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To: Distribution
From: Bob Boorstin
Carolyn Gatz
Date: October 21, 1993
Re: The Report to America

Here is the draft of Health Security: A Report to the American People. We are planning to produce this material for the release of the legislation next week.

The text will be interspersed with quotes from citizens and validators, and graphs. The list of that material is attached.

In order to meet our printing deadlines, all comments must be submitted to me by 9am tomorrow, Friday, October 22. Please pay special attention to any numbers in the text and to any areas or items that are not in the text, but should be.

Thank you.

Distribution:

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Health Security:
A Report to the American People

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Foreword to The Report to America

Hillary Rodham Clinton

The United States stands at a unique moment in history. In the coming months, we have an opportunity to accomplish what our government has never before succeeded in doing: providing health care security to every American -- health care that can never be taken away.

Each month, 2 million Americans lose their insurance for a period of time. Every day, thousands of Americans discover that despite years of working hard and paying for their health insurance, they are no longer covered. Every hour, hundreds who need care walk through the door of an emergency room because, without health insurance, it is the only place available to them. And business owners, large and small, contend with premium increases, struggling to keep doing the right thing for themselves and their employees.

These are not isolated incidents. Each time someone loses health coverage, or is denied insurance, their experience becomes another chapter in a growing national tragedy. Anxiety and fear about the cost of health care affect millions of Americans -- those with health insurance and those without. Even those with good benefits worry that their insurance will not be there tomorrow.

These statistics -- two million people who lose their insurance each month for some period of time, 40 percent of insurers refuse to cover people with preexisting conditions -- can be just that, statistics. The stories and the human faces that we need to put on this problem can fade behind the statistics, the details, and the problems that we read about. I hope, that as we move forward in this great national discussion, each of us keeps in the back of our mind, the picture of some person who will be helped by what we will do. And we will remind eachother of the stories of the real people who stand to gain because of the action we take.

For the past eight months, I have had the extraordinary opportunity of listening to thousands of Americans talk about health care. I've sat in living rooms talking to farm families in Iowa. I've sat on loading docks talking to people who have worked for 10, 15, and even 20 years without insurance. I've sat in hospital waiting rooms talking to doctors and nurses. I know about the tragedies of hard-working families and innocent children who are locked out of our health care system for all the wrong reasons.

As a mother, I can understand the feeling of helplessness that must come when a parent can not afford a vaccination or well-child exam, or cannot pay for that x-ray or prescription for a sick child. As a wife, I can imagine the fear that grips a couple whose health insurance vanishes because of a lost job, a layoff or an unexpected illness. I can see, as a sister, the inequities and inconsistencies of a health care system that offers widely-varying coverage, depending on where a family member lives or works. And, as a daughter, I can appreciate the suffering that comes when a parent's

treatment is determined as much by bureaucratic rules and regulations as by doctors' expertise. And as a woman who has spent many years in the workforce, I can empathize with those who labor for a lifetime and still cannot be assured they will always have health coverage.

I have read letter after letter of the more that 800,000 received at the White House from people all over the country who took the time to sit down and share their concerns about health care. I have been moved by stories of families that are barely hanging on financially and emotionally, by people trying to start a new business suffocated by the skyrocketing insurance costs, by older Americans forced to choose between food and medicine, and by young people just leaving school unable to afford health care premiums.

I carried their stories in my mind as we worked long and hard to devise solid answers to tough questions. I think all of us, as we move through this debate, must imagine ourselves in the lives and the stories we hear of people having worked hard all their lives find themselves without health care coverage, because of economic changes, a move, or loss of a job.

The President's plan is a product of all the people who took the time to share their ideas, their research, and their personal experiences with us. It is not the product of any one person or group.

The concerns that were expressed again and again -- from those who get care and those who give care -- convinced me of one point: we must do something about the insecurity that is gripping our country and bringing fear into the lives of responsible, productive citizens every day.

The time has come for us to acknowledge that parts of our system are broken and if we go on without change, the consequences will be devastating for millions of Americans and disastrous for the nation in human and economic terms.

Throughout this process we have maintained the President's commitment to preserve the high quality of care that Americans expect -- our unparalleled doctors, nurses, and other health professionals, our hospitals, clinics, and researchers. And the Health Security plan will honor and preserve every family's ability to choose their doctor.

We may disagree on the details of the exact formula for achieving reform, but we must agree on the fundamental principles that the President has laid out: security, simplicity, savings, quality, choice, and responsibility. True health security means guaranteeing every American a comprehensive package of benefits that can never be taken away.

Now, I speak to you as a mother, a wife, a daughter, a sister, a woman. I write as an American citizen concerned about the health of her family and the health of the nation.

I know that we must change our mindset and emphasize a new philosophy when it comes to the health of American citizens. Everyone must take responsibility for their own health. The President's plan encourages primary and preventive care, including better opportunities for people to seek diagnostic tests to point out problems before they become emergencies, and helping those who wish to give up smoking or change their diet. We need to keep people healthy, instead of treating them only when they get sick.

But when tragedy strikes -- as it does all of us some time in our lives -- the real question is what to do after the fear and grief have passed. Now, we have an opportunity to take tragedy and turn it into advocacy. We can transform the sorrows of those families and individuals who have been financially and emotionally devastated by the current health care system into the promise of hope and security for millions.

Over the past few months, I have met with health care professionals, economists, and other experts, and I have learned a great deal about the technical aspects of our health care system. But like most Americans, I have also learned from personal experience.

I have seen first hand the strengths of our system as well as the frailties. I know what it's like to be overwhelmed with forms and regulations and confusing medical choices when a family member is dying. Caring for my father, I witnessed the highly professional care he received from the nursing staff. I will always appreciate the sensitivity and skill they showed in caring for my father and for those whose names I will never know.

The task confronting us is complex and urgent. It is a chance for the American people to make a difference for every fellow citizen no matter how rich or how poor, whether employed or not. The President believes this plan to be the best hope for providing health security for all Americans. He believes this is the path to economic security for our nation. With your help, we can and will achieve lasting, meaningful reform.

Chapter I

WHAT'S WRONG

In many ways, the American medical system represents our nation at its best, pioneering in the most noble of human pursuits, the healing of the sick. But the health care system also presents America with one of its gravest challenges. A year from now, the nation's health care bill will reach one trillion dollars. If we continue on the same course, the national bill will approach two trillion dollars by the end of the decade.

Bring together any group of Americans and the crisis in our nation's health care emerges from their stories: Stories about insurance coverage lost, policies cancelled, fear of financial ruin, better jobs not taken, endless forms filled out, high-handed responses from insurance companies. They are stories of insecurity and frustration -- and sometimes pain and fear.

Everything that is wrong with the American health care system threatens everything that is right. That is the reality that drives the call for reform, the reality from which President Clinton's Health Security Act arises.

WHERE WE ARE TODAY

Nearly half a century ago, the United States set out to build the most scientifically advanced system of health care in the world. Encouraged by medical breakthroughs during World War II, the federal government invested hundreds of millions of dollars in research, construction of hospitals and medical schools. In the 1960s, federal investments in medical education increased the number of medical school graduates, eventually more than doubling the number.

Decades of national investment produced an advanced and technologically superior health care industry that sets a standard of excellence in many areas. No other health care system in the world exceeds the level of scientific knowledge, professional skill and technical resources. In many American cities, the medical center stands as the single most imposing complex of buildings. Research discoveries, technological advances and new treatments continually force physicians, nurses and hospital administrators -- as well as patients and their families -- to confront ultimate questions about life and death and the power of medicine.

Tens of thousands of health care professionals -- doctors, nurses, technicians, hospital administrators and other professionals -- marry the technologically advanced equipment and procedures for which American health care is renowned to skill, dedication and knowledge to deliver some of the most advanced medical care in the world.

But this system which provides the highest-quality care in the world is coming apart at the seams.

GROWING INSECURITY

From the 1940s through the 1970s, the United States made steady progress toward broader health insurance coverage. Both employment-based insurance and public programs expanded to reach more people and to offer more benefits. Since 1980, however, the number of Americans who lack health insurance has increased steadily, and health care costs have increased faster relative to the economy than they did even in the 1970s.

Some 2 million people lose their coverage every month. Many get it back within a few weeks or a few months, but a growing number of Americans are counted among the 37 million who go without health insurance -- including 8.3 million children. Millions more have insurance coverage so inadequate that a serious illness will devastate family savings and security.

Other Americans watch anxiously as their health benefits erode. Even those with good benefits cannot feel secure if they lose or change jobs.

"The way the system works now even employed, insured people are just one major illness away from financial disaster. An employee is literally at the mercy of the employer when stricken with a catastrophic illness".

K.P.

West Lafayette, Indiana

Unlike other countries that have made health insurance a right of citizenship, the United States continues to rely on a system that treats health insurance as a "fringe benefit" to be given or taken away. Over the course of any two-year period, one in four Americans learns how easily it can be taken away, leaving them vulnerable to the financial threat of illness or injury.

"We're spending over 14 percent of our income on health care --Canada's at 10; nobody else is over nine. We're competing with all these people for the future. And the other major countries, they cover everybody, they cover them with services as generous as the best company policies here in this country."

President Clinton,

Sept. 22,1993

Americans value what health care can do for them; increasingly, many also fear what the health care system can do to them.

At the root of the problem, a fragmented insurance industry uses sophisticated techniques to weed out people who need health care. Insurance carriers divide people into rigid categories based on the size of their purchasing group and how often they've been sick. They pick and choose who they cover. They charge small business twice the rates they charge major corporations, and they drop people when they get sick and need insurance most. People with pre-existing medical conditions either cannot obtain coverage at all or pay more.

In the existing system, insurance companies hold all the cards. Risk selection and underwriting practices lock many Americans into jobs they want to leave. The fear of losing insurance discourages them from changing jobs or venturing out to start a new business. Americans caught in that trap pay the ultimate price for health insurance.

Many Americans work part time or are self-employed, which often excludes them from group benefits. Many lose their insurance coverage when a spouse dies or they divorce. Others lose their jobs in an era when unemployment carries a double risk: Families lose their health coverage at the very time they lose their incomes.

What many Americans fear most about losing their jobs is losing their health insurance.

Among the 37 million Americans who lack insurance, 85 percent are members of a family that includes an employed adult. Many of them work for small businesses -- more than two-thirds of whom would like to provide health coverage.

"My husband and I own and operate a small business. This year we will make our employees pay for any increase in premiums and may drop [some benefits] altogether. Our company cannot shop around for lower cost health insurance because I am uninsurable."

B.M.

Phoenix, Arizona

Even for fully employed Americans, health coverage grows increasingly insecure. Prompted by ever-rising costs, employers of all sizes reduce benefits, raise deductibles, limit coverage and switch to more part-time and contract workers in part to avoid paying health benefits.

For Americans employed by the largest corporations, rising health costs present an increasing competitive disadvantage, prompting re-negotiation of benefits, reduc-

tions in coverage, higher deductibles, limits on the choice of doctors and attempts to shepherd everyone into one health plan. As health costs continue to rise, those trends become more pronounced -- and increasing numbers of American families find health security beyond their reach.

"It seems very unfair that people such as ourselves who have worked all our adult lives and raised a family in an honest and God-fearing manner paying our own way and the way of many others in the welfare system should be brought down to the choice of going without health care or food or shelter."

N.C.

Avoca, NY

At the same time, any physician or nurse knows that thousands of elderly people in every state must decide every week between buying medicine and food. Doctors who care for the elderly know that cutting down on a dosage to stretch a prescription longer or simply skipping a refill is commonplace, particularly among the elderly who live only a little above the poverty line.

"I know of cases where friends with insurance that covers medication will get prescriptions so that their poorer contemporaries will have the medication they need. Elderly patients try to help those without money for prescriptions by getting a doctor

to prescribe for them in their name. We are playing Russian Roulette with medication because our system does not work."

M.J.

Detroit, MI

Even as America confronts the crisis in health care, the second -- perhaps even more daunting -- challenge of growing needs for security against the devastating costs of long-term care among the elderly and disabled lies on the horizon. With the number of Americans over age 85 expected to double by the year 2010, the number of people disabled enough to require long-term care is expected to rise precipitiously as the next century begins.

In the past, the United States has attempted to remedy the failings of the health care system by expanding public programs, such as Medicaid, or adding new categorical programs aimed at filling specific, gaping holes. Community health clinics, public health clinics, clinics for migrant workers, public hospitals, state and local indigent care funds -- all contribute to a patchwork of services, caring for specific populations but never providing seamless, reliable, secure coverage.

"When my two sons were 3 and 6, Spencer and Evan were diagnosed with cystic fibrosis. In the blink of an eye, my two beautiful, healthy boys became part of our worst nightmare. We had to face the fact that we could lose them to this dreadful dis-

ease. We live in constant fear of losing our medical coverage... Without the drug coverage that we now have, it would cost us at least $1500 a month for their medicine alone.

These little boys are virtually uninsurable...As mothers we need to protect our children, and I don't want to feel frightened about this all my life."

A.B.

Pleasanton, CA

Among the unproductive uses of health dollars, none is more frustrating than bureauc4racy. Administrative costs are higher in the American health care system than in other countries and rising rapidly. Consumers feel caught in a web of restrictions, buried in the fine print of incomprehensible insurance policies.

As consumers, doctors and nurses know, high administrative costs arise from the peculiarities of the health insurance system. It costs far more to administer insurance for employees in small companies than large groups. Consequently, for a firm with fewer than five employees, insurance administration absorbs as much as forty cents out of every premium dollar. Administrative costs alone account in large measure for the fact that so many employees of small business do not have health insurance: Those firms simply cannot purchase insurance that is economically priced.

The sheer number of insurance providers and plans also adds costs. Hospitals, clinics, doctors and other health providers must deal with hundreds of different insurance plans, each with its own benefit package, exclusions and limitations -- as well as mountains of forms to fill out. Hospitals establish whole departments and hire special clerks trained in the mysteries of medical record coding to handle the paperwork. Some of the occupations that fill administrative departments in hospitals, clinics and insurance companies didn't even exist a decade ago.

Federal programs, each with different restrictions, finance coverage for certain types of patients. Auto insurance and workers' compensation pay other claims. These overlapping systems duplicate administration and generate coordination problems.

Attempting to hold down costs, public agencies and private insurance companies restrict what doctors and other health providers can do requiring them to seek authorizations before treatment and to submit case records for reviews after the fact. The resulting tangle of regulations and requirements makes health care inefficient.

"While we go about our business caring for our patients, we are being buried in paperwork. Everyday, my mailbox is filled with directives, new regulations and papers to sign. The truth is, if I read all my mail, there would be no time left to see my patients."

Dr. Jules Zysman

The trend toward management practices that intrude between doctors, nurses and their patients are among the major concerns of health professionals -- that and the "hassle factor" that drains time and energy away from the actual delivery of care. Changes in the organization of care have heightened these concerns. Requirements such as pre-admission certification, concurrent review and case management -- all functions that, again, didn't even exist a few years ago -- originated with health maintenance organizations but have now been widely adopted by many different types of health plans. More than 90 percent of privately insured Americans are now enrolled in a plan that uses those types of gatekeeping procedures in the attempt to control rising costs.

Doctors, nurses and other providers feel frustrated by remote administrative control. They worry that they will be restricted from practicing in certain types of health plans or forced to accept methods of review and management that sacrifice their autonomy. They worry that such policies will harm their ability to provide good care.

"I didn't become a nurse to spend more and more time on meetings on paperwork...I became a nurse to spend time with patients."

Debbie Freiberg

The Children's Medical Center

Washington, DC

The steps employers, insurance companies and public regulators take to slow rising costs set off a vicious cycle, producing frustration and anger over interference on the part of physicians, nurses and hospitals, more paperwork and bureaucracy that overburdens the health care system as a whole -- and probably little real difference for the patient.

For example, a government program or insurance company considering a $30,-000 bill for hospital care delivered weeks ago has no direct knowledge of the case or the services delivered, so the examiners want evidence that the care was necessary, actually delivered and that the bill is accurate and justified. Each insurance carrier comes up with its own approach to making that determination. To keep track of all the different health plans, hospitals and physicians hire coders, clerks and administrators to staff back offices, perform what's called utilization review, code patient records, file them and send out bills -- and then argue with insurers on the telephone about what's covered and what's not. Those staffs spend countless hours determining whether an individual has health coverage, which company carriers the primary policy, what services are covered, whether another the patient is entitled to other benefits that require coordination, how much the company is willing to pay and how to fill out the forms properly. All of that is wasteful.

"The duplication of documentation, the authorization forms, the insurance claims forms and all of the complicated and often more contradictory instructions devised by the more than fifty insurance plans we accept are all overwhelming."

Dr. Lillian Beard

pediatrician

Children's Medical Center

Rising Costs

Between 1980 and 1992, health expenditures rose from 9.1 percent of Gross Domestic Product to 14 percent. Without reform, by the year 2000, spending on health care will reach 18.6 percent of GDP, robbing resources from workers' wages, investments in other sectors of the economy, education and every other public good. Without reform, costs are rising at a rate that will double the price of health care to American families by the end of the decade -- to $14,000 each year for a family of four.

American employers spend over $200 billion a year on health care, a cost that puts American products at a disadvantage in international competition, adding $1,100 -- about twice as much as in Japan -- to the cost of every automobile manufactured in America.

American workers already feel the impact of rising health costs in their pay-checks. If health care had continued as roughly the same proportion of employee compensation from 1975 to 1993, the average American worker would receive a $1,0-00-a-year pay increase after taxes, with no extra cost to the employer. If current trends continue, real wages will fall an additional $600-a-year by the end of this de-cade.

Rapidly escalating costs threaten the security of the two population group -- Americans older than age 65 and the severely disabled -- for whom we as a nation decided more than three decades ago to extend health security through the Medicare program. With growth in charges for Medicare running 23 percent higher than the rate of inflation over the last decade, calls to limit the fedearl financial obligation have be-come common place.

Rising health care costs deal the same blow to government budgets that they do to worker's pay. If the current rate of increase continues, health spending will con-sume as much as 111 percent of the real increase in federal tax revenues during this decade, driving up the national deficit. The same is true at state and local levels where increasing demands for public spending on health care, particularly through the state-federal Medicaid program, threatens state budgets and drains resources away from other needs. Health care will consume a third of the projected real increase in state and local budgets during this decade.

