THE NEED FOR REFORM

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THE NEED FOR REFORM

THE NEED FOR REFORM:
PRINCIPLES

Five principles must underlie health reform: *security, cost control, quality, choice,* and *simplicity*. Today's system falls short of these goals and fails to give the American people the security and protection they deserve.

- **Security:** Health reform will be guarantee all Americans health security no matter where they work, what they earn, where they live, how old they are or whether or not they are healthy.

  The current system denies health security to millions of Americans. They are rejected as "uninsurable," frozen out because of the job they hold, or forced to continue in jobs because they have illnesses that insurers don't want to cover. If not covered by insurers, one illness can wipe out the resources of a family.

- **Cost Control:** Health reform must bring down the rapidly rising cost of health care to make it more affordable for consumers and businesses.

  The amount the average American family spent on health care doubled over the last decade and will double again by the year 2000 if nothing is done to control costs. For businesses, health care costs have been rising by almost 15% every year -- for small business at much greater rates. This has caused wages to be depressed and the U.S. to lose its competition in the world economy.

- **Quality:** Health reform must assure American consumers of the highest quality medical services and the system must encourage greater emphasis on primary and preventive care as well as innovation in treatment and technology.

  Today, insurers compete to insure the healthy and avoid the sick, rather than competing on quality and service. Consumers cannot compare doctors and hospitals because information about quality is not available. Too little is invested in preventive care and research into lifesaving treatments.

- **Choice:** Health reform will ensure that Americans have the right to choose their own doctors and to select a health plan that suits them best.

  With a growing number of insurers using exclusions for preexisting conditions, arbitrary cancellations and hidden benefit limitations, consumers have few choices for affordable policies that provide real protection. [Workers who have coverage through their job increasingly are offered a single, employer-chosen plan.

- **Simplicity:** The system will be simple enough for consumers to understand their health plan, how much it costs and how to use it. It will also free doctors from burdensome paperwork and allow them to focus on treating patients.

  The complexities of reimbursement, fragmented coverage and care, and case-by-case cost control produce a paperwork nightmare and ballooning administrative expenses that confound consumers and providers alike. Over 20% of payments to doctors go to cover administrative expenses.

Comic book
* Illustrators + copywriters
Mr + Mrs America.
Bob Kerry.
[redacted]
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THE NEED FOR REFORM:
INSECURITY

- Working Americans face a growing threat to security from the uncertainties created by the health insurance system. Even people with good health insurance coverage cannot count on protection if they lose or change jobs, especially if someone in their family has a pre-existing health condition.

- The number of Americans who are uninsured has been growing dramatically. At any one time in 1988, 33.6 million Americans had no insurance; now the number is closer to 40 million.

- As a result of rising premiums, many small and mid-size firms have been forced to cut back or eliminate coverage. Nearly one of every three small employers say they expect that rising costs will soon force them to stop offering health care, according to a 1991 Harris survey.

- A 1993 survey conducted for the Kaiser Family Foundation asked low-income Americans to name their biggest worries. Their top concern was paying doctors' bills; five of their ten biggest worries involved health care costs.

OBJECTIVES OF REFORM: Provide Health Security for all Americans. No American will lose insurance coverage because of preexisting conditions, because of sickness or health conditions. Complete portability: no gaps in coverage because of unemployment, change of jobs, change of family status, or change of residence. Provide family security when facing expensive long-term health care needs.

THE NEED FOR REFORM:
RISING COSTS

- Rising health costs mean lower wages, higher prices for goods and services, and higher taxes. Yet few Americans realize how much they are affected. The average worker today would be earning $1,000 more a year if the cost of health insurance had not risen faster than wages over the previous 15 years. If the cost of health care continues at the current pace, by the year 2000, wages may go down another $650 [OMB].

- The practice of "experience rating" drove up rates for employee groups with older and less healthy workers.

- Small firms also pay an exorbitant amount for insurance administration. For firms with fewer than five workers, 40 cents out of every premium dollar pays for administration.

- Health costs create a major burden for American business, particularly manufacturing companies with older workers and large numbers of retirees. National health reform will strengthen American competitiveness.

- Rising health costs have become the principal threat to the long term fiscal health of the federal and the states. Without reform, rising health costs will force the elimination of other programs and raise the federal deficit. Projections are that health spending will consume 111 percent of the real increase in federal tax revenues collected over this decade.

- Since 1980, health care has consumed an additional 1 percent of gross domestic product every 35 months. Between 1980 and 1992, health expenditures shot up from 9.1 percent to 14 percent of GDP; under current policies, they will hit 18.6 percent by the year 2000. [OMB]

- Other industrialized countries spend, on average less than 8 percent of their GDP on health care. U.S. health costs are nearly twice high and are growing at a faster rate compared with major European countries with comparable medical standards. Over the last decades, health costs grew more than twice as fast here as they did in Germany.

OBJECTIVES OF REFORM: Control rising health costs to a level the economy can sustain. Health reform will create incentives for greater efficiency so that overall health care costs increase no faster than the rest of the economy.

THE NEED FOR REFORM:
QUALITY THREATENED

- Attempting to assure quality has resulted in a bloated insurance bureaucracy that has become an oppressive regulatory nightmare for providers with mountains of forms, numerous levels of review, yet provides little useful information to consumers about quality.

- The system is biased toward specialty care, rather than more cost-effective preventive and primary care.

- Innovation in the delivery of health care revolves around "gaming" the system -- shifting costs, cutting corners or self dealing -- rather than improving quality of care or controlling costs.

OBJECTIVES OF REFORM: Assure quality of care and promote innovation. Health reform will create a competitive market that rewards quality and innovation. It will empower consumers to enforce quality providers and health plans by providing them with information on performance and patient satisfaction. Enhance investment in biomedical research to develop less costly and more effective alternatives for diagnosis and treatment.

THE NEED FOR REFORM:
DIMINISHING CHOICES

- As insurance companies have increased the use of preexisting condition exclusions and other limitations on coverage, individuals and small businesses have had with fewer choices among affordable health insurance policies that provide good benefits and offer real protection.

- Small businesses that provide insurance to their workers have a difficult choice to make when an employee becomes seriously ill. They can retain their policy but pay huge premium hikes each year; drop the policy and try to find other coverage, exclude the sick worker from the policy; or go without insurance.

- Individuals who purchase insurance outside a large group face essentially the same unsatisfactory choices as small businesses.

- Insurance coverage for most Americans is not a matter of choice at all. In most cases, they are limited to whatever policy their employer offers.

OBJECTIVES OF REFORM: Preserve choice of providers and increase choice of health plans. Health reform will restructure the insurance market to create a competitive environment which rewards service and efficiency and eliminates competition based on avoiding risk. It will provide choice of high quality health plans to deliver comprehensive benefits to individuals and small businesses. It will preserve the right of all Americans to choose their own doctors.

THE NEED FOR REFORM:
GROWING COMPLEXITY AND INEFFICIENCY

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

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

- Small business owners face the same difficulties working through the insurance maze. For firms with fewer than five workers, 40 percent of health care premiums go to pay administrative expenses.

- Doctors and other providers are frustrated by growing interference with their decisions about medical care. A bloated administrative system has developed in which checkers check checkers on work done by doctors they have never met, and care given to patients they've never seen. Time and money that could be devoted to treating patients is spent pushing paper instead.

- Administration has become increasingly complicated. No standard forms exist for enrollment, reimbursement, and other functions. The typical hospital bill might as well be written in hieroglyphics. Not even the hospitals' computers can talk to each other.

OBJECTIVES OF REFORM: Simplify administration and reduce paperwork and red tape. Health reform will provide a universal health security card which guarantees a standard, comprehensive benefit package for all Americans. It will create simple standard enrollment and claim forms, expand the use of computer information systems for medical records, claims and billing, while protecting patient confidentiality. It will develop results-oriented methods to assure quality and replace micromanagement of providers.

THE NEED FOR REFORM:
THE HISTORY OF HEALTH REFORM IN THE UNITED STATES

Health care reform has been on the American agenda for nearly a century. Since the early 1900s, commissions, committees, groups and organizations have put forth proposal after proposal to overhaul the way the nation delivers and pays for medical care. Over time, the forces of opposition have shifted, somewhat, as have their arguments against change. Remarkably, the solutions to the American health care problem have been clear from nearly 75 years. What has eluded us is the political will to tackle the health care problem once and for all.

Early Attempts at Reform:

A group called the American Association for Labor Legislation made the first large scale proposal for health care reform in 1915, starting a national discussion on reforming the way health care was paid for and delivered. The group put forth nine principles for reform. **Its recommendations: employers, employees and government should share in the cost of an integrated health care system; the system should focus on prevention rather than cure; and people should have protection against bankruptcy if they become disabled.**[1]

Early opposition came from insurers, who, although they didn't sell health insurance, said they hadn't been included in formulating the plan and who feared loss of business. In the wake of American involvement in World War I, opponents of national health insurance associated reform with Germany, which had begun a system of national health insurance in the late 1800s.[2]

Continued pressure from the insurance industry, coupled with anti-German sentiment, pushed national health insurance to the back burner for more than a decade.

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[1]A Chronology of Health Insurance and Health Care Financing Reform, The Alliance for Health Reform, November 1992

[2]In 1883 Germany's Prince Bismarck launched the world's first social insurance program, which included health coverage.

The Roosevelt Era:

As the Great Depression took hold, more and more Americans found themselves unable to pay for needed medical care. Hospitals took the lead in sponsoring pre-paid health care plans.

In 1932, blue-ribbon commission called the Committee on the Costs of Medical Care urged comprehensive reform. **Its proposal: create a national network of community care centers to replace the fee-for-service system of individual doctors in separate practice.** Around the same time, President Roosevelt began his own push for national health insurance. His landmark social legislation, the Social Security Act, was to include provisions for national health insurance shaped largely by the committee's report. But the AMA attacked the proposal, and President Roosevelt was faced with the choice between abandoning his plans for national health insurance or risking defeat of the entire Act. FDR decided not to include the health reform provisions, vowing to fight for national health insurance in his second term. But when Congressional elections weakened the original New Deal coalition in 1938, Roosevelt abandoned her plans for reform.

During World War II, as wage and price control policies led more employers to compete for workers by offering health insurance benefits not subject to controls, Congress introduced a bill to create a national government health insurance program within Social Security. FDR pledged to make passage a top priority after the war.

The Truman Era:

After the President's death in April 1945, President Truman vowed to continue FDR's fight for national health reform. In November he introduced a large scale plan. **His proposal: federal aid to build new hospitals, increased federal support for public, maternal and child health, and-- for the first time-- universal, compulsory federal health insurance.** In response to questions about the programs high costs, President Truman noted that the U.S. spent only 4 percent of its gross national product on health care and "we can afford to spend more."

For several years, President Truman fought for passage of his national health reform bill. Initially, public support was strong, but opposition brought together organized medicine, big business and the media to sway public opinion. Pieces of the plan were broken off and passed, such as the Hill-Burton Act, which in 1946 increased federal funding for new hospital construction, and federal aid for maternal and child health.

The Truman plan was re-introduced in 1948, and legislative inaction caused the President to rail against the "do-nothing Congress." The opposition was well organized and effective, labeling reform "socialism." The Cold War and anti-communist mood of the country, along with foreign upheavals distracted Americans and their leaders. The movement lost momentum, and the coalition that had pushed for reform disintegrated.

Another factor that dampened the push for national health reform after the war was that increasing numbers of Americans had health insurance through work. Though health coverage was increasingly common through work, changes in the insurance market sowed the seeds for many of the most devastating inequities in today's health insurance market. Commercial insurance companies-- those that sold fire and home and life insurance-- entered the health insurance market, challenging the Blue Cross and Blue Shield plans that traditionally provided health insurance.

The Blues had traditionally set premiums based on a "community rating"-- spreading the health costs of an entire community evenly and fairly among all members. They also offered "open enrollment" taking all applicants who wanted to buy insurance regardless of their health status.

Commercial insurers competed by using different practices. They adopted "experience rating," basing premiums on a group's claims history, and "medical underwriting" using the age and health status of a groups' members to anticipate the risk of future claims. This change in approach to rating and underwriting practices allowed the commercial insurers to undercut the "Blues" by offering firms with young, healthy workers lower rates, a practice now known as "cherry picking". This process increasingly left the Blues and other community-rated insurers with fewer healthy members until they began to abandon community rating and play by the new rules.

Health care costs began to rise during the 1950s, making health care services increasingly inaccessible to the two groups least likely to have coverage through a job-- the poor and retirees. In 1958, legislation was introduced to help extend coverage to these groups. That movement would eventually lead to the passage of Medicare and Medicaid.

President Kennedy advanced the health reform cause in the early sixties, and the AMA again bitterly opposed what they "socialized medicine". Despite opposition from organized medicine, President Johnson signed Medicare and Medicaid into law on July 30, 1965. Medicare extended health insurance coverage to people over 65 and those with disabilities. Medicaid expanded and reorganized federal assistance to the states to care for the poor. These laws were seen as important first steps toward national health insurance for populations at most risk. Working Americans were perceived to be less vulnerable because employers provided adequate health benefits.

A shortage of doctors, nurses and other health professionals in the mid-1960s produced laws that began federal financial help for training health professionals.[3]

The Nixon Era and Beyond:

Until the 1970s, health costs were not a major focus of reform. In fact, most reformers argued in favor of more on health care. A number of factors -- high rates of inflation, slow economic growth, an explosion of medical technology, an increasing number of specialized health providers and the Medicare program --pushed the total economy spent on health care increasingly higher. With the election of 1968, the push for national health insurance was revived for the fourth time. For the first time, the focus shifted from expanding services to controlling costs.

President Nixon embarked on a health reform agenda aimed at: **expanding managed care to change incentives in which "doctors and hospitals benefit most from sickness, rather than health" establishing universal coverage by requiring all employers to provide at least a minimum health benefit and establishing a federal insurance program for the working poor and unemployed. The administration's legislation all introduced by Senator Bob Packwood and Representative Wilber Mels.**

President Nixon's health reforms almost passed with bi-partisan support. The public had grown increasingly alarmed about the crisis in health care. However the oil shock of 1973, the political demise of the Ways and Means chairman, and the Watergate scandal sidetracked the issue. Major labor unions had supported of the bill withdrew, hoping to help a more expansive package with a more liberal Congress in the wake of Watergate.

Costs continued to climb for the next twenty years, with government, businesses and insurers piecemeal at reform. Lacking a unified approach, the effect on access or costs was minimal. In the absence of an overall national framework, many of the piecemeal reforms skewed the system and added to the problem: America has an excess number of hospital beds, a shortage of primary care doctors, an insurance system that specializes in avoiding risk rather than managing it. ERISA led to large companies playing by a different set of insurance rules. Reduction in Medicaid weighed on state budgets and added to the "cost-shifting" problem.

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[3] Just as the Truman's Hill-Burton Act led to a sharp increase in the number of hospitals, these laws served to greatly increase the supply of health care providers. Many now argue that the increased supply itself created increased use of doctors and hospitals, and in turn increased health care spending.

Today's Challenge:

Throughout the late eighties and early 1990s, an increasing number of legislators introduced comprehensive reform proposals, and health reform rose again in the public consciousness. The approaches vary-- "play-or-pay," "single payer," "managed competition"-- but an increasing number of elected officials tried to respond to the public's deafening call: do something.

So why has nothing been done? It is not because the answers eluded us. We knew in 1915 that employers, employees and the government should contribute to the costs of health care, and that the system should focus on prevention.

We knew in 1935 that we should encourage doctors and hospitals to form networks and share responsibility for high quality, cost-effective care. President Truman proclaimed in 1946 that health care should be considered a right, not a privilege. President Nixon told the American people in 1972 that the only way to insure universal access was to ask employers to take responsibility for their workers' coverage.

It is up to President Clinton and this Congress to decide whether the 1990s will become yet another decade in which the leaders of this nation almost did something about health care. The stakes rise each time. As the problems become worse, tackling them becomes more difficult. As costs have risen higher, the cost of doing nothing has also risen. We can no longer afford to delay.

THE NEED FOR REFORM:
THE COST OF DOING NOTHING

Ever since President Roosevelt was forced to abandon his national health insurance proposal, America's health care crisis has grown. Yet we have failed to act to guarantee American families the security they deserve. We have undertaken innumerable studies, reports, commissions, pilot projects, and piecemeal attempts at reform. For too long we have treated the symptoms, not the disease, while the patient got sicker.

The time to act is now. If we choose to do nothing, we threaten the future security of every American family and business -- and the long-term health of our economy.

