with regard to drug pricing and will it harm research?**

(FOR DETAILS OF SUBSTANCE OF POLICY, PLEASE REFER TO ANSWER TO SENATOR METZENBAUM'S SIMILAR QUESTION).

- With regard to research, we believe we have developed a policy that balances the need to expand access, contain costs, and retain incentives for research. Having said this, there are strong feelings on all sides of this issue.
- We welcome suggestions from all parties. In recent days, some representatives of the industry have suggested that they would like to suggest language on how best to evaluate drug cost effectiveness. They point out that some drug prices, although seemingly expensive, are much less costly than alternative treatment options.
- We look forward to receiving specific suggestions from the pharmaceutical industry, as well as advocates for consumers, businesses, insurers, and other interested parties.

SENATOR PAUL SIMON

b. Explain what your plan will do to get primary care providers into rural areas.

- Right now two-thirds of rural counties do not have enough doctors. It's no wonder. Rural areas have a higher proportion of uninsured people than the rest of the nation. Rural doctors provide more charity care than any doctors in the country, and they often get paid late. In many cases rural doctors can't take a day off because there isn't another doctor for miles around.
- With universal coverage, rural doctors will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural practice.
- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.
- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers

SENATOR PAUL SIMON

- c. **How will Federally Qualified Health Centers be protected and people be assured of their services? (Federally Qualified Health Centers are organizations like community health centers that now get cost reimbursement under Medicaid and Medicare.)**
- For many in urban and rural areas, federally qualified health centers, community and migrant health centers provide the only access to health care services today. They play a critical role that we want to preserve.
 - Under reform, health plans will contract with "essential community providers" so that all Americans -- regardless of where they live, what their income is, or what race or ethnicity -- will be guaranteed access to quality care.
 - And, because everyone will be covered under our proposal, the patients that come to these clinics will now be paying patients -- at the same reimbursement rate as everyone else. This will provide a substantial boost in funding for these centers.
 - Finally, we're increasing funding so that these centers can link up with other clinics in their area and with centers of excellence so that they can build their own community-based plans.

SENATOR TOM HARKIN

- a. **Rural areas have historically had low spending. Does the budget lock in current inequities.**
- Coming from Arkansas, there are few people more sensitive to this issue than the President and me.
 - Because we do not yet have the ability to fairly and equitably level the playing field among states, our budget allocations are based on historic spending patterns.
 - However, we direct the National Health Board to initiate a study to the Congress and the Administration that is charged with developing a formula that brings states spending closer together. In recent weeks, a number of Members have suggested that we have a very specific reporting date and timeframe for action on this issue. We are looking at these suggestions very closely as we modify our plan.

SENATOR TOM HARKIN

b. What will be the impact of Medicare cuts on rural providers?

- Rural areas have a much higher proportion of elderly residents than other areas of the country. As a result Medicare payments are an important source of income for the doctors and hospitals that serve these areas.
- If you were to look at the savings we are proposing to Medicare, in isolation, rural providers would have every right to be concerned. But you need to view this in the overall framework of the reform we are proposing.
- Rural doctors and hospitals will benefit enormously from the predictable payments that will result from all their patients having comprehensive insurance coverage.
- Some of the savings to the Medicare program will come from working beneficiaries who will now get coverage through their employers rather than through Medicare.
- Other savings to Medicare will come as we slow the overall growth in both public and private health care spending. These savings are not cuts in current levels of spending but reductions in the projected increases in Medicare spending.
- These savings are realistic and achievable without harming doctors, hospitals or patients.

Harkin
C.

Q: The plan calls for periodic exams. Will you follow the recommendations of the U.S. Preventive Services Task Force?

A: Yes, our plan has adopted the periodicity between screenings and other preventive health services recommended by the U.S. Preventive Services Task Force.

All the services prescribed in this table will be provided, at these recommended intervals, free of charge-- no co-payments, no deductibles.

SENATOR TOM HARKIN

d. Shouldn't your public health programs and medical research have a guaranteed source of funding?

- Over the course of this century we have seen that vast gains in the health of people worldwide from breakthroughs in medical research.
- As a leader in the Congress in this area, you well know that medical research and public health initiatives pay great dividends and are among the most cost-effective health care investments we can make.
- Your proposal to establish a medical research trust fund paid for from a portion of health premiums is a thoughtful and innovative approach to assuring a steady funding stream for these important efforts. I look forward to continuing to work with you on this issue.

SENATOR HARRIS WOFFORD

- b. **What is the realistic timeframe for the paperwork reductions and administrative simplifications your plan proposes?**
- Some of the reductions we're proposing can happen almost immediately. Take the Medicare program -- one of the things I've heard hospital administrators complain most about is having to chase down doctors to get them to sign off on bills before they go out. That can hold up payment for days. I'll give you an example of what I mean -- the Lakeland Regional Medical Center in Florida estimates that this paper chase costs them \$100,000 in personnel and supply costs alone. We can do this and look at other ways to streamline Medicare immediately.
 - For the system-wide paperwork reductions, they'll be phased in as states get their systems up and running.
 - And, even once the system is in place, we'll be continuously looking for ways to reduce the "hassle factor" for doctors, nurses and other health care workers. If you have any suggestions for how we can peel off the layers of paperwork, we'd welcome your input.

Senator Wofford

C. Q. How will workers compensation be integrated into the new health care system?

A.

- Health plans will deliver the health care for any injuries that are job related.

- We will retain workers compensation insurance under the state systems, but the employer or workers compensation insurer will make payments directly to the health plans.

- The health plans will be required to have available the services that are necessary for treatment of work-related injuries, like long-term rehabilitation.

- A Commission will study what further integration of the health component of workers compensation we can accomplish.

- The existing system of workers compensation has an important incentive -- those with a safe workplace pay less than those with a lot of injuries. We need to maintain that incentive.

SENATOR HARRIS WOFFORD

d. How will your program affect low-income senior citizens?

- Low-income seniors will benefit under the Health Security Plan in two ways: through a new prescription drug benefit and home and community-based long-term care services.
- For 3 out of 4 elderly Americans, the greatest out-of-pocket cost is prescription drugs. The vast majority of these low-income elderly have no insurance whatsoever against the cost of prescription drugs. Today, over 8 million elderly have to choose between food and medicine. We think this is a crime. By covering prescription drugs and making them affordable, this choice will no longer have to be made.
- The greatest fears of older Americans are that they will have to spend down their hard-earned savings in order to qualify for any long-term care coverage. And, the coverage they get is usually for the type of care they do not want -- nursing home care. The Health Security Plan provides for more cost-effective, humane and desirable home and community-based care that preserves and protects not only older Americans' incomes and savings but their dignity as well.

Mikulski
b.

Q: Some small businesses may have difficulty under your plan. How will you assure that the program is affordable for them?

A: We have taken a number of specific steps aimed at making health care coverage affordable to even our smallest businesses.

The plan will offer significant discounts to help the small firms who are getting killed by rising costs. For the two-thirds of small businesses who can still afford to cover their workers today, this plan will very likely lower their costs.

How?

First, it will give small businesses discounts of up to 80% off of health care premiums, by capping the amount they have to pay.

Second, by pooling small businesses together to increase their bargaining clout and allow them to get the same good rates large businesses get.

Third, it will drastically reduce the administrative overhead costs that eat up nearly half of the premiums small businesses pay today. In the new system, small business contributions will go to health care, not to administrative waste.

Fourth, it will limit the amount health care premiums rise every year, protecting businesses from the huge cost increases they face year after year.

Fifth, it will increase the tax deductibility for self-employed businesses from 25% to 100%, making health care expenses fully deductible.

And finally, it will integrate the health portion of worker's compensation insurance over time, so that employers don't end up paying twice for health coverage.

SENATOR BARBARA MIKULSKI

- a. How will your plan assure that alternate providers (e.g. nurse practitioners) will be allowed to fully participate in delivering services?**
- In a country that trains too many specialists and not enough primary care providers, we cannot afford to waste a resource as valuable as advance practice nurses.
 - Nurse practitioners, nurse midwives and physicians assistants, along with primary care doctors, are at the center of our efforts to emphasize primary and preventive care.
 - Our plan will work to remove inappropriate practice barriers so that all health professionals can work to the full scope of their training.

Mikulski
C.

Q: How will your plan solve the terribly important problem of long-term care?

- growing elderly population, this is a problem that won't be solved overnight
- this plan takes significant steps toward extending availability and affordability of long-term care for seniors
- creates new federal home care program, providing home and community-based care to elderly and disabled
- adds a drug benefit to the Medicare program, lifting a major financial burden off of the backs of many seniors
- strengthens protections for nursing home recipients

Mikulski

d.

Q: What will your program do for women's health?

- unlinks access to health care from employment status, health status, marital status
- offers full coverage of primary and preventive care for women such as pre- and post-natal care, mammograms, Pap smears, cholesterol screenings, etc.
- directs new research funds into illnesses that strike primarily women, such as breast cancer, redressing the lack of research attention that has been paid to women's health problems in the past
- offers broad coverage for children and new benefits for seniors, helping ease the caregiving burden on American women today

Response to Senator Bingaman

- a. *Alain Enthoven says that by not capping the exclusion from income of employer paid health insurance premiums at the level of the lowest price plan you have reduced the effectiveness of your cost containment program.*

Taxing health benefits hurts the middle class

We looked at the possibility of taxing health insurance, but concluded that it was the wrong way to pay for health care reform. According to the Treasury Department, if our plan taxed all premiums over the average, it would raise taxes for over 35 million working Americans a year. We rejected this idea because we think it would be wrong to raise taxes on middle class working Americans.

Taxing health insurance will not bring us health security. It would only result in a bigger tax burden on the middle class. Health care reform must control costs without creating new or hidden taxes on the middle class. Taxing health benefits is just that -- a new tax on the middle class.

During the last two decades most Americans have seen little or no growth in wages. Many working Americans have traded higher wages for health insurance.

Under the Clinton health reform plan, comprehensive health insurance will not be taxed -- now or in the future. Only insurance coverage *over and above comprehensive insurance* will be subject to any tax, and this will not apply to anyone now covered by a collective bargaining agreement for many years.

Other health reform plans would tax all or some of the employer contributions for basic health insurance, without requiring universal coverage through employer contributions. This is wrong for several reasons:

If the cost for employers to provide health insurance goes up, fewer employers will provide health insurance.

If basic health benefits are taxed at the individual level, it will increase middle class taxes by taxing the only portion of their income that has seen any growth over the past two decades.

SENATOR JEFF BINGAMAN

b. How will your program assure an adequate supply of primary care providers and get them into rural areas.

- Right now two-thirds of rural counties do not have enough doctors. It's no wonder. Rural areas have a higher proportion of uninsured people than the rest of the nation. Rural doctors provide more charity care than any doctors in the country, and they often get paid late. In many cases rural doctors can't take a day off because there isn't another doctor for miles around.
- With universal coverage, rural doctors will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural practice.
- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.
- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers

SENATOR PAUL WELLSTONE

a. How will your plan protect the poor and middle class in view of the high co-payment and deductible requirements even for HMO-type plans?

- For HMOs, there are no deductibles, but some advocates have raised concerns about the \$10 co-payment per service requirement.
- For the lowest income of our nation, (150 percent of poverty or less), the Health Security Plan picks up all or most of this vulnerable population's premiums and co-payments. We believe this is an important protection for the low income of our nation.
- However, some still believe that the co-payment is too high for some lower middle income class individuals. We believe this is a legitimate concern and would like to work with you and others to evaluate options to address it.

SENATOR PAUL WELLSTONE

b. Won't we have two-class medicine, with only the upper-incomes able to afford fee for service?

- We believe that in the reformed health care delivery system that it is very possible that fee-for-service plans will be competitive with managed care options.
- With the operation of market forces, Doctors and hospitals that wish to assure the success of the fee-for-service plan will find a way to keep costs down so and such a plan can be offered at prices competitive with HMOs and PPOs.
- However, in response to feedback we have received from your office and a number of others, we are considering of providing for some kind of point-of-service option for closed model HMOs plan.

Senator Kassebaum

A, Q. How will workers compensation be integrated into the new health care system?

A.

- Health plans will deliver the health care for any injuries that are job related.

- We will retain workers compensation insurance under the state systems, but the employer or workers compensation insurer will make payments directly to the health plans.

- The health plans will be required to have available the services that are necessary for treatment of work-related injuries, like long-term rehabilitation.

- A Commission will study what further integration of the health component of workers compensation we can accomplish.

- The existing system of workers compensation has an important incentive -- those with a safe workplace pay less than those with a lot of injuries. We need to maintain that incentive.

SENATOR KASSEBAUM

B. 1) On experimental procedures, who will make the decision, and based on what criteria?

- Our doctors and hospitals deliver the highest-quality care in the world. That's because we have long encouraged research into new cures and treatments for diseases.
- We'll continue to encourage innovation, but we want to also ensure that patients are protected from both the costs and the dangers of experimental procedures that are unsafe.
- Approved research trials achieve both goals -- they advance medicine and lead to new cures and treatments, but they're also safe. The comprehensive benefits package covers the routine medical costs for patients whose treatment is part of a research trial. So, if your child needs a bone marrow transplant and that's approved, your child will have the benefits of the best that science has to offer and you will have the comfort in knowing that your child is in safe hands.
- The National Health Board will have the authority to add new procedures to the covered benefits as they as proven safe and effective.

SENATOR NANCY LANDON KASSEBAUM

C. How can we assure our constituencies that savings will be there and cover new spending?

- Our plan lays out specific line item savings. They have been scored by the Office of Management and Budget and they will be scored by the Congressional Budget Office.
- Let me also say that over the last eight months, I have talked to hundreds of people involved at all levels of our health care delivery system. I have heard stories about waste and inefficiency to numerous to mention. I have also heard success stories where doctors and hospitals are working to hold cost down, far below the national average.
- We must and we can spend our health care dollars more wisely.

DIETARY SUPPLEMENTS

SENATOR HATCH:

I would like to ask you a question about Dietary Supplements. Millions of people have found vitamins, minerals, herbs and other supplements to be essential to protect their health. Yet these consumers are concerned that the Food and Drug Administration is going to take away their supplements.

I have introduced a bill which is cosponsored by more than half of the United States Senate, which would guarantee the availability of these products. What will the Administration do to insure that people will be able to use dietary supplements to decrease their chance of illness?

POSSIBLE HRC RESPONSE:

- Senator Hatch, I agree with you that dietary supplements can be valuable in promoting health. I believe in vitamins and take them on a regular basis. I believe that the decision to use these products should be left largely to American consumers. As long as supplements are safe, people should have the right to purchase them.
- But I am sure that you share my concern about false and misleading claims that some have made about these products by those who are attempting to make money off of sick and desperate people. We need to strike the proper balance between getting accurate information to people about the value of these products and prohibiting false and misleading claims.
- The Clinton Administration looks forward to working with you on how best to achieve this balance.

Background on Dietary Supplements

Recently, Members have been inundated with mail from people who use dietary supplements. Most of the mail is generated by an extremely effective campaign conducted by the supplement industry, a significant part of which is based in Utah. In its literature, the supplement industry has made completely inaccurate charges against the Food and Drug Administration, including the charges that the FDA intends to require prescriptions to purchase vitamins and the charge that it intends to ban herbs and other similar products.

For many years, the FDA was relatively lax about regulating these products. As a result, manufacturers have become accustomed to making illegal and deceptive claims (for example, there are products marketed to AIDS patients that claim they will enhance the immune system).

