Congressional member

Q & A

MELANNE VERVEER

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THE WHITE HOUSE

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SENATOR MAX BAUCUS

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

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

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

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

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

SENATOR TOM HARKIN

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

- Rural areas have a much higher proportion of elderly residents than other areas of the country. As a result Medicare payments are an important source of income for the doctors and hospitals that serve these areas.

- If you were to look at the savings we are proposing to Medicare, in isolation, rural providers would have every right to be concerned. But you need to view this in the overall framework of the reform we are proposing.

- Rural doctors and hospitals will benefit enormously from the predictable payments that will result from all their patients having comprehensive insurance coverage.

- Some of the savings to the Medicare program will come from working beneficiaries who will now get coverage through their employers rather than through Medicare.

- Other savings to Medicare will come as we slow the overall growth in both public and private health care spending. These savings are not cuts in current levels of spending but reductions in the projected increases in Medicare spending.

- These savings are realistic and achievable without harming doctors, hospitals or patients.

SENATOR JOHN CHAFEE

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

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

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

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

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

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Response to Question from Senator Kennedy

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

Medicare

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

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

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

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

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

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

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

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

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

Reform and Competition will reduce Medicare costs.

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

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

Medicare savings will be used to provide new Medicare benefits.

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

Medicaid and Low-income Issues

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

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

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

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

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

Rationing

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

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

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

SENATOR TED KENNEDY

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

- Choice is a critical part of every doctor-patient relationship. That's why we're making sure that everyone has a choice of plan and a choice to remain with their doctor.

- If you want to stay with your doctor or hospital, you could choose the plan they signed up with. But, you'll also have a wider choice of plans - - from fee-for-service to preferred provider organizations to health maintenance organizations.

- Our doctors and hospitals deliver some of the highest-quality care in the world today. They do this in spite of the flood of paper and forms, and rules and regulations they have to wade through every time they try to treat a patient. We're stripping away the hassle in delivering care - - freeing up doctors and nurses and other health care workers to spend more time caring for their patients instead of worrying about crossing t's and dotting i's on forms for insurers.

- Patients will have an increased voice in ensuring that doctors and hospitals meet quality standards. Public accountability is one of the strongest motivators I know of to make sure that the job gets done right. That's what the report cards will do.

- Finally, we're investing more to find out what treatments really do work. Medicine is an art - - even though most people think it's a science. So much is unknown in what's practiced today, and sometimes the treatments are not always in the best interest of the patient. We need to take more of the guesswork out of medicine.

Senator Metzenbaum

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

A.

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

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

- No limitations on preexisting conditions.

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

Senator Metzenbaum

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

A.

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

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

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

Senator Metzenbaum

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

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

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

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

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

SENATOR HOWARD METZENBAUM

d. **How will excessive drug prices be controlled?**

- Prescription drug cost containment is one of the most difficult issues that we had to deal. Our goal has to find a way to contain costs while assuring adequate incentives for research and development. A number of Members believe we have been overly harsh with the drug industry and a number of others fear we have not been tough enough.

- **In the private sector,** after years of skyrocketing health care costs, health care plans -- particularly hospitals, HMOs, PPOs and other managed care plans -- have used purchasing mechanisms (such as formularies) to assure that the most appropriate and cost effective medications are prescribed and dispensed. In most cases, these techniques have been quite successful in finally containing costs.

- We will build on the success of these purchasers as we are reorienting the entire health care system towards true competition. However, like you, we remain concerned about the costs of breakthrough drugs -- medications that have no therapeutic alternatives with which purchasers can compete.

- To address this issue, as part of our National Health Board, we propose the establishment of a Breakthrough Drug Committee. This body will review new drug costs and have the authority to make public declarations about excessive drug prices. We believe this body will provide crucial information to both public and private purchasers that strengthen their bargaining hands, without regulating prices.

- **For the public sector,** by now being the largest single purchaser of prescription drugs, we believe the Medicare program should have access to a reasonable discount of between 15 and 17 percent. To protect the trust fund from an abnormally high priced new drug, the Secretary of Health and Human Services is given the discretion to negotiate with the manufacturer of the drug. If the company does not negotiate, Medicare does not have to cover the drug -- an option private sector purchasers make today. (Congress already gave her this authority earlier this year within the immunization provisions of the reconciliation bill.)

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

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

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

How?

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

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

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

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

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

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

Dodd
b.