American Families:

If we continue to do nothing, tens of thousands of Americans will lose their health insurance each month, joining the ranks of the uninsured. American families will continue to be denied coverage because of preexisting health conditions. Workers will continue to be locked in jobs they want to leave because they're afraid to take the risk of losing the insurance company.

If we do nothing, experts estimate that the annual cost of health care will **more than double -- to $14,000 for each American family --** by the end of the decade. At the same time, by the end of the decade, Americans **workers will lose $655 in income <u>each year</u>** if health care costs continue to eat up wage increases, as they have over the past decade. Workers have lost 58 percent of wage increases since 1980, and will lose 100 percent in coming years due to the rising cost of health benefits to employers. [Families USA, OMB]

American Business:

If we do nothing, small businesses will continue to face the pressure of escalating premiums from insurance schemes designed to discriminate against them. Companies will be forced to cut benefits or drop coverage altogether.

If we do nothing, large employers' rising health care costs -- which some estimate could amount to **$20,000 a year for each employee** by end of the decade -- will continue to erode their profits. U.S. competitiveness will continue to decline, as rising health care costs are passed on as higher prices for American goods. [<u>Christian Science Monitor</u>, 11/21/91]

American Economy:

If we do nothing, all the sacrifices we are making today to reduce the deficit will be not control it. Health care cost increases will eat up **more than half of $738 billion** in new federal revenue expected over the next four years. Health care spending will rise from 14% of GDP to 18% by the year 2000. **Seven years from today, almost $1 out of every $5 earned by Americans will go to health care spending.** [OMB]

[This section needs to be much stronger. It is vague and doesn't really dramatize the risks of the status quo. -- IM]

OVERVIEW OF HEALTH REFORM

OVERVIEW OF HEALTH REFORM:
DESCRIPTION

Today's System:

The existing health insurance system fails to provide Americans with security when they need it.

Most Americans' access to health insurance and care depends on where they work and how much money they have, but even well-insured Americans increasingly fear that adequate protection won't be there when they need it.

Millions of Americans -- including many employed full-time -- go without health insurance or with incomplete coverage either because their employers do not provide it or because they are caught in a small-group market that is expensive and excludes many people or conditions.

The cost of health care has risen faster than prices for other goods and services for more than a decade. Incentives within the system reward providers for performing costly tests and procedures, and attempts to control spending amount to creating more bureaucracy and paperwork. Hospitals and other health providers shift the cost of treating uninsured patients onto those with insurance, further increasing their costs.

Under Health Reform:

Under the Clinton plan, every American will be guaranteed access to a comprehensive benefit package. No one will be denied insurance because of a pre-existing medical condition, a sudden illness, a change of jobs or any other life event. Employers will provide insurance to all employees. Individuals and families will choose their own doctors and health plans within a streamlined system that will provides high-quality care.

The federal government will establish and oversee the over-all framework of the American health care system. Federal law will:

- Define the guaranteed benefit package
- Prohibit discrimination in health insurance based on medical conditions or other individual characteristics
- Establish and enforce a national budget to control health expenditures.

- Set standards for assuring quality and consumer protection.

Within the federal framework, states will establish and oversee the system, tailoring its design to the needs of each community.

A system of consumer health alliances will provide individuals, families and employers with a choice of health plans, creating an organized market through which plans will compete to provide the best care at the lowest price. Some states may elect to operate health alliances themselves, while others will oversee non-profit alliances.

Health plans, including HMOs, fee-for-service plans and innovative new delivery systems will enroll any American, assuming responsibility for providing quality care at a negotiated price. Every alliance will include among its offerings a plan based on the traditional fee-for-service approach.

Physicians and other providers can elect to participate in more than one health plan. Patients can choose to follow their physician into a plan, which may differ from their current insurance arrangement, or they can choose a new plan and a new doctor.

- **HOW WILL PEOPLE OBTAIN HEALTH INSURANCE COVERAGE?**

TODAY: Whether Americans have health insurance depends on many factors outside their control: Whether and where they work, pre-existing medical conditions and economic circumstances. Close to 40 million Americans have no health insurance, and millions of others are locked into jobs because they fear losing health insurance.

In most cases, companies, not employees, choose the health plans through which workers obtain coverage.

REFORM: All Americans will have guaranteed access to a comprehensive benefit package at a predictable price, regardless of where they work, how much money they earn, or whether they've ever been sick.

Individuals -- not employers -- will choose from a variety of health plans. Patients satisfied with their current health plans and physicians can continue with their current arrangement. Others can choose a different approach to care, with choices ranging from HMOs to a fee-for-service plan.

- **WHERE DO PEOPLE GO TO GET HEALTH INSURANCE?**

TODAY: Most people obtain insurance from their employers. Some purchase individual policies from insurance agents or agencies. Federal, state and local governments all provide care to specific categories of people, including the elderly and some low-income people. Nearly forty million Americans do not have any form of health insurance.

REFORM: Consumers will have the right to enroll in a health plan offered through a health alliance, choosing from among a variety of plans. Alliances will provide consumers with information about coverage, costs and the quality of plans. Employers will also make information about alliances and health plans available. Some large employers may decide to offer their own plans.

Individuals who are unemployed will be able to continue in their current health plan or obtain coverage through the alliance in their area.

- **HOW WILL THE INSURANCE MARKET CHANGE?**

TODAY: Small firms and individuals are at a disadvantage in negotiating with large insurance companies and end up paying higher premiums or not obtaining coverage.

More than a thousand of health insurance companies add inefficiency to the system and creating administrative burdens for consumers and providers.

REFORM: Firms and individuals will band together into health alliances, putting consumers and employers in control to negotiate with health plans to deliver quality and price.

One standard form will replace thousands of different insurance claim forms. Problems arising from the coordination of benefits between insurers will disappear.

Fewer, insurance pools will spread risk over a larger group and reduce administrative costs.

- **WHERE WILL PEOPLE GO FOR HEALTH CARE?**

TODAY: People with insurance go to doctors, hospitals, pharmacies, HMOs, or other providers covered by their insurance.

People without insurance often don't get care or go to hospital emergency rooms, community clinics or doctors willing to provide uncompensated care. That drives up costs for other patients.

REFORM: Patients will have the option of continuing to use the same doctors, hospitals, pharmacies, HMOs, or other providers. Providers may organize into "networks" through which they will coordinate the care of their patients and control costs. All Americans will be have guaranteed coverage.

- **HOW WILL HEALTH PLANS CHANGE?**

TODAY: Health insurance plans select the healthiest people to enroll. Plans avoid taking risk and discriminating against individuals based on health status and the size of the group through which they purchase coverage. Often insurance won't pay for treatment for health problems diagnosed

before a patient joined the plan. Many insurers refuse coverage to individuals because of pre-existing medical conditions.

In many underserved areas, including both rural areas and inner-city neighborhoods, patients do not have access to health plans or providers.

REFORM: All plans will enroll all applicants and charge premiums based on a community rate negotiated with the alliance. While prices may vary between plans, health plans will charge everyone enrolling the same price for the guaranteed benefit package.

States and health alliances will see that health plans are available in all areas.

- **WHAT HEALTH CARE SERVICES WILL PEOPLE RECEIVE FROM THEIR PLANS?**

TODAY: Benefits vary widely. Some provide mental health services; others do not. Some pay for prescription drugs, and other do not. Some pay for preventive care.

REFORM: Every American will have the security of a guaranteed, comprehensive package of benefits, including a full range of medical services. The benefit package will include preventive services such as immunizations, and mammograms not offered in many existing plans.

- **HOW WILL COSTS BE CONTROLLED?**

TODAY: Rapidly rising health costs driven by:

- Administrative waste:

  High claims processing and billing costs resulting from the fact that more than 2,400 entities pay for health care in the U.S. Each imposes its own reporting requirements.

  High administrative costs (as much as 40 cents of each $1 in premiums) particularly for small businesses and individual policyholders.

High insurance administration costs associated with underwriting practices.

- Providers and consumers who use excessive or unnecessary services because they are insulated from cost considerations.

- Fee-for-service medicine that encourages providers to perform excessive tests and procedures.

- Use of high-cost settings, such as hospital emergency rooms, by patients who don't have access to other care.

REFORM: Controls costs by:

- Eliminating insurance underwriting.

- Streamlining claims and reimbursement by moving to simple payment systems and developing a standard billing form.

- Reducing costs for small groups and businesses that will gain the purchasing power of a large group.

- Health alliances will hold plans accountable for delivering the guaranteed benefit package for a fixed rate, creating incentives to deliver cost-effective care.

- Technology assessment and research into health outcomes will assist providers in judging the effectiveness of treatment, enhancing cost conscious, quality and innovation.

- Operating within a budget, plans will avoid unnecessary duplication of expertise and equipment, leading to more prudent investment in technology.

- Through price competition and consumer information, patients will be able to distinguish among plans to make cost-conscious choices.

As a safety net to control costs, a national health care budget will limit growth in spending each year.

OVERVIEW OF REFORM:
QUESTION AND ANSWERS

Q: Will I still be able to choose my doctor?

A: Yes. You can see any doctor you want. However if you choose a doctor outside of your plan, you may have to pay a little more to do so.

Q: How it is possible that the government will get more involved in our health care system but there will be less paperwork?

A: The government is getting less -- not more -- involved in the health care system. Under the Clinton plan, the government role will change dramatically. These reforms will simplify and standardize administrative procedures not add levels of complication and regulation but rather. A single forms will be developed for filing claims and reporting reimbursement. Transactions will be streamlined through increased use of computerized billing. Automated systems will also be used for keeping patient records with safeguards to protect privacy. Utilization review will be revamped to eliminate government micromanagement of medicine.

Q: Won't these health alliances create more bureaucracy and paperwork?

A: Not at all. The health alliances are a way that businesses and individuals can band together to get the same bargaining power as big companies -- so they can go to insurance companies and negotiate for high-quality care at an affordable price. They are also are way to make competition in the insurance market work in a positive and constructive way for consumers. Under the Clinton plan, insurance companies will compete on efficiency and service, not on avoiding risk. By leveling the playing field and providing a central point of contact for purchasing insurance paperwork hassles will be reduced.

Q: I have decent insurance. Why should I pay to insure others?

A: You won't. Most people without insurance are employed. These workers and their employers will pay for their health coverage. For those with health insurance, any increases provide you with health security. It ensures that you always have insurance protection and controls costs so that your wages won't continue to be eroded by rising health care costs.

Q: How are you going to control costs?

A: The Clinton plan is based on establishing a competitive insurance market that competes on the basis of efficiency, service and price. It would reward health plans which did the best job providing quality care at an good price. Small businesses, employees and other individuals would join together in health alliances to negotiate for affordable prices. Simplified and standardized claims and reimbursement procedures will drastically reduce paperwork and bureaucracy, cutting administrative costs.

While this new system is being established, providers will be called upon to voluntarily hold the line on health care costs. A national health budget will also be imposed as a safety net to ensure that costs don't rise out of control.

Q: Why are we changing so much about health care?

A: Because the system is seriously flawed, comprehensive reform is the only approach that will work. All Americans will gain the security if guaranteed coverage. Most people will not see major changes in how to get health care. They will still have the option of continuing with their same doctor. They will obtain care in the same way as they do now -- and they'll still have the highest-quality care in the world.

Q: Isn't it true that managed competition is untested?

A: The Clinton plan is not managed competition. It draws on elements of the theory of managed competition, but the Clinton plan combines the best of several ideas from different models to design a system that will work for all Americans.

Q: Won't this plan kill small business?

A: No, it will help small business. The Clinton plan stops insurance companies from discriminating against small businesses, aggressively controls costs, and pools small businesses and individuals to give them the same bargaining power in purchasing insurance that big companies have. The plan will be gradually phased-in to ensure that small businesses that don't currently provide insurance can afford to cover their employees.

Q: How can you have a comprehensive health reform package that doesn't comprehensively cover long-term care?

A: This package does address the need for long-term care. It takes vast strides toward covering home- and community-based care with a special emphasis on creating ways for older Americans to continue to live in their own home and communities with dignity and independence.

[This section needs beefing up -- IM]

OVERVIEW OF HEALTH REFORM:
DRAFT SPEECH

Security for you and your family. That's what the President's health care plan is all about.

Now a lot of you may be perfectly happy with the health care you have today. But even if you are, look around this room.

Every one of you here knows somebody who can't get health insurance -- or can't afford it. You probably know someone who's lost a job and ended up without any coverage for their family. Or somebody who came down with a terrible illness -- and all of a sudden discovered hidden limits buried in the fine print of their insurance policy. And everybody knows somebody who lives in fear that a parent or a child will need longterm care, and they won't even be able to choose whether their loved one ends up in a nursing home.

Today every one of you is probably paying more for a lot less health care. Take a look at how much you're charged every year for your share of insurance. Or at the terrible prices you're charged for prescription drugs. The fact is that even the best, most generous businesses in our nation are trading pay hikes for benefits that, a few years ago, seemed rock solid -- or they're being forced to just cut back the benefits to almost nothing.

And that's just what you can see. Every day, every hour, exploding health care costs are picking all our pockets and handbags. Right now -- as you sit here -- you're paying for someone who's been forced to go into an emergency room because he or she doesn't have insurance. So the next time a hospital charges you $35 for a towel, remember that you're paying for the 35 patients in the emergency room who will never see a bill -- and couldn't pay it if they did.

Most of us don't see that, here, in the richest country in the world, millions simply go without. And I'm not talking about the 40 million uninsured people we hear so much about.

I'm talking about families in rural America who can't afford to get sick because the closest doctors is 300 miles away. I'm talking about pregnant women who should see an obstetrician -- but can't because high malpractice fees forced that doctor to close down shop. I'm talking about children who live 10 miles from a hospital that's got plenty of subspecialists -- but can't get them an appointment with a pediatrician.

So here's what the President's plan is going to do.

It's going to give you security -- give you the peace of mind you deserve. It's going to get hold of costs and make the mess make sense. It's going to

make sure that the best parts of our health care system stay the same -- that if you want to stay with the doctor you've got now, you'll be able to. And it's going to improve the quality of treatment that you get.

We're going to stop this crazy system of putting the insurance company in charge -- and put all of you in charge instead. We're going to guarantee benefits and provide more choices -- and then go on to give you simple information about them. Instead of them dumping you, you'll be able to dump them.

When the new health care plan is up and running, you're going to get a health security card. You carry that card with you. That card will guarantee you access to a comprehensive package of benefits. And that package will include a lot of things you're probably not getting right now. Not just care if you wind up in the hospital or have terrible trouble. But the kind of care that will keep you and your children from getting sick in the first place.

Here's how it will work. You'll be able to choose from a variety of health plans -- and follow your doctor. Stick with the same arrangement you have now if you like, where you go to a doctor and hospital and get charged each time. Or join a network of doctors and hospitals and pay a little less. Or you can decide to pay a flat fee that covers all your services for the year. And

whatever you decide, if you're unhappy with your choice, you'll be able to vote with your feet.

And remember this: if you lose your job, nobody will be able to take your health care away from you. You won't have to worry about what happens if you or your child or your parents get sick. No more preexisting conditions. No more staying in a job because you're worried about what might happen next. No more losing your health care just when you need it most.

The next thing we're going to do is to bring your costs under control. We're going to force the insurance companies and the drug companies and everyone else to live within a budget -- just like you have to. And when we do that, we're going to help bring down the deficit -- and find money to invest in our children and our communities again.

We're also going to take the paperwork mess and clean it up. We're going to get rid of the 1,500 separate insurance forms and replace them with one form -- a form that you can understand. And we're going to free doctors and nurses and hospitals from the bureaucratic hassles that take them away from you, their patients.

If you're a small business and you're covering your employees right now, we're going to bring your costs down. We will stop the insurance schemes that

discriminate against you and drive your premiums through the roof. We're going to let you team up with other small businesses and negotiate for the same rates that insurance companies give the big guys. And if you're not covering your employees now, we're going to help you take responsibility for your employees' coverage.

[paragraph on rural access and more primary care physicians]

Now there are a lot of people out there who are going to tell you that we don't need to change. They're going to try to scare you by making up all sorts of stories about terrible things. Then they'll tell you that they agree we need some reform -- but only on their terms. What they won't tell you is that they're the ones who have been lining their pockets in this system while the rest of us have had our pockets emptied.

But, together, we're not going to let the lobbyists and the special interests win this one. Because what should really scare you most is more of the same.

Every day, more American families lose their health insurance -- and even if you're one of the lucky ones who likes what you've got, the odds that you'll have it next year aren't very good. Every day, health care costs keep rising out of control -- and eating up your incomes and the future of our kids.

And every day the special interests back in Washington keep telling us that nothing can or should be done.

You and I know that they're wrong. We need the change. And we need it now.

