FRAUD AND ABUSE:
The Current System

- Health care fraud depletes resources, erodes public confidence in the operation of the health care system and government in general. The sheer volume of money spent on health care system makes it particularly vulnerable to fraud and abuse. Worse yet, health care fraud is often directed at those least able to protect themselves: the elderly, the sick, the disabled, and needy families with children.

- Estimates of fraud and abuse are put at 10 percent of health care expenditures or over $80 billion in 1992 to over $200 billion per year. [GAO; Washington Post, 5/4/93]

- The structure of the current fee for service system invites abuse by creating incentives to increase the number of services and encouraging paying physicians and others for referrals.

- The complexity of the current system also encourages abuse. It is estimated that over 1,000 payers process over 4 billion claims per year. Each uses different forms, procedures, reimbursement schedules. For example, each year Medicare processes an estimated 700 million claims, with 48 intermediaries, 34 carriers, and 82 contractors who use 22 different processing systems.

- Health care providers submit false or improper claims to private health plans. [Blue Cross/Blue Shield]

MALPRACTICE

MEDICAID

MEDICARE

MEDICARE:
The Clinton Plan

We are committed to preserving the fundamental contract between older Americans and the government. The Clinton plan will protect all Medicare beneficiaries. Older Americans will continue to receive their Medicare benefits as they do today, with no new costs or penalties. In fact, they are likely to have more choices after reform. They will also benefit from the added security of a prescription drug benefit and increased long-term care options.

NOTHING CHANGES FOR MEDICARE BENEFICIARIES IN THE NEW SYSTEM:

- In the new system, Medicare will remain a distinct federal program and Medicare beneficiaries can continue to receive their Medicare benefits as they do today.

HEALTH REFORM OFFERS INCREASED BENEFITS:

- The Clinton plan will give Medicare beneficiaries the security of a **prescription drug** coverage and will phase in options for **home and community based long-term care services**.

REFORM OFFERS OLDER AMERICANS MORE CHOICES:

- One of the goals of reform is to give older Americans, along with all other Americans, increased choices for their health coverage.

Short term . . .

- The government will improve and enhance the managed care benefit plans now offered to Medicare beneficiaries.

- These plans may offer a richer benefits package or lower co-payments than people now receive under fee-for-service Medicare. Under no circumstances will plans be able to offer fewer benefits to Medicare beneficiaries.

Long term . . .

- In time, states that have their new system up and running may want to bring all their citizens -- including Medicare beneficiaries -- into a comprehensive state program.

- States who wish to integrate Medicare will have to meet strict federal standards and clearly demonstrate to the federal government that their program will provide the same, **or better**, coverage, quality, services, and access as Medicare beneficiaries currently receive.

MEDICARE:
Questions and Answers

Q: Is it true that you will force people on Medicare into the new system?

A: No. Health care reform will protect all people receiving Medicare. Medicare will remain a distinct federal program and older Americans will still be able to receive their Medicare benefits as they do today. In fact, Medicare beneficiaries are likely to have more choices after reform -- they can continue to get care the way they do today **or they may be able to get increased benefits through the enhanced managed care plans** offered through the reformed and improved Medicare program.

Q: How would I benefit by joining a plan in the new health system?

A: If you decide to, you will be able to choose from a wide variety of plans beyond the managed care and fee-for-service options you now have. These plans are likely to offer a richer benefits package, and/or lower co-payments, than you currently receive under your traditional Medicare policy.

Q: If Medicare remains outside of the new system, how will health reform affect me at all? Will I get any benefit from it?

A: As part of overall health reform, you will see an increase in your benefits. The program will be expanded to finally provide for an outpatient prescription drug benefit. In addition, an unprecedented expansion of home and community-based long-term care services will be provided.

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

A: In fact, health reform will decrease the growth of health care spending in the Medicare program by offering providers new incentives to hold down costs. The Medicare program will operate under its own budget, controlling increases in out-of-pocket costs health care costs for beneficiaries as well as the government.

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

A: Absolutely. Medicare beneficiaries can continue to choose their own providers 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 -- including increased benefits and/or lower out-of-pocket costs -- but the decision to enroll will be left entirely to the individual.

Q: Will states have the flexibility to incorporate Medicare into their new program?

A: In time, in special cases where states have implemented programs that have proven that they can maintain quality while achieving cost savings, Medicare may participate in the state's health alliances. In order for Medicare to participate, the state would be required to provide guarantees and demonstrate that the beneficiaries and the federal government will not be disadvantaged in any way. Beneficiaries must be able to receive the same level of benefits, pay no additional money, and maintain access to needed services.

Q: Will savings from my Medicare program be used to pay for health care coverage for the uninsured?

A: Medicare savings are likely to be used for enhancements in the Medicare benefits package such as prescription drugs and some long-term care.

MEDICARE:
The Current System

35 MILLION PEOPLE DEPEND ON MEDICARE:

- Medicare was enacted in 1965 and now covers 35 million people -- including 32 million elderly and 3 million disabled individuals.

OLDER AMERICANS ARE VERY SATISFIED WITH MEDICARE:

- According to a poll, over three fourths of all Americans -- the elderly and the general public -- were very satisfied with the Medicare program. Only about one fourth of older Americans expressed a desire for major change in the health care system. [Advisory Council on Social Security]

- According to a 1991 survey, overall satisfaction with Medicare is very high: 79 percent find the program understandable; 90 percent can get the information they need; 93 percent were satisfied with Medicare's claims processing; and 84 percent who called their carrier were satisfied with the service they received. [Office of the Inspector General, Department of Health and Human Services, 1991]

ADMINISTRATIVE COSTS LOWER UNDER MEDICARE:

- In 1991, Medicare spent just 2 percent of its funds for administration -- 8 times lower than private health insurance as a percent of benefit payments.

MEDICARE IS BETTER AT COST CONTROL THAN PRIVATE INSURERS:

- Medicare's cost containment has been more successful than private insurance. From 1984 - 1991, Medicare expenditures per enrollee rose by 7.2 percent annually compared to 9.3 percent for private health insurance.

MEDICARE OFFERS INCOMPLETE, INADEQUATE BENEFITS:

- Today Medicare offers neither an outpatient prescription drug benefit nor any significant coverage for home and community-based long-term care. As a result 64 percent of the elderly have no drug insurance coverage. [EBRI, January 1992]

MEDICARE COSTS CAUSING INCREASED FEDERAL SPENDING:

- In 1991, the federal government spent $120.2 billion dollars -- or 16 percent of the national personal health care bill -- on Medicare. This cost has risen to $145 billion this fiscal year and is expected to grow 12.3 percent annually over the next 5 years -- reaching $265 billion by 1998.

MENTAL HEALTH

MENTAL HEALTH AND SUBSTANCE ABUSE
The Clinton Plan

The Clinton plan is based on several principles:

- **Providing access to a broad array of services for individuals with serious and persistent mental and substance abuse disorders**, with the flexibility to provide the appropriate care based upon medical and psychological need.

- **Encouraging alternatives to hospitalization**, including home- and community-based treatment, and ensure that services are delivered in the least restrictive environment appropriate to the needs of the individual.

- **Eliminating the fragmented system of care** that causes costs and responsibilities to be shifted to the public sector.

- **Encouraging early intervention** by using incentives to initiate mental health and substance abuse treatment.

MENTAL HEALTH AND SUBSTANCE ABUSE
Questions and Answers

Q: Aren't mental illnesses and substance abuse disorders very different than other conditions? If these aren't real medical problems, we shouldn't cover them in health care reform.

A: No, MH/SA disorders are not different than other conditions. MH/SA disorders cause disability and dysfunction. Medical treatments are available that reduce distress and dysfunction, and prevent disability. Left untreated, MH/SA disorders lead to other health care problems and lost productivity.

The majority of private insurance plans now cover MH/SA treatment, as do Medicaid, Medicare, and CHAMPUS. Insurance companies have recognized the legitimacy of the suffering and disability that MH/SA disorders cause.

Q. Won't everyone see a therapist if insurance will pay for it?

A: No, everyone will not want to see a therapist under health care reform. In a given year, only 10-11 percent of the American people seek care for a MH/SA problem from a health provider. Only 6 percent of the population currently seek specialty MH/SA services.

Q. Won't we be paying for coverage of the worried well? I don't want to pay for someone to talk to my neighbor about their love life.

A: Individuals with mental illness are not the "worried well" -- they have a treatable disease. Everyone will be evaluated if they perceive a need for MH/SA treatment, but no one will get care unless they have a diagnosed disorder. People will still be free to pay out-of-pocket for services they may desire outside the health plan.

Q: Aren't mental health and substance abuse treatments open-ended, without clear cut goals or endpoints?

A: Not at all. When people feel better and their symptoms resolve, they stop treatment. And medications now offer help for many who previously required hospitalization because of mental illness. Scientific advances promise to improve treatments even more in the future.

Q: Why should we cover substance abuse in this plan?

A: Right now, we are spending much more in this country to deal with the consequences of substance abuse than we are on treating the problem itself. If we redirect adequate dollars to prevention and early intervention, we can improve the quality of life for many Americans, and save many billions of dollars at the same time.

MENTAL HEALTH AND SUBSTANCE ABUSE
The Current System

MENTAL HEALTH COSTS ESTIMATED AT $273 BILLION:

- The estimated **annual economic cost to society of mental illness and substance abuse is $273 billion**, including direct care, lost productivity, social welfare and the criminal justice system (Rice, DP, et al. (1990), *Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985*).

- Mental and addictive disorders account for $80.7 billion, or about 12 percent of total health costs (Rice et al., 1990).

- Health care spending on mental health and substance abuse (MH/SA) disorders amounts to about $300 per person (including nursing homes) per year in the current system, after subtracting research and education costs.

- Inpatient care accounts for slightly more than 60 percent of the costs, even though 72 percent of care is delivered on an outpatient basis. (Rice et al., 1990; NIMH, 1992)

MENTAL DISORDERS LIKE OTHER COMMON DISORDERS:

- Mental disorders are treated as a group similar to other common disorders, such as cardiovascular diseases, with substance abuse disorders occurring at rates similar to physical disorders such as chronic bronchitis (NIMH, Report to Senate Appropriations Committee, 1993).

TRADITIONAL INSURANCE DISCRIMINATES AGAINST MENTAL HEALTH:

- In addition to excluding pre-existing conditions, **traditional insurance coverage discriminates against mental health and substance abuse disorders relative to general medical care.** Coverage for MH/SA disorders is often subject to arbitrary annual limits on days of inpatient care and number of outpatient visits, lifetime caps on total benefits payable, and restrictions on types of services, settings and providers.

- Individuals and families face **significant financial risks** if they develop a serious mental or substance abuse disorder. <u>For these disorders, the current insurance system does not protect against financial disaster -- defeating the entire purpose of insurance.</u>

- The structure of traditional insurance coverage (e.g., deductibles and copayments) create **financial barriers to early intervention** in MH/SA disorders.

- **Limitations** on insurance benefits for MH/SA disorders have **resulted in shifting both the responsibility for and the costs of care onto the public sector.**

AMERICAN INDIANS AND ALASKAN NATIVES

AMERICAN INDIANS AND ALASKA NATIVES AND HEALTH CARE:
The Clinton Plan

Health reform initiatives that affect Native American people will proceed within the framework of government to government relationships with over 500 sovereign Native American nations. Under the Clinton plan, the federal government will continue to pay costs of health care. And tribal governments will have the autonomy and flexibility to devise a health care system which is right for them.

- **A Comprehensive Benefits Package:** The Clinton plan will ensure that the comprehensive package of benefits is delivered to American Indians and Alaska Natives.

- **End Rationing:** The plan will end the de facto rationing of health care that results from limited funding and availability of services for Native American people living on and off reservations.

- **Supplemental Assistance:** Supplemental services provided by the Federal government to Native American people -- such as environmental assistance, translation services, and outreach services -- will continue as an appropriated program.

- Indian Health Service (IHS) and Tribal Health Programs (THPs) may participate in the new health care system as health plans or providers of health care, obtaining payments from health plans that contract for their services; or remain independent of the new system

- **Choice:** Individual Native Americans may enroll in the IHS or THP plan or in any plan offered by the health alliance.

- **Flexibility and Assistance:** To accommodate some tribes' objections to state control, IHS and THPs may operate outside the health alliance and will receive the necessary funding to provide the comprehensive benefit package.

- **Reimbursement for Individuals other than Native Americans:** The IHS or THP may choose to serve residents who are not Native Americans. However, unlike today's system, IHS will be reimbursed for these services.

- **Barriers Removed:** Regulatory and organizational barriers -- such as limits on ability to hire and assign staff, cumbersome federal procurement rules, financial systems not designed to bill for services,

and restrictions on providing services to individuals other than Native Americans -- will be gradually removed in order to phase in the new system.

AMERICAN INDIANS AND ALASKA NATIVES AND HEALTH CARE:
Questions and Answers

Q. Can a tribe choose to operate outside of the health alliance?

A. Yes. The tribe will be given the choice to join the new system as a plan or a provider. The tribe will be given the opportunity to remain outside the system if it decides that is the most preferable course of action.

Q. How will Indian Health Service and Tribal Health Plans be able to deliver the comprehensive health benefits package with current limited funding levels?

A. Additional resources will be appropriated to enable IHS and THPs to provide the comprehensive benefits package.

Q. How will IHS or THPs be reimbursed for services if they do decide to operate as a plan?

A. The health alliance will reimburse the IHS or THP just like any other plan.

Q. Will tribes be able to receive employer contributions?

A. Yes. The IHS or THP will receive the standard employer payment, just as other plans do.

Q. In an employer-based system will Native Americans living on reservations with chronic unemployment enter the new system?

A. Premiums for unemployed Native Americans will be covered like those for all other unemployed Americans.

Q. If my tribe chooses <u>not</u> to participate in the new system, will I be able independently to join the health alliance?

A. These are decisions which the individual tribal leadership will have the flexibility to decide.

AMERICAN INDIANS AND ALASKA NATIVES AND HEALTH CARE: The Current System

- **Rural problems:** Approximately 60 percent of IHS programs are located in rural and remote areas. Many facilities are old and in poor condition and have very limited capacities for delivering specialized care and serve small scattered communities with no other source of health care. They confront problems common to all rural settings, including financial barriers and shortages and high rates of turnover among providers.

- **Budget Constraints/Rationing:** Per capita spending for the Indian Health Service and Tribal Health Program delivery system is lower than the nation as a whole. Because of limited, fixed budgets for the delivery system, many Indian people feel the effects of de facto rationing.

- **Poor Health Status:** Native American people have, on average, poorer health status than the nation as a whole. Thirty one percent live below the poverty level. Distressed economic, social and environmental conditions under which Native American people live place them at high risk of disease, injury, and premature death. Excessive rates of poverty and unemployment among Native Americans intensify health problems and erect barriers to necessary health care services.

- **Insufficient Benefits:** IHS benefits are limited and vary widely by location.

CHOICE OF PROVIDER

PHYSICIAN CHOICE AND THE CLINTON PLAN

The Clinton Plan assumes that choice of provider is highly valued by Americans and, therefore, sustains this ability to select a caregiver. In many cases, the new plan will provide more choice than is currently available to many consumers.

The ability to follow your physician: The Clinton Plan recognizes that many Americans have long-standing and important pre-existing relationships with personal physicians. Consumers will be able to sustain these critical relationships by "following" their physician's choice of plans.

The ability to change plans: Once the new system is operational, as physicians change plans, so may patients who wish to stay with that provider. It is also likely that physicians will affiliate with more than one plan, so sticking with your doctor won't mean you are stuck with only one choice of plan.

Significant flexibility will be built into the system so that individual family members may even select different plans.

Traditional fee-for-service: All alliances will support at least one fee-for-service plan so that people will be able to see whatever doctor they like.

Managed care, "HMO" type practice settings will be required to allow people to choose between doctors within their own systems. They won't be locked into seeing only one doctor.