None of that is inevitable. As international comparisons show, the cost of health care in the United States is increasingly out of line with other countries. Run-away health costs pose a distinctively American challenge, one that is all too real for millions of individual Americans and their families who confront it daily.

For all the good of programs to help the uninsured -- and the more than $25 billion-a-year in uncompensated care paid by private insurance carriers -- do, they also create a mounting burden for American taxpayers and employers. For every American family and business that purchases health coverage, the total real cost of health care is substantially higher than most of us realize: We pay our own insurance and whatever co-payments, deductibles and co-insurance our policies require. We pay what is in effect a surcharge added to the cost of insurance in the form of higher bills to cover uncompensated care. We pay a payroll tax to cover the cost of Medicare, and mounting federal, state and local taxes to support the safety net of public programs and indigent care to fill in the gaps.

If health care costs continue to rise at projected rates, it will erode the basic structure. The burden of excessive cost blocks a solution built around simply increasing public spending. Although in the short term, guaranteeing health security to all Americans will require additional investment, unless expansion of coverage is linked to strong controls on rising costs, the economic burden will undermine the security we gain.

"I am a 43 year old, married professional woman. I am self-employed, owning a property management business. I am a one-person business; I have no employees. I will soon be without health insurance because the company I'm with in two and a half years has raised my monthly premium from $126 to $389, and I cannot afford $389, and as they have raised the premiums, they have deleted benefits including coverage for prescription drugs.

In addition, I, like many others, have what insurance companies call a `preexisting condition' (I once saw a doctor for childhood arthritis, strained lower back) and am considered an uninsurable risk. I should mention that I am trim, healthy and extremely active; six mornings a week I swim with a Master competition swum team. I am probably more healthy and fit than 99 percent of the U.S. population, but apparently health insurance is intended only for the young and those who have never visited a doctor.

I desperately need affordable health insurance. I am not poor...I can and am willing to pay a reasonable amount for it, but none is available to me".

M.G.M.

Los Angeles, CA

The fundamental problem in America is not that we spend too little for health care. It is that we don't get good value for the billions of dollars we spend.

To control costs, health care reform must reduce the waste and bureaucracy that make American health care the most costly in the world. We pour our money into the most expensive machines, competing helicopters that land in hospital parking lots and huge building expansions -- but allow expensive equipment and hospital beds to sit empty because of excess capacity. At great expense, we train more medical specialists than we need but don't train enough primary-care doctors and nurses to deal with everyday health needs. Health reform must reverse the incentives that lie behind those decisions. We must set the health care system on a less wasteful course.

The excessively high cost of health care is not the result of forces beyond our control. Other advanced countries provide coverage for all their people at far lower and more stable costs and with higher levels of consumer satisfaction (and, in some cases, life expectancy). The American health care system consumes enough money to provide health security to every citizen and legal resident over time. As in other countries, the financial discipline needed to make access affordable also can keep health costs in line with the rest of the economy.

A researcher at the Dartmouth Medical School documented the impact of the health care system's perverse incentives. He compared how often patients covered by

the Medicare program went into the hospital in two northeastern cities and found that elderly patients were one-and-a-half times as likely to be sent to the hospital in Boston as in Hartford. In addition, the cost for each patient was almost twice as high in Boston as in New Haven. But there wasn't any evidence that Medicare patients were any healthier in one city than in the other.

Other studies have documented similar variations. A study published recently in The New England Journal of Medicine found that after adjusting for differences in age and gender, Medicare payments for doctors' care for each patient varied from lows of $822 in Minneapolis, $872 in San Francisco and $954 in New York City to highs of $1,493 in Detroit, $1,637 in Fort Lauderdale and $1,874 in Miami, with no readily discernible difference in health explain the difference in cost.

Even when such puzzling variations are highlighted, few incentives exist to probe why they occur or bring about change. Put off by the fear that any change will impair quality, well-meaning doctors and hospitals provide more and more services and collect more and more money from American consumers.

"I can't believe that charging $10,000 for a three-day stay in a hospital, not including doctor's and surgeon's services, testing and medicines, can be legal."

E.B.

Brooklyn, NY

After years of attempting to slow the frightening rate of increase in health care costs by tinkering with the existing system, it is clear that only comprehensive reform -- changing the incentives and rewards to promote good health care and prudent investment -- can achieve the level of change that needs to occur. Only a fundamental change of direction can bring about savings of the magnitude required or make the promise of security real. In some states and communities in the United States, from the state of Hawaii to Rochester, N.Y., progress toward that goal is remarkable: Nearly everyone has health coverage and costs are below the national average.

"I am married with two children. My husband was laid off as an aerospace engineer three years ago and is presently a self-employed consultant. I am nursing director of an outpatient surgery center, and we are insured through my employer...

My then three year old son was diagnosed with a very rare form of cancer, Burkitt's lymophona. Although he is now is remission, the intensity of his treatment involved nearly all of 1992 in the hospital, and, of course, the costs were atrocious.

Since I understand medical billing procedure, I read through every copy of the bills we received and was appalled at the charges. For the first time in my life I realized exactly what an `upcharge' was -- e.g. $33 for one Tylenol...

As of October, 1992 my $1 million lifetime limit was at $814,000. I applied for other insurance coverage through private companies... but was denied either because of my son's illness or because I made too much money. It was suggested that I quit my job and then apply for government aid programs. I think that speaks for itself..."

J.J.

Costa Mesa, CA

The difference lies in institutions. Much research has demonstrated the waste and inefficiency of the health care system -- as any doctor, nurse, patient or consumer can attest. According to experts, the way we choose to spend our money generates excessive costs:

- We train too many specialist physicians and not enough doctors who provide the basic health care that most Americans require for most of their lives.

- We build too many hospitals and invest too much in expensive, high-tech equipment while neglecting the basics of good medical care.

DECREASING QUALITY

Traditional regulatory approaches to assure quality in any public program have involved setting national standards and then searching for infractions -- or weeding out the bad apples. In the oldest form of quality assurance, federal and state laws require health professionals and institutions to satisfy minimum criteria for licensing and certification. While necessary protection, licensing and certification do little to improve quality, to reward excellence, or to promote continuing efforts at improvement.

Attempting to assure a minimal level of quality, government and private-sector regulators have written thousands of pages of rules and regulations covering everything from the qualifications of nurses' aides to the square footage of hospital rooms. Review agencies require doctors, nurses and hospitals to document each step in treatment and scrutinize case records. To many health professionals, quality assurance has come to mean reviewers poring over case records in search of erring physicians and hospitals. It has become synonymous with interference and punishment rather than the pursuit of excellence.

Information is a critical missing piece in each of those traditional quality systems. Information is critical not only to ensure quality, but also to the working of any competitive market. Only informed consumers are free to make the wise purchasing decisions criticial to competitive markets.

Yet information that would allow consumers to make meaningful comparisons among health care providers does not exist. Until recently, physician and hospital groups opposed publication of comparative prices and quality indicators, and no consensus existed about how best to measure quality. Consequently, consumers and other purchasers have had little way of knowing whether the care they received was acceptable in quality or how costs compared.

Without information, doctors, nurses and hospitals cannot learn how to correct problems in quality, and consumers cannot choose intelligently among plans and practitioners. Doctors and health care managers have frequently been unaware of the patterns of care at their own institutions -- for example, how often surgeons perform various operations, at what cost and with what outcome. They are even less likely to know how their performance compares to that of other professionals in the same community, much less across the country. As the Pennsylvania Health Care Cost Containment Council discovered, in the same community, the bill a hospital sends for the same surgery, with the same result, can vary from $21,000 to $84,000.

If doctors and hospitals don't know how they stack up, patients are really in the dark on most medical decisions, unaware of alternative treatments, their risks and benefits.

Although millions of Americans lack access to basic health care, problems related to quality do not only involve the failure to provide care or inadequacy of service. Sometimes the problem is too much treatment, rather than too little, the wrong kind or even care that injures the patient. Prescribed drugs sometimes cause serious adverse reactions; patients contract infections in the hospital. One study found that in more than a third of cases involving elderly patients, a stay in the hospital produced a complication that made the patient worse. Over-treatment can be harmful, even life threatening. In situations in which quality indicators reveal excessive and inappropriate treatment, they can highlight areas for improvement and save money at the same time.

LIMITED CHOICES

The doctor-patient relationship has become strained - - when care is discontinued because of the fine print on insurance forms; when third-party reviewers intervene in the decisions about the practice of medicine; when frivolous lawsuits are brought against qualified, experienced physicians; when doctors spend more time lost in the paperwork than at the bedside of a patient in need. It is long past time to move aggressively to preserve the doctor-patient relationship and reform our health care system.

Free choice cuts to the core of the American health care system and the core of the doctor-patient relationship. For patients, the ability to keep seeing their doctor - - someone who knows their medical history, who knows how to comfort and care for them when they are ill - - can mean the difference between a good experience and a frightening one, between a successful outcome and poor one.

Perhaps no issue is more important to patients. It seems remarkable that the current system does so poorly in this regard.

Every month, 2 million people lose their health coverage. Over the next two years, one out of every four Americans will be without health coverage at some point. Choice is a luxury millions of americans simply can not afford.

Even patients who have private insurance coverage have restricted choices. Almost every practicing doctor has had his or her patients call the office, upset because they had to transfer their care when their employer or a job change made them switch insurance carriers. For doctors, different forms and complex coverage rules result in greater administrative burdens, and discouraging them from joining multiple plans, even if that means their patient base erodes.Growing Complexity

Just one out of three companies with less than 500 employees offers any choice of health plan. And increasingly, the plan available from the employer limits access to

particular networks of doctors and other providers, often disrupting valued relationships.

In another sense, choices are especially limited for older Americans. When the elderly or disabled need long-term care, they generally have only one place to go if they want coverage: the nursing home. But many would rather stay in their homes and communities to receive care -- a choice that is usually less expensive than the nursing home alternative. Today, older and disabled Americans have no choice.

GROWING IRRESPONSIBILITY

Instead of promoting responsible behavior, the rising cost of health care in our nation has led many companies and individuals to take advantage of the system. Experts estimate that the United States wastes more than $80 billion each year in health care fraud. Individuals and companies game the system in order to squeeze the most out of a government program or take advantage of hidden clauses in insurance policies. In many cases, these activities prove harmful or fatal to individuals; stories of patients who are injured by improperly tested equipment and teenagers held in for-profit psychiatric hospitals until their insurance coverage runs out are all too common. In every case, they drain away health care dollars that could be put to better use.

The perverse incentives in our health care system also promote irresponsible behavior. Insurance companies, as has been noted, are no longer in the business of insuring against risk; instead, they focus on finding only the healthiest people to cover, those who they calculate will cost them the least. Pharmaceutical companies charge Americans three times what they charge citizens of other nations for prescription drugs made here at home. They argue that the high prices enable them to continue much-needed research but last year spent $1 billion more on promotion and advertising than on efforts to develop new drugs.

Our broken medical malpractice system has also led to irresponsible behavior. Although the direct costs of malpractice are not great -- experts estimate that they account for no more than 2 percent of health spending -- the threat of lawsuits has bred distrust and fear in doctors and other providers, while adding billions in so-called "defensive medicine" charges to our medical bills. A handful of patients, some of whom move from state to state in an attempt to game the system, have filed hundreds of frivolous lawsuits. In turn, some lawyers take advantage of patients, pocketing huge fees from jury awards and skimming off money meant to care for patients left permanently disabled or injured from malpractice.

This lack of responsibility is also central to our inability to get health costs under control. In our nation, even those people who have not health insurance or who have inadequate coverage still get health care. The problem is that many get the most

expensive kind of health care in the most expensive place: the emergency room. In order to keep their doors open, doctors and hospitals are forced to pass those costs along to the rest of us. This phenomenon -- what academics call "cost shifting" -- leads to rapidly rising health costs for everybody who has coverage.

Take the example of two business owners in a small town: the owner of a gas station and the owner of a car wash. As he has ever since he opened his business, the gas station owner provides good health insurance coverage for his employees. Down the street, the owner of the car wash wants to provide insurance coverage. But he does not because the insurance companies won't offer his small business a reasonable rate.

Not having health insurance, of course, doesn't protect the employees of the car wash from injury. So when one of them gets hurt in an accident at work, he goes to the emergency room. The doctors treat the injured man and the hospital bills him, knowing full well that he cannot pay all or, in some cases, any of that bill. In turn, the hospital is forced to raise its prices for insured patients, like the employees of the gas station. In effect, the gas station owner and his employees are paying for the health care of the car wash owner and his employees.

The bottom line is simple: every American pays when a company or individual takes advantage of our health care system, be it through fraud, malpractice, or a decision not to contribute to one's care. Those who take responsibility and pay for their

health coverage are paying for those who don't. Restoring responsibility is vital to providing health security for every American.

THE COST OF DOING NOTHING

The cost of doing nothing far outweighs the cost of reform. Without reform, one of every four of us will lose our health insurance at some point in the next two years. If you fall ill or get in an accident during this time, your finances could be devastated.

Seven years from today, experts estimate almost $1 out of every $5 dollars earned by Americans will go to health care. By the end of the decade, American workers will sacrifice $655 in wages every year just to keep their health care benefits. Millions more will find that rising costs will force their firms to cut back on benefits and limit choices of doctors and health plans. This is our future if we do not take action.

A DISTINCTIVELY AMERICAN CHALLENGE

Like a patient denying the symptoms of serious illness, for decades America has put off confronting the crisis in health care. Health care reform has long seemed

so formidable, complex, and costly that we have denied the threat it poses to our own lives, the lives of our children, the course of our nation.

The time for denial and delay has ended. The truth is that we can no longer afford to avoid it. We have no choice but to accept the challenge: to design an American solution to an American dilemma.

The first principle of medical ethics captures the fundamental challenge confronting the American health care system: "Do no harm," the maxim dictates. Yet the health care system in America harms millions of people each year, undermining security, the ability to compete in the global economy and, ultimately, liberty. The challenge of health reform is to alter that course, to redirect the system, reversing the harm while improving the quality of health care.

"Two years ago my husband and I were laid off within a month of each other. We both had to go on unemployment. We fed our family lots of grilled cheese, took any odd jobs that came along and cut out any unnecessary expenses...COBRA insurance cost us $400 monthly, a hefty expense just when we had no extra money. We kept this insurance because our youngest daughter needed surgery to patch holes in her eardrums. Our daughter was in the hospital for 24 hours; the total cost of this stay was $12,000. One month later we had to drop the insurance, we could no longer af-

ford it. The surgery, by the way, was a failure; our daughter is faced with more reconstructive surgery, but we have no way to pay for it.

One year ago, unable to find a decent job, my husband opened his own shop...We are sticking to the bare necessities and just managing to keep our heads above water. I looked into health insurance because it is so important to us. For $400 monthly, my family can get a policy with a $3,000 yearly deductible. This policy won't cover my husband's heart because of a heart attack he had five years ago, nor will it cover my daughter's ears.

I could sell everything and go on welfare in order to get medical aid. Short of that, there is nowhere in my country I can turn to for help. I love my country, but I sometimes wonder, does it love me?

There are many others out there like us. If things continue as they have, there will be no middle class, only a wealthy class and a welfare class...."

P.R.

Danbury, Conn.

Chapter 2

PRINCIPLES OF REFORM

As part of reform, the President has proposed several specific steps to meet each of the following six principles: security, simplicity, savings, quality, choice and responsibility. Whatever happens to the details of the legislation, health care reform must meet these principles.

SECURITY:

Guaranteeing comprehensive benefits.

1) The Health Security plan guarantees all Americans comprehensive benefits, including prescription drugs and preventive care. And it will ensure that those benefits can never be taken away.

2) The plan outlaws insurance company practices that hurt consumers. Insurers will not be able to deny anyone coverage, charge older people more than younger people, or use a "lifetime limit" to deny coverage.

3) There will be limits on how much consumers will pay for health coverage. No one will be asked to pay more than 20% of the average plan premium in a region, and no health plan can have more than a $200 deductible for an individual.

4) Older Americans will be protected under the Health Security plan. Medicare will be preserved and strengthened with the addition of a prescription drug benefit, and there will be some coverage of home- and community-based care.

5) All Americans will be guaranteed access to quality care, so that people know that there will always be a doctor that they can get to and a hospital that will treat them. There will be particular attention to the needs of underserved rural and urban areas.

SIMPLICITY:

Simplifying the system and cutting red tape.

1) The Health Security plan will reduce paperwork by giving everyone a Health Security Card and asking all health plans to adopt a single, standard claims form to replace the thousands that exist today.

2) The plan will cut insurance company red tape by creating a uniform, comprehensive benefits package, standardizing billing and coding, and eliminating fine print. This will eliminate the confusion caused by conflicting insurers' requirements.

SAVINGS:

Controlling health care costs.

1) The Health Security plan will increase competition, forcing health plans to compete on price and quality, rather than on who can cover only the healthiest patients. So health plans will have an incentive to provide high-quality care and control costs in order to attract more patients.

2) It will strengthen buying clout by allowing consumers and businesses to band together in "health alliances" -- large purchasing pools that will negotiate with health plans to drive down costs and improve quality.

3) The plan will lower administrative costs by cutting paperwork, simplifying the system, and putting consumers and businesses into large purchasing pools.

4) There will be a limit on how much premiums can rise -- this limit will act as an emergency brake to ensure that health care costs don't spiral out of control.

5) The Health Security plan will make health-care fraud a crime, including overbilling, and imposes stiff penalties on those who cheat the system.

QUALITY:

Making the world's best care better.

1) The Health Security plan emphasizes preventive care -- putting a new emphasis on preventing illness before it becomes a medical crisis. The comprehensive benefits package fully pays for a wide range of preventive services, which most current insurance plans don't cover.

2) Consumers will have the power to judge the quality of care. armed with the quality "report cards" that provide information on the performance of health care plans and patient satisfaction. These report cards will help hold health plans accountable for meeting high standards. Consumers will have the concrete evidence of which health plans provide high-quality care.

3) The Health Security plan will invest in new research initiatives -- into new cures for diseases, how to make prevention work, and what treatments are the most cost-effective.

4) The plan will help build a stronger health care work force -- training more nurses, family doctors and other health professionals to provide care into the next century.

CHOICE:

Preserving and increasing what you have today.