PHOTOCOPY PRESERVATION

ALTERNATIVE OPTIONS

ALTERNATIVE OPTIONS

WHY NOT A SINGLE PAYER SYSTEM?

Under a single payer system, the government takes on full responsibility as the sole purchaser of health care services. The government collects taxes from individuals and businesses and establishes or negotiates rates of payments to physicians and other health providers, who deliver care within a set budget.

Many elements of the Canadian system and other single-payer models -- cost containment, administrative simplification, less paperwork and guaranteed, universal coverage for a set package of benefits -- are central features of the Clinton plan for health reform. In addition, states will have the flexibility to choose to a single-payer model for their citizens.

However, financing a single payer system requires raising and distributing as much as half a trillion dollars in new federal taxes. Such large transfer of dollars through the federal treasury raises understandable concerns by most Americans. The Clinton plan is founded on a uniquely American system, rooted in the private sector, providing high-quality care and fostering innovation through competition.

WHY NOT EXTEND MEDICARE TO EVERYONE?

The concept of extending the Medicare program for the elderly to all Americans represents a variation on the single-payer approach to health reform. Under such a plan, the federal government would dictate health benefits and payment rates for providers, with private insurance firms administering the program on a regional basis. The federal government would collect taxes from individuals and businesses to pay providers at a negotiated rate within a budget.

The President's plan for health reform embraces elements of the single-payer approach, including the model based on Medicare. Universal coverage and a guaranteed comprehensive benefit package all are key to the President's plan. Under the Clinton plan, states that prefer to adopt a single-payer system based on the Medicare model will have the flexibility to do so.

As with the traditional single-payer system, covering everyone through Medicare is not a workable solution. By putting the federal government in charge of the health care system, a single payer system creates too much government with administratively cumbersome requirements for providers and consumers alike. In addition, covering the entire population under Medicare represents a "one-size-fits-all" approach to health reform and doesn't address key failures in the existing system. It denies states the flexibility to design innovative approaches to health coverage and delivery tailored to the needs of their citizens.

In addition, it would perpetuate the perverse incentives of fee-for-service medicine and does little to end the rewards for physicians who pad their income by ordering unnecessary procedures and return visits.

WHY NOT MANAGED COMPETITION?

Managed competition is an economic theory that attempts to combine elements of government regulation and free-market competition. Purchasers of health care would be organized into large groups, giving small businesses and individuals the same economic clout that large employers have in the current system. Managed competition calls for reforming the insurance market to prohibit medical underwriting, exclusions for pre-existing conditions and setting premiums based on health status. Providers then compete for the business on a level playing field.

Like managed competition, the Clinton plan is based on principles that the American people value -- market-based solutions rooted in the private sector and providing ample consumer choice. The plan centers on reforming the health insurance market to create a truly competitive market that rewards quality, service, efficiency and innovation and eliminates competition based on avoiding risk.

It relies on informed consumers to choose health plans that offer services they want at a price they are willing to pay, while assuring quality and protecting consumers. The Clinton plan reorients incentives for insurers to compete on price and service rather than by avoiding risk.

There are also notable differences between the Clinton plan and managed competition. The managed competition model relies solely on market forces to control costs over time. The Clinton plan recognizes that rapidly rising health costs create a critical problem for our national economy that must be addressed. For that reason, it provides the safety net of a national health budget to ensure the control of costs. It also relies on doctors and other health providers to do their part by holding

the line on prices.

The Clinton plan recognizes that competition may not work everywhere. States are provided with the flexibility to use other approaches better suited to conditions in their communities.

WHY NOT PLAY OR PAY?

The "play or pay" approach to health reform would expand insurance coverage by requiring employers to cover their employees. Employers would choose either to "play" by purchasing private insurance themselves or "pay" by contributing a fixed amount, usually a percent of payroll, toward the cost of coverage through a government plan like Medicare.

Like "play or pay", the Clinton plan is based on reforming the existing system and building on it to create a new system that provides security and access to all Americans.

However, the "play or pay" models would require employers to make the choice between purchasing private insurance or paying for coverage under a government plan. It opens up the possibility that the government could assume responsibility for insuring a large number of Americans, much like a single-payer system, depending on what employers were required to pay for government coverage.

The Clinton plan reject the "play or pay" approach and instead provides health insurance coverage only through private health plans, rather than a large new government program. It also puts consumers in the driver's seat, and lets them choose plan which best suits their individual needs.

WHY NOT HEALTH VOUCHERS?

With health vouchers, responsibility for securing insurance would shift away from employers to individuals. All Americans would receive a government voucher to use toward the purchase of health insurance. To encourage cost-consciousness among consumers, the voucher would only cover a portion of the cost of a basic benefit package. Individuals would be required to pay the balance. Low-income people would receive tax subsidies to them pay their share.

Like the health voucher approach, the Clinton reform plan relies on consumers to make informed choices about health coverage. Both plans also require consumers to share financial responsibility for purchasing coverage and paying for care. However, health voucher plans leave consumers at the mercy of insurers, failing to establish a structure to ensure the health plans deliver quality care at reasonable prices.

In addition, vouchers would represent a radical departure from the current employer-based system for providing health insurance. Such an approach would require a large tax increase to pay for vouchers and tax subsidies to assist individuals in purchasing insurance and to replace current contributions toward the cost of coverage made by employers. And unless the tax subsidies for individuals were substantial, the burden for individuals would increase dramatically.

Proponents of health vouchers often favor it as an answer to concerns about the financial burden faced by small businesses from providing health insurance. Imposing such a drastic change is not necessary to minimize the burden on businesses that already provide insurance. By ending cost shifting, cutting administrative red tape, eliminating waste and reforming the insurance market, the Clinton plan for health reform can control health costs for small businesses.

WHY NOT MEDICAL IRAs OR "MEDISAVE" ACCOUNTS?

This approach would also shift responsibility for health care from employers to individuals. It revolves around the creation of "Medisave" accounts, medical accounts along the lines of Individual Retirement Accounts, to encourage individuals to put money away to cover small medical bills. Employers might be asked to contribute a certain amount for each employee to the accounts but employer provided insurance would no longer be tax deductible.

State requirements for minimum insurance benefits would be eliminated to create a market for catastrophic health plans that would cover only major medical expenses. Tax incentives would encourage consumers to purchase such plans. Individuals would pay for routine care and deductibles out of their Medisave accounts, using insurance only for more serious medical problems. They would retain whatever funds they did not use from their accounts, creating an incentive for them to keep health care use down.

The Clinton, like the "Medisave" plan, relies on consumers to make informed choices regarding health plans. Both plans also ask consumers to share the financial responsibility for purchasing

insurance coverage and paying for care in order to make their decisions sensitive to cost.

However, the Medisave model would leave too many Americans with inadequate protection against health care costs. Further, it seeks to control costs by pitting individual consumers against doctors and hospitals without giving them the clout to bargain effectively. As a result, health care costs would continue to rise, leaving the American consumer paying the bill. Medisave accounts create incentives for consumers to delay needed care, resulting in more complex medical problems and ultimately require more costly treatments.

WHY NOT THE GERMAN SYSTEM?

Germany provides full coverage of health care to all of its citizens for almost half the cost of the American health care system. Germans belong to private, nonprofit "sickness funds" to which they pay a percent of their wages. The funds allow patients to choose any doctor willing to accept the funds' payment rates. No one loses insurance if they change jobs or become unemployed.

The government sets the rules of the system and imposes annual caps on the growth of spending. Annual negotiations among sickness funds, physicians and other health care providers determine the pool of funds. In some years, physician fees decline if the volume of services exceeded projections, creating an incentive for physicians to control costs.

The commercial insurance sector in Germany sells to the economically elite accounting for about one-tenth of all health insurance. Commercial insurance pays providers higher rates than the sickness funds. However, consumers who choose to purchase commercial insurance cannot later join a sickness fund.

Like the German system, the Clinton plan will provide health security, control costs and guarantee the right to choose your own doctors. However, in Germany employers choose the plan for their employees. If consumers are not satisfied with this choice, their only option is to purchase expensive private coverage. The Clinton plan puts consumers in the driver's seat, and gives them the choice of a variety of high-quality, affordable health plans.

And while the German system has been successful in holding down provider fees, but fee-for service medicine which fails to control use of services remains. Unlike the German system, the Clinton plan will create a competitive market where plans to compete to appropriate care

at reasonable prices. It will reward service, efficiency, quality and innovation and create incentives for plans to eliminate wasteful spending. It would encourage innovation in health delivery would improve efficiency and quality of care.

WHY NOT THE CANADIAN SYSTEM?

Canada provides universal, tax-financed, comprehensive coverage to its citizens, through its ten provincial health insurance plans. Its health costs rank second in the world, trailing only the United States. Their costs are growing as rapidly as costs in the U.S., but since they began from a lower base, their total costs continue to be significantly lower than ours. Health care accounts for about 9 percent of GNP in Canada compared to 14 percent here.

The Canadian federal government and provinces share the costs of health insurance, although the federal share has dropped in recent years. Each province organizes and raises revenue for its health care system differently. In general, Canadian provinces provide hospitals with lump-sum, or "global" budgets, and set fees for doctors, who practice in traditional, fee-for-service arrangements.

The Canadian health care system differs from the American system in other important ways. They have lower levels of specialization and investment in technology. About half of its doctors provide primary care, compared to less than a third in the U.S. Also, Canadian hospitals, which are all nonprofit, purchase less high-technology equipment and use it less frequently. As a result, hospital costs are lower even though the average patient stays longer.

Many elements of the Canadian system -- cost containment, administrative simplification, less paperwork and guaranteed, universal coverage for a set package of benefits -- are central features of the Clinton plan for health reform. In addition, states will have the flexibility to choose to a single-payer model for their citizens.

However, this approach is not desirable or workable at the national level. Financing such a system requires raising and distributing as much as half a trillion dollars in new federal taxes. The Clinton plan is founded on a uniquely American system, rooted in the private sector, providing high-quality care and fostering innovation.

WHY NOT THE BRITISH SYSTEM?

Great Britain operates a national health service, not a system of national health insurance. The government owns hospitals and pays for health care out of general tax revenues, not insurance premiums.

In Great Britain, the medical profession divides into two groups: private general practitioners, who are paid according to the number of people who enroll with them, and consultants (or specialists), who practice in hospitals as salaried government employees. Many in the latter group also have private patients as well.

To control health care spending certain technology and procedures are strictly rationed. To avoid the waiting lists for these treatments, private health insurance and private hospitals also are available. They account for about 1 percent of Britain's total health expenditures.

The Clinton plan has little in common with the British system except the goal of providing health care to all citizens. The British system run entirely by the government, doctors and other health providers work for the government. The Clinton plan is rooted in the private sector, relying on competition and consumer choice. It will preserve the ideal of American medicine, by providing high-quality care and fostering innovation. Health plans will compete on the basis of service and efficiency, assuring the needed care as received on a timely basis. The Clinton plan will provide health security to all Americans by guaranteeing a comprehensive set of benefits.

WHY NOT EXPERIMENTAL STATE-BASED PLANS?

Some advocate providing waivers to states to enable them to experiment with designing their own approaches to health reform. Indeed, states stand at the forefront of the movement toward health reform. Hawaii, Florida, Minnesota, Vermont and others have been working on innovative ways to control health care costs and increase insurance coverage.

Recognizing the innovation and creativity of the states, the Clinton plan provides significant flexibility for states, making that approach the cornerstone of national reform. It will build a partnership between the federal government and the states to design a comprehensive solution to the crisis in health care, while at the same time allowing for regional differences in that solution.

Despite the significant efforts of the states, it has become clear that the United States will not be able to achieve cost containment and universal coverage approaching the problem only on a state-by-state basis. States that have addressed health reform find that without a national framework, establishing a level playing field among the states, comprehensive reform proves difficult, particularly achieving cost containment. Governors who are leading the way on health reform agree on the necessity to address this problem at the national level.

The need to address America's health care crisis is urgent. Rapidly rising health care costs are an economic drag on the nation, undermining the competitiveness of American business and placing American families at risk. While the United States cannot afford to wait for results from state demonstrations to implement national health reform, we can learn from and build on innovations already underway at the state level.

WHY NOT A PILOT PROGRAM?

Some have suggested that before undertaking a major overhaul of the health care system we should establish a pilot program to test concepts for reform. However, America cannot delay addressing its health care crisis while a pilot program is designed, implemented, operated and evaluated. There is an urgent need to address our health care crisis. Skyrocketing health care costs are an economic drag, undermining the competitiveness of American businesses and placing American families at risk. The longer we wait to begin reform, the more difficult and the more expensive the task will be. We cannot afford to wait for results from the pilot program to begin national health reform.

If history has told us anything it is that piecemeal approaches to reform do not work. We need to establish a national framework for reform but by providing states with the flexibility to design their own plans, we can learn from their innovations as we go and perfect the system over time.

CONSTITUENCY-SPECIFIC TALKING POINTS

CONSUMERS

CONSUMERS AND HEALTH CARE:

The Clinton plan offers a bold new direction for health care in America and provides health security to all Americans. The plan will overhaul the system fundamentally, controlling costs and improving access to care while maintaining the high quality and choice of doctors Americans expect.

- **Controlling Costs:** The President's plan will tackle the growth of health care costs that threaten to place health insurance protection beyond the means of a growing number of Americans. It will ensure that the cost of health care never rises faster than the cost of inflation.

- **Security:** The Clinton plan will guarantee health security to every American. No longer will the protection of health insurance depend on your job, your health, your income or your age. Exclusions for pre-existing conditions will be eliminated. Health plans will enroll all applicants within a community -- whether they're healthy or sick -- at the same rate.

- **Comprehensive Benefits:** All Americans will receive a card that represents their right to a guaranteed comprehensive benefit package, including preventive services, well-child checkups and mental health services.

- **Choice of Health Plans:** Consumer choice is the cornerstone of the Clinton plan. Americans, not their employers nor insurance companies, will choose their health plans through local alliances. These group purchasers also will monitor plans for quality and provide consumers with information they need to make good decisions.

- **Choice of Doctors:** The right to choose your own doctor is a hallmark of American medicine. Preserving this right for all Americans is at the center of the Clinton plan.

- **Simplicity and Affordability:** People will know what coverage they are getting, how much it will cost, and how to use it.

CONSUMERS AND HEALTH CARE:
The Clinton Plan

Under the new system all Americans will be guaranteed health insurance coverage for a comprehensive benefit package. The Clinton plan will improve access to care, control costs, and maintain the high quality Americans expect.

How it Works:

- **Offering Insurance:** Consumers will obtain insurance through health alliances, group purchasers that will offer a choice of plans to people in a community. Each state will design its alliances to best meet the needs of the people of that state. Plans wishing to offer coverage for the comprehensive benefit package must enroll everyone in the community at the same price. Alliances will negotiate with insurance companies and health plans to set appropriate prices. Prices may vary from plan to plan depending on how efficient they are in providing care.

- **Choosing a Plan:** All Americans will receive a health security card that represents their guarantee of access to a comprehensive benefit package. Consumers, not employers, will choose their health care plan, from a variety offered by alliances ranging from traditional fee-for-service to HMOs. The alliances will provide consumers with information so that they can make an informed decision about the plan which is right for them.

- **Choosing Your Doctor:** Once consumers have selected their health plan, they will choose their doctor according to the rules of the plan -- just as they do now. If they select an HMO or preferred provider arrangement, they will select their doctor from the list of physicians who participate. Consumers can select a physician outside of the plan if they are willing to pay more. If they choose a fee-for-service approach, they can see any provider they want.

- **Paying for coverage:** Consumers will pay a share of the cost of their coverage with the balance paid by their employer. Employers may choose to pay a larger share than they are required to pay. Individuals who cannot afford their share of the premium will be eligible for government subsidies based on income.

- **Paying for care:** The plan will pay for services guaranteed in the comprehensive benefit package, with reasonable cost-sharing arrangements on their own or through negotiating with their employers

and limits on the amount out-of-pocket expenses charged to the consumers.

CONSUMERS AND HEALTH CARE:
Questions and Answers

Q: Will I still be able to see my own doctor?

A: Yes. Allowing people to choose their own doctor is a hallmark of American medicine. The Clinton plan preserves this right and expands it by giving consumers a broader range of health plans from which to choose. Under the Clinton plan, consumers will no longer be restricted to a single health plan offered by their employers. Instead, they will choose from a variety of plans that will provide them access to a greater selection of doctors.

Q: Will health reform reduce my current benefits?