NOT JUST CHOICE OF PROVIDER, BUT MORE CHOICE FOR MANY AND MORE INFORMED CHOICE FOR MOST PEOPLE.

- Alliances help make quality health plans more available in areas that are currently underserved or unserved.
- Many employers currently offer very limited choice of plan or provider to their employees; the new system will open up the process to all consumers within the alliance.
- People will be able to choose among all approved plans in their community.
- Individuals, not employers, will choose the plan they want.

- For the first time, Americans will experience informed choice, since alliances will each year be providing "consumer-friendly" information about the performance of all available plans. This information will, in part, cover issues like cost and efficiency of services, but will also provide useful feed-back on how plans are doing in terms of patient satisfaction and medical quality.

PRESCRIPTION DRUGS

PRESCRIPTION DRUGS:
The Clinton Plan

The Clinton health care plan will protect Americans from excessive prescription drug prices by instituting strong cost containment provisions and guaranteeing insurance coverage for pharmaceuticals. In so doing, the plan will assure that there continue to be adequate incentives for drug manufacturers to invest in research and development on cost-effective prescription drugs.

Prescription Drug Prices Held To Inflation:

- During the transition to a competitive health care market, the new system will assure that prescription drug prices will not increase above the general inflation rate.

New Drugs Subjected To Public Review:

- The new system will establish a pharmaceutical review commission for new drugs. While this commission will not regulate the price of drugs, it will provide invaluable information to the purchasers (employers, employees, and health plans) of these medications about the new product's relative value. (For example, information on the product's value compared to other treatment choices will be evaluated, as well as a comparison to what other industrialized nations are paying for the same drug will be required.) In so doing, manufacturers will be forced to become more sensitive to their "launch" prices of new drugs in the United States.

Prescription Drug Coverage For All Americans:

- The new system will guarantee that all Americans, young and old alike, will have prescription drug insurance. To achieve coverage, the comprehensive benefit plan for all Americans not eligible for Medicare will be required to cover prescription drugs. Likewise, Medicare will be expanded to finally cover the costs of outpatient medications.

End Inequitable Treatment Towards Community Pharmacists:

- The new program will ensure that community pharmacists who form large buying groups can have access to the same type of discounts other purchasers now receive. This will help ensure that consumers, most of whom purchase their medications at these pharmacies, will benefit from

these discounts as well.

PRESCRIPTION DRUGS:
Questions and Answers

Q: Won't the plan's cost containment initiatives stifle research and development?

A: No. We spent a great deal of time developing an adequate balance between the need to retain adequate incentives for investment in R&D, while still assuring that prescription drugs are more reasonably priced. Rather than establishing permanent price controls and regulating the price of new drugs, the Clinton plan incorporates a balanced model that moves the market into more of a competitive mode, while still assuring that cost increases are stabilized.

Q: Why do we need prescription drug price inflation caps? Haven't companies already said that they would not increase prices faster than inflation?

A: It is true that several drug manufacturers have pledged to keep prices increases to inflation. However, not all companies have taken this pledge, and not all have taken pledges that result in meaningful prescription drug price cost containment for the average American buying medications. We hope, and will give the industry the opportunity, to comply voluntary with the proposal's price inflation protection provision. We expect that many will do just that, but we must make sure that all comply. Some probably won't. That is why we have "fall-back" enforcement provisions.

Q: Prescription drugs are only a small part of the health care pie. Why are we placing so much emphasis on containing drug costs here? Shouldn't we look more at doctors and hospitals?

A: We are looking to contain costs all sectors of the health care system, not just pharmaceuticals. While drugs are a small part of total health care spending -- about 8 percent -- we are spending well over $800 billion on health care each year. That's about $64 billion just on prescription drugs. That's no small chunk of change. In addition, during the phase in to the new system and universal drug coverage, Americans will still be paying for most of their drugs out-of-pocket, which means that we have to be particularly sensitive to making sure that they are protected against unfair price increases.

Q: **A few months ago, my mother had to be admitted to the hospital because she had a reaction to two drugs she was taking. What will your plan do to assure me this kind of thing won't happen again?**

A: Your mother's problem isn't uncommon. The elderly sometimes have to see a number of different doctors to treat heart problem, arthritis, diabetes, and impaired vision. Sometimes doctors don't know what drugs another doctor has prescribed; sometimes the patient doesn't remember all the different instructions to follow. In the new system, pharmacists will be able to pull up information on their computers that tell them what's been prescribed for that patient by each different doctor. That way, the pharmacist will see if there's a potential problem ahead of time and take the necessary steps.

Q: **I am an older American who already has private drug coverage through my previous employer. Why should I have to pay for a drug benefit that I don't need?**

A: Under the Clinton plan, private insurance plans that offer drug coverage to older Americans would have to adjust their policies to meet the coverage provided under the Medicare benefit. That is, any savings to the plan from eliminating drug coverage from the private insurance plan would have to be passed on to the consumer in the form of lower premium costs. As an alternative to lowering the premium, the plan could offer another health care benefit that equals the value of the drug plan. For example, the private plan could fill in the "gaps" in the Medicare drug benefit's coverage.

Q: **Is it fair for Medicare beneficiaries to have higher deductibles and copayments for their drug benefit as compared to the under 65 population?**

A: The average older American uses about $800 in prescription drugs each year, while the average person under 65 has much lower average annual drug costs -- about $230. Therefore, the average annual dollar value of the Medicare drug benefit for older Americans will be equal to or greater than the dollar value of the benefit for the person who is under 65, even though the cost sharing for the Medicare beneficiary is higher.

Q: **Won't this plan encourage the overutilization of prescription drugs and increase costs?**

A: Anytime you provide insurance coverage for a health care service, there is a risk that there will be inappropriate or unnecessary utilization. Under the proposal, the Medicare drug benefit will have a program of drug use review that is designed to protect against these very problems. Most managed care plans have similar programs in place today, and because of the tremendous pressure on these plans to contain drug costs, it is likely that they will use these plans to assure appropriate and necessary utilization of medications in the under 65 population. Lastly, while drugs can be very expensive, when used appropriately, they frequently are much more cost effective than any other service available. While we may see a rise in some drug costs, we also may well see a decrease in unnecessary and much more expensive surgical alternatives.

PRESCRIPTION DRUGS:
The Current System

Pharmaceuticals Are Generally Cost-Effective Treatments:

- The value of pharmaceuticals in the treatment, prevention, and diagnosis of disease is irrefutable.

Prescription Drug Prices Are Forcing Unacceptable Burdens:

- Over 8 million Americans over 55 say that they have to make choices between buying food and paying for medications. (AARP Survey, Summer 1992).

Drug Inflation Tripled General Inflation From 1980 to 1992:

- Between 1980 and 1992, while the inflation rate of products produced by all other manufacturers averaged about 22 percent, the inflation rate at the prescription drug manufacturer's level was more than 6 times this, 132 percent. (Bureau of Labor Statistics).

Prescription Drug Insurance Coverage Is Totally Inadequate:

- Largely because Medicare does NOT cover outpatient prescription drugs, 64 percent of medications purchased by older Americans are not covered by insurance. For the under 65 population, about 55 percent of total prescription drug costs are paid out-of-pocket. (Employee Benefits Research Institute, January 1992).

Americans Pay Higher Drug Prices Than Other Nations:

- Americans pay 32 percent more for their prescription drugs than do Canadians. (General Accounting Office Report, October, 1992).

Pharmaceutical Companies Still The Most Profitable:

- In 1992, the pharmaceutical industry's return on sales quadrupled (12.4% vs. 3.1%) the average Fortune 500 industry. (Fortune Magazine, April 23, 1993).

Drug Companies Spend More On Advertising Than on R&D:

- Pharmaceutical manufacturers spend more on marketing and advertising (22%) than they do on research and development (16%). (Report of the Office of Technology Assessment, February, 1993).

RURAL HEALTH CARE

RURAL AMERICANS AND HEALTH CARE:

With fewer health care providers, a dearth of preventive care, a growing population of uninsured, and rapidly rising costs, rural Americans -- a quarter of the nation's population -- experience some of the worst flaws in our current health care system.

- **Providing Universal Coverage:** More rural Americans lack health insurance than Americans in other parts of the country. Without coverage, many can't pay for care even if they have a doctor close by. Under reform, all Americans will have coverage under the comprehensive benefits package.

- **Attracting Doctors to Practice in Rural Areas:** Many rural Americans truly know what it is to not be able to choose their own doctor. Rural doctors and providers are discouraged by high numbers of uninsured patients, the lack of medical support services, and the difficulty involved in operating a practice in a remote area. Reimbursement levels are often low and payments delayed. All of these problems lead to **a high rate of doctor turnover**. A study in North Carolina found that almost half of rural physicians left their rural practices within three years of practice. The Clinton health care plan provides real access, not just a promise and a piece of paper. The reform will provide economic incentives to doctors who practice in rural locations.

- **Expanding Emergency Services:** For people with serious health conditions, choosing to live in a rural area may represent a "death defying" act, given the scarcity of health care services. Our plan will **break the isolation** which is so discouraging to rural providers, by setting up links with hospitals and other providers and health networks; coordinating rural health care providers; and enhancing emergency support services.

- **Expanding Preventive Care:** The shortage of health care professionals and lack of access to pre-and post-natal care can lead to serious problems for pregnant women and their children. The Clinton plan will build on existing rural health systems by investing more in community and migrant health centers and investing in prevention initiatives.

RURAL AMERICANS AND HEALTH CARE:
The Clinton Plan

REAL REFORM NOT JUST A PROMISE AND A PIECE OF PAPER ...

Rural Americans are hit hard by the current health care system. The Clinton health care plan provides real reform not just a promise and a piece of paper. We will help provide a more stable economic base for providers -- putting rural communities in a better position to get and keep providers.

- The Clinton plan will secure a **comprehensive benefits package** for America's rural communities -- farmers, small business owners, and families. We will end insurance underwriting practices that discriminate against people based on whether they're young or old, sick or healthy, married or single. **We will ensure greater stability in premiums from year to year**.

- Rural small business owners and farmers will get the advantages of being part of a large group -- gaining leverage to buy wholesale not retail and the safety in numbers that comes from being part of a large group including stable premiums.

- Rural Americans will have alliances working to get them good coverage and protect them from bad insurers.

HOW IT WORKS ...

- The plan makes rural settings more attractive for doctors and other providers by:

  - Removing the heavy burden of uncompensated care paid by providers and reduce paperwork
  - Making sure providers are paid on time by reliable and efficient insurers
  - **Breaking the isolation**, by setting up links with hospitals, other health networks and providers to increase rural access to the latest and best information.
  - Coordinating rural health care providers, hospitals, and home care services.
  - Providing emergency service support

- The Clinton plan will **train and recruit providers** for rural areas by building strong financial incentives into student loan programs, providing rural medical school residency locations, and building links between rural physicians and regional medical schools. We will expand the **National Health Service Corps**.

- **Improve the Public Health Infrastructure:** The Clinton plan will build on existing rural health systems by investing more in community and migrant health centers and investing in **prevention initiatives**.

RURAL AMERICANS AND HEALTH CARE:
The Current System

- 22.5 percent of the Americans live in rural areas. Many are isolated by economics as much as by distance. Small communities may not be able to support a physician practice -- and few young physicians are interested in taking over the solo practices of the many physicians who will retire in the next decade. [Bureau of the Census]

- 32 percent of rural Americans did not have health care for at least one month over a two year period ending in 1987. About 40 percent of all agricultural workers and their families have no health insurance at all. [Office of Rural Health]

- Rural Americans with insurance coverage typically have policies which cover less and cost them more out-of-pocket. [Working Group Paper]

- Rural areas have less than one half the number of doctors as urban areas. Twenty-eight percent of rural residents live in areas which have a shortage of primary care physicians compared to only 9.5 percent in urban areas. [Office of Rural Health]

- In 1988, 68 percent of rural counties did not have enough doctors. In fact, 111 rural counties had **no physician at all**. [Office of Rural Health]

RURAL AMERICANS AND HEALTH CARE:
Questions and Answers

Q. How will managed competition work in a rural area when there are no providers to compete?

A. The Clinton reform provides secure coverage to all Americans regardless of where they live. Rural Americans will be able to choose to go to their local doctor through traditional insurance plan or an integrated health plan. Rural hospitals and providers will develop community-based health plans in rural areas linked to regional medical centers. In some cases, urban health plans will expand to cover rural areas.

Q. How will the plan help rural areas?

A. The biggest help for rural areas is providing secure coverage. That means that all rural Americans -- regardless of where they work -- can get secure coverage to a good benefit package for a fair price. By building in economic incentives for doctors to practice in rural areas and encouraging community-based networks to form, rural Americans will be able to get the high quality care they need. Providers won't have to continue to provide even more uncompensated care than urban providers. They will get paid and paid on time.

Q. How will reform work in rural America?

A. State flexibility is a dominant feature of the Clinton health reform. The President, as a former governor, is fully aware of the tremendous differences among the states. That's why this plan encourages states to find the solution that's best for them -- it may mean alliances in one state and a single-payor model in another. We don't want to micromanage what states do so long as they meet the federal guarantees of universal coverage, access, quality and cost containment.

Q. Anti-trust and other state anticompetitive laws seem to be hampering rural network development. What does the plan do to alleviate this problem?

A. The proposes that the federal government develop model legislation, which can be adopted by states, to protect developing networks from federal anti-trust laws.

Q. How will rural health interests be represented and assured?

A. Rural residents will be members of the governing board of the alliance in

direct proportion to the percentage of rural residents who are members of the alliance.

STATE/FEDERAL ROLE

STATE/FEDERAL PARTNERSHIP AND HEALTH CARE
The Clinton Plan

States no longer have to go it alone:

- For twelve years, states have taken the lead on reforming the health care system -- developing innovative solutions to the health care crisis. Several states have enacted comprehensive laws aimed at providing health security to more Americans and controlling health care costs.

The Clinton Plan establishes a state/federal partnership:

- States alone cannot solve this country's health care crisis. Controlling costs, providing security and guaranteeing all Americans a comprehensive package of benefits are challenges our entire nation must solve. That's why the Clinton plan will establish a state/federal partnership that allows the state and federal government to take on this challenge together.

- Under our health reform proposal, the federal government will establish a broad framework within which states will have the flexibility to design the health care system that works best for them. This framework will:
  - define the comprehensive benefits package guaranteed to all Americans;
  - set high standards for quality;
  - reform malpractice laws;
  - and set national goals for controlling costs.

States will have flexibility:

- The solutions that work well in one state may not work as well in another. That's why each state will have flexibility on how the system is implemented as long as states work to:

  - set up health alliances to replace the fragmented insurance market;
  - guarantee affordable coverage;
  - assure high-quality care;
  - and aggressively control costs.

- The system won't be perfect, and this is one of the reasons why state flexibility is so important: states can learn from each other the best ways to make the system work.

STATES/FEDERAL PARTNERSHIP AND HEALTH CARE
Questions and Answers:

Q: Right now state budgets are overrun by the explosive growth in Medicaid spending. What will your program do to bring Medicaid costs in line?

A: Medicaid has been the culprit behind most state budget deficits in recent years. As employers begin to cover their workers who currently receive Medicaid, and as Medicaid is folded into the new system, health care costs will be more predictable and grow at slower rates.

Q: How much state money will we have to contribute to the new system?

A: The states will be asked to maintain their current level of spending on health care, indexed to some negotiated level (perhaps inflation and population); this is frequently called "maintenance of effort." Understanding that some states will have greater financial needs (because they have, for example, much higher levels of uninsured), there will be financial assistance made available to help ease the transition into an universal covered system.

Q: What works in California won't necessarily work in Maine; we're wary of a "one size fits all" approach. Can we adapt your program to the needs of our state?