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

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

- 30% of all children under two have not been immunized against preventable childhood disease. In many inner cities, that figure is 50%.

- One in five American children had no contact with a doctor in 1992.

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

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

Dodd
c.

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

- we don't think caps will come into effect, competition will bring prices below caps-- they are backstop

- mechanism already in place-- insurance premiums are regulated today

- easier and less regulatory than alternative approaches such as setting doctor and hospital fees

- same approach as advocated in bi-partisan legislation put forth by Kassebaum/Glickman

SENATOR PAUL SIMON

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

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

- With regard to research, we believe we have developed a policy that balances the need to expand access, contain costs, and retain incentives for research. Having said this, there are strong feelings on all sides of this issue.

- We welcome suggestions from all parties. In recent days, some representatives of the industry have suggested that they would like to suggest langauge on how best to evaluate drug cost effectiveness. They point out that some drug prices, although seemingly expensive, are much less costly than alternative treatment options.

- We look forward to receiving specific suggestions from the pharmaceutical industry, as well as advocates for consumers, businesses, insurers, and other interested parties.

SENATOR PAUL SIMON

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

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

- With universal coverage, rural doctors will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural practice.

- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.

- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers

c. **How will Federally Qualified Health Centers be protected and people be assured of their services? (Federally Qualified Health Centers are organizations like community health centers that now get cost reimbursement under Medicaid and Medicare.)**

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

- Under reform, health plans will contract with "essential community providers" so that all Americans – – regardless of where they live, what their income is, or what race or ethnicity – – will be guaranteed access to quality care.

- And, because everyone will be covered under our proposal, the patients that come to these clinics will now be paying patients – – at the same reimbursement rate as everyone else. This will provide a substantial boost in funding for these centers.

- Finally, we're increasing funding so that these centers can link up with other clinics in their area and with centers of excellence so that they can build their own community–based plans.

SENATOR TOM HARKIN

a. **Rural areas have historically had low spending. Does the budget lock in current inequties.**

- Coming from Arkansas, there are few people more sensitive to this issue than the President and me.

- Because we do no yet have the ability to fairly and equitably level the playing field among states, our budget allocations are based on historic spending patterns.

- However, we direct the National Health Board to initiative a study to the Congress and the Administration that is charged with developing a formula that brings states spending closer together. In recent weeks, a number of Members have suggested that we have a very specific reporting date and timeframe for action on this issue. We are looking at these suggestions very closely as we modify our plan.

Harkin
c.

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

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

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

SENATOR TOM HARKIN

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

- Over the course of this century we have seen that vast gains in the health of people worldwide from breakthroughs in medical research.

- As a leader in the Congress in this area, you well know that medical research and public health initiatives pay great dividends and are among the most cost-effective health care investments we can make.

- Your proposal to establish a medical research trust fund paid for from a portion of health premiums is a thoughtful and innovative approach to assuring a steady funding stream for these important efforts. I look forward to continuing to work with you on this issue.

SENATOR HARRIS WOFFORD

b. **What is the realistic timeframe for the paperwork reductions and administrative simplifications your plan proposes?**

- Some of the reductions we're proposing can happen almost immediately. Take the Medicare program - - one of the things I've heard hospital administrators complain most about is having to chase down doctors to get them to sign off on bills before they go out. That can hold up payment for days. I'll give you an example of what I mean - - the Lakeland Regional Medical Center in Florida estimates that this paper chase costs them $100,000 in personnel and supply costs alone. We can do this and look at other ways to streamline Medicare immediately.

- For the system-wide paperwork reductions, they'll be phased in as states get their systems up and running.

- And, even once the system is in place, we'll be continuously looking for ways to reduce the "hassle factor" for doctors, nurses and other health care workers. If you have any suggestions for how we can peel off the layers of paperwork, we'd welcome your input.

Senator Wofford

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

A.

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

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

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

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

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

SENATOR HARRIS WOFFORD

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

- Low-income seniors will benefit under the Health Security Plan in two ways: through a new prescription drug benefit and home and community-based long-term care services.

- For 3 out of 4 elderly Americans, the greatest out-of-pocket cost is prescription drugs. The vast majority of these low-income elderly have no insurance whatsoever against the cost of prescription drugs. Today, over 8 million elderly have to choose between food and medicine. We think this is a crime. By covering prescription drugs and making them affordable, this choice will no longer have to be made.