A: No. The guaranteed comprehensive benefits package will be modeled on the best of today's insurance plans. These benefits will be guaranteed to all Americans. No longer will workers face the tradeoff between health benefits and higher wages. No longer will retirees have to worry about losing their negotiated health benefits -- benefits they plan and depend on. In fact, most Americans will face a broader range of choices for health care plans covering a greater variety of services than they do today. For workers with contracts that provide more costly coverage than the guaranteed benefit packages, the coverage will continue for the duration of the contract.

Q: Will my care be limited in any way?

A: No. Those who oppose reform often raise the specter of health care rationing to scare consumers and undermine prospects for reform. The truth is that health plans competing on the basis of service and quality to attract and retain patients, there will have every incentive to provide necessary care on a timely basis. In addition, health alliances will protect consumers and ensure that health plans provide appropriate high-quality care.

Q: Will I still obtain my health insurance through work?

A: Yes, most Americans will continue to receive their insurance through their jobs. Under the President's plan, employers will continue to contribute to the cost of employees' health insurance. In fact, many more people, including those who work for small businesses, now will be

insured through their job. Under the new system, rather than employers choosing the insurance plan available to employees, employees will choose their own plans through the health alliances.

Q: What happens if I lose or change my jobs?

A. You will still be covered. Health insurance coverage will no longer depend on whether you work or where you are employed. Employees will choose their health plans through local health alliances and once they are covered, they will always be covered. Even if they change or lose their job, workers who become unemployed will receive assistance to help pay their premiums until they find a new job.

Q: Can I be denied insurance coverage because of a pre-existing condition?

A: No. Excluding individuals from coverage because of so-called pre-existing conditions is one of the major failings of our current health insurance system. A primary reason why so many Americans do not feel secure in their health care coverage. All health plans will be required to take all applicants, regardless of health status, and change the same rate they charge others in the community.

Q: Does my coverage extend to my family?

A: Yes, and, with a greater range of health plans to choose from, you will be better able to meet the health needs of your family.

Q: Will all plans cost the same?

A: The cost of plans may vary but all will deliver the guarantee comprehensive benefit package. Rates will vary. Each plan will negotiate with alliances to set the price at which they will provide the comprehensive benefit package. Plans will compet ont he basis of quality, service, and price. Plans that streamline administration and privide efficient care will charge less fo the same package.

Q: Will I pay more for health care?

A: People who have insurance now are already paying for people who do not have insurance. It is not that the uninsured do not get care, they delay seeking care until their condition becomes more expensive to treat and

then seek care in more expensive settings such as hospital emergency rooms. By covering all Americans and stressing primary and preventive care, the President's plan will end cost-shifting from the uninsured to the insured. If you currently have insurance, the President's plan will provide a broader range of choices, many of which will be more cost effective than today's plans. If you do not have insurance, you will be asked to contribute to the cost of your coverage, but your contribution will be based on your ability to pay.

Q: How will quality be assured?

A: The federal government will create a national system of quality assurance that will be enforced by the states. In addition, health alliances will provide information about on customer satisfaction with health plans. Armed with this information, consumers will be able to take their business to plans that do the best job of providing care.

Q: Will I have to wait a long time for care?

A: No. Those who oppose reform often raise the specter of rationing of health care to scare consumers and undermine reform. The truth is that with health plans competing on the basis of service and quality, to enroll and keep patients, they will have every incentive to provide care on a timely basis.

CONSUMERS AND HEALTH CARE:
The Current System

RISING HEALTH CARE COSTS PUT PINCH ON CONSUMERS:

- Over the last decade, the amount the average American family spent on health care more than doubled (from $1,742 to $4,296) and is projected to double again by the year 2000 if nothing is done to control costs. [Families USA]

CURRENT SYSTEM FAILS GROWING NUMBER OF CONSUMERS:

- 100,000 Americans lose their health insurance each month. [Washington Post 1/26/93]

- 57 million Americans will be without health insurance for some period this year. [Families USA]

CONSUMERS ARE AT RISK FOR PRE-EXISTING CONDITION EXCLUSIONS:

- Pre-existing condition rules, which bar or limit insurance coverage to those with health conditions, are included in 69 percent of employer provided health insurance policies. [Foster Higgins Survey, 1991]

LACK OF INSURANCE CHOICES LIMITS JOBS OPPORTUNITIES:

- Nineteen percent of workers say they or their families face "job lock" because new jobs offer limited or no health insurance or because they have health problems that would be considered "pre-existing" conditions. [Henry J. Kaiser/Louis Harris and Associates survey, Oct. 2-4, 1992]

Under our current system, purchasing insurance and filing claims for benefits can be a major headache for consumers. Policies contain different levels of benefits, co-payments and deductibles. Comparisons are confusing even for the most informed consumer. Objective information on quality and service is difficult to find.

Filing claims is also difficult and time-consuming due to complicated reimbursement schemes and lengthy forms. Claims forms vary from company to company and form policy to policy. Those with more than one insurance policy can often confront a mountain of paperwork.

DISABLED AMERICANS

PEOPLE WITH DISABILITIES AND HEALTH CARE:

The Clinton plan will promote independence and empowerment for disabled Americans by ensuring them health insurance protection, guaranteeing them a comprehensive benefit package including prevention and long-term care and preserving their right to choose their own doctor.

- **Insurance Reform:** With health reform, Americans who have disabilities will no longer be denied health insurance protection because of health status. The President's plan will eliminate exclusions for so-called pre-existing condition. Health plans will be required to enroll all applicants, including people with disabilities. Individuals will be charged the same rate, regardless of whether they're healthy or sick, young or old.

- **Security and Independence:** The Clinton plan will build on the foundation laid by the Americans with Disabilities Act to empower persons with disabilities to live productive and independent lives. Disabled Americans no longer be limited in their choice of where they work or where they live because of concerns over insurance coverage. All Americans will have guaranteed access to the same comprehensive benefit package.

- **Long-Term Care:** Long-term care services, particularly, home and community-based care, are critical to the independence of persons with disabilities. Home and community-based care are an integral part of the Clinton reform package.

- **Choice of Doctors:** The right to choose your own doctor is a hallmark of American medicine and matter of particular concern for people with disabilities. The Clinton plan preserves this right for all Americans. In addition, the Clinton plan will foster better coordination between health providers so that people will receive the care they need when they need it.

- **Single Claim Form:** Under the Clinton reform, all plans will use the same easy-to-understand claim form.

PEOPLE WITH DISABILITIES AND HEALTH CARE:
The Clinton Plan

Under the new system all Americans, including disabled Americans, will be guaranteed health insurance coverage with a comprehensive benefit package. It will preserve the right to choose your own doctor while improving coordination of care. Disabled Americans will also be protected against the cost of long-term care.

How it Works:

Health Care Services: Disabled Americans will have access to the same high-quality medical care delivered through the same system and at the same price as for other Americans. (See description of Clinton Plan under Consumers and Health Care).

Long-Term Care Services: Home and community-based long-term care, including personal assistance services, will form an integral part of the benefit package, providing many disabled Americans with the freedom to live productive and independent lives.

PEOPLE WITH DISABILITIES AND HEALTH CARE:
Questions and Answers

Q: Will I get personal assistance services?

A: Yes, some expanded access to personal assistance services will be included in the long-term care package. These services build on the foundation laid by the Americans with Disabilities Act and aid people with disabilities to lead independent and productive lives.

Q: Will I still be able to see my own doctor?

A: Yes, allowing people to choose their own doctor is a hallmark of American medicine. We understand how important this right is to all Americans but particularly to persons with disabilities. The Clinton plan preserves this right and ensures that disabled Americans will be able to choose a doctor who understands the special health needs of people with disabilities.

Q: Will my current benefits be reduced?

A: No. The comprehensive benefits package in the Clinton plan is based on the best of today's plans. These benefits will be guaranteed to all Americans. Disabled Americans will no longer have to choose between a job and health care coverage. No longer will people with disabilities be locked into jobs because changing jobs could jeopardize their insurance coverage. In fact, most Americans will face a broader range of choices for health care plans covering a wider array of services than they do today.

Q: Will the program cover long-term care?

A: We understand the importance of long-term care services for disabled Americans of all ages. The Clinton reform package includes expanded coverage for home and community-based care to help people with disabilities lead independent and productive lives. In addition, the federal government will set national standards for private long-term care insurance to improve quality of policies and ensure they provide value.

Q: Will my care be limited in any way?

A: No. Those who oppose reform often raise the specter of rationing of health care to scare consumers and undermine attempts at reform. The

truth is that health plans competing on the basis of service and quality to attract and retain patients, will have every incentive to provide necessary care on a timely basis.

Q: Will I lose any of the services I currently receive under Medicaid?

A: The comprehensive benefit package will cover most of the services you now receive under Medicaid. Any additional services will continue to be provided by the Medicaid program.

Q: Will I have to join a managed care plan?

A: No. Over the years, concerns have been raised that managed care plans may have financial incentives to delay or withhold care, a particular concern for people with disabilities. Under the Clinton plan, Americans will be able to choose between traditional fee-for-service plans and managed care plans. All plans will be monitored for service and quality to ensure that whatever plan you choose, you will receive the care you need when you need it.

Q: Will I still get my health insurance through work?

A: Yes, most Americans will continue to get their insurance through their jobs and, employers will continue to contribute to the cost of their employees' health insurance. In fact, many more people, including those who work for small businesses, will now be insured through their job. Under the new system, rather than employers choosing the insurance plan, employees will choose their own plans from those offered through the health alliance.

Q: What happens if I lose my job or change my job?

A: You will still be covered. Health insurance coverage will no longer depend on whether you work or where you are employed. Employees will choose their own health plan through their local health alliance. Once they are covered they will always be covered even if they change or lose their job. Assistance to help them pay their premiums will be provided to those who become unemployed.

Q: Can I be denied coverage because of a pre-existing condition?

A: Absolutely not. Since people with disabilities experience exclusions at a

much higher rate than other Americans, their insurance status is much more tenuous. Under the President's plan, all health plans will be required to enroll all applicants, regardless of health status, at the same community rate.Excluding individuals from coverage because of a pre-existing medical condition is one of the major failings of our current system. It is a primary reason why so many Americans do not feel secure in their health care coverage.

Q: Will all plans cost the same?

A: Rates will vary. Each plan will negotiate with alliances to set the price at which they will provide the comprehensive benefit package. Plans will compete on the basis of quality, service and price. Plans that streamline administration and provide efficient care will be able to charge less for the same package.

Q: How will quality be assured?

A: The federal government will create a national system of quality assurance that will be enforced by the states. In addition, the health alliances will provide information to consumers on customer satisfaction. Armed with this information, consumers will take their business to plans that do the best job of providing high quality care.

Q: Will I have to wait a long time for care?

A: No. Those who oppose reform often raise the specter of rationing of health care to scare consumers and undermine at reform. The truth is that health plans competing on the basis of service and quality to enroll and keep patients, there will have every incentive to provide care on a timely basis.

PEOPLE WITH DISABILITIES AND HEALTH CARE:
The Current System

PRIVATE INSURANCE UNAVAILABLE TO MANY DISABLED AMERICANS

- Disabled Americans are presumed to be high health care users. Despite the fact that most are not sick, many are charged higher premiums, subjected to pre-existing condition exclusions or rejected as "unacceptable risks."

DISABLED AMERICANS ARE MORE LIKELY TO FACE JOB LOCK

- When looking for work, people with disabilities face a more limited range of job choices since smaller businesses are less likely to provide them with insurance. When they are employed, disabled Americans are more likely to be locked into a job fearing loss of their insurance if they change jobs.

INSURANCE PRACTICES FOSTER DEPENDENCE FOR DISABLED

- Insurance practices threaten not only the security of people with disabilities but their independence, as well. The ongoing need for care in the face of limited insurance choices can force people with disabilities out of work to obtain coverage through Medicaid. In addition, disabled Americans are more likely to exhaust insurance benefits, reaching the lifetime limit set on their policies.

DELIVERY SYSTEM PROBLEMS POSE BARRIERS TO SPECIALTY CARE REQUIRED BY DISABLED AMERICANS

- Gaps in the health care delivery system -- the lack of coordination between health care providers, and the lack of coverage for preventive services and long-term care -- make it difficult for disabled Americans to get specialized care.

- While many think of long-term care as a problem only for older American, as many as one-third of those in need of long-term care services are under age 65.

GOVERNMENT PROGRAMS PROMOTE INSTITUTIONALIZATION NOT INDEPENDENCE

- Currently, the only government programs that provide assistance, Medicare and Medicaid, emphasize on nursing home care rather than home and community-based care. These programs undermine rather than support efforts of people with disabilities to live independent and productive lives.

LARGE EMPLOYERS

LARGE EMPLOYERS AND HEALTH CARE:

Major American employers have carried the burden of excessive health care costs for too long, depressing profits and undermining competitive position. We must solve the health care cost crisis to improve our major employers' competitive position. The Clinton plan will guarantee that innovative companies that have led the way in developing new approaches to health care no longer pay excessive premiums to compensate for companies that don't provide coverage and for under-funded government programs.

- **Rising Health Costs:** The cost of health insurance for businesses' health costs have risen at an annual rate of almost 15 percent. Some estimate that if costs to provide health coverage continue to climb at current rates, employers will pay as much as $20,000 per employee by the end of the decade.

- **Eroding Competitive Position:** Rising health costs undermine the competitive position of American business and products. The American health care system adds over $1,100 to the cost of every automobile made in the U.S. -- almost twice as much as competitor nations.

- **Reforming workers' compensation:** Under the current system, employers pay more than they should for medical care under workers' compensation. Providers charge about twice as much for these patients as they do for others; there's double billing; and we're adding to the unnecessary tests and procedures by requiring them before we'll pay. Under the Clinton plan, a worker's health insurance will cover workers' compensation claims to reduce waste in the system.

- **Administrative Simplification:** The Clinton plan will cut dramatically the administrative waste and paperwork that drive up the cost of insurance for businesses.

- **Self-Insured Health Plans:** Many large businesses have led the way in the movement for health reform by implementing innovative approaches to the delivery of care for their employees. The Task Force is currently exploring ways to permit these companies to retain these programs within the framework of the national reform.

- **Consumer Driven System:** In a reformed system, the government will set broad standards and allow plans to compete for members on the basis of quality and cost. The government will not micro-manage the system: Health plans will have flexibility to decide how to deliver care and be held accountable to their members.

LARGE EMPLOYERS AND HEALTH CARE:
The Clinton Plan

THE CLINTON PLAN WILL HELP BUSINESSES CONTROL COSTS:

Recognizing the need to protect leading businesses from spiralling health care costs, the Clinton plan will:

- **Aggressively control** the rising costs of health care.
- **Reform workers' compensation** so that businesses don't pay for duplicate benefits and waste in the current system.
- **Dramatically cut administrative hassle** and paperwork that drive up the cost of insurance.
- **Reform the malpractice system** to reduce costs while protecting consumers from poor quality care.
- **Absorb the medical cost component of automobile insurance** to simplify the system and avoid duplication.

THE CLINTON PLAN WILL PROTECT BUSINESSES FROM COST SHIFTING:

Companies that insure will no longer pay for companies that don't

- We are going to ask all employers to contribute toward paying for health insurance for their employees. This approach will reduce costs for businesses already covering their employees because they will no longer pay for companies that do not provide coverage.

Large employers will no longer the bear burden of uncompensated care

- In today's system, large employers pay higher premiums to cover the cost of uncompensated care for patients who have no insurance. Over time, costs will go down for these companies in a system that provides comprehensive coverage for all.

LARGE EMPLOYERS AND HEALTH CARE:
Questions and Answers

Q: My company already offers health insurance that provides low cost, affordable care. Will it be able to continue and will I be able to remain outside of the health alliance?

A: The Task Force is working to devise an approach that will allow large businesses successfully managing comprehensive health plans to continue to do so within the framework of the reformed health system. No final decision has been made.

Over time health alliances will prove their value by controlling costs, creating incentives for all employers to participate.

Q: I'm afraid that the new system will not really control costs. How can I know this approach will control costs?

A: In the last 5 years, health care costs for employers have risen almost 15 percent every year. That's why a tough approach to controlling costs is a cornerstone of the Clinton plan. Providing universal coverage and a comprehensive benefit package will cut uncompensated care costs. Insurance reform, streamlining administration, and folding in workers' compensation and auto insurance health coverage will dramatically reduce paperwork and other administrative costs. In addition, the whole system -- including Medicare and Medicaid -- will operate under a budget as a backstop to contain costs.

Q: How will this plan end cost-shifting that drives up health costs?