A: The whole philosophy behind this Clinton plan is that the key to a successful and responsive health reform initiative is that states must have the flexibility to respond to their own needs and priorities. Inherent in this philosophy is the understanding that there is no "right" answer for health care that can be applied universally to all 50 states. For example, there are wide differences in opinion as to what constitutes the most appropriate approaches to health care technology and personnel distribution. Within the Federal framework, meeting the Federal criteria, states will be able to adapt the national program to the needs of their state.

INNER CITIES

INNER CITIES AND HEALTH CARE REFORM:
The Clinton Plan

ENSURING HEALTH CARE IN LOW-INCOME URBAN AREAS . . .

Suffering from an isolation caused by poverty and violence rather than distance, many cities have been unsuccessful in battling back the AIDS epidemic, a terrifying outbreak of tuberculosis and homelessness and poverty. We must ensure that health reform meets the needs of our nation's cities, especially the children of the inner cities -- the disenfranchised and neglected -- by making sure they have health care.

HOW IT WILL WORK ...

- **Comprehensive Benefits Package:** Our plan will provide the security of a comprehensive package of benefits to all Americans. We will provide health care coverage to the millions of Americans who live in inner cities who currently don't have insurance.

- **Financing Care/Ensuring Access:**

  - **Medicaid:** Medicaid, the State-Federal program for low-income people, is the health care insurer for many living in the inner city. However, for many who depend on it, delayed payments, low reimbursement and complicated regulations have limited choice of provider and rendered the program ineffective in ensuring access to care.

    The Clinton plan will incorporate Medicaid so that all Americans have the security of the same health care system.

  - **Working Americans:** Eight-five (two?) percent of the uninsured are working Americans. For those working Americans who currently do not have health care, our system will require that their employers provide coverage.

  - **The Unemployed:** For those who are unemployed, the Clinton plan will extend subsidies to ensure that all Americans have the security of health care when they need it.

- **Expand Availability of Primary Care:** Our plan will expand access to primary care physicians, and provide incentives for medical students to set up practice in urban areas through financial incentives. The plan will enhance the National Health Service Corps to reach urban communities and improve the definition of medically underserved to ensure that all areas receive the resources they need.

- **Encourage Family Practices:** The reform will stabilize the economic base and encourage providers to locate with the promise of an insured population and timely and consistent payment.

- **Outreach/Immunization:** The Clinton plan will enhance outreach services and encourage preventive and primary care. The Administration has already proposed an unprecedented campaign to immunize all infants and toddlers.

- **AIDS:** The new Administration has already made an unprecedented commitment towards fully funding the Ryan White Act which provides needed AIDS money to cities across the country. Reform will expand home-care services for the chronically ill to allow them to remain in communities.

- **The Homeless:** The plan, which will finally provide non-discriminatory coverage for mental illness, will go a long way towards addressing the complex problems of homelessness.

- **Prevention:** The reform will begin to refocus our health care system on preventing illness and injury, rather than just on treating them.

  With the advent of universal coverage for personal health services, state departments will be able to refocus on prevention. As preventive services such as immunizations and substance abuse become reimbursable under the new system, many will feel a burden lifted.

- **Essential Providers:** The plan will increase investment in essential community providers such as public hospitals and community health centers, to improve the quality and range of services to vulnerable populations.

- **Public Health Services:** The plan will make sure that reform does not neglect or impede activities of the public health service. Certain public health functions targeted at whole populations -- such as T.B. control, AIDS prevention, reduction of infant mortality, infrastructure system support and national health promotion -- will remain under federal control.

INNER CITIES AND HEALTH CARE REFORM:
The Current System

- Approximately 37 million Americans lack health insurance. Eighty five (two?) percent of the uninsured are working Americans. [Employee Benefit Research Institute]

- Forty-five million Americans live in medically underserved communities that, by definition, lack sufficient resources to effectively and efficiently deliver health care.

- Availability of services and low-insurance rates are complicated by complex social problems such as substance abuse, homelessness, communicable diseases.

- State and local health departments have been overburdened as they have become "safety net" deliverers of health care services for the uninsured, underserved, and vulnerable populations. As a result, their ability to provide core public health and preventive services has been limited.

- In many cases, the emergency room is the sole source of treatment for the uninsured. Here people do not receive primary care or preventive care.

- Forty-three percent of the 99 million patients seen in emergency rooms in 1990 had minor ailments that could have been treated elsewhere. [Robert Wood Johnson Foundation]

- In inner cities, lack of insurance and access to primary care -- especially pre- and post-natal care -- leads to higher infant mortality and morbidity rates as well as high costs for preventable illnesses.

- Americans spend $10 in avoidable health care costs for every $1 of immunization.

ADMINISTRATIVE SIMPLIFICATION

ADMINISTRATIVE SIMPLIFICATION
The Clinton Plan

In today's system, paperwork in hospitals and doctors' offices consumes time and money -- time that could be better spent caring for patients. The Clinton Plan will cut paperwork, decrease the regulation that drives up administrative costs, and create a single insurance form to replace the thousands of forms that currently exist. Most importantly, simplifying the system will free doctors and nurses to concentrate on providing patients with responsive, high-quality care.

THE CLINTON PLAN WILL CUT PAPERWORK BY:

- Creating a single, uniform set of rules for getting paid, cutting away the red tape hospitals and physicians have to go through today to get paid by different plans.

- Eliminating insurance underwriting -- the practice of insuring only those who are good risks and charging more to those who are sick.

- Creating a single insurance form so that doctors don't have to deal with thousands of insurance forms.

- Eliminating "dual eligibility" so that doctors and nurses don't have to waste time figuring out which insurance company is responsible for a given claim.

- Creating a system of "24-hour coverage" -- so people are covered at all times in all places by one plan.

- Banding small businesses and individuals together in health alliances that negotiate for high-quality care at an affordable price -- this will eliminate the excess paperwork involved when each individual or small business deals separately with an insurance company.

THE CLINTON PLAN WILL EASE FEDERAL REGULATION BY:

- Modifying the Clinical Laboratory Improvement Act (CLIA) regulations that currently micromanage doctor' offices and labs.

- Cutting the budget of the Peer Review Organization and reinforcing its new role to review outcomes rather than being a checklist regulator.

- Coordinating the inspections hospitals have to undergo and eliminating

redundant inspections.

- Requiring that all payers let physicians know up front what criteria they use to determine payment. Plans must respond to requests in a timely manner so that treatment can be provided when it's needed.

- Replacing "over-the-shoulder" quality review with an outcomes based report card on quality.

THE CLINTON PLAN WILL MAKE IT EASIER FOR CONSUMERS BY:

- Simplifying and standardizing the benefit package so that consumers can decide between health plans and know how much they'll have to pay.

- Publishing information about a plan's quality of care in a way that consumers can understand.

ADMINISTRATIVE SIMPLIFICATION
The Current System

Nearly $200 billion, or one health dollar out of every five health care dollars, is now spent on administration -- much of it duplicative, wasteful and unnecessary. (Lewin-VHI)

WHAT CAUSES THE HIGH ADMINISTRATIVE BURDEN:

- Excessive regulation -- particularly by Medicare
- 1500 different insurance companies
- Hundreds of different benefits packages, which means time spent figuring out what's covered and what's not
- Different kinds of health coverage for each employee -- health insurance, auto insurance and workers' compensation

HOSPITALS FACE A MAZE OF REGULATION AND REIMBURSEMENT:

- Hospitals have to meet the requirements of half a dozen different groups just to open their doors and keep them open -- the fire marshall, OSHA, the Joint Commission on Accreditation of Healthcare Organizations, the College of American Pathologists, state departments of health, and other state and private organizations.

- To get paid, hospitals have to make sure that the patient meets the insurer's sickness test, fill out the necessary forms, follow the billing rules and use the right codes. If they treat a patient but make a mistake on a form, payment will be delayed or may be denied.

HEALTH PROFESSIONALS SPEND TOO MUCH TIME DOING PAPERWORK:

- Nurses may have to complete as many as 19 different forms that trace a patient's stay in the hospital. If the patient has a complicated condition, a nurse's day can get quickly swallowed up filling out charts.

- The AMA estimates that the average doctor's office devotes 80 hours per month pushing paper.

OVERREGULATION MAKES IT HARDER TO GIVE CARE:

- Some doctors have closed their labs because they can't afford the inspections, the paperwork and the daily administrative hassles that result from regulation.

MEDICARE REGULATION CREATE UNNECESSARY COSTS:

- Medicare patient expenses go through layers of checkers before a payment is made -- three hospital departments get involved -- utilization review, coding, billing. Once it leaves the hospital, the bill goes to the insurer on contract with the Health Care Financing Administration for review and payment. The insurer sends copies of the bills to the Peer Review Organization and the regional HCFA office. These organizations check the hospital's accuracy. Other groups -- the Super-PRO in California and the national HCFA office -- check the work of the checkers.

- Over 1000 payers process over 4 billion claims per year. For example, each year Medicare processes an estimated 700 million claims, with 48 intermediaries, 34 carriers and 82 contractors who use 22 different processing systems. (HHS, Inspector General)

THE CONFUSING SYSTEM OVERWHELMS CONSUMERS:

- Health insurance, especially Medicare and Medicaid, constantly changes. In many cases, consumers aren't made aware of these changes. The programs are so complicated that when they ask their doctor or nurse or social worker, the answers they get may be wrong.

- All the different rules and conflicting information about health plans make it nearly impossible for consumers to make informed decisions about the health plan that's right for them. It's hard to choose between plans that cover different services, for different amounts of money, for different periods of time.

- The challenge of filling out complicated forms when a person's ill and in need of help can make an already stressful and frightening experience worse.

ADMINISTRATIVE SIMPLIFICATION:
Questions and Answers

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

A: The Clinton plan recognizes that running the country's health care system from Washington only creates more regulation - - that's why this plan builds on state and local flexibility. It puts employers and employees in the driver's seat.

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

A: Not at all. The health alliances are merely 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. This will reduce the paperwork created when small businesses and individuals each deal separately with insurance companies.

Q: Without forms, how can we assure quality?

A: There is no evidence that filling out 10 different forms improves quality. Freeing up doctors and nurses to concentrate on practicing medicine is the way to improve quality. A quality report card will let consumers measure how well a health plan delivers care. With this information, consumers can "vote with feet".

Q: Won't cutting the paperwork mean cutting the jobs of the people that do the paperwork?

A: Cutting paperwork will free doctors, nurses and other health care providers to do what they do best -- provide high-quality care to patients. Some people who only do paperwork in the current system may switch jobs after reform -- when there are more people providing care and less people filling out forms.

UNDOCUMENTED PERSONS

UNDOCUMENTED PERSONS

Undocumented persons would not be eligible for guaranteed benefits under the reform plan. Services provided currently, however, ranging from care at community to clinics to hospital services, would be preserved. In addition, through investments in our public health infrastructure, the availability and variety of health care services to undocumented persons will be improved.

Q: Will the undocumented be covered in the Clinton plan?

A: There has been a fear among certain groups that the reform plan would take away services from certain populations currently receiving care. The current system protects undocumented persons; under the reform plan those protections would continue. Services ranging from care at community clinics to hospital services would still be available. Moreover, these safety net programs that this population relies upon would be enhanced to improve the availability of services. However, coverage for guaranteed benefits will be limited to legal residents and American citizens.

Q: Will undocumented children be covered?

A: Services now available for undocumented children will also be preserved.

Q: Will counties and states receive uncompensated care funding to cover the undocumented and other disenfranchised populations?

A: The Clinton Plan will continue and strengthen investments in our public health institutions and programs. Under the President's plan, health promotion and health care delivery will be improved by assuring that providers have the resources they need to provide services to targeted populations.

Q: Will there be a universal health security card?

A: We understand your concerns about using a universal card for enrollment in the health care plan. We look forward to working with you in developing guidelines for ensuring confidentiality and eliminating the risk of discrimination.

Q: Will the health security card become a model for a national

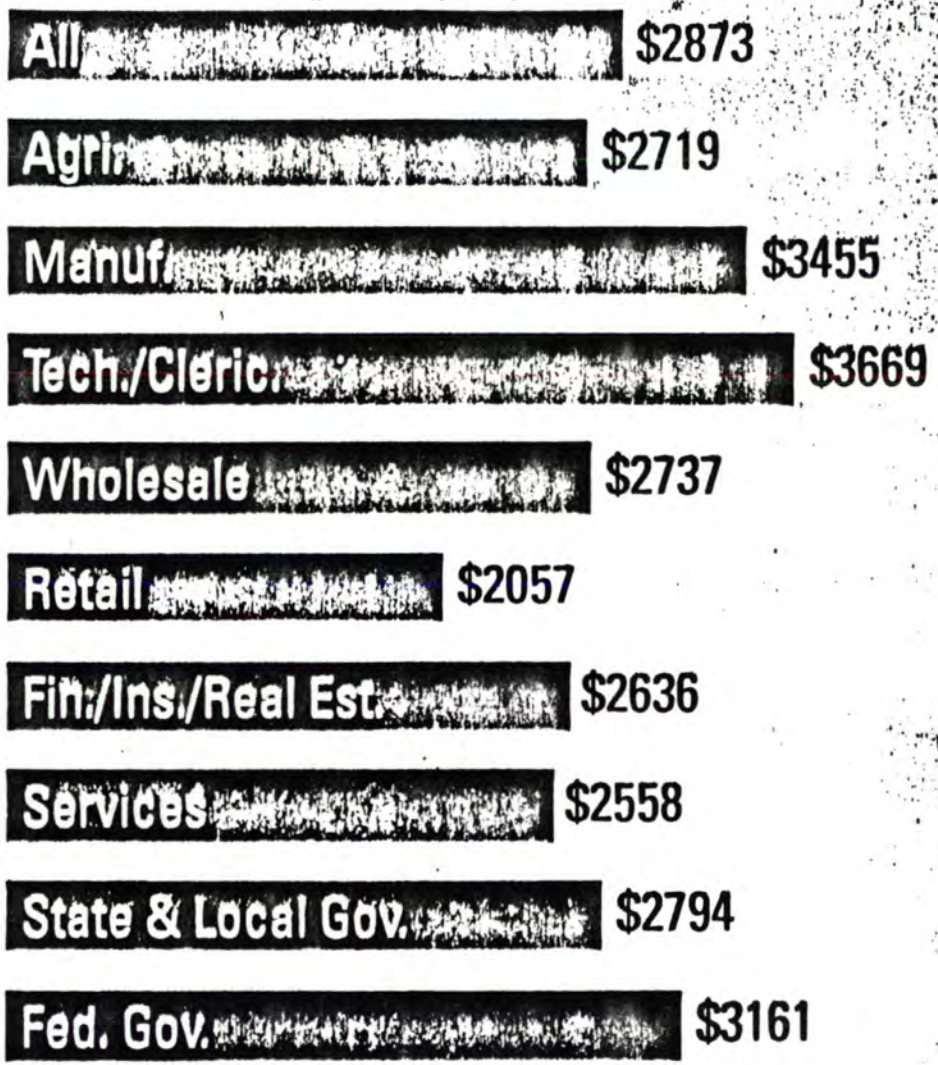
identification card that would allow Federal programs to discriminate against certain individuals because of their immigration status?

A: We are sensitive to this issue and have met with interested individuals and organizations, including the Congressional Hispanic Caucus and the Congressional Border Caucus, to ensure that appropriate safeguards are developed and instituted.