- The greatest fears of older Americans are that they will have to spend down their hard-earned savings in order to qualify for any long-term care coverage. And, the coverage they get is usually for the type of care they do not want -- nursing home care. The Health Security Plan provides for more cost-effective, humane and desirable home and community-based care that preserves and protects not only older Americans' incomes and savings but their dignity as well.

Mikulski
b.

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

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

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

How?

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

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

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

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

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

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

SENATOR BARBARA MIKULSKI

a. **How will your plan assure that alternate providers (e.g. nurse practitioners) will be allowed to fully participate in delivering services?**

- In a country that trains too many specialists and not enough primary care providers, we cannot afford to waste a resource as valuable as advance practice nurses.

- Nurse practitioners, nurse midwives and physicians assistants, along with primary care doctors, are at the center of our efforts to emphasize primary and preventive care.

- Our plan will work to remove inappropriate practice barriers so that all health professionals can work to the full scope of their training.

Mikulski
c.

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

- growing elderly population, this is a problem that won't be solved overnight

- this plan takes significant steps toward extending availabiity and affordability of long-term care for seniors

- creates new federal home care program, providing home and community-based care to elderly and disabled

- adds a drug benefit to the Medicare program, lifting a major financial burden off of the backs of many seniors

- strengthens protections for nursing home recipients

Mikulski
d.

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

- unlinks access to health care from employment status, health status, marital status

- offers full coverage of primary and preventive care for women such as pre- and post-natal care, mammograms, Pap smears, cholesterol screenings, etc.

- directs new research funds into illnesses that strike primarily women, such as breast cancer, redressing the lack of research attention that has been paid to women's health problems in the past

- offers broad coverage for children and new benefits for seniors, helping ease the caregiving budren on American women today

Response to Senator Bingaman

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

Taxing health benefits hurts the middle class

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

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

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

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

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

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

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

SENATOR JEFF BINGAMAN

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

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

- With universal coverage, rural doctors will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural practice.

- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.

- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers

SENATOR PAUL WELLSTONE

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

- For HMOs, there are no deductibles, but some advocates have raised concerns about the $10 co-payment per service requirement.

- For the lowest income of our nation, (150 percent of poverty or less), the Health Security Plan picks up all or most of this vulnerable population's premiums and co-payments. We believe this is an important protection for the low income of our nation.

- However, some still believe that the co-payment is too high for some lower middle income class individuals. We believe this is a legitimate concern and would like to work with you and others to evaluate options to address it.

SENATOR PAUL WELLSTONE

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

- We believe that in the reformed health care delivery system that it is very possible that fee-for-service plans will be competitive with managed care options.

- With the operation of market forces, Doctors and hospitals that wish to assure the success of the fee-for-service plan will find a way to keep costs down so and such a plan can be offered at prices competitive with HMOs and PPOs.

- However, in response to feedback we have received from your office and a number of others, we are considering of providing for some kind of point-of-service option for closed model HMOs plan.

Senator Kassebaum

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

A.

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

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

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

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

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

SENATOR KASSEBAUM

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

- Our doctors and hospitals deliver the highest-quality care in the world. That's because we have long encouraged research into new cures and treatments for diseases.

- We'll continue to encourage innovation, but we want to also ensure that patients are protected from both the costs and the dangers of experimental procedures that are unsafe.

- Approved research trials achieve both goals - - they advance medicine and lead to new cures and treatments, but they're also safe. The comprehensive benefits package covers the routine medical costs for patients whose treatment is part of a research trial. So, if your child needs a bone marrow transplant and that's approved, your child will have the benefits of the best that science has to offer and you will have the comfort in knowing that your child is in safe hands.

- The National Health Board will have the authority to add new procedures to the covered benefits as they as proven safe and effective.

SENATOR NANCY LANDON KASSEBAUM

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

- Our plan lays out specific line item savings. They have been scored by the Office of Management and Budget and they will be scored by the Congressional Budget Office.

- Let me also say that over the last eight months, I have talked to hundreds of people involved at all levels of our health care delivery system. I have heard stories about waste and inefficiency to numerous to mention. I have also heard success stories where doctors and hospitals are working to hold cost down, far below the national average.

- We must and we can spend our health care dollars more wisely.

