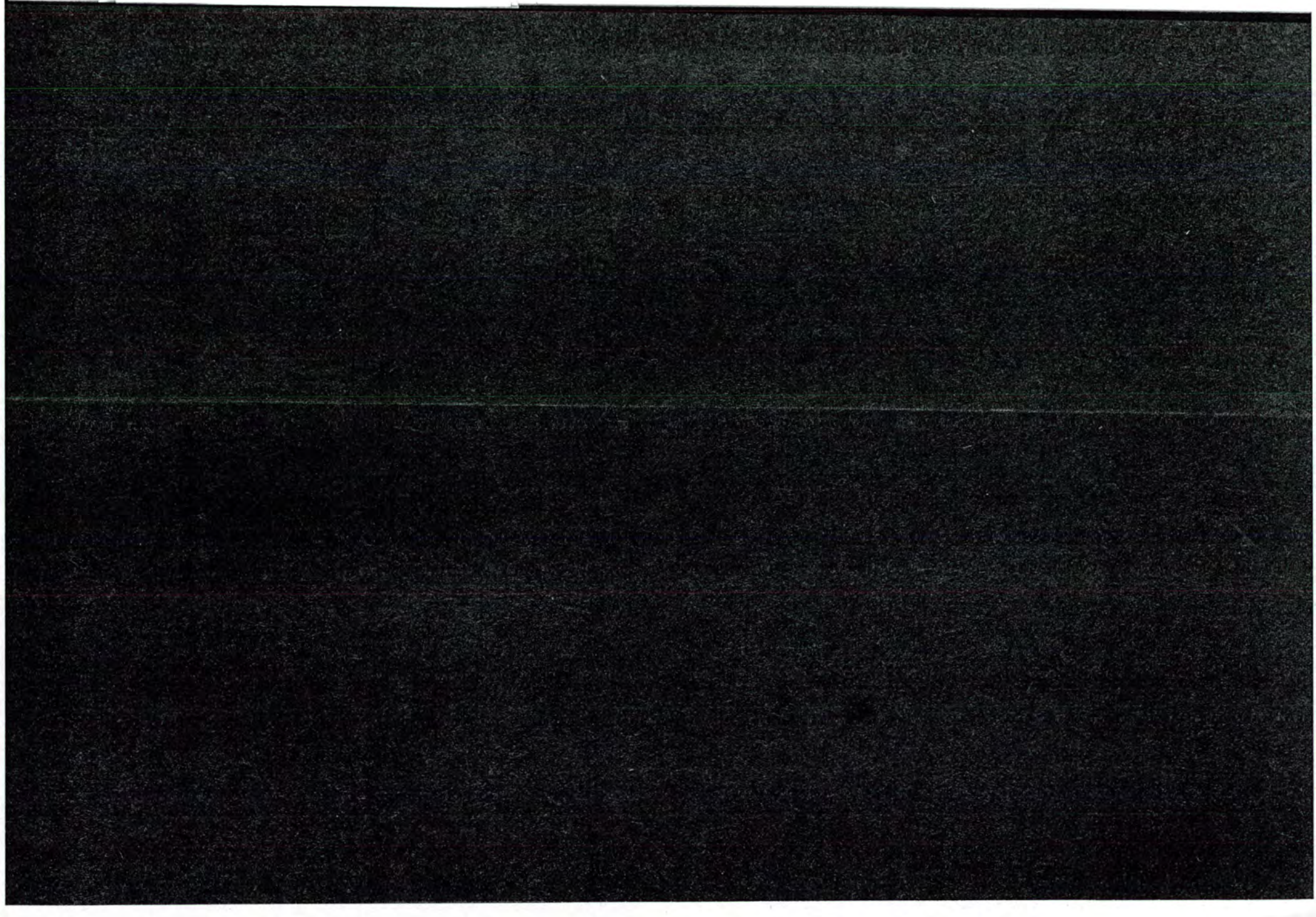

FROM BARBARA GARCIA -WEED

CALL TO ACTION

AARP board of directors issues appeal to members

The following is the full text of the AARP board appeal to members:

The voice of individual Americans is being lost in the noisy health-care reform debate. We have had enough of slogans, soundbites and partisan politics. This time for action is now.

As the Congress begins to act, the AARP board of directors calls upon its members and their families to urge their representatives and senators to enact meaningful health-care reform in 1994.

Reflecting the clearly expressed wishes and concerns of our members, AARP supports real health-care reform that provides every American:

- quality health care coverage, not merely as a goal, but on a timetable, specified in the law;
- a long term care benefit that guarantees security and peace of mind to Americans of all ages faced with severe disabilities and chronic illnesses;
- prescription drug coverage to assure that no American is denied access to essential, often life-saving, drug therapies;
- system-wide cost containment that assures consumers affordability and doctors and hospitals a fair price;
- financing that is fair and adequate.

Real health-care reform must ensure current and future Medicare beneficiaries that the Medicare program will be strengthened to protect access, quality and affordability.

Real health-care reform must also guarantee every American the same health security that we already guarantee each member of Congress and the president.

It is time to move health care reform legislation forward toward solutions. It won't be easy. But doing nothing means higher costs, fewer benefits and increasing loss of coverage for all, including Medicare beneficiaries and those privately insured. We are all vulnerable.

The great achievements in our history have come from leaders who weren't afraid to challenge the status quo. We applaud the president's courage and leadership in the effort, as well as those members of Congress who are taking up the challenge to improve our health-care system. It is now time for the American people to become actively involved.

AARP pledges to work with the president and Congress as we fight to provide health security and peace of mind to all Americans, young and old. This is our legacy. It is also our future. Make your voice heard. Call your representative and senators today.

AARP call: time for action on reform

BY ELLIOT CARLSON

To broaden support in America for sweeping health-care reform, AARP's board of directors has issued a "call to action" to Association members to take the lead in bringing about fundamental change.

"As the Congress begins to act," the AARP board stated, "[we're] calling upon members and their families to urge their representatives and senators to enact meaningful health-care reform in 1994."

In its unprecedented "call to action," the board urged members to press for a reform bill that reflects "the clearly expressed wishes" of older Americans.

AARP campaign logo.

Such a bill must include, the board said, quality health care for all, prescription drug coverage, long-term care benefits, system wide cost containment and financing that's fair and affordable. [See page 7 for full text of board statement.]

As a way to help members become more "actively involved," AARP announced a massive, grass-roots campaign across the country to generate support among people of all ages for comprehensive health reform.

"We're going to the country to help people better understand the need for reform," said AARP Executive Director Horace B. Deets. "And to mobilize our volunteers and ask our members to push Congress to produce a satisfying health reform bill."

Beginning in March, AARP-sponsored television advertisements started appearing in cities across the country emphasizing the importance of reform to the well-being of American families.

Recently ads highlighting the need for prescription drug coverage and a long-term care

continued on page 7

FROM: BARBARA GARCIA-WEED

AARP call

continued from page 1

benefit appeared in newspapers in 18 cities around the country, including Seattle, Houston, Detroit, Philadelphia, Topeka, Tampa, Nashville and Bakersfield, Calif.

The AARP campaign comes at a critical time—just when Congress is starting to consider specific reform bills [see story on page 1].

Also, the AARP campaign follows a massive negative drive mounted by some parts of the insurance industry to head off a major overhaul of the American health system. "People are being subjected to misleading scare tactics about health reform," says AARP legislative director John Rother. "Some insurers and direct-mail groups are giving older Americans a completely false impression that they have more to lose than gain from reform."

Partly as a result, Rother says, many older Americans are now expressing strong concerns about some reform proposals, especially the plan advanced by President Clinton [see story on page 4].