A: Today, large businesses pay for the many weaknesses in the health care system. They pay higher premiums to cover the cost of treating patients who do not have insurance and for public health care programs, such as Medicaid. Major employers also purchase insurance for their workers' spouses, who often work at companies that don't provide health benefits. That creates a system that isn't fair. The Clinton plan for health reform will ask all employers to contribute to providing health insurance for their employees. All Americans will receive a guaranteed, comprehensive benefit package. Businesses will no longer pay extra to make up for the uninsured. Under our plan, all businesses will pay a fair price to insure their employees.

Q: Will the federal government micro-manage the new health care system?

A: No, the government will not run the reformed health care system. Consumers will. Competing health plans will form at the local level, with each plan making its own decisions about how to control costs. Since costs and conditions differ in each region of the country, the government will leave much of the design of the new system to the states and local health plans. If plans do a good job -- and deliver high-quality care at affordable prices -- more people will choose to enroll in those plans. If quality suffers or costs rise for any particular plan, consumers will switch to more successful health plans.

Q: My company operates in a number of different states. Today, I provide health benefits for my employees through one system. Under reform, will I have to change the way my employees get coverage?

A: We understand the concerns of multi-state employers and are considering special arrangements to meet those concerns.

LARGE EMPLOYERS AND HEALTH CARE:
The Current System

COMPANIES THAT PROVIDE INSURANCE PAY FOR THOSE WHO DON'T:

- Companies that provide insurance to their employees **paid $11.5 billion** in 1991 to cover spouses and other dependents of their employees who worked for companies that did not provide insurance. [National Association of Manufacturers in Washington Post, 5/13/93]

RISING HEALTH CARE COSTS EAT UP BUSINESS PROFITS:

- For the first time in American history, health care costs **exceed business after-tax profits**. [Health Care Finance Review, Winter 1991]

- American Telephone and Telegraph spends **$3 million a day** on employee health benefits. [Christian Science Monitor, 11/21/91]

- Employers **would have saved $1,015** per insured worker in 1992 if health care costs had grown at the rate of the overall economy from 1980 to 1990. [Robert Wood Johnson Foundation]

IF WE DO NOTHING, COSTS WILL CONTINUE TO EXPLODE:

- In 1992, American businesses paid almost $4,000 for health care for each employee -- more than twice as much as they paid eight years before. If the current pace continues, some estimate that this amount could rise to **$20,000 a year** for each employee by the year 2000. [Robert Wood Johnson; Christian Science Monitor, 11/21/91]

- Health benefits consume an average of 8 percent of payroll today. Without reform, they will consume as much as 17% by the year 2000. [Karen Davis, Johns Hopkins University, 1992]

HEALTH COSTS THREATEN U.S. COMPETITIVE POSITION:

- In 1990, General Motors spent $3.2 billion for medical coverage for its 1.9 million employees and retirees. **This was more than the company spent on steel**. Health care costs add $1,100 to the price of every car made in America -- double the cost added to Japanese imports. [University of Michigan, 1990; TIME, 11/25/92]

HEALTH CARE DISPUTES ARE THE MAJOR CAUSE OF LABOR DISPUTES:

- In 1989, reductions in health benefits were a major cause of labor disputes, accounting for **78 percent of all strike activity** -- a fourfold increase since 1986. [Christian Science Monitor]

SMALL EMPLOYERS

SMALL EMPLOYERS AND HEALTH CARE:

The Clinton plan for health reform will protect small business from rapidly rising costs. For small businesses that provide comprehensive insurance benefits, the plan will reduce costs -- and gradually phase in coverage for those who do not now provide benefits. It will bring small businesses together, giving them the buying power of large groups to bargain with insurance companies.

- **Current System Discriminates:** Small businesses are being driven into bankruptcy by a health insurance system stacked against them. For many small businesses, insurance practices make it impossible for owners to purchase health coverage for themselves and their families or their employees. We can no longer afford to let skyrocketing health care costs stifle the most vibrant sector of our economy.

- **Make It Easier for Small Businesses to Insure:** Despite rapidly rising premiums, most workers are employed in businesses that offer insurance for their families and employees. The Clinton plan will **reduce health costs for small businesses that provide comprehensive coverage,** and it will **provide financial assistance** to make it possible for all small businesses to cover their families and employees.

- **Insurance Company Reform Will Cut Costs:** Under our plan, small business owners will no longer have to go without insurance and risk their families' health to avoid bankruptcy. Insurance reform will end the practice of charging higher rate to small businesses than insurers charge Exxon or General Electric. **Health reform will prohibit insurance underwriting schemes that send small business premiums through the roof.**

- **Small businesses will combine their purchasing power to negotiate with insurance companies for high-quality care at affordable prices.**

- **Reform Workers' Compensation and Cut Waste:** Our plan will **reform workers' compensation** to **cut administrative waste** and paperwork that drive up the cost for small businesses.

- **Protect Small Businesses:** Special interests are already gearing up to charge that the Clinton plan for health reform will drive small firms out of business. That's not true. In fact, the Clinton plan will protect small

businesses, while it controls their costs and helps them provide adequate health coverage for their families and employees. **President Clinton recognizes the vital role that small business plays in the American economy and offered an unprecedented set of investment incentives for small business in his economic package.**

SMALL EMPLOYERS AND HEALTH CARE:
The Clinton Plan

HEALTH CARE REFORM PROTECTS SMALL BUSINESSES

Every business -- small and large -- will be protected under health reform. The Clinton plan protects small businesses through these specific steps:

- **Take on insurance companies** by preventing them from charging small businesses more than they charge Exxon or General Electric. The plan prohibits insurance underwriting schemes that pushes premiums for small businesses through the roof.

  In today's system, if an employee of a small business gets sick, insurance companies charge exorbitant rates or cancel coverage altogether. Health reform will ensure that no insurance company can tell an employer whom to fire or hire because of medical conditions.

- **Phase-in coverage** for employees of small businesses that do not now provide insurance in order to give companies time to adjust to the new requirement to contribute to coverage.

- **Provide financial assistance** to help small businesses insure their employees.

THE CLINTON PLAN FOR HEALTH CARE REFORM HELPS SMALL BUSINESS CONTROL COSTS

The Clinton plan will help cut costs for small businesses with these specific steps:

- **Aggressively control the rising costs of health care.**

- **Reform the insurance market** to consolidate small businesses in large purchasing pools that give them the same bargaining power as large companies. For the first time, small businesses will be able to obtain high-quality care at affordable prices -- like big companies do today.

- **Reform workers' compensation** eliminate duplication in the system.

- **Cut administrative waste** and paperwork that drive up the cost of insurance.

- **Increase the tax deduction for health insurance premiums for self-employed workers to 100 percent.**

SMALL EMPLOYERS AND HEALTH CARE:
Questions and Answers

Q: I have heard that health reform will drive thousands of small companies like mine out of business. How will you protect me?

A: The Clinton plan includes several mechanisms designed to protect small businesses and help them make the transition to a system that guarantees their families and employees the health security they deserve. Small businesses will not be required to begin providing health coverage immediately. The reforms will be phased in gradually over time. The federal government also will provide financial assistance for small businesses that need help in making the transition.

Q: I am a small business owner who now buys insurance for my family and my employees. What will your reform do for me?

A: Health care reform will lower costs for most small businesses that now provide comprehensive insurance to their employees. Each year your premiums go up by 50 percent more than premiums paid by large employers. Our plan will control costs, cut administrative waste and paperwork that drive your premiums up, and make insuring your employees easier and more affordable. Small employers and others will join a health alliances to have more bargaining power in dealing with health plans. In addition, you and your family will gain the security of knowing that you will never lose your insurance coverage.

Q: I own a small business and can't afford to give my employees health insurance. What will your plan do to me?

A: Small business owners already risk enough; they shouldn't have to go without health insurance coverage, risking their families' health security. Most small businesses today provide their employees with health coverage. Most of the rest would like to provide that benefit but find it impossible in a health insurance system that works against their interests. The Clinton plan will help small businesses provide insurance to employees at affordable prices through these steps: controlling costs and making insurance more affordable, regulating insurance companies and prohibiting discriminatory pricing against small firms, helping small business gradually move toward covering their employees.

Q: I'm afraid that you will not really control my costs. How tough is your plan?

A: You're right to worry about rising health costs. Small business premiums have increased between 25 and 50 percent each year. That's why a tough approach to controlling health costs is a cornerstone of the Clinton plan. Under health reform, a national budget will control the rising costs of health care and dramatically cut the paperwork that drives up insurance costs for small businesses today.

SMALL EMPLOYERS AND HEALTH CARE:
The Current System

MOST SMALL BUSINESSES CURRENTLY PROVIDE HEALTH INSURANCE:

- Despite rising health insurance premiums, about 75 percent of businesses with fewer than 100 employees provide coverage. [Employee Benefit Research Institute; New York Times, 5/3/93]

SMALL BUSINESSES' HEALTH COSTS RISE FASTER THAN LARGE COMPANIES':

- A survey by the National Association of Manufacturers reported that premiums for small employers continued to rise at a rate 50 percent higher than for all other employees. [National Small Business United]

- Small businesses experience annual health insurance premium increases as high as 50 percent in recent years. In one recent year, a third of small business owners saw their premium costs increases more than 25 percent. [Washington Post, 1/26/93; Arthur Andersen, 7/92]

ADMINISTRATIVE COSTS BURDEN SMALL BUSINESS:

- Small employers pay substantially higher administrative costs than large companies. Administrative costs consumed 40 cents of every dollar paid in total health premiums for businesses with less than five employees. Administrative costs for large companies often are as low as 5 percent. [CBO, 10/92]

INSURANCE COMPANIES DISCRIMINATE AGAINST SMALL BUSINESS:

- Insurance companies "**blacklist**" large sectors of the small business market and refuse to sell these small businesses insurance at any price. [New York Times, 2/5/90]

THE SMALLEST COMPANIES ARE HARDEST TO INSURE:

- The fewer employees a business has, the less likely it is to find affordable coverage. More than a third of workers in companies with fewer than 10 employees have no insurance. [EBRI in New York Times, 5/3/93]

INSURANCE INDUSTRY

THE INSURANCE INDUSTRY AND HEALTH CARE:
The Clinton Plan

- **Guarantees security**. Under health reform, if you get sick, you can't lose insurance coverage. Insurance companies will not be able to limit your coverage because of illness.

- **Eliminates pre-existing condition.** Everyone is guaranteed coverage. Insurance companies will not be allowed to refuse to cover people because they're ill or have an on-going medical condition.

- **Helps small business**. Small businesses and individuals will band together in large groups that have the same bargaining power as big companies. They will be able to negotiate effectively for high-quality care at an affordable price.

- **Puts consumers in the driver's seat.** Under the Clinton plan, the power to control access and care shifts from the insurance companies to consumers. Consumers can choose from a variety of health plans. If you're unhappy with your coverage, you can drop your insurance company -- but your insurance company can't drop you.

- **Community rating**. Insurance companies will use a community rating system to set prices-- charging everyone in a certain region the same rate whether healthy or sick, young or old, married or single.

- **Risk-adjustment.** Reform will remove incentives only to insure healthy people. Health plans that enroll more sick people will receive more money to provide their care.

THE INSURANCE INDUSTRY AND HEALTH CARE:
Questions and Answers

Q: How will the role of insurance companies change?

A: They will change the way they do business from avoiding risk to managing risk. Many of them will run health plans. Instead of figuring out how to avoid covering sick people, they will figure out the best way to provide high quality care to everyone.

Q: Under the Clinton plan, won't a lot of insurance companies go out of business?

A: Not necessarily. The companies that are efficient will flourish by managing superior health plans. Those that aren't efficient probably will shift to other lines of insurance.

Q: Aren't you subjecting the insurance industry to excessive government regulation?

A: Not at all. Under reform, an insurance company will not be able to deny you coverage because of a pre-existing condition, drop you from a plan if you're sick, or charge you a higher rate. But that's not excessive regulation -- it's just fairness.

Q: What about the insurance agents and underwriters who will lose their jobs under reform?

A: They won't lose their jobs, but they will do different types of work. Underwriters that currently spend time trying to avoid risk will figure out how to manage risk. Some people may work for health alliances negotiating to obtain high-quality care at an affordable price.

Q: If insurance companies are running health plans, won't they be telling doctors what to do?

A: No. Some insurance companies will manage health plans, but their role will be limited to enrolling patients and organizing networks of doctors and hospitals. Doctors and hospitals also can form their own health plans, if they want.

THE INSURANCE INDUSTRY AND HEALTH CARE:
The Current System

- **Covering Only Healthy People:** Insurance companies focus exclusively on giving very low premiums to healthy individuals, and increasing premiums when people get sick.

- Most insurance companies won't even accept people unless they're healthy. In some cases, insurance companies will drop people from a plan if they become sick.

- Insurance companies often refuse to cover a pre-existing medical condition. For example, if you have a particular disease, they're likely to accept you on the condition that they don't have to cover any costs associated with that disease.

- **Discriminating Against Small Business:** If you're an employer with an mid-sized or small firm or an individual, it's nearly impossible to purchase real comprehensive health coverage at an affordable price.

- If you're a small employer and one of your employees gets sick, your premium will rise much faster than the premium for a large employer.

- **Insurance Companies Are In the Driver's Seat:** Insurance companies are in control. If they don't want to cover you, they don't have to. If they don't want to cover the cost of treating a particular illness, they don't have to. If they want to inflate your premiums, they do. There's usually nothing a consumer or individual small business can do about it.

AMERICAN WORKERS

AMERICAN WORKERS AND HEALTH CARE:

American workers and employers will benefit by reform of a health care system in crisis. Workers will no longer see money that should go toward wages go to increased health costs. Americans workers will have the choice to remain in their current health plans -- many of which have been negotiated in collective bargaining agreements. Retired workers will have the peace of mind of guaranteed health care coverage.

- **Wage Loss:** American workers who have seen wages consumed by ever increasing costs of health care will gain from a reform plan that ends the tradeoff between health benefits and wage increases.

- **Strikes:** Health care cutbacks cause tension between labor and management and have been a major issue in strike activity. The Clinton plan reforms a health care system at the root of so many labor-management disputes.

- **Job Lock:** American workers will no longer fear that changing jobs or losing jobs will mean losing their health coverage. The Clinton plan will ensure continuation of coverage and stop the insurance underwriting practices that refuse to cover pre-existing conditions or refuse coverage to people who are ill.

- **Comprehensive benefits package**: The comprehensive benefit package will incorporate the best elements of today's health plans. Federal standards will ensure that all plans offer the guaranteed comprehensive package of benefits at an affordable price.

- **Choice:** Workers will have the choice to keep their current benefits, many of which were won in collective bargaining.

- **Retirees:** As hard economic times cut profit margins, many employers have reduced health care benefits to employees and retirees, leaving millions of Americans vulnerable. Under the Clinton reform, retired workers will have the security of knowing they will have guaranteed coverage.

- **Competitiveness and Jobs:** Workers and businesses are hurt when health care costs, burden industry in a highly competitive global economy. When American products can't compete, American workers lose jobs. The Clinton plan will help businesses and workers compete and win again.

- **Single Payer:** While some labor leaders might prefer a single payer system, our plan follows a different method toward the same goal providing all Americans with security of knowing they will have health care when they need it. Ours is a state-run system. But state aren't locked into any rigid formula -- if it makes more sense to adopt a single-payer system, a state can choose to do so.

AMERICAN WORKERS AND HEALTH CARE:
The Clinton Plan

OUR HEALTH CARE PLAN PROVIDES SECURITY FOR AMERICAN WORKERS

American workers deserve a health care system that gives them the security of coverage when they need it. The Clinton reform plan will expand coverage to all American's workers and ensure that workers who have coverage today still have it tomorrow. The Clinton plan will:

HOW IT WORKS ...

- Provide security of coverage to American workers.
- Guarantee a comprehensive benefit package that will be available to every American, incorporating the best elements of today's plans.
- Allow workers **the choice** to remain in their current health plans, many of which have been negotiated in collective bargaining agreements and expand the number of plans available to workers.
- Ensure retired workers the peace of mind that they will always have coverage and safeguard the long-term economic survival of America's largest industries.
- Free up resources for wage and salary increases stymied by rising health costs.

AMERICAN WORKERS AND HEALTH CARE :
Questions and Answers

Q. I am the employee of a large business. Will my employer be allowed to remain out of the new system?

A. That decision has not yet been made.

Q. Will I be allowed to join the health alliance even if my employer remains out of the health alliance?

A. Your employer will be encouraged to become part of the new system. Regardless, you will be guaranteed the same comprehensive benefit package and pay no more than the 20% employee share of the premium. Whatever plan you have meet national quality standards.

Q. Will I have to pay taxes on my health care benefits if they exceed a certain limit?

A. Workers who receive an expansive benefit package that includes such things as elective plastic surgery and private hospital rooms may have to pay for them with after-tax dollars.

