DEMOCRATS UNITE IN CALL FOR FEDERAL LEGISLATION TO MAKE CONSUMER BILL OF RIGHTS REAL FOR ALL AMERICANS

January 14, 1998

Today, the President, the Vice President, and the Congressional Democratic Leadership called on Congress to enact Federally enforceable health care consumer protections before it adjourns this fall.

The Democratic Leaders All Agree That Consumer Bill of Rights Legislation Should Include a Range of Protections Including:

- **Guaranteed Access To Needed Health Care Providers to ensure that patients are provided appropriate high quality care.** This right includes giving women access to qualified providers to cover routine women's health services, providing access to specialists for consumers with complex or serious medical conditions, and ensuring that chronically ill people are protected against sudden changes in provider participation in health plans that threaten continuity of care.

- **Access to Emergency Services when and where the need arises.** This provision requires health plans to cover these emergency services in situations where a prudent layperson could reasonably expect that the absence of care could place their health in serious jeopardy.

- **Confidentiality of Medical Records to ensure that individually identifiable medical information is not disseminated and to provide consumers the right to review, copy, and request amendments to their own medical records.**

- **Grievance and Appeals Processes for consumers to resolve their differences with their health plans and health care providers -- including an internal and external appeals process.**

- **The Democratic Leaders Underscored Their Belief That These Rights Should Be Protected By Law.** To make these rights real for all Americans, the Democratic Leaders stated that these protections would require Federal legislation to establish enforceable rights for consumers. Although many states have passed legislation in this area, this patchwork of protections is not sufficient, particularly because tens of millions of Americans are covered by plans which are not governed by state law.

- **Democratic Leaders Welcome Republicans Who Share This Vision to Work With Them to Pass Legislation This Year.** Many Republicans recognize the need for national, federally-enforceable consumer protections. In fact, legislation sponsored by Congressman Norwood has the support of nearly 100 Republican House Members. In addition, Democrats and Republicans in state legislatures across the country have passed consumer rights legislation into law. Forty-three states have enacted into law one or more of the basic protections outlined above, and over 25 of these states have Republican Governors.

PRESIDENT CLINTON ANNOUNCES NEW PROPOSALS TO PROVIDE AMERICANS AGES 55 TO 65 IMPROVED ACCESS TO HEALTH INSURANCE
January 6, 1998

President Clinton today announced a targeted, paid-for proposal to give Americans under 65 new options to obtain health care coverage. The President's proposal:

-- Enables Americans Ages 62 to 65 to Buy into Medicare, by paying a full premium.

-- Provides Vulnerable Displaced Workers 55 and over Access to Medicare, by offering those who have involuntarily lost their jobs and their health care coverage a similar Medicare buy-in option.

-- Provides a New Health Option to Americans 55 and over Whose Companies Reneged on Their Commitment to Provide Retiree Health Benefits, by extending COBRA continuation coverage until age 65.

Americans ages 55 to 65 are one of the most difficult populations to insure: they have less access to, and a greater risk of losing, employer-based health insurance; and they are twice as likely to have health problems. Some lose their employer-based health insurance when their spouse becomes eligible for Medicare. Many lose their coverage when they lose their jobs due to company downsizing or plant closings. Still others lose insurance when their retiree health coverage is dropped unexpectedly.

These older Americans are often left to buy into the individual insurance market, which can be prohibitively expensive (in some cases, more than $1,000 per month for a person with a pre-existing condition) and altogether unavailable for many older Americans with health problems. In virtually all states, people purchasing individual policies pay much higher insurance rates when they have a pre-existing condition; in many states, these same people can be denied coverage altogether.

The President's targeted proposal provides greater access to health coverage by:

- **ENABLING AMERICANS AGES 62 TO 65 TO BUY INTO MEDICARE,** by paying a premium. The premium would be paid for in a two-part payment plan. First, participants would pay a base premium of about $300 per month -- the average cost of insuring Americans this age range. Second, participants would pay an additional monthly payment, estimated at $10 to $20, for each year that they buy into the Medicare program. This premium, to be paid once participants enter Medicare at age 65, covers the extra costs of sicker participants. This two part payment plan enables these older Americans to buy into Medicare at a more affordable premium, while ensuring that the buy-in option is self-financing in the long run.