1) The Health Security plan ensures that you can follow your doctor and his or her team to any plan they might join.

2) All Americans will be able to choose from among all the health plans offered in their region -- no matter where they work.

3) The Health Security plan will make it possible for more elderly and disabled Americans to continue to live in their homes and communities while receiving care.

RESPONSIBILITY:

Making everyone responsible for health care.

1) Without setting prices, the Health Security plan asks drug companies to take responsibility for keeping prices down.

2) The plan will limit lawyers' fees in order to discourage frivolous medical malpractice lawsuits. It will also encourage patients and doctors to try to work out disputes before they end up in court.

3) Everybody will be asked to pay something, even if the contribution is small. Low-wage small businesses and workers will get substantial discounts on the cost of insurance, but everyone must take responsibility.

IT WORKS - CHAPTER TWO

CITY OF ROCHESTER

In Rochester, medical costs are 25 percent lower per capita than national levels, administrative costs are half the national average, and 94% of the population is insured.

Doctors, hospitals and local businesses have banded together to keep the quality of health care high, and the cost low. Through insurance reform, Rochester has been able to serve the needs of its large businesses -- by keeping costs down -- while also enabling small business and families to purchase competitively priced insurance. Most importantly, small and large businesses in Rochester pay the same monthly premium per person for equal benefits, and no one pays more or is denied coverage because of preexisting conditions.

HAWAII

Hawaii has moved closer to universal access than any other state in America, with only 2 percent of its population uninsured (compared to 15.3 percent nationwide).

Hawaii depends on an employer-based system, and 88 percent of the non-elderly population receives insurance through their jobs. The rest of the population receives either

Medicaid or state-subsidized private insurance. **Although Hawaii established a "rainy day fund" for small businesses that were unable to pay for their employee's insurance, only 2 percent of small businesses have had to use these funds.**

EMPLOYEE GROUP INSURANCE PROGRAM IN THE STATE OF MINNESOTA

The Employee Group Insurance Program in Minnesota has seen its rates of increase for health insurance drop dramatically.

The program offers six health plans -- for which it negotiates rates and comparable comprehensive benefits packages -- to its 140,000 members. The employer contribution toward the cost of coverage is based on the health plan that offers the lowest family premium in each county. This low cost plan is available at no cost to employees, and employees choosing higher cost plans pay the difference.

The program also conducts patient satisfaction surveys to provide patients with information on the quality of the health care plans offered.

Chapter III

HOW THE NEW SYSTEM WORKS

How Reform Will Affect You

After reform, every American citizen and legal resident will have 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 start a small business, you're covered.

The 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. It includes doctor and hospital care, as most insurance plans do, and also covers prescription drugs. But it also includes one major benefit rarely found in today's insurance plans -- preventive care.

No matter what plan you choose, it would pay 100 percent of the costs of preventive care, and that would include prenatal and well baby care, immunizations for children, disease screening for adults, like mammograms, Pap smears, cholesterol screening and routine physical exams, and health promotion programs, like stop-smoking classes and nutrition counseling.

You will be able to choose your doctor. Everyone will have a choice of health plans -- and plans will have to enroll all Americans that apply, regardless of age, occupation or medical history. You will be able to choose a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. And for older Americans, the Medicare program will be preserved and strengthened. While prices may vary between plans, each health plan will charge everyone the same price for the guaranteed, comprehensive benefit package. Your boss or insurance company won't decide how or where or from whom you get your care -- you will.

Like today, almost all of us will be able to sign up for a health plan where we work. You'll get brochures that give you easy-to-understand information on several health plans -- the doctors and hospitals involved, 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 the health alliance in your area -- run by consumers and local businesses that will bargain for affordable health care for you.

Once you've picked a plan, if you need to go to the doctor for a check-up, or if you get sick, you'll simply take your health security card, you'll show it at the doctor's office, and they'll take care of you. Then you'll fill out one standard form, and you're done. So when you get sick, you won't be buried in forms -- and neither will your doctor or hospital.

An Overview of the New System

The Health Security plan rejects the idea of a government-run health care system. Health care will remain rooted in the private sector. And most people will get insurance through their employer, as nine out of ten people do today.

The essential strategy of the Health Security plan is to extend the advantages that large employers and their workers bring into negotiations with health plans and providers to all Americans. Purchasing alliances that organize health plans and enroll consumers take on roles similar to major corporate benefit offices.

The largest employers in any American community exercise considerable clout in negotiating with insurance plans, doctors, clinics and hospitals over how much they charge. Often, they obtain significant discounts over the rates that other employers and groups pay at hospitals, clinics and doctors' offices -- sometimes driving costs up for other buyers. They bring the clout of major purchasing power to those negotiations.

Under the Health Security Act, consumers and employers in local communities will follow the lead of the largest employers and organize regional purchasing groups, or alliances. Regional alliances will serve workers employed by firms with less than 5,000 employees but also self-employed individuals and their families and everyone

else in the community. The largest national corporations -- those employing 5000 workers or more -- have the option to operate their own corporate alliances or joining regional alliances. Every American and legal resident will purchase health coverage through one type of alliance or the other.

Alliances, organized as not-for-profit corporations run by boards of directors made up equally of consumers and employers, will bring together the purchasing power of large numbers of consumers and employers to negotiate with health plans. Acting as purchasing agents, alliances will bargain with health plans over rates and services and exclude plans that fail to live up to national standards.

Health plans will be forced to compete on who can provide the best care at an affordable price. This will provide incentives for everyone in the health care business to operate more efficiently -- incentives that don't exist today. Consumers will choose which plan they wish to join, and they will have the choice of at least three plans, including one based on the traditional "fee-for-service" model.

To get care, most people will do what they've always done -- go to the same doctors, hospitals, pharmacies, or other providers. More providers may organize into "networks" -- groups of doctors, nurses, hospitals, and labs that cooperate together to coordinate the care of their patients and control costs.

But to realize the goals of the Health Security plan, we must build in flexibility about the means to achieve them. National reform is not an architect's blueprint specifying every dimension and detail. Rather, it forms a framework within which the states and the people of each American community build their own designs and make their own choices.

Americans cannot, and need not, come to one vision of the single-best approach to health care. If our vision of reform is founded on the principles of security, savings, simplicity, quality, choice and responsibility, a workable consensus is within reach.

The Health Security Act establishes a framework to support those goals, spelling out standards and qualifications, but it does not prescribe how to deliver care or organize services. It leaves those decisions to consumers, doctors, nurses, hospitals and managers of health plans, rather than to government. The Health Security Act establishes essential protection at the national level to ensure security, the solid foundation upon which American communities are free to build -- and then it gets government out of the way to allow the reformed market for private health coverage to work.

Reflecting the broad geographic diversity of America, the Health Security Act allows for each state to tailor health reform to its unique needs and characteristics, working within the framework of national guarantees and national standards for quality and access to care.

The Health Security Act provides states with a variety of tools to control the rate of increase in health insurance premiums, for example, but it does not dictate which tools states use. It sets standards for health plans, but assigns responsibility for applying those standards to states and, through them, to alliances, which organize the purchase of health coverage in regions.

If a state fails to carry out the responsibility for health reform, ignoring or jeopardizing the national guarantee of comprehensive health coverage for all, the federal government will ensure that its commitment to security is carried out. As a last resort, the federal government could retract the allowance for tax deductibility for health benefits that employers and employees enjoy, using that power of the pocketbook as leverage to persuade a state to implement health reform. If such a case were to occur, the intent would be for the state to resume its proper role as the basic manager of health reform as quickly as possible.

Chapter 4

SECURITY

"Six months ago, my sister-in-law, Pam, had a disabling stroke. Pam is only 39 years old, and she's a severe diabetic. Six months have passed, her short-term memory has deteriorated, her vision is leaving, and it looks as if my brother will either have to hire someone to come into their home full time to care for her, or put her in a nursing home, which his medical plan does not cover.

My brother's attorney has advised him to divorce Pam so that her medical bills don't pull him into financial ruin. My brother has two young sons that he's caring for and in order to continue to provide for them, he is giving this consideration...

A man who loves his wife must divorce her so that her misfortune (in sickness and in health) does not leave him with the inability to raise their family."

A.P.

Toledo, Ohio

Americans buy health insurance to provide security for themselves and their families. Security, in its full sense, is what health care reform must give us all. We must be secure that no American will face exclusion from coverage because of illness, occupation or age. We must be secure that health benefits will be comprehensive enough to cover our need for health care throughout life.

Comprehensive Benefits

Under the Health Security plan, all Americans and legal residents will be guaranteed a comprehensive package of health benefits that can never be taken away. They will receive a Health Security Card entitling them to enroll in a health plan. The vast majority of Americans will continue to receive information about health plans and enroll at work, as they do today. But all workers have a choice among at least three -- and, in most communities, more -- health plans that meet national standards related to quality and reliability.

The nationally guaranteed health benefit covers a full array of clinical services, from doctors' offices, to clinics, to hospitals, to rehabilitation centers, to laboratories, hospices, home-health agencies and other professional offices. The quality of coverage provided in the nationally guaranteed package equals that provided by America's major employers, such as Fortune 500 companies.

In line with the commitment to redirect health care toward greater emphasis on prevention and comprehensive primary care, the nationally guaranteed benefit provides far more coverage for clinical preventive services than traditional insurance coverage. It waives the usual co-payments and deductibles for a specific set of preventive services based on recommendations of the United States Preventive Services Task Force.

Preventive services covered without co-payments include well-baby and well-child checkups, physicals for adults, immunizations and regular screening tests such as mammograms and Pap smears, vastly expanding the access of most Americans to basic preventive health services.

The fundamental change in direction on health benefits reflects the imperative to redirect health care resources. The traditional health insurance system in American developed around an old and easily understood rule of commerce: Invest where the money is. Traditionally, the bulk of the money in health care has been in high-cost treatments, hospitals, specialist physicians' offices and the latest technology. The Health Security plan will bring the system into better balance, prudently redirecting resources and ensuring that health plans provide good care.

The benefit package also substantially expands traditional coverage of mental health and substance abuse treatment, which usually comes with strict limits that postpone care and push patients into hospitals. Insurance companies adopt that policy

partly because they depend on the public mental health system -- and the taxpayers who pick up the bill -- to serve the millions of people who lack coverage for even basic treatment, or who suffer from chronic or serious illness.

For millions of Americans, the guaranteed national benefit will provide a significant expansion of coverage. Those whose current benefits are more generous -- a much smaller number -- have every right to continue those richer benefits. Nothing in the Health Security Act prevents employers from providing more extensive benefits, with no strings attached.

In addition, individuals will be free to purchase supplementary insurance, although the comprehensive national benefit package leaves little need for supplementary coverage. Employers also are free to offer additional benefits or absorb co-payments and deductibles.

Whatever form of health care they choose, the critical gain for all Americans is the knowledge that they will always have a comprehensive health benefit that can never be taken away -- no matter what happens in their lives or their jobs. If they lose a job or change employers, their coverage will continue without interruption and at the same price. If they move, get married, separate from a spouse or obtain a divorce, experience a catastrophic illness or confront any other crisis, their health coverage will continue, uninterrupted and seamless.

INSURANCE REFORM

The difference between traditional health insurance and a health plan captures a key distinction critical to comprehensive reform. Left to its own dynamics, the traditional risk-based market for health insurance turns the concept of insurance on its head: Using sophisticated techniques, it distinguishes between people likely to need medical care and those who do not. Rather than protecting those who need medical care, the economic forces behind traditional insurance force the system to prefer insuring people who don't need it. Consumers have few avenues for obtaining valid information to compare health coverage and providers. When they need medical care, they're in no position to function as prudent buyers.

In general, insurance companies try to avoid patients who need medical care by shaping their benefits and policies to attract the healthy and avoid the sick. It's a system geared least to the people who need it most. A uniform, comprehensive benefit returns the concept of health insurance to its roots: community-wide sharing of the risk of illness.

Alliances also help overcome these obstacles, organizing the private health coverage market so that consumers can compare plans and providers and make informed choices. Their mission is to bring about competition among health plans based on quality and price -- not on who can screen out the sickest patients. The Health Securi-

ty Plan requires health plans to base premiums on community rates, erasing distinctions based on age, gender and medical history that lock so many Americans out of affordable coverage.

By eliminating what's called risk underwriting -- trying to insure only the healthiest people -- and enacting a full range of other, significant insurance reforms, the Health Security Act eliminates the competitive disadvantage that plans encounter when they attempt to offer even an adequate level of coverage for certain benefits, such as mental health care.

Under the Health Security Act, traditional insurance practices that prevent people from getting care they need will change dramatically. What patients experience when they seek health care will change much less significantly -- unless they want it to. The same health plans that exist today will continue to deliver the style and quality of care to which most Americans are accustomed.

Health plans are bound to follow some basic rules:

- **Enroll every eligible person**
- **Charge everyone community rates**
- **No exclusions for pre-existing medical conditions**
- **No refusing to cover certain kinds of businesses**

The Health Security Act also prohibits no lifetime limits or restrictions on the amount of care provided so long as it is medically necessary or appropriate, which is a typical standard. The Health Security Act meets that higher standard because it is meant to provide secure financial protection against the most devastating illnesses and injuries. If coverage were restricted, no one would be secure from potential financial ruin caused by a catastrophic illness.

LIMITS ON WHAT CONSUMERS AND BUSINESSES PAY

The Health Security plan will also take several important steps to protect individuals and families from rising health costs and financial ruin. It limits deductibles -- the amount people pay each year before insurance kicks in, which can run into the thousands today -- to $200 for an individual, and $400 for a family per year. It says that no employee can ever be asked to pay more than 20% of the average plan's premium in the region. And it eliminates lifetime limits, which are included in six out of every ten insurance policies today and can mean bankruptcy for families in which a person gets very sick.

Employers will pay no more than 7.9 percent of their payroll for health care. Small businesses -- those with fewer than 50 employees -- will receive discounts of between 30 and 80 percent, compared to what the average large business pays. And the self-

employed will be able to deduct from their taxes 100 percent of their health costs, up from today's 25 percent.

PROTECTING OLDER AMERICANS

Medicare will be preserved under the Health Security plan. Individuals enrolled in Medicare will see little difference in how, where or from whom they receive their health care. There will, however, be a strengthening of Medicare to include the prescription drug benefit. Americans eligible for Medicare will automatically qualify for the new prescription drug benefit when they enroll in the Part B benefit. Part B premiums will increase to cover 25 percent of the cost of this new benefit. However, Medigap insurance premiums should decline by a proportionate amount as the policy will no longer covers drugs.

With the new drug benefit there is a $250 annual deductible for each person. Individuals on Medicare also pay 20 percent of the cost of each prescription. The maximum amount a person can pay however, is $1,000 over the course of a year. The prescription drug benefit covers all drugs and biological products, including insulin, approved by the Food and Drugs Administration.

As the health care reform plan evolves, Medicare recipients will get the chance to consider enrollment in fee-for-service health plans, or in new types of health plans, including health maintenance organizations and preferred provider networks.

As Americans enrolled in health plans turn sixty-five, they can choose between remaining in their health plan or entering the Medicare system. When each state's alliances are up and running, Medicare will begin to integrate into the alliances.

Older Americans will also see their long-term care options expanded and improved under health care reform. The Health Security plan stresses home and community-based care and expands the range of choices for individuals who require long-term care.

The reform of long-term care includes:

- Expanding home and community-based services
- Improving Medicaid coverage for people in institutionalized care.
- Improving the quality and reliability of private long-term care insurance and tax incentives to encourage people to buy it.
- Tax incentives that help individuals with disabilities to work.
- a demonstration study set up to examine ways of integrating acute and long-term care.
- An interim and final performance review of all the parts of the new long-term care program.

ACCESS TO CARE IN RURAL AND URBAN AREAS

The challenges in creating health security in rural and inner-city communities are essentially similar: Both include unusually high numbers of people without health insurance, making it difficult to attract doctors, and scarce economic resources create unusual barriers to organizing effective networks of care.
In addition, the intensity of health problems is more severe in rural and urban areas, in part because of higher levels of poverty in both types of communities. In part because of the nature of the work in rural areas.

The causes behind each of those realities are very different in each area, however. In rural area the challenge essentially is geography. With a relatively small population dispersed over a large area and an inadequate supply of health care professionals, patients often find themselves traveling significant distances to see a doctor. As a result, it becomes more difficult to build networks, and attract enough health plans to foster competition.

In inner-city communities, the challenge stems from the concentration of population -- and the consequent concentration of health problems. All of the social and economic problems that undermine inner-city neighborhoods also present barriers to the effective delivery of health care. Only a few blocks away from a world famous academic health center, densely populated neighborhoods contend with too few doctors and nurses, too many people who lack health coverage, high rates of infant mortality and low-birthweight babies and frequent violence.

In both cases, health plans provide coverage to underserved rural and urban communities reluctantly, and health professionals are more likely to establish practices in areas where a larger proportion of patients are likely to have health insurance.

To serve both communities, the goals of health care reform are similar: Increase the economic base for health care, bolster the power of coverage with discounts to make care affordable and create incentives to attract health care providers to the area.

The Health Security Act lays out a substantial agenda on both fronts, with loan programs and investments to increase the level of service available in underserved urban and rural communities. Expansion of the National Health Service Corps will send new physicians and health professionals into the communities, substantially increasing the supply.

Hospitals, clinics, doctors and other health professionals also are eligible for designation as essential community providers, gaining special protections during the implementation of health reform. To support the adaptation of those critical providers to new requirements under health reform, the Health Security Act requires health plans to contract with essential community providers to continue serving their traditional roles for five years.

For rural areas specifically, the federal government will back up rural communities that want to develop health plans, and will invest in health care centers, clinics, hospitals and equipment in areas where more than half of the residents earn less than 200 percent of the official poverty level. Expansion of the National

Health Service Corps will place as many as 5,800 new primary care doctors and other health professionals in rural areas by the year 2000.

The Health Security plan also supports the development of health care technology, opening the way for a new era in rural health care. Technological links between specialized regional health centers and remote rural health providers will provide access to new and improved treatment options.

In urban areas, there will also be extra funding for community health clinics and hospitals so that they can either form their own networks or join other networks. The Health Security plan includes specific provisions designed to bring new primary care doctors into the community and to build or renovate clinics in inner-city areas. And hospitals that serve disproportionately low income individuals whose intensity of care is greater than other populations, will also receive assistance.