There is a preception that this approach changed in 1990 with the enactment of the Nutrition Labeling and Education Act, which established the rules making health claims (such as "this product is useful in preventing cancer") on foods and dietary supplements. As the FDA has proceeded to issue regulations to implement the NLEA, the dietary supplement industry has become very nervous that companies will be prohibited from making many of the claims that they have become accustomed to making.

Under the NLEA, prior to making a claim, a company must present its scientific evidence to the FDA and get a ruling from the agency that the claim is valid. The food processing industry supported the NLEA and strongly opposes any proposal to establish a separate standard for dietary supplements.

Senator Hatch's bill would not require premarket review. Instead to prohibit a false claim, the FDA would have to take the company to court and prove that the claim was false and misleading. Senator Hatch would also remove the regulation of claims from the FDA and place it in the National Institutes of Health. This proposal reflects Senator Hatch and the supplement industry's hostility towards the FDA.

Democrats in the Senate and the House strongly oppose both eliminating premarket review for claims on supplements and taking the program out of the Food and Drug Administration. However, Congressman Waxman is working on a compromise bill that would address a number of issues raised by the supplement industry, and, most important, would guarantee the availability of these products as long as they are safe.

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Democrats

Baucus (D-MT)

- Global budgeting
- Fuller explanation for rural access to health care
- Premium caps
- Impact on small business
- Public health program funding

Boren (D-OK)

- Tax caps - wants greater explanation
- Employer contribution - wants greater explanation
- Impact on subsidies if financing is not solid

Bradley (D-NJ)

- Alternative financing plan (wants additional sin taxes)
- Basic benefits package - what's in it/ability to get 2nd opinion
- (NOTE: He is likely to ask you a question regarding pharmaceuticals as is Hatch.)

Breaux (D-LA)

- Global budget - dictating insurance behavior/premiums at cap
- Alliances - too regulatory/won't allow competition to work
- Small business ability to afford employer mandate
- Financing mechanisms other than those already mentioned
- Paying for elderly, prescription drugs, long term care
- Retiree benefit - explanation of \$4 billion estimate
- Tax cap

Conrad (D-ND)

- Growth in expenditures/Rise in GDP
- Rural areas under global budget
- Funding infrastructure improvements for rural areas out of discretionary monies
- Funding for Public Health Funds/Medicare GME funds (pro-GME)

Daschle (D-SD)

- Rural access
- Burden reduction on small business under reform

Mitchell (D-ME)

- Explain why plan won't result in \$600 billion new spending (Senator Mitchell wants this on the record. Steve Edelstein gave them the numbers of \$350 in new spending and \$250 in redirected spending.)
- Rural health care

Moynihan (D-NY)

- Trade-offs/benefits for those currently Medicaid covered who won't be under the new system
- State role in financing Medicaid
- Rationale for allowing Medicaid premiums paid into the Alliance to decrease more slowly than premium payments made by private sector

- Explain \$80 billion Long Term Care estimate/what services and #'s people served
- Rate of health care expenditure growth after year 2000/what happens after that year
- Policy basis for allowing employers continued tax deductibility for supplemental policies, but having employees pay their share of the supplemental premium with after tax dollars
- Making the Alliances accountable to consumers and employers
- Explain why our plan is better than either single payer or market system
- Job loss as result of reform
- Plan's ability to address lack of physician/providers in inner cities/rural areas
- Since issuing plastic "Health Security Cards" for everyone, why not plastic Social Security cards?
- Wage cap/health insurance premiums

Pryor (D-AR) - unable to attend due to illness

Rockefeller (D-WVA)

- Decision on residency slots - regional council or state-by-state (He favors state.)

Republicans

Chafee (R-RI)

- Gun control and costs to health care
- Community based care & federally qualified health center
- Budget - overambitious Medicare cuts

Danforth (R-MO)

- Financing - spending \$\$ we don't have
- Plan phase in/benefit distribution

Dole (R-KS)

- No information provided

Durenberger (R-MN)

- Treatment of State Health Care Plans & federal entitlements

Grassley (R-IA)

- Medicaid - worried about negative impact on Iowans based on Medicaid distribution
- Global budgets

Hatch (R-UT)

- Examples of improved quality while reducing costs

Packwood (R-OR)

- Abortion (Disturbed over recent action on the Hyde Amendment, he will probably focus quite hard on this issue.)
- Oregon - Ability to implement its plan limiting services
- Global Budgeting - equity among states
- Inordinate federal regulation

Roth (R-DE)

- Cost Containment
- Seniors and federal employees access to plan

Wallop (R-WY)

- Opposed to employer mandate - focus on excessive government expansion, subsidies, retirement encouragement
- United Mine Worker "Orphan" program - fear it will be negated under reform

SENATOR MAX BAUCUS

ISSUE: **How will rural areas be affected by global budgets?**

ANSWER: First, Senator, we are not using global budgets. Our back-up enforcement mechanisms will be used only on the cost of the benefit package that is provided to all Americans.

Secondly, although this is a little known fact, health care inflation in rural areas is running at as high a rate as it is in other areas of the nation. As a result, like all parts of the country, slowing down growth rates benefits all populations.

Lastly, premium targets in all states begin at what health care costs there are today, plus increases for people who are now uninsured.

The National Health Board will provide information about cost differences to states and alliances. This should provide high cost areas with information they need to bring costs down. Over time, the National Health Board will monitor differences in costs and will make recommendations to the Congress to narrow differences across areas.

SENATOR MAX BAUCUS

ISSUE: Rural areas – pleased with what he has heard so far, but may ask her to elaborate.

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

- With universal coverage, rural doctors will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural practice.
- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.
- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers

Baucus

Premium caps - will they be decided on by the States?

- States will not be responsible for setting or enforcing premium caps.
- Federal law will specify the allowable increase in premiums over time.
- Premiums targets for each alliance will be set by the National Health Board.
- Premium targets for alliances in each state will be set based on the real cost of providing the guaranteed benefits in that state today, with increases for those now uninsured.

SENATOR MAX BAUCUS

ISSUE: **Impact on small businesses**

ANSWER: Two-thirds of small businesses currently cover their employees. For these businesses, health care reform will mean a chance to expand and create new jobs. **The Wall Street Journal calls the plan "an unexpected windfall" for small businesses.**

Some people say that this proposal is going to hurt small businesses. And it's important to keep in mind that my critics are right on one important point: asking all employers -- including low-wage small businesses -- to provide comprehensive coverage for their employees without discounts would be unreasonable. But that's not what my plan is -- my plan provides **discounts of between 30 and 80%** for small businesses, depending on the average wage of their workers.

Most small businesses will receive a windfall because they will be getting substantial discounts compared to what they pay now. Studies show that **the fastest growing small businesses are the ones that provide health insurance.** So they will be able to create new jobs and expand their businesses.

You see, the whole problem with the way people get insurance today is that **the insurance companies have all the power, and small businesses and consumers get the short end of the stick.** My plan changes the market to give small businesses and consumers more bargaining power and really put them in the driver's seat.

A lot of small businesses that don't provide insurance want to -- they just can't afford it. Listen to Diane Welch of San Jose, California -- she owns an Italian restaurant there with 40 employees. She says -- this was in the newspaper a few days ago -- that she is looking forward to my proposal because it has bothered her that she and her husband couldn't afford to provide coverage for their employees. With the discounts, health care would finally be reasonable, she said. And she said of the price: "It's something we could definitely handle."

Let's look at what a low-wage small business might pay. For a small business whose employees make an average of \$12,000 a year, they would only have to pay \$420 a year per employee to get their employees comprehensive health benefits. In today's market, they might have to pay as much as \$4000 per year per employee, but after reform, it's affordable because of the discounts which we are proposing for small businesses. Now compare that to the average big business, paying \$2200 a year for each employee. We're talking about a discount of 80% for the small business.

When we look at what effect this will have on small businesses, one interesting example is Hawaii. Hawaii passed a plan in 1974, the Prepaid Healthcare Act, that requires all businesses to contribute to the cost of their employees' health insurance. But small businesses have continued to thrive. In 1991, Hawaii was the nation's third fastest-growing state for small businesses, and Hawaii's unemployment rates are consistently among the lowest in the country.

SENATOR MAX BAUCUS

ISSUE: **How much funding will be given to public health programs?**

ANSWER: One of the key goals of health reform is to improve the health of Americans at an affordable cost. Public health programs play a pivotal role in achieving this goal. The Health Security Plan will inject billions of dollars into public health programs and will redirect current funding to ensure that all Americans have access to high-quality health care.

We're injecting new funds into community health centers, migrant health centers, public hospitals and clinics to expand capacity and support enabling services such as outreach, transportation, case management and counseling services.

We're also continuing and expanding public health programs that protect Americans against preventable, communicable diseases, harmful products, toxic pollutants and poor quality health care.

The Health Security Act will define and validate new prevention and control interventions.

Senator Boren

2. What does the employer contribute under the employer mandate, and why do we need an employer mandate?

- The employer contributes 80% of the premium for the average plan in the alliance. There are adjustments because of dual wage earners in families, but fundamentally it is 80% of the average premium.

- Employer mandate is necessary if we are to provide the security of universal coverage.

- It builds on the system we have today -- 90% of people insured today with private insurance get it through their employer.

- Employers who do not cover employees today are pushing the cost of health care on to the employers who do provide coverage - through uncompensated care.

SENATOR BILL BRADLEY

ISSUE: **FINANCING.** Are there any alternatives to financing the plan as currently established?

ANSWER: We are still considering the most appropriate level of taxation of tobacco. The ranges are between 75 cents and \$1 more than the current tax. I know you have been a long time advocate of increases on tobacco taxes as both a disincentive to use and a revenue raiser. Except for a 1 percent corporate assessment on firms with over 5,000 employees, we do not believe additional revenue is necessary. However, we are more than willing to review and discuss alternatives that you or other Members may have in mind. Do you?

SENATOR BRADLEY

ISSUE: **What's in the basic benefits package? Can a person get a second opinion?**

ANSWER: The **comprehensive** benefits package is as comprehensive as what most Fortune 500 companies offer today. It covers a full range of services, including mental health services, substance-abuse treatment, some dental services and clinical preventive services.

Just as they do today, health plans will determine whether second opinions will be covered.

Senator Breaux

1. Global budget - concern that budget will dictate insurance behavior and that premiums will be set at cap from the beginning
 - We do not believe that the budget enforcement mechanism will ever be used. It is simply a backstop and provides employers and consumers with greater bargaining power.
 - There is evidence from other public and private systems that competitive forces can and will result and premiums that are below the budget targets.
 - Since consumers will choose plans based on price and service, health plans will be under strong competitive pressure to keep premiums below the budget targets. Consumers are paying out of pocket to enroll in more expensive plans.

Senator Breaux

2. Alliances - too regulatory; would not allow competition to work

- The opposite is true. With limited exceptions, alliances must offer all health plans that want to participate.
- States will qualify health plans, as they do today.
- The real function of alliances is to give employers and consumers the same bargaining power large groups have today.
- We have examples of this working today -- for example, CALPERS or the public employees program in Minnesota.

Senator Breaux

4. What is the financing mechanism?

- Uninsured workers and their employers, approximately 30 million people, will contribute under the new system.
- Savings from slowing the rate of growth in Medicare and Medicaid, as we phase in the new system, will also be available.
- The tax on tobacco and the contribution from large corporations that choose to self-insure to help support the health services that they use, such as academic health centers.

Senator Breaux

5. Prescriptions drugs for the elderly and long-term care, how will we pay for these? Isn't it spending more money without requiring more from beneficiaries?

- Prescription drugs are cost-effective and necessary. Seniors shouldn't be forced to choose between food and medicine; if they don't take their drugs, they end up back in the hospital.

- Long-term care can save money. Why do we force people to spend down, or go into nursing homes when they are just as happy to stay at home if they have some services.

Senator Breaux

6. New retiree benefit - how did you arrive at a cost of \$4 billion

- Without the enhanced retiree health benefit, early retirees would be treated like other non-workers under the President's plan. Since many retirees have low incomes, they would receive substantial subsidies anyway. The \$4 billion figure represents the additional cost of the enhanced benefit.
- Our cost estimates are prudent, and build in the expense of expected increases in retirement as a result of the plan.

Senator Breaux

7. Tax cap - why not apply it to employers also.

- All benefits in the nationally guaranteed package are tax deductible and not counted as income for employees. Additional benefits now offered are also not taxed, for a period of ten years.
- Our nationally guaranteed benefits are comprehensive, and are comparable to those now offered by Fortune 500 firms. The package meets all of the needs of the vast majority of Americans.
- Ultimately, employer-paid benefits over and above the guaranteed package should be treated just like wages -- tax deductible for employers but counted as income for employees.

SENATOR KENT CONRAD

ISSUE: **Slowing GDP Growth at Faster Rate.** Even under the President's cost containment proposal, GDP growth rates will still be far in excess of our competitors. Can't we do better than the President is proposing?

ANSWER: Senator, you are right. Even under what some people claim are excessively rigid cost containment goals of the President's proposal, health care spending will still be in the high teens later in this decade. This will be much higher than any competitor.

However, most critics have stated that we cannot even meet our targets. The President and I believe that these experts are off-target. We believe the potential is there for doing even better than our projections, but I doubt we could get any tighter cost containment goals passed. . .

ISSUE: **How will rural areas be affected by global budgets?**

ANSWER: First, Senator, we are not using global budgets. Our back-up enforcement mechanisms will be used only on the cost of the benefit package that is provided to all Americans.

Secondly, although this is a little known fact, health care inflation in rural areas is running at as high as rates as they are in other areas of the nation. As a result, like all parts of the country, slowing down growth rates benefits all populations.

Lastly, premium targets in all states begin at what health care costs there are today, plus increases for people who are now uninsured.

The National Health Board will provide information about cost differences to states and alliances. This should provide high cost areas with information they need to bring costs down. Over time, the National Health Board will monitor differences in costs and will make recommendations to the Congress to narrow differences across areas.

SENATOR KENT CONRAD

ISSUE: Will the infrastructure improvements for rural areas be funded out of discretionary monies? If so, aren't these funds much harder to maintain?

ANSWER: First, since rural populations are disproportionately uninsured, underinsured, and on Medicaid, the primary structural change in rural areas will be that health care providers will benefit from a higher paying insured population. These monies are obviously not discretionary and should help contribute to underwriting the costs of necessary infrastructure improvements.

With regard to the other improvement investments, there is no questions that discretionary monies are more difficult to obtain. We are looking at options and would welcome suggestions.

SENATOR KENT CONRAD

ISSUE: Where will new funding come from for the commendable training, recruitment, and retention initiatives you are contemplating for rural primary care mid level providers? Is it from Public Health funds or Medicare GME funds.

ANSWER: Expanding coverage without ensuring an adequate provider base is like having a movie ticket with no theater to go to. To address this issue, we will use funding sources from PHS. We feel very positive about our commitment to solving the rural mid-level provider access problem. However, we are open to any suggestions you may have.

SENATOR DASCHLE

ISSUE: May ask for an example of how the plans will help those in rural areas.