CHARTS AND GRAPHS

Employer Premiums Per Worker

By Industry; All Firm Sizes



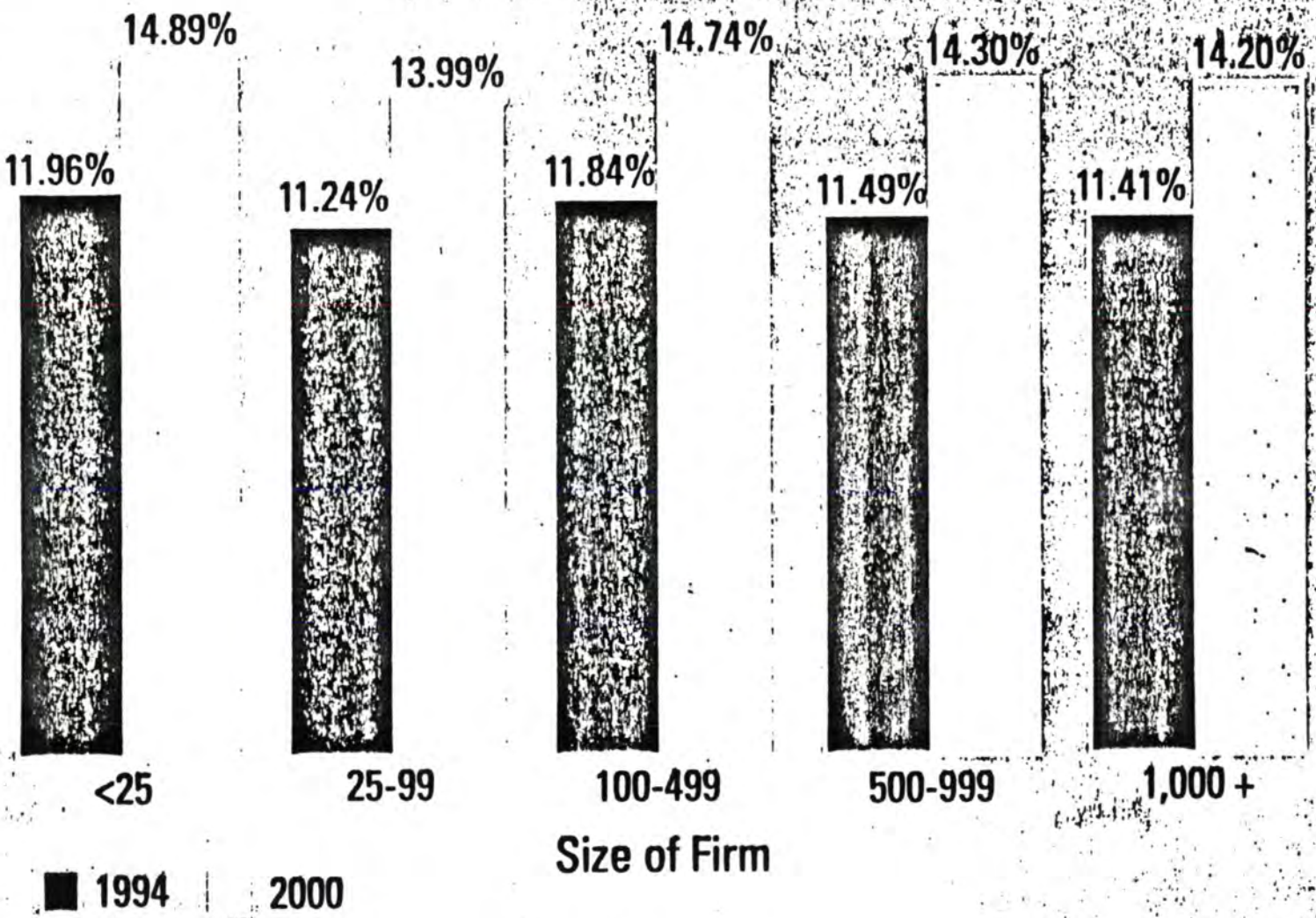
Source: The Urban Institute (1993), based on the March 1992 CPS and TRIM2

employee premium + copay + deductible

(2)

Total Premiums for Insured Workers and Their Families

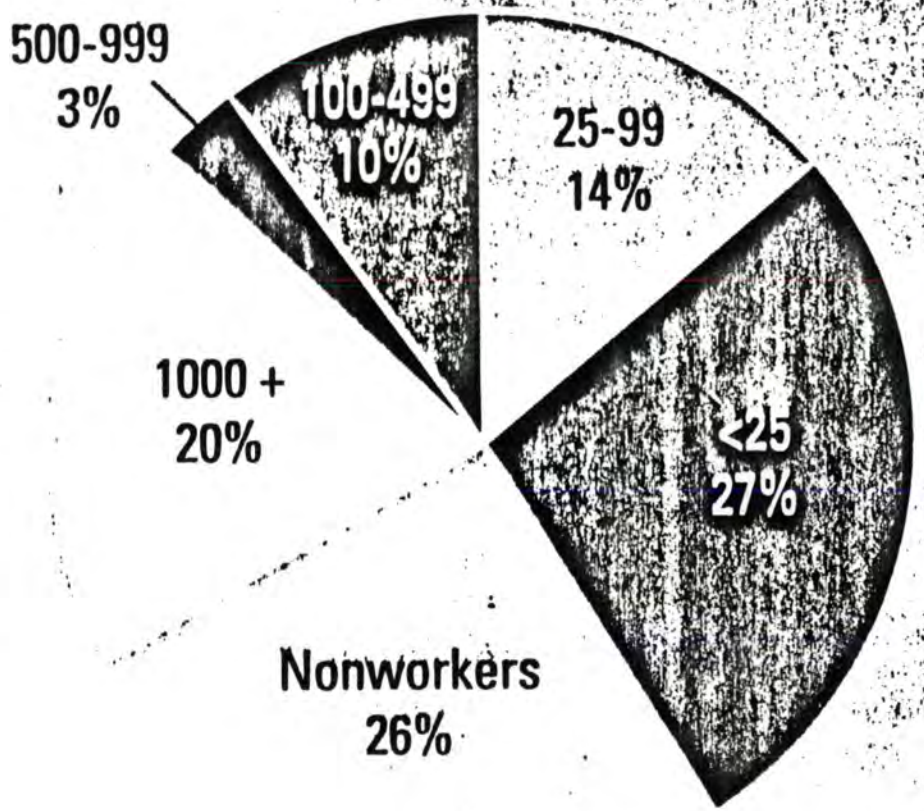
Premiums as percent of payroll, 1994 and 2000, without health care reform



Source: HHS analysis of Urban Institute Tabulations of the March 1992 CPS.

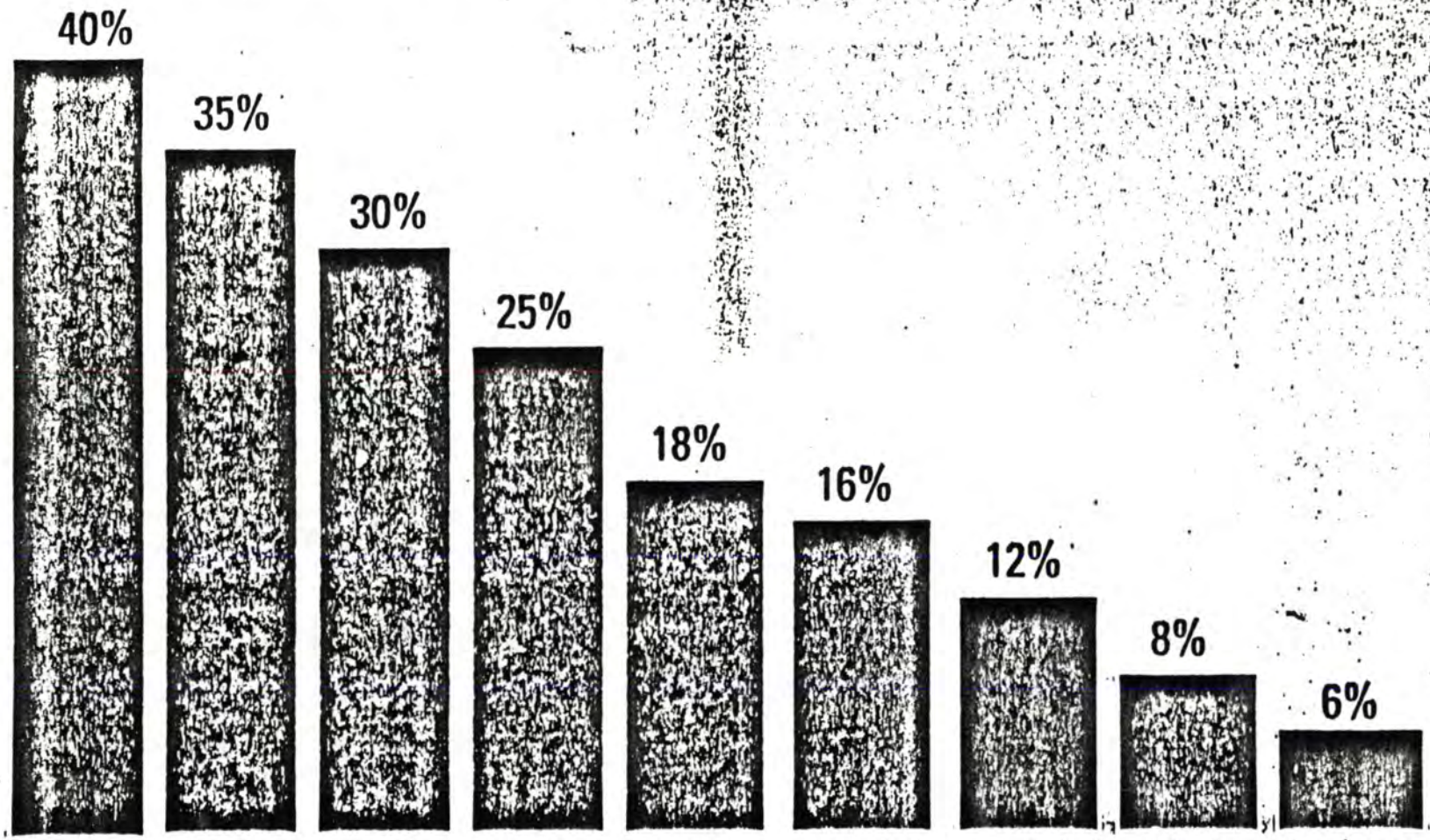
Who Are The Uninsured?

Distribution of the uninsured by family head's work status / size of employer

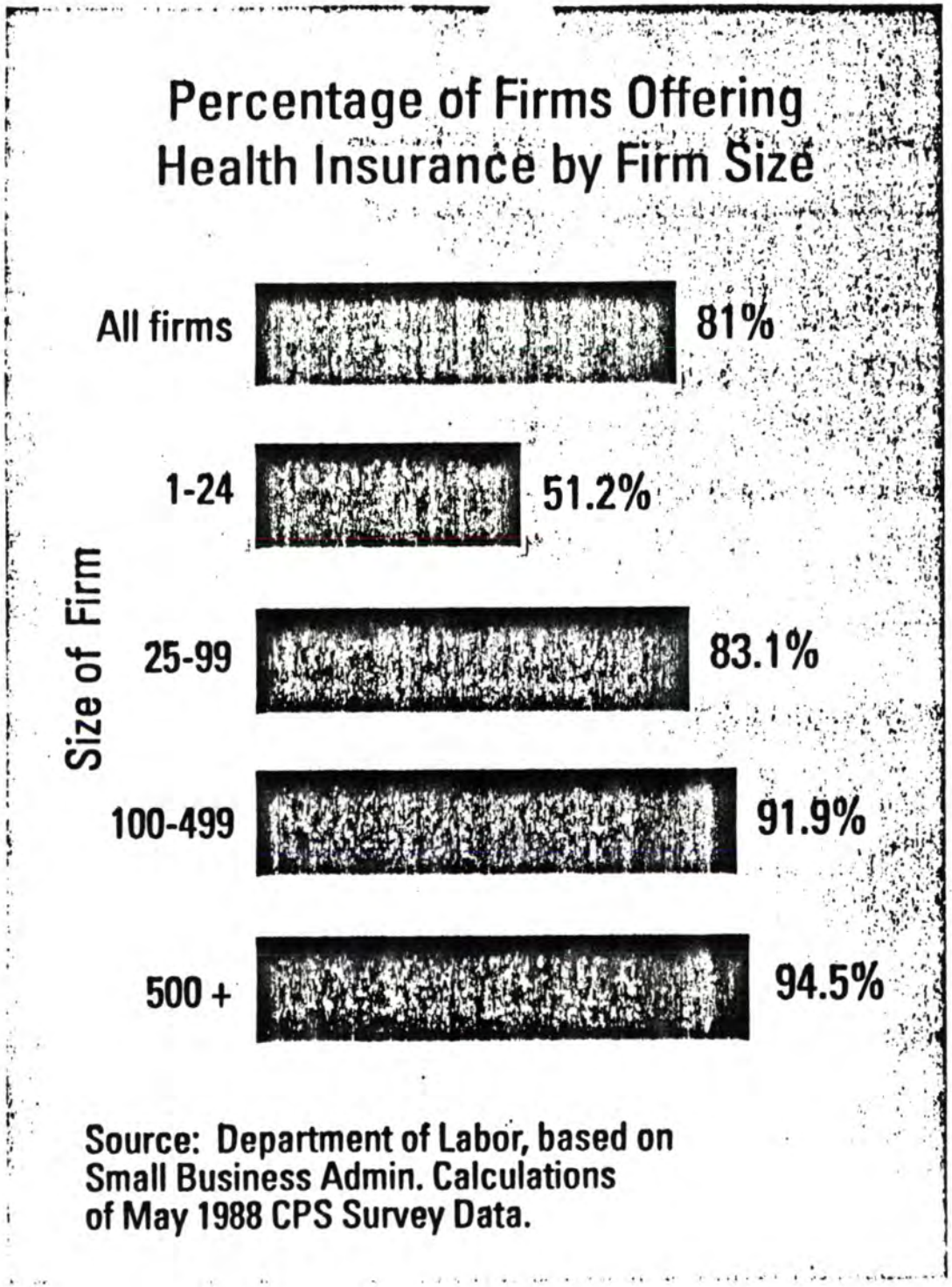


Source: The Urban Institute (1993), based on the March 1992 CPS and TRIM2. Numbers are in thousands.

Administrative Costs As A Percent of Incurred Claims

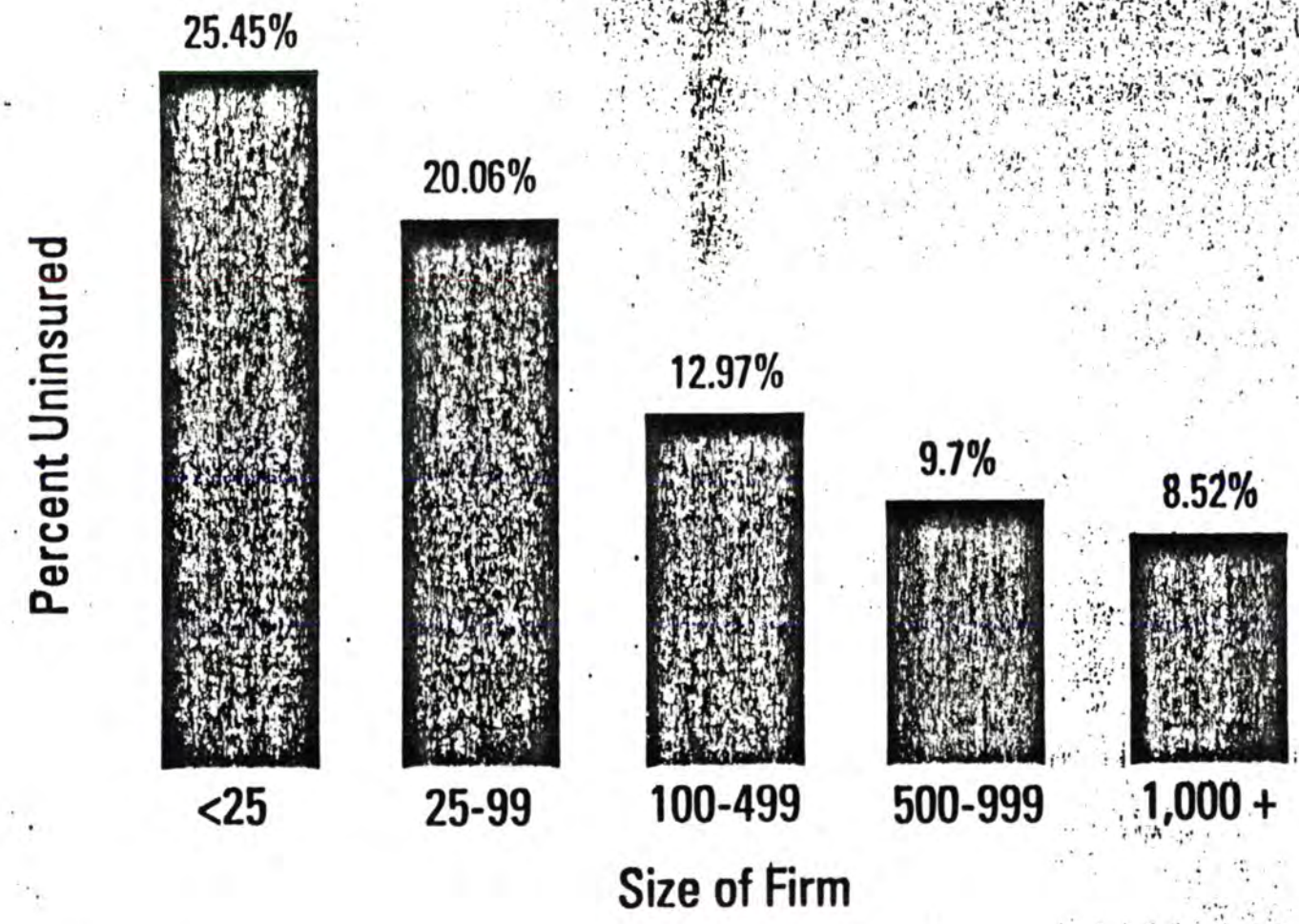


Source: Hay/Huggins Company, Inc.