Rather than focus on a particular plan, AARP is asking members to ensure that whatever bill emerges from Congress includes key changes. And it's moving to ease concerns many older Americans have about reform itself.

"We want to reassure members," says AARP's Rother, "that health reform properly done will not damage Medicare, but will mean a stronger and better Medicare program."

To convey its message, AARP is deploying more than 5,000 volunteers nationally to organize community forums and other events, as well as meetings with members of Congress.

In Iowa, AARP leaders took a bus trip that stopped at cities in each of the state's five congressional districts where volunteers held rallies for health-care reform and asked those attending to write their members of Congress.

"We are encouraging members in each community to join us in making legislators aware of our concerns and needs," said Mary Rose Brown of Iowa Falls, Iowa coordinator of AARP/VOTE, the Association's nonpartisan voter education program.

In several states in the Pacific Northwest, AARP volunteers have organized a phone campaign to reach members of Congress. People at public events or in malls are handed a cellular phone and asked to call their local congressional district office to urge action on long-term care.

continued on page 1

file

Bringing lifetimes of experience and leadership to serve all generations.

AMERICAN ASSOCIATION OF RETIRED PERSONS
BOARD OF DIRECTORS
November 10, 1993

America needs comprehensive health care reform. Americans need bold, not timid, steps now.

Comprehensive health care reform means:

* A guarantee that all individuals have access to and coverage for health and long term care;
* System-wide cost containment that slows the explosive growth in health spending;
* Comprehensive benefits from prenatal care and prevention to prescription drugs and long-term care;
* Broad-based, fair and affordable financing, so that government, businesses, and individuals all pay their share and everyone is protected against the high costs of care; and
* Consumer-centered governance of the health care system.

While AARP has not yet endorsed any specific health care reform plan, we believe the President's proposal provides the strongest and most realistic blueprint to date for achieving our goals. At the same time, we commend the members of Congress in both parties who have introduced proposals that would achieve universal coverage. We recognize that Congress, on a bipartisan basis, will consider a range of legislative proposals as it moves towards enactment of health care reform. The final legislation may differ from any of the proposals now under discussion.

We especially appreciate the President's including in the Health Security Act:

* the vital provisions for home and community-based long-term care for disabled persons of all ages;
* coverage of prescription drugs on similar terms for Medicare beneficiaries as for all other Americans; and,
* protection for pre-65 retirees in the Health Security Act.

American Association of Retired Persons 601 E Street, N.W. Washington, D.C. 20049 (202) 434-2277
Lovola W. Burgess *President* Horace B. Deets *Executive Director*

For more than three decades, AARP has taken a leadership role on issues of health and long-term care. The Association's draft health care reform plan, "Health Care America," was developed with the extensive involvement of AARP members across the country. It reflects the Association's commitment to improving the quality of life for all generations -- a commitment we believe is shared by President and Mrs. Clinton, members of Congress, and the American people.

While the debate will be complex and emotional, we urge every American not to be misled. We call upon all citizens to ask their elected representatives to enact a plan that assures every American comprehensive benefits -- including long-term care and prescription drugs -- that can never be taken away. We also urge Americans to demand that effective, system-wide cost controls be enacted to keep health care affordable for our children and grandchildren.

AARP will work with the Congress in a bipartisan way to ensure that these important and comprehensive benefits are guaranteed to Americans of all ages in a final health care plan.

We ask every American to join in the effort to reform our health care system -- not only for us -- but for future generations. The time for action is now. We call upon AARP members to directly participate in this debate. We stand for health reform, and we will fight to make it a reality in 1994.

AARP

Bringing lifetimes of experience and leadership to serve all generations.

STATEMENT OF HORACE B. DEETS
AARP EXECUTIVE DIRECTOR

August 4, 1993

AARP is deeply disappointed by the agreement reached by the House-Senate Budget Reconciliation Conference Committee.

AARP has supported every major deficit reduction bill since 1982; and, in each of these bills older Americans were asked to bear part of the burden of deficit reduction. In each case the Association viewed the final bills as fair and equitable.

While the $496 billion package before us is a step towards deficit reduction, it unfortunately does not meet the standard of shared sacrifice. The $56 billion cut in Medicare will be felt by Medicare beneficiaries in both the higher premiums that they will pay and in reduced access to needed health care. Individuals with private insurance coverage and businesses will also feel this cut as they pay what the Medicare program will not.

We are pleased that this agreement eases -- compared to earlier proposals -- the burden of higher Social Security taxes on middle-income older Americans, though many will still see a significant tax increase not experienced by others in the same income bracket.

Given the efforts that were made to make this package even more onerous -- efforts that persist -- it is unlikely that any further negotiations or a "summit" will improve the situation.

Now it is time for the President, the Congress and the American people to move on to the next order of business: health care reform. To truly deal with the nation's deficit will require confronting the critical condition of our health care system. Unfortunately, this challenge will be harder to meet because of the Medicare and Social Security provisions in this package, as well as the manner in which this package evolved.

As we take on the challenge of health care reform it is our hope that the Congress, the President and the American people will remember the positive contribution that older Americans have made in this and earlier deficit reduction bills. We hope they will view that contribution as a down-payment on the cost of much needed health care benefits, particularly prescription drugs and long term care.

ICM
AARP

AARP

Bringing lifetimes of experience and leadership to serve all generations.

October 19, 1993

Mr. Ira Magaziner
Senior Adviser to the President for Policy Development
Old Executive Office Building
Room 216
Washington, D.C. 20500

Dear Mr. ~~Magaziner~~ Ira,

AARP appreciates the opportunities that it has had to meet with you and others in the Administration to discuss health and long-term care reform and the President's draft proposal.

Members of my staff have now completed a comprehensive review of the September 7 version of the plan. In conducting this review and in the course of discussions with others in the Administration involved with the plan's development, we have identified several areas about which we have significant questions. These areas concern the treatment of current and future Medicare beneficiaries, the potential integration of the Medicare program into the alliance system, long-term care (e.g., the entitlement cap, administrative costs, phase-in), financing and cost containment, low income protections, and state flexibility.

We are aware that legislative language is currently being developed that could ultimately answer some of the questions we have identified. Nevertheless, we believe that most of these questions will still obtain upon introduction of the bill itself, and would therefore be grateful for any clarification you or your staff could provide at this time.

Sincerely,

John

John Rother, Director
Legislation and Public Policy

10/19/93

I. MEDICARE

- Current Medicare Beneficiaries

  Plan reads:

  ***"Individuals over age 65 continue to enroll in the Medicare program."* (p. 14)**

  - Are current Medicare beneficiaries permanently enrolled in the traditional Medicare program or do they have the option of leaving the traditional Medicare program, and, instead, obtaining coverage through a health alliance?

  Plan reads:

  ***"The Medicare secondary payer program remains for Medicare eligible individuals who continue to work."* (p. 14)**

  - Are current working Medicare beneficiaries covered through the traditional Medicare program or through a health alliance? What are the beneficiary's, employer's and government's responsibilities with respect to contributing towards the cost of the beneficiary's coverage? If the beneficiary receives coverage through the alliance, must the beneficiary continue to make Part B premium payments?

  Plan reads:

  ***"Individuals who are eligible for Medicare because of disability continue to receive Medicare coverage."* (p. 14)**

  - Will an alliance member who becomes disabled (in accordance with Social Security regulations) have a choice of remaining in an alliance, or must (s)he move into the traditional Medicare program? If (s)he is permitted to remain in the alliance, how would the government's contribution be calculated? Would the premium charged the individual be the same as that charged any other alliance member under age 65?

- Qualified Medicare Beneficiaries

  - Under the plan, do the low income protections that are now available to certain current Medicare beneficiaries (i.e., QMB's) remain unaltered?