DIETARY SUPPLEMENTS

SENATOR HATCH:

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

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

POSSIBLE HRC RESPONSE:

- Senator Hatch, I agree with you that dietary supplements can be valuable in promoting health. I believe in vitamins and take them on a regular basis. I believe that the decision to use these products should be left largely to American consumers. As long as supplements are safe, people should have the right to purchase them.

- But I am sure that you share my concern about false and misleading claims that some have made about these products by those who are attempting to make money off of sick and desperate people. We need to strike the proper balance between getting accurate information to people about the value of these products and prohibiting false and misleading claims.

- The Clinton Administration looks forward to working with you on how best to achieve this balance.

Background on Dietary Supplements

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

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

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

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

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

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

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

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Rockefeller (D-WVA)

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

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SENATOR MAX BAUCUS

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

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

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

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

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

SENATOR MAX BAUCUS

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

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

- With universal coverage, rural doctors will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural practice.

- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.

- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers

Baucus

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

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

SENATOR MAX BAUCUS

ISSUE: **Impact on small businesses**

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

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

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

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

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

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

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

Senator Boren

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

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

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

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

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

SENATOR BILL BRADLEY

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

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

SENATOR BRADLEY

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

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

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

Senator Breaux

1. Global budget - concern that budget will dictate insurance behavior and that premiums will be set at cap from the beginning

   - We do not believe that the budget enforcement mechanism will ever be used. It is simply a backstop and provides employers and consumers with greater bargaining power.

   - There is evidence from other public and private systems that competitive forces can and will result and premiums that are below the budget targets.

   - Since consumers will choose plans based on price and service, health plans will be under strong competitive pressure to keep premiums below the budget targets. Consumers are paying out of pocket to enroll in more expensive plans.

Senator Breaux

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

   - The opposite is true. With limited exceptions, alliances must offer all health plans that want to participate.

   - States will qualify health plans, as they do today.

   - The real function of alliances is to give employers and consumers the same bargaining power large groups have today.

   - We have examples of this working today -- for example, CALPERS or the public employees program in Minnesota.

Senator Breaux

4. What is the financing mechanism?

- Uninsured workers and their employers, approximately 30 million people, will contribute under the new system.

- Savings from slowing the rate of growth in Medicare and Medicaid, as we phase in the new system, will also be available.

- The tax on tobacco and the contribution from large corporations that choose to self-insure to help support the health services that they use, such as academic health centers.

Senator Breaux

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

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

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

Senator Breaux

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

   - Without the enhanced retiree heath benefit, early retirees would be treated like other non-workers under the President's plan. Since many retirees have low incomes, they would receive substantial subsidies anyway. The $4 billion figure represents the additional cost of the enhanced benefit.

   - Our cost estimates are prudent, and build in the expense of expected increases in retirement as a result of the plan.

Senator Breaux

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

- All benefits in the nationally guaranteed package are tax deductible and not counted as income for employees. Additional benefits now offered are also not taxed, for a period of ten years.

- Our nationally guaranteed benefits are comprehensive, and are comparable to those now offered by Fortune 500 firms. The package meets all of the needs of the vast majority of Americans.

- Ultimately, employer-paid benefits over and above the guaranteed package should be treated just like wages -- tax deductible for employers but counted as income for employees.

SENATOR KENT CONRAD

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

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

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

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

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

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

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

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

SENATOR KENT CONRAD

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

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

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

SENATOR KENT CONRAD

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

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

SENATOR DASCHLE

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

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

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- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.

- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers

SENATOR DASCHLE

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

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

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

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SENATOR GEORGE MITCHELL

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

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

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

-- Of that amount, $259 billion is money the federal government is already spending on coverage for working people on Medicare and Medicaid. Their coverage will now be paid for by their employers and this money will be redirected to the alliances to help pay for their care.

-- $169 billion is needed to insure that health insurance premiums are affordable for small businesses and people with low incomes.

-- $80 billion goes to pay for the new home and community-based long-term care services.

-- $72 billion pays for the new prescription drug benefit under Medicare to improve security for older Americans.

-- $29 billion is spent on public health initiatives and administration of our program.

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

SENATOR MITCHELL

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

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

- With universal coverage, rural doctors will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural practice. Further, rural hospitals will see increased per person payments as Medicaid rates are spread across all consumers in the alliance area, including private-paying consumers.

- In addition, the plan will include specific incentives for doctors to practice in rural areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to rural needs.