Percentage of Firms Offering
Health Insurance by Firm Size
Size of Firm
All firms
81%
1-24
51.2%
25-99
83.1%
100-499
91.9%
500 +
94.5%
Source: Department of Labor, based on
Small Business Admin. Calculations
of May 1988 CPS Survey Data.

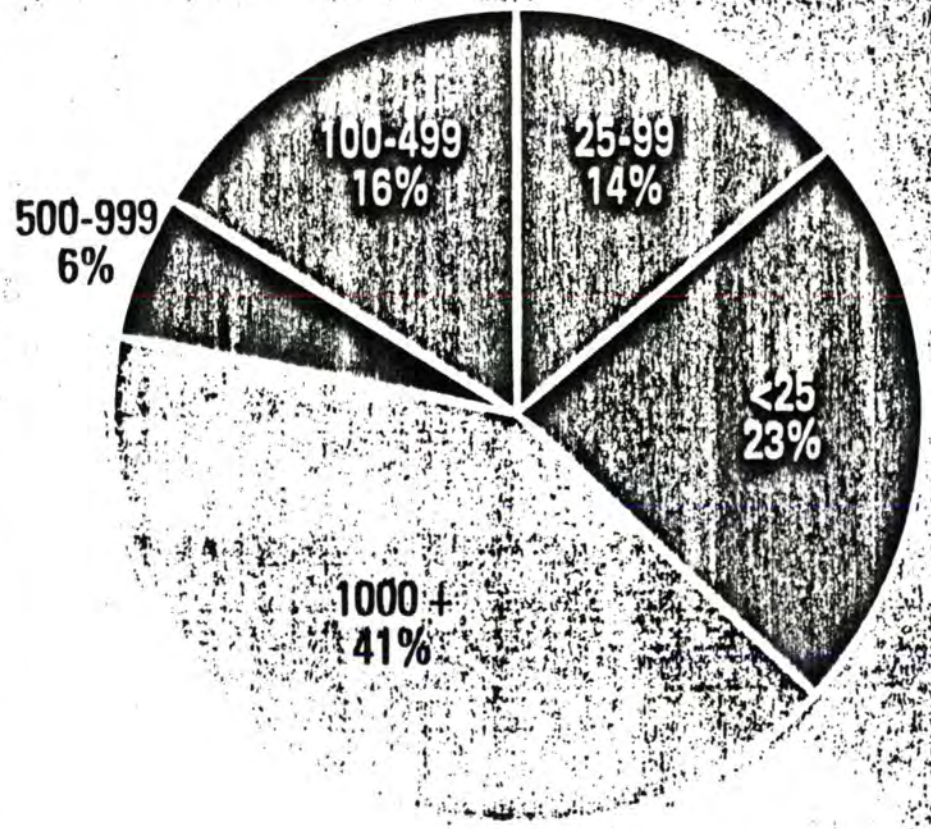
Workers in Small Firms are Most Likely to be Uninsured

Percent of workers and their dependents who are uninsured, by size of firm



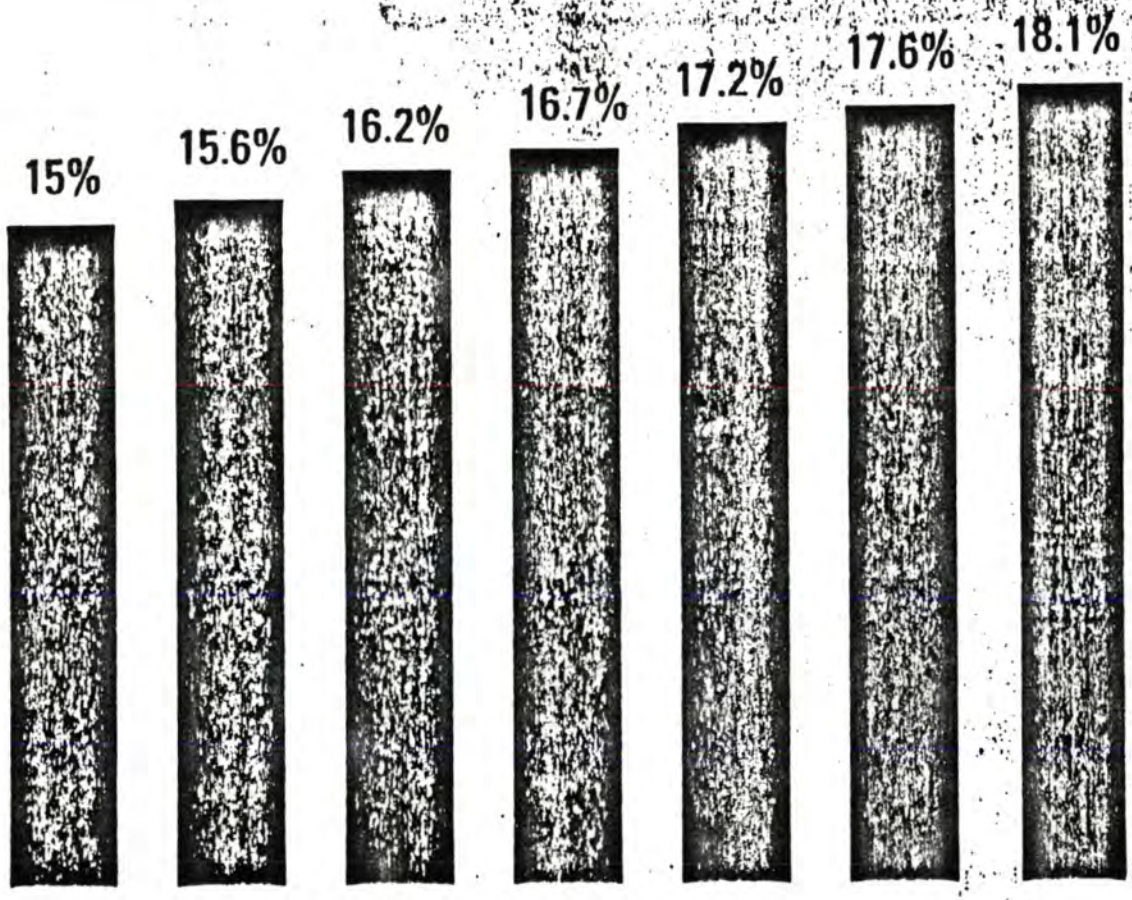
Source: The Urban Institute (1993), based on the March 1992 CPS and TRIM2.

Workers: How Many Work for Small Firms



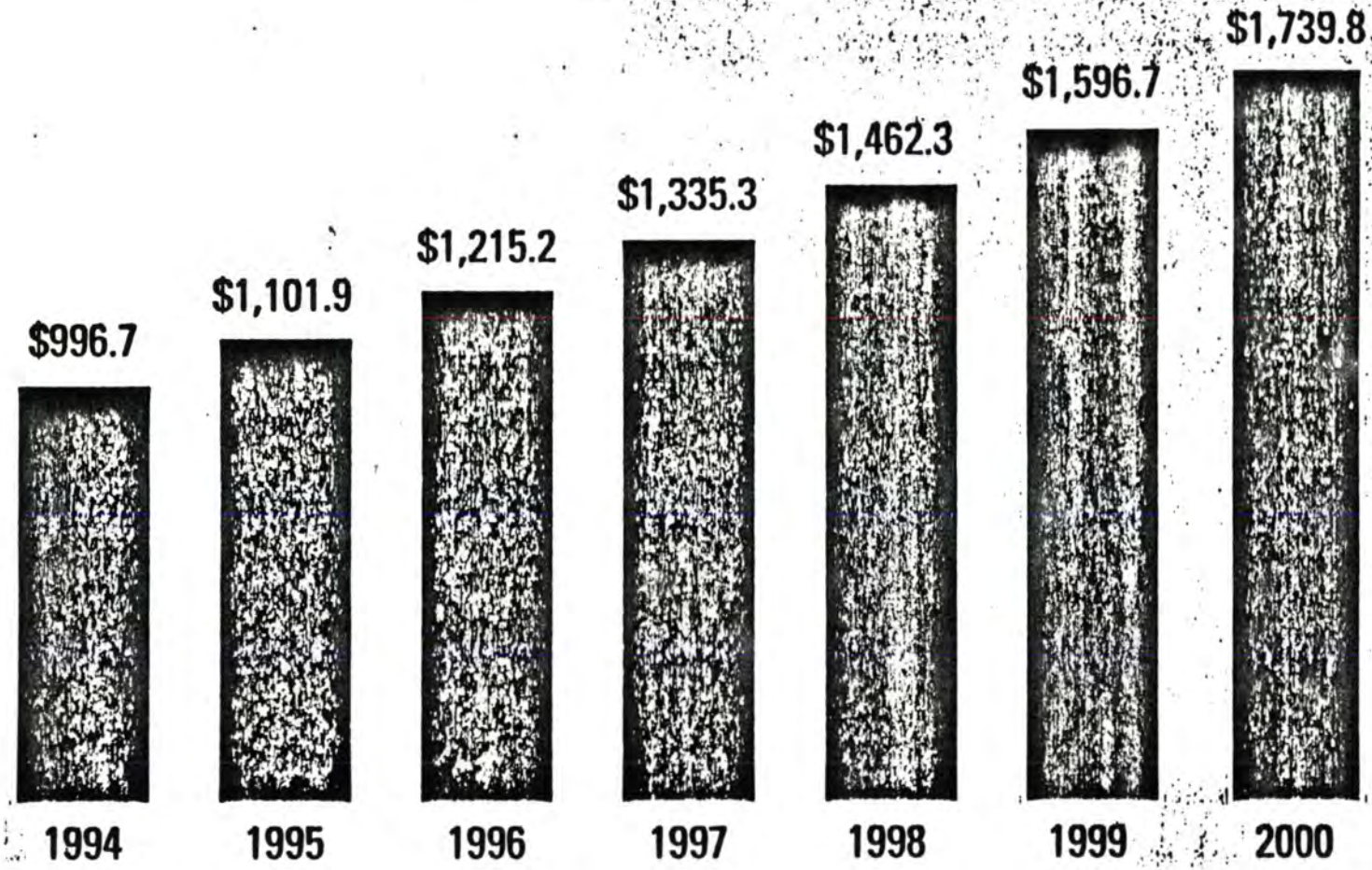
Source: The Urban Institute (1993), based on the March 1992 CPS and TRIM2. Numbers are in thousands.

National Health Spending as Percent of GDP



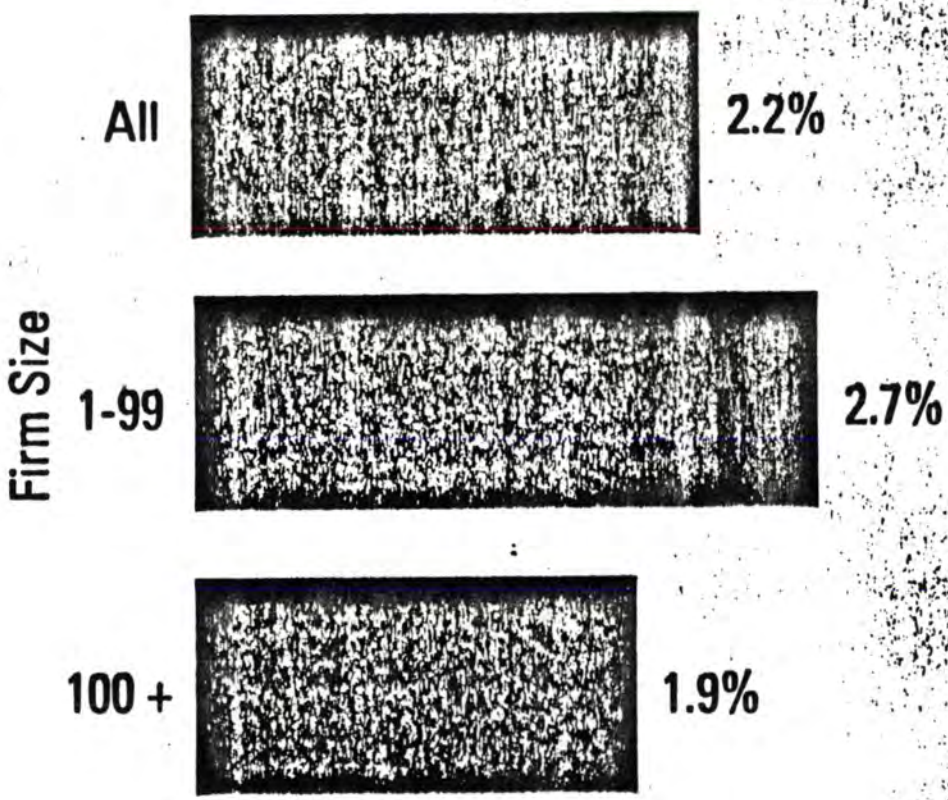
Source: Office of the Actuary, HCFA

National Health Spending
(billions)



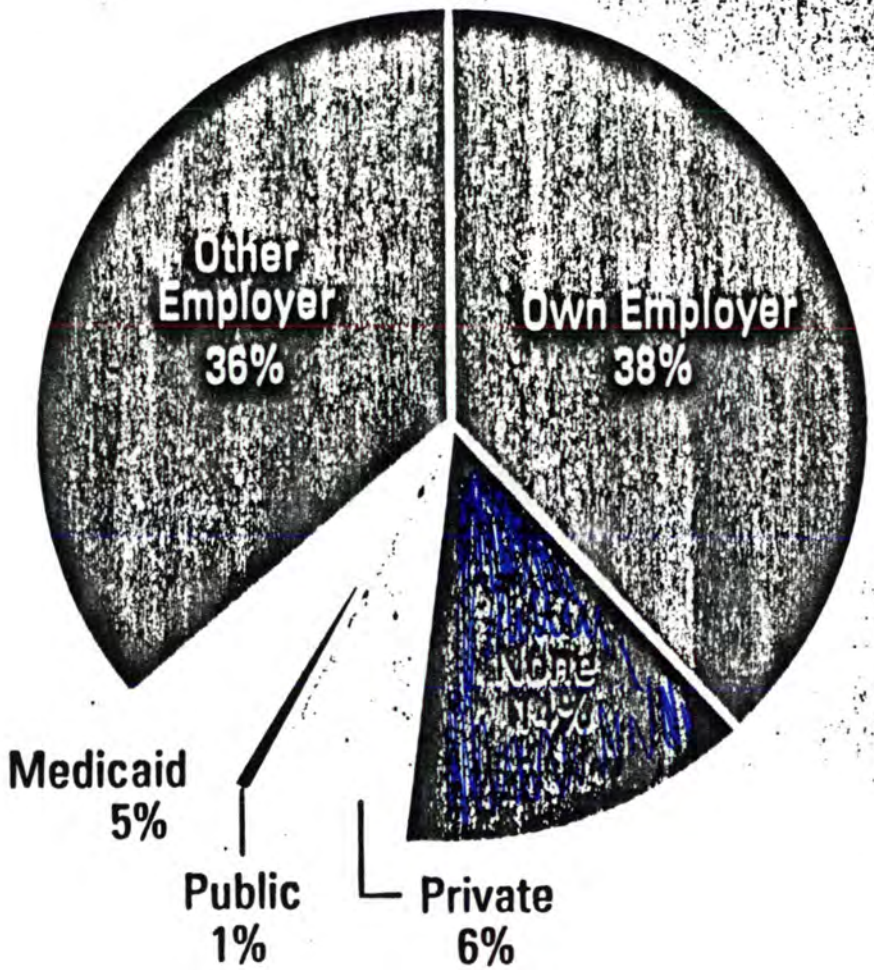
Source: Office of the Actuary, HCFA

Worker's Compensation as a Percent of Total Compensation



Source: Bureau of Labor Statistics, March 1992
Employment Cost Index

Working Families: What Are Their Sources of Health Insurance?