- Individuals Turning 65 Who Elect to Remain in a Health Alliance

  Plan reads:

  "Medicare pays a fixed contribution to alliances equal to the costs that Medicare would be expected to bear--under the new budget constraint--for the same beneficiary population in the alliance. Beneficiaries pay the difference between Medicare's payment and the plan's premium." **(p. 92)**

  - How is Medicare's contribution for these individuals determined? Is it based on the costs that Medicare would have incurred had the beneficiary received (1) care in the traditional Medicare program for the standard Medicare package, or (2) through the alliance for the nationally guaranteed comprehensive benefit package? If the former, would Medicare's contribution be based on fee-for-service rates or 95% of the average adjusted per capita cost (AAPCC) formula used in the current HMO/CMP risk program?

  Plan reads:

  "Plans negotiate rates with alliances for participants over 65 choosing to remain in the alliances; these rates are separate from those covering younger participants." **(p. 192)**

  - Are the rates for those over 65 who receive coverage through a health alliance community-rated (e.g., would a 65-year old pay the same premium as an 80-year old)? It is our impression that Medicare beneficiaries who continue to work would obtain coverage through an alliance with their employer contributing toward their coverage. Would these individuals be included in the same risk pool as those turning 65 who elect to remain in an alliance (whether working or not)?

- Balance Billing

  Plan reads:

  "Medicare eliminates extra billing for Part B providers such as durable medical equipment providers, orthotic and prosthetic suppliers and ambulances." **(p. 119)**

- Will any other Part B services (particularly physician services) be subject to the balance billing prohibition?

- State Integration of Medicare

  Plan reads:

  "The Secretary of the Department of Health and Human Services has authority to permit states to integrate Medicare beneficiaries into health alliances under specified conditions..." **(p. 189)**

  - If a state integrates Medicare, will beneficiaries have the same coverage (i.e., the same benefit package, the same annual cost-sharing limits, and no balance bills) as other alliance members?

  Plan reads:

  "A state may establish a single-payer health care system rather than an alliance system offering multiple plans." **(p. 54)**

  - Will Medicare beneficiaries who reside in states that have established single payer systems be eligible to receive the same coverage (i.e., the same benefit package, the same annual cost-sharing limits, and no balance bills) as those who are not Medicare beneficiaries?

  Plan reads:

  "To approve a waiver* (for a state to integrate Medicare), *the federal government requires assurance that Medicare beneficiaries have: access to the same, or higher level or benefits as standard Medicare; access to care that is substantially comparable to standard Medicare; equal or better protection against balance billing; protections under comparable, or better quality assurance mechanisms assurance of the same or better appeals rights." **(p. 190)**

  - What specific actions would the federal government take to ensure that the state was complying with the assurances it had made? How would the federal government ensure protection of the Medicare Trust Fund?

- Cost Sharing Protections

  Plan reads:

"The Health Care Financing Administration also: Gives physicians presumptive waivers from collecting or filing for beneficiary cost sharing in cases where cost sharing would pose a financial hardship on the beneficiary or in cases of professional courtesy." **(p. 120)**

- Do physicians have full authority to determine which Medicare beneficiaries will be exempted from cost-sharing? Do physicians have the authority to extend this exemption to others groups?

II. LONG-TERM CARE

- State Flexibility

  Plan reads:

  "States have the flexibility to design and define their community-based service system..." **(p. 153)**

  - It appears that states have the option not to participate in the home and community-based program at all. Is this correct? Will the federal government have any recourse if a state chooses not to participate in the program?

  - States appear to be given almost total flexibility in designing and running their programs. Will states be required to work within federal standards (e.g., in areas such as provider reimbursement, quality assurance, etc.)?

  - What incentives will be created to promote high quality residential care alternatives, such as assisted living, that can serve those with moderate and low incomes?

  - The plan seems to be silent on a role for care management/service coordination. How will clients negotiate the system and obtain the appropriate level and mix of services?

  - Without mandated care management, how is it anticipated that long-term care services will be coordinated with acute service delivery?

- Serving the Low-Income Population

  Plan reads:

  "To avoid reductions in service for this population, current Medicaid programs for those that do not meet the eligibility criteria of the new program are replaced with a new community based LTC program for low income people." **(p. 156)**

  - The Association understands that the new home and community-based services program to serve the low income population may have been eliminated from the Administration's proposal and, as a result, that services for this population will continue to be provided through Medicaid. Is this correct?

- If the new home and community-based services program for the low income has been eliminated, how will Medicaid recipients be protected against service reductions over time?

- Capped Entitlement

  Plan reads:

  "When fully implemented, federal funding is capped based on the cost of serving the eligible population." **(p. 151)**

  - Will the annual budget for the new long-term care program be subject to an annual appropriation and to sequestration, should it occur?

  - When the cap is reached, will persons who have been deemed eligible but who have not yet received services be served at all? What will happen to those already receiving services?

  - What will be expected from or required of states if federal funding falls short in a given year?

- Plan Submission Process

  Plan reads:

  "Each state submits for federal approval a plan outlining the implementation of expanded home and community-based services." **(p. 151)**

  - Given the flexibility that states have in designing, implementing and operating their respective long-term care programs, how will the federal government both evaluate state plan submissions and provide meaningful oversight of plan implementation?

- Assessments and Care Plans

  Plan reads:

  "At a minimum, states provide to each eligible individual a standardized assessment and an individualized plan of care." **(p. 152)**

  - It appears that states will be expected to determine eligibility prior to assessing the individual. If this is the case, will federal-

state matching funds pay for the screenings and will the federal government require the use of a standard screening instrument and protocol?

- Will there be minimum federal requirements relating to reassessment, i.e., when must clients be reassessed?

- State Administration

  Plan reads:

  "To implement the program, the state plan: designates an agency or agencies to administer the program..." **(p. 153)**

  - Will any mechanisms be established to encourage states to restructure their long-term care systems to achieve more coordinated systems?

  - Will consumers, providers, and other affected individuals or organizations have any opportunity to help shape and monitor the state program on an on-going basis, other than through a public hearing?

- Administrative Costs

  Plan reads:

  "The costs of administering the program (including the eligibility determination process and care planning) are included under the national budget ceiling. The Secretary of HHS defines administrative costs and specifies limits on the proportion of expenditures that may be used for such costs." **(p. 154)**

  - Are the costs of assessments and developing care plans considered "administrative costs" ?

- Eligibility and Equity Among Recipients

  Plan reads:

  "To be eligible, an individual meets one of the following conditions: 1)... requires personal assistance.. to perform three or more of the following five ADLs; 2) presents evidence of severe cognitive or mental impairment...; 3)...has severe or profound mental retardation..., and 4) for children under the age of six, is dependent on technology and otherwise requires hospital or institutional care." **(p. 152)**

- The expense of caring for the different populations varies significantly, which could result in significant "budget battles" over limited resources. Will there be federal standards to assure that the needs of each group will be met?

- Funding

  Plan reads:

  "The maximum budgeted amount (or national expenditure ceiling) increases annually consistent with the rate of increase allowed in the national budget for health care and changes in the number of people over the age of 75." **(p. 155)**

  - Why does the annual update to set the national expenditure ceiling not include other groups such as the mentally retarded or children needing long-term care services?

- Phasing-In of Program

  Plan reads:

  "Funding phases in beginning in fiscal year 1996... in FY-2000." **(p. 155)**

  - Can a state choose to enter into the program during the latter stages of the phase-in period? For example, can states enter the program in year four, when the federal government will pay 80 percent of full funding, rather than year one, when only 20 percent will be paid?

  - During the phase-in period, are states required to maintain their current level of Medicaid spending?