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

- With universal coverage, rural doctors will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural practice.
- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.
- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers

SENATOR DASCHLE

ISSUE: **How the health care burden on small businesses will be reduced if the proposal is adopted.**

ANSWER: Two-thirds of small businesses currently cover their employees. For these businesses, health care reform will mean a chance to expand and create new jobs. **The Wall Street Journal calls the plan "an unexpected windfall" for small businesses.**

Some people say that this proposal is going to hurt small businesses. And it's important to keep in mind that my critics are right on one important point: asking all employers -- including low-wage small businesses -- to provide comprehensive coverage for their employees without discounts would be unreasonable. But that's not what my plan is -- my plan provides **discounts of between 30 and 80%** for small businesses, depending on the average wage of their workers.

Most small businesses will receive a windfall because they will be getting substantial discounts compared to what they pay now. Studies show that **the fastest growing small businesses are the ones that provide health insurance.** So they will be able to create new jobs and expand their businesses.

You see, the whole problem with the way people get insurance today is that **the insurance companies have all the power, and small businesses and consumers get the short end of the stick.** My plan changes the market to give small businesses and consumers more bargaining power and really put them in the driver's seat.

A lot of small businesses that don't provide insurance want to -- they just can't afford it. Listen to Diane Welch of San Jose, California -- she owns an Italian restaurant there with 40 employees. She says -- this was in the newspaper a few days ago -- that she is looking forward to my proposal because it has bothered her that she and her husband couldn't afford to provide coverage for their employees. With the discounts, health care would finally be reasonable, she said. And she said of the price: "It's something we could definitely handle."

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SENATOR GEORGE MITCHELL

Issue: Many in the Senate have been asserting that the Clinton plan will cost \$600 billion in new spending, we know this isn't true, but what exactly is the breakdown?

Answer: I appreciate the opportunity to clarify this issue which has generated some confusion and much misunderstanding.

We project that over the first seven years of reform, \$609 billion in federal dollars will be required to fund the program.

- Of that amount, \$259 billion is money the federal government is already spending on coverage for working people on Medicare and Medicaid. Their coverage will now be paid for by their employers and this money will be redirected to the alliances to help pay for their care.
- \$169 billion is needed to insure that health insurance premiums are affordable for small businesses and people with low incomes.
- \$80 billion goes to pay for the new home and community-based long-term care services.
- \$72 billion pays for the new prescription drug benefit under Medicare to improve security for older Americans.
- \$29 billion is spent on public health initiatives and administration of our program.

So in reality, the actual figure for new spending is \$350 billion over the first seven years of the program.

SENATOR MITCHELL

ISSUE: Rural health care – How the plan deals with that.

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

- With universal coverage, rural doctors will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural practice. Further, rural hospitals will see increased per person payments as Medicaid rates are spread across all consumers in the alliance area, including private-paying consumers.
- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.
- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers.

SENATOR DANIEL PATRICK MOYNIHAN

Issue: **What are the trade-offs and benefits for those people now covered by Medicaid who would not be entitled to Medicaid under the new system you propose?**

Answer: The Health Security plan offers real benefits to people covered by Medicaid. First, and foremost it guarantees them the same comprehensive benefits and the same choice of plans as everybody else.

It also eliminates welfare-lock, by allowing people to move from welfare to work with the assurance that they will still have coverage.

Some have raised concerns about what happens to benefits offered by some state Medicaid programs above those offered in our comprehensive benefits package. By maintaining a supplemental program for additional benefits, we make sure that Medicaid beneficiaries still have access to these services.

Moynihan

What is the state role in financing the continuing Medicaid system and the new health care system?

- New government spending -- for increased benefits for the elderly and for discounts for small businesses and low income families -- will be financed by the federal government.
- States are expected to continue spending what they are today under Medicaid for the nationally guaranteed benefits. But state spending will be limited over time at a much lower rate than today.

Moynihan

What is the rationale for allowing Medicaid premiums paid into the alliance to decrease more slowly than the premium payments made by the private sector.

- We expect the premiums paid into alliances by states for Medicaid recipients to increase at the same rate as private premiums.
- But since the Medicaid population is expected to grow faster than the general population, Medicaid spending in total will increase and as a percentage will rise faster than private spending.

SENATOR DANIEL PATRICK MOYNIHAN

ISSUE: Please explain how the \$80 billion program cost estimate was arrived at for long-term care: what services are assumed in that estimate and how many people are served?

ANSWER: We based the \$80 billion program cost for the long-term care program on the per capita cost of state programs and national demonstrations that offered a wide array of services (ranging from skilled nursing services to personal assistance services and help with shopping). Included in this figure is the cost of improvements in Medicaid coverage for institutional care and tax incentives for long-term care insurance. The \$80 billion also assume a premium of \$10 per month.

Just over 3 million people have the level of disability that would qualify them for the home and community-based services program.

SENATOR DANIEL PATRICK MOYNIHAN

ISSUE: **How does the President's plan insure that alliances are accountable to consumers and employers? What options do consumers and employers have if they are displeased with the performance of an alliance?**

ANSWER: The Health Security Plan has very strict rules preventing anyone associated with the health care industry from serving on the board of an alliance. Only representatives of the employers and consumers who receive coverage through the alliance can serve on the board.

The board and the alliance will be held accountable, with all its workings in full, public view. If any problems develop, there would be a powerful constituency -- everyone who gets health care in that region -- with an interest in solving the problem immediately. Because consumers and employers sit on the board of the alliance, if they don't like how it's functioning they have both every incentive and authority to see that it's changed.

SENATOR DANIEL PATRICK MOYNIHAN

ISSUE: **Single payer vs individual mandate – Why is your plan the best?**

ANSWER: Given that we want to guarantee everyone comprehensive benefits that can never be taken away, there are a couple of approaches as to how you could do that.

The first is, you could go with a single-payer system as they have in Canada. It achieves universal coverage, people can choose their doctor, and their system is simpler than the one we have now. But to go to a single-payer system in America would mean turning a lot of the parts of the health care system that are currently in the private sector over to the government. And it would also mean raising a lot of new tax revenue. And with all that we're currently wasting in our health care system, we didn't think that was the way to go.

Then some of the Republicans have proposed what's called "an individual mandate" -- requiring all individuals to purchase insurance. Now we agree with the idea behind this: that everybody should take responsibility for their health care, and everyone must contribute something to the cost.

But the question is: how do you make sure that people actually go out and buy the insurance? Most people agree that it would require some kind of new and intrusive bureaucracy to track down people and make sure that everyone buys insurance, and that's not something we wanted to do. And then there's the problem of how you prevent employers from just dropping people's coverage once they realize that they're basically off the hook and don't have to provide insurance to their employees. And once employers start dropping people, that would mean we need more subsidies for low-wage people, which would mean a need for more taxes. So after really thinking this through, we decided that that was not the way we wanted to go.

We finally decided that the best approach builds on the current system -- a system where most people get their insurance through their workplace, and if you're unemployed, the government helps out until you get back on your feet.

There is widespread support for this idea. The United States Chamber of Commerce, representing hundreds of thousands of businesses all over the country, supports the idea, because they agree that everyone must take responsibility for the cost of health care in this country. The AMA supports this idea, and so does the HIAA. The first person to propose this was President Nixon in 1974. It was introduced by Senator Packwood at that time, and Senator Jeffords has also proposed a bill supporting the same idea. So there is real bipartisan support for these ideas.

Right now, three-quarters of all employers cover their employees. And the businesses that cover their employees are paying for those that don't. When someone without insurance goes to the hospital, don't think those costs disappear into thin air. Those costs are passed along to you, your business and every consumer in higher premiums, \$20 Tylenols at the hospital, and higher Medicaid and Medicare taxes in every state.

So we ask all businesses to take some responsibility for their own employees. For low-wage small businesses who can't afford insurance, we will provide substantial discounts -- of up to 80% -- so that small business owners can finally get comprehensive coverage for themselves, their families, and their employees at an affordable price.

SENATOR DANIEL PATRICK MOYNIHAN

ISSUE: What happens to the rate of health care expenditure growth after the year 2000? The administration documents only look at spending until the year 2000, and I am curious what the Administration anticipates for expenditures growth after that time.

ANSWER: We believe the out-of-control spending has to get under control immediately – that's why we've focused on the period up to 2000.

Our primary concern is creating economic incentives and a framework that encourages competition on the basis of quality and efficiency. If we do this right, we won't have to inevitably assume that the open-ended cost increases that have characterized our system will continue. With this accomplished, we as a nation will have to consider the level of health care spending that's acceptable. We'll have a mechanism in place to do this.

SENATOR DANIEL PATRICK MOYNIHAN

ISSUE: **There is considerable lack of physicians and other providers who are willing to serve in inner cities and rural areas. How does the President's plan address this problem?**

ANSWER: Rural areas and inner cities have a higher proportion of uninsured people than the rest of the nation. Rural and inner city doctors provide more charity care than any doctors in the country, and they often get paid late.

- With universal coverage, these providers will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural and urban practice.
- In addition, the plan will include specific incentives for doctors to practice in rural and urban areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to needs of underserved areas.

Moyrinhaw

QUESTION:

If you are planning to issue plastic "Health Security Cards" for every American, why can't you issue plastic Social Security cards to everyone?

ANSWER:

- ▶ Mr. Chairman, I must confess I haven't spent that much time studying the issue of a permanent Social Security card, so I would defer to your judgment and that of Social Security Commissioner nominee Shirley Chater in this area.
- ▶ With respect to a health security card, as with any health insurance card that is used regularly -- even many times in a month for some people -- durability will be an important consideration.
- ▶ Furthermore, we envision that information would be encoded on the card that also would need to be accessed regularly -- such as information regarding plan enrollment, the status of one's deductible, and so on.
- ▶ Finally, we hope that the Health Security card will give Americans the same sense of security they now feel with respect to the Social Security system. In addition to its utilitarian purposes, the card is an important reminder to everyone that they have comprehensive health coverage that can never be taken away.

If he asks about the card being one in the same as that of Social Security, I'd advise saying that there have been confidentiality/privacy issues raised, but that we would be happy to discuss this issue with him & staff at later date

W. Bush

QUESTION:

I opposed the President's budget proposal to lift the wage cap on contributions into the Medicare trust fund, although it was enacted anyway as part of reconciliation. How can you now turn around and propose a wage cap on health insurance premiums for the under 65? Won't some people end up paying more for their Medicare payroll tax than they pay for their current health plan?

ANSWER:

- ▶ Mr. Chairman, while I very much appreciate your concern for the Medicare program and the integrity of its financing, I do believe the issues are separable.
- ▶ Medicare is a payroll tax funded program. It is a pay-as-you-go system. Young workers pay a tax to cover the expenses of today's retirees. Years from now, tomorrow's retirees will be supported by the generations behind them. The proposal we made in Reconciliation was meant to shore up the solvency of the Medicare trust fund for years into the future. That was an important change.
- ▶ In our health reform plan, by contrast, each individual is responsible for paying their own health insurance plan premium. If they work, their employer will contribute toward that premium. If they are low income, we will subsidize that premium. And if their employer is a small business or low wage firm, we will subsidize that contribution, too.
- ▶ We chose this method because it is the way people under 65 purchase health insurance coverage today.
- ▶ It is possible that some high income people will pay more in Medicare taxes -- or more in income taxes or more in their home mortgage -- than they do for their health insurance premium. We must be careful not to compare apples and oranges in weighing the significance of these differences.

Senator Moynihan

④. Global budgeting - some states will get more, others less

- The beginning point for alliances in each state is the real cost of providing the guaranteed benefits in that state today, with increases for those now uninsured. This is fair.
- Over time, premiums in every state will be held to the same rate of increase -- inflation in the rest of the economy.
- The National Health Board will provide information to alliances on cost differences, and may make recommendations to narrow those differences.

SENATOR JAY ROCKEFELLER

ISSUE: **Primary care training incentives.** Specifically, would the President consider having the residency slots allotment done by a state-by-state council, rather than a regional council? I am concerned that individual states should have the authority and not be influenced by factors outside the state.

ANSWER: Senator, you have been the first person to raise this with me. However, your concerns make sense and your suggestion is, as always, well worth considering. I would like to follow-up this question with a meeting with you or staff to discuss your and other options on this very important matter.

SENATOR JOHN CHAFEE

QUESTION: What will be doing to control the costs associated guns?

ANSWER: Senator Chafee, you have been a leader on this issue for some time now. Your bill banning hand guns is just one example of this. I could not agree more with you that the health care costs associated with violent gun crime is extraordinary.

Earlier this week, Congressman Reynolds pushed for his legislation to tax guns and ammunition. I am personally sympathetic to his and any other proposal aimed at reducing violent crime and the health care costs associated with it. Although we have no specific proposal on this issue, I am sure we would welcome any suggestions that you and other Members might have.

SENATOR CHAFEE

ISSUE: **Community-based care and federally qualified health centers. If phasing in health care reform, what are you doing to protect them? How will the plan help them in the long run to remain as part of our health care infrastructure?**

ANSWER: For many in urban and rural areas, federally qualified health centers, community and migrant health centers provide the only access to health care services today. They play a critical role that we want to preserve.

- Under reform, health plans will contract with "essential community providers" so that all Americans – – regardless of where they live, what their income is, or what race or ethnicity – – will be guaranteed access to quality care.
- And, because everyone will be covered under our proposal, the patients that come to these clinics will now be paying patients – – at the same reimbursement rate as everyone else. This will provide a substantial boost in funding for these centers..
- Finally, we're increasing funding so that these centers can link up with other clinics in their area and with centers of excellence so that they can build their own community-based plans.

SENATOR JOHN CHAFEE

ISSUE: **Budget – With regard to the Medicare cuts where are you expecting that to come from. Aren't they a little overambitious?**

ANSWER: First of all, I would like to point out that our plan does not call for cuts to the Medicare program but rather reductions in the projected rate of increase in Medicare spending as we slow the overall growth in health care spending.

Some have questioned whether such savings can be realized. Over the last eight months, I have talked to hundreds of people involved at all levels of our health care delivery system. I have heard stories about waste and inefficiency to numerous to mention. I have also heard success stories where doctors and hospitals are working to hold cost down, far below the national average.

We must and we can spend our health care dollars more wisely. If we do, we will have the funds we need to pay for this program.

I might also point out, Senator, that as we calculate it, over the same period of time, there is no more than \$11 billion difference between your plan and our plan.

SENATOR JOHN DANFORTH

Issue: **How will the plan be paid for? Will we be spending money that we don't have?**

Answer: As I stated in my opening statement, the majority of this plan will be paid for the way most health care is today -- through premiums paid by employers and employees.

In addition, to help pay for the new prescription drug and home care benefits and to ensure that premiums will be affordable to small businesses and low-income individuals, our plan lays out specific line item savings and calls for an increase in the tax on tobacco. The savings have been scored by the Office of Management and Budget and they will be scored by the Congressional Budget Office.

Some have raised questions as to whether such savings can be realized. Over the last eight months, I have talked to hundreds of people involved at all levels of our health care delivery system. I have heard stories about waste and inefficiency to numerous to mention. I have also heard success stories where doctors and hospitals are working to hold cost down, far below the national average.

We must and we can spend our health care dollars more wisely. If we do, we will have the funds we need to pay for this program.

Danforth

How quickly will the plan be phased in? How will the benefits be distributed.

- The plan will be phased in by state, with states coming in as they are ready.
- The earliest states -- those who have been most active -- can begin in 1995. All states will be part of the system by 1997.
- Benefits are phased in two stages, with expanded mental health and substance abuse benefits and expanded dental benefits beginning in 2001.

SENATOR DAVE DURENBERGER

ISSUE: Worried about how State Health plans will be treated.