Source: The Urban Institute (1993), based on the March 1992 CPS and TRIM2. Numbers are in thousands.

HEALTH CARE POLICY DEVELOPMENT PROCESS

HEALTH POLICY DEVELOPMENT PROCESS:
DESCRIPTION

The Task Force:

President Clinton established the Task Force on National Health Care Reform on January 25, 1993 to develop a proposal to fundamentally reform America's health care system. Heis charge: prepare health care reform legislation to give American families the security they need and bring spiralling health care costs under control. The President set a 100-day schedule for this policy development, emphasizing in his "Joint Address to Congress" that there is urgent need for action: *"... all of our efforts to strengthen the economy will fail unless we also take this year -- not next year, not five years from now, but this year -- bold steps to reform our health care system."*

Demonstrating his level of commitment to solving this complex problem, the President appointed First Lady Hillary Rodham Clinton to chair the Task Force -- citing both the First Lady's experience and her ability to "bring people together around complex and difficult issues to hammer out consensus and get things done."

The President's policy development structure has two tiers: first is the Task Force itself, which includes representatives from the highest levels of the government -- including the Secretaries of Health and Human Services, Labor, Treasury, Commerce, Defense, and Veterans Affairs -- as well as senior White House officials. The second level is comprised of 34 working groups -- whose members include federal, state and Congressional employees, health professionals, and outside experts -- which were set up to advise the Task Force and develop health care policy within the "Tollgate" system.

Policy Development:

The "Tollgate" Process: The policy evaluation effort of the Task Force is being coordinated by the President's Senior Adviser for Policy Development, Ira Magaziner, and is based on the "Tollgate" system -- a research and evaluation process commonly used in the business world for large-scale projects that need to be completed quickly. To advise the Task Force, Mr. Magaziner formed 34 working groups -- involving health professionals, Congressional staff, health care experts, officials from various agencies, and White House personnel. These working groups -- which are divided into health policy subject areas such as Rural Health and Administrative Simplification -- guided their research efforts through a series of tests, or "tollgates", before presenting a comprehensive set of options to the Task Force for consideration.

In the first series of tollgates -- the broadening phase -- each working group was asked to put all options "on the table" -- ensuring that all issues were considered, all questions discussed, and that correct methodology was used. In the second phase, this broad group of options was narrowed, and research and assumptions were again revisited to assure accuracy.

The Final Decisions: After the tollgate process had refined the options, the working groups made draft recommendations which were synthesized into a comprehensive set of proposals. Working group members began a series of meetings with the President, the First Lady and Task Force members to present their proposals and outline the final decisions. The President is currently reviewing these proposals and making the final decisions.

At the same time, a legislative drafting group has been working to accurately capture the full intent of the policy proposals and turn the plan into legislation that can be introduced to Congress.

Outside Auditors: A series of independent auditors, from outside the Task Force process, are being brought in to challenge all assumptions and question the final conclusions.

- A **Health Professionals Review Group** of more than 40 doctors, nurses and other practicing health professionals has been conducting an intensive, critical review of working groups proposals in light of their real-world applications. A review team of experts from **Academic Health Centers** includes Deans from the most prestigious medical schools in the country.

- **Diverse panels of consumers** -- many selected from letters they sent to the Task Force -- were brought in regularly to advise the working groups as they developed their recommendations and are now examining the final proposals and making suggestions.

- An **Administrative Simplification Review Group**, which includes innovative health care leaders who have run major health plans and hospitals, has been formed to ensure that the recommendations meet the test of those who will have to implement them.

- **Financial auditors** will check to ensure that all cost and savings projections are sound and that all assumptions are both accurate and clearly laid out.

- **Legal auditors** will ensure that all questions of regulatory authority, jurisdiction, and interaction with existing laws have been addressed.

- Finally, a group of "**Contrarians**", both health policy experts and average

Americans, who have not been involved with the process, will be brought in to serve as "devil's advocates" to the Task Force's recommendations. They have been asked to critically examine all proposals and expose any possible weaknesses or oversights.

An Inclusive Process:

To ensure that this process was open and inclusive, the President structured the system to encourage participation from the American people, all categories of health care providers, the business community, and all levels of government. In **the most open policy making process in history**, more than 500 people from all over the country were directly involved in developing policy within the working groups.

Health Care Providers and Consumers Closely Involved: In an attempt to make health care reform respond to the concerns both of those who receive health care and those who provide health care, **more than 100 health care professionals** -- including 60 doctors, 20 nurses and 6 social workers -- were members of the working groups developing policy options for the Task Force. In addition, the Health Providers Review Groups and the Consumers Review Group, described above, have been closely involved throughout this process.

Exhaustive Outreach Process: The White House is actively reaching out for advice from the American people, members of Congress, representatives from small and large businesses, state and local officials, and organized health care interest groups. All groups have been encouraged to submit written proposals and **more than 400 [???] groups** have been brought into the White House to meet personally with the President, the First Lady, Ira Magaziner and/or working group members. In turn, their written proposals have been distributed to each applicable working group and have formed the basis for debate and policy development.

The Task Force operates an intake room to receive the thousands of speaking requests, policy papers, letters and phone calls from Americans concerned about the health care crisis. Since the Task Force was formed in January, **more than 200,000 letters** have been received and read. From a hospital administrator's treatise on malpractice reforms to a widow's handwritten letter expressing outrage at her skyrocketing prescription drug costs, each inquiry is taken seriously and channeled to the appropriate working groups.

The First Lady, Secretary Shalala and Tipper Gore -- who has been advising the Task Force on mental health issues -- have been travelling throughout the nation talking to the American people about their health care concerns. Over the past few months, they have attended several roundtable discussions across the country to discuss the recommendations of all those eager to contribute to

health care reform.

The Task Force met for the first time on Monday, March 29. Over the course of 13 hours, the Task Force members listened to more than 65 organizations -- representing diverse groups of consumers, health care providers, and businesses -- present their ideas on health care reform. These groups have continued to be closely consulted as policy options were narrowed and recommendations prepared.

Congressional Consultation: In developing its health care reform proposal, the Health Care Task Force has based its research and policy options on the significant foundation of work that many Members of Congress have laid in the last 20 years. In order to benefit from this expertise -- and build strong, bipartisan support -- the Task Force has **regular, broad-based, and substantive consultation** with Members of Congress, including an **extensive bipartisan outreach** effort.

- Senate Majority Leader Mitchell, House Majority Leader Gephardt, Senate Republican Leader Dole, and House Republican Leader Michel have been appointed Congressional Liaisons to the Health Care Task Force;

- There have been virtually daily meetings with the House and Senate Members and staff since the Task Force was formed. The First Lady herself has discussed health care reform with more than **90 Senate Democrats and Republicans**, and well over **160 House Democrats and Republicans** -- including meetings with the members of the Black, Hispanic, and Women's Caucuses;

- The First Lady, Ira Magaziner, and Judy Feder, of the Department of Health and Human Services, have established a close cooperative relationship with the Committees that have primary legislative jurisdiction over health care -- holding numerous one-on-one and group meetings with the House Ways and Means Committee, the Senate Finance Committee, the House Energy and Commerce Committee, the Senate Labor and Human Resources Committee, and the House Education and Labor Committee; and

- Working group leaders have briefed Members and Congressional staff from both parties on specific components of the health care options currently being proposed and analyzed.

as of 4/21/93

CONSULTATIVE HEALTH CARE MEETINGS
(Organizations)

AARP
Abbotsford Clinic Community Health Centers
Abbott Laboratories
ACLI
ACTWU
Actuaries Association
ADATT
ADAPT
ADAPT of Texas
Aetna Life and Casualty Group
AFL-CIO
American Federation of State, County and Municipal Employees
AHCPR
AIDS Action Council
AIDS Action Foundation
Alan Guttmachar Institute
Alliance for Aging Research
Alliance for Continuing Medical Education
Alliance of American Insurers
Alzheimer Association
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Pediatrics
American Association for Respiratory Care
American Association of College of Osteopathic Medicine
American Association of College of Podiatric Medicine
American Association of Colleges of Nursing
American Association of Colleges of Pharmacy
American Association of Critical Care Nurses
American Association of Homes for Aging
American Association for Medical Colleges
American Association of Nurse Anesthetists
American Association of Preferred Providers Organizations
American Association of Partial Medicine
American Association of University Women
American Business Conference
American Cancer Society
American Coalition for Citizens with Disabilities
American College of Emergency Physicians
American College of Preventive Medicine
American College of Cardiology
American College of OBGYN
American College of Physicians
American College of Surgeons
American Counseling Association
American Express

American Family Life Assurance Company, Inc.
American Federation of Home Health Agency's
American Federation for Clinical Research
American Foundation for AIDS Research
American Group Practice Association
American Health Care Association
American Health Care System
American Health Insurance Agents
American Health Policy Association
American Heart Association
American Home Products
American Hospital Association
American Insurance Association
American Lung Association
American Managed Care & Review Association
American Medical Association
American Medical Student Association
American Medical Women's Association
American Nurses Association
American Occupational Therapy Association
American Osteopathic Hospital Association
American Pharmaceutical Association
American Protestant Health Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Public Welfare Association
American Society for Healthcare Education & Training
American Society for Internal Medicine
American Society of Consultant Pharmacists
American Society of Hospital Pharmacists
American Speech-Language-Hearing Association
AMI
APGA
ARCO
Arkansas Able
Arthur G. James Cancer Hospital & Research Institute
Arthritis Foundation
Association for Care of Children's Health
Association for Hospital Medical Education
Association for Practitioners in Infection Control
Association of Academic Health Centers
Association of Academic Surgeons
Association of American Medical Colleges
Association of American Universities
Association of Maternal & Child Health Programs
Association of Medical School Pediatric Department Chairmen
Association of Minority Health Profession Schools
Association of Operating Room Nurses
Association of Private Pensions & Welfare Plans
Association of Professors of Medicine
Association of State & Territory Health Officials
ASTHO
AT&T
AZ Physician IPA
Ball State University, School of Nursing
Bankers Life
Bass & Howes
Bazelon Center for Mental Health Law
Black Psychiatric Association

Black Psychiatrists of America
Blue Cross/Blue Shield Association
Blue Cross/Blue Shield of Ohio
Boston Federal Reserve
BPHC
Brigham and Women's
Bristol-Myers Squibb
Brookings Institute
Brooklyn Hospital Center
Brotherhood of Teamsters
Bureau of Health Professions
Business Roundtable
California Children's Hospitals
California Department of Health
California Group - MICRA
Catholic University, School of Nursing
Coalition for Women's Health
Carl C. Icahn Foundation
Carter Center
Charles R. Drew University of Medicine & Science
Child Care Action Campaign
Child Welfare League of America
Children's Defense Fund
Children's Hospital, Wash., DC
Children's Mental Health Research Group
Chiropractic Coalition of America
Chrysler Corporation
Church Women United
CIGNA Corporation
CIS
Citizen Action
City of Hope
Clagett Memorial Hospital
CliniCorp-Northeast, Inc.
Coalition of Voluntary Mental Health Agencies
Coalition on Smoking OR health
College of American Pathologists
Columbia University
Commission for Hospitals & Health Care
Commission on Immigration Reform
Commonwealth Foundation in New York
Communication Workers of America
Communicating for Agriculture
Congressional Budget Office
Consortium for Citizens w/ Disabilities
Consumer Federation of America
Consumer/Survivor Mental Health Research and Policy Work Group
Consumers Union
Cooperative Healthcare Network
Dana-Farbar Cancer Institute
Davis (CA) Community Clinic
Delta Dental Plans Association
Department of Education
Depression After Delivery
Disability Rights Education Defense Fund
District of Columbia, Commerce & Regulatory Affairs
Eastern Tennessee State University, School of Nursing
EDS
Eli Lilly and Company
Employee Benefit

Emergency Room Nurses Association
Emory University, Neil H. Woodruff School of Nursing
Epilepsy Foundation of America
ERISA Industry Committee
Families USA
Family Services America
Family Voices
Federation of American Health System
Federation of Nurses & Health Prof. (AFT)
Federal Legislative Associates
Federation of American Health Systems
Feldesman, Tucker, Leifer, Fidell, Bank
Fenwick Center (Immunization)
First Hospital Corp.
Florida Legal Services
Ford
Ford Foundation
Fox Chase Cancer Center
Fred Hutchinson Cancer Research Center
General American Life Insurance
General Electric
General Motors
Generations United
Generic Pharmaceutical Industry Association
German Delegation
George Washington University
Georgia Legal Services
Georgia Southern University, Department of Nursing
Glaxo
GMHC
Grady Memorial Hospital
Grambling State University, School of Nursing
Grant Memorial Hospital
Graphic Artists Guild
Group Health Association of America
Group Health Cooperative of Puget Sound
Group Health Northwest
Group of Pharmaceutical Companies
Hartford Foundation
Harvard Medical School
Harvard University
Hawaii Child and Adolescent Mental Health Division of the Department of Health
Health Care Delivery Advisory Group
Health Care Financial Management Association
Health Care Financing Association
Health Care Management Alternatives
Health Care Purchasers Association
Health Industry Manufacturers Association
Health Insurance Association of America
Health Plus, Inc.
Health Policy & Strategy Association
Healthcare Fin. Management Association
HealthCare Compare Corporation
Henry Ford Hospital
Hispanic Health Care Leaders
HOSPICE Association of America
Hospital Corporation of America
Howard University
Human Rights Campaign Fund
Humana, Inc.