- The plan will also help break the isolation of rural doctors by encouraging networks with regional medical centers, hospitals and other doctors. Technologies such as interactive video will give rural residents access to the kind of care once available only at major medical centers.

SENATOR DANIEL PATRICK MOYNIHAN

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

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

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

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

Moynihan

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

- New government spending -- for increased benefits for the elderly and for discounts for small businesses and low income families -- will be financed by the federal government.

- States are expected to continue spending what they are today under Medicaid for the nationally guaranteed benefits. But state spending will be limited over time at a much lower rate than today.

Moynihan

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

- We expect the premiums paid into alliances by states for Medicaid recipients to increase at the same rate as private premiums.

- But since the Medicaid population is expected to grow faster than the general population, Medicaid spending in total will increase and as a percentage will rise faster than private spending.

SENATOR DANIEL PATRICK MOYNIHAN

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

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

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

SENATOR DANIEL PATRICK MOYNIHAN

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

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

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

SENATOR DANIEL PATRICK MOYNIHAN

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

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

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

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

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

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

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

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

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

SENATOR DANIEL PATRICK MOYNIHAN

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

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

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

SENATOR DANIEL PATRICK MOYNIHAN

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

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

- With universal coverage, these providers will be guaranteed that they'll be paid for every patient they see, eliminating a major disincentive to rural and urban practice.

- In addition, the plan will include specific incentives for doctors to practice in rural and urban areas including expanding the National Health Service Corps and its loan repayment program and incentives to medical schools to train primary care doctors. It also gives states the flexibility to develop programs that are more responsive to needs of underserved areas.

Moynihan

QUESTION:

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

ANSWER:

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

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

Bunning

QUESTION:

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

ANSWER:

- Mr. Chairman, while I very much appreciate your concern for the Medicare program and the integrity of its financing, I do believe the issues are separable.

- Medicare is a payroll tax funded program. It is a pay-as-you-go system. Young workers pay a tax to cover the expenses of today's retirees. Years from now, tomorrow's retirees will be supported by the generations behind them. The proposal we made in Reconciliation was meant to shore up the solvency of the Medicare trust fund for years into the future. That was an important change.

- In our health reform plan, by contrast, each individual is responsible for paying their own health insurance plan premium. If they work, their employer will contribute toward that premium. If they are low income, we will subsidize that premium. And if their employer is a small business or low wage firm, we will subsidize that contribution, too.

- We chose this method because it is the way people under 65 purchase health insurance coverage today.

- It is possible that some high income people will pay more in Medicare taxes -- or more in income taxes or more in their home mortgage -- than they do for their health insurance premium. We must be careful not to compare apples and oranges in weighing the significance of these differences.

Senator Moynihan

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

- The beginning point for alliances in each state is the real cost of providing the guaranteed benefits in that state today, with increases for those now uninsured. This is fair.

- Over time, premiums in every state will be held to the same rate of increase -- inflation in the rest of the economy.

- The National Health Board will provide information to alliances on cost differences, and may make recommendations to narrow those differences.

SENATOR JAY ROCKEFELLER

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

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

SENATOR JOHN CHAFEE

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

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

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

SENATOR CHAFEE

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

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

- Under reform, health plans will contract with "essential community providers" so that all Americans – – regardless of where they live, what their income is, or what race or ethnicity – – will be guaranteed access to quality care.

- And, because everyone will be covered under our proposal, the patients that come to these clinics will now be paying patients – – at the same reimbursement rate as everyone else. This will provide a substantial boost in funding for these centers.

- Finally, we're increasing funding so that these centers can link up with other clinics in their area and with centers of excellence so that they can build their own community-based plans.

SENATOR JOHN DANFORTH

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

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

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

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

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

Danforth

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

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

SENATOR DAVE DURENBERGER

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

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

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

SENATOR DAVE DURENBERGER

ISSUE: **What will happen to federal entitlements?**

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

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

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

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

Senator Grassley

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

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

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

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

For Hatch

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

A:

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

Mrs. Clinton:

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

SENATOR BOB PACKWOOD

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

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

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

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

SENATOR BOB PACKWOOD

ISSUE: **Could Oregon implement its plan which limits services?**

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

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

Packwood

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

- The beginning point for alliance premium targets in each state is the real cost of providing the guaranteed benefits in that state today, with increases for those now uninsured. This is fair.