- **PROVIDING VULNERABLE, DISPLACED WORKERS OVER 55 ACCESS TO MEDICARE** by offering those who have involuntarily lost their jobs and their health

care coverage a similar Medicare buy-in option. Individuals choosing this option would pay the entire premium at the time they receive the benefit without any Medicare loan, in order to ensure that Medicare does not pay excessive up-front costs and participants do not have to make large payments after they turn 65. This policy responds to the increased vulnerability of older Americans to work transitions and company layoffs. Such workers have a harder time finding new jobs: only 52 percent are reemployed compared to over 70 percent of younger workers. Nearly half of these unemployed, displaced workers who had health insurance remain uninsured.

- **PROVIDING AMERICANS OVER 55 WHOSE COMPANIES RENEGED ON THEIR COMMITMENT TO PROVIDE RETIREE HEALTH BENEFITS A NEW HEALTH OPTION,** by extending COBRA continuation coverage until age 65. This proposal allows these retirees to buy into their former employers' health plan through age 65 by extending the availability of COBRA coverage to these families. In recent years, the number of companies offering retiree benefits has declined: in 1993, only about half of full-time workers in medium-to-large firms had access to retiree health insurance, compared to 75 percent in 1985. Some companies have ended coverage only for future retirees, but others have dropped coverage for individuals who have already retired. This policy provides much needed access to affordable health care for these retirees and their dependents whose health care coverage is eliminated after they have retired. Retirees would pay a premium similar to that of other COBRA participants.

The President's proposal is fully funded and does not burden the Medicare Program.

- **THE POLICY IS DESIGNED TO BE SELF-FINANCING.** All three proposals are designed to be paid for by the people who benefit. People ages 62 to 64 who buy into Medicare would, over time, repay the amount that Medicare loans them when they are buying in. Displaced workers would pay a premium that takes into account participants' costs. And, the COBRA buy-in policy has no Federal budget impact whatsoever.

- **ANY TEMPORARY COSTS ARE OFFSET BY PROPOSALS TO REDUCE MEDICARE FRAUD, ABUSE AND WASTE.** The short-term Medicare loan to buy-in participants, plus the costs of the displaced workers' buy-in, cost approximately $2 to $3 billion over 5 years. These costs are financed by a series of new Medicare anti-fraud and waste proposals, which will be announced in the President's budget.

1998 HEALTH CARE BUDGET HISTORIC HEALTH INVESTMENTS IN CRITICAL AREAS SUCH AS BIOMEDICAL RESEARCH, PREVENTION, AND TREATMENT
November 13, 1997

Today, the President signed into law the Labor-HHS-Education Appropriations bill, legislation which contains historic health investments in critical areas. This important bill expands the nation's biomedical research investment by nearly $1 billion; extends AIDS prevention efforts and treatments to more Americans; takes new steps to prevent chronic and environmental diseases, such as diabetes, heart disease, and cancer; improves health care in underserved rural areas; and enhances efforts to prevent and control infectious diseases.

- **A Historic Investment in Biomedical Research**. The Labor-HHS bill increases funding for the National Institutes of Health (NIH) by over $900 million, for a total of $13.6 billion for NIH in FY 1998. This increase will be used to advance research in a number of critical areas, such as cancer research, the Human Genome Project, heart disease, and mental health research. This funding will also support a new AIDS vaccine center, which will help fulfill the President's commitment to develop an AIDS vaccine.

- **Increased Funding for the Ryan White Care Act.** The bill increases funding by $153.5 million for the Ryan White Care Act which helps prevent and treat HIV and AIDS. The bill includes about $118 million for the AIDS Drug Assistance Program (ADAP), which helps low-income people with HIV gain access to promising new therapies. During any given month, ADAP helps an estimated 40,000 people with HIV, who have limited or no coverage by private insurance or Medicaid, gain access to medication.

- **New Steps to Prevent Chronic and Environmental Diseases.** New funding provided by the bill will help to improve local diabetes prevention and control programs, establish comprehensive State diabetes prevention programs, and implement a National Diabetes Education Prevention Program to educate Americans about how to take the necessary preventive precautions against this disease, which affects over 16 million Americans. Similar programs for cancer, lead poisoning, birth defects and disabilities, fetal alcohol syndrome, and heart disease, the nation's leading killer, will be established with this $50 million increase.

- **New Efforts to Improve Health Care in Rural Communities.** The bill includes a nearly 20 percent increase for rural outreach grants. These grants support demonstrations of new and innovative ways to extend health care services to rural communities, such as improving the use of telemedicine, and enhancing outreach efforts and information dissemination to underserved rural areas.