Hunter College of CUNY, Hunter-Bellevue School of Nursing
IBM Corporation
Illinois Wesleyan University, School of Nursing
Independent Insurance Agents of America
Indiana University
International Chiropractic Association
Inova Health System
Institute for Medical Information & Technology
Institute for Quality Improvement
Intermountain Health Care
Intermountain Systems
International Communications Industries Association
ISystems, Inc.
ITT Hartford
IVAX
Jackson Hole Group
Jewish Hospital Representatives
John Hancock
Johns Hopkins Oncology Center
Johns Hopkins University
Johnson & Johnson
Julia Norrell & Associates
Kaiser Foundation
Kaiser Permanente
Kalamazoo Center for Medical Studies
Keck, Mahin, & Cate
Kemper National Insurance Company
Kennesaw State College, Department of Nursing
Kids Count-Cent for Study of Social Policy
Konrad Adenauer Group
Laurel Health System
Legal Action Center
Legal Aid Society of San Diego
Legal Services Homelessness Task Force
Legal Services of Greater Miami
Lifeplans
Loma Linda University, California, School of Nursing
Long Term Care Home Health Care Coalition
Los Angeles County
Lutheran Medical Center
Managed Care Association of Pennsylvania
Managed Health Care Association
Managed Health Care Inc.
Managed Health Care System
March of Dimes Birth Defects Foundation
Marion Merrell Dow, Inc.
Mariposa Community Health Center
Massachusetts League of Community Health Centers
Massachusetts Mutual Life Insurance Co.
Mayo Clinic
Medco Containment Services
Medicare Advocacy Project
Medical College of Ohio, School of Nursing
Meharry Medical College
Memorial Sloan-Kettering Cancer Center
Mental Health Law Project
Mental Health Liaison Group (representing more than 30 mental health organizations)
Mental Health Research Group
Merck & Co., Inc
Mercy Clinic System

Metroplex Health Care Systems, Inc. (subsidiary of Ramsey Corporation)
Metropolitan Life
MGH Institute of Health Professions, Nursing Program
Michigan Medicaid
Migrant Legal Action Program
Montefiore Medical Center
Morehouse School of Medicine
Mutual of Omaha Companies
NAPNAP
NARAL
National Rural Health Association
National Academy of Social Insurance
National Alliance for the Mentally Ill
National Alliance of State AIDS Directors
National Association for Home Care
National Association for the Mentally Retarded
National Association of Addiction Treatment Providers
National Association of Chain Drug Stores
National Association of Child Advocates
National Association of Child Care Research & Referral Agencies
National Association of Children's Hospitals & Related
National Association of Community Health Centers
National Association of Counties
National Association of County Health Officials
National Association of County Officials
National Association of Developmental Disabilities Councils
National Association of Future Consumers
National Association of Health Career Schools
National Association of Health Service Executives
National Association of Health Underwriters
National Association of Insurance Commissioners
National Association of People with AIDS
National Association of Pharmaceutical Manufacturers
National Association of Private Psychiatric Children's Treatment Centers
National Association of Private Psychiatric Hospitals
National Association of Professional Insurance Agents
National Association of Protection & Advocacy System
National Association of Psychiatric Hospitals Systems
National Association of Public Hospitals
National Association of Rehabilitation Facilities
National Association of Retail Druggists
National Association of Small Business Investment Company
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Association of State Mental Directors
National Association for State Health Policy
National Association of Women Business Owners
National Black Caucus of Health Workers
National Black Child Development Institute
National Black Dental Association
National Black Women's Health Project
National Catholic Charities
National Center for Youth Law
National Child Abuse Coalition
National Coalition of Cancer Research
National Coalition of Hispanic Health & Human Services Organizations (COSSMHO)
National Commission on Children Summit
National Commission to Prevent Infant Mortality
National Committee on Quality Assurance
National Conference of State Legislators

National Consumers League
National Council of Churches
National Council of Community Hospitals
National Council of Senior Citizens
National Council of State Legislatures
National Council on Addiction
National Council on Aging
National Council on Alcoholism and Drug Dependence
National Council on Compensation Insurance
National Council on Independent Living
National Committee to Preserve Social Security & Medicine
National Depressive/Manic Depressive Association
National Easter Seal Society
National Farmers Union
National Federation for Specialty Nursing Organizations
National Federation of Independent Business
National Federation of Societies for Clinical Social Work
National Governors' Association
National Head Injury Foundation
National Head Start Association
National Health Law Project
National Health Policy Council
National Hemophilia Foundation
National Hispanic Council on Aging
National Immigration Law Center
National Institute on Adult Day Care
National Insurance Consumer Organization (NICO)
National Leadership Coalition for Health Care Reform
National Leadership Coalition on AIDS
National League of Cities
National Medical Association
National Mental Health Association
National Minority AIDS Council
National Minority Health Association
National Moving and Storage Association
National Nurse Practitioner Coalition
National Pharmaceutical Alliance
National Pharmaceutical Association
National Prevention Coalition
National PTA
National Public Health and Hospitals Institute
National Retail Federation
National Small Business Legislative Council
National Small Business United
National Task Force on AIDS Prevention
National Women's Health Network
National Women's Law Center
National Commission on AIDS
NCLR
NEIC
Nelson A. Rockefeller Institute of Government, SUNY Albany
New York City
New York Department of Finance
New York Department of Taxes
New York University
New York Lawyers for the Public Interest
New York Life Insurance Company
NFPRHA
North Carolina A&T State University, School of Nursing
Northwestern University School of Management

Office of Minority Health, HRSA
Office of Women's Health, U.S. Public Health Service
Ohio Psychiatric Association
Ohio State University, School of Nursing
Oil, Chem. & Atomic Workers Int. Union
Older Women's League
Oregon Health Plan
Oregon Health Science University, School of Nursing
Pan American Health Organization
PAR Pharmaceutical
Partnership for Prevention
PCS
Penn State, Milton S. Hershey Med. Center
PEPCO
Pfizer Inc.
Pharmaceutical Manufacturers Ass.
Phoenix Home Life Mutual Insurance Company
PHS, Office of Population Affairs
Physician for a National Health Program
Physicians Who Care
Planned Parenthood Federation of America
PPOs
Preferred Health Care
Premier Hospitals Alliance, Inc.
President's Committee on Employment of People w/ Disabilities
Price Waterhouse
Princeton University
Prudential Life Insurance
Public Citizen
Public Health Service
Rainbow Babies Children's Hospital, OH
Rainbow Coalition
Regional Insurers
Regional Medical Center, Memphis
Rockefeller Foundation
Roswell Park Cancer Institute
Rutgers, College of Nursing
Saint Louis University, School of Nursing
Save the Children
Schering-Plough
Screen Actors Guild/AFTRA
Searle
SEIU
Select Narcotics Subcommittee
Self Help for the Hard of Hearing
Self Insurance Institute of America
Seminar Group of Experts
Shering Plough
Shriners
Siegel Company
SmithKline Beecham
SMS
Society of Thoracic Surgeons
Society on Gen. Internal Medicine
South Carolina Department of Mental Health
South Main Center Association, Houston
Southern California Healthcare Network
St. Agnes Community Medical Center
State Farm Insurance
Stanford University

PHYSICIANS ADVISORY GROUP AND WORKING GROUP MEMBERS MET WITH THESE PEOPLE

ACEVEDO, JAMES
ALCORN, MERRIT, MD
ALUM, JEROME, MD
BENDIXEN, HENDRICK, MD
BENNET, ALAN
BENSON, JOHN, MD
BLIM, DONALD, MD
BOSNAK, ROSEMARIE
BOWEN, JOHN, MD
BOXER, RICHARD, MD
BRISTOW, LONNIE, MD
BURCIAGA, RAUL,
BUTLER, ROBERT, MD
CAREY, WILLIAM, MD
CARPENTER, CHARLES, MD
CASSEL, CHRISTINE, MD
CHUCKER, FRANK, MD
CLAGHORN, DEAN, EDD
COHN, DEBRA, ESQ.
CONNERTON, PEGGY
COPELAND, ROBERT, MD
CORLIN, RICHARD, MD
COYLE, JOSEPH, MD
DE LA TORRE, ADELA, MD
DELGADO, JANE
DIAZ, JOE, MD
DICKEY, NANCY, MD
DOZORETZ, RONALD, MD
ECKSTAT, STEVE R., DO
EDWARDS, ADRIAN, MD
EHRAT, KAREN S., PH.D
EISENBERG, JOHN, MD
ELLIOT, LARRY P., MD
FALCON, ANTONIO, MD
FASTWOLF, STEPHEN, RPT
FREEDMAN, PAUL
GAFFNEY, TERRY, RN
GALLIN, PAM, MD
GREELY, HENRY, MD
GRIEF, PAUL, MD
GUICE, KAREN, MD
GUTIERREZ, NILSA, MD
HACHTEN, RICHARD, MHA
HANSON, JIM, MD
HARTMANN, MARLENE
HEGARTY, STEVE, MD
HENION, JULIA
HEYSSEL, ROBERT, MD
HILL, LAWRENCE, DDS
HILL, HUGH F., MD, JD
HOCKSTETTER, SUSAN
HOPKINS, SUE
HOUPT, JEFFREY, MD
HOWLEY, JOHN
KLIMBERG, V. SUZANNE
KOHRMAN, ARTHUR
KYLE, REGINA, MD

LANSTEIN, JOEL
LEVIN, MICHAEL S.
LEVINE, HOWARD, JD
LEVY, RICHARD, JD
LIERMAN, TERRY
LOH, IRV, MD
LOPEZ, OSVALDO
MARGOLAS, ROBERT, MD
MAYNARD, DOUGLAS, MD
MCDONALD, JOHN
MCKANE, STEVE URANGA, DDS
MORALES, SUSAN, MD
NETTLESHIP, MAE, MD
NORTON, MEG, RN
ODEN, CLYDE, DO
OFFIT, KENNETH, MD
PAROLY, WARREN, MD
PIERCE, PHILLIP, PHD
REYNA, ROBERT, MD
SAVINO, PETER, MD
SCHETTMAN, MARY ELLEN, MD
SCHEUR, BARRY, JD
SCHLACKERMAN, NEIL, MD
SCHNEIDER, DON
SLAVEN, JOHN, MD
SOLOMONT, ALAN, MD
SPAETH, GEORGE L., MD
STRINGER, MIKE
TAKEY, CHRIST, MD
TANGALOS, ERIC
VOLLA, STEVE
WARD, JANET, RN
WATERS, ROBERT
WESTBROOK, KENT
WESTBROOK, KENT, MD

4/19/93

WORKING GROUP MEMBERS MET WITH THESE CONSUMERS

ALLEN, ELIZABETH	CITIZEN ACTION
ALLEN, KARIN	CITIZEN ACTION
ALLEN, JOHN	'ON OUR OWN'
APPLETON, MILES	INTAKE
APPLETON, MRS.	INTAKE
ARIO, JOEL	CONSUMER FEDERATION
ARNOLD, JENNIFER	INTAKE
BAKR, SADDIQ	CCNV
BENN, RICHARD	INTAKE
BENN, MINDY	INTAKE
BIDDLE, CORNELIA	INTAKE
BIDDLE, MR.	INTAKE
BLACKFORD, ALLEN	INTAKE
BLAISDELL, CARMI T.	INTAKE
BOBO, YANCEY	CCNV
BORELLI, MARYANNE	HOMELESS NURSE
BRADEN, RON	INTAKE
BREWER, TOM	INTAKE
BROOKTER, MARIE	INTAKE
BROWN, MARRISA	-
BRUBAKER, RACHEL	INTAKE
BURKHOLDER, DIANE	INTAKE
BUTTERWORTH, MEG	-
BYRNE, ROBERT	AARP
CAIN, ELIZABETH	WHITE HOUSE VOLUNTEER
CALDAGHAN, LAURIE	R.I. SCHOOL NURSE
CAPLINS, KATHY	INTAKE
CAVANAUGH, CAROL	INTAKE
CHRISTCH, KAREN	CALLED AFTER HCTF HEARING
CICLER, BONNIE	FAMILIES USA
CLEGHORN, STEVEN	JOBS FOR HOMELESS PEOPLE INC.
COXON, EUNICE	INTAKE
CROSS, EASON	INTAKE
CULBERTSON, CHARLES	INTAKE
CURRIE, JIM	INTAKE
DE'ALLESANDRO, OLYANDA	INTAKE
DERATTO, PATRICIA, A.	INTAKE
DEWIND, ELLEN	CONSUMER FEDERATION
DOBBUNS, JUDITH	COALITION FOR THE HOMELESS
DORSEY, CAROL	INTAKE
ECONOMOU, KATINA	CITIZEN ACTION
ELKIND, EDWARD	HOMELESS LEGAL FUND
ESBHEACH, SHERYL	FAMILIES USA
EWELL, STACY	INTAKE
FALL, PENNY	INTAKE
FINNELY, CAROL	CCNV
FISHER, DANIEL	PSYCHIATRIST
FLANAGAN MONTGOMERY, DIANE	PRIVATE INDUSTRY COUNCIL
FRANCO, CAROL	INTAKE

GALLO, TONY	FAMILIES USA
GARZA, ANDY	CCNV / NEW WAY RECOVERY, INC.
GEARHART, CHARLIE	CITIZEN ACTION
GENRICH, CHUCK	INTAKE
GEUARTER, MARY L.	INTAKE
GLENDENING, ANNE	-
GOTCHUS, JANELLE	DC HEALTH CARE FOR THE HOMELESS
GURLIK, CHERYL	CONSUMER FEDERATION
HALFILL, MARY	INTAKE
HARLAN, JOHN	FAMILIES USA
HAWKINS, EDITH	GREEN DOOR
HOLBROOK, TERI	BALTIMORE COUNTY SCHOOL NURSE
HUDSON, WINSON	HEAD START - MISSISSIPPI
HUFF, BARBARA	-
JACKSON, SYLVIA	INTAKE
JAEGER, SUSAN	INTAKE
JEHLE, CARLYN	R.I. SCHOOL NURSE
JOHNSON, EARLANE	INTAKE
JOHNSON, CONCHA	NATIONAL COUNCIL OF SENIOR CITIZENS
JONES, RICHARD	INTAKE
KACHANIS, ANNE MARIE	R.I. SCHOOL NURSE
KRANZ, SHIRLEY	NATIONAL COUNCIL OF SENIOR CITIZENS
KRANZ, HARRY	NATIONAL COUNCIL OF SENIOR CITIZENS
LACEY, DR. BERNADINE	CCNV
LAWHICZAK, JOHN	NATIONAL COUNCIL OF SENIOR CITIZENS
LEECH, IRENE	CONSUMER FEDERATION
LIGHT, JANIS	INTAKE
LONGA, BARBARA	R.I. SCHOOL NURSE
LUCKHARD, BILL	AARP
MARLAN, HOPE	-
MAST, DAVID	FAMILIES USA
MAST, SUZANNE	FAMILIES USA
MATEER, SUSAN	INTAKE
MATEER, RON	INTAKE
MAWER, MARTHA	INTAKE
MAYS, KATHY & FRIEND	INTAKE
MCCALL, ELLA	SOCIAL WORKER
MCELDOWNEY, KEN	CONSUMER FEDERATION
MCKENNA, THERESA	NATIONAL COUNCIL OF SENIOR CITIZENS
MCLEOD, ANNE	NATIONAL COUNCIL OF SENIOR CITIZENS
MCNABB, WANN	INTAKE
MEILI, STEVE	CONSUMER FEDERATION
MILLER, LINDA	INTAKE
MITCHELL, KEITH	CCNV
MITCHELL, LOIS	CCNV
MITCHELL, REGENE L.	CONSUMER FEDERATION
MOEHRLE, GEORGE	CITIZEN ACTION
MONTGOMERY, DOROTHY	INTAKE
MOORE, TERRY	INTAKE
MUNDELL, MR.	INTAKE
MUNDELL, PAMELA	INTAKE
NAULT, LORRAINE	R.I. SCHOOL NURSE
NELSON, DAVID	INTAKE
NEWELL, BETTY	FAMILIES USA
NEWELL, KATHLEEN	FAMILIES USA
OBRACHTA, CAROL	-
OLINICK, JULIAN	INTAKE
OLINICK, MR.	INTAKE
ONWUCHUKEWA, DIANE	INTAKE
PACHECO, GUADELUPE	PAUL JACKSON