IT WORKS - RURAL AND URBAN UNDERSERVED AREAS

CHILDREN'S HEALTH FUND

In areas where health care is hard to access, prevention is non-existent.

The Children's Health Fund recognizes that with out adequate preventive care, the health crisis in inner city and remote rural areas will only grow worse. The Children's Health Fund addresses this problem by sending a pediatric team in a mobile-based, fully equipped pediatrician's office -- with examining rooms, supplies and equipment -- to visit children in these underserved areas each week. The mobile health centers provide a full range of comprehensive primary care service such as immunizations, well child examinations, and treatment for routine childhood ailments. With regular preventive and primary care, these children have a chance to become healthy adults instead of life long burdens to the system.

WATTS HEALTH FOUNDATION

The Watts Health Foundation has found a way to allow consumer choice and flexibility while maintaining high quality, affordable health care.

The foundation, originally a very large, well run community health center, now accepts privately insured individuals as well as MediCaL and Medicaid patients. Clients of the Watts Health Foundation can choose to get all their services in one building or at the private doctor's offices and group practices with which Watts negotiates. Watts also understands the importance of ethnic and cultural factors when choosing a doctor, and offers a diverse group of providers.

COMMUNICATING FOR AGRICULTURE

No member of Communicating on Agriculture has ever had their insurance canceled.

Communicating on Agriculture represents nearly 80,000 self employed farmers and ranchers and negotiates quality health insurance for all of them. Because the group is so large, Communicating on Agriculture is able to obtain low cost insurance rates for its participants. All members receive the same rates for insurance which cannot be raised if an individual gets ill.

Communicating on Agriculture can provide such quality health care because it encourages its members to audit their own bills, and makes the insurance companies pay for their mistakes. There is also a 24 hour toll free "Ask the Nurse" hotline and discount pharmacies operating in small rural towns. An extensive quality review program ensures that members are provided only the best health care.

IT WORKS - HOME AND COMMUNITY BASED CARE

ELDERDAY ADULT DAY HEALTH CARE CENTER

At Elderday Adult Day Health Care Center, the goal is to help frail elderly and younger disabled people maintain their highest level of independence and remain in their own homes for as long as possible.

Too many elderly and disabled people are placed in institutions before they need to be. Elderday helps these people develop and learn how to function in day-to-day life. Home care is not only cheaper than institutional care, it is also preferred by patients and their families. Elderday provides their services to all sections of society, using a sliding scale based on a participants ability to pay.

Chapter V

SIMPLICITY

"Each of our medical insurance policies requires separate and different applications for reimbursement, each of which have to be mailed to different addresses. This mountain of paperwork places an undue burden on older Americans...".

J.H.

Venice, Florida

Making the American health care system simpler requires a two-pronged effort. First, standard insurance forms and simplified administrative rules will reduce the level of confusion and complexity. It will make the health care system less daunting and frustrating to consumers and more supportive and flexible for the doctors, nurses and hospitals working on the front lines. Second, a system that holds health plans and providers accountable for results does not require as much regulation and oversight of every step.

REDUCING PAPERWORK

Using electronic billing and standardizing forms will help simplify the system. The introduction of new information technology holds great promise to improve health care, but making the most of new technology will involve more than automating administrative tasks. It will mean adapting how doctors, nurses and hos-

pitals work, using computers, and other telecommunications to strengthen links between health care providers in even remote areas with the wider medical world. Health care reform and the new information technology complement one another. Through administrative simplification and uniform standards of coverage, reform will reduce the complexity of health care. Information technology will help manage the complexity that remains.

Requiring everyone to participate in the health coverage system and establishing a uniform, comprehensive set of benefits represent the first, vital steps toward simplifying health care in the United States. If all Americans have guaranteed coverage for uniform, comprehensive health services, doctors, hospitals and clinics have less work to do when a patient walks in the door. And the patient no longer will have to deal with confusing sets of insurance company requirements and forms. The Health Security Card that every citizen and legal resident receives will act as a universal key to health care.

Like the cards that activate bank-teller machines, a magnetic strip on the cards will provide basic registration information, including identifying the health plan in which the patient is enrolled. A personal identification number will serve as the patient's authorization for his or her doctor to have access to insurance information, reducing the process of registering and billing.

But let's be clear about what the Health Security Card is not. It is not a "smart card," a national ID card, or a credit card. And it does not hold the key to your medical records. It's simply a way to streamline the billing process, reduce paperwork for doctors and patients, and let people know that they have a comprehensive set of benefits that can never be taken away.

All plans will adopt a standard form that patients and health providers file to seek reimbursement for services; doctors, nurses and hospitals will no longer have to figure out a different set of instructions and forms to deal for each health plan. Today, insurance companies use hundreds of different claim and billing forms and codes for diagnoses and treatments. A uniform claim form reduces the work generated by dealing with all of those different forms, making it one of the simplest steps for gaining administrative savings. Startlingly, that simple change saves an estimated 75 cents for each claim, saving the health care system and its customers $3.5 billion.

Similarly, adoption of a standard enrollment form will allow employers and individuals to collect and send the same information to all health plans and alliances.

Consolidating multiple systems of payment for health services, including comprehensive health coverage particularly in families with more than one employed adult, automobile insurance, workers' compensation and benefits for retirees, will simplify the system and generate more savings.

ELIMINATING RED TAPE

Other benefits will flow from reducing unnecessary regulation. Hospitals and other health care institutions will obtain relief from overlapping federal and state requirements for certification and licensure. The federal government will develop national certification standards, largely based on outcomes and provide incentives to states to use them as the basis for their licensing process.

Instead of surveying all health care institutions on a regular schedule, agencies and outside institutions charged with ensuring that institutions meet established standards will be encouraged to coordinate their visits, reducing the total investment in time preparing for and following up on inspections. Agencies that perform inspections also will concentrate their efforts on institutions with histories of problems, pursuing complaints and responding to problems.

Regulatory programs, such as the Professional Review Organizations (PROs) that check up on treatment of Medicare patients will be phased out as the strength of the new quality system builds. Under reform, all health plans will have to make clear to consumers and doctors who sign up to participate precisely how they perform utilization review -- a step intended to reduce frustration, delay and the discovery of new rules in the middle of treatment. New performance standards developed jointly by health professionals and industry groups -- will establish new rules for utilization review, eventually reducing reliance on obtrusive methods of control. They will set deadlines, for example, for how quickly health plans must respond to requests from hospitals and doctors to clear hospital admissions and treatment decisions.

In addition to protecting information, the establishment of national standards for information required from health plans, doctors, hospitals and consumers when they use health care is critical. Efforts in the health care industry to develop standards are already underway. The Health Security Act can impose deadlines and back agreed-upon standards the force of law.

IT WORKS - SIMPLICITY

CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM

The California Public Employees Retirement System (CALPERS) holds annual premium increases down to 3.1 percent while forcing its insurers to root out wasteful administrative costs, reduce inappropriate care, and encourage hospitals and doctor's groups to moderate their rates.

CALPERS administers health care plans for almost 900,000 government employees in California, and it uses this large group of consumers to negotiate for quality, affordable health care. Small companies and individuals join CALPERS because it allows them to bargain with the insurance companies for low rates as if they had the clout of a large business. In addition to quality care and low rates, CALPERS does not short change the customers in the one area of health care that most find so important -- choice. CALPERS offers 19 different plans to choose from.

ARIZONA HEALTH CARE COST CONTAINMENT PROGRAM

Arizona has a Medicaid program that doctors like.

It is the only state that has a capitated Medicaid program -- one where providers are paid a flat rate for a given time period regardless of how much service is actually used.

Under this system, doctors are satisfied, so Medicaid recipients no longer face the humiliation of being refused service because of their Medicaid status. Costs of the Medicaid program in Arizona are significantly less than any other Medicaid system in the country.

Chapter 6

SAVINGS

"Twenty percent of our income is going for health insurance and there is nothing we can do about it. We are afraid to be without insurance in case of an emergency, so all of our savings for the future are used to pay health insurance."

M.F.

New York, NY

The Health Security plan creates a new framework that will ensure all Americans secure, affordable coverage -- and a vehicle to assure that the money we spend on health care is spent wisely.

The Health Security plan addresses those issues, that's why its comprehensive approach serves the dual purpose of improving care while controlling the rise of costs. Major reform initiatives take aim at waste, inefficiency, fraud and abuse that bloat the health care system, squeezing out excesses that thwart the delivery of high-quality care at reasonable prices.

But the key to achieving the savings that lie at the heart of health reform is to release the good, old-fashioned American spirit of competition -- aimed not at making consumers and employers pay ever-higher fees but at getting value for our dollars.

That requires action on several fronts. It requires reversing incentives. It requires streamlining and simplifying overly burdensome regulations and requirements. It requires redirecting some resources, such as public and private investments in medical education and taking aggressive steps to stamp out fraud and abuse, which the General Accounting Office estimates drain $80 billion each year away from real health needs.

INCREASING COMPETITION

The Health Security plan controls rising costs primarily through the power of a competitive market that empowers consumers to make choices. Reform will change incentives so that health plans compete on the basis of quality, service and cost -- not risk selection. Physicians, hospitals and other health professionals will be given the incentives and opportunities to shape a health care system that works for patients.

Consumers will be empowered to choose among health plans based on quality and price. Consumers reap the savings from enrolling in health plans that deliver care most efficiently -- and, therefore, charge lower premiums.

The Health Security plan will promote the development of health plans that give consumers better value for their money. In the current system, doctors and hospitals get paid extra for each service they perform, creating incentives to perform more services. Under reform, health plans and providers are judged by what happens to their patients -- and the incentives change from "doing more" to giving better care.

The incentives under reform are clear: it will be in the interest of the health plan to operate efficiently -- providing the best quality care at an affordable price. If health plans operate inefficiently, they lose money. If they operate too efficiently, and start cutting corners, they'll lose patients -- and the business that those patients bring. Competition is about finding the balance -- providing high-quality care while controlling costs.

STRENGTHENING BUYING CLOUT

Increased buying clout can bring down costs. Let's look at the way the insurance market works today. The big companies like IBM and Xerox can go to an insurance company and say, "Look, if you want the business of our 10,000 employees, you've got to give us a good deal." And they get a good deal -- comprehensive benefits, high-quality care and an affordable price. But if you don't work for a large employer, you've probably got high premiums, barebones coverage or nothing at all. The Health Security plan will change that -- putting consumers and small businesses in the driver's seat.

It's based on the simple idea that pooling resources tends to get you a better deal. By banding consumers and small businesses together in large purchasing pools, the Health Security plan gives the little guys the same buying clout as the big companies. Prudential doesn't have to give any kind of deal to the Mom and Pop store in Peoria -- but they can't afford to ignore 5000 Mom and Pop stores in Central Illinois. This will mean that everyone -- not just the people that work for the big companies -- will be able to get high-quality care at an affordable price.

Regional health alliances stand at the financial crossroads of the reformed health insurance system. Because of their buying power, alliances represent an economic counterweight to the health plans and medical providers. It's a counterweight that will produce savings. Alliances will have more complete information on costs in health plans, quality of care, service and consumer satisfaction than any buyer in today's market. And they'll be able to enlist economies of scale to reduce administrative overhead.

LOWERING ADMINISTRATIVE COSTS

The plan will simplify the business side of health care with standard forms for insurance reimbursement and other changes, replacing the paper jungle generated by some 1,200 insurance companies, as well as conflicting regulations and inspections by a variety of federal, state, local and private agencies.

There will be lower administrative costs for small groups and individuals as firms with fewer than 5,000 employees and the self-employed come together to form purchasing pools that consolidate administrative tasks.

That last step alone could produce savings as high as $8 billion: Small businesses pay as much as 30 to 40 percent of their premium dollars for administrative costs in the current system, while large purchasers pay only 5 to 7 percent for administrative overhead. Simply eliminating the market for small group and individual insurance produces substantial savings from the costs of sales and administration. For all private health insurance, the cost of administration totalled $44 billion in 1991, an average of 16 percent of the benefits those policies paid out.

Similarly, consolidating the multiple systems of payment for health care -- including health insurance, automobile liability, workers compensation, and secondary coverage for families with more than one worker and for retirees -- will produce another source of savings. Today, doctors and hospitals often submit separate claims for payment to two or more insurers. Under the new system, everyone will have coverage, and most will have one and only one source of coverage. Doctors and hospitals will no longer contend with sorting out conflicting insurance coverage.

The Health Care Financing Administration (HCFA) estimates that American consumers and employers will save 1 percent of total hospital revenues by implementing the changes proposed in the Health Security Act -- and they only count savings in what they call "pure" administrative departments. The same federal agency estimates a potential savings of approximately 3.4 percent of total revenue paid to physicians as an effect of reform.

A more expansive definition of administrative costs shows potential savings as high as $9 billion in 1996 under reform and $52 billion by the year 2000. Other bills introduced in Congress have carried estimates as high as $16 billion in the year 2000 if the health care system is streamlined and simplified. A conservative estimate is that administrative savings in physicians' office and hospitals will total $16 billion in 2000 and that cumulative savings over the five-year period from 1996 to 2000 will be $52 billion.

After reform, far fewer people will push paper in insurance companies and the billing departments of hospitals, clinics and doctors' offices. Many more will be available to care for patients. The imperative is

clear: Only effective control over health costs will provide the American people with the secure and affordable care they deserve.

A LIMIT ON PREMIUMS

The Health Security Act contains deliberate, built-in redundancy to create a fail-safe approach to achieving the goals of cost containment. It provides a variety of tools to control costs but does not dictate which tools states use, for example.

But it does provide a national emergency brake to back up the power of competition unleashed in the effort to control rising health care costs. The Health Security Act offers employers and American workers the safeguard of national limits on how much health insurance premiums can rise. Enforceable caps that limit the amount of health insurance premiums can rise act as an insurance policy, reinforcing the new system of incentives to slow the rate of growth in costs. The safety net of national limits on premium growth assures American employers and consumers that the responsibility for health security will prove manageable.

After their first year, health alliances will limit annual increases in the weighted-average premium among their health plans to the increase in the Consumer Price Index plus 1 percent, with some adjustments for changes in population. No one will ever step in and order health plans to reduce their premiums, however. The proposed system works automatically, without creating another bureaucracy issuing regulations and making inspection tours. Instead, the National Health Board will hire experts to figure out how much insurance premiums can rise in each region of the country (based on how much each region spends on

health care now). When health plans propose premiums out of line with those targets, regional alliances will simply reject the bids and pay them less. The health plans will have to turn around and adjust their payments to doctors, hospitals and other professionals.

The Health Security Act only sets defined limits on the rate of increase for insurance premiums through the first five years of implementation of health reform. The relatively strict limits it imposes are intended to squeeze the waste and excess out of the health care industry that every doctor, nurse, patient, consumer and insurance carrier knows exists. Once American consumers and employers have reaped the gain of those savings -- which many experts acknowledge are attainable -- it will be time to reassess the national goal of cost containment and set new limits on future investments in health care.

MAKING FRAUD A CRIME

The Health Security plan will, for the first time, designate health care fraud a crime. The plan takes aggressive steps to combat fraud and abuse, increasing penalties for those who cheat the system, expanding enforcement activities, imposing new prohibitions against kickbacks and conflicts of interest, such as self-referral. Among the consequences it establishes are strict rules for excluding health care providers convicted of fraud and related crimes from participation in health plans.

Leading the effort to combat fraud will be the Departments of Justice and Health and Human Services -- who will organize an All-Payer Health Care Fraud and Abuse Enforcement Program to coordinate federal, state and local law-enforcement activities. Federal authority to seize assets from fraudulent providers and to

levy criminal penalties for health care fraud expand to include filing false claims against health plans and other fraudulent activity. Assets seized will be used to help support anti-fraud efforts. The effort will target fraud and abuse such as overcharging for services, charging for medical care that was never received, providing financial incentives to doctors who refer their patients to certain clinics or pharmacies, and delivering unnecessary services.

There are other elements of the Health Security plan that will make it more difficult for fraud to flourish, as it does in today's system. Simplifying the paperwork involved with the health care industry, will eliminate the fraud that is so easily hidden in today's overly complex system. Changes such as the use of standard forms throughout the industry, and a uniform coding system, not only reduce administrative costs but also reduce opportunities for fraudulent billing. The new quality management system -- which releases to the public information comparing the performance of health plans and providers -- will make it more difficult to hide abuses.

The change in how the market for health coverage is organized will also help root out health care fraud. By itself, that fundamental reform will deter fraud and abuse easily concealed in the fragmented and overly complex system that exists today. Genuine savings in health care will come not from shifting the risk of costs onto individuals -- as some other reform proposals suggest -- but from assigning those risks to organizations that can manage them -- and holding those organizations accountable.

IT WORKS - SAVINGS

THE MAYO CLINIC:

The Mayo Clinic is holding their cost increases to less than half the national average.

The Mayo Clinic is the largest group practice in the United States and is very well known for its high quality of care and its sophisticated technological services. They have been holding their costs down through the use of "practice guidelines". These practice guidelines in addition to having doctors who are all on salary has helped the Clinic to provide its high quality service at a surprisingly low cost.

XEROX CORPORATION IN ROCHESTER, NY

Health care costs at Xerox used to rise by 20 percent a year because employees chose the most expensive, inefficient health care packages.

Now, Xerox has given all employees the option of either choosing a benchmark "standard" plan and pocketing the savings, or allowing them to choose a more expensive one, and pay the difference. Competition among health plans at each of Xerox's 250 sites across the country is the cornerstone of the plan. All plans are screened each year to ensure that

they meet high quality standards and offer comprehensive benefits packages. Premiums have fallen significantly, and many employees have switched to the benchmark plan.

Chapter 7

QUALITY

"I am a first grade teacher in a very poor neighborhood in North Philadelphia...Many of (my students) have never seen a family physician; many have never even been inside a public health clinic. I was shocked to find that eight our of ten of their absence notes are written by doctors in the emergency room of nearby hospitals...I feel bad for my students who have never had an ounce of preventive medicine, but I feel angry, as do many of my middle-income peers, who are ultimately footing the bill for the emergency treatment these children are driven to.."

J.G.

Philadelphia, PA

Many Americans worry that strong action to restrain costs will compromise the quality of health care. We value the relationships we have with doctors, hospitals and other health providers and the quality of care most of us receive. Reform must not impinge on those. The goal of the Health Security Act is to improve care by building attention to quality into all levels of the new system.