- **New Steps to Prevent and Control Infectious Diseases.** The bill includes a $27 million increase to prevent and control emerging and reemerging infectious diseases. New funding will be used to improve prevention efforts and to strengthen our ability to respond to outbreaks of infectious diseases, including Lyme disease, infectious diseases in child care settings, and foodborne diseases.

PRESIDENT CLINTON'S STRONG RECORD OF FIGHTING FRAUD AND ABUSE
September 15, 1997

Today President Clinton added three new weapons to the anti-fraud arsenal to combat fraud and abuse in the home health industry. The President announced: (1) an immediate moratorium on all new home health providers coming into the Medicare program to allow the Health Care Financing Administration to implement new regulations to prevent fly-by-night providers from entering Medicare; (2) a new renewal process for home health agencies currently in the program to ensure that all Medicare providers have to abide by these tough new regulations; and (3) a doubling of audits that will help weed out bad apple providers. These actions are consistent with recommendations to reduce fraud in home health by the Inspector General at the Department of Heath and Human Services following a recent report on fraud in the home heath care industry. The new initiatives announced today build on the President's unprecedented record of fighting fraud and abuse in Medicare and Medicaid.

- **Took Strong Action to Fight Fraud and Abuse Right When He Took Office.** The President's first budget closed loopholes in Medicare and Medicaid to crack down on fraud and abuse. In 1993, the Attorney General put fighting fraud and abuse at the top of the Justice Department's agenda. Through increased resources, focused investigative strategies and better coordination among law enforcement, the Justice Department increased the number of health care fraud convictions by 240 percent between FY1993 and FY1996 and saved taxpayers more than $20 billion.

- **Launched Operation Restore Trust -- a Comprehensive Initiative to Fight Fraud and Abuse in Medicare and Medicaid.** Two years ago, the Department of Health and Human Services launched Operation Restore Trust, a comprehensive anti-fraud initiative in five key states. Since its inception, Operation Restore Trust has identified more than $187.5 million in fines, recoveries, settlements, audit disallowances, and civil monetary penalties owed to the Federal Government.

- **Obtained Additional Resources to Fight Fraud and Abuse When the President Signed Into Law Kassebaum-Kennedy Legislation.** In 1996, the President signed the Health Insurance Portability and Protection Act (Kassebaum-Kennedy) into law which, for the first time, created a stable source of funding for fraud control. This legislation is enabling HHS to expand Operation Restore Trust to twelve states.

- **Passed New Initiatives to Combat Fraud and Waste Proposed by the President in the Balanced Budget Act of 1997.** The Balanced Budget Act the President signed into law in August also included important new protections to fight fraud and abuse in Medicare and Medicaid. These new initiatives included:

    -- requiring providers to give proper identification before enrolling in Medicare;

-- implementing new penalties for services offered by providers who have been excluded by Medicare or Medicaid;

-- establishing guidelines for the frequency and duration of home health services;

-- clarifying the definition of part-time or intermittent nursing care which will clarify the scope of the Medicare benefit and will make it easier to identify inappropriate services;

-- establishing a prospective payment system (PPS) for home health services to be implemented in FY 1999, enabling HCFA to stem the excessive flow of home health care dollars;

-- clearly defining skilled services so that home health agencies can no longer pad their bills with unnecessary services when a patient simply needs a simple service such as their blood drawn;

-- and eliminating periodic interim payments that were made in advance to agencies and not justified until the end of the year.

PRESIDENT CLINTON UNVEILS NEW WEAPONS TO FIGHT FRAUD IN HOME HEALTH CARE
September 15, 1997

Today President Clinton added three new weapons to the anti-fraud arsenal to combat fraud and abuse in the home health industry. The President announced: (1) an immediate moratorium on all new home health providers coming into the Medicare program; (2) a new renewal process for home health agencies currently in the program; and (3) a doubling of audits that will help weed out bad apple providers. These actions are consistent with recommendations by the Inspector General of the Department of Heath and Human Services following a recent report on fraud in the home heath care industry.