ANSWER: Health reform intends to build on, not undo successful state efforts. State flexibility is a cornerstone of our plan for precisely this reason. In your state, for example, the group purchasing activity, the attention to children and preventive care, the successful rural health outreach efforts... all would be maintained and enhanced under reform.

It may be that some state plans set out different policies on which we cannot be flexible, for example the guaranteed benefits package. In some areas..benefits, quality standards, choice of doctor, cost control...states will have to conform with the federal framework to guarantee all Americans the same high quality care, the same comprehensive benefits, and the same affordability.

SENATOR DAVE DURENBERGER

ISSUE: What will happen to federal entitlements?

ANSWER: The Health Security plan offers real benefits to people covered by Medicaid. First, and foremost it guarantees them the same comprehensive benefits and the same choice of plans as everybody else.

In addition, we strengthen the Medicare program by increasing choices and benefits for beneficiaries. Seniors will continue to enjoy the security that the Medicare program provides with the addition of new benefits for prescription drugs. For the protection of our seniors, it will remain a separate program.

Over time, once the new system is successfully up and running, as seniors turn 65 and become eligible for Medicare they will have the option of remaining in their health plans through the alliance or joining traditional Medicare.

States will also be able to integrate all their citizens, including Medicare beneficiaries into a single plan with approval from the federal government.

Senator Grassley

Q. How will Medicaid fit into the new system? Why should states pay based on historical payments?

- For the first time, Medicaid recipients will be just like everyone else. They will be guaranteed what everyone else is guaranteed, through the regional alliance. Current Medicaid recipients who work will be covered through employer and individual contributions, and those covered by AFDC or SSI will be paid for by state and federal contributions.

- States pay based on what they are paying today, adjusted for inflation.

- Provides enormous fiscal relief to states because the double digit increases in Medicaid spending will end. Medicaid increases will be limited to inflation plus population over time.

For Hatch

Q: Are there other examples of systems being able to demonstrate improved quality while reducing costs?

A:

Yes, doctors at the Hospital of Latter Day Saints in Salt Lake City targeted the problem of post operative wound infections and improved quality while reducing costs. It has been estimated that this problem costs the nation 1.5 billion dollars in excess hospital days. These doctors reduced the rates of post operative infection by improving the timing of pre-operative antibiotic administration. They demonstrated giving antibiotics 2 hrs before surgery they could cut the infection rate by half. When this information was used to improve quality hospital wide, infection rates were reduced at a cost savings of \$ 450,000 in the first year. This is an example of appropriate care resulting in shorter hospital stays, savings of hundreds of thousands of dollars and most important better outcomes for surgical patients.

Mrs. Clinton:

We should have a report "prop" for you tomorrow morning. (This was the info I was referring earlier).

SENATOR BOB PACKWOOD

ISSUE: **Abortion – how will the plan handle this? Does it have to be in the benefit package? Will people have access to these services even with the "conscience clause"? Will you fight to have this service available in your plan?**

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

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

We've worked to create a health plan that covers abortion where necessary, but we have also worked to make sure that people have a choice and that abortion is as rare as possible.

SENATOR BOB PACKWOOD

ISSUE: Could Oregon implement its plan which limits services?

ANSWER: Health reform intends to build on, successful state efforts. Oregon is to be commended on its efforts to assure a level of health care coverage to all its citizens. With its emphasis on primary and preventive care, it is a model for the rest of the nation.

But while state flexibility is a cornerstone of our plan, it may be that some state plans set out different policies on which we cannot be flexible, for example the guaranteed benefits package. In some areas..benefits, quality standards, choice of doctor, cost control...states will have to conform with the federal framework to guarantee all Americans the same high quality care, the same comprehensive benefits, and the same affordability. As a result, to the extent Oregon does not meet these criteria, it would not be able to implement its plan.

Packwood

Global budgeting - some states will get more and some less, will this be fair?

- The beginning point for alliance premium targets in each state is the real cost of providing the guaranteed benefits in that state today, with increases for those now uninsured. This is fair.
- Over time, premiums in every state will be held to the same rate of increase -- inflation in the rest of the economy.
- The National Health Board will provide information to alliances on cost differences, and may make recommendations to narrow those differences over time.
- Some compare these premium caps to payments by Medicare to providers or health plans. But the two are different.

Higher Medicare payments mean more federal dollars going into a state. In our plan, most of the money to pay for premiums is coming from a state's own employers and residents. A higher target means more spending for employers and consumers.

SENATOR BOB PACKWOOD

ISSUE: Amount of federal regulation – Isn't there an inordinate amount of regulation in this plan, is the government going to be running this or the private sector?

ANSWER: If you tried your hardest to create the most complicated system you could think of, you couldn't come up with something more complicated than the system we have today. Hundreds of forms confront doctors, nurses and consumers at every turn. Because the benefits packages are so complicated – with different rules for coverage and different rules for cost sharing, patients wind up paying bills they never thought they'd have to pay. And, it's no wonder. You'd have to be a lawyer or hire a good one to even begin to understand the fine print.

Hospitals have to hire people who specialize in different insurers and they have manual after manual that become their Bibles – all so they can figure out what's covered and what's not, and who's going to pay. And then you have utilization reviewers looking over their shoulders to make sure every t is crossed and every i is dotted.

That's what's got to change. The President specifically rejected a government-run system, opting instead for a system rooted in the private sector and based on what we have today. **Under our proposal, government will set standards, provide security and safety, and then get out of the way.** The Health Security Plan will free doctors from the avalanche of paperwork, and streamline the system. It will create a single claims form, give every American a Health Security card which will lead to electronic billing, and it will reduce regulation of doctors and hospitals to cut the unnecessary paperwork for doctors and patients. , ..

There will be, however, some more regulation of the insurance industry. We will stop insurers from refusing to cover people because of pre-existing conditions, make it illegal for an insurance company to raise your premium when someone in your family gets sick, and make it impossible for insurance companies to charge small businesses 35% more than big businesses.

SENATOR BILL ROTH

Issue: **How will Seniors and Federal Employees have access to the plan?**

Answer: Seniors will continue to enjoy the security that the Medicare program provides with the addition of new benefits for prescription drugs. It will remain a separate program.

Over time, once the new system is successfully up and running, as seniors turn 65 and become eligible for Medicare they will have the option of remaining in their health plans through the alliance or joining traditional Medicare.

The Federal Employees Health Benefits Program is very much a model for our plan. That program will be folded into to the new system with federal employees entering health plan offered in their area. They will continue to enjoy a wide choice of high quality health plans much as they do today.

They will also benefit from an increase the government's share of the contribution from 72 to 80%.

SENATOR WALLOP

ISSUE: He is against the employer mandate so he'll probably ask theoretical questions concerning the plan, i.e., why the expansion of government, why the implied subsidies, why have people give up gainful employment in order to get better health insurance coverage?

ANSWER: The President specifically rejected a government-run system, opting instead for a system rooted in the private sector and based on what we have today. Under our proposal, government will set standards, provide security and safety, and then get out of the way.

There will be, however, some more regulation of the insurance industry. We will stop insurers from refusing to cover people because of pre-existing conditions, make it illegal for an insurance company to raise your premium when someone in your family gets sick, and make it impossible for insurance companies to charge small businesses 35% more than big businesses.

The Health Security Plan provides security to all Americans -- that means a comprehensive package of benefits individuals and businesses can afford. We're providing discounts to the low-income individuals and we're providing discounts of 30-80% for small businesses.

Economists and business leaders agree that comprehensive health care reform is a necessary element in a strategy to increase long-term economic growth, reduce the deficit, and create jobs. **Today, the rising cost of health care is a hidden tax on American workers and employers -- hurting businesses, limiting job creation and threatening our competitiveness. The bottom line is this: most businesses provide health care to their workers. Health care reform will lower their health care costs -- allowing them to create jobs and increase wages.**

Manufacturers -- the employers that pay the highest wages to middle-class Americans -- have been forced to lay off workers because of rising health costs. **Our health care reform proposal will have dramatically lower health costs for manufacturers and make it easier for them to compete and create new jobs.**

From small businesses that provide insurance to manufacturers like Chrysler and US Steel, costs will be controlled and money will be freed up for job creation. The Wall Street Journal has called the plan "an unexpected windfall" for small businesses. Studies show that **the fastest growing small businesses are the ones that provide health insurance.**

In addition, **there will be jobs created in the health care industry,** particularly for nurses and home health workers who will be providing more

care. Joshua Weiner, a health economist at the Brookings Institution, predicts that the Health Security Act will create 750,000 home health care jobs, and that overall the plan will be a job creator.

SENATOR MALCOLM WALLOP

QUESTION: How will this plan affect the United Mineworker "Orphan" program.

ANSWER: I am well aware that this is an important issue to both you and Senator Rockefeller. We believe that our plan should have no negative impact, and perhaps a positive impact, on the United Mineworker "Orphan" program.

This is because the UMW program is ostensibly a supplemental plan for the over 65 population of retired coal miners and their widows, and (we believe) Medigap-type plans like these should not be affected. In fact, reform may well have a positive impact because the new Medicare drug and long-term care benefit should reduce the health care liability of the coal companies that underwrite the costs of these plans.

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THE HEALTH SECURITY ACT OF 1993

Health Care That's Always There

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

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

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

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

What's Wrong With the Current System

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

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

The Health Security Plan

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

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

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

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

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

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

- **Security of guaranteed, comprehensive benefits.**
- **Health care costs that are under control.**
- **Improved quality of care.**
- **Increased choices for consumers.**
- **Less paperwork and a simpler system.**
- **Responsibility from everyone.**

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

Principle #1:

Security: Guaranteed, comprehensive benefits.

Over the next two years, one of every four of us will lose health coverage for some time. The Clinton plan guarantees that you will never lose your insurance -- no matter what. All Americans will receive a Health Security card that guarantees you a benefits package that is as comprehensive as those offered by most Fortune 500 companies...and then some. Here's how the plan guarantees security:

- **Makes it illegal for insurance companies to deny you coverage because of "pre-existing conditions."** The Health Security Act also makes it illegal for insurers to raise your premiums or drop you because you get sick. All health plans will be required to accept anyone who applies -- healthy or sick, young or old.
- **Guarantees coverage if you lose your job.** The proposal guarantees that you will keep your health coverage even if you lose your job, with the employer portion picked up by Federal revenues and savings. Under the current system, if you lose your job, you lose your health insurance.
- **Guarantees coverage if you switch jobs, move or start a small business.** You will always be protected -- no matter what. Today, if you switch jobs, move or start a small business, you can find yourself without health insurance -- and risk bankruptcy.
- **Emphasizes preventive care.** The comprehensive benefits package goes beyond virtually all current insurance plans by covering a wide range of preventive services, including mammograms, Pap smears, and immunizations -- **at no charge to you**. It puts a new emphasis on helping you stay healthy, rather than waiting until you get sick. Prevention saves money and improves people's health.
- **Includes prescription drugs.** Many insurance companies and Medicare have failed to cover prescription drugs. But drug costs are breaking family budgets, forcing many older Americans to choose between food and medicine. Health insurance should cover prescription drugs. The Health Security plan does.

All Americans will be guaranteed coverage of :

- Preventive Care (i.e., screenings, physicals, immunizations, mammograms, prenatal care)
- Doctor Visits
- Prescription Drugs
- Hospital Services
- Emergency/Ambulance Services
- Laboratory and Diagnostic Services
- Mental Health and Substance Abuse Treatment
- Expanded Home Health Care
- Hospice Care/Outpatient Rehabilitation
- Vision and Hearing Care
- Children's Preventive Dental Care

Principle #2:

Savings: Controlling health care costs.

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

- **Limits how much insurance companies can raise your premium.** Insurance companies will no longer be able to raise your premiums as they please. Today, insurance companies hike your premiums -- sometimes at several times the rate of inflation -- if you get sick, if someone in your family gets sick, and for any other reason.
- **Introduces competition to the health care marketplace.** The Health Security plan will release the chokehold that in today's system, insurance companies have on all of us -- consumers, nurses, doctors, and businesses. Reform will encourage competition -- forcing costs down as health plans compete by offering high-quality care at an affordable price.
- **Cracks down on fraud.** The health security proposal makes health-care fraud a crime and imposes stiff penalties on those who cheat the system. It prohibits doctors from referring patients to outside facilities, like labs, which they own a piece of. It stops the kickbacks that some laboratories give doctors in an effort to get their business.
- **Asks the drug companies to hold down prescription drug prices.** The Health Security plan asks drug companies to take responsibility for keeping prices down, without setting prices. In today's system, overcharging runs rampant -- certain prescription drugs cost Americans three times more than people pay in other industrialized countries.
- **Reduces paperwork.** All health plans will adopt a single, standard claims form by Jan. 1, 1995. Along with other measures to streamline the system and free nurses and doctors from excess bureaucracy, this will reduce paperwork, cut red tape, and save money.
- **Squeezes the waste out of Medicare and Medicaid.** By slowing the growth of these government programs, the proposal uses funds that have been wasted on excessive charges and funnels them into comprehensive benefits. Under reform, Medicare will be expanded to cover prescription drugs, and there will be a new long-term care program to help cover home- and community-based care. Today, Medicare and Medicaid spending keeps going up and up. But the elderly and poor aren't getting any extra benefits. Health security will change that.

Principle #3:

Quality: Making the world's best care better.

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

- **Gives consumers the power to judge the quality of care.** Consumers will receive quality "report cards" that provide information on the performance of health care plans and patient satisfaction. These report cards will hold health plans accountable for meeting high standards. The National Quality Program will help states share information on health plan performance.
- **Reforms malpractice.** The President's proposal will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to use alternative forms of dispute resolution before they end up in court. This will help eliminate the "defensive medicine" that drives up costs and hurts quality -- doctors ordering extra tests because they fear lawyers looking over their shoulders.
- **Encourages cooperation in rural and urban areas.** Rural residents will have access to the latest technology and emergency services through telecommunications links set up between local doctors and advanced networks of specialists and hospitals. In urban areas, the plan will increase investment in public hospitals and community health centers.
- **Provides incentives for more family doctors to practice in rural and urban areas.** The health security plan will give financial breaks to doctors and nurses who work in underserved rural and urban areas. It will expand the National Health Service Corps. Two of three rural counties today do not have enough doctors and 111 rural counties have no physician at all.
- **Increases funding for prevention research.** The National Institutes of Health (NIH) will expand research in areas like children's health, and health and wellness promotion. Preventive care keeps people healthier and saves money at the same time.
- **Promotes research on the effectiveness of treatments.** Today, a lack of information about the most cost-effective methods of treatment often leads to expensive defensive medicine and wide variation in treatments and costs. The plan's investments in research into what treatments really work will help improve the quality of care.

Principle #4:

Choice: Preserving and increasing what you have today.

- **Preserves your right to choose your doctor.** The proposal ensures that you can follow your doctor and his or her team to any plan they might join. Today, more and more employers are forcing their employees into plans that restrict your choice of doctor. After reform, your boss or insurance company won't choose your doctor or health plan -- you will.
- **Increases your choice of health plan.** You will be able to choose from among all the health plans offered in your area -- no matter where you work. Only one of every three companies with fewer than 500 employees offer any choice of health plan. After reform, every employee will be able to choose a health plan.
- **Puts consumers in the driver's seat.** The Health Security Act brings competition to health care -- unleashing the market forces that will lower costs and improve quality. Giving small

businesses and consumers the power to band together in alliances will level the playing field and give them the same bargaining strength as big businesses.