Q. Will I lose the benefit package I currently receive?

A. No. Employers who provide more comprehensive benefit packages -- some of which were won through collective bargaining -- may continue to do so.

Q. Will retirees be covered under the Clinton plan?

A. Yes. Obligations under current contracts will be honored and retirees will receive guaranteed coverage just like other non-working Americans.

AMERICAN WORKERS AND HEALTH CARE:
The Current System

- In 1989, health care cutbacks were a major issue in 78 percent of all strike activity. Large companies such as GM are at a "significant competitive disadvantage" because of huge pension and health care obligations to retirees. [Standard and Poors] In the last two years, two-thirds of the nation's employers made or intended to make changes to retiree health plans. [RWJ]

- Retiree health obligations make up 70% of the book value of GM; 54% of Chrysler; 38% of AT&T; 29% of Ford; 14% of Boeing; and 8% of General Electric. [RWJ]

- Workers have lost 58 percent of wage increases since 1980, and will lose 100 percent in coming years because of rising health benefit costs for employers. [Henry Aaron, Brookings Institution, 1992; President's Advisory Committee on Social Security]

- From June 1980 to June 1992, average weekly wages of production and non-supervisory workers adjusted for inflation, fell from $235 to $218. Rising health care costs were a central reason. [Bureau of Labor Statistics]

- **Both Ford Motor Co. and GM spend more money on health care than they do on steel.** [Ford Motor Co.] In 1990, GM spent $3.2 billion in medical coverage for its 1.9 million employees and retirees. ["Condition Critical," Time, 11/25/92]

- Ford Motor Company's **health care costs have tripled as a percentage of payroll -- from 6% in 1970 to nearly 20% percent in 1991.** Health care costs add more than $1100 to the price of every car made in America; that's more than double what the Japanese spend. [Ford]

HOSPITALS

HOSPITALS AND HEALTH CARE:

Hospitals serve as focal points for integrated, community-based health care in the Clinton plan for health reform. Hospitals will no longer need to provide expensive emergency care to uninsured people, knowing they'll never receive payment. Under the Clinton plan, all Americans will have coverage. Hospitals will operate in a system with new incentives that promote and ensure quality by measuring results, not by micromanaging care. Health reform will streamline billing procedures, insurance claims and paperwork. It won't add new layers of bureaucracy or create more paperwork.

- Today hospitals bear the burden of caring for Americans who don't have health insurance. **Hospitals come out ahead in a system of universal coverage** -- when every American has health insurance, every hospital will have the security of knowing that they will be paid for their services.

- Today insurers control costs by arbitrarily ratcheting down doctor and hospital payments. Under the Clinton plan, hospitals will have budgets to meet but will exercise more local authority.

- **Reform of the medical malpractice system will guarantee hospitals increased protection** against frivolous lawsuits and reduce the costly practice of defensive medicine.

- Bureaucracy strains American hospitals, many of which now employ as many people to deal with billing and administration as to care for patients. **The Clinton plan will reduce administrative burdens on hospitals and doctors** by standardizing and streamlining billing and claims forms and reducing unnecessary regulation.

- **Recognizing that teaching hospitals play a unique role in advancing health research and treating the most difficult cases,** the new system will continue support for advanced care innovation and the evaluation of new clinical approaches.

HOSPITALS AND HEALTH CARE:
The Clinton Plan

- **Hospitals at the Center of Community Care**

  Hospitals have always carried the primary responsibility for caring for the seriously ill and played a leadership role in health care problems. In a new system of community-centered health plans, hospitals will continue to play a pivotal role.

- **Health Providers Working Together**

  Health plans will bring hospitals together with area doctors, nursing services, pharmacies and other health care providers to provide the comprehensive, guaranteed benefits to everyone enrolled in the plan.

- **Hospitals Working Together**

  Under health reform, hospitals will work more cooperatively, and share services where it makes sense.

- **Streamline Administration**

  Reductions in bureaucracy will allow hospitals to redirect resources away from administrative tasks such as billing and toward patient care.

HOSPITALS AND HEALTH CARE:
The Current System

CARING FOR UNINSURED IS A FINANCIAL DRAIN

Hospitals form a safety-net that serves the nation's uninsured population in emergency rooms. Caring for the uninsured causes a financial drain on many American hospitals, particularly those located in rural communities and inner-city neighborhoods.

PAPERWORK STIFLES HOSPITALS

Among all health care providers, hospitals are most burdened by requirements of the bureaucracy that's built up within the health care industry. Under the weight of peer review organizations, government inspectors, industry regulators, reviewers, and coders, and all their accompanying forms, today hospitals treat as many pieces of paper as patients.

DEFENSIVE MEDICINE DRIVES UP COSTS

The tensions caused by physicians practicing defensive medicine are played out in hospitals under the current system. It's in hospitals that countless tests and procedures are performed not because they are necessary to improve patient health, but in order to avoid lawsuits.

HOSPITALS AND HEALTH CARE:
Question and Answers

Q: Hospitals are hit hard by the growing ranks of uninsured people who show up at our doors for care. How soon will you achieve universal coverage?

A: We are committed to insuring all Americans as quickly as possible. This is not only an economic imperative, as well as a societal one: The longer we take to cover everyone, the more it will cost. On the other hand, phasing in the new system should cause as little disruption to businesses and individuals as possible. The goal is to provide coverage for everyone by January 1, 1997. We will give states financial incentives to move more quickly if they can.

Q: It is important that the guaranteed benefit package be comprehensive enough to cover a full range of hospital-related services. How much will the national benefit package cover?

A: The Clinton plan will guarantee a broad and comprehensive benefit package, covering a full range of hospital care. The package also will stress preventive and primary care to help ensure that hospital admissions that can be avoided occur less often.

Q: Teaching hospitals care for some of the country's sickest patients with the most complicated conditions, and perform a number of teaching and research functions. These programs cost money. Will academic medical centers be compensated adequately in the new system?

A: We recognize that teaching hospitals serve a unique role in the health care system. Public and private funding for teaching and clinical research will be maintained so that academic medical centers can continue to advance medical practice and search for new treatments and cures. To keep them competitive in the new system, teaching costs will be separated when plans that include teaching hospitals bid to provide care.

PHYSICIANS

PHYSICIANS AND HEALTH CARE:

The President's health security plan will allow doctors to return to the business of practicing medicine. It will reform malpractice and reduce bureaucracy to help physicians provide responsive, effective patient care.

- The Clinton plan will maintain the best of the American health care system-- the highest quality care and an individual's right to choose a doctor.

- But the existing health care system has grown so large and so overregulated and bureaucratic that doctors spend more and more time filling out forms and less and less time with their patients.

- **The Clinton plan will reduce paperwork by standardizing forms and reducing micromanagement by insurance companies.** By making the system simple, the Clinton plan will drastically reduce the burdens of bureaucracy, and turn attention away from paperwork and back to patient care.

- **Malpractice reforms are essential to giving physicians back their professional autonomy**, promoting trust in the doctor-patient relationship and lowering health care spending caused by "defensive medicine".

- By guaranteeing a fee-for-service network in every alliance, **doctors who want to keep their private practices in an individual office will be able to do so** and still participate in the new system.

- Our plan will provide incentives for more medical students to become primary care physicians. By guaranteeing a benefit package that emphasizes preventive health services, **the plan will place increased importance on the family physician.**

PHYSICIANS AND HEALTH CARE:
The Clinton Plan:

PROMOTING AN INDIVIDUAL'S RIGHT TO CHOOSE THEIR DOCTOR

The Clinton plan will take a number of steps to guarantee individuals increased choice. Health alliances will offer a wide variety of plans, in most cases more choices than employers typically offer today. Individuals will choose the plan that makes the most sense for them-- in terms of convenience, participating hospitals, and doctors affiliated with the plan. Doctors may choose to take part in more than one plan. In order to let independent doctors continue their private practice, each health alliance also will offer a fee-for-service plan, a loosely formed network that will allow doctors autonomy while holding the group responsible for a budget.

REDUCED BUREAUCRACY AND PAPERWORK

Health reform will focus on simplicity, including a drastic reduction in the paperwork and regulatory requirements that currently consume time and money in physician's offices. The national health board, through an advisory committee on administrative simplification, will standardize reimbursement and clinical encounter forms; automated insurance transactions; and utilization review. It will also streamline Medicare.

The advisory committee will consult with providers, health plans, employer groups, consumer groups and others to adopt common forms and set standards. By January 1995, all plans will report reimbursement on a single form for different classes of providers.

REAL MALPRACTICE REFORMS

The Clinton plan will reform malpractice laws. Enterprise liability will result in health plans taking collective responsibility for quality, rather than leaving each doctor out on his or her own. Alternative dispute resolution will give doctors and patients the opportunity to resolve disagreements amicably, outside the courtroom. Practice guidelines will establish national parameters for defining best-practice medicine. This will protect doctors providing thorough and responsive care to their patients.

Tort laws also will be reformed under the Clinton plan. Lawyers fees will be limited to one-third of the award. Damages will be reduced by any payments from other sources including health plans. Lump-sum payments will be replaced with periodic payments. (States may be required to limit

noneconomic damages.)

COMPREHENSIVE BENEFITS PACKAGE

The Clinton plan will ensure that every American is covered by a comprehensive benefits package that stresses primary care and preventive medicine. Primary care doctors and other health professionals have contributed to defining a benefit package that is truly preventive.

INCREASED INCENTIVES TO PRACTICE PRIMARY CARE MEDICINE

To improve the geographic distribution of physicians and the mix of primary and specialist care, the federal government will redirect its support for health training and education to include a variety of practice settings.

Health reform will also address the imbalance between primary-care and specialist physicians by:

- Establishing a national limit, phased in over 5 years, of 50 percent on the number of specialty training positions with the balance reserved for general internal medicine, general pediatrics and family practice.

- Set the number of training positions each year for each medical specialty based on recommendations by a subcommittee of the national health board.

- Allocate positions to individual residency training programs through a process similar to the National Institutes of Health's grant review process.

- Remove Graduate Medical Education (GME) restrictions on training in ambulatory care, and community-based sites.

- Authorize programs to retrain specialist physicians for primary care careers.

PHYSICIANS AND HEALTH CARE:
Question and Answers

Q: Will the patients in my practice still be able to see me in the new system?

A: Of course. All Americans will be able to follow their doctor-- they will simply sign up for one of the plans their doctor joins. If you as a doctor decide to change plans, your patients will always have the choice of switching, too.

Q: As a doctor, I'm concerned that budgeting will lead to rationed care and poor quality medicine. How can we be sure that won't happen?

A: People often raise the concern that greater attention to health care costs will result in reduced quality in the system. Not true. Much of the cost in today's system can be removed without affecting service delivery or quality. Unnecessary tests and procedures, paperwork and duplication can be reduced, freeing up resources to pay for care. Throughout the United States, innovative corporations, group practices, and health care institutions have proven that cost-effective care does not reduce quality; in fact, it increases it.

Q: When it comes to bureaucracy and regulation, the government has traditionally been part of the problem. Why should I believe that you're now part of the solution?

A: It's true that government has been as much to blame as the private sector for creating overgrown bureaucracy and excessive rules. But health care reform will result in less paperwork and regulation. Here's how: the government will streamline reimbursement by instituting a single claims forms, replacing the thousands of different forms used by over 1,500 different insurance plans today. Peer review will be simplified and inspections coordinated. Washington will not micromanage the health care system. The federal government will establish a national framework and standards for quality. Those who purchase and deliver health care will be free to make decisions that suit individual needs and preferences.

Q: Defensive medicine drives up my costs, and my malpractice premiums are a further burden. What will your plan do for me?

A: Defensive medicine and frivolous lawsuits are certainly part of the health care problem, and any viable solution has to address malpractice reform. By focusing on enterprise liability, individual doctors don't need to worry that they're out on their own. By instituting practice guidelines and methods for alternative dispute resolution, doctors will be freed from practicing based on the fear of ending up in a courtroom.

Tort reform will accompany malpractice reform. To minimize the incentives to bring frivolous cases to court, The Clinton plan will limit contingency fees and collateral source recovery. Payments will be made when services are necessary, not in one lump sum. States may be required to impose caps on noneconomic damages.

PHYSICIANS AND HEALTH CARE:
The Current System

A SYSTEM RULED BY PAPERWORK

One of the greatest frustrations in today's health care system is the burden of paperwork. Paperwork in hospitals and doctors' offices consumes time and money -- resources better spent providing patients responsive, high quality care. We have created a system ruled by regulation, a system in which checkers check other checkers who check on the work of doctors they've never met, and the care given patients they've never seen.

"DEFENSIVE MEDICINE"

Multi-million dollar lawsuits have come between doctors and their patients and have driven up medical costs due to "defensive medicine." These pressures have resulted in unnecessary tests and procedures performed not to protect patients' health but to protect against malpractice suits.

A SHORTAGE OF PRIMARY CARE DOCTORS

Our nation's health care system is threatened by a serious shortage of primary care and generalist physicians. Yet each year, medical schools churn out more specialists and sub-specialists and too few primary care doctors.

Part of the problem is that we don't pay primary care doctors -- those who focus on early detection, health education, and prevention -- enough. From the private sector to Medicare, today's flawed financing system puts less value on early intervention and more on specialist treatment.

Primary care physicians should be at the center of our nation's health care system -- preventing disease, promoting wellness, and keeping people healthy and out of the hospital. In today's system, too many Americans lack access to primary care doctors, because they don't have insurance. When people lack access to health care, they pass up cost-effective care of primary care doctors and wind up in emergency rooms, in need of expensive care.

NURSES AND OTHER HEALTH CARE PROFESSIONALS

NURSES AND HEALTH CARE:
The Clinton Plan

The Clinton plan will place nurses on the front line of primary and preventive care. It will reduce professional barriers for nurses and cut the paperwork that forces them to spend as much time at a desk as a bedside.

- **Increase nurses' roles** in providing primary, preventive, mental health and long-term care. Advanced practice nurses -- registered nurses who have met advanced educational and clinical practice requirements -- will play a crucial role in guaranteeing that every American receives high-quality care. Nurses in community and primary care settings will see people when they first need care.

- **Reduce barriers** and move toward a level playing field among health professionals. Nurses will be able to contribute on the basis of their skills and work to the full scope of their training. Nurses will work in partnership with other health providers to ensure high-quality care.

- **Cut paperwork** so that nurses can concentrate on providing care to patients -- not filling out forms.

- **Provide incentives** for nurses to work in underserved rural and urban areas.

- **Rely on nurses to provide home-based and community care** for older Americans, persons with disabilities, the chronically ill and other vulnerable populations, such as the mentally ill and children with special needs.

- **Increase racial and ethnic diversity among nurses**, so that patients will be served by nurses who have roots in those communities.

NURSES AND HEALTH CARE:
Questions and Answers

Q: Will the Clinton plan make me see a nurse when I want to see a doctor?

A: No, but under reform, nurses will play a much greater role in giving primary and preventive care -- a role in which they have proven effective. Health plans will ensure that patients have a choice of whom to see for care.

Q: Will nurses be thrown out of work under the Clinton plan?

A: No. Reform will help nurses return to doing what they were trained to do -- caring for people in need. The Clinton plan will increase the number of nurses practicing in community settings.

Q: How will the Clinton plan make sure that nurses are located in areas where they are needed?

A: The Clinton plan will make funding available for training programs that target current and projected needs for care in underserved areas and increasing the number of nurses who come from those communities.

Q: Won't the Clinton plan pit nurses against physicians as it moves to make nurses more independent?

A: No. The Clinton plan will enable nurses to perform to the full scope of their skills and training in partnership with other health providers. Nurses will not assume the role of the physician. Reform will set the stage for improved relations within teams of providers. It will eliminate the difficult and costly process of states making case-by-case changes in practice guidelines for advanced practice nurses. It will mean higher-quality, affordable care for more Americans.

NURSES AND HEALTH CARE:
The Current System

NURSES ARE THE BACKBONE OF THE HEALTH CARE SYSTEM

- Our nation's 1.8 million working nurses form the backbone of our health care system, the largest group of health care providers in America.

- Nurses work on the front lines of medicine. They are the professionals that people turn to first when they walk into the hospital or clinic.

NURSES PROVIDE PREVENTIVE AND PRIMARY CARE

- Nurses make an important contribution to preventive and primary care -- getting people the care they need before they become seriously ill.

- Nurse practitioners, nurse midwives and certified registered nurse anesthetists have a record of delivering high-quality, cost-effective care, particularly in rural and urban areas.

UNNECESSARY BARRIERS PREVENT NURSES FROM GIVING CARE

- Unnecessary barriers prevent nurses from giving all the care they are trained to provide. In today's system, nurses are often not allowed to work to the full scope of their practice and prevented from receiving direct payment for their services. Those restrictions make it difficult to practice in underserved areas.