EMPHASIZING PREVENTIVE CARE

Prevention is the cornerstone of the Health Security plan. Incentives for patients and doctors alike to use and prescribe methods are woven into every part of the plan -- from free coverage of a wide range of

preventive services, to wellness education and counseling and increased research funding, the plan will offer an unprecedented focus on prevention.

The comprehensive benefits package includes a broad array of preventive services not covered by the vast majority of insurance plans -- immunizations, mammograms, well-baby care, and other screenings and early detection methods which solve health problems before they become serious illnesses. The Health Security plan covers all of these -- with no coinsurance or copay.

The Health Security plan will fundamentally restructure incentives in the health care system. For the first time, every doctor, nurse and health provider will know that they can provide the services they believe are necessary -- and know they will be reimbursed.

EMPOWERING CONSUMERS TO JUDGE QUALITY

Information is a key element in empowering consumers to force health plans to compete by offering high quality care. Under the Health Security Act, American consumers will exercise not only the technical right to choose doctors, other health providers and health plans but the right to make informed choices based on meaningful information about how health plans, professionals and hospitals perform.

The quality of health care has two sides: the objective effectiveness of treatment and the personal attention and respect shown to patients. The Health Security Act treats both as equally important, creating new channels through which consumers obtain meaningful insights into quality, performance and consumer satis-

faction. Annual performance reports provided by health alliances will tell consumers how their health plans, doctors and hospitals measured up on a set of critical indicators, including how they fared in surveys of consumer satisfaction.

When the Medicare and Medicaid programs were enacted, neither the federal government nor any private organization could have undertaken the approach to monitoring and improving quality envisioned in the Health Security Act. The necessary tools simply did not exist. But over the last three decades, steady progress has occurred in developing the tools to make widespread quality improvement feasible. Researchers and panels of health professionals have developed new ways to report on the appropriateness of care and its results. The federal government, the American Medical Association and its specialty groups have led an extensive, on-going effort to develop guidelines for effective medical care for specific conditions and illnesses.

Many programs around the country have begun using the new approaches to quality. Business groups are now joining with doctors, hospitals and health plans to publish information about comparative quality and price. In communities such as Nashville, Tenn.; Cincinnati, Ohio; Rochester, N.Y.; and Minneapolis, Minn., as well as the state of Pennsylvania, major employers, local hospitals and state governments have begun collecting information that allows businesses and consumers to make valid comparisons among hospitals and physicians. The Joint Commission on Accreditation of Health Care Organizations, which monitors the quality of hospitals, and the National Committee for Quality Assurance, which accredits health maintenance organizations, both have revised their standards to place greater emphasis on nationally accepted performance measures.

Although much work remains to be done, monitoring quality on a national level and creating a national quality improvement program are cornerstones of the Health Security Act. Its key elements are simple: Health plans will hold themselves accountable for their performance and report information used to assess both the appropriateness of care delivered and its effectiveness. Consumers will have a direct say in the evaluations through regular surveys probing their level of satisfaction -- as well as the answer to the critical question: What happened to the patient?

A basic premise of medicine is that greater knowledge of science advances professional practice. A major premise of the Health Security Act is that greater knowledge of performance empowers consumers to make informed decisions, alerts the public to potential problems and inspires doctors, clinics and hospitals to improve. Regular monitoring of the quality of care is particularly important to balance incentives built into the system to keep down the growth in health care costs. Those two goals must stand as equal cornerstones in the foundation of health care reform. Quality measures reported to the public will focus attention on quality and trigger corrective action when necessary.

A reformed health care system emphasizing accountability can improve the quality of health care, improve safeguards for patients and reduce bureaucratic regulation.

One promise of reform is better health care through a new emphasis on accountability for results. Focusing on results can reduce the paperwork, micromanagement, gaming, and bureaucracy that strangle doctors, nurses, hospitals and clinics. Accommodating the desire of health professionals for less intrusion from insurance companies and bureaucrats and less hassle means creating a system will support them in their real

work, caring for patients. The reformed health care system also must hold the professionals in whom its clients entrust their lives strictly accountable for their stewardship of patients' money and health. The new approaches to ensuring quality based on information are scientifically advanced approaches to achieve a critical goal: high-quality care at a sustainable cost. They are key steps in creating an American solution to an American dilemma.

Under reform, doctors, clinics and hospitals will have to examine ways to make their delivery of care more efficient while improving quality. "Business as usual" will no longer be profitable. Leading hospitals across the country are already moving in this direction:

- When doctors at the Hospital of Latter Day Saints in Salt Lake City, Utah realized that post-operative wound infections were causing excessive hospital stays, they experimented with changing the timing of administering antibiotics before surgery. Patients got fewer infections, left the hospital earlier and saved $450,000 in the first year.

- The Pennsylvania Health Care Cost Containment Council documented that no difference in quality exits between coronary artery bypass surgeries performed at hospitals that charge $21,000 and the same surgery performed at other hospitals for approximately $84,000.

Under the Clinton Health Security Act, a hospital that charges a patient $84,000 for surgery that can be performed for $21,000 simply will not survive the competition.

To expand knowledge about what works in health care requires research specifically aimed at reducing uncertainty. Second, American consumers need regular, comparative measurement of health care providers and plans, translated into lay terms and widely disseminated. Four elements are critical to evaluate the quality of care:

- Access
- Appropriateness
- Outcome
- Consumer satisfaction

Researchers know, for example, that children with asthma shouldn't end up in the hospital. With good care, medication can control asthma attacks so they don't have to go to the hospital. Under the quality program, the annual performance report might tell parents how well a particular plan did on that measure -- and also explain why it's a valid indicator of the quality of care delivered to all children.

Other indicators known to provide valid insights into overall performance include measurements such as the percentage of patients who survived coronary by-pass surgery or developed bedsores while bedridden, or who regained their ability to walk after repair of a hip fracture. Simpler measures that also tell consumers valuable information might include the answers to such questions as: How many patients decided to leave this plan last year? Did it serve many people in my neighborhood? How many low-birthweight babies were born under its care? How many pregnant women got early prenatal care? What percentage of children received all their immunications?

Performance reports based on these types of indicators form a crucial innovation of health reform, valuable to consumers, professionals and purchasers alike. When choosing a plan and providers within a plan, consumers will be able to judge whether they can expect prompt access to treatment, how the care stacks up against other health plans and what other consumers think about the plan. Merely having the information available will stimulate plans and providers to focus on quality.

Relying primarily on annual performance reports, backed up by regional foundations established to assist doctors, hospitals and other institutions in their efforts to make improvements, the Health Security Act will reduce the cost of quality, making it less expensive to identify shortcomings, set goals for improvement and monitor results. Since mistakes are costly, improved quality is a form of cost containment -- the very best kind.

Once a year, consumers receive solid information to use in making comparisons among health plans and providers. It will report how various plans performed on carefully selected indicators that show how one plan compares to another. For example, researchers know that certain medical indicators provide clues about overall performance: How many children with asthma in this plan ended up in the hospital last year? How many older people who suffered a fall didn't recover their ability to walk? How many patients who suffered heart attacks survived? On the simplest level: How many patients didn't like this plan and chose another? Consumers use that information to decide to remain in their plan or select another.

Indeed, the new system hinges on improved information. Without useful and meaningful information, consumers, health plans and alliances cannot make valid comparisons of quality and cost. The development

of this new system will occur in the private sector; it is well underway, but government can act as a catalyst, reducing the barriers to change and creating incentives and support for innovation.

INVESTING IN RESEARCH

Under the Health Security Act, there will be significant initiatives to increase research. Advances in medical science, new medications and technology, and innovations in health care delivery will improve the quality of life for all Americans.

Research related to health promotion and prevention of disease will focus on many common illnesses and other priority areas:

- heart disease
- bone and joint disease
- Alzheimer's disease
- cancer
- AIDS
- birth defects
- mental disorder
- substance abuse
- nutrition
- health and wellness programs

Research regarding clinical practice will increase with an emphasis on quality and effectiveness, as well as access and financing. There will be an emphasis on "outcomes research," research into what treatments work and which treatments are the most cost-effective. Expanded research will also measure consumer awareness, decision-making and satisfaction.

BUILDING A STRONGER WORKFORCE

Fortunately, the moments when a patient needs the most advanced medical care in the nation delivered by the one leading specialist developing a new approach to treatment are rare in most American's lives. It is on the day-to-day level of providing good, basic care that the existing health care system too often fails us.

As the American health care system has become more complex, specialized, and technical, it has neglected some simpler and, ironically, less costly needs. The cost of treatment for acute illness has soared, but we continue to spend relatively little on preventive and public health services. While more physicians become specialists, the number of doctors providing basic, routine care has declined, and many states have erected artificial barriers to advance-practice nurses and other health professionals that prevent them from filling in the gap.

Good basic care is one of medicine's essential responsibilities. Meeting that need represents one of the essential requirements under health care reform. If the American health care system is to provide high-quality care at an affordable price, it must strike a better balance between physicians, nurses and other profes-

sionals who take care of basic needs and those who provide the most sophisticated and specialized treatment for serious illness.

Without sacrificing the scientific and technical excellence we value, we must shift gears, giving equal attention to another compelling interest -- a people imperative, the imperative to good care for the American people.

Primary care doctors and nurses work on medicine's front line. They diagnose and treat routine medical problems, refer patients when necessary, and coordinate specialist care. Family physicians, general internists and pediatricians are the principal primary care practitioners among physicians, although many women also most consistently see obstetricians and gynecologists. Advance-practice nurses, nurse practitioners and physician assistants provide essential primary care as well.

For decades federal policy has reinforced the shift away from training primary care doctors and toward training more specialists. Federal funding of graduate medical education averaged $70,000 for each resident in 1992, with nearly all of the money going training in hospitals. Little went to other health care institutions in local communities that would provide more basic care. Responding to that incentive, between 1980 and 1993, American hospitals increased the number of residents in training from 82,000 to 97,000, with 94 percent of the new positions devoted to training in specialty fields of medicine.

Because the overwhelming majority of graduates of U.S. medical schools choose to specialize, hospitals increasingly must turn to graduates of foreign medical schools to fill primary care positions in emergency

rooms and clinics. While medical school graduates from abroad fill the gap in primary care doctors, the United States trains relatively few members of minority groups. African-Americans, Hispanics, native Americans and Asian Americans make up 22 percent of the population but only 7 percent of physicians. ~~(check numbers)~~

Health care reform will increase the demand for primary care physicians, nurses and other health professionals and probably cause their pay to increase, correcting the long-standing incentives that discouraged medical students from becoming family doctors. But change won't happen quickly. To encourage American teaching hospitals to switch some residency positions from specialist to primary care, the federal government must make it more worthwhile to train them.

Consequently, rather than pay for graduate medical education without regard to specialty, public and private investment will depend on bringing about a redistribution between residency slots devoted to primary care and those devoted to specialty training. Other federal programs, including an expanded National Health Service Corps, will support students selecting primary care and locating in traditionally underserved areas, such as rural and urban communities. The National Health Service Corps will support "loan forgiveness" programs for medical students who are trained in primary care, and re-training programs for mid-career specialists who want to work as primary care physicians. The Health Career Opportunities Program, minority loan and scholarship programs, and minority faculty development programs will improve workforce diversity. Financial assistance and improved recruitment will greatly increase the level of under-represented minorities in the health professions by 2000.

Even with the steps outlined in the Health Security Act, shifting resources invested in residency education to promote more training in primary care still will not bring the mix of doctors in the United States into balance until the year 2030.

The Health Security Act proposes several important steps to remove those barriers. It will encourage states to modify practice acts, providing a model statute for consideration. Other changes in federal policy will help ensure that qualified professionals participate in health plans and alliances to the extent of their training and legal scopes of practice. In addition, federal funds will provide additional resources for training nurses, doubling the number of annual graduates. Support will also be provided for training in geriatrics and long-term care, and in mental health and substance abuse treatment. School-based providers will be educated on relevant issues such as immunizations and reducing community violence.

IT WORKS - QUALITY AND CHOICE

GROUP HEALTH COOPERATIVE OF PUGET SOUND

At Group Health Cooperative of Puget Sound (GHC), customer satisfaction is high and patient turnover is low.

GHC's doctors are so satisfied with the plan that their attrition rate is almost two-thirds less than national levels.

GHC is the largest consumer-run HMO in the country, with almost 500,000 members. It is a working example of how HMOs can control costs while providing high quality comprehensive services. Customer satisfaction is the key to GHC's success, and it is measured regularly to make sure that GHC is maintaining its high standards.

LAKELAND REGIONAL MEDICAL CENTER

At Lakeland Regional Medical Center, they have found a way to spend less time on paperwork and more time with the patient, all at a lower cost.

To combat skyrocketing hospital costs, Lakeland Regional Medical Center implemented a team strategy for patient care. Patients at the 897 bed facility are looked after by a "care pair" -- usually a registered nurse and a helper -- from check in to discharge.

These care teams preform medical functions as well as housekeeping chores and administrative tasks for their patient.

This approach saves the hospital money by keeping staff busy, (lowering personnel costs by 40 percent). Most importantly, patient satisfaction is very high because hospital staff spend 60 percent more time caring for the patients, and the patients receive personal, individual care from their "care pair".

Chapter 8

CHOICE

"The business I work for is a small business with only five employees. These rates are becoming so high, that for the first time in my life, I am afraid of losing my job. I am afraid my employer will be unable to afford this much longer. If that happens, I would mever be able to afford medical coverage on my own."

J.A.

Manhasset, NY

American consumers value the right to choose, seeing it as a key measure and protector of quality. Yet thousands of Americans lose that right each year, as employers restrict their choices of health plans and doctors in the struggle to hold down rising costs.

Americans will gain a new level of control over their health care through the Health Security Act. For many, no element of that gain will be more important than the right to choose their own doctor, clinic, hospital or other health provider.

CHOOSING A DOCTOR

A fundamental flaw in the traditional employer-based approach to health coverage is that it delivers to employers -- rather than employees -- the power to choose health plans, and, consequently, the doctors, hospitals and others who provide care.

The Health Security Act corrects that flaw. Through comprehensive reform, it transfers the power to choose back to individual Americans and families. It requires regional and corporate alliances to organize a broad choice of health plans, including at least one plan organized around the traditional fee-for-service style. It requires all health plans to include a "point-of-service" option, which means consumers can see any doctor or go to any hospital.

For patients who choose certain types of health plans, exercising the right to see a doctor who does not participate in the plan will cost more. But the right will always be there, for those who need it. The requirement for a "point-of-service" rider applies even to HMOs, which do not always offer that option today. It reserves for every American the right to seek out the care of doctors and hospitals on the leading of edge of treatment if they ever confront an illness in which even specialized care available through their regular doctors and hospital is not adequate.

Health reform will also make it easier for patients to follow their doctors, even if their doctors decide to switch health plans. Because an increasing number of employers restrict the choice of plans available to employees, a patient whose doctor leaves one plan probably has little choice but to find another doctor. Un-

der health reform, the patient will always have the option of switching plans during the annual open enrollment period, continuing the relationship with a particular doctor or other health provider regardless of which plans they participate in.

CHOOSING A HEALTH PLAN

Millions of Americans choose physicians and other health care providers and pay for their services one at a time through traditional indemnity coverage, a style of coverage usually described as fee-for-service. Over the last two decades, millions of other Americans have moved into new styles of health plans called preferred provider organizations (or PPOs), health maintenance organizations (or HMOs) and even new models still under development.

All of those options -- and other innovations that will evolve -- will continue. What the Health Security Act will provide is the guarantee that a wide range of alternatives will exist and that American consumers will have the opportunity to choose among them, not their employers.

INCREASING OPTIONS FOR LONG-TERM CARE

Long-term care options are expanded and improved under health care reform. The Health Security Act stresses home and community-based care and expands the range of choices for individuals who require long-term care.

The reform of long-term care includes:

- Expanding home and community-based services
- Improving Medicaid coverage for people in institutionalized care.
- Improving the quality and reliability of private long-term care insurance and tax incentives to encourage people to buy it.
- Tax incentives that help individuals with disabilities to work.
- A demonstration study set up to examine ways of integrating acute and long-term care.
- An interim and final performance review of all the parts of the new long-term care program.

Chapter IX

RESPONSIBILITY

"Our health insurance policy is so expensive that we will have to drop it this year at a time in our lives when we will probably need it most.

My husband and I are 59 and 63 years of age, so we are not yet eligible for Medicare to help us...A brief summary of our health insurance costs for the last 11 years are:

1981- $1,654 with $100 deductible

1988- $3,578 with $500 deductible

1989- $4,008 with $1,000 deductible

1990- $4,607 with $2,500 deductible

1991- $8,306 with $2,500 deductible

1992- $10,500 with $2,00 deductible

I have a preexisting condition. I had rheumatic fever as a child which I have never been hospitalized for but, because for the past 13 years I have taken medication, I have to pay a penalty on the rates. Neither my husband nor myself, fortunately, has ever had a claim of any kind...

We do not want a 'free ride'. We are more than willing to pay our share, but these amounts are just too excessive".

M.M.

Joliet, Ill.

Every one of the principles of the Health Security plan hinges on the concept of responsibility. As the President said in his address to the Joint Session of Congress, "We need to restore a sense that we're all in this together and that we all have a responsibility to be a part of the solution."

For insurance companies, responsibility means a stop to the practice of casting people aside when they get sick. For doctors, a halt to ordering unnecessary procedures. For medical companies and laboratories, an end to fraudulent billing practices. "In short," as the President said, "responsibility should apply to anybody who abuses this system and drives up the cost for honest, hard-working citizens and undermines confidence in the honest, gifted health care providers we have."

For employers -- both large and small -- responsibility means following the lead of our nation's most successful businesses and helping to provide health security to every employee. And for every American, it means taking care of one's health, rejecting the culture of violence that devastates lives and drives up health costs, and

making a contribution to health coverage. "Responsibility," as the President said, "isn't just about them. It's about you, it's about me, it's about each of us."