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

Principle #5:

Simplicity: Reducing paperwork and cutting red tape.

- **Gives everyone a Health Security Card.** The card -- with full protection for privacy and confidentiality -- will allow for electronic billing and the creation of health care information networks. This will reduce paperwork and simplify the system.
- **Requires insurance companies to use a single claim form.** The Health Security Act will reduce the insurance company red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. All health plans will adopt a single, standard claims form by Jan. 1, 1995. It will enable doctors and nurses to spend more time taking care of you -- and less time wrestling with paper.
- **Eliminates fine print.** Everyone will get a comprehensive benefits package -- and what you get will be spelled out in easy-to-understand language. If you get sick, insurance companies won't be able to point to fine print and deny you the coverage you've paid for.
- **Streamlines billing reimbursement for doctors, nurses and hospitals.** The comprehensive benefits package, a standard rules and codes for payment, and elimination of excessive government regulations will reduce confusion. Doctors, nurses, and hospitals will have more time to care for patients; and all of us will benefit.
- **Removes the burden on business of negotiating insurance.** Groups of businesses and consumers -- regional health alliances -- will negotiate for high-quality care at affordable prices. This will simplify today's system, where hundreds of thousands of businesses negotiate with more than 1500 insurance companies. The burden of finding insurance will be lifted -- and so will administrative costs -- which can run as high as 40% of total health costs for small business.

Principle #6:

Responsibility: Making everyone responsible for health care.

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

- **Asks the drug companies to hold down prescription drug prices.** The Health Security plan asks drug companies to take responsibility for keeping prices down, without setting prices. In today's system, overcharging runs rampant --certain prescription drugs cost Americans three times more than people pay in other industrialized countries.
- **Emphasizes preventive care.** The Health Security plan puts a new emphasis on preventing illness before it becomes a medical crisis. Prevention will improve the quality of care by helping people stay healthy rather than treating them after they get sick. It offers you full coverage of a wide range of preventive services, but asks you to take responsibility for keeping yourself healthy.
- **Reforms malpractice.** The President's proposal will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to use alternative forms of dispute resolution before they end up in court. This will help eliminate the "defensive medicine" that drives up costs and hurts quality -- doctors ordering extra tests because they fear lawyers looking over their shoulders.
- **Everyone contributes, and no one gets a free ride.** In America, rights and responsibilities go hand-in-hand. Everyone will get a Health Security card that guarantees you a comprehensive package of benefits that can never be taken away. But we will ask everybody to pay something, even if your contribution is small. Small businesses and low-wage workers will get substantial discounts on the cost of insurance, but everyone must take responsibility.

HOW THE SYSTEM IS FINANCED

The financing proposal was developed under the most rigorous and conservative forecasting standards. For the first time, representatives from every federal agency involved in fiscal accounting and financial projections have been brought together to work out the numbers. Then teams of actuaries, health economists and other financial analysts from outside the government served as auditors and consultants, checking and rechecking.

The system is financed from five major sources:

- 1) Medicare savings -- The savings from reducing the growth of Medicare are based on specific, scorable policy proposals. Every penny of these savings will be channeled back into benefits -- prescription drugs and long-term care -- for the people which these programs serve.
- 2) Medicaid savings -- The rate of growth of Medicaid can be reduced primarily by folding the acute care portion of Medicaid into the overall health care system. Since everyone will be insured, there will be savings in "uncompensated care" -- the money that goes to doctors and hospitals to compensate for caring for the uninsured.
- 3) Savings from federal employee health care costs -- As all federal workers are integrated into the overall health care system, there will be less expense to taxpayers to provide for their health care.

4) Reducing the benefits of tax-free compensation -- By reducing the rate of growth for health insurance, the President's proposal lowers the amount of compensation paid as tax-free health benefits, and frees up money for higher wages, wages for new workers, or profits -- all of which are taxable and thus bring in new federal revenues.

5) Sin taxes -- There will be some new "sin taxes," the composition of which is not yet decided.

In addition, there will be other savings. Reducing paperwork and administration, cracking down on health care fraud, and emphasizing prevention will save money in the long-run.

PAYMENT SCENARIOS

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

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

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

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

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

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

EXCEPTIONS

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

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

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

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

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

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

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

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

QUESTIONS AND ANSWERS

THE COSTS OF DOING NOTHING

Q: I like my health plan. Why can't we keep the system the way it is?

A: For those Americans with good health insurance, our hospitals and doctors provide some of the highest-quality care in the world. Under reform, we will preserve this.

But, the current system needs fixing. If we do nothing:

- One of every four of us will lose our health insurance at some point over the next two years. And if you get in an accident during this period, your finances could be devastated.
- By the end of the decade, American workers will lose \$655 in wages each year just to keep health benefits that shrink year after year.
- Seven years from today, almost \$1 out of every \$5 earned by Americans will go to health spending.
- Millions will find that their firms are forced to cut back on benefits and limit choice of doctor and health plan.

I'VE GOT GOOD INSURANCE

Q: Why should I support this plan? I'm happy with my insurance, and so are most people I know.

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

People who like their health insurance today will also get

- increased choices
- the chance to stop trading wage increases for the same health benefits
- preventive care benefits that will keep them healthy

Even those Americans who are satisfied with what they've got now have plenty to gain. And they'll probably pay less for high-quality care. **The bottom line is this: you can't guarantee that what you have today will still be there tomorrow. This reform proposal provides you with that guarantee.**

WHY NOT SINGLE-PAYER?

Q: Isn't the Clinton plan administratively complicated and unduly costly? Wouldn't single payer be cheaper and simpler?

A: In designing my reform proposal, I reaffirmed an American principle: that **health care should be rooted in the private sector and respond to market forces**. Most people get insurance through their employer today, and that will not change under the Clinton plan.

Some have argued for a "single-payer" system. We are leaving it as an option for states to set up single-payer systems in their own state. But **we explicitly rejected a national, government-run system**. In many countries that might be a good system, but to change to that kind of system now in America would require a massive tax increase and too much government. I think that middle-class Americans are already paying too much for their health care. We can do better, and we will with the Health Security plan.

Q: Isn't the Clinton plan the worst combination of single-payer and managed competition?

A: No, in fact, I think it's a good blend of some of the different approaches out there. One of the important things in this process is that we looked at different kinds of approaches and models -- from Canada to Germany, from Hawaii to New York. **So this is an approach that draws on already existing reform efforts and models out there already.**

Now, some people ask: why not just propose a "pure" single-payer or managed competition plan. The answer is this: our proposal is based on the belief that **unleashing the forces of the marketplace -- allowing health plans to compete based on price and quality -- will help control costs and improve the quality of care**. Competition is the engine of reform, but as a backstop, to make sure that we achieve all the savings necessary to guarantee coverage, we put a limit on health insurance premiums -- a device more in line with the single-payer approach. If the market works as we expect, then the backstop becomes unnecessary.

I want to point out something else apart from the different theories. We have really tried to make this a bipartisan effort, and that is reflected in the proposal that we are presenting to Congress. **This proposal contains many ideas that have come from Republicans and have been in past Republican bills.**

- The idea that we should ask all employers to contribute to the cost of their health care was proposed by President Nixon in 1974. It was introduced by Senator Packwood at that time, and Senator Jeffords has also proposed a bill supporting the same idea.
- Senators Kassebaum and Danforth have limits on the growth of insurance premiums in their bill, as we do.
- Senators Chafee, Kassebaum, Danforth, Bond and Cohen all have proposed setting up these large purchasing pools -- or "health alliances" -- to give consumers and small businesses bargaining power in getting affordable insurance.

So this is not one idea. It is a uniquely American solution that will work for this country.

to the hospital, don't think those costs disappear into thin air. Those costs are passed along to you, your business and every consumer in higher premiums, \$20 Tylenols at the hospital, and higher Medicaid and Medicare taxes in every state.

So we ask all businesses to take some responsibility for their own employees. For low-wage small businesses who can't afford insurance, we will provide substantial discounts -- **of up to 80%** -- so that small business owners can finally get comprehensive coverage for themselves, their families, and their employees at an affordable price.

GOVERNMENT REGULATION

Q: Doesn't the Clinton plan rely on heavy government regulation?

A: No. Nothing could be more confusing than the current system. Hundreds of forms confront doctors, nurses and consumers at every turn. And insurers are constantly looking over their shoulder.

After reform, there will be less regulation of doctors, nurses and hospitals so that they can spend less time filling out forms and more time caring for patients. There will be, however, some more regulation of the insurance industry. We will stop insurers from refusing to cover people because of pre-existing conditions, make it illegal for an insurance company to raise your premium when someone in your family gets sick, and make it impossible for insurance companies to charge small businesses 35% more than big businesses.

I specifically rejected a government-run system, opting instead for a system rooted in the private sector and based on what we have today. Under my proposal, government will set standards, provide security and safety, and then get out of the way. My plan will free doctors from the avalanche of paperwork, and streamline the system. It will create a single claims form, give every American a Health Security card which will lead to electronic billing, and it will reduce regulation of doctors and hospitals to cut the unnecessary paperwork for doctors and patients.

EMPLOYER VS. INDIVIDUAL MANDATE

Q: Why not just do an individual mandate instead of an employer mandate?

A: OK, let's look at what we're trying to do with reform and then talk about some of the different approaches and why we chose what we did.

Given that we want to guarantee everyone comprehensive benefits that can never be taken away, there are a couple of approaches as to how you could do that.

The first is, you could go with a single-payer system as they have in Canada. It achieves universal coverage, people can choose their doctor, and their system is simpler than the one we have now. **But to go to a single-payer system in America would mean turning a lot of the parts of the health care system that are currently in the private sector over to the government.** And it would also mean raising a lot of new tax revenue. And with all that we're currently wasting in our health care system, we didn't think that was the way to go.

Then some of the Republicans have proposed what's called "**an individual mandate**" -- requiring all individuals to purchase insurance. **Now we agree with the idea behind this: that everybody should take responsibility for their health care, and everyone must contribute something to the cost.**

But the question is: how do you make sure that people actually go out and buy the insurance? **Most people agree that it would require some kind of new and intrusive bureaucracy to track down people** and make sure that everyone buys insurance, and that's not something we wanted to do. **And then there's the problem of how you prevent employers from just dropping people's coverage** once they realize that they're basically off the hook and don't have to provide insurance to their employees. And once employers start dropping people, that would mean we need more subsidies for low-wage people, which would mean a need for more taxes. So after really thinking this through, we decided that that was not the way we wanted to go.

We finally decided that **the best approach builds on the current system -- a system where most people get their insurance through their workplace**, and if you're unemployed, the government helps out until you get back on your feet.

There is widespread support for this idea. **The United States Chamber of Commerce, representing hundreds of thousands of businesses all over the country, supports the idea, because they agree that everyone must take responsibility for the cost of health care in this country.** The AMA supports this idea, and so does the HIAA. The first person to propose this was President Nixon in 1974. It was introduced by Senator Packwood at that time, and Senator Jeffords has also proposed a bill supporting the same idea. So there is real bipartisan support for these ideas.

Right now, three-quarters of all employers cover their employees. And the businesses that cover their employees are paying for those that don't. When someone without insurance goes

to the hospital, don't think those costs disappear into thin air. Those costs are passed along to you, your business and every consumer in higher premiums, \$20 Tylenols at the hospital, and higher Medicaid and Medicare taxes in every state.

So we ask all businesses to take some responsibility for their own employees. For low-wage small businesses who can't afford insurance, we will provide substantial discounts -- **of up to 80%** -- so that small business owners can finally get comprehensive coverage for themselves, their families, and their employees at an affordable price.

AN UNTESTED PLAN

Q: Isn't this plan untested? Should we really be using America for some kind of social experiment?

A: No, our plan is not untested. Our plan builds on the private, employer-based system that's already in place. Over 90% of privately insured people get their insurance from their employers. For most of them, the system works very well. They have access to some of the highest-quality care in the world.

Yet, for the 37 million Americans who are uninsured and the 22 million underinsured, our current system does not work.

Our plan seeks to preserve what's right with the current system and fix what's wrong -- that means providing security for all Americans. We're doing this by requiring employers and individuals to take responsibility for purchasing health insurance.

Preserving what's right also means getting skyrocketing health care costs under control. We can surely do both.

If we look at our international competitors and at models of reform around America, we know this can work. **There's no reason why other countries spend so much less than we do on health care -- and still guarantee comprehensive benefits for their people.** Look at Germany and Japan for a few examples. Germany and Japan have been able to keep the growth in their health care costs in line with the rest of their economy while ours have been growing at twice and three times the rate of inflation.

Look at California, where hospitals have kept the rates at which their costs grow well below the national average in the last decade.

Look at Minnesota -- with health care costs 15-20% lower than the national average -- they've enacted limits on the rate of growth of public and private health care spending that will achieve a 10% reduction in the rate of growth each year for the first five years of their cost containment program. The Mayo Clinic has also kept its costs down -- below 4%.

Washington State also believes it can rein in spending. Under their reform, growth in premiums is limited to 5% per year by 1998 -- down from 11% today. With these targets in place, Washington State expects to save \$8 billion through 2000.

There's plenty of evidence out there in places that have made serious attempts to cut waste, reduce paperwork and red tape, and encouraging competition that this can work.

B. COMPREHENSIVE BENEFITS

POLICY BRIEFS:

COMPREHENSIVE BENEFITS
MENTAL HEALTH AND SUBSTANCE ABUSE
WOMEN'S HEALTH
PRESCRIPTION DRUGS

Q & A

- what you will pay
- Benefits package ..
- ABORTION
- mammography
- mental health

→ see

Older Americans
Section for ~~the~~ complete
info & answer

• [Policy Brief: The Role of the State in the Digital Economy](#)

POLICY BRIEF

• [Policy Brief: The Role of the State in the Digital Economy](#)

• [Policy Brief: The Role of the State in the Digital Economy](#)

COMPREHENSIVE BENEFITS

Today's insurance market offers a multitude of policies, each of which spells out benefits, co-insurance schemes, and detailed exceptions and policy riders. The vast majority of policies place severe limits on certain conditions and have lifetime limits. They pay doctors and hospitals only when people get sick, rather than reimbursing providers to keep people healthy. Consumers must also cope with policies that are incomprehensible and are often denied benefits after discovering exclusions hidden in the fine print.

Guaranteeing every American a comprehensive package of benefits that can never be taken away will do much to eliminate these problems.

Guaranteed Comprehensive Benefits

- Every American will receive a Health Security Card that will guarantee a comprehensive package of benefits as generous as those offered by most Fortune 500 companies - - including hospital and professional services, hospice and home care, durable medical equipment, mental health, and other services.

No Lifetime Limits

- Unlike many current insurance plans, the plan places no lifetime limits on medical coverage and guarantees a full range of medically necessary or appropriate services.

Uniform Benefits Help Consumers Choose

- A single set of benefits and standard cost-sharing arrangements will replace the hundreds of different benefits packages in today's market. Consumers, not insurers, will be in the driver's seat, choosing among plans on the basis of price and quality. There will be no hidden loopholes - - and regardless of age, income, or health status, the same set of rules apply to everyone.

Preventive Services

- This benefits package will include a full range of services that detect and prevent illness -- going beyond virtually all current insurance plans. Preventive services -- including annual physicals, well-baby care, immunizations, pre-natal care, cholesterol screenings, mammograms, and Pap smears -- are provided at no charge, no matter how a person gets care.