DECLARING A FIRST EVER MORATORIUM TO STOP HOME HEALTH PROVIDERS FROM ENTERING THE PROGRAM. The moratorium will give the Administration the opportunity to implement new regulations to provide better safeguards and protections to screen out problem home health providers. This action is consistent with strong evidence that the best way to stop fraud and abuse in our Medicare program is to prevent bad apple providers from ever entering the program. Home health care is the most rapidly expanding part of Medicare, with nearly 100 new home health providers entering Medicare each month. This moratorium -- which will authorize the Department to grant exceptions for areas of the country with no access to home health care services -- will be in place about six months until a new regulation. It will enable HHS to implement regulations to help prevent risky providers including:

- **Posting surety bonds of at least $50,000:** Home health agencies will be required to post surety bonds of at least $50,000 before they can enroll or re-enroll in Medicare. Surety bonds have proved to be an effective way to prevent bad apple providers from entering Florida's Medicaid program;

- **Requiring a minimum number of patients prior to seeking Medicare enrollment:** This will require home health agencies to establish an agency's experience in the industry before serving Medicare enrollees; and

- **Targeting home health agencies more likely to abuse Medicare:** This regulation will require home health agencies to submit detailed information about all of the businesses they own. This will ensure they do not use shaky financial transactions to exploit Medicare, such as preventing billing through companies that do not exist or are unauthorized to bill Medicare for services. This loophole allowed one home health agency in Georgia to defraud Medicare of $16.5 million before being found and convicted.

IMPOSING TOUGH NEW STANDARDS ON HOME HEALTH AGENCIES THROUGH A NEW RE-ENROLLMENT PROCESS. Under this new rule, HCFA will re-enroll home health providers every three years. Home health agencies will be required to submit an independent audit of their records and practices at the time of re-enrollment. The new regulations HHS will implement during the moratorium will apply to all home health agencies -- making it easy to expel fly-by-night operators who are more likely to cheat Medicare. Currently HCFA can kick providers out of Medicare only if they have been convicted of fraud.

DOUBLING THE NUMBER OF AUDITS AND INCREASING CLAIMS REVIEWS TO WEED OUT BAD APPLE PROVIDERS. HCFA will nearly double the number of comprehensive home health agency audits it performs each year -- from approximately 900 to 1800. HCFA will also increase the number of claims reviews by 25 percent from 200,000 to 250,000. This increased oversight will build on HHS efforts already underway to increase investigations, prosecutions, and audits under Operation Restore Trust, the Department's comprehensive initiative.

PRESIDENT CLINTON CALLS ON CONGRESS TO PASS EXISTING LEGISLATION TO IMPROVE CONSUMER PROTECTIONS AND QUALITY HEALTH CARE
September 15, 1997

Today in his speech before the Service Employees International Union (SEIU), President Clinton called on the Congress to take immediate action to pass existing legislation to improve consumers protections and quality health care. The President asked Congress to pass right away three bills currently before it that he has already endorsed that would: (1) ensure women are allowed to stay in the hospital at least 48 hours after a mastectomy; (2) put in place anti-gag rules that give patients the right to know their treatment options; and (3) prevent health plans from discriminating on the basis of genetic information. The President also asked Congress to work to pass legislation to adopt the new strong federal standards on medical privacy.

- **Allowing Women to Stay in the Hospital at Least 48 Hours Following a Mastectomy.** This legislation -- sponsored by Representative DeLauro and Senator Daschle and already endorsed by the President -- would ensure that a woman will be allowed to stay in the hospital at least 48 hours after undergoing a mastectomy. It would guarantee that decisions of when to leave the hospital are made between a woman and her doctor rather than a health plan. Earlier this year, the First Lady brought national attention to the horrifying practice of kicking women out of the hospital on the same day they undergo mastectomies. The President strongly encouraged the Congress to hold hearings and pass legislation on this important issue.

- **Implementing Anti-gag Rules for Private Health Plans.** Patients should have the right to be informed of all of their treatment options -- not just the cheapest. The President has already banned gag rules that prevented doctors from telling Medicare and Medicaid patients about all their options for treatment. Today he is calling on Congress to do its part -- pass legislation protecting patients in private health care plans so that no American is left in the dark about how best to treat his or her illness. President Clinton encouraged Congress to pass legislation similar to that proposed by Representative Ganske and Representative Markey.

- **Preventing Health Plans From Discriminating on the Basis of Genetic Information**. Important advances in genetics are offering new potential to identify hidden genetic disorders and spur early treatment. While these new strides will fundamentally change the way that we treat diseases, genetic information can also be used to discriminate against or stigmatize individuals. President Clinton called on Congress to pass legislation that will prevent health plans from denying or dropping coverage or raising premiums on the basis of genetic information. The President has already endorsed the principles of the legislation introduced by Representative Slaughter and Senator Snowe. In a similar vein, later this year the Administration will release a report which makes recommendations to prevent discrimination based on genetic information in the workforce. The President encourages the Congress to move forward on that issue as well.