CONTROLLING DRUG PRICES

Slowing down skyrocketing increases in prescription drug costs -- asking manufacturers to take more responsibility -- will help all American health consumers, especially those older Americans who today face the terrible choice of buying food or medicine. "Responsibility has to start with those who profit from the current system," the President said, and the Health Security Act aims to stop American drug manufacturers from charging our citizens three times more for prescription drugs than they charge citizens of other countries. In return, universal coverage will offer drug manufacturers a hugely expanded market of tens of millions of customers -- and the certainty that every American, including those on Medicare, will have a prescription drug benefit.

Increased competition in the medical field and efforts by President Clinton to force down drug prices are already helping consumers. Some 17 major drug companies have voluntarily agreed to hold price increases to the general rate of inflation. And according to the Pharmaceutical Manufactueres Association, drug prices rose 3.9 percent in 1992, a remarkable decrease compared to the 10 percent rise the year before.

The Health Security Act will help continue these trends. Although it does not call for setting prices on individual drugs, it takes several steps to keep prices under control. First, it gives power to large buyers -- from health plans to the Federal government -- that will enable them to negotiate with drug companies for discounts on the price of prescription drugs. It follows on the example of managed care programs that have successfully used their purchasing clout to contain drug costs. And when new drugs enter the market, private-sector buyers will have the benefit of solid price information.

Under the Health Security Act, Medicare beneficiaries will, for the first time, receive a prescription drug benefit. In turn, the Medicare program will become the world's largest purchaser of medications and will be in a position to bargain for discounts on prescriptions. The Health Security Act empowers the Secretary of Health and Human Services to negotiate the price of new drugs for the Medicare program. It will level the playing field and introduce competition and responsibility into the new health care system.

Medical Malpractice

Responsibility also means bringing common sense to our medical malpractice system. Although experts believe that the direct cost of malpractice accounts for less than two percent of our spending on health care, reform of our existing system is bad-

ly needed. We must work to remove the threat of lawsuits that leads to so much "defensive medicine" and drive up costs for everyone. We must free doctors to do what they do best -- care for patients -- while protecting patients from the tiny minority of irresponsible doctors. And we must take steps to let lawyers who profit from huge settlements know that they can no longer take advantage of the system.

In an effort to end frivolous lawsuits and protect doctors, the Health Security Act will change tort laws and develop new alternatives to resolve patients' claims against providers before they get to court. The Act will require those who believe they have been the victims of malpractice to first submit their claims to an out-of-court panel to resolve the dispute. If the patient is still unsatisfied with the resolution, the case can be taken to court, but only after obtaining a "certificate of merit," an affidavit from another doctor stating that the patient received substandard care.

The Act will also:

Limit attorneys' fees to one-third of an award, and allow states to impose even lower caps (California, for example, caps economic damages for "pain and suffering" at $250,000)

Allow damages to be paid over a period of time rather than all at once;

Prevent injured patients from gaming the system and getting paid twice for the same injury -- once by a doctor and a second time by a health or disability insurance plan; and

Promote experiments with progressive ideas such as a program in Maine that frees doctors from malpractice liability if they can demonstrate that they followed prescribed clinical practice guidelines.

Taken together, these steps represent the first serious national effort to take what has been learned in the states and apply it on a national level. Once implemented, these steps will help turn the incentives in our health care system right side up. By restoring responsibility to our medical malpractice system, we can also restore trust to the doctor-patient relationship which lies at the heart of health care.

Paying for Health Security

Without reform, we Americans will spend more than one trillion dollars next year on health care. That's one of nearly every seven dollars in our economy.

In 1994, without reform, health care for the average working American will total more than $7,000. Employers will pick up about $3,400 and American workers will, on average, pay more than $1,850. Federal, state and local taxes for health care will total almost $2,150. And the per person total of $7,000 will double by the end of the decade unless we take action.

Although there are plenty of disputes about how we spend that trillion dollars, there is no mystery about where it comes from.

More than half of what we pay for health care every year comes from employers and individuals -- Americans who create jobs, work hard and play by the rules. Private dollars spent on health care include:

Insurance premiums paid by businesses;

Insurance premiums paid by individuals -- normally through monthly withholding from payroll, sometimes through checks written to insurance companies; and

So-called "out-of-pocket" expenses, which include:

-- "deductibles," the amount people pay each year before their insurance kicks in;

-- "co-payments," the amount individuals pay when they go to the doctor or hospital or receive other medical services

-- the amount people spend on medical services above and beyond what their insurance covers.

The rest of our nation's health care bill -- about $xxx billion each year -- is paid by Federal and state governments, through programs like Medicare, Medicaid, Veterans and the Defense Department's plans for active military personnel, retirees and their families. Added to the private sector dollars, these public funds bring the total amount of health care spending to one trillion dollars.

But even after we spend that much, tens of millions of American lack health security. More than 37 million Americans, as has been noted, have no health insurance. And more than 25 million have insurance that's inadequate -- so-called "bare bones" coverage or policies that don't cover them when they need it most.

In America, of course, even those people who are not covered or who have inadequate insurance still get health care. The problem is that they get the most expensive kind of health care in the most expensive place: the emergency room. That care isn't free and doctors and hospitals, in order to keep serving everyone, pass those costs along to the rest of us. This phenomenon -- what academics call "cost shifting" -- leads to the health care inflation that we all face.

Moving beyond today's insecure system and guaranteeing health security to every American will require -- at least in the initial years -- additional money. Those who argue that no new money is required to achieve universal health benefits that can never be taken away are, frankly, not telling the truth. And we can never control rising health care costs until everyone is covered. The question is who will pay and how we will pay.

After considering all the options, the President decided that we must take the world's finest private health care system and make it even better. He rejected a govern-

ment solution and any broad-based taxes. Instead, the President believes, we must build on what works today -- and make it work for everyone.

The vast majority of funding for the Health Security plan will continue to come from where it comes from today: premiums and out-of-pocket health spending by employers and employees. New funding will be drawn from three primary sources:

Asking all employers and the 30 million Americans who work for them and have no health insurance to contribute to their health care;

Limiting the growth in Federal health care programs; and

Increasing excise taxes on tobacco and requiring small contributions from large corporations who choose to form their own health alliance.

This combination represents the best, fairest and most workable way to guarantee Health Security. It will yield sufficient money and it makes sense.

Two-thirds of the new money needed to finance health care premiums for everyone will come from asking employers and employees who pay nothing now to start taking some responsibility. To accomplish this, the Health Security Act proposes an extension of the current system, where employers take the primary responsibility but all individuals must contribute. It's a pretty conservative idea, one first introduced to

the nation by President Richard Nixon some 25 years ago. All told, it will yield $ billion, or xxx of the money needed to finance health security for all.

Some call this system an employer mandate, but we believe that it's the fairest way to achieve responsibility in the health care system. It builds on what we already have and requires the least disruption and bureaucracy of any way of achieving health security for all Americans.

It will reverse the system that requires all of us to pay for the uninsured and stop the practice of penalizing firms and individuals who take responsibility and contribute to health insurance today. Finally, to make sure that the vast majority of the uninsured -- 85 percent of whom are working people or their families -- can afford insurance, the Health Security Act will provide discounts for low income workers, the unemployed, and low-wage and small businesses.

A second, much smaller portion of the new money needed to fund health security will come from slowing the growth of government spending on health care programs. This is something that people in Washington have talked about for a long time. And although we recognize that it's tough to stop government spending, we believe that we can slow it down and have offered specific ways to do so without hurting beneficiaries. Over time, the Health Security Act will aim to cut the growth in Medicare and Medicaid from three times the rate of inflation to two times the rate of inflation.

Let's be clear about this: the President will not put Medicare or Medicaid beneficiaries at risk. Indeed, Medicare recipients will see an actual increase in their benefits under the Health Security Act. For the first time Medicare beneficiaries will receive prescription drug coverage they need, and new options for long-term care they deserve.

Such savings have not been easy to achieve in the past. Once proposed, they immediately raised the specter that costs would only be shifted to the private sector, as doctors and hospitals charged more to other patients to make up for shortfalls in reimbursement under Medicare and Medicaid. But the Health Security Act recognizes that we can slow the growth in Federal health care programs as part of fundamental health care reform. Only by controlling the costs of care on the private side of the equation at the same time can we stop the cost-shifting and stop giving doctors a reason to dump Medicare and Medicaid patients out of their offices and into emergency rooms. We will, in short, turn the incentives in today's upside down system right side up.

The third and final part of our financing plan calls for increasing the federal excise tax on tobacco by 75 cents, and asking large corporations that form their own alliances to contribute to the maintenance of the health infrastructure that serves them.

When our nation is struggling to encourage good health, it seems appropriate to increase the tax on tobacco. Tobacco is the only product that is harmful to one's health

when used as directed, and evidence demonstrates that such a tax increase will help discourage smoking, especially among young people, and help promote good health.

In addition, large corporations that form their own alliances should help support the backbone of our health care system -- academic health centers and advanced medical research. By requiring large corporations to pay one percent of their payroll to the health alliance in their region, they can support the teaching hospitals, technologies and advanced research that benefit us all.

These are the three primary sources of private and public sector funding that will help pay for health security for every American. This combination of funding is a conservative approach: one that does not take into account the billions in cost savings that can be achieved from a new emphasis on preventive care, by encouraging real competition among health providers, and by cracking down on health care fraud. It is an approach that asks responsibility of everyone and, in return, guarantees every American comprehensive health benefits that can never be taken away. It is the least disruptive, easiest way to achieve our goals. It is fair, it is even-handed, and it will work.

INDIVIDUALS AND FAMILIES

For most individuals and families that have health insurance, the Health Security Act will mean little change in the way you get coverage and lower prices for the

same or better benefits. For those who don't currently have coverage, the plan will provide a chance to purchase a comprehensive package of benefits that can never be taken away.

Right now, nine of every ten Americans who has private health insurance get it through their employer. Even with all the problems associated with health insurance today -- high deductibles and co-payments, incomprehensible policies and fine print, and insecurity -- this way of getting and paying for health care works for most Americans.

Under the Health Security Act, employers and individuals who pay premiums today will continue to do so. Employers who currently pay for 100 percent of their employees' health benefits may continue to do so. If you like your insurance and your financial arrangement with your company, nothing has to change.

But every American and legal resident will get something that no amount of money can buy in today's insurance market: real security. No matter what happens -- if you move, get sick or lose your job -- you'll be guaranteed a comprehensive package of benefits that can never be taken away.

Everyone will be responsible for contributing something to the cost of their health care, even if they can only afford a small amount. Premiums will vary -- as

they do today -- from plan to plan and state to state, but the system will be much simpler and much more fair.

The Health Security Act will eliminate all the discriminatory factors that insurance companies use today to determine how much to charge. Instead, everyone will pay the same price for the same plan -- no matter whether a person is sick or healthy, old or young, or the employee of a small or large company. Premium prices will only depend on the number of workers in a family, where you live, and the type of plan you choose.

Households with a full-time worker will pay an average of 20 percent of the average premium. Their employers will pick up the rest. If the average plan for a single person in an area, for example, costs $160 a month, the employer would pay a minimum of $128 (80 percent) to cover the employee. The employee would pay the remaining $32 (20 percent). And employers can, of course, choose to pay the entire $160 a month; in fact, it will be easier for them to continue doing so.

The result: six of every ten Americans who currently has insurance will pay the same or less as they do today for health benefits that are as good or better than what they get today.

The Health Security Act will also take several important steps to protect individuals and families from rising health costs and financial ruin. [see chart] It limits deductibles -- the amount people pay each year before insurance kicks in, which can run into the thousands today -- to $200 for an individual, and $400 for a family per year. And it eliminates lifetime limits, which are included in six out of every ten insurance policies today and can mean bankruptcy for families in which a person gets very sick.

Finally, the Health Security Act will protect individuals and make selection of health plans easier by limiting and standardizing the size of co-payments -- the amount a person pays out-of-pocket for a visit to the doctor or hospital. To begin with, the comprehensive benefits package includes a wide range of preventive services offered without any co-payments, no matter what plan a person selects. Co-payments for other services are based on the type of plan one selects, with higher out-of-pocket costs for traditional fee-for-service plans and lower costs for networks of doctors and HMOs. [see chart]

BUSINESSES

Under the Health Security Act, all employers will be required to contribute to workers' coverage. Several basic rules govern how much a business will pay:

Employers who currently cover 100 percent of employee health costs may continue to do so.

All employers will pay 80 percent of the premium of an average price plan in their area.

Employers in a health alliance will pay no more than 7.9 percent of their payroll for health care.

Small businesses -- those with fewer than 50 employees -- will receive discounts of between 30 and 80 percent, compared to what the average large business pays.

The self-employed will be able to deduct from their taxes100 percent of their health costs, up from today's 25 percent.

The Health Security Act will aim to make financing fair and equitable. First, guaranteeing comprehensive benefits to every American and requiring all employers to contribute to coverage will lift the burden of "cost shifting" from businesses that cover their employees today. Second, requiring all employers to contribute to their own workers benefits and share responsibility for family coverage will relieve the burden on those companies that offer excellent benefits today and bear all the cost of benefits for a family in which two people work.

The Health Security Act will also maintain the tax deductibility of health premium payments, both for employers and employees. Employers will be free for ten years to continue to offer whatever benefits they offer today -- and to exclude these payments from taxable income for employees. And to help our nation's largest manufacturers better compete in global markets, the Federal government will help pick up a large portion of the cost of health care for retired workers.

For the two-thirds of the nation's small businesses that currently cover their employees, the Health Security Act -- in the words of The Wall Street Journal -- will provide "an unexpected windfall." For the first time, small businesses will be able to compete on a level playing field, using the power of the health alliance to get affordable health care and cut their administrative costs. Small businesses that currently provide health benefits will likely pay substantially less under reform, due to a combination of lower premium rates and smaller administrative costs. And those who can only afford to provide bare bones insurance for their employees and families today will be able to provide a comprehensive benefits package.

Those small businesses that provide no health coverage today will have to help pay for their employees' health care. But the Health Security Act is designed specifically to protect small businesses and help them make the transition to a system that guarantees their families and employees the health security they deserve. Those low-wage businesses with 50 or fewer employees will receive discounts of between 30 and

80 percent, compared to what the average big business pays. For the smallest firms that pay the lowest wages, the percent of payroll devoted to health care may be as low as 3.5 percent -- or about one dollar per day for low-wage employees.

In addition, the Health Security Act will greatly reduce the administrative costs for small business, which today run as high as 40 percent of their health premiums (compared to 5 percent for large businesses.) Health alliances will absorb the burdens of administering benefits, negotiating and renewing coverage and the often agonizing task of bargaining for reasonable coverage. The Health Security Act will also outlaw insurance company practices -- ranging from price gouging to exclusion of entire industries -- that make it impossible for small businesses to get or afford insurance today. And it will streamline the workers' compensation system, which is a never-ending source of frustration, fraud and high cost for small business.

When combined, these reforms will give small businesses their first real chance to do what most of them have always wanted to do: provide affordable health coverage for their employees and families that can never be taken away. It is not surprise that those small businesses that provide health insurance today are the fastest growing small companies in our nation. New, more affordable coverage will help create a more stable, high-quality workforce -- and help small businesses grow and expand, offering higher wages and creating more jobs.

[The new system of health security will succeed only if it stands on a secure foundation formed by broad participation by all American employers and consumers. Just as we pay for fire protection even though our house may never burn, we must pay for health coverage because it may someday save our lives. To ensure that medical care is available when we need it, we must contribute even if we do not.

If we allowed participation in health coverage to continue as an option for each individual to decide, some will shirk the responsibility and then -- as happens now -- throw themselves at the mercy of doctors, nurses and hospitals when they are sick or injured. The calculation is correct: A decent society will not allow its citizens to die for lack of health insurance. But a prudent nation would ask its citizens beforehand to share in the cost.

The requirement is not excessive -- so long as that prudent nation also controls how high and how fast the cost of fulfilling it can rise. It is not excessive, so long as the cost is manageable. Carrying out that imperative in a private market for health coverage requires organizing the market to produce the twin goals of high quality and controllable costs.

But to create reliable security and control costs, it is vital that everyone participate. To do otherwise is to guarantee higher costs and ultimate failure. While employers with older or less healthy workers might join alliances, for example, firms with

younger and healthier workers would buy insurance elsewhere -- repeating the erosion of community rating that occurred several decades ago and lead to the distortions that require reform now. If participation were voluntary, alliance could do little to correct the critical problems that challenge American health care. They might reproduce those problems or make them worse.

The change will prove beneficial for the vast majority of American employers. Firms that now pay as much as 20 percent of total payroll for health coverage should see costs decline. The vast majority of small businesses -- the "Mom and Pop" firms so vital to America and its economy -- will find that the savings they reap in the cost of coverage for their own families will substantially offset any new spending required to cover employees.

Fairness is the watchword for health reform. Fairness requires a counter-weight to the traditional clout that insurance companies and providers carry in negotiating fees and premiums with American consumers and their employers. It also requires everyone to assume shared responsibility -- even if it's limited to only a small amount -- toward the cost of health care. Those are key elements in laying a strong foundation for health security.

In a fair system, with discounts that make new responsibilities manageable, the Health Security Act becomes a "win-win" proposition for the vast majority of businesses, employees and all Americans.]

Chapter X

CONCLUSION

"Now it is our turn to strike a blow for freedom in this country. The freedom of Americans to live without fear that their own nation's health care system won't be there for them when they need it.

It's hard to believe that there was once a time in this century when that kind of fear gripped old age, when retirement was nearly synonymous with poverty, and older Americans died in the street.

"That's unthinkable today because over a half a century ago Americans had the courage to change -- to create a Social Security system that ensures that no American will be forgotten in their later years.

When President Clinton spoke those words, concluding his historic address to a joint session of Congress on Sept. 22, he laid out the challenge that confronts America and its leaders over the coming months:

The challenge to create health security for every American through guaranteed health benefits that can never be taken away.

The equal challenge is to accomplish that goal while bringing the rising cost of health care in the United States under control.

As members of Congress, the Governors of 50 states, policymakers and advocates, doctors, nurses and the American people engage in a national debate over health care reform over the coming months, one idea must overshadow all others: As daunting as the task of comprehensive reform may be, it is not so daunting as the cost of doing nothing.

Joined in that conviction, the American people and their elected representatives will resolve the crisis in health care, creating security for every American and controlling costs.