III. FINANCING/COST CONTAINMENT

- Savings Offsets to Federal Subsidies

Plan reads:

"An individual eligible for cash assistance (AFDC or SSI), whether employed or unemployed, has coverage purchased from the regional alliance by the Medicaid program," (p. 14) and "Employers of AFDC or SSI recipients make payments to the alliance as specified in the financing chapter." (p. 202)

- There seems to be a potential inconsistency in the plan language with respect to financial responsibility for AFDC/SSI cash recipients. Does Medicaid make payments to the alliance on behalf of AFDC and SSI recipients or do employers pay for them (or do both pay)?

- To what is the $198 billion in Medicaid savings (expected to accrue between 1994 and 2000 from both federal and state savings) attributable:

  1) The shift of financial responsibility for working cash recipients of AFDC/SSI from Medicaid to employers; or

  2) The discontinuation of Medicaid support for non-cash Medicaid recipients; or

  3) Both?

Plan reads:

For those reaching age 65 and remaining in alliances, *"Medicare pays a fixed contribution to alliances equal to the costs that Medicare would be projected to bear...for the same beneficiary population in the alliance."* **(p. 192)** At the same time, the tables at the end of the plan show $61 billion in offsets to subsidies from shifts of working Medicare beneficiaries to alliance coverage.

- If the Medicare program continues to make payments for those electing to remain in alliances at age 65, is the $61 billion in Medicare offsets claimed in the plan attributable solely to those over age 65 who continue to work, or are they due in any part to those who age into alliances for whom Medicare continues to make payments? Does the $61 billion also include savings from shifting the

responsibility for those who turn 65 while in an alliance (and continue to work) to employers?

- Premiums/Employer Contributions

Plan reads:

***"All employers pay 80 percent of the weighted average premium (WAP) for health insurance coverage in the regional alliances which serve their employees...capped at a percentage of payroll."* (p. 15) The plan also reads, *"Firms in the regional alliance pay a fixed per-worker contribution for each employee according to his or her family status"* (p. 222) and that the per worker contribution is 80 percent of the average family premium divided by the average number of workers per family within each family status in the alliance (p. 223).**

- If the premium for couples is $4,200, and the average number of workers per family is 1.5 (as in the example on p. 223), the per worker contribution is $2,240. If a family has two full time workers, does the employer contribute $3,360 (80 percent of the WAP) or $4,480?

Plan reads:

***"Employers who realize a reduction in retiree health costs may be assessed a one-time payment for the extra cost associated with induced early retirements due to the retiree subsidy program."* (p. 225)**

- How will this one-time payment be assessed?

Plan reads:

***"Nonworking and part-time single people and families make contributions based on their unearned income."* (p. 234)**

- How would unearned income be determined for the purpose of requiring a premium payment?

- Would unrealized capital gains and tax-exempt interest income be included in the definition of unearned income?

- Does unearned income include cash or in-kind government transfers?

Plan reads:

"When the National Board notifies the Secretary of Health and Human Services that a state has failed to comply with federal requirements, the National Board shall also notify the Secretary of the Treasury. The Secretary of the Treasury will impose a payroll tax on all employers in the state." **(p. 47)**

- On what authority would the Secretary of the Treasury be able to levy a tax of any kind?

- Spending Caps

Plan tables:

The tables in the plan show reductions in Medicare and Medicaid of $238 billion resulting from the imposition of spending caps. Although the plan itself does not mention it, these reductions are from outlays net of Part B premiums; thus, the reductions are even larger than they at first appear.

- Are the reductions in Medicare and Medicaid due to the spending cap also calculated net of the savings due to the moving of working beneficiaries into alliances?

- In the event that the expected reductions in spending are not as great as anticipated, what enforcement mechanism would operate to keep spending in these programs in line with the inflation factor?

- Is the additional spending for the Medicare drug benefit also net of premiums for drugs?

- Will the Medicare Part B premium continue to be set at 25 percent of costs for physician services?

- Cost Containment

Plan reads:

"The federal government assumes responsibility for enforcing alliance budgets." **(p. 93) The enforcement mechanism discussed in the plan is that** *"if the estimated weighted average premium for the alliance exceeds the alliance's premium target, an assessment is*

imposed on each plan whose bid exceeds the target, and on the providers receiving payment from that plan. Revenues from assessments on plans are used to reduce required employer premium contributions. The assessment on the plan is equal to a portion of the percentage amount by which the alliance target is below the bid. The 'portion' is calculated so that the weighted average of premiums after assessments equals the alliance's premium target. Payments to providers by that plan are assessed at the same percentage, with revenues from the assessment retained by the plan." **(p. 96)**

- Are the assessments on plans flat amounts or are they proportional to the amount by which a plan's bid exceeds the target?

- How are the revenues from assessments on the plans with bids exceeding the target apportioned among employers to reduce their premium contributions?

- Would the revenues from these assessments also be used to reduce worker contributions?

Plan reads:

"If an alliance's actual weighted average premium in a given year exceeds its premium target, then the inflation factor for that alliance is reduced for the following two years to recover excess spending." **(p. 97)**

- Would this enforcement mechanism penalize all plans and all providers as a result of the behavior of a few or possibly only one plan?

IV. LOW-INCOME PROTECTIONS

Plan reads:

"Families and individuals with incomes below 150 percent of poverty in a regional alliance may apply to their alliance for help in paying their premiums. The subsidy will depend on their family income and the average premium for that family type in the alliance." **(p. 222)**

- Will families and individuals below 150 percent receive a total subsidy for their premiums or will a sliding-scale be used? Will any families and individuals receive a total subsidy?

Plan reads:

"Single people members of families who work only part-time or part of the year owe one per worker contribution for the appropriate family status minus any employer contribution (before subsidies) made on their behalf. The required payment is reduced for families whose family income is less than 250% of poverty." **(p. 235)**

- What is the extent of the subsidy for those with family incomes less than 250% of poverty? Will a sliding-fee scale be applied?

Plan reads:

"Determination of eligibility is based on family income. When applying for a subsidy, eligible individuals and families submit a declaration of estimated annual income. After the end of the year, the alliance or another agency designated by the state checks self-declared estimates of income against income tax returns and other data presented by the beneficiaries and reconciles estimates with final income for the year." **(p. 227)**

- Will penalties be imposed on families and individuals who received subsidies based on an underestimate of their income? Will families and individuals who did not initially apply for a subsidy, but would have been eligible for a subsidy, have an opportunity to do so at a later date? Will there be a requirement that families and individuals must submit an income tax return in order to receive a subsidy?

Plan reads:

"In areas not served by a plan or network with low cost sharing and a premium at or below the average premium in the alliance, individuals with family incomes less than 150 percent of the poverty level qualify for subsidies to cover co-payments and deductibles. Subsidies reduce cost sharing to the level charged by a low cost sharing plan."

- It is our understanding that all individuals and families, even those with income below poverty, will be required to pay at least the cost sharing amounts charged by a low cost sharing plan. Is that the intent of the proposal? Can low-income individuals and families be denied services for inability to pay cost sharing?

V. STATE FLEXIBILITY

- Alliance Governance

  Plan reads:

  "A regional alliance may operate as a non-profit corporation, an independent state agency or an agency of the state executive branch. A board of directors, composed of representatives of consumers and employers who purchase coverage through the alliance, governs alliances that are non-profit corporations. States establish a mechanism for selecting members of alliance boards." **(p. 56)**

  - Are alliances that are not non-profit corporations required to have a Board of Directors? If they are not, how will employer and consumer participation be accomplished?

- Budget Enforcement

  Plan reads:

  "A state may not regulate premium rates charged by health plans, except when necessary to meet budget requirements or to ensure plan solvency." **(p. 52)**

  - In other sections of the document, it is stated that it is the responsibility of the alliance to negotiate rates and meet budget requirements. Does this mean that the state and alliance share this responsibility?