Mental Health Services

- For the first time, mental health and substance abuse services will be an integral component of the national system of health care. This historic change in the treatment of mental illness and substance abuse will require a phase-in period to allow time to develop the service system capacity to deliver and manage this more comprehensive benefit.
- The year 1996 will mark the first time every American will have some mental health and substance abuse coverage.
- Expanded mental health and substance abuse benefits will be offered no later than the year 2001, once the service and management capacity is in place.

Prescription Drugs Coverage

- Medicare recipients will receive all the benefits that they do today. In addition, the Health Security plan will expand Medicare coverage to include outpatient prescription drugs.

New Home and Community-Based Long-Term Care Benefits

- Seniors and Americans with disabilities will be able to stay at home or in the community and still receive the care they need through a new long-term care benefit.
- Medicaid nursing home coverage will be improved so that individuals can keep more of their resources.

BENEFITS UNDER THE HEALTH SECURITY PLAN

COVERED:

- Hospital Services
- Emergency Services
- Services of Physicians and other Health Professionals
- Clinical Preventive Services
- Mental Health and Substance Abuse Services
- Family Planning Services
- Pregnancy-related Services
- Hospice
- Home Health Care
- Extended-care Services
- Ambulance Services
- Outpatient Laboratory and Diagnostic Services
- Outpatient Prescription Drugs and Biologicals
- Outpatient Rehabilitation Services
- Durable Medical Equipment, Prosthetic and Orthotic Devices
- Vision and Hearing Care
- Preventive Dental Services for Children
- Health Education Classes

NOT COVERED:

- Services that are not Medically Necessary or Appropriate
- Private Duty Nursing
- Cosmetic Orthodontia and other Cosmetic Surgery
- Hearing Aids
- Adult Eyeglasses and Contact Lenses
- In Vitro Fertilization Services
- Private Room Accommodations
- Custodial Care
- Personal Comfort Services and Supplies
- Investigational Treatments, (except for Medically Necessary or Appropriate Care provided as part of an Approved Research Trial)

CHART 13

BENEFITS: THE HEALTH SECURITY PLAN COMPARED WITH CURRENTLY OFFERED PLANS

BENEFITS	HEALTH SECURITY PLAN		BLUE CROSS STANDARD, FEHBP	FORTUNE 500 COMPANY
	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS) ¹		
Medical Plan Maximum	No lifetime dollar maximum limit	No lifetime dollar maximum limit	Lifetime maximum for organ/ tissue transplants, mental health and substance abuse	Lifetime maximum for inpatient substance abuse
Out-of-Pocket ²	\$1500 / individual \$3000 / family maximum	\$1500 / individual \$3000 / family maximum	\$3000 / individual \$3000 / family	\$1,000 per covered individuals - does not include deductibles
Deductibles	None	\$200 / individual \$400 / family	\$200 / individual \$400 / family	\$200/individual \$400/family
Inpatient Hospital ³	Full coverage, no coinsurance no dollar or day maximum	20% coinsurance no dollar or day maximum	\$250 per admission deductible No dollar or day maximum	Full coverage in-network; 20% coinsurance out-of- network
Doctors Office Visits, Hospital Outpatient	\$10 copay per visit no dollar or visit maximum	20% coinsurance no dollar or visit maximum	25% coinsurance	20% coinsurance
Outpatient Lab	Full coverage	20% coinsurance	25% coinsurance	Full coverage in-network 20% coinsurance out-of- network
Emergency	\$25 copay per visit, waived in emergency	20% coinsurance	Full coverage within 72 hrs. of accident	Full coverage - required plan notification within 48 hours
Preventive Services ⁴	Full coverage, based on periodicity schedule	Full coverage, based on periodicity schedule	25% coinsurance 100% well childcare	not specified
Prescription Drugs	\$5 per prescription	\$250/year deductible 20% coinsurance	\$50 deductible 40% coinsurance	20% coinsurance 50% coinsurance for drugs for treatment of mental or nervous conditions

1. FFS - fee for service

2. Deductibles counted toward out-of-pocket limits.

3. Mental health and substance abuse have separate provisions, see below.

4. Including well-child and prenatal care, periodic health exams, targeted tests and vaccines.

BENEFITS	LOW COST SHARING (HMO)	HIGH COST SHARING (FFS)	BLUE CROSS STANDARD, FEHBP	FORTUNE 500
Inpatient Mental Health (MH) and Substance Abuse (SA) ⁵	Full coverage 30 day limit / episode 60 day annual limit	~~Full coverage~~ 20% coinsurance 30 day limit / episode 60 day annual limit	\$250 per admission deductible; 40% coinsurance Unlimited days \$3,000 maximum for substance abuse treatment program - 28 day max. \$50,000 lifetime maximum	20% coinsurance pre-certification required Substance abuse: Full coverage in-network 20% coinsurance out-of-network; 30 days per stay; 2 stays maximum
Outpatient Mental Health and Substance Abuse	All outpatient except psychotherapy - \$10 / visit Psychotherapy - \$25 / visit; 30 visits annual maximum Hospital alternatives - full coverage; 120 day annual maximum	All outpatient except psychotherapy - 20% coinsurance Psychotherapy - 50% coinsurance; 30 visits annual maximum Hospital alternatives - 1 day deductible, 20% coinsurance; 120 day annual maximum	40% coinsurance; 25 visits annual maximum - includes partial hospitalization \$50,000 lifetime maximum	20% coinsurance for employee 50% coinsurance for dependent Substance Abuse: 20% coinsurance, 30 visit maximum
Hospice	Full coverage	20% coinsurance	100% coverage for home hospice; \$250 per admission for inpatient hospice with 5 consecutive day limit	Not specified
Home Health (HH)/ Extended Care (ECF - SNF and Rehab Hospitals)	Full coverage as inpatient alternative 100 day annual limit extended care facilities	20% coinsurance as inpatient alternative 100 day annual limit extended care facilities	25% coinsurance 25 visit limit for home nursing care	20% coinsurance
Routine Eye Exams, Eyeglasses	\$10 per exam, or 1 set of glasses. Glasses limited to children only	20% coinsurance Glasses limited to children only	Not covered	Not specified
Preventive and Emergency Dental ⁶	\$10 / visit Preventive services limited to children <18	20% coinsurance Preventive services limited to children <18	Covered at fee schedule	Not specified
Prenatal Care	Full Coverage	Full Coverage	25% coinsurance	20% coinsurance
Outpatient Rehabilitation	\$10 copay per visit; reassessed at 60 days for continuing improvement	20% coinsurance; reassessed at 60 days for continuing improvement	25% coinsurance 25 visit limit	Not specified
Durable Medical Equipment	Full coverage	20% coinsurance	25% coinsurance	Not specified

5. In 2001, inpatient and outpatient MH/SA limitations and higher cost sharing are phased out.

6. In the year 2000, adult prevention / restoration, orthodontia.

MENTAL HEALTH AND SUBSTANCE ABUSE BENEFIT SUMMARY

When untreated, mental disorders and substance abuse generate high social and economic costs. Treatment yields important benefits to both the individual and society, such as improvement in overall health, increased productivity, and reduced costs for health services, social welfare, and other public services.

Traditional mental health and substance abuse coverage, however, has been an impediment to realizing these aims. Currently, most private insurance plans cover only a very narrow band of mental health services and limit inpatient hospital care and outpatient visits to mental health professionals. Annual limits, lifetime caps, and copayments higher than for other illnesses further restrict access to mental health care.

Recent experience shows the promise of a different approach. Under this model, a health plan covers a comprehensive array of services and has the flexibility to manage the services according to medical and psychological necessity. This approach underlies the mental health coverage in the Health Security Act.

[Note: Work is still underway on this particular aspect of the health care reform plan so there may be changes in this coverage prior to the time the proposed legislation is submitted to Congress.]

Mental Health and Substance Abuse included in Comprehensive Benefit Package

- For the first time, mental health and substance abuse services will be an integral component of the national system of health care. This historic change in the treatment of mental illness and substance abuse will require a phase-in period to allow time to develop the service system capacity to deliver and manage this more comprehensive benefit.
- The year 1996 will mark the first time every American will have some mental health and substance abuse coverage.

Annual and Lifetime Limits and Preexisting Condition Exclusions will be Eliminated

- Lifetime and annual mental health and substance abuse coverage limits will be eliminated.

- Individuals with a wide range of mental and substance abuse disorders are covered and exclusion from coverage based on pre-existing conditions will be eliminated.

Encourages use of Innovative Alternatives to Inpatient Treatment

- The new benefit is designed to encourage use of proven, cost-effective, innovative alternatives to inpatient treatment by including non-residential options such as partial hospitalization, day treatment, psychiatric rehabilitation, ambulatory detoxification, home-based services, behavioral aide services.
- In addition, outpatient services including diagnosis, brief office visits for medical management, substance abuse counseling and relapse prevention are covered to encourage early intervention and less restrictive treatment options.

Support Provided for Family Members of Patients

- Family members of an individual receiving mental or substance abuse services may receive medically necessary or appropriately related services in conjunction with the patient (so-called collateral treatment).

Expansion of Benefits in 2001

- Efficient management of benefits will determine the utilization of these services by the year 2001, prior to then utilization limits will exist.
- At this time, beginning in 1996, inpatient treatment is covered a maximum of 30 days per episode with a 60 day annual limit. As the treatment system adapts to the anticipated changes, the annual limit increases to 90 days in 1998 and is replaced by benefit management by 2001.

Maintenance of Current Public Programs During Phase-in

- The phase-in period requires continuation of the existing public system of mental and substance abuse treatment services. However, states are encouraged to integrate all aspects of treatment by combining their expenditure for public mental health and substance abuse programs with the funds available to health alliances .

Health Research Initiatives

- Under health research initiatives, research in the area of mental disorders in children and adolescents, child abuse and neglect, women's mental health, mental disorders in the elderly and their caregivers, severe mental disorders and violence.

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WOMEN'S HEALTH

Women are more likely to need health care than men, and yet are less likely to have insurance. Women are most likely to provide health care -- both professionally and informally-- yet are least likely to receive needed care themselves. They are increasingly the victims of life-threatening illness, yet still are at the bottom of our medical research agenda.

- *Women make up a larger portion of the population holding part-time jobs and clerical or sales jobs--jobs which usually don't offer health insurance to employees.*
- *Women tend to live longer and thus require more long-term and home health services, services that are often unavailable and underfinanced.*
- *Many women must rely on their spouses for health insurance, and risk being dropped if they divorce or if they are widowed.*

A Comprehensive Benefits Package

- Women will be guaranteed a comprehensive package of benefits that will include unprecedented coverage of preventive care, such as mammograms, diagnostic services, and prenatal care.
- All women will be guaranteed universal coverage regardless of marital status, employment status, or their ability to pay.
- It also provides coverage for diagnostic for women experiencing menopause including diagnostic visits and estrogen replacement therapy when medically advised.

New Emphasis on Women's Health Research

- New research initiatives will concentrate on child health (including birth defects, prenatal care, and adolescent health), and on chronic and recurrent illnesses that primarily strike women -- including breast cancer, ovarian cancer, and osteoporosis.
- Medical research initiatives will be expanded to include efforts to isolate and cure diseases such as breast cancer and cervical cancer.

Expansion of Home and Community-Based Long-Term Care Services

- Long term care services will be expanded to include new coverage for home and community care and strengthened coverage for nursing home care. This will alleviate the undue burden born by women, our nation's primary care givers for both children and elderly relatives.

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PRESCRIPTION DRUGS

Prescription drugs are frequently the most cost effective intervention to treat medical conditions. However, these potentially life-saving products are often inaccessible because there is inadequate insurance coverage for Americans and because the cost of pharmaceuticals have far outpaced the general inflation rate. Until very recently, prescription drug price increases dwarfed percentage increases in the rest of the economy. Between 1980 and 1992, while the general inflation rate increased by 22 percent, drug prices increased 128 percent. New medications, especially biotechnology drugs -- although full of potential to advance medical treatment advance potential, are extremely expensive.

Almost 25 percent of Americans under age 65 do not have any type of public or private prescription drug insurance coverage. As a result, expensive, frequently taken medications (like antibiotics for children) become such a financial burden that many vulnerable populations go without.

The high cost of prescription drugs and their heavy reliance on medications, cause a significant financial burden for Older Americans. Since Medicare does not cover outpatient prescription drugs, only 46 percent of all drug costs for seniors are paid for by public or private insurance plans. As a result, prescription drug costs are the highest out-of-pocket medical costs for 3 out of 4 older Americans. A recent AARP study found that nearly 8 million Americans over the age of 55 report that they must choose between buying food and paying for prescription drugs.

Coverage for Prescription Drugs Included within the Comprehensive Benefit Package:

- All health plans for the under 65 population will be required to cover outpatient prescription drugs. Under the low-cost sharing option plan, the beneficiary will pay \$5 per prescription. Under the high-cost sharing option plan, the beneficiary will be covered for 80 percent of his/her prescriptions after a \$250 deductible is met. The insured person's copayments will count towards the overall out-of-pocket \$3,000 cap.

Provides a New Medicare Outpatient Prescription Drug Benefit:

- Like the nationally guaranteed package, Medicare beneficiaries will have 80 percent coverage for their medications after a \$250 deductible is reached. In addition, a \$1,000 annual cap is placed on out-of-pocket prescription drug costs. Costs above this amount will be fully covered.

Drug Costs for the Under 65 Population will be Controlled:

- The national guaranteed benefit, offered by private sector plans, will use managed care purchasing mechanisms to hold down the rate of growth of current drug prices. For new drugs, private purchasers will have the benefit of information provided by the National Health Board about the appropriateness of prices. The Board cannot regulate prices.

Provides for Cost Containment of Medicare Prescription Drug Benefit:

- The Medicare program, which will become the world's largest purchaser of medications, will receive a discount for prescription drugs currently on the market. Without the authority to use parallel private sector purchasing tools, the Secretary of Health and Human Services will be given authority to negotiate the price of new drugs for the Medicare program.

Patient Counseling by Pharmacists:

- To help avoid unnecessary, inappropriate and expensive hospitalizations, pharmacists will be required to provide patient counseling.

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QUESTIONS AND ANSWERS

WHAT YOU WILL PAY

Q: How much will I have to pay for the new benefits package?

A: Nobody can tell you exactly how much you'll pay for health care when the reform takes affect in your state. It will vary, of course, depending on where you live and which plan you choose. Everyone -- employers and individuals -- will be asked to take responsibility for contributing something, even if its only a small amount, to the cost of their health care. Premiums for working Americans will be shared by employers who pay 80% of the average cost premium and employees who pay the remaining 20%. If you choose a lower cost plan, you'll pay a little less and, like today, if you choose a higher cost plan, you'll pay a little more.

BENEFITS -- SPECIALIZED SERVICES

Q: If I develop cancer will I still be able to go to the Mayo Clinic?

A: Academic health centers like the Mayo Clinic are the flagships of our health care system. Their research has fueled advances in medical care that have spread throughout the world. We also know that for some medical conditions, especially where treatment is very complex or the technology is changing rapidly, care is best provided in an academic center.

Under our proposal, all health plans must contract with one or more academic health centers for certain, specialized procedures and diseases. Health plans will be monitored to ensure that patients are offered appropriate referral to those centers.