The Health Security Act lays out a far-reaching design for comprehensive reform grounded in six principles:

Security

Simplicity

Savings

Quality

Choice

Responsibility

The Health Security Act embodies the principles outlined by the President. But to realize them, comprehensive reform must build in flexibility about the means to achieve them. National reform is not an architect's blueprint specifying every dimension and detail. Rather, it forms a framework within which the states and the people of each American community and family will build their own design and make their own choices.

Americans cannot, and need not, come to one vision of the single-best approach to health care. If our vision of reform is founded on the principles of security, savings, simplicity, quality, choice and responsibility, a workable consensus is achievable.

Fundamentally, the Health Security Act outlines a framework to support those goals. It lays out specific proposals to simplify the system of health care in the United States, to begin the difficult chore of squeezing out the millions of dollars of waste that bloats the existing system. It articulates a vision of a comprehensive approach to guaranteeing quality, as well as choice for all Americans in selecting their health plans, doctors and the hospitals they use.

The Health Security Act lays out a plan for accomplishing those goals. But it does not prescribe how to deliver health care or how to organize services. It leaves

those decisions to consumers, doctors, nurses, hospitals and managers of health plans, rather than to government.

It establishes essential guarantees and protections at the national level to ensure security, the solid foundation upon which American communities will build -- and then it gets government out of the way to allow the reformed market for private health coverage to work.

Reflecting the broad geographic diversity of America, the Health Security Act allows each state to tailor reform to its unique needs and characteristics, working within the framework of national guarantees and standards for quality and access to care.

If a state should fail to carry out the responsibility for health care reform, ignoring or jeopardizing the national guarantee of security for all, the federal government will ensure that its commitment is carried out. Its over-arching intent, however, is to invest the power to manage the market for health coverage in the consumers and employers of each local community.

When other major industrialized countries made health coverage a right of citizenship, they built on institutions that already existed. The Health Security Act follows this pattern. Although it outlaws many entrenched practices in the private insurance market, it builds on the integrated health plans, new methods of quality improve-

ment and other reforms developing in both the private and public sectors. Many elements of the new system outlined in the Health Security Act already exist; reform constructs a new framework around them.

Like universal health coverage in other countries, the Health Security Act establishes nationally set limits on the growth of health costs. It has a distinctive emphasis, however, on helping consumers get value for their money by requiring health plans to compete for enrollment on both price and service.

The Health Security Act seeks to restrain costs first and foremost by unleashing the power of competition around both quality and price in health care. But it seeks not only to restrain costs through competition; it also create a new system of quality monitoring and improvement to hold health plans and providers accountable for access, the appropriateness and effectiveness of treatment and consumer satisfaction.

Perhaps no area of public policy except the national defense touches so many lives and carries such critical ramifications for the quality of life in America. Parallel to the goal of creating national security, health care reform is critical to the creation of domestic security.

The spectrum of thought on the shape that health reform should take ranges from advocates of a single-payer system, in which government becomes the sole pur-

chaser of coverage, to those who would simply throw treat health care like any other commodity subject to trade on an open market.

Some would continue the traditional link between employment and health coverage. Others would not, severing the connection and leaving it to individuals to purchase health coverage on their own.

The Health Security Act stands between those two poles, building on the existing system of coverage through employment. It solidifies that foundation for security, which has begun to erode, strengthening it and shoring it up by requiring everyone to participate.

Over many years, many other leaders in both major political parties have cleared the path on which we now launch this historic journey. Every member of the United States Senate and the House of Representatives who has participated in the ongoing debate on this critical issue has contributed to the alternatives now before the nation.

Each of their voices will bear on the debate that will follow now, as the American people set a course for the future in this critical arena. So will the voices of other American leaders who attempted to take on the issue of health reform and failed:

When President Franklin Roosevelt launched the initiative that became the Social Security Act, he intended to include national health insurance among its provisions. It did not happen.

When President Harry Truman vowed to continue Mr. Rooselvet's fight after his death, he introduced the first full-scale plan for national health reform. It did not happen.

When President Richard Nixon embarked on a national health reform agenda, he proposed requiring all employers to provide at least minimum coverage. It did not happen.

In each instance, entrenched interests that reap the enormous economic gain of a health care system whose rising costs threaten our national economy won out against the interests of the American people. Economic interests won out against the interest of security.

History must not repeat itself as America once again confronts the issue of national health care reform. Through shared responsibility, Americans of all ages, races, backgrounds and persuasions can join together to create security for our generation and for the next generations to come.

"Forty years from now," the President said in concluding his address to Congress, "Our grandchildren will also find it unthinkable that there was a time in this country when hard-working families lost their homes, their savings, their businesses, lost everything simply because their children got sick or because they had to change jobs.

"Our grandchildren will find such things unthinkable tomorrow if we have the courage to change today."

ADDRESS OF THE PRESIDENT

TO THE JOINT SESSION OF CONGRESS

September 22, 1993

THE PRESIDENT: Mr. Speaker, Mr. President, members of Congress, distinguished guests, my fellow Americans. Before I begin my words tonight I would like to ask that we all bow in a moment of silent prayer for the memory of those who were killed and those who have been injured in the tragic train accident in Alabama today. Amen.

My fellow Americans, tonight we come together to write a new chapter in the American story. Our forebears enshrined the American Dream -- life, liberty, the pursuit of happiness. Every generation of Americans has worked to strengthen that legacy, to make our country a place of freedom and opportunity, a place where people who work hard can rise to their full potential, a place where their children can have a better future.

From the settling of the frontier to the landing on the moon, ours has been a continuous story of challenges defined, obstacles overcome, new horizons secured. That is what makes America what it is and Americans what we are. Now we are in a time of profound change and opportunity. The end

of the Cold War, the Information Age, the global economy have brought us both opportunity and hope and strife and uncertainty. Our purpose in this dynamic age must be to change -- to make change our friend and not our enemy.

To achieve that goal, we must face all our challenges with confidence, with faith, and with discipline -- whether we're reducing the deficit, creating tomorrow's jobs and training our people to fill them, converting from a high-tech defense to a high-tech domestic economy, expanding trade, reinventing government, making our streets safer, or rewarding work over idleness. All these challenges require us to change.

If Americans are to have the courage to change in a difficult time, we must first be secure in our most basic needs. Tonight I want to talk to you about the most critical thing we can do to build that security. This health care system of ours is badly broken and it is time to fix it.

Despite the dedication of literally millions of talented health care professionals, our health care is too uncertain and too expensive, too bureaucratic and too wasteful. It has too much fraud and too much greed.

At long last, after decades of false starts, we must make this our most urgent priority, giving every American health security; health care that

can never be taken away; health care that is always there. That is what we must do tonight.

On this journey, as on all others of true consequence, there will be rough spots in the road and honest disagreements about how we should proceed. After all, this is a complicated issue. But every successful journey is guided by fixed stars. And if we can agree on some basic values and principles we will reach this destination, and we will reach it together.

So tonight I want to talk to you about the principles that I believe must embody our efforts to reform America's health care system -- security, simplicity, savings, choice, quality, and responsibility.

When I launched our nation on this journey to reform the health care system I knew we needed a talented navigator, someone with a rigorous mind, a steady compass, a caring heart. Luckily for me and for our nation, I didn't have to look very far.

Over the last eight months, Hillary and those working with her have talked to literally thousands of Americans to understand the strengths and the frailties of this system of ours. They met with over 1,100 health care organizations. They talked with doctors and nurses, pharmacists and drug company

representatives, hospital administrators, insurance company executives and small and large businesses. They spoke with self-employed people. They talked with people who had insurance and people who didn't. They talked with union members and older Americans and advocates for our children. The First Lady also consulted, as all of you know, extensively with governmental leaders in both parties in the states of our nation, and especially here on Capitol Hill.

Hillary and the Task Force received and read over 700,000 letters from ordinary citizens. What they wrote and the bravery with which they told their stories is really what calls us all here tonight.

Every one of us knows someone who's worked hard and played by the rules and still been hurt by this system that just doesn't work for too many people. But I'd like to tell you about just one.

Kerry Kennedy owns a small furniture store that employs seven people in Titusville, Florida. Like most small business owners, he's poured his heart and soul, his sweat and blood into that business for years. But over the last several years, again like most small business owners, he's seen his health care premiums skyrocket, even in years when no claims were made. And last year, he painfully discovered he could no longer afford to provide coverage for all his workers because his insurance company told him that two of his workers

had become high risks because of their advanced age. The problem was that those two people were his mother and father, the people who founded the business and still worked in the store.

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

Now, we all know what's right. We're blessed with the best health care professionals on Earth, the finest health care institutions, the best medical research, the most sophisticated technology. My mother is a nurse. I grew up around hospitals. Doctors and nurses were the first professional people I ever knew or learned to look up to. They are what is right with this health care system. But we also know that we can no longer afford to continue to ignore what is wrong.

Millions of Americans are just a pink slip away from losing their health insurance, and one serious illness away from losing all their savings. Millions more are locked into the jobs they have now just because they or someone in their family has once been sick and they have what is called the preexisting condition. And on any given day, over 37 million Americans --

most of them working people and their little children -- have no health insurance at all.

And in spite of all this, our medical bills are growing at over twice the rate of inflation, and the United States spends over a third more of its income on health care than any other nation on Earth. And the gap is growing, causing many of our companies in global competition severe disadvantage. There is no excuse for this kind of system. We know other people have done better. We know people in our own country are doing better. We have no excuse. My fellow Americans, we must fix this system and it has to begin with congressional action.

I believe as strongly as I can say that we can reform the costliest and most wasteful system on the face of the Earth without enacting new broad-based taxes. I believe it because of the conversations I have had with thousands of health care professionals around the country; with people who are outside this city, but are inside experts on the way this system works and wastes money.

The proposal that I describe tonight borrows many of the principles and ideas that have been embraced in plans introduced by both Republicans and Democrats in this Congress. For the first time in this century, leaders of

both political parties have joined together around the principle of providing universal, comprehensive health care. It is a magic moment and we must seize it.

I want to say to all of you I have been deeply moved by the spirit of this debate, by the openness of all people to new ideas and argument and information. The American people would be proud to know that earlier this week when a health care university was held for members of Congress just to try to give everybody the same amount of information, over 320 Republicans and Democrats signed up and showed up for two days just to learn the basic facts of the complicated problem before us.

Both sides are willing to say we have listened to the people. We know the cost of going forward with this system is far greater than the cost of change. Both sides, I think, understand the literal ethical imperative of doing something about the system we have now. Rising above these difficulties and our past differences to solve this problem will go a long way toward defining who we are and who we intend to be as a people in this difficult and challenging era. I believe we all understand that.

And so tonight, let me ask all of you -- every member of the House, every member of the Senate, each Republican and each Democrat -- let

us keep this spirit and let us keep this commitment until this job is done. We owe it to the American people.

Now, if I might, I would like to review the six principles I mentioned earlier and describe how we think we can best fulfill those principles.

First and most important, security. This principle speaks to the human misery, to the costs, to the anxiety we hear about every day -- all of us -- when people talk about their problems with the present system. Security means that those who do not now have health care coverage will have it; and for those who have it, it will never be taken away. We must achieve that security as soon as possible.

Under our plan, every American would receive a health care security card that will guarantee a comprehensive package of benefits over the course of an entire lifetime, roughly comparable to the benefit package offered by most Fortune 500 companies. This health care security card will offer this package of benefits in a way that can never be taken away.

So let us agree on this: whatever else we disagree on, before this Congress finishes its work next year, you will pass and I will sign legislation to guarantee this security to every citizen of this country.

With this card, if you lose your job or you switch jobs, you're covered. If you leave your job to start a small business, you're covered. If you're an early retiree, you're covered. If someone in your family has, unfortunately, had an illness that qualifies as a preexisting condition, you're still covered. If you get sick or a member of your family gets sick, even if it's a life threatening illness, you're covered. And if an insurance company tries to drop you for any reason, you will still be covered, because that will be illegal. This card will give comprehensive coverage. It will cover people for hospital care, doctor visits, emergency and lab services, diagnostic services like Pap smears and mammograms and cholesterol tests, substance abuse and mental health treatment.

And equally important, for both health care and economic reasons, this program for the first time would provide a broad range of preventive services including regular checkups and well-baby visits.

Now, it's just common sense. We know -- any family doctor will tell you that people will stay healthier and long-term costs of the health system will be lower if we have comprehensive preventive services. You know how all of our mothers told us that an ounce of prevention was worth a pound of cure? Our mothers were right. And it's a lesson, like so many lessons from

our mothers, that we have waited too long to live by. It is time to start doing it.

Health care security must also apply to older Americans. This is something I imagine all of us in this room feel very deeply about. The first thing I want to say about that is that we must maintain the Medicare program. It works to provide that kind of security. But this time and for the first time, I believe Medicare should provide coverage for the cost of prescription drugs.

Yes, it will cost some more in the beginning. But, again, any physician who deals with the elderly will tell you that there are thousands of elderly people in every state who are not poor enough to be on Medicaid, but just above that line and on Medicare, who desperately need medicine, who makes decisions every week between medicine and food. Any doctor who deals with the elderly will tell you that there are many elderly people who don't get medicine, who get sicker and sicker and eventually go to the doctor and wind up spending more money and draining more money from the health care system than they would if they had regular treatment in the way that only adequate medicine can provide.

I also believe that over time, we should phase in long-term care for the disabled and the elderly on a comprehensive basis.

As we proceed with this health care reform, we cannot forget that the most rapidly growing percentage of Americans are those over 80. We cannot break faith with them. We have to do better by them.

The second principle is simplicity. Our health care system must be simpler for the patients and simpler for those who actually deliver health care -- our doctors, our nurses, our other medical professionals. Today we have more than 1,500 insurers, with hundreds and hundreds of different forms. No other nation has a system like this. These forms are time consuming for health care providers, they're expensive for health care consumers, they're exasperating for anyone who's ever tried to sit down around a table and wade through them and figure them out.

The medical care industry is literally drowning in paperwork. In recent years, the number of administrators in our hospitals has grown by four times the rate that the number of doctors has grown. A hospital ought to be a house of healing, not a monument to paperwork and bureaucracy.

Just a few days ago, the Vice President and I had the honor of visiting the Children's Hospital here in Washington where they do wonderful, often miraculous things for very sick children. A nurse named Debbie Freiberg

told us that she was in the cancer and bone marrow unit. The other day a little boy asked her just to stay at his side during his chemotherapy. And she had to walk away from that child because she had been instructed to go to yet another class to learn how to fill out another form for something that didn't have a lick to do with the health care of the children she was helping. That is wrong, and we can stop it, and we ought to do it.

We met a very compelling doctor named Lillian Beard, a pediatrician, who said that she didn't get into her profession to spend hours and hours -- some doctors up to 25 hours a week just filling out forms. She told us she became a doctor to keep children well and to help save those who got sick. We can relieve people like her of this burden. We learned -- the Vice President and I did --that in the Washington Children's Hospital alone, the administrators told us they spend $2 million a year in one hospital filling out forms that have nothing whatever to do with keeping up with the treatment of the patients.

And the doctors there applauded when I was told and I related to them that they spend so much time filling out paperwork, that if they only had to fill out those paperwork requirements necessary to monitor the health of the children, each doctor on that one hospital staff -- 200 of them -- could see another 500 children a year. That is 10,000 children a year. I think we can save

money in this system if we simplify it. And we can make the doctors and the nurses and the people that are giving their lives to help us all be healthier a whole lot happier, too, on their jobs.

Under our proposal there would be one standard insurance form -- not hundreds of them. We will simplify also -- and we must -- the government's rules and regulations, because they are a big part of this problem. This is one of those cases where the physician should heal thyself. We have to reinvent the way we relate to the health care system, along with reinventing government. A doctor should not have to check with a bureaucrat in an office thousands of miles away before ordering a simple blood test. That's not right, and we can change it. And doctors, nurses and consumers shouldn't have to worry about the fine print. If we have this one simple form, there won't be any fine print. People will know what it means.

The third principle is savings. Reform must produce savings in this health care system. It has to. We're spending over 14 percent of our income on health care -- Canada's at 10; nobody else is over nine. We're competing with all these people for the future. And the other major countries, they cover everybody and they cover them with services as generous as the best company policies here in this country.

Rampant medical inflation is eating away at our wages, our savings, our investment capital, our ability to create new jobs in the private sector and this public Treasury. You know the budget we just adopted had steep cuts in defense, a five-year freeze on the discretionary spending, so critical to reeducating America and investing in jobs and helping us to convert from a defense to a domestic economy. But we passed a budget which has Medicaid increases of between 16 and 11 percent a year over the next five years, and Medicare increases of between 11 and 9 percent in an environment where we assume inflation will be at 4 percent or less.

We cannot continue to do this. Our competitiveness, our whole economy, the integrity of the way the government works and, ultimately, our living standards depend upon our ability to achieve savings without harming the quality of health care.

Unless we do this, our workers will lose $655 in income each year by the end of the decade. Small businesses will continue to face skyrocketing premiums. And a full third of small businesses now covering their employees say they will be forced to drop their insurance. Large corporations will bear vivid disadvantages in global competition. And health care costs will devour more and more and more of our budget. Pretty soon all of you or the people who succeed you will be showing up here, and writing out checks for health

care and interest on the debt and worrying about whether we've got enough defense, and that will be it, unless we have the courage to achieve the saving that are plainly there before us. Every state and local government will continue to cut back on everything from education to law enforcement to pay more and more for the same health care.

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

So how will we achieve these savings? Rather than looking at price control, or looking away as the price spiral continues; rather than using the heavy hand of government to try to control what's happening, or continuing to ignore what's happening, we believe there is a third way to achieve these savings. First, to give groups of consumers and small businesses the same market bargaining power that large corporations and large groups of public employees now have. We want to let market forces enable plans to compete. We want to force these plans to compete on the basis of price and quality, not simply to allow them to continue making money by turning people away who are sick or old or performing mountains of unnecessary procedures. But we also

believe we should back this system up with limits on how much plans can raise their premiums year in and year out, forcing people, again, to continue to pay more for the same health care, without regard to inflation or the rising population needs.

We want to create what has been missing in this system for too long, and what every successful nation who has dealt with this problem has already had to do: to have a combination of private market forces and a sound public policy that will support that competition, but limit the rate at which prices can exceed the rate of inflation and population growth, if the competition doesn't work, especially in the early going.