- State Coordination

  Plan reads:

  "An alliance may not cross state lines, but two or more contiguous states may coordinate the operation of alliances. Coordination may include adoption of joint operating rules, contracting with health plans, enforcement activities and negotiation of fee schedules with health providers." **(p. 50)**

  - The language specifies that coordination can include joint "contracting with health plans." Does this mean that contiguous states could negotiate premiums? If so, how would this be reconciled with the responsibility of the National

Health Board and the alliances for establishing and negotiating premiums?

- State Plan

  Plan reads:

  "Each state submits to the National Health Board a plan for implementation of health reform, demonstrating that its health care system meets requirements under federal laws. States periodically update their plans, as required by the National Health Board." **(p. 49)**

  - Does the National Health Board have authority to approve state plans? Does the Board have authority to enforce state plans and use fiscal and other sanctions for noncompliance? Must states receive plan approval before implementing, or can states implement while pending review as is the case under current Medicaid rules?

- Transition Incentives

  Plan reads:

  "Incentives are offered for states implementing reform prior to January 1, 1997. The incentives include:

  • Expedited federal consideration, with federal disapproval of state plans only if failure to comply with statutory requirements." **(p. 215)**

  - Does this mean that states will be permitted to avoid regulations issued after the statute is enacted? If so, how will federal oversight of these states be accomplished?

- Relationship to Health Plans

  Plan reads:

  "States must ensure that all consumers have the opportunity to purchase coverage under a qualified health plan at a price equal to or less than the weighted-average premium. To fulfill that obligation, states may either require at least some plans to cover the entire alliance area, or sub-alliance areas, or may provide a subsidy that allows consumers to pay only the weighted-average premium. Where no plan applies, the state must assure that at least one health plan is

***available for every eligible individual residing within an area."* (p. 51)**

- Do alliances have a role in requiring plans to be available throughout the state at a price equal to or less than the average-weighted premium? Since states are responsible for assuring not only a sufficient number of plans, but also that there be plans priced below the weighted average premiums, can states set up their own plans? If a state chooses to establish a subsidy mechanism, is that subsidy amount subject to the budget cap?

VI. OTHER

- The Retiree Subsidy Program

    - Can a retiree, upon reaching the age of 65, elect to remain in a corporate alliance? Could corporate alliance members who retire between the ages of 55-64 be eligible for subsidies provided through the retiree subsidy program that retirees in regional health alliances are eligible to receive?

- Cost Sharing

    Plan reads:

    "Health plans use standard consumer cost sharing requirements. Health plans may offer consumers one of three cost sharing schedules." **(p. 34)**

    - Are health plans restricted to only the three cost sharing schedules delineated in the plan? May individual plans offer more than one of the schedules?

THE WHITE HOUSE

Office of the Press Secretary
(Culver City, California)

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REMARKS BY THE PRESIDENT
AT AARP PRESIDENTIAL FORUM

Dr. Paul Carlson Memorial Park
Culver City, California

8:50 A.M. PDT

THE PRESIDENT: Good morning, ladies and gentlemen. Thank you all for coming today. I want to thank Judy Brown and the other board members of the AARP up here, and the AARP nationwide for their wonderful cooperation and work with the First Lady and our health care effort over the last several months.

There is no organization in America that better represents the needs and desires of older Americans than the AARP. I've been working with them for nearly 20 years now, and it won't be long until I'll be old enough to be a member. (Laughter.) So I have a vested interest in your lobbying on the health care plan.

I want to thank especially Mayor Mike Balkman and the people here in Culver City for their warm welcome to all of us today. I thank the Mayor. (Applause.) I'd also like to say a special word of thanks to your representative in the United States Congress who's here with me, and a great Congressman and a great ally in this fight for health care security, Congressman Julian Dixon. Congressman. (Applause.)

There are some people here from Congressman Waxman's district. I told him yesterday that since he had a longtime standing interest in health care I would mention today that the reason he's not here is that he's back in Washington having the next hearing on health care. So he took a red-eye back last night to do the work that we have to do.

Ladies and gentlemen, as all of you know by now, we have launched a major national debate on health care, with a proposal designed to achieve a disarmingly simple, but exceedingly complicated task -- to provide health security for all Americans, health care that can never be taken away, that's always there, for the first time in our history; and to do it be trying to fix what is wrong with our system while keeping and, indeed, enhancing what is right with our system.

The first and foremost thing is we have to have more health care security. There is an article today on the front page of many of the papers of the United States saying that last year there were more Americans living in poverty than at any time since 1962; that 37.4 million Americans have no health insurance; about two million Americans a month lose it, about 100,000 of them permanently because the system we have is coming unraveled. It is the most expensive system in the world, and yet the only advanced nation which doesn't provide basic coverage to all Americans.

We have gotten 700,000 letters to date, and we're getting about 10,000 more every week at the White House from people describing their personal experience and frustrations in problems with America's health care system. Not only American

health care consumers from parents with sick children to senior citizens who can't afford their medicine, but also from doctors and nurses who can't do what they hired out to do -- keep people well and treat them when they're sick -- from all the bureaucracy and paperwork that's in our system.

I have personally met many older Americans who are literally choosing every month between buying food and buying medicine. And I know that many of these people are actually, in the end, adding to the cost of the health care system because eventually they wind up having to get expensive hospital care for lack of proper medication in managing whatever health condition they have.

We received a letter and then I had a chance to meet a man named Jim Heffernan from Venice, Florida, who came to the Rose Garden a couple of weeks ago. He volunteers at a local hospice trying to help people understand the tangle of forms they have to fill out just in order to get the health care they're entitled to. And he wrote the following thing to me.

"I can recall one patient who was in tears and shaking because the hospital in her hometown had placed the balance of her medical charges in the hands of a collection agency and wrote that she might be sent to jail for failure to pay her hospital bill. This kind of senseless action on an elderly, terminal widow is unforgivable."

Stories like this need to be told over and over again in the halls of the Nation's Capital until, finally, we get action. Our plan will improve what is great about our health care system: the quality of our doctors and nurses; the depth of our research and our technological advance. Those things will not be interrupted. We will strengthen them. This plan has a lot of aspects which actually strengthen the quality of the American health care system; strengthen the stream of funds going to medical research to deal with the whole range of problems that now confront us -- everything from AIDS to Alzheimer's to various kinds of cancer.

We are committed to keeping what is best about this system. Indeed, more and more doctors and nurses who have had a chance to study this system say that we'll have more quality, because they'll have more time to practice their professions, they'll be able to spend less time filling out forms and hassling insurance companies.

I also want to say one thing -- (applause) -- there's one frustrated doctor starting the applause out there. (Laughter.) There's also one thing I want to say over and over again to the AARP membership of this nation. And that is that our plan maintains the Medicare program. It will protect your freedom to choose your doctors. (Applause.)

Let's face it: Medicare is one thing the government has gotten right, it has worked. And its own administrative costs for the government are pretty modest. There are a lot of problems with Medicare in terms of how doctors and hospitals and others have to deal with it, in light of the complexities of the health care system as a whole. But I think, on balance, the plan works well.

However, if you don't like some parts of your Medicare program today, I can say this: This plan will increase your options. It will give you a chance to pick from any of the health plans offered where you live, some of which may offer plans that are more comprehensive and less expensive than what you receive today.

Second, this health care security plan will give you the help you deserve in paying for prescription drugs. This plan, for the first time, will make people on Medicare who are

not poor enough to be on Medicaid eligible for help with their prescription drugs. (Applause.) It also will cover prescription drug benefits for working families. We believe this is important, and if coupled with a reasonable effort to hold prices down and to stop practices that we have in America today where some not experimental drugs, but well-established drugs made in America cost three times as much in America as they do in Europe -- that needs to be changed. If we can change that we can afford this benefit and still do what needs to be done. (Applause.)