Of course, not every health plan in the country will contract with the Mayo Clinic. If you live far away from Minnesota, you may have to join the fee-for-service option in the alliance which will cover the Mayo Clinic and any other hospital. If, on the other hand, you are interested in assuring that you can be cared for in a local academic center, plans will publish a listing of their contractual relations. And you can choose a plan which contracts with that center.

ABORTION

Q: Does the plan cover abortion?

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

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

The President has
~~I~~ worked to create a health plan that covers abortion where necessary, but ~~I have~~ *he has* also worked to make sure that people have a choice and that abortion is as rare as possible.

Mammography

Q: I am a women who is 42 years old and am concerned about the issues surrounding mammography screening. Under the Health Security Act will it be difficult to get this screening and will I have to pay a lot of money for this service?

A: The Health Security Act is deeply committed to womens' health issues. The plan is designed to work toward ensuring appropriate mammography screening in order to reduce the tragedy of breast cancer. Mammography screening is included for women over the age of 50, at no cost every two years. This recommendation was based on the best scientific literature available today, including the National Cancer Institute. For all other women mammography screening will be covered when it is medically necessary or appropriate. This decision will be made between a women and her physician. For these women, mammography will be covered with the same co-payments, just as any other medical procedure.

MENTAL HEALTH BENEFITS Q & A

- 1. Aren't mental illnesses and substance use disorders very different than other conditions? If these aren't real medical problems, we shouldn't cover them in health care reform.**

- 1A.** No, MH/SA disorders are not different than other conditions. MH/SA disorders cause distress, and disability. They can produce significant dysfunction. Medical treatments are available that reduce distress and dysfunction, and prevent disability. Left untreated, MH/SA disorders lead to direct costs (including other health care problems) and indirect costs (e.g., lost productivity).

The majority of private insurance plans now cover MH/SA treatment, as well as Medicaid, Medicare, and CHAMPUS. Insurance companies have recognized the legitimacy of the suffering and disability these disorders cause.

- 2. Won't everyone want to see a therapist if insurance will pay for it?**

- 2A.** No, everyone will not want to see a therapist under health care reform. In a given year, only 10–11% seek care for a MH/SA problem. Only 6% of the population currently seek specialty MH/SA services. Of those who use ambulatory services, 50% only go once or twice. There is a great deal of misunderstanding of MH/SA conditions, as well as resistance to treatment, and stigma about seeking treatment. Many people are reluctant to admit they have MH/SA problems and seek help for them.

Furthermore, not everyone seeks care because not everyone has a mental disorder. Even those people with symptoms do not always experience distress or functional impairment sufficient to seek help.

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**If there aren't any benefit limits, won't people be entitled to receive everything they want?
How will decisions be made about who receives services?**

3A. People will receive services based upon what they need. Like all of health care services under health care reform, providers will be operating within a budget and will have to manage care. Their incentive will be to provide only care that is medically appropriate. Providers will make decisions about the scope, volume, and duration of services that are necessary and appropriate. A wide range of services will be available for those who need them.

4. Won't we be paying for coverage of the worried well? I don't want to pay for someone to talk to my neighbor about their problems of living.

4A. Enrollees will not receive care unless they have a diagnosable MH/SA disorder. Not everyone meets the criteria for such illnesses. Even when they meet the criteria, not everyone would meet the criteria of significant risk for functional impairments at work, home, school, or community. Any enrollee will be evaluated if they perceive a need for MH/SA treatment, but no one will get care unless it is medically necessary and appropriate. Persons with SA problems or serious psychological symptoms will be eligible for these services. Enrollees will still be free to pay out-of-pocket for services they may desire outside the health plan.

5. Given the dissatisfaction among providers with managed care, why is this being proposed?

5A. People have complained about restricted access, micro-management, intrusion on professionals' decisions about care. Utilization management strategies will now be used for all of health care -- mental health providers are not being singled out for special attention. Health care reform offers the opportunity and challenge to providers to organize and manage care, to assure efficient and appropriate utilization of health care resources.

Does the health reform proposal include treatment on demand for drug abuse?

- 6A. The plan includes treatment for substance abuse. Experience tells us that this benefit will increase access and number of users of the benefit, likely by 30–40%. However, careful management of the benefit will decrease the volume of services per user. This is not a costly treatment, compared to the costs that result from lack of treatment. Substance abuse is estimated to encompass only approximately 1.5% of total health care costs, and 15% of MH/SA care costs.

7. Why should we cover substance abuse in this plan?

- 7A. Right now, we are spending much more in this country to deal with the effects of substance abuse than we are on treating the problem itself. Increased crime, criminal justice costs including incarceration, lost productivity, premature mortality, child abuse, fetal alcohol syndrome, crack babies, spread of the AIDs epidemic, a resurgence of TB -- all of these costs are a direct or indirect result of the monumental drug abuse problem in this country.

If we redirect adequate dollars to prevention and early intervention, we can improve the quality of life for many Americans, and save many billions of dollars at the same time.

8. How will we know that plans don't ignore the needs of the severely ill and undertreat those with mental illness or substance abuse? How will we know if plans are doing what they are paid to do?

- 8A. The system includes stringent accountability standards for AHPs. A "report card" will be completed on each plan every year. Plans will be monitored for their treatment of the severely ill, and those suspected of undertreatment will be investigated. HAs may reprimand, reeducate, or decertify substandard AHPs. Consumer surveys will be another important measure of AHP performance.

Aren't we taking a major risk if health care reform leads to an elimination of the public sector MH/SA system and "safety net"?

- 9A. The Plan provides for an array of services that cover all of the functions once performed by the public system, except forensic services. One goal of health care reform is to create a unitary system of care. The current system is fragmented, duplicative, unfair, confusing, inequitable, and discriminatory. Health care reform allows the elimination of this two-class, two-tiered system. The states will have a major role in system oversight and monitoring.

Resources from the public sector are brought in to be part of the reformed system. States can bring in public sector providers and programs as preferred providers during a transition period; the transition period is intended to ensure that states can develop necessary capacity.

10. **How will health care reform help the homeless person on the street who has a mental illness? Won't the elimination of the public sector safety net result in more homeless persons with mental illness?**

- 10A. The Plan includes a strong outreach effort. A special funding stream has been proposed which will provide outreach to the homeless mentally ill and other historically underserved populations. We will also increase access through educational programs for all Americans about what health care reform means for them.

Currently, no one is accountable to provide services to the homeless. This plan provides guaranteed coverage, outreach, and flexibility to provide mobile services and a range of services that are more likely to respond of homeless persons with mental illness. We do not believe this plan will create more homeless mentally ill, and monitoring activities will watch this issue closely.

Aren't mental health and substance abuse treatments open-ended, without clear cut goals or endpoints?

11A. This is a myth. The fact is that when people feel better and their symptoms resolve, they stop treatment. Most people only go for 1 or 2 sessions of therapy. Mental health and substance abuse experts have developed innovative treatments, which are able to help people with these problems in shorter time than ever. Traditional, longer therapies are still available for those with more complex problems. In addition, medications now offer symptom control for many persons who previously required indefinite hospitalization because of mental illness. Scientific advances promise to improve treatments even more in the future.

12. Does the plan stipulate who can provide mental health and substance abuse treatment?

12A. The President's plan leaves decisions about providers and settings to the states, which will be responsible for licensing and certification. These decisions will not be made more explicit at the federal level. If a given professional group provides cost-effective services, it would be to the state's advantage to include them as providers.

13. What will happen to solo practitioners?

13A. Solo practitioners will be able to enroll as providers in AHPs, to qualify for reimbursement for the care of plan enrollees. They may remain independent, and receive reimbursement as out-of-plan providers. Individuals will be permitted to pay out-of-pocket for any service they desire which the AHP does not provide to them.

Does this plan cover psychotherapy?

- 14A. The Plan covers medically necessary individual, group, and family therapies of all types. Most people will have brief episodes of treatment. Persons with more severe and complex disorders (who are very symptomatic and functionally impaired) will be provided extended psychotherapy. Like all MH/SA treatment, this will be part of a managed system of care.

15. Is the fact that MH/SA is being included going to increase premiums?

- 15A. It is likely that most people will see an increase in their premiums. In return, enrollees receive full MH/SA benefits, including catastrophic coverage in the private sector (which now results in transfer to the public system of care).

6. Are there gatekeepers? Is there a procedure for grievance? Denial of services?

- 16A. Under the plan, each enrollee will be entitled to screening and assessment of MH/SA complaints, with referral for medically appropriate services. For enrollees unhappy about treatment or denial of services, a grievance procedure will be available.

What happens if an enrollee doesn't get along with the assigned therapist?

17A. Each AHP will have a selection of therapists. If the enrollee does not get along with one therapist, others will be available.

18. Won't AHPs want to avoid enrolling people with mental illness and substance abuse?

18A. The Plan will include a system of risk adjustment. AHPs will be paid a combination of pre-payment and reimbursement based on services provided. Adjustments will be made for high-cost cases, to minimize the incentives to undertreat. In addition, because AHPs have responsibility for the care of their enrollees, and have no public system in which to dump patients, it will make financial sense for them to treat those with MH/SA disorders rather than waiting until symptoms become so severe that more expensive treatment is required.

Clinical Laboratory Improvement Act (CLIA)

Ease regulatory burden on laboratories performing simple and moderately complex tests. Revise personnel standards for rural and urban underserved areas.

Rural Cooperatives

C. STATES UNDER REFORM

POLICY BRIEFS:

TRANSITION TO NEW SYSTEM
STATES: THEIR ROLE IN REFORM

Q & A

- Single Payer

POLICY BRIEF

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TRANSITION

States may enter the new system as early as January 1, 1995 and all states must enter the new system by January 1, 1997. States are given start-up funds and technical assistance in developing state plans and legislation. States entering the new system on a fast track have some additional flexibility in complying with federal regulations, all of which may not have been completed at the time of a state's entry into the new system. To assure a rapid transition, the National Health Board, the Department of Labor and the Department of Health and Human Services are authorized to issue any regulations on an interim and final basis.

Incentives for States to Enter the New System Quickly:

- Federal discounts for low-wage small businesses and individuals;
- Access to additional start-up funds;
- Reduced Medicaid costs;
- Faster achievement of guaranteed, comprehensive benefits for the state's residents.

Immediate Insurance Reform Measures:

To reduce the potential for disruption in the health care system during the transition, certain insurance reform measures will be enacted, and will take effect immediately upon passage of the legislation. These include:

- Prohibiting insurers from dropping people or failing to renew their coverage, with strictly defined exceptions.
- Limiting premium increases. Premium increases that exceed a prescribed percentage will be subject to prior approval by state insurance commissioners.
- Limiting the application of exclusions for pre-existing medical conditions to new employees and their dependents.
- Prohibiting self-funded health plans and employers with insured health plans from imposing waiting periods for coverage on any employee otherwise eligible under terms of the plan.

- Prohibiting employers and insurers from reducing existing coverage for any medical condition or course of treatment if the anticipated cost is likely to exceed \$5,000 a year.
- Authorizing the Secretary of HHS to establish a national high-risk pool. It will provide insurance coverage to individuals who get dropped by their health plans or who otherwise could not get coverage during the transition. The pool will be funded through premiums charged to enrollees and assessments against health insurers included self-funded plans.

Limiting Price and Expenditure:

While there is no imposition of short-term cost controls, the President will urge all health care sectors to limit price and expenditure increases to a specified amount.

- The Secretary of HHS will monitor prices and expenditures and periodically report on conformity with the President's request.
- The Secretary is given increased statutory authority to obtain information on prices and expenditures to assist in monitoring compliance.
- Confidentiality of data is assured.

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STATES-- A NEW ROLE UNDER HEALTH REFORM

Right now, federal and state governments lack sufficient authority to control costs. Many states, facing rising Medicaid budgets and diminishing private insurance coverage, have tried to contain costs and expand access, only to run into road blocks in federal law, such as ERISA, Medicaid, and Medicare. Although the states regulate private insurers, the haven of self-insurance created by ERISA has greatly limited the states' ability to control health costs.

On the other hand, while the federal government determines policy for Medicare, it shares authority with the states over Medicaid, and it has no responsibility for regulating private health insurance. Federal cost containment measures focus on public programs and often have the effect of shifting costs to private payers. Limiting expenditures only for federal programs has resulted in increased cost-shifting from Medicaid and Medicare to private insurers and the states.

The health reform proposal follows a comprehensive approach to controlling the growth of costs in both the public and private sectors, and establishes a new partnership between the states and federal government, with joint responsibility for assuring high quality health care, universal coverage, and enforceable cost control.

The program will not try to run health care from Washington-- it will allow states, alliances, and health plans competing for consumers to work out solutions at the local level.

The Federal Framework

The federal framework sets a uniform standard for financing, benefits, and quality assurance. Under the new system, employers and individuals have the same obligations nationwide. A state cannot deny coverage to any person guaranteed health benefits under federal law, nor can a state reduce benefits beneath the federally guaranteed level. Similarly, states must adhere to the financing system established for the guaranteed benefit package.

The State Role

Within the national framework, the program allows for wide variations in state policy on the organization and delivery of health services. Under the Health Security program, direct control of the regional health alliances, the certification of health plans, and the licensing of providers will rest with the states.

- Under the new system, the states remain responsible for regulating health plans and health care providers. The states also immediately become responsible for establishing the new regional health alliances. Thus, the states have the capacity to adapt the national framework to suit their own conditions.
- The phasing in of the new program will proceed state by state. Within the years 1995 to 1997, states will determine how quickly the alliances are established and coverage is extended to all. State-by-state phase in and a central role for the states in running the new system will allow for adjustments in the national framework to fit local conditions.
- Federal support will make it possible to extend coverage to all without overburdening employers and employees in low-wage areas. Without this financial assistance, states with low per capita income and large numbers of part-time and unemployed workers would be hard-pressed to achieve universal coverage.
- A reserve fund established under the program will help states cope with regional recessions.
- States will continue to administer the Medicaid program for long-term care, and to oversee or conduct enrollment for cash assistance recipients who get their plan paid for through Medicaid.

HEALTH CARE REFORM - BENEFITS TO THE STATES

Governors and state legislators find themselves in the position of writing smaller and smaller checks for schools and roads and libraries and bigger and bigger checks for Medicaid and state employee health benefits.

In an effort to lighten the load of exploding Medicaid costs, state capitals and Washington have engaged in a game of fiscal hot potato -- shifting costs of the program back and forth to one another, while costs keep rising. The health security plan will help to end the gaming and build a new and constructive partnership between states and the federal government. A partnership based on seamless coverage, enforceable cost control, and Medicaid savings will benefit everyone -- especially the states.

DISCOUNTS

- The Federal government will provide the funds for employer and consumer discounts for low-wage firms and low-income families.
- The Federal government, not state employee health programs, will help pay for the health benefits of early retirees.

CAPS

- The Federal government will take responsibility for enforcing caps on premium increases.
- State Medicaid spending for the guaranteed benefits will be capped at the budgeted rate of growth, resulting in substantial savings from projected spending.

REDUCED SPENDING

- States and localities will be able to reduce direct spending on the thousands of residents on General Assistance/General Relief medical assistance when those individuals will be guaranteed the comprehensive benefits package.
- States and localities will be able to reduce direct support to hospitals and clinics that now care for the uninsured.

- Spending on Medicaid long-term care services will be transferred to the new long term care program and capped at the budgeted rate of growth. In aggregate, state spending for the new long term care program will be the same as baseline spending for long term care services under Medicaid.

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QUESTIONS AND ANSWERS

SINGLE PAYER

How would the single payer system work?