- **Adopting Strong New Federal Standards to Protect Medical Privacy.** Medical records were once protected by family doctors -- who kept handwritten records filed away. Today, revolutions in the health care delivery system mean that entire networks of insurers and health care professionals have access to this now computerized private and personal information. Today the President called on Congress to enact legislation to protect medical privacy in the information age and to adopt the new strong federal standards on privacy such as those issued by Secretary Shalala last week.

GULF WAR VETERANS' ILLNESSES: ONGOING INITIATIVES
March 7, 1998

President Clinton established the Presidential Advisory Committee on Gulf War Veterans' Illnesses in May 1995 to ensure an independent, open and comprehensive examination of health concerns related to Gulf War service. The Committee published a Final Report on December 31, 1996 which contained numerous recommendations based on a thorough evaluation of the available data on the nature of Gulf War veterans' illnesses and the health effects of suspected risk factors, as well as the Federal Government's programs related to Gulf War veterans' illnesses.

In accepting the Committee's Final Report on January 7, 1997, the President announced his decision to extend the Committee to: (1) provide independent oversight of the ongoing investigation being conducted by the Department of Defense into possible chemical or biological warfare agent exposures during the Gulf War; and (2) evaluate the Federal Government's response to the Committee's recommendations. The President also directed the preparation within 60 days of an action plan for the Committee's recommendations and requested the Secretary of Veterans Affairs to review whether the presumptive period related to the compensation of Gulf War veterans with undiagnosed illnesses should be extended.

The President's actions have resulted in three significant initiatives:

1. A new recommendation from Secretary Brown -- which the President has accepted -- to initiate rulemaking to extend the eligibility period relating to the compensation of Gulf War veterans with undiagnosed illnesses to December 31, 2001.

2. Development of an integrated Action Plan, received today from the Secretaries of Defense, Health and Human Services, and Veterans Affairs, for implementing the Committee recommendations across the full range of issues relating to the health of Gulf War veterans.

3. Initiation of a comprehensive Presidential Review Directive (PRD) process to ensure that all relevant agencies effectively promote "Health Preparedness for and Readjustment of Veterans and Their Families After Future Deployments."

These major initiatives reflect the Administration's strong and continuing commitment to ensure that all Gulf War veterans receive the care and benefits they deserve, that we learn as much as we can about the possible causes of undiagnosed Gulf War illnesses, and that we incorporate the lessons learned to better safeguard our forces in future deployments.

THE REPUBLICAN BUDGET RESOLUTION CONFERENCE AGREEMENT: IMPACT OF MEDICARE AND MEDICAID CUTS ON STATES
July 28, 1995

Republicans are proposing to cut more than $450 billion from health care between 1996 and 2002 -- $270 billion from Medicare and $182 billion from Medicaid. Over one-third of these cuts would come from just four states: California ($54 billion), Florida ($38 billion), New York ($37 billion), and Texas ($28 billion). In combination, these cuts are more than four times anything ever enacted. Most of the $270 billion in Medicare cuts would not be necessary without the Republicans' $245 billion tax cut for well-off Americans.

Medicare

Nationally, the $270 billion in Medicare cuts means that the average beneficiary would pay at least $2,825 more in premiums and co-payments over seven years; couples would pay at least another $5,650. Under a recent House Republican proposal, in 2002 alone an average beneficiary in a nursing home would face an increase of at least $1,400. Beneficiaries using home health care services would pay on average an additional $1,700 in 2002.

These cuts will affect all states, but some states more so than others. States such as Florida and Texas, where there are high numbers of beneficiaries, will be particularly hard hit. California, Florida, Texas, New York and Pennsylvania, for instance, will bear more than 40% of all the Medicare cuts. On a per beneficiary basis, Massachusetts, Tennessee, Alabama and Rhode Island would also have higher than average increases in the out-of-pocket costs.

Medicaid

The Medicaid cuts proposed by Republicans would force states to slash services, provider payments, and eliminate coverage for 8.8 million children, elderly, and disabled individuals in 2002, according to the Urban Institute. The only way to avoid these reductions in coverage would be for states to increase their spending by 40% -- by raising property or sales taxes, or cutting other critical state spending.

The Medicaid cuts have enormously different impacts on states. While all states will see about a one-third reduction in their Federal Medicaid spending, states with high growth -- for any reason, including recessions or an increase in their elderly population -- will be particularly hard hit. New York and California alone will bear 20% of the total Medicaid cuts, while West Virginia, Florida, and Georgia will see the largest reductions as a proportion of their current Federal grant.