- Over time, premiums in every state will be held to the same rate of increase -- inflation in the rest of the economy.

- The National Health Board will provide information to alliances on cost differences, and may make recommendations to narrow those differences over time.

- Some compare these premium caps to payments by Medicare to providers or health plans. But the two are different.

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

SENATOR BILL ROTH

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

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

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

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

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

SENATOR WALLOP

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

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

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

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

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

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

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

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

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

SENATOR MALCOLM WALLOP

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

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

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

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POLICY BRIEF

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

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

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

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

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

What's Wrong With the Current System

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

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

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

- Insurance companies charge small businesses as much as 35% more than the big guys.
- Only 3 of every 10 employers with fewer than 500 employees offer any choice of health plan. Millions of Americans have almost no choice today.

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

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

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

The Health Security Plan

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

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

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

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

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

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

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

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

Principle #1:
Security: Guaranteed, comprehensive benefits.

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

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

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

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

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

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

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

Principle #2:
Savings: Controlling health care costs.

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

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

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

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

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

- **Reduces paperwork**. All health plans will adopt a single, standard claims form by Jan. 1, 1995. Along with other measures to streamline the system and free nurses and doctors from excess bureaucracy, this will reduce paperwork, cut red tape, and save money.

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

Principle #3:
Quality: Making the world's best care better.

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

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

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

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

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

- **Increases funding for prevention research**. The National Institutes of Health (NIH) will expand research in areas like children's health, and health and wellness promotion. Preventive care keeps people healthier and saves money at the same time.

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

Principle #4:
Choice: Preserving and increasing what you have today .

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

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

- **Puts consumers in the driver's seat**. The Health Security Act brings competition to health care -- unleashing the market forces that will lower costs and improve quality. Giving small

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

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

Principle #5:
Simplicity: Reducing paperwork and cutting red tape.

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

- **Requires insurance companies to use a single claim form.** The Health Security Act will reduce the insurance company red tape that forces doctors and patients to spend their time filling out forms and fighting bureaucrats. All health plans will adopt a single, standard claims form by Jan. 1, 1995. It will enable doctors and nurses to spend more time taking care of you -- and less time wrestling with paper.

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

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

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

Principle #6:
Responsibility: Making everyone responsible for health care.

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

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

- **Emphasizes preventive care.** The Health Security plan puts a new emphasis on preventing illness before it becomes a medical crisis. Prevention will improve the quality of care by helping people stay healthy rather than treating them after they get sick. It offers you full coverage of a wide range of preventive services, but asks you to take responsibility for keeping yourself healthy.

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

- **Everyone contributes, and no one gets a free ride**. In America, rights and responsibilities go hand-in-hand. Everyone will get a Health Security card that guarantees you a comprehensive package of benefits that can never be taken away. But we will ask everybody to pay something, even if your contribution is small. Small businesses and low-wage workers will get substantial discounts on the cost of insurance, but everyone must take responsibility.

HOW THE SYSTEM IS FINANCED

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

The system is financed from five major sources:

1) Medicare savings -- The savings from reducing the growth of Medicare are based on specific, scorable policy proposals. Every penny of these savings will be channeled back into benefits -- prescription drugs and long-term care -- for the people which these programs serve.

2) Medicaid savings -- The rate of growth of Medicaid can be reduced primarily by folding the acute care portion of Medicaid into the overall health care system. Since everyone will be insured, there will be savings in "uncompensated care" -- the money that goes to doctors and hospitals to compensate for caring for the uninsured.

3) Savings from federal employee health care costs -- As all federal workers are integrated into the overall health care system, there will be less expense to taxpayers to provide for their health care.

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

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

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

PAYMENT SCENARIOS

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

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

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

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

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

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

EXCEPTIONS

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

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

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

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

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

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

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

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

QUESTIONS AND ANSWERS

THE COSTS OF DOING NOTHING

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

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

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

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

I'VE GOT GOOD INSURANCE

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

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

People who like their health insurance today will also get

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

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

WHY NOT SINGLE-PAYER?

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

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

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

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

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

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

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

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

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

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

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

GOVERNMENT REGULATION

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

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

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

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

EMPLOYER VS. INDIVIDUAL MANDATE

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

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

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

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

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

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

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

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

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

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

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

AN UNTESTED PLAN

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

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

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

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

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

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

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

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

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

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

Clinton Presidential Records
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