A state that wants to use a single payer system would describe in a plan how its single payer system will work, just as it would describe how a regional alliance system would work. It would submit the plan to the National Board.

The plan would have to demonstrate how the state will accomplish the requirements under the new system -- the comprehensive benefit package, universal coverage, quality, information, and compliance with budget requirements. A state has the authority to include everyone in the single payer system, including those who would otherwise be covered by corporate alliances.

If a state wants to include the Medicare population, it would have to receive a waiver from HHS. The waiver would be granted only if the state could demonstrate that Medicare recipients and the Medicare trust fund would be no worse off.

The National Board will approve the plan if the state plan demonstrates how it will meet the requirements, such as universal coverage and the benefit package.

A state must finance a single payer system either with the financing under this plan or with a payroll tax that produces the same amount of revenue. Additional costs, such as for reduced premium payments by individuals, or for additional benefits, could be financed in any way the state chooses.

A single payer system is one in which the state or a designated agency makes payments directly to health care providers with no intermediaries, health plans, or other entities assuming financial risk. Providers, such as HMO's, networks of doctors, and hospitals, may continue to assume risk by accepting capitated payments to cover individuals.

D. HEALTH ALLIANCES

POLICY BRIEF:

HEALTH ALLIANCE BOARD

Q & A

- *Alliances*

• [Link](#)

• [Link](#)

POLICY BRIEF

• [Link](#)

• [Link](#)

HEALTH ALLIANCE BOARDS

Health alliances will represent the interests of local consumers and employers, bargaining on their behalf and ensuring that health plans meet quality and information standards. The alliance boards will negotiate and contract with health plans. Although states will appoint board members of regional alliances, the Health Security plan will specify general criteria to ensure that alliances represent the business and families paying for health care in that area.

Status of Alliance Boards

- Alliances may be established as nonprofit corporations, their boards will include an even number of employer and consumer representatives, plus one member to serve as chair.
- States may also establish alliances as public agencies or independent public corporations, but they must include advisory boards representing both consumers and providers.

Board Representation

- Boards must include representatives of at least four groups that purchase coverage through the alliance: employers, employees, self-employed individuals, and consumers.
- Health care providers, owners of health plans, individuals who derive substantial income from health plans or providers, or owners, employees, board members, and others who derive substantial income from pharmaceutical companies or suppliers of medical equipment, devices, and services will be prohibited from serving on alliance boards.

Provider Advisory Boards

- Each alliance will establish a Provider Advisory Board, with representation of doctors, nurses, and other health care professionals who practice in the plans offered in that area.

Nominating Councils

- States may establish statewide councils composed of representatives of employer and consumer organizations to prepare lists of nominees for alliance boards.

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QUESTIONS AND ANSWERS

ALLIANCES

~~Two issues are of particular concern to Republicans on the Committee, and it might make sense for Mrs. Clinton to address them in her opening statement. Senator Kassebaum is very concerned that the alliances will be too big, regulatory, and bureaucratic--more like government agencies than purchasing cooperatives?~~

Q:
Won't

A: --The alliances will represent the purchasers of health care in an area; it is the purchasers who will control the alliance, not the Federal government.

--The alliances resemble the benefits departments of large corporations much more than they do governmental entities. Their job is to negotiate the best deal possible with health plans on behalf of the members of the alliance, to provide information to consumers, to handle enrollment, and to adjudicate complaints.

--Alliances do not regulate health plans. That responsibility is left to state governments, where it is today.

--In fact, alliances are required to offer any health plan that is certified by the State government, is willing to fulfill the same contractual obligations as any other insurer offered by the alliance, and will offer a premium consistent with the budget.

--The whole point of the managed competition system is to put the individual consumer in the driver's seat, not the government and not the health plans.

HEALTH ALLIANCES

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

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

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

E. HEALTH PLANS/INSURANCE REFORMS

POLICY BRIEFS:

INSURANCE REFORMS

RISK ADJUSTMENT AND REINSURANCE

Q & A

- Risk Adjustment & Reinsurance

POLICY BRIEF

INSURANCE REFORM

Currently, health insurers use a variety of strategies to discourage or prevent less healthy people from getting insurance. For example, insurers commonly (1) refuse coverage to people who cannot meet "medical underwriting" criteria; (2) limit benefits to people with preexisting health conditions; (3) charge higher premiums for less healthy people; and (4) refuse to insure people in certain industries or occupations. As a result, many people who need health insurance cannot get it.

The Health Security plan will change the insurance market by doing the following:

- **Requiring all health plans to accept all applicants,** regardless of health status
- **Prohibiting all pre-existing condition exclusions** and guaranteeing that coverage cannot be dropped for any reason
- **Spreading risk broadly** through the use of community rating
- **Enhancing financial protection** of enrollees and providers in the case of financial failure of health plans.

Guarantees Choice of Health Plans:

- The Health Security plan will require all health plans to accept any person who applies for coverage, regardless of the applicant's health status, job or claims history.

Provides Security:

- The Health Security Act will provide security to all Americans by assuring that their coverage will not be limited or dropped for any reason. People who switch jobs or move to a new place will have no gaps in their coverage.

Community Rating:

- The Health Security plan will rely on community rating -- charging healthy people the same as sick people -- to spread health costs over a large population. Premiums for the comprehensive benefit package will be adjusted only for geographic location and family status.
- Rate increases will not be targeted to sick people or groups. No one will pay more for health insurance because of a pre-existing condition, current illness or any other individual characteristic.

Enhanced Financial Protection:

- If a health plan does have financial problems, people will be protected through immediate enrollment in new health plans. Physicians and hospitals will not be permitted to bill individuals for the unpaid claims of a financially troubled health plan.
- Health plans will be required to meet federal minimum standards for solvency.

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ADDRESSING BIASED SELECTION THROUGH REINSURANCE AND RISK-ADJUSTMENT

BACKGROUND

Competitive insurance markets must address the problem of "biased selection." Biased selection occurs when a health plan enrolls a population with a better or worse than average health status.

The problems of biased selection can result from the actions of individual consumers or health plans.

Individual consumers can contribute to biased selection through their decisions about when to purchase insurance and the level of coverage to purchase. Consumers who know they are in poor health or at higher risk for needing health care services are more likely to choose to insure and to choose more extensive benefits when they do insure. This tendency is often referred to as "adverse selection." In a reformed market, adverse selection may occur if higher-risk people systematically select certain types of health plans (e.g., plans that offer greater choice of health care providers).

Health plans can contribute to biased selection through the use of various techniques which discourage enrollment by higher-risk people and attract healthier enrollees. In the current marketplace, insurers use medical underwriting, preexisting condition exclusions, minimum group participation requirements, and industry exclusions to prevent enrollment by poorer risks. Even in a reformed market, health plans may attempt to influence the composition of their enrollment. Decisions relating to which providers to contract with, where to locate service areas and facilities, and the amount of service and support to provide higher-cost patients all can affect the mix of enrollees attracted to a health plan.

Biased selection affects the premiums charged by health plans and therefore how the competitive market operates. If biased selection occurs, health plans with relatively sicker or higher-risk enrolled populations generally will have higher claims expenses than plans with average enrollment mixes, and will be forced to charge higher premiums to cover their higher costs. On the other hand, health plans with relatively healthier enrolled populations will have relatively lower claims expenses and can charge lower premiums.

To the extent that health plan premiums reflect biased selection rather than the efficiency and quality of the competing plans, the benefits of competition are diminished. To achieve all of the benefits of competition among health plans, strategies to address the problem of biased selection must be pursued.

ADDRESSING BIASED SELECTION

The health reform plan addresses biased selection in several ways:

- Universal coverage and insurance reform address the problem of health plans cherry-picking only healthy risks.
- In the short-run, limited premium adjustments and mandatory reinsurance is used to protect health plans from adverse selection.
- Within a couple years after reform, a prospective risk-adjustment system will be developed. Premiums paid to health plans will be adjusted to reflect the health status of the plan's enrollees.

Universal Coverage and Insurance Reform

Many of the risk selection problems that exist in the current system are addressed through assuring universal coverage to comprehensive benefits and through insurance reforms.

- Universal coverage. In the current system, insurers worry that people with or at high-risk for health problems are more likely to seek coverage. In the reformed system, everyone will have health insurance coverage. People will be unable to wait until they have health problems to choose coverage, so this component of the adverse selection problem will disappear.
- Uniform comprehensive benefit package. In the current system, insurers worry that less healthy people tend to choose richer benefits. In the reformed system, everyone will have the same comprehensive benefits package. There will be less reason for high-risk or low-risk people to systematically choose a particular health plan because of the level of benefits offered.
- Guaranteed issue and renewability of coverage. Insurers use medical underwriting and a host of other strategies to discourage enrollment by higher-risk people. Under a reformed system, all health plans will be required to accept any enrollee who applies for coverage. Plans will not be able to discourage enrollment based on health status.
- Enrollment through alliances. Under the current system, health plans can influence the composition of their enrollment through their marketing activities. Under a reformed system, enrollment will occur through alliances. Regulations can be used to assure that marketing is not directed only toward more desirable areas. Standard service areas for integrated health plans could be used

to limit the ability of health plans to avoid higher-cost areas.

- Satisfaction and disenrollment surveys. Health plans can discourage higher-risk enrollees by giving them poor service or failing to contract with providers that can address special needs. Under a reformed system, enrollees can be periodically surveyed to detect problems with health plan service. People who switch plans can be surveyed to determine if they left their former plan because of poor service or inadequate access to specialists. Problems uncovered can be addressed through alliance contract negotiations or state certification.

Mandatory Reinsurance

Mandatory reinsurance will be used to protect health plans that attract a disproportionate share of enrollees with high-cost or chronic illnesses.

Under a reinsurance approach, health plans share the costs of treating higher-cost or chronically ill enrollees. If a health plan has a high-cost claim or enrollee, the reinsurance system reimburses a portion of a health plan's payments for these cases. Health plans are required to pay premium to the reinsurance fund for this protection.

Reinsurance systems are being used today in a number of states as part of their insurance reform efforts. For example, as part of its community-rating law, the State of New York created a reinsurance pool for high-cost cases. Insurers are required to pay a premium to the reinsurance pool; in exchange they receive lump-sum or periodic payments from the pool when they have a claim for one of the conditions covered by reinsurance.

Risk Adjustment to Health Plan Premiums

Short Term Strategy

A short-term strategy to address biased selection will be pursued that contains both prospective and retrospective components. This approach was recommended by a panel of experts on risk adjustment

In the short-term, the following measures will be relied upon:

- Demographic adjustments to premiums. Cost weights for demographic cells (age, sex, etc.) will be developed from National Medical Expenditure Survey (NMES) and private insurance data sources.
- Limited health status adjustments. Adjustments may be made for perceived health status or the presence of

chronic conditions, based on data collected through the use of health status surveys. NMES and private insurance data will be used to develop cost weights in the short term.

- Retrospective adjustments for high cost cases. Reinsurance will be used to reimburse health plans for some of the costs associated with high-cost cases or diagnoses. Reinsurance may reimburse a percent of costs above a reinsurance threshold or may provide specific payments for identified high cost conditions, like AIDS or organ transplantation. Cost weights will be developed from a private insurance data base (New York State uses weights developed from Kaiser data).
- Geographic adjustment. Adjusters will be developed to adjust for price (and perhaps utilization) variations within health alliance areas. Such adjusters already exist to some extent for Medicare. Cost weights will be developed from private insurance and Medicare data.

Medium Term Strategy

Within a few (3-5 years) years, health status risk adjusters will be developed which rely on diagnosis-based measures. The risk adjustment system will rely on diagnosis and treatment information collected through the data and quality information system implemented as part of health care reform. Reinsurance may continue to be used for particularly high-cost cases.

Mental Illness

Given the present state of knowledge, mental illness will need to be treated differently than other conditions in a risk adjuster system. There is more disagreement about an appropriate patient classification system than with physical illness, and the severity and resource demands of patients within a diagnostic category probably vary more than with physical illnesses. In addition, underservice is a problem for the severely mentally ill, and a purely prospective payment could exacerbate the problem. A heavy reliance on reinsurance will be necessary in the short and medium terms.

Research and Model Systems

Federal research efforts will be necessary to support the development of model risk adjustment and reinsurance systems that can be used by states and alliances. The federal government will increase its support for new research related to the development and testing of risk adjustment systems for the short and medium terms. An on-going program aimed at improving existing risk adjustment measures and developing new approaches will be maintained at the federal level.

QUESTIONS AND ANSWERS

Risk-Adjustment Questions and Answers

Q: Researchers and others have been trying to develop a risk-adjustment system for Medicare for ten years and have not succeeded. How are you going to develop a system in two years?

Our plan deals with the risk-adjustment problem in two stages. During the first couple years after reform, we rely on a combination of demographic premium adjustments and mandatory reinsurance to address biased selection. Demographic adjusters for age, gender and area are possible with current technology. Reinsurance is currently being used in a number of states as part of small group reform. We also will develop limited health status adjusters, based in survey information collected from health plan enrollees.

Beginning several years into reform, risk-adjusters will be developed which rely on diagnosis-based measures. Health plans will be paid based on the relative health status of the population they enroll.

The new quality management system is key to our ability to develop a sophisticated risk-adjustment system. Current efforts to implement good risk-adjusters have been frustrated by the lack of information about the relative health status of enrollees of health plans, especially HMOs. Our quality management system captures diagnosis and treatment information about each patient encounter, which will for the first time give us the ability to evaluate the relative health status of the enrollees of each health plan.

Q: How did you arrive at this strategy?

During the task force process, we met with the leading experts in risk-adjustment field. We also met with health plans that are currently experimenting with or actually using risk-adjustment, for example to adjust payments to group practices. There was broad agreement that our approach was appropriate.

Q: Current risk-adjusters explain only a small amount of the variation of costs for any specific enrollee. Critics question whether this is enough to protect health plans?

No adjustment system can explain all expected cost variation at the individual level-- much of the variation in costs is random. The goal is to develop adjusters that predict enough variation in health care costs so that health plans can compete successfully on the basis of efficiency.

The issue of how much variation in costs can be "explained" by risk adjusters is very complicated. For example, critics claim that current adjusters based on demographic factors, such as age and gender, explain only about one percent of variation in expected costs for an individual. This is true. However, these factors explain quite a bit of the variation in expected costs across

groups, such as the groups of enrollees in two health plans. Thus, adjustments for age and gender are very important to assure proper payment to health plans that get a disproportionate share of older people or woman of child-bearing age.

Several promising risk-adjustment approaches are currently being developed and implemented. They use prior health care use by individuals to predict their future costs and have the potential to explain a meaningful percent of the cost variation that can be explained. The federal government will be conducting and sponsoring research efforts and demonstrations to develop and improve these adjusters over the next couple of years.

Q: Until risk adjusters are perfected, won't health plans have incentives to avoid higher risk enrollees? How will these people be protected?

While the incentive may still be there, the insurance reforms under the proposal -- such as community rating, enrollment through alliances, guaranteed renewability -- effectively eliminate the tools health plans use to cherry-pick.

Q: Critics are concerned that fee-for-service plans suffer from adverse selection if the risk-adjusters are not good enough. For example, the fee-for-service plan in the Minnesota public employees program became financially inviable when managed competition was put in place there. How will these plans be protected?

We recognize the need to protect fee-for-service plans from adverse selection. That is why we mandate reinsurance for high-cost cases. Reinsurance will be required until better risk-adjusters are developed.