The President's Balanced Budget Proposal

The President shows how it is possible to balance the budget, assure that the Medicare Trust Fund remains solvent for at least another decade, and expand benefits and choice of plans without imposing any new Medicare beneficiary cost-sharing increases. His Medicare savings,

which are less than half ($124 billion) of the Republican proposal ($270 billion), come from health care providers and through a major new fraud and abuse initiative.

SECURE, COMPREHENSIVE CARE:
BREAST CANCER COVERAGE UNDER THE HEALTH SECURITY PLAN
October 18, 1993

Women are increasingly the victims of life-threatening illness, yet still are at the bottom of our medical research agenda. Funding for research into breast and ovarian cancers, osteoporosis and other diseases remains inadequate. Of all the health problems American women face, however, breast cancer is the deadliest.

The Facts on Breast Cancer in America:

-- One in nine women in the U.S. will develop breast cancer in her lifetime. (National Breast Cancer Coalition)

-- 2.6 million women in the U.S. have breast cancer today, and this year another 182,000 American women will be diagnosed with the disease, approximately one women every three minutes. (National Breast Cancer Coalition)

-- 46,000 women will die from breast cancer this year in the U.S., approximately one woman every 12 minutes. (National Breast Cancer Coalition)

-- There is no known cause or cure for breast cancer.

The Health Security Act addresses women's health care seriously and comprehensively, guaranteeing coverage to all women, regardless of health status, marital status, employment status, or ability to pay. Specifically, the Health Security Plan will cover a schedule of preventive screenings, tests and checkups at no cost, protection available in only a few of today's insurance policies.

BREAST CANCER EARLY DETECTION AND CARE COVERAGE UNDER THE HEALTH SECURITY PLAN

- **Medically necessary or appropriate care:** Women of any age can receive clinical services, including clinical breast exams, and mammograms at any time when they are medically necessary or appropriate with cost sharing as specified by their plan.

- **Care for women at risk:** Women of any age who are defined to be at risk of breast cancer by the National Health Board will receive additional visits, including clinical breast exams, and mammograms at a schedule appropriate to their risk status with no cost sharing.

- **Care for all women:** All women receive regular clinician visits, including clinical breast exams, every three years from age 20 - 39 and every two years from age 40 - 64 with no cost-sharing. All women will also receive routine screening mammograms every two

years, beginning at age 50, with no cost sharing.

In addition, the following services are covered for pap smears:

- **Pap/pelvic exams are covered annually for women who have reached childbearing age and are at risk of cervical cancer as part of clinical preventative services with no cost-sharing.** Once three negative smears are obtained, pap smears are covered every three years for women age 20 - 39 and every two years for women 40 and above. If the patient is at risk for fertility-related infectious illnesses, pap smears may be covered more frequently.

- **Additional pap smears:** Additional, or more frequent pap smears may be done at any time they are medically necessary or appropriate. In these cases, the services are covered with cost-sharing as is any other medical procedure.

SUPPORTING WOMEN'S HEALTH RESEARCH UNDER THE HEALTH SECURITY PLAN

The clinical preventive services package will be supported by significant increases in investments in breast cancer research.

-- This year the National Institute of Health's breast cancer research budget increased by 44 percent, from $208 million to almost $300 million.

Additional increased funding for early detection and preventive services is available through the following agencies, which have increased investment in their own breast cancer research programs:

--	Centers for Disease Control	From$71 million to $78 million
--	The Food and Drug Administration	From $3 million to $13 million
--	The Department of Defense	This year earmarked $210 million for breast cancer research.

Under reform, new research initiatives will concentrate in prevention of many illnesses affecting large numbers of women, including mental health, reproductive health and osteoporosis.

Economic Effects Of Health Care Reform
October 6, 1993

Comprehensive health care reform is a necessary element in an overall strategy to increase long-term economic growth, lower interest rates, reduce the deficit, and create jobs. Today, the rising cost of health care is a hidden tax on employers -hurting businesses, depressing wages, limiting job creation and threatening our competitiveness. The bottom line is this: health care reform will lower business costs, raise wages, and increase opportunities for workers.