The second thing I want to say is that unless everybody is covered -- and this is a very important thing -- unless everybody is covered, we will never be able to fully put the breaks on health care inflation. Why is that? Because when people don't have any health insurance, they still get health care, but they get it when it's too late, when it's too expensive, often from the most expensive place of all, the emergency room. Usually by the time they show up, their illnesses are more severe and their mortality rates are much higher in our hospitals than those who have insurance. So they cost us more.

And what else happens? Since they get the care but they don't pay, who does pay? All the rest of us. We pay in higher hospital bills and higher insurance premiums. This cost shifting is a major problem.

The third thing we can do to save money is simply by simplifying the system -- what we've already discussed. Freeing the health care providers from these costly and unnecessary paperwork and administrative decisions will save tens of billions of dollars. We spend twice as much as any other major country does on paperwork. We spend at least a dime on the dollar more than any other major country. That is a stunning statistic. It is something that every Republican and every Democrat ought to be able to say, we agree that we're going to squeeze this out. We cannot tolerate this. This has nothing to do with keeping people well or helping them when they're sick. We should invest the money in something else.

We also have to crack down on fraud and abuse in the system. That drains billions of dollars a year. It is a very large figure, according to every health care expert I've ever spoken with. So I believe we can achieve large savings. And that large savings can be used to cover the unemployed uninsured, and will be used for people who realize those savings in the private sector to increase their ability to invest and grow, to hire new workers or to give their workers pay raises, many of them for the first time in years.

Now, nobody has to take my word for this. You can ask Dr. Koop. He's up here with us tonight, and I thank him for being here. (Applause.) Since he left his distinguished tenure as our Surgeon General, he has spent an enormous amount of time studying our health care system, how it operates, what's right and wrong with it. He says we could spend $200 billion every year, more than 20 percent of the total budget, without sacrificing the high quality of American medicine.

Ask the public employees in California, who have held their own premiums down by adopting the same strategy that I want every American to be able to adopt -- bargaining within the limits of a strict budget. Ask Xerox, which saved an estimated $1,000 per worker on their health insurance premium. Ask the staff of the Mayo Clinic, who we all agree provides some of the finest health care in the world. They are holding their cost increases to less than half the national average. Ask the people of Hawaii, the only state that covers virtually all of their citizens and has still been able to keep costs below the national average.

People may disagree over the best way to fix this system. We may all disagree about how quickly we can do what -- the thing that we have to do. But we cannot disagree that we can find tens of billions of dollars in savings in

what is clearly the most costly and the most bureaucratic system in the entire world. And we have to do something about that, and we have to do it now. (Applause.)

The fo urth principle is choice. Americans believe they ought to be able to choose their own health care plan and keep their own doctors. And I think all of us agree. Under any plan we pass, they ought to have that right. But today, under our broken health care system, in spite of the rhetoric of choice, the fact is that that power is slipping away for more and more Americans.

Of course, it is usually the employer, not the employee, who makes the initial choice of what health care plan the employee will be in. And if your employer offers only one plan, as nearly three-quarters of small or medium-sized firms do today, you're stuck with that plan, and the doctors that it covers.

We propose to give every American a choice among high-quality plans. You can stay with your current doctor, join a network of doctors and hospitals, or join a health maintenance organization. If you don't like your plan, every year you'll have the chance to choose a new one. The choice will

be left to the American citizen, the worker -- not the boss, and certainly not some government bureaucrat.

We also believe that doctors should have a choice as to what plans they practice in. Otherwise, citizens may have their own choices limited. We want to end the discrimination that is now growing against doctors, and to permit them to practice in several different plans. Choice is important for doctors, and it is absolutely critical for our consumers. We've got to have it in whatever plan we pass. (Applause.)

The fifth principle is quality. If we reformed everything else in health care, but failed to preserve and enhance the high quality of our medical care, we will have taken a step backward, not forward. Quality is something that we simply can't leave to chance. When you board an airplane, you feel better knowing that the plane had to meet standards designed to protect your safety. And we can't ask any less of our health care system.

Our proposal will create report cards on health plans, so that consumers can choose the highest quality health care providers and reward them with their business. At the same time, our plan will track quality indicators, so that doctors can make better and smarter choices of the kind of care they pro-

vide. We have evidence that more efficient delivery of health care doesn't decrease quality. In fact, it may enhance it.

Let me just give you one example of one commonly performed procedure, the coronary bypass operation. Pennsylvania discovered that patients who were charged $21,000 for this surgery received as good or better care as patients who were charged $84,000 for the same procedure in the same state. High prices simply don't always equal good quality. Our plan will guarantee that high quality information is available is available in even the most remote areas of this country so that we can have high-quality service, linking rural doctors, for example, with hospitals with high-tech urban medical centers. And our plan will ensure the quality of continuing progress on a whole range of issues by speeding the search on effective prevention and treatment measures for cancer, for AIDS, for Alzheimer's, for heart disease, and for other chronic diseases. We have to safeguard the finest medical research establishment in the entire world. And we will do that with this plan. Indeed, we will even make it better. (Applause.)

The sixth and final principle is responsibility. We need to restore a sense that we're all in this together and that we all have a responsibility to be a part of the solution. Responsibility has to start with those who profit from the current system. Responsibility means insurance companies should no longer be

allowed to cast people aside when they get sick. It should apply to laboratories that submit fraudulent bills, to lawyers who abuse malpractice claims, to doctors who order unnecessary procedures. It means drug companies should no longer charge three times more per prescription drugs made in America here in the United States than they charge for the same drugs overseas.

In short, responsibility should apply to anybody to abuses this system and drives up the cost for honest, hard-working citizens and undermines confidence in the honest, gifted health care providers we have.

Responsibility also means changing some behaviors in this country that drive up our costs like crazy. And without changing it we'll never have the system we ought to have. We will never.

Let me just mention a few and start with the most important -- the outrageous cost of violence in this country stem in large measure from the fact that this is the only country in the world where teenagers can rout the streets at random with semi-automatic weapons and be better armed than the police.

But let's not kid ourselves, it's not that simple. We also have higher rates of AIDS, of smoking and excessive drinking, of teen pregnancy, of low birth weight babies. And we have the third worst immunization rate of any

nation in the western hemisphere. We have to change our ways if we ever really want to be healthy as a people and have an affordable health care system. And no one can deny that.

But let me say this -- and I hope every American will listen, because this is not an easy thing to hear -- responsibility in our health care system isn't just about them, it's about you, it's about me, it's about each of us. Too many of us have not taken responsibility for our own health care and for our own relations to the health care system. Many of us who have had fully paid health care plans have used the system whether we needed it or not without thinking what the costs were. Many people who use this system don't pay a whether we needed it or not without thinking what the costs were. Many people who use this system don't pay a penny for their care even though they can afford to. I think those who don't have any health insurance should be responsible for paying a portion of their new coverage. There can't be any something for nothing, and we have to demonstrate that to people. This is not a free system. Even small contributions, as small as the $10-copayment when you visit a doctor, illustrates that this is something of value. There is a cost to it. It is not free.

And I want to tell you that I believe that all of us should have insurance. Why should the rest of us pick up the tab when a guy who doesn't

think he needs insurance or says he can't afford it gets in an accident, winds up in an emergency room, gets good care, and everybody else pays? Why should the small businesspeople who are struggling to keep afloat and take care of their employees have to pay to maintain this wonderful health care infrastructure for those who refuse to do anything?

If we're going to produce a better health care system for every one of us, every one of us is going to have to do our part. There cannot be any such thing as a free ride. We have to pay for it. We have to pay for it.

Tonight I want to say plainly how I think we should do that. Most of the money we will -- will come under my way of thinking, as it does today, from premiums paid by employers and individuals. That's the way it happens today. But under this health care security plan, every employer and every individual will be asked to contribute something to health care.

This concept was first conveyed to the Congress about 20 years ago by President Nixon. And today, a lot of people agree with the concept of shared responsibility between employers and employees, and that the best thing to do is to ask every employer and every employee to share that. The Chamber of Commerce has said that, and they're not in the business of hurting small business. The American Medical Association has said that.

Some call it an employer mandate, but I think it's the fairest way to achieve responsibility in the health care system. And it's the easiest for ordinary Americans to understand, because it builds on what we already have and what already works for so many Americans. It is the reform that is not only easiest to understand, but easiest to implement in a way that is fair to small business, because we can give a discount to help struggling small businesses meet the cost of covering their employees. We should require the least bureaucracy or disruption, and create the cooperation we need to make the system cost-conscious, even as we expand coverage. And we should do it in a way that does not cripple small businesses and low-wage workers.

Every employer should provide coverage, just as three-quarters do now. Those that pay are picking up the tab for those who don't today. I don't think that's right. To finance the rest of reform, we can achieve new savings, as I have outlined, in both the federal government and the private sector, through better decision-making and increased competition. And we will impose new taxes on tobacco.

I don't think that should be the only source of revenues. I believe we should also ask for a modest contribution from big employers who opt out of the system to make up for what those who are in the system pay for medical

research, for health education center, for all the subsidies to small business, for all the things that everyone else is contributing to. But between those two things, we believe we can pay for this package of benefits and universal coverage and a subsidy program that will help small business.

These sources can cover the cost of the proposal that I have described tonight. We subjected the numbers in our proposal to the scrutiny of not only all the major agencies in government -- I know a lot of people don't trust them, but it would be interesting for the American people to know that this was the first time that the financial experts on health care in all of the different government agencies have ever been required to sit in the room together and agree on numbers. It had never happened before.

But, obviously, that's not enough. So then we gave these numbers to actuaries from major accounting firms and major Fortune 500 companies who have no stake in this other than to see that our efforts succeed. So I believe our numbers are good and achievable.

Now, what does this mean to an individual American citizen? Some will be asked to pay more. If you're an employer and you aren't insuring your workers at all, you'll have to pay more. But if you're a small business with fewer than 50 employees, you'll get a subsidy. If you're a firm that pro-

vides only very limited coverage, you may have to pay more. But some firms will pay the same or less for more coverage.

If you're a young, single person in your 20s and you're already insured, your rates may go up somewhat because you're going to go into a big pool with middle-aged people and older people, and we want to enable people to keep their insurance even when someone in their family gets sick. But I think that's fair because when the young get older, they will benefit from it, first, and secondly, even those who pay a little more today will benefit four, five, six, seven years from now by our bringing health care costs closer to inflation.

Over the long run, we can all win. But some will have to pay more in the short run. Nevertheless, the vast majority of the Americans watching this tonight will pay the same or less for health care coverage that will be the same or better than the coverage they have tonight. That is the central reality.

If you currently get your health insurance through your job, under our plan you still will. And for the first time, everybody will get to choose from among at least three plans to belong to. If you're a small business owner who wants to provide health insurance to you family and your employees, but

you can't afford it because the system is stacked against you, this plan will give you a discount that will finally make insurance affordable. If you're already providing insurance, your rates may well drop because we'll help you as a small business person join thousands of others to get the same benefits big corporations get at the same price they get those benefits. If you're self-employed, you'll pay less; and you will get to deduct from your taxes 100 percent of your health care premiums.

If you're a large employer, your health care costs won't go up as fast, so that you will have more money to put into higher wages and new jobs and to put into the work of being competitive in this tough global economy.

Now, these, my fellow Americans, are the principles on which I think we should base our efforts: security, simplicity, savings, choice, quality and responsibility. These are the guiding stars that we should follow on our journey toward health care reform.

Over the coming months, you'll be bombarded with information from all kinds of sources. There will be some who will stoutly disagree with what I have proposed -- and with all other plans in the Congress, for that matter. And some of the arguments will be genuinely sincere and enlightening. Others may simply be scare tactics by those who are motivated by the self-in-

terest they have in the waste the system now generates, because that waste is providing jobs, incomes and money for some people.

I ask you only to think of this when you hear all of these arguments: Ask yourself whether the cost of staying on this same course isn't greater than the cost of change. And ask yourself when you hear the arguments whether the arguments are in your interest or someone else's. This is something we have got to try to do together.

I want also to say to the representatives in Congress, you have a special duty to look beyond these arguments. I ask you instead to look into the eyes of the sick child who needs care; to think of the face of the woman who's been told not only that her condition is malignant, but not covered by her insurance. To look at the bottom lines of the businesses driven to bankruptcy by health care costs. To look at the "for sale" signs in front of the homes of families who have lost everything because of their health care costs.

I ask you to remember the kind of people I met over the last year and a half -- the elderly couple in New Hampshire that broke down and cried because of their shame at having an empty refrigerator to pay for their drugs; a woman who lost a $50,000-job that she used to support her six children because her youngest child was so ill that she couldn't keep health insurance, and

the only way to get care for the child was to get public assistance; a young couple that had a sick child and could only get insurance from one of the parents' employers that was a nonprofit corporation with 20 employees, and so they had to face the question of whether to let this poor person with a sick child go or raise the premiums of every employee in the firm by $200. And on and on and on.

I know we have differences of opinion, but we are here tonight in a spirit that is animated by the problems of those people, and by the sheer knowledge that if we can look into our heart, we will not be able to say that the greatest nation in the history of the world is powerless to confront this crisis.

Our history and our heritage tell us that we can meet this challenge. Everything about America's past tells us we will do it. So I say to you, let us write that new chapter in the American story. Let us guarantee every American comprehensive health benefits that can never be taken away.

In spite of all the work we've done together and all the progress we've made, there's still a lot of people who say it would be an outright miracle if we passed health care reform. But my fellow Americans, in a time of change, you have to have miracles. And miracles do happen. I mean, just a few days ago we saw a simple handshake shatter decades of deadlock in the

Middle East. We've seen the walls crumble in Berlin and South Africa. We see the ongoing brave struggle of the people of Russia to seize freedom and democracy.

And now, it is our turn to strike a blow for freedom in this country. The freedom of Americans to live without fear that their own nation's health care system won't be there for them when they need it. It's hard to believe that there was once a time in this century when that kind of fear gripped old age. When retirement was nearly synonymous with poverty, and older Americans died in the street. That's unthinkable today, because over a half a century ago Americans had the courage to change -- to create a Social Security system that ensures that no Americans will be forgotten in their later years.

Forty years from now, our grandchildren will also find it unthinkable that there was a time in this country when hardworking families lost their homes, their savings, their businesses, lost everything simply because their children got sick or because they had to change jobs. Our grandchildren will find such things unthinkable tomorrow if we have the courage to change today.

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

Thank you very much. And God bless America.

APPENDIX

What Happens To Existing Government Health Programs

MEDICARE/OLDER AMERICANS

Individuals enrolled in Medicare will see little difference in how, where or from whom they receive their health care. There will, however, be a major expansion of Medicare to include the cost of prescription drugs.

Under reform, Medicare recipients will pay less for their health care as growth in the cost of Medicare comes under control.

Americans eligible for Medicare will automatically qualify for the new prescription drug benefit when they enroll in the Part B benefit. Part B premiums will increase to cover 25 percent of the cost of this new benefit. However, Medigap insurance premiums should decline by a proportionate amount as the policy will no longer covers drugs.

With the new drug benefit there is a $250 annual deductible for each person. Individuals on Medicare also pay 20 percent of the cost of each prescription. The maximum amount a person can pay however, is $1,000 over the course of a year.

The prescription drug benefit covers all drugs and biological products, including insulin, approved by the Food and Drugs Administration.

As the health care reform plan evolves, Medicare recipients will get the chance to consider enrollment in fee-for-service health plans, or in new types of health plans, including health maintenance organizations and preferred provider networks.

As Americans enrolled in health plans turn sixty-five, they can choose between remaining in their health plan or entering the Medicare system. When each state's alliances are up and running, Medicare will begin to integrate into the alliances.

VETERANS AFFAIRS

Under the Health Security Act, the Department of Veterans Affairs may either organize its health centers and hospitals into health plans or allow them to act as health providers and contract with health plans to deliver services.

Health plans organized within the VA system must meet the requirements for all health plans. If a VA plan meets the requirements, that plan is offered as an enrollment choice within the regional health alliance that serves the area in which the VA plan is based.

All veterans may choose to join a VA health plan if one exists in their area. If the health plan can only hold a certain number of people, however, veterans with service-connected disabilities have first priority for enrollment, followed by low-income veterans.

The Department of Veterans Affairs continues to provide services that have become its specialty -- for example, head injuries and trauma, as well as long-term care to elderly, disabled veterans.

THE DEPARTMENT OF DEFENSE

The Department of Defense may establish military health plans covering broad regions in which military medical centers exist. Military health plans may also contract with civilian health providers to deliver services.

Military health plans must meet the same requirements and standards that all health plans meet under regional alliances.

In areas in which a military health plan is established, active-duty personnel will automatically enroll. Dependents of active duty personnel, military retirees, and dependents of retirees may also choose to enroll.

Military health plans will provide the nationally guaranteed benefit package, and in addition, any other services they currently provide.

Employers of individuals enrolled in military health plans pay the employer share of the premium, as they do in civilian health plans.

THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

Under the Health Security Act, federal employees and early retirees will join other members of their communities in choosing from among health plans offered by the regional alliance in their area. Federal employees and retirees, like other Americans, will be guaranteed the security of knowing that if they change jobs, lose their job or move, they will still be covered. The benefits package provided in the Health Security Act is based on today's best plans, including those offered through FEHBP.

Under reform, government contributions will increase for federal workers to 80 percent of the average premium, up from the average 75 percent contributed today.

Under the Health Security Act, individuals who retire between age 55 and 65 choose from the health plans offered in their area. For federal retirees covered by Medicare, the Office of Personnel Management will offer a Medigap option to continue the additional protection they currently receive.

INDIAN HEALTH SERVICE

Under the Health Security Act, Indian Health Service clinics and hospitals, tribal health centers and urban Indian programs will continue to operate as they do now.

Alaskan Natives and American Indians and their dependents may choose whether they want to receive care from the Indian Health Service or through a plan in a regional alliance. The IHS offers many services including public health nursing and education, outreach services and health promotion and injury prevention. All eligible American Indians and Alaskan natives must choose to receive care through the IHS if they want to receive these services.

During a five year time period, the Indian Health Service will renovate and expand its clinics so that they will be able to provide all of the services guaranteed in the comprehensive benefits package in addition to their supplemental services.

Once they provide the comprehensive benefits package, Indian Health Service clinics, hospitals and health centers may allow non-American Indians and non-1Alaskan Natives to join.