The third thing that I want to emphasize is that this plan greatly expands your options for finding long-term care services in the home, in the community, in the hospital, not simply in a nursing home. We're not going to be able to do all of this at once. We have to work in the system and make sure we have the funding before we undertake programs we can't pay for. And so we phase in the long-term care benefit between 1996 and the year 2000, and we start the drug benefit right away.

But in the end, we have to have a comprehensive set of long-term care services. And again I will say, if we do it right it will save money. It is ridiculous for the only kind of long-term care to be reimbursed by the government that which is most expensive and which pushes people toward institutional care at a time when the fastest growing group of Americans are people over 80 and more and more people are more active longer.

I think here in California there's probably as much support for an active independent approach to long-term care as anywhere in the United States. And I want you to stay after it and make sure we maintain the commitment to long-term care and to choice in long-term care. (Applause.)

Let me make one last comment that I think is very important. This program also provides for coverage for early retirees. A lot of AARP members are people between the ages of 55 and 65 who have retired early and who don't have access to adequate health care now. Under our program, those people with incomes will have to pay up to 20 percent of their coverage, just like they would if they were in the workplace and uncovered, but at least they will have access to comprehensive services, with 80 percent contributions by the federal government. I hope that you will all support that. (Applause.)

Let me say finally that we are interested in passing a program that meets the basic criteria that I laid down in my address to the Congress. I have searched this country and the hundreds of people working with us who searched this country for better ideas: How can we continue to simplify this plan? How can we make it even easier to administer? But we must meet certain basic principles. The first one is security. We owe it to the American people, finally, to say that America will join the ranks of the other advanced nations and give every American health care that's always there that can't be taken away. (Applause.)

We have to simplify this system in order to pay for it. You live in the only country in the world that's spending at least 10 cents on the dollar -- now that's a dime on a $900 billion health care bill -- on every dollar -- that's $90 billion a year being spent on paperwork that no other country finds it necessary to have. Hospitals hiring clerical workers at four times the rate of direct health care providers. Doctors seeing their income from the money that comes into the clinic go from 75 percent of what comes in down to 52 percent in 10 years, the rest of it being taken away in a vast wash of paperwork and unnecessary bureaucracy. I tell you we can do better than that. And we have to do it. (Applause.)

We have to maintain quality. I've already addressed that. We have to maintain choice of physicians and other health care providers. I have addressed that. We will have to ask

every American to be more responsible. And those that have no health insurance today who aren't paying anything into the system, but who can afford to pay, should be asked to pay because the rest of you are paying for those.

There are people who say -- (applause.) -- and I want to emphasize this. People say, this will be terrible for small business. Folks, most small business people have health insurance. And I met a small businessman yesterday in San Francisco with 12 employees whose premiums went up 40 percent this year and he had no claims. Now, I'm worried about those small business people. They're going to go broke or have to dump their employees and make the situation worse. Those people are trying to do their part by asking everyone to do something in giving discounts to small businesses with low-wage workers -- we stop the sort of irresponsible shifting of costs onto the rest of you.

We also stop the practice of people getting health care when it's too late, too expensive and when things don't work right and shift back to preventive and primary care services so people can stay well, instead of just be cared for when they get sick. (Applause.)

Finally, let me say this. We have to achieve some savings, and that's been one of the most controversial parts of this proposal. People say, "Oh, you can't get any savings out of Medicare and Medicaid." I hope we can talk more about this, but let me just tell you how this program is paid for.

Two-thirds of the cost of this program will be paid for by contributions from employers and employees who pay nothing to this system today, but still get to use it when they get sick -- two-thirds of it. One-sixth of the money will come from a tax on tobacco and from asking big companies -- (applause) -- and from asking big companies that will still have the right to self-insure, because many of them have their costs under control and have adequate benefits -- they'll be able to continue to do that, but they will be asked, since their costs will go down, too, to pay a modest fee to pay for medical research and technology, and to keep the public health clinics of this country open to do the work that they will have to do. And then one-sixth of it will come from what we call savings.

But I want you to understand what's happening. Today, Medicaid and Medicare are going up at three times the rate of inflation. We propose to let it go up at two times the rate of inflation. That is not a Medicare or Medicaid cut. And we have kept private sector increases so that they won't go up as much. So only in Washington do people believe that no one can get by on twice the rate of inflation. (Laughter.) So when you hear all this business about cuts, let me caution you that that is not what is going on. We are going to have increases in Medicare and Medicaid, and a reduction in the rate of growth will be more than overtaken by the new investments we're going to make in drugs and long-term care. We think it's a good system. We hope you'll support it.

Let me just acknowledge two other people I just saw in the audience I didn't know were here. First, Congresswoman Lucille Roybaugh Allard. Thank you for being here. (Applause.)

Are there any other members of the California Congressional Delegation here? Congressman Martinez, stand up there. It's good to see you. (Applause.) I'm sorry. And I want to thank your Insurance Commissioner John Garamendi for all of the work he did to try to show us what's been done in California that we put into our plan. Thank you very much. (Applause.)

MS. BROWN: Thank you, Mr. President. We are, indeed, sorry that the current world situation prevents you from

staying with us as long as we had originally hoped. But we understand the constraints on your time. And we are, as I said before, absolutely delighted that you've been able to spend some time with us this morning.

Now to get to the discussion and the questions. I have asked for assistance from some of my colleagues who have become experts on the respective issues. We will begin now by focusing first on the impact of the plan on Medicare. I have asked Anne Jackson, who is Chair of the Health Care Committee of AARP's National Legislative Council to start the discussion.

Q Thank you. The first issue as has been identified, is what is the impact that the plan makes on Medicare. The President has also alluded to the fact that the Medicare program which began in 1965 has provided a measure of security and peace of mind for millions of our senior citizens. Another thing we have found is that, as you know, or as the President knows, he has reviewed our proposal that we have for a health care system. And we have found that with our health care system, our proposal at least, that it does provide care for all Americans, built on an expanded and strengthened Medicare system.

We also realize that our proposal is built on the strength of Medicare, which includes the positive aspects such as cost containment, universal care, long-term care and finally -- the words are evading me. The long-term care, the cost containment and administration, basically those are the ideas that we are concerned with.

The other thing that we need to know about our new proposal is that not only does it build on the positives, we have to be concerned with other problems that might be there. But needless to say, whatever we have is building on something that we know is working at this point and hopefully that corrections can be made at a later date.

One of the things that we know that our members are concerned with is whether or not there can be integration of the new plan that Mr. President has into or with Medicare. So, as I look out here at the audience, I wonder if some of you might have a question that deals with this issue.

We have a question from the audience?

THE PRESIDENT: He said much of the program is funded with cuts in Medicare; do I really think it won't affect the recipients? Absolutely.

Let me just tell you. We just adopted a budget in Washington which cuts defense deeply; just as much as we can and we shouldn't do a dollar more. But we have cut it dramatically. And that's one of the reasons the California unemployment rate is up, right, because defense has been cut since 1987. But there's a limit to how much it can be cut. It's cut, absolutely. It freezes all domestic discretionary spending. That is, if I want to put more money into defense conversion in California, or Head Start, or public health clinics, the Congress and the members here will tell you, they have to find for the next five years a dollar in cuts somewhere else for every dollar we want to spend in some new program.

The only thing we're increasing, except for the cost of living in retirement programs, is Medicare and Medicaid. Everything else is declining or frozen. And Medicare and Medicaid, under this budget that they just adopted, with an inflation rate of under four percent, Medicaid is projected to grow at between 16 percent and 11 percent a year, and Medicare at between 11 percent and nine percent a year.