I. The Health Security Plan Will Lower Costs For Many Businesses, Freeing Up Money For New Jobs, Higher Wages, And More Investment. Most businesses provide health care, and the Health Security plan will lower their costs by slowing the rate of growth of health care costs, eliminating "free riders," and lowering the markup for uncompensated care. This will make it easier to hire future workers and to give wage increases to existing workers.

II. Small Businesses Who Now Provide Coverage Will Particularly Benefit. Most small businesses provide health care to their workers and have to pay up to 35% more for health care than their big business competitors. The Health Security plan will lower health care costs for these small businesses, giving these firms more money to hire more workers and pay their existing workers higher wages. As the Wall Street Journal said, "for many small businesses, saddled with escalating health care costs, President Clinton's health care package comes as an unexpected windfall."

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

III.The Health Security Plan Will Reduce "Job Lock" And Increase People's Ability To Find Better Jobs. Up to 30% of people report that they are afraid to leave their current jobs because they could lose their health insurance. The guaranteed security of the Health Security plan means that people will be free to switch jobs or start a small business.

IV. The Health Security Plan Will Reduce "Welfare Lock." One of the reasons people do not leave welfare is the loss of Medicaid benefits. Studies suggest that as many as one million of the four million welfare recipients would take jobs if they were guaranteed health care.

V. Health Care Reform Will "Level The Playing Field" Among Small Businesses, And Between Large And Small Businesses. Small businesses that provide insurance currently pay more for labor than their competitors that do not insure, and pay more for insurance than their large business competitors. They also must bear the cost, in the form of higher premiums, to finance care for the uninsured.

VI. The Health Security Plan will increase health care jobs in the short run and increase

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

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

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

THE COSTS OF FAILING TO REFORM HEALTH CARE
October 6, 1993

I. Health Care Spending Per Working American Will Be Over $7,000 In 1994. Working Americans will, on average, pay $1,864 directly for health care in 1994. Their employers will pay $3,409 for health insurance and other medical payments. Federal, State, and Local taxes for health care will total $2,149.

II. Without Health Care Reform, American Workers' Wages Will Continue To Stagnate. The rapid growth in health care costs relative to the rest of the economy may have depressed wages by up to $1,000 since 1975. If current trends continue without reform, real wages may be further reduced by over $600 by the end of the decade.

III. The Lack Of Security Affects Employment. Many individuals are afraid to leave their current job, for fear that they will be unable to obtain insurance on a future job. Some individuals do not work for small businesses or do not become self-employed because of the high cost of health insurance for these groups. Many individuals on welfare would like to work but cannot take a job without losing Medicaid benefits.

THE NEED FOR REFORM

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

> "...As we undertake this journey of change, we clearly must preserve what's right with our health care system -- the close patient-doctor relationship, the best doctors and nurses, the best academic research, the best advanced technology in the world."
>
> --President Clinton, September 20th, 1993

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

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

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

"...Because we cannot control health care costs and become further and further behind in our efforts to do so, we find our economy, and particularly the federal budget, under increasing pressure. Just as it would be irresponsible, therefore, to change what is working in the health care system, it is equally irresponsible for us not to fix what we know is no longer working."

--Hillary Rodham Clinton, June 13, 1993

"...The ethical imperative is perhaps the most important thing. We have to decide that the costs, not just the financial costs, but the human costs, the social costs of all of us continuing to conduct ourselves within the framework in which we are now operating is far higher than risk of responsible change."

--President Clinton, September 20th, 1993

In short, today's American health care system falls short of providing high quality care and choices for all Americans.

"...Some things, like universal access, are not negotiable. And that's exactly the way it should be."

--C. Everett Koop, 20 September 1993

LACK OF SECURITY

Every month, 2 million Americans lose their insurance. One out of four -- 63 million --Americans will lose their health insurance coverage for some period during the next two years.

37 million Americans have no insurance and another 22 million have inadequate coverage.

Losing or changing a job often means losing insurance. Becoming ill or living with a chronic medical condition can mean losing insurance coverage or not being able to obtain it.

Long-term care coverage is inadequate. Many elderly and disabled Americans enter nursing homes and other institutions when they would prefer to remain at home. Families exhaust their savings trying to provide for disabled relatives.

Many Americans in inner cities and rural areas do not have access to quality care, due to poor distribution of doctors, nurses, hospitals, clinics and support services.

Public health services are not well integrated and coordinated with the personal care delivery system. Many serious health problems -- such as lead poisoning and drug-resistant tuberculosis

-- are handled inefficiently or not at all, and thus potentially threaten the health of the entire population.