PAPERWORK TAKES UP TOO MUCH OF NURSES' TIME

- The burden of paperwork forces nurses to turn their attention away from patients.

NURSES NEEDED IN UNDERSERVED AREAS

- More nurses are needed in rural and urban areas where people often have trouble obtaining the care they need. Many of these nurses can work in primary care and community-based settings, such as public health, schools and home health.

- Although the ranks of nurses traditionally have included more members

of ethnic and racial minorities than other health professionals, the number of nurses from minority groups still must be increased to more closely reflect the populations they serve.

OLDER AMERICANS

OLDER AMERICANS AND HEALTH CARE:

The Clinton plan will protect older Americans, maintaining health benefits they now receive while adding coverage for prescription drugs and increasing options for long-term care, particularly for services based in the home and community.

- Under the current system, older Americans are squeezed between fixed incomes and rising health care costs, especially for expensive prescription drugs. The Clinton plan will offer older Americans a prescription drug benefit and preserve the coverage they now have.

- **Maintaining Medicare:** We are committed to preserving **the fundamental contract between older Americans and the government** -- including maintaining the Medicare benefits that they depend on.

- **More Health Care Choices:** All Americans, including Medicare recipients, will have more choices under the President's health reform plan. Medicare beneficiaries can continue to receive care under their current Medicare system or choose among the different health plans offering richer benefit packages and lower co-payments.

- **Prescription Drug Benefit:** Pharmaceutical prices have been skyrocketing, driving up health care costs for older Americans and forcing millions to choose between buying food and filling prescriptions. Our plan will guarantee a prescription drug benefit to older Americans and crack down on pharmaceutical price gouging.

- **Long-term Care Services:** Most older Americans want to receive long term care in their homes and communities but today must contend with a system that encourages institutional care. The Clinton plan will provide increased opportunities for people to receive the health care they need where they need it, at home with their families.

- **Protection Against Long-Term Care Costs:** Older Americans are forced to impoverish themselves today so they will be poor enough to qualify for long-term care benefits under Medicaid. The Clinton plan will begin to change these incentives and restoring dignity to patients who need long-term care.

OLDER AMERICANS AND HEALTH CARE:
The Clinton Plan

MEDICARE BENEFITS WILL NOT BE AFFECTED

- In the new system, Medicare will remain a distinct federal program and Medicare beneficiaries can continue to receive their benefits as they do today with no new costs or penalties.

INCREASED CHOICES FOR MEDICARE RECIPIENTS

- Medicare beneficiaries are likely to have more choices after reform -- they can continue to receive care the way they do today **or they may be able to get increased benefits through the different health plans** offered through the health alliances.

SENIORS WON'T HAVE TO CHOOSE BETWEEN DRUGS AND FOOD

- The Clinton health care plan will provide insurance coverage for prescription drugs and protect older Americans from escalating drug prices by controlling costs.

INCREASED OPTIONS FOR LONG-TERM CARE OPTIONS

- People want to receive health care at home with their families. The Clinton plan will offer greater flexibility to provide long-term care at home and in the community. While a comprehensive long-term care program may take several years to phase-in, older Americans will receive increased financing options through improvements in private long-term care insurance.

- Older Americans will no longer be forced to "look poor" and impoverish themselves to qualify for long term care. Under our health care plan, the amount of lifetime savings the elderly are allowed to keep but still qualify for Medicaid coverage will **rise -- from $2,000 to $12,000.**

- The Clinton plan will make private long-term care insurance more accessible and improve the quality of policies. Under reform, tax laws will be changed to treat long-term care insurance like other health insurance.

OLDER AMERICANS AND HEALTH CARE:
Questions and Answers

Q: Is it true that you will require people on Medicare to obtain coverage through the new system?

A: No. Seniors will still be able to receive their Medicare benefits as they do today, with no new costs or penalties. In fact, people with Medicare are likely to have more choices after reform. They will be able to choose to **receive increased benefits through the different health plans** the new system will offer.

Q: Will I have to pay more in the new system?

A: Over time, you will probably pay less, as cost controls limit the growth in your out-of-pocket costs under Medicare and make prescription drugs affordable for all older Americans. You also will likely see increased funding and service options for long-term care, which is the largest out-of-pocket health cost for older Americans.

Q: I am a Medicare beneficiary. Will I still be able to choose my own doctor under the new plan?

A: Absolutely. Medicare beneficiaries can continue to choose their own doctors with no additional costs or penalties. They will have an increased opportunity to enroll in different plans under the new system and receive more for their money -- increased benefits and/or lower out-of-pocket costs -- but the decision to enroll will be left to the individual.

Q: What long-term care benefits does your plan provide?

A: We will begin immediately to address the need for greater flexibility for patients to receive care in home and community-based settings. Older Americans will benefit from increased funding and options for home care in the short-term although a comprehensive long-term care program may take several years to phase-in.

Q: I am often forced to choose between drugs and food. How will your plan help?

A: Prescription drugs represent the largest cost of daily living for 3 out of 4

older Americans; yet 64% of older Americans have no outpatient prescription drug insurance. The Clinton plan will provide security to older Americans by guaranteeing a prescription drug benefit and eliminate the need to choose between necessities.

OLDER AMERICANS AND HEALTH CARE:
The Current System

OLDER AMERICANS SPEND MORE ON HEALTH CARE THAN EVER BEFORE:

- More than 10 percent of the average older American's income was spent on health care services in 1990, compared to 7 percent ten years before. **In fact, persons over age 65 now spend more of their incomes on health care than they did before Medicare began in 1966.** [Robert Wood Johnson/Alliance for Health Reform]

OLDER AMERICANS ARE FORCED TO CHOOSE BETWEEN FOOD AND DRUGS:

- Because nearly two thirds of Americans over the age of 65 have no insurance for drugs, more than 8 million Americans over age 55 say they have to choose between buying food and paying for medication. [EBRI, 1/92; AARP Survey, Summer 1992]

- Prescription drugs -- the cost of which has grown 10 to 15 percent faster than the rapid rate health care costs as a whole -- represent the largest single cost of daily living for 3 out of 4 older Americans. [USA Today, 1991]

LONG-TERM CARE IMPOVERISHES OLDER AMERICANS:

- Medicare will only help pay for nursing home care for persons who are poor or who have impoverished themselves. Unmarried individuals may keep only $2,000 in assets other than their home and must contribute almost all of their income toward the cost of care.

- Nursing home care is the largest out-of-pocket health care expense of the elderly, accounting for 42 percent of all out-of-pocket health care payments. [HCFA]

- Paying for nursing home care costs almost $36,000 per year -- about the same as an average family's annual income -- and is estimated to rise to $46,000 by the end of the decade. [Robert Wood Johnson Foundation]

CURRENT SYSTEM IS BIASED TOWARD INSTITUTIONAL CARE:

- Most long-term care expenditures are for institutional care. Two thirds of the $108 billion that will be spent in 1993 -- or $75 billion -- will pay for nursing homes and other institutional services.

- Aetna Life and Casualty reported a **$78,000 per case** savings from its Individual Care Management Program which provided care for accident victims in their homes. [Robert Wood Johnson Foundation]

VETERANS

VETERANS' HEALTH
The Clinton Plan

The Clinton plan will honor the nation's commitment to provide health care to veterans, give veterans more choices about how and where they receive care and preserve the VA health system.

THE VA SYSTEM WILL HAVE ITS OWN HEALTH PLANS:

- The Department of Veterans Affairs will have the option of organizing its hospitals and clinics into health plans that will compete with other health plans to enroll veterans.

VETERANS WILL HAVE INCREASED CHOICES:

- In areas where VA health plans exist, all veterans will have the option of enrolling in them to receive the nationally guaranteed, comprehensive benefit package.

- If veterans choose another health plan, they will pay the same portion of their premiums as other Americans pay. Higher-income veterans who choose to enroll in the VA health plan also will pay a portion of premiums.

- Veterans who enroll in a fee-for-service health plan may obtain care through the VA system. Under that arrangement, veterans will be responsible for any contribution required.

VETERANS BENEFITS WILL BE PRESERVED:

- Veterans with service-connected disabilities and those with low incomes who enroll in the Veterans Administration health plan will not pay for services.

VA HEALTH SYSTEM WILL HAVE INCREASED FLEXIBILITY:

- The VA health system will undergo some changes to enable it to compete effectively as a plan. Current law will be amended to:

- Permit the VA to retain funds recovered from third-party payers for the cost of veterans' care.

- Provide broad authority for VA hospitals and clinics to enter into contract with other health plans to provide services to veterans.

- Allow VA managers to control budgets without the traditional restrictions of line items or earmarked funds and delegate to managers of VA clinics and hospitals flexibility in hiring.

- Eliminate excessive and unnecessary reporting requirements and inspections.

SPECIALIZED SERVICES FOR VETERANS WILL BE MAINTAINED:

- Under health reform, Congress will continue to fund specialized services, such as treatment for post-traumatic stress disorder. Low-income veterans and those with service-connected disabilities will have access to these specialized services whether or not they enroll in a VA health plan.

VETERANS' HEALTH
Questions and Answers

Q: Don't these changes drastically alter the VA system?

A: No. Change will occur in the structure and financing of the VA system, but it won't have much an effect on how a veteran receives care. However, these changes will improve the efficiency of the VA system and give veterans more health care choices.

Q: What will be done to improve the deteriorating quality of the VA hospitals?

A: The Clinton plan removes regulatory barriers such as procurement and personnel rules that have prevented VA hospitals from operating at top efficiency. Also, VA hospitals will become more competitive because they will have to compete to give veterans care.

Q: Can non-veterans join a VA health plan or go to VA hospitals?

A: No but VA hospitals will be open to veterans who previously have been unable to receive care because of limited capacity.

Q: Will supplemental benefits, such as treatment for post-traumatic stress disorder still be available?

A: Yes, even if a veteran joins a health plan other than the VA plan.

VETERANS' HEALTH
The Current System

THE VA OPERATES ITS OWN HEALTH SYSTEM:

- The Department of Veterans' Affairs currently serves 2.6 million veterans a year, about 10% of all veterans. The Department operates 171 hospitals, 358 outpatient clinics and 132 nursing homes. It employs over 200,000 people and trains over 100,000 health care professionals annually.

VETERANS GET COMPREHENSIVE BENEFITS:

- Health care benefits are very comprehensive. In addition to hospital and physician services, the VA provides nursing home care, home care, extensive psychiatric services, prescription drugs and prosthetics.

CAPACITY IS LIMITED IN THE VA SYSTEM:

- Because funding is limited, many veterans are unable to receive care in the VA system. Veterans with disabilities that resulted from active duty have first priority, veterans with annual incomes less than $20,000 have second priority, and all other veterans have third priority. Veterans with service-connected disabilities and low-income veterans do not pay for services.

MILITARY PERSONNEL

MILITARY PERSONNEL
The Clinton Plan

Under the Clinton plan, the Department of Defense will maintain the unique readiness responsibilities of military medicine, and fulfill health care commitments to current beneficiaries. Any changes to the military health care system will occur after a year-long internal review process and consultation with the Armed Services and Appropriations Committees of the Senate and House of Representatives.

The Department will consider the following proposal during a year-long internal review process and after consultation with Congress with the exception of active-duty personnel, the Department of Defense gradually will coordinate its health care programs with the new system.

REFORM OFFERS MILITARY PERSONNEL MORE CHOICES:

- Current beneficiaries of CHAMPUS will continue to pay no premiums. Current beneficiaries who join a civilian health plan will pay the same premiums as civilians. The Department of Defense and Congress will determine the cost for beneficiaries who choose a military health plan.

DOD MAY RUN ITS OWN HEALTH PLAN:

- If fully implemented, the Department of Defense health care system will have the following features:
    - The Department will operate military health plans that serve each geographic region in which military medical centers are located.
    - The military health plans will compete with civilian health plans to enroll military beneficiaries.
    - The Department will require that beneficiaries enroll for military health care, ending space-available care for those who do not enroll.
    - Military beneficiaries will receive the comprehensive benefit package and pay a portion of costs on the same basis as other citizens.

- Private employers will pay the employer's standard share of premiums for Department of Defense beneficiaries employed elsewhere.

- The Department would receive money from Medicare for beneficiaries who use the military health care system.

MILITARY HEALTH PLAN MAY HAVE MORE FLEXIBILITY:

- To enable military health plans to compete, the Secretary of Defense may consider enacting regulations to increase the flexibility and autonomy of managers of military plans.

MILITARY PERSONNEL
Questions and Answers

Q: Does this mean that anyone can join a military health plan?

A: No. Only military personnel will be able to join under this recommendation.

Q: What happens to military hospitals? Can anyone go?

A: No, only military personnel will be able to receive care from military hospitals.

Q: How would benefits change?

A: Military personnel will receive better benefits because they will be guaranteed the comprehensive benefit package.

Q: Will DOD have to pay more to become a health plan?

A: No. In fact, DOD will get an influx of money to pay for military health care from the employer contributions for dependents of military personnel who are employed elsewhere.

MILITARY HEALTH
The Current System

DOD HAS ITS OWN HEALTH CARE NETWORK:

- The Department of Defense provides direct service through a network of 18 medical centers, 124 community hospitals and 561 medical clinics.

- Dependents of active-duty personnel and retired military personnel and their dependents under age 65 may use the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to pay some costs of care delivered by civilian providers.

- Retired military personnel and their dependents age 65 and older are eligible for Medicare.

HEALTH SPENDING CLAIMING MORE OF DOD BUDGET:

- Just as health care has consumed an ever larger percentage of GDP, so too has health care been claiming an ever larger share of the Department of Defense budget. Spending on health care has climbed from less than 3 percent of the department's budget in 1984 to more than 5 percent in 1993.

BENEFICIARIES' COSTS VARY DEPENDING ON WHERE THEY LIVE:

- Beneficiaries' out-of-pocket expenses for health care depend on where they live and their ability to obtain care form military hospitals. Those who gain access to the direct care system pay very low out-of-pocket costs. Those who do not -- because of overcrowding or because there is no nearby hospital -- must pay higher out-of-pocket costs under CHAMPUS or Medicare.

CHILDREN AND FAMILIES

CHILDREN AND FAMILIES AND HEALTH CARE:

The Clinton health plan will provide security to all American families. All Americans will be guaranteed access to a comprehensive benefit package including prenatal care as well as coverage of preventive services and immunizations for children. The Clinton plan will invest in children and families by reigning in health care costs and ending the strain they place on family budgets.

- **Controlling Costs:** The Clinton plan will tackle health care costs that threaten to place health insurance protection beyond the means of a growing number of American families. It will ensure that the cost of health care never rises faster than inflation.

- **Security:** The Clinton plan will guarantee health security to every American family. No longer will health insurance protection depend on your job, your health, your income or your age.

- **Insurance Reform:** Pre-existing condition exclusions will be eliminated. Health plans will take all applicants, healthy or sick, charging the same rate for everyone in the community.

- **Comprehensive Benefits:** All Americans will receive a card that ensures their right to a comprehensive benefit package, including prenatal care for pregnant women, as well as coverage for immunizations and preventive services for children.

- **Choice of Health Plans:** Consumer choice lies at the foundation of the Clinton plan. Americans, not their employers or insurance companies, will choose own plans from local health alliances. These group purchasers also will monitor quality and provide consumers with the information they need to pick the right plan for themselves and their families.

- **Choice of Doctors:** The right to choose your own doctor is a hallmark of American medicine. Preserving this right for all Americans is central to the plan.

CHILDREN AND FAMILIES AND HEALTH CARE:
The Clinton Plan

Under the new system all Americans will be guaranteed health insurance coverage with a comprehensive benefit package. The Clinton plan will improve access to care, control costs, and maintain the high quality Americans expect. Preventive and primary care will be the centerpiece of health care in America, especially for children.

The proposal will be based on the following principles:

- **Security:** The Clinton plan will provide all Americans with the security of knowing that wherever they move or whenever they change jobs, coverage will continue for themselves and their families. American families also will have the security of knowing that their health insurance premiums will never grow beyond their means.

- **Access for All:** Americans will receive a card that guarantees access to the same high quality coverage regardless of where they live, how much they earn, whether and where they are employed, and whether they have a so-called pre-existing medical condition.

- **Comprehensiveness:** The Clinton plan will guarantee a comprehensive benefit package and support community-based delivery systems.

- **Continuity:** The Clinton Plan will maintain the best of the current system and improve it. Americans will continue to be able to choose their own doctors but also have greater choice among high quality, affordable health care plans.