In other words, over the next five-year period, both will grow at more than three times the rate of inflation. What

we propose to do is to let them grow at twice the rate of inflation, too. I think we can live with twice the rate of inflation. Yes, I do. Why? Because the rate of reimbursement increases to doctors and hospitals need not go up so fast in Medicare, because we're going to close the gap between Medicare in the private sector and what doctors and hospitals get. And they will actually save money because we're going to dramatically cut their administrative costs. So they will be getting a raise through reduced administrative expenses that they won't have to get through greater outlays of taxpayer money. And we're going to turn right around and invest that money and more into the drug benefit in the long-term care.

I don't know anybody who has really looked at this thing closely who doesn't think we can get it. Now, there may be people who try to stop us from getting it, but if we can't get a government health care program down to the point where it can run on twice the rate of inflation, we're in deep trouble. I believe we can, and the program explicitly provides that none of the benefits can be cut.

Q The issue of prescription drugs will be led by Jo Barbano, who is the National Chair of the AARP Legislative Council.

Q Mr. President, many Americans, including the older ones, cannot afford the prescription drug prices. According to the Pharmaceutical Manufacturers Association, 72 percent of Americans do not carry health care insurance for prescription drugs.

From 1980 to 1992, the rate of inflation on drug prices was 188 percent. What's it going to be without health care reform? Will that double?

THE PRESIDENT: Without it?

Q Without it. Is there -- are there any questions out in the audience?

THE PRESIDENT: On the drug issue. We want specifically questions on --

Q On prescription drugs.

Q I have a question. I realize -- agency -- target the older American population? Are very concerned that you have integrated into your plan, the Medicare plan that encompassed prescription drugs. We applaud you for that. We think you're wonderful and we just think you're fantastic, and I think we should give him a hand. (Applause.) There's one inclusion that we have forgotten about, and I'd like to personally ask you from the 84 older Americans -- I just finished a 15-city tour of older Americans. They were asking me this question.

The question was whether you would be including a cost containment on the drugs that are now being sold and drugs in the past. Will there be a limit or a cap on those drugs from the drug companies? Because they will increase. They are now at 69 percent. They -- $68 billion, I'm sorry -- and by eight more years, I don't know about you, but I'll be a senior citizen. And I'm really concerned, because in eight years it will increase to $145 billion. Thirty-eight percent of the older population buys those prescription drugs. And I'm wondering whether you're factoring that into your health care plan. Thank you.

THE PRESIDENT: Yes. We have sought and received assurances from many of the drug companies that for nonexperimental or non-newly developed drugs, which do -- it costs a fortune to develop a new drug and bring it to market.

And we all know they have to be priced at very high levels early on.

The thing that has bothered me is that other countries have cost controls on their drugs, and so we have companies from America selling drugs made in America in other countries with incomes as high as our elderly people have for prices one-third of what they're charging Americans. It's just not right. So we're trying to work through that. But a number of the drug companies, to be fair to them, have come forward and said, while you're implementing this program, we'll keep our cost increases to inflation. Then, when we get into the program, the drug services, like every other part of it, will be subject to significant pressures to stay within the rate of inflation or pretty close to it. But what the drug companies will get out of this program, they'll win big, because they will have people able to purchase drugs who never were able to do it before.

So what they give up on the rate of increase, they will make back in the volume of sales, if you see what I mean. So they're not going to lose on this deal, they're just going to have to stop increasing the same drugs more and stop charging people so much more for the same health care, but they'll be able to increase their volume.

I saw one person being critical of our health care program the other night on one of these C-SPAN forums that I watched. And he said, "Well," he said, "you know in Germany, the president's always talking about Germany, and they only spend 8.8 percent of their income on health care and we spend 14.5 percent, but they rely so much more on medicine." Yes, the do -- as a result of which they don't have to go to the hospital as much. (Laughter.)

So the way our system will work -- let me just briefly say -- is that the drug benefit itself, for elderly people, will have a $250 deductible and a co-pay, but no matter how serious the drug needs are, no one can be required to pay more than $1,000 a year. (Applause.) And, obviously, income needs will be taken into account. But we will also have the same benefit for people under 65 as for people over 65. To get the drug benefit, the Part B premium will go up modestly, but it will really help to provide that service to people.

I think it's going to make a huge difference in the quality of life to millions of elderly people. And I think it's going to reduce their need for more extensive care by giving them a maintenance schedule with the most modern medicines. And it will be good for the drug company -- it will be a good swap for them, to let their regular prices go up less, but to be able to sell more.

Q You were asking for information and those 25,000 older Americans that I just visited and were asking me these questions gave me a report to give to you today. Could I give that to your staff?

THE PRESIDENT: Absolutely.

Q Thank you.

Q Thank you very much. Now we're going to talk about long-term care which is something that is near and dear to our heart, Mr. President. We've asked Mildred McCauley, a member of our national board of directors, to discuss that with you.

Q Thank you, Mr. President. Today a one-year stay in a nursing home costs an average of $30,000 and as high as $60,000 in some areas. To the family sitting around the kitchen table there is only one critical difference between $30,000 hospital bill and a $30,000 nursing home bill. More often than

not, the hospital bill is covered by insurance, while the family must pay 100 percent of the nursing home care.

In addition, Medicare offers very little in the way of nursing home benefits. A relatively small percentage of individuals have private long-term care insurance. And for those who do, it's a very expensive and yields few benefits.

Is there anyone in the audience who has a comment or a question?

Q Good morning, Mr. President. My name is Anita Miller from the Alzheimers Association. And I'm here representing the thousands of care-givers from Los Angeles County. Could you address your commitment to increase funding for the prevention and treatment of Alzheimer's Disease? And also could you talk about the home and community-based long-term care in your plan?

THE PRESIDENT: Yes. Let me first say what was said here is absolutely right. As all of you know, who have ever had a family member affected by this, if you're older and you go to a hospital, you can get care covered by your policies or by Medicare. If you go to a nursing home, you basically have to spend yourself into abject poverty to get any benefits. And as a result of that, we've got a lot of folks in this country who are in trouble.

Also, the least expensive and best way to care for people might be in some community-based setting or at home and there are relatively limited coverages available for long-term care services. And Alzheimer's is a particular example of this because a lot of people want to care for their loved ones at home, or want them to be able to stay at home for as long as possible, but can't get any help in that regard. I'll come back to the research issue in a moment.

The way this program will work, the long-term care program, is that we will permit home and community-based care to be reimbursed just like nursing home care, number one. (Applause.) Number two, the programs will not be means tested. That is, if people have the ability to pay something, they'll be asked to pay, but they won't be cut out of the program because their income is above a certain amount. So that solves the whole Medicare-Medicaid differential issue.

Number three, in order to be eligible for Medicaid nursing home care, today you have to have -- there's a spend down limit of $2,000. You can only have $2,000 in assets to be eligible for 100 percent coverage under Medicaid. We're going to raise that to $12,000. And people who are in Medicaid funding in nursing homes -- funded nursing homes -- only get $30 a month in spending money -- $30 a month. In 1977, when I entered public life and became an advocate for people in nursing homes, they got $25 a month. You can imagine -- so in other words, in effect, people are getting less than half as much as they did per month in 1977. We propose to raise that to $100 which will take it back about to its 1972 levels.

So I think these things will work if we also provide better regulation and some tax preference for private long-term care insurance to supplement whatever people want or get from our government program. But this long-term care issue is a very big issue. Keep in mind, again, elderly people are the fastest growing group of our population. Most people will prefer not to be in an institutional setting if they can be cared for at home or in a community setting. (Applause.)