RISING COSTS

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

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

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

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

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

QUALITY THREATENED

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

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

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

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

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

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

The average doctor's office spends 80 hours a month pushing paper. Nurses often have to fill out as many as 19 forms to account for one person's hospital stay. This is time that could be better spent caring for patients.

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

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

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

GROWING COMPLEXITY

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

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

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

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

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

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

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

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

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

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

What's Wrong With the Current System

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

-- Over the next two years, one out of four of us will be without health coverage at some point. Change jobs, lose your job, or move -- and your insurance company is currently allowed to drop you.

-- Today's system is rigged against families and small businesses. Insurance companies pick and choose whom they cover. Then they drop you when you get sick. If you have a pre-existing condition, you usually can't get any insurance at all.

-- Insurance companies charge small businesses as much as 35% more than the big guys.

-- Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have almost no choice today.

-- Twenty-five cents out of every dollar on a hospital bill goes to bureaucracy and paperwork -- not patient care.

-- Fraud and abuse are exploding, costing us at least $80 billion a year. That's a dime of every dollar we spend on health care.

-- Our nation's health costs have nearly quadrupled since 1980. Without reform, by the year 2000, one of every five dollars we spend will go to health care.

The Health Security Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Principle #2:
Comprehensive benefits: Keeping you healthy.

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

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

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

prescription drugs. The Health Security plan does.

All Americans will be guaranteed coverage of :

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

Principle #3:
Savings: Controlling health care costs.

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

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

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

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

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

- **Reduces paperwork.** All health plans will adopt a single, standard claims form by Jan. 1,

1995. Along with other measures to streamline the system and free nurses and doctors from excess bureaucracy, this will reduce paperwork, cut red tape, and save money.

- **Squeezes the waste out of Medicare and Medicaid.** By slowing the growth of these government programs, the proposal uses funds that have been wasted on excessive charges and funnels them into comprehensive benefits. Under reform, Medicare will be expanded to cover prescription drugs, and there will be a new long-term care program to help cover home- and community-based care. Today, Medicare and Medicaid spending keeps going up and up. But the elderly and poor aren't getting any extra benefits. Health security will change that.

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

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

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

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

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

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

- **Increases funding for prevention research.** The National Institutes of Health (NIH)

will expand research in areas like children's health, and health and wellness promotion. Preventive care keeps people healthier and saves money at the same time.

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

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

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

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

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

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

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

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

- **Requires insurance companies to use a single claim form.** The Health Security Act will reduce the insurance company red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. All health plans will adopt a single,

standard claims form by Jan. 1, 1995. It will enable doctors and nurses to spend more time taking care of you -- and less time wrestling with paper.

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

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

- **Removes the burden on business of negotiating insurance.** Groups of businesses and consumers -- regional health alliances -- will negotiate for high-quality care at affordable prices. This will simplify today's system, where hundreds of thousands of businesses negotiate with more than 1500 insurance companies. The burden of finding insurance will be lifted -- and so will administrative costs -- which can run as high as 40% of total health costs for small business.

HOW THE SYSTEM IS FINANCED

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

The system is financed from five major sources:

1) Employer and employee contributions -- Everyone will pay a portion of health insurance premiums, even if your contribution is small, because everyone must assume responsibility. Today, the overwhelming majority of employers cover their employees, and they'll continue to do so. But the businesses that provide insurance are paying for those who don't. No one should get a free ride.

2) Medicare and Medicaid savings -- Specific savings can be achieved by slowing the rate of growth of these programs. Every penny of these savings will be channeled back into benefits -- prescription drugs and long-term care -- for the people which these programs serve.

3) "Uncompensated care." -- Savings can be achieved from money now paid to hospitals and doctors who care for people who can't afford care but receive it anyway and the uninsured.

4) Sin taxes and other federal revenues -- There will be some new "sin taxes," and other revenues will be added as health care costs slow, less money is spent, and the difference is no longer tax-deductible.

5) Other savings -- Reducing paperwork and administration -- estimated to cost $100 billion or more a year -- will cut bureaucracy and save money. Cracking down on health care fraud -- estimated to be at least $80 billion annually -- and imposing new stiff penalties will also yield savings.

PAYMENT SCENARIOS

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

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

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

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

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

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

EXCEPTIONS

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

- **Self-employed/independent contractors:** The self-employed and individual contractors

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

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

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

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

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

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

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which are less than half ($124 billion) of the Republican proposal ($270 billion), come from health care providers and through a major new fraud and abuse initiative.