- **Simplicity and Affordability:** People will know what coverage they have, how much it will cost them, and how to use it.

CHILDREN AND FAMILIES AND HEALTH CARE:
Questions and Answers

Q: My spouse, my children and I all have our own doctors. Under the new system will we still be able to see different doctors?

A: Yes. Allowing people to choose their own doctor is a hallmark of American medicine. The Clinton plan preserves this right and expands it by giving consumers a broader range of health plans from which to choose. Under the President's plan, no longer will consumers be restricted to a single plan offered by their employer. Instead, they will choose form a variety of health plans with access to a selection of doctors. Those wishing to see doctors outside their plan can do so, but will have to pay more.

Q: Will my benefits or my family's benefits be reduced?

A: No. The comprehensive benefit package in the Clinton plan will be based on the best of today's plans and will be guaranteed to all Americans. Most Americans will see a broader range of choices among health care plans covering a greater variety of services than they have today.

Q: Will my family's health care be limited in any way?

A: Those who oppose reform often raise the specter of rationing of health care to scare consumers and undermine reform. The truth is that health plans competing on the basis of service and quality to attract and retain patients, will have every incentive to provide necessary care on a timely basis. In addition, the alliances will protect consumers and enforce quality standards.

Q: Will I still receive my health insurance through work?

A: Most Americans obtain their insurance through their jobs. Under the Clinton plan, employers will continue to contribute to the cost of their employees' health insurance. Under the new system, rather than the employer choosing an insurance plan, employees will choose their own plans from among those offered through health alliances.

Q: What happens if I lose my job or change my job?

A. You'll still be covered. You family's health insurance coverage will no

longer depend on whether you work or where you are employed. Once you are covered, you will always be covered. Employees will choose their own health plans through their local health alliance. Assistance will be provided to those who become unemployed to help them pay their premiums.

Q: Can we be denied coverage because of a pre-existing condition?

A: No. Excluding individuals from coverage because of a so-called pre-existing medical condition is one of the major failings of the current system. It is a primary reason why so many Americans do not feel secure in their health coverage. All health plans will be required to enroll all applicants, regardless of their health status, charging the same community rate for premiums.

Q: Does my coverage extend to my family?

A: All American will be covered.

Q: Will all plans cost the same?

A: Plans will negotiate with the health alliance to set the price at which they will provide the comprehensive benefit package. Plans will compete on the basis of quality, service and efficiency. Plans that are able to streamline administration and provide care more efficiently will be able to charge less for the same benefit package.

Q: Will I pay more for health care for my family?

A: People who have family coverage now are already paying the cost of people who do not have insurance. It is not that the uninsured do not get care, they delay seeking care until their condition worsens and becomes more expensive to treat and they get their care in more expensive settings like hospital emergency rooms rather than outpatient clinics and doctor's offices. By covering all Americans and stressing primary and preventive care, the Clinton plan will end this cost-shifting from the uninsured to the insured. If you currently have insurance, the Clinton plan will give you a broader range of choices, many of which will be more cost effective than today's plans. If you do not have insurance or you currently have only individual coverage, you will be expected to contribute toward the premium but the government will provide assistance if you cannot afford it.

Q: How will quality be assured?

A: The federal government will create a national system of quality assurance enforced by the states. In addition, the health alliances will provide information to consumers about customer satisfaction with various health plans. Armed with this information, consumers will be able to take their business to plans that do the best job of providing high quality care.

Q: Will we have to wait a long time for care?

A: Those who oppose reform often raise the specter of rationing of health care to scare consumers and undermine attempts at reform. The truth is that with health plans competing on the basis of service and quality to attract and retain patients, will have every incentive to provide care on a timely basis.

CHILDREN AND FAMILIES AND HEALTH CARE:
The Current System

MILLIONS OF AMERICAN CHILDREN ARE BEING BORN AT RISK

- 25% of all American children, 40 % of African American children, are born to mothers who have received inadequate prenatal care. These children are three times as likely to be low birth weight, the leading cause of infant death or disability. [National Commission on Children]

- The United States ranks 22nd out of all industrialized nations in infant mortality, with a rate twice as high as Japan and 50% higher than Canada. [National Commission on Children]

FEWER EMPLOYERS OFFER FAMILY COVERAGE

- Employer-sponsored health plans are less likely to cover dependents than they did a decade ago. In 1990, 33 percent of employers paid for dependent coverage in full, compared to 40% in 1980. [National Commission on Children]

LACK OF INSURANCE KEEPS CHILDREN FROM RECEIVING NEEDED HEALTH CARE:

- 8.3 million children are uninsured -- nearly one quarter of all the uninsured in the United States. [National Commission of Children]

- 20% of American children had no contact with a doctor in the previous year and therefore did not receive the routine pediatric care necessary to improving children's long-term health. [National Commission on Children]

- 30% of all children, 50% in some inner city areas, have not been fully immunized by age 2. Lack of immunization has contributed to recent outbreaks of measles and mumps [National Commission on Children]

SKYROCKETING HEALTH CARE COSTS PUT PINCH ON FAMILY BUDGETS:

- Over the last decade, the amount the average American family spent on health care more than doubled (from $1,742 to $4,296) and they are projected to double again by the year 2000 if nothing is done to control costs. [Families USA]

- When hidden health care spending being channelled through government and employers is taken into account, it is estimated that the average household spends $8,060 per year on health care. [Alliance for Health Reform]

ISSUE-SPECIFIC TALKING POINTS

CONTROLLING COSTS

CONTROLLING COSTS

The Clinton plan will control skyrocketing health care costs, while maintaining high-quality care, fostering innovation, and improving consumer choice.

- **Administrative Savings:** One health dollar in five, nearly $200 billion, is spent on administration (Lewin-VHI). By streamlining and standardizing regulations, forms, and billing, doctors' offices and hospitals will devote fewer resources to paperwork, which means lower costs for us.

- **Competition Between Plans:** The Clinton plan will force insurers and health plans to compete to provide the best value for the price rather than seek to avoid risk.

- **Increased Efficiency:** The health care dollar of small employers and individuals doesn't go very far in today's system -- as much as 40 cents pays for administration when it could go toward services. A health alliance will pool their purchasing power so they get more value for the dollar. Plans competing for consumers on price will have an incentive to lower their prices and provide better service.

- **Cost Control Safety Net:** The new plan will provide market-based incentives to reign in costs. Additional savings will come from increased efficiency and decreased bureaucracy. But controlling costs is of such critical importance to our economy that the President's plan calls for further guarantees-- an iron-clad national budget.

- **Short-Term Cost Controls:** While this system is established, health care providers will be called upon to hold down increases in their rates. If providers fail to meet targets for holding down fee increases, mandatory price controls would be enforced.

CONTROLLING COSTS
QUESTIONS AND ANSWERS:

Q: Will there be a freeze on doctors and hospitals fees?

A: Freezing prices is a harsh measure which often does not work to control costs. Instead, the President's plan calls on doctors, hospitals and other health providers to do their part to help control our skyrocketing health care costs on a voluntary basis. But if voluntary cost controls don't work, the federal government will put controls in place to hold the growth in health care expenditures to within a certain percentage of inflation.

Q: Will the national budget cause my health care to be rationed?

A: Special interests and opponents of health reform often raise fears of rationing to undermine any attempt at reform. The truth is that we spend more than we should on health care right now. The United States spends more per person and a higher percentage of gross national product on health care than any other nation in the world. Billions of dollars are wasted in administrative expenses and unnecessary tests and procedures. The national health care budget will impose some discipline on our health care spending and insure that appropriate care is provided as efficiently as possible so that we are getting the best value possible for our health care dollars.

Q: Will the budgets be allocated to the states based on their historical health care spending?

A: In the current health care system, health care costs vary widely from state to state. The cost of insuring those currently without coverage will also differ in each state. The Clinton plan will ensure that states have the resources to insure all their citizens; the federal government will make investments in underserved areas, especially rural and urban centers. Differences due to the way providers practice health care will be smoothed out over time. We can't do that overnight. Once the system has been operational for a few years and states have had the chance to get a handle on spending, the Clinton plan will eliminate those imbalances.

Q: How will the budgets be enforced?

A: The States will be responsible for meeting a budget and will be given a range of tools to guarantee they can meet their goal. If states want to spend more, they can, up to a point. But, if they spend more than their budget, they can't ask employers and employees to pick up more of the tab. If a state can't meet the budget on its own, the federal government will step in to make sure the budget is met.

Q: How can you be sure that voluntary controls will work and that we will see real savings?

A: The American people understand that the problems with our health care system did not develop overnight and that everyone must do their part to set things right. Health care providers, as much as anyone, know that we cannot afford business as usual. The President is confident that those involved in the health care industry are willing to sacrifice in the near term to pave the way for a long-term system that controls costs, covers everyone, eliminates red tape and bureaucratic hassles. If they don't, price controls will be imposed to ensure that targets are met.

COSTS/FINANCING

LONG TERM CARE

LONG-TERM CARE:
The Clinton Plan

Increasing options for long-term care is an essential part of a comprehensive health reform package. While it is not possible to solve all the challenges of long-term care immediately, we will begin right away to reduce the burdens on families now coping with elderly parents or children with disabilities. The Clinton plan addresses the need for greater flexibility for home and community-based services.

More options for home care:

- Our system today is biased towards expensive institutional care, even though people prefer to receive care in their homes and communities. We are committed to expanding opporunities to enable people who would otherwise be institutionalized to remain at home with their families and maintain their independence.

- The Clinton plan will make home and community-based care more available and affordable by establishing the Federal Home Care Program. This will increase funding and options for home care for chronically ill Americans -- young and old.

Prescription drug benefit:

- Since the vast majority of medications taken by older Americans treat chronic conditions, the prescription drug benefit provided under the plan will help older Americans live independently and stay healthy over the long term.

Added security for older Americans entering long-term care institutions:

- Older Americans will no longer be stripped of their dignity, forced to "look poor" and impoverish themselves to qualify for long term care. Under the Clinton plan, the amount of their lifetime savings the elderly are allowed to keep and still qualify for federally funded long-term care will be **raised -- from only $2,000 per individual today to $12,000.**

- We will restore the dignity of long-term care by raising the allowance nursing home residents receive for their personal needs from $30 to $100 each month.

- We will encourage and regulate the market for private long-term care so that it is more affordable and accessible for all American families as they begin to plan for a future of independence, dignity, and choices.

LONG-TERM CARE:
Questions and Answers

Q: Why do we need yet another program that primarily benefits the elderly, financed mostly by the non-elderly?

A: The elderly are not the only people needing long-term care -- as much as half of the community-based disabled population is under age 64. In addition, younger people bearing the burden of family members needing long-term care will benefit from the increased options that our plan offers. Today's younger generation will also benefit, both in the short term -- with the added security of knowing that their parents and grandparents have the choices and the peace of mind they deserve -- and over time -- as they are likely to live longer than today's generation of elderly.

Q: How will your long-term care plan help young people with disabilities?

A: The President is committed to improve the quality of life for all people with disabilities. We will provide a **broad range of personal assistance services** to people of all ages with severe disabilities. Our plan is particularly sensitive to the desires of young people with disabilities to be independent.

Q: How does your plan encourage private long-term care insurance?

A: Our health reform plan recognizes the need for all Americans to begin today to protect themselves against the catastrophic costs of long-term care. Many people today are not even aware that private long-term care insurance is available. We will provide consumer education to increase individual awareness of the risks and costs of long-term care and how they can prepare themselves for the future. Our plan will also make this insurance more available and affordable through tax incentives. The government will ensure that private insurance is mandated accurately and protects the consumers.

Q: Why haven't you included nursing home coverage in your plan?

A: We've tried to address what we've heard from the elderly across the country--that they want to be able to stay at home with their families when they become sick. That's why our plan focuses on expanding access to home and community-based services, including personal assistance. People want to retain their independence and dignity. By making more services available in the home, our plan facilitates the development of a variety of residential arrangements for people with disabilities that will offer them many more choices about where to live independently and economically.

While nursing home protection is desirable in the long-run, it is simply too expensive to include in this package. Our plan does provide additional resource protection for individuals qualifying for Medicaid nursing home coverage, increasing the maximum amount of assets an individual may have from $2,000 to $12,000 and raising the personal needs allowance from $30 to $100 each month.

LONG-TERM CARE:
The Current System

Long term care is not just for the elderly:

- Overall, 12.6 million Americans -- or five percent of the U.S. population -- need long-term care, including one quarter of all people with disabilities.

- Over forty percent of those who need long-term care are under 65. All together, 500,000 children, 4.8 million non-elderly adults and 7.3 million older Americans need long-term care. [1990 Survey of Income and Program Participation, 1990 Census]

The current system places undue burden on family members:

- Three quarters of people with disabilities living in the community rely solely on family members, who are often overburdened and financially strained, for long-term care.

The public financing system is highly fragmented and poorly coordinated:

- Long-term care services are financed today through a patchwork of multiple programs. People in need of these services have a limited understanding of how these programs work, who is eligible and how they can access these services.

Our current national long-term care policy is based on a welfare model:

- Public financing is dominated by Medicaid, which accounts for over three fourths of public spending for long-term care and is available only to low-income people.

- People who have been financially independent throughout their lives are **stripped of their dignity**, dependent on "welfare" at the end of their lives. Many don't ever return home, even if they are able, because all their savings have been depleted.

- A welfare-oriented system forces the elderly to impoverish themselves -- creating perverse incentives for people to "look poor" -- to qualify for public assistance. As a result, **long-term care is the largest out-of-pocket health care expense faced by older Americans.** [HCFA]

Public funding is biased toward expensive, institutional care:

- Two thirds of the $108 billion that will be spent in 1993 for long-term care -- $75 billion -- will go to nursing home and other institutional care, in spite of the fact that people prefer in-home and community services.

The public long-term care system is not responsive to consumers:

- Today, professionals make almost all decisions on behalf of others -- despite the fact that younger people with disabilities and older Americans want to make their own decisions about what services they need and where they want them delivered.

FRAUD AND ABUSE

FRAUD AND ABUSE:
The Clinton Plan

ROOT OUT FRAUD AND ABUSE AND RESTORE CONFIDENCE ...

The Clinton plan will root out the fraud and abuse which is adding costs to the current health care system, depleting our resources, and eroding the public's confidence. We will simplify a system whose very complexity encourages fraud and abuse. The plan will increase enforcement efforts and crack down hard on those who have gotten rich exploiting the system.

HOW IT WORKS ...

- **Simplify Payment:** We will simplify payment by using a standard form and a uniform set of rules for payment. This will prevent those who defraud health care payers from exploiting the myriad of payment methodologies, inconsistent rules and codes that exist under the current system.

- **Fraud and Abuse Enforcement:** The Clinton plan will establish a Health Care Fraud and Abuse Enforcement Program to coordinate law enforcement activities aimed at health care fraud and abuse, facilitate communication and complement investigative resources.

- **Anti-Kickback Laws**: Anti-kickback laws will be expanded to cover all payers.

- **Physician Self-Referral**: Physicians won't be able to refer patients to labs and clinics where they have a financial stake.

- **Seize Assets from Fraudulent Activities:** We will change current law so that proceeds derived from health care fraud are subject to federal forfeiture authorities giving the government the ability to seize assets derived from fraudulent or otherwise illegal activities.

- **Enact A New Criminal Health Care Fraud:** The new statute will specifically penalize schemes to defraud either public or private health care programs.

- **Abusers Excluded:** Providers, who have committed fraud or tried to abuse the system, will be excluded from participation in the new system.

- **Put fee-for-service under a budget:** fee-for-service providers will have to meet a budget just as other health plans do. There'll be less incentive to perform unnecessary tests and procedures that drive up costs.

FRAUD AND ABUSE:
Questions and Answers

Q. How much fraud is there?

A. It is impossible to measure all the fraud and abuse in the system, but current estimates are astounding. All knowledgeable authorities agree the figure is in the tens of billions of dollars a year with estimates starting as $80 billion and ranging to $200 billion a year. [GAO, Washington Post]

Q. Do we really need so much Big Brother looking over the shoulders of health care providers in order to have meaningful reform?

A. The great majority of health care providers in this country are honest, hardworking people who want to care for their patients. The intent of the anti-fraud program is to come down hard on the greedy minority who feed off the current system by exploiting its vulnerabilities.

Q. Will health reform's anti-fraud program convert a simple mistake into a federal offense?

A. No. The Program will not penalize people for simple billing errors or other innocent mistakes.

Q. Will anti-fraud penalties inhibit quality of care by making providers fearful of straying from the "lowest common denominator" of care?

A. Obviously there is a balance to be drawn. Rooting out fraud and abuse should not inhibit legitimate decisions about a patients care.