And again, I will say to you, this is another example where sometimes we strain at a gnat and swallow a camel. Yes, it will cost more money to start this program, but over the long run, 20 years from now our health care system in the

aggregate will be cheaper because we provide a wider range of care options and we don't shove everybody into the most expensive option to get any help at all. So that's how that will work.

Now, on the Alzheimer's question in particular, the way this system of funding works, we are going to develop a stream of funding that will increase our investment in medical research of all kinds, including research in the care and treatment of Alzheimer's. So you'll get more medical research. I will say again -- we have been driven here not to mess up what is right with American medicine and American health care. We want to enhance what is right and only focus on what is wrong in trying to deal with it. (Applause.)

Q Thank you for that response, Mr. President. I'm sure that you recognize that the issue of long-term care is one that is so very, very important to us, and that we will be reminding you about it. You can be sure of that.

THE PRESIDENT: You don't have to remind me, you've got to remind Congress. Because there will be people who say, "Well, now, wait a minute." And that's why I really thank the three members from California who are here today. They're going to have some tough decisions to make. You know, there will be a lot of people who won't want to go through some of these changes that we're recommending, and there will be a lot of people who say, well, let's just play it safe and take the -- we know the least expensive course. There will be those who say, let's take these reductions in Medicare and Medicaid increases, these savings from projected increases, and put them into paying for the regular package that the President has proposed, and think about long-term care and medicine some other day.

So we need you guys to show up and be heard in the Capitol to support the members of Congress who want to see this as a critical element of the ultimate resolution of our health care crisis.

Q You can be sure that we will do that, every opportunity we get. (Applause.)'

I've now asked Marie Smith, who is the Chair of the Economics Committee of the National Legislative Council to lead the discussion on cost containment.

Q Mr. President, and assembled group here, I have spent a lot of time, along with other members of AARP across the country, asking about health reform, what do you think about the AARP plan, about the President's plan. A lot of input has come in. But there is one word that comes up -- every group that we talk with, and it's cost -- and it's cost. And there's concern not only with people who are currently in the work force who are paying premiums that are going up -- the fear of losing a job or the fear of changing from one position to another. But there's also the fear of those who are receiving Medicare, Medicaid. We know that we've already, in the last budget, done some things with Medicare that will increase prices, although not directly. Medicaid persons are also very concerned. And even employers are concerned -- even the good ones who are trying to have a proper health care for their employees. They know that either they're going to have to let their employees go, or they're going to have to do something because their businesses are suffering.

And so this is a major issue. Some concerned about, is cost containment properly addressed in the plan? And I wonder if anyone out in the audience has --

Q My name is Bill Eisner and I'm an AARP retired county employee. Many Americans support your concept of health care reform. However, there is concern with cost containment, as mentioned, and its future impact on the budget. What provisions

are being built into the program to prevent runaway costs? Thank you, Mr. President.

THE PRESIDENT: Thank you. First of all, as all of you know, we have runaway costs now, both in the system as a whole and for individuals who are paying into it. To keep down individual cost increases, as well as systematic cost increases, we seek to do three things that we've factored in -- there are a lot of things we are doing, I want to try to emphasize this -- we think we'll get more cost containment than we have budgeted for, and I want to explain why.

Number one, if you simplify the system so that essentially every patient, every doctor, every insurer is dealing with a single uniform form, one for each category of people in the system, you will drastically cut the administrative cost of this health care system.

We were at the Children's Hospital in Washington the other day; one hospital in one city in America estimates that they spend $2 million a year, and enough time for their doctors to see another 10,000 children a year on paperwork that has nothing to do with the care of the kids or keeping up with their records necessary to monitor the care of the kids. That's the first thing.

Number two, if you cover everybody and require everybody to make some contribution to the system, that will stop a lot of the cost shifting. Keep in mind, a lot of your costs keep going up every year more and more and more because you are paying into the system, either through Medicare or through private insurance, and you pay for everybody else because the hospital shift their uncompensated care bills to you or to insurance companies who turn around and raise the price, or the government who comes around and raise the price. So through simple administrative simplification and stopping cost shifting you're going to have some savings.

Number three, as a backup, we also propose a cap, a limit on how much the cost of the system can increase in any given year, moving down towards inflation plus population growth over a period of years. But still, I will tell you, that we still believe -- this budget is very modest. We still project over the next five -- between now and the year 2000, the American health care system will go from spending 14.5 percent of our income on health care to about 18 percent, picking up the drugs and the long-term care. If we don't do anything we'll have no drugs, no long-term care, and be spending over 19 percent of our income on health care.

But those are very modest. Now, that means that we are calculating no savings from putting all the people in the country in these large buyer groups so that they can compete for lower prices. Look what happened to the California Public Employees Plan. Look how little their inflation was this year. The Mayo Clinic Managed Care Plan -- most people believe Mayo Clinic provides pretty good health care. You know what their inflation was this year -- 3.9 percent and their prices before they started were lower than the national average.

We don't calculate any of those savings in our budget. The things that will come from better organizing and delivering health care and giving consumer groups the right to bargain to keep their prices lower. We have an initiative to eliminate fraud and abuse, which is significant in this system. We calculate none of those savings into our budget.

So we believe we will easily make the budget because a lot of the things we're going to do that will save money we don't even try to claim credit for to try to bend over backward to be realistic. So I think we'll get there. (Applause.) But you're right, you've got to have cost control.

Let me just say one other thing. There's one other thing we need to help the AARP on. There are a lot of people in the Congress who say that limitations on the rate of increases amount to some sort of price controls and we shouldn't have them. But look what we've had so far. If you have a third party pay system, where the people who are working the system can get a check every time they send a bill, there are no normal market forces. You have to have some sort of discipline on the system. Now, I know the AARP favors that. And, again, I want you to help us get that when this bill goes to the Congress. We believe we will more than meet the cap that we've set. We don't think we can ever necessarily even meet that cap, but we better have it in the law so people will have to know they're going to have to manage their business better -- they can't keep breaking the bank. (Applause.)

Q Well, Mr. President, the time has passed so quickly. I believe it's now time, if you have some closing remarks.

THE PRESIDENT: Let me say, first of all, I think when I leave, Mr. Magaziner is going to come up here. Ira Magaziner who has been the sort of leading light of our health care efforts in the First Lady's group on health care, and who knows the answers to questions you haven't even thought of yet -- at least questions I haven't thought of yet --is going to come up here and spend up to another hour answering any questions you have about the specifics of our plan. So I hope that those of you here who are interested will stay and continue to ask questions. He and some others who have come all the way to California with me, who are working in our health care effort, are going to stay. So we want to encourage all Americans to ask questions and to give us our ideas -- their ideas. We don't pretend to have all the answers.

I just want to make two points in closing. Number one, I am not interested in having this become a partisan, political issue. I am profoundly grateful, for example -- (applause.) I am profoundly grateful to the distinguish Republican Senator from Vermont, Jim Jeffords, for announcing that he intends to be a cosponsor of our initiative. That's the kind of thing we need more of -- working together. (Applause.)

Number two, we've got to keep working on making this better the evidence of other countries is, but you have to keep working every year. But that's why we've built this in a phased-in fashion, so that the more we learn, the more we can make adjustments and the more we can make improvements.

The point I want to make, the two of you have already made out here in these questions is, if we do nothing, it will be more costly and less satisfactory than if we take steps. And, finally, let me say, we have to overcome the disbelief in America. A lot of folks don't think we can do this, but that's what they said when Social Security came in. People said we couldn't do it, but we did it. (Applause.)

I hold this health security card up all the time, but you just think -- if everybody had a Social Security card and a health security card, what a better country this would be, and how much better life would be for all the American people.

Thank you very much.

END 9:33 A.M. PDT

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