PARKE, ANNE	NATIONAL COUNCIL OF SENIOR CITIZENS
POWERS, SHERYLE	-
QUINLIN, MARY JO	-
REES, BEVERLEY	INTAKE
RESSALLOT, JUDY	R.I. SCHOOL NURSE
ROADS, DAVID	INTAKE
ROBERTS, MR.	INTAKE
ROBERTS, LOIS	INTAKE
ROBINSON, VIRGINIA	INTAKE
ROBINSON, BRENDA	INTAKE
ROGAN, SUSAN	INTAKE
ROURKE, JOSEPH	INTAKE
RUSSO, TONY	CONSERVE
SCHULER, MELINDA	INTAKE
SEARLE-WHITE, LISBET	INTAKE
SEGU, MARY & DAUGHTER	SEGU
SIMONTON, THOMAS	AARP
SMITH, SHIRLEY	INTAKE
STAFFORD, THOMAS	-
STARKWEATHER, LYNNE	INTAKE
STARKWEATHER, MR.	INTAKE
STEWART, SARAH JANE	FAMILIES USA
SUMMERS, ROBERT	-
TAYLOR, SISTER CAROL	CENTER FOR CLINICAL BIO-ETHICS
THOMAS, JACKIE	AARP
THURMAN, RANDY	INTAKE
VEIDT, CYNTHIA	HARTFORD SCHOOL NURSE
WALKER, JANICE	-
WALLACH, FRANKLIN	NATIONAL COUNCIL OF SENIOR CITIZENS
WAYMAN, ROSA LEE	-
WEDGE, SYLVESTER	CCNV
WEINSTEIN, CAROLE	INTAKE
WHEYNNERY, MARIE	CCNV
WILLIAMS, FRANCENE	GREEN DOOR
WINANS, JEFFREY	INTAKE
WOODY, WILLIAM	NATIONAL COUNCIL OF SENIOR CITIZENS
WRIGHT, OLGA	WILLIAM RAMSEY SCHOOL NURSE
WYATT, HUGH	PAUL JACKSON

THE HEALTH CARE TASK FORCE VISITS ACROSS THE COUNTRY
Scheduled through June 1993

Arizona
Phoenix
Scottsdale
Tuscon

Arkansas
Little Rock

California
Anaheim
Long Beach
Los Angeles
Manhattan Beach
Pebble Beach
San Diego
San Francisco
San Jose
Santa Cruz
Whittier

Colorado
Denver

Connecticut
Hartford

District of Columbia
Washington

Florida
Miami
Orlando
St. Petersburg
Tampa

Georgia
Atlanta

Illinois
Chicago

Iowa
Des Moines

Kentucky
Louisville

Louisiana
New Orleans

Maryland
Baltimore
Bethesda
Rockville

Massachusetts
Boston

Michigan
Dearborn
Detroit

Minnesota
Duluth
Minneapolis

Missouri
Kansas City
St. Louis

Montana
Billings

Nebraska
Lincoln

New Jersey
Newark
Trenton

New York
Ithaca
New York City

North Carolina
Raleigh

North Dakota
Bismarck
Fargo
Grand Folks

Ohio
Columbus

Oklahoma
Tulsa

Pennsylvania
Philadelphia
Pittsburgh
Harrisburg

South Carolina
Charleston
Hilton Head

Tennessee
Memphis
Nashville

Texas
Austin
Dallas
San Antonio

Virginia
Alexandria
Arlington
Richmond

Washington
Puget Sound
Seattle

West Virginia
Charleston
Morgantown
Wheeling

Wyoming

Jackson Hole

HEALTH CARE EVENTS
Scheduled through May 1993

LOCATION	DATE	EVENT
Arizona		
Tucson	05/13/93	Council of Presidents
Scottsdale	05/24/93	U.S. Public Health Service Professional Association
Arkansas		
Little Rock	04/20/93	Center for Substance Abuse Treatment
California		
Los Angeles	04/19/93	Surgeon General's Hispanic/Latino Regional Health Meeting
Los Angeles	04/20/93	National Council on Aging
Whittier	04/25/93	Mark Twain Democratic Club
San Jose	05/08/93	National Health care for the Homeless
Pebble Beach	05/14/93	CA Assoc. of Prepaid Dental Plans
San Francisco	05/17/93	Society for Academic Emergency Medicine
San Francisco	05/17/93	Leadership Institute
Manhattan Beach	05/19/93	Hemophilia 2000
Ukiah	05/22/93	Rep. Hamburg's Town Hall Meeting

LOCATION	DATE	EVENT
San Francisco	05/24/93	American Psychiatric Association
Colorado		
Denver	05/03/93	National Indian Health Board
Connecticut		
Stamford	05/21/93	WEB of CT Health Care Symposium
District of Columbia		
Washington	03/08/93	American Psychological Association
Washington	03/12/93	Small Businss Legis Council
Washington	03/12/93	National Conference of State Legislators
Washington	03/15/93	American Psychiatric Association
Washington	03/18/93	National Rural Health Board Meeting
Washington	03/23/93	American Association of Colleges of Nursing
Washington	03/30/93	National Association of Childrens Hospitals and Related Institutions
Washington	03/30/93	American Business Conference
Washington	04/01/93	American College of Physicians
Washington	04/06/93	National Wholesale Druggists Association Meeting

LOCATION	DATE	EVENT
Washington	04/07/93	League of Women Voters Meeting
Washington	04/07/93	Richard Schrushy Meeting
Washington	04/07/93	American Farm Federation Meeting
Washington	04/12/93	Older Women's League Campaign for Women's Health
Washington	04/12/93	Center for the Advancement of Health
Washington	04/13/93	National Managed Health Care
Washington	04/13/93	Center for National Policy
Washington	04/14/93	National Federation of Mental Health
Washington	04/14/93	Prevention Intervention and Treatment for Health & Wellness Coalition Meeting
Washington	04/15/93	Federated Council for Internal Medicine
Washington	04/15/93	Greenbrier Study Group Meeting
Washington	04/15/93	Wine Institute Meeting
Washington	04/16/93	Public Relations Society of America
Washington	04/16/93	American College of Cardiology
Washington	04/17/93	Association of American Universities and Nat'l Assoc of Land Grant Colleges
Washington	04/17/93	Alzheimer's Association
Washington	04/19/93	Health Industry Distributors Association Meeting

LOCATION	DATE	EVENT
Washington	04/19/93	National People's Action
Washington	04/19/93	Teachers of Preventive Medicine
Washington	04/20/93	Blue Cross/Blue Shiled of VA
Washington	04/20/93	Health Executives Roundtable (MGMA, AMA, AHA, PMA, WBGH, AARP, Chamber, AAMC)
Washington	04/22/93	Association of Schools of Public Health Meeting
Washington	04/22/93	National Grocers Association Meeting
Washington	04/23/93	Congressional Youth Leadership Council
Washington	04/25/93	National Association of Psychiatric Treatment Centers
Washington	04/26/93	Foster Higgins Meeting
Washington	04/28/93	American Federation of Home Health Agencies Meeting
Washington	04/28/93	National Council of Senior Citizens Meeting
Washington	04/28/93	PITCH
Washington	04/28/93	National Association for Home Care
Washington	04/29/93	National Association of Manufacturers
Washington	04/29/93	AHA, Congress of Hospital Trustees

LOCATION	DATE	EVENT
Washington	04/29/93	National Association of Managed Care Physicians
Washington	04/30/93	Academy of Nurse Practitioners
Washington	04/30/93	Health Care For All
Washington	05/02/93	National Coalition of Hispanic Health and Human Services Organization
Washington	05/02/93	American Academy of Dermatology
Washington	05/03/93	National Medical Association
Washington	05/03/93	American College of OB-GYN's
Washington	05/05/93	Lehman Brothers
Washington	05/05/93	Combined Jewish Philanthropies of MA
Washington	05/07/93	World Conference of Mayors Meeting
Washington	05/07/93	Conference Board
Washington	05/10/93	International Foundation of Employee Benefit Plans
Washington	05/11/93	National Women Business Owners Meeting
Washington	05/11/93	Small Business United Meeting
Washington	05/11/93	Direct Market Institute Meeting
Washington	05/11/93	Business Roundtable
Washington	05/12/93	National Manufacturers Association
Washington	05/12/93	Nurses of America

LOCATION	DATE	EVENT
Washington	05/12/93	Howard University Hospital Nurses Week
Washington	05/12/93	National Health Policy Forum
Washington	05/13/93	National Pediatric AIDS Resource Center
Washington	05/13/93	National Tooling and Machine Meeting
Washington	05/13/93	Chamber of Commerce Meeting
Washington	05/14/93	National Association of Rehabilitation Centers
Washington	05/14/93	Public Officials Spouses from Rep. Fingerhut's district (D-OH)
Washington	05/14/93	Church Alliance Meeting
Washington	05/14/93	Legal Review Group
Washington	05/14/93	American Psychiatric Association at St. Elizabeth Hospital
Washington	05/15/93	American College of Radiation Oncology
Washington	05/15/93	National Multiple Sclerosis Society
Washington	05/17/93	American Managed care & Review Association
Washington	05/17/93	CEO Institute, *Carol Rasco
Washington	05/17/93	Brookings Institution, "Inside DC"
Washington	05/18/93	Coalition for Health Funding

LOCATION	DATE	EVENT
Washington	05/19/93	American Medical Peer Review Association
Washington	05/20/93	National Health Policy Council
Washington	05/20/93	Interhealth
Washington	05/20/93	National Health Lawyers Association
Washington	05/20/93	Congress on Ministries Meeting
Washington	05/21/93	National Academy of State Health Policy
Washington	05/22/93	American Federation of Teachers
Washington	05/23/93	National Wellness Coalition
Washington	05/23/93	Society for Human Resource Management
Washington	05/24/93	SEIU Legislative Conference
Washington	05/24/93	American Physical Therapy Association
Washington	05/24/93	American Academy of Pediatrics briefing
Washington	05/26/93	Association of Private Pension and Welfare Plans
Washington	05/26/93	Health Care Leadership Conference
Washington	05/26/93	Women in Government Relations
Washington	05/27/93	President's Executive Exchange
Washington	05/27/93	National Council on Chain Restaurants
Washington	05/28/93	Howard University Town Hall Meeting

LOCATION	DATE	EVENT
Florida		
Orlando	04/14/93	Visiting Nurses Association
Miami	04/29/93	Miami Chamber of Commerce
Georgia		
Atlanta	05/29/93	Coalition of Black Trade Unionists
Illinois		
Chicago	04/25/93	HIAA Annual Meeting
Chicago (via telephone)	05/10/93	Illinois Senate Democratic HCTF
Louisiana		
New Orleans	04/29/93	American Association of Health Executives
Maryland		
Bethesda	05/03/93	National Council of Community Mental Health Centers
Baltimore	05/24/93	National Association of Boards of Pharmacy
Massachusetts		
Boston	05/04/93	National Association of Attorneys General
Minnesota		
	05/20/93	University of Minnesota Health Sciences

LOCATION	DATE	EVENT
Missouri		
St. Louis	05/10/93	American Infomatics Association
Kansas City	05/12/93	National Rural Health Association
New Jersey		
Newark		Governor Florio's Event (MEG)
New York		
New York City	04/14/93	National Conference of Black Mayors
Ithaca	04/24/93	Cornell Journal of Law and Public Policy Forum
New York City	04/26/93	City University of New York Lunch Series
New York City	05/17/93	Rep. Maloney's Town Hall Meeting
New York City	05/24/93	Rep. Maloney's Town Hall Meeting
North Carolina		
Raleigh (via satellite)	05/06/93	North Carolina Dept. of Administration
North Dakota		
Grand Folks	03/30/93	Indians Into Medicine
*location unspecified	04/24/93	Women's Democratic Association of North Dakota

LOCATION	DATE	EVENT
Oklahoma		
Tulsa	05/07/93	Growing Healthy
Pennsylvania		
Pittsburgh	04/22/93	Blue Cross Blue Shield of Western Pennsylvania
Pittsburgh	05/04/93	National Urban League
South Carolina		
Hilton Head	05/12/93	Computers in Healthcare
Charleston	05/20/93	South Carolina Home Care Association
Tennessee		
Nashville (via satellite)	04/19/93	National Conference on Public Employee Retirement Systems
Nashville	04/20/93	National Conference on Public Employees Retirement Systems
Memphis	04/23/93	National Black Caucus of State Legislators
Nashville	05/01/93	American College of Health Care Administrators
Texas		
San Antonio	04/22/93	Medical Records Institute Symposium
Austin	05/18/93	American Urological Association

LOCATION	DATE	EVENT
Virginia		
Arlington	03/22/93	Association of Academic Health Centers
Arlington	03/25/93	National Association of Residential Care Facilities
Arlington	04/22/93	Council for Affordable Health Care
Arlington	05/19/93	National Hospice Organization
Richmond	05/19/93	Virginia Health Council
Washington		
Seattle	04/16/93	Group Health Cooperative
West Virginia		
Wheeling	04/19/93	West Virginia Primary Care Association
Morgantown	04/20/93	West Virginia University Law School Panel
Morgantown	05/21/93	West Virginia Human Resources Association
Europe		
Luxembourg	05/25/93	World Health Organization

HEALTH REFORM -- STATE BY STATE BREAKDOWNS

Alabama

Factors Impacting Health Care Reform:

1. Over 700,000 Alabama residents (about 20%) had no health insurance in 1991. In 1993, it is estimated that more than 1 million Alabamians will be without insurance at some point during the year.

2. In 1992, the premium for an average family without employer-sponsored health insurance was $3,780 a year, even if they remained healthy.

3. The cost of health care in Alabama has risen by about 421 percent since 1980, with the average family's payments increasing 200 percent faster than wages.

4. Similarly, businesses have experienced a cost increase of about 214 percent in the last decade. It is projected that total expenditures will rise from the current figure of $2.6 billion to over $5.6 billion by the year 2000, which would produce a 578 percent increase in health costs since 1980.

5. As of 1990, 32.6% of Alabama's population lived in rural areas.

6. Also as of 1990, 19.2% of the population lived below the poverty level.

7. As of 1989, Alabama was distinctly above the national average for infant mortality, low birth weight babies, and percentage of children under the age of twelve who were hungry.

Legislation:

1. Rural Services Task Force / Created 1989

   A. Established a task force to study and make recommendations on the crisis in rural obstetrical care and the survival of rural hospitals.

2. Physician Task Force / Created by the Alabama Medicaid Agency, 1989

   The Task Force was designed to involve physicians in decisions regarding management issues that effect their practices.

3. Division of Maternal and Child Health / Created by the Alabama Medicaid Agency, March 1990

   The primary aim of the program was to begin the reform process by targeting special populations, in this case children and pregnant women. The basic initiatives of the Division are as follows:

   A. Increasing reimbursement rates for obstetrical services.

   B. Enhancing EPSDT services and expanding participation in the Maternity Waiver program (a managed care program providing primary care services to Medicaid eligible pregnant women).

   C. Creation of " Healthy Beginnings " (1990), a program designed to enroll all pregnant women in early prenatal care.

4. Family Practice Rural Health Board / House Bill 177 / Passed 1990

   A. Allocates funds for the recruitment of physicians to practice in underserved areas.

   B. Provides for rotations in rural residency programs as well as periodic tracking of medical students enrolled in such programs.

5. Rural or Small Hospitals / House Bill 170 / Signed into law by Governor Folsom, May 4, 1993

   A. Provides state income tax credits for physicians choosing to practice in rural and underserved areas.

6. Certificate of Need Review / House Bill 165 / Signed into law by Governor Folsom, May 6, 1993

   A. Exempts rural hospitals from previously established certificate of need review procedures, giving them more opportunity and incentive to improve their facilities.

7. Group Health Insurance / Senate Bill 8 / Signed into law by Governor Folsom, May 13, 1993

   A. Establishes the Insurance Board, which negotiates with insurers to provide low group health rates for Alabama

residents who are not covered by large insurance companies, HMOs, or other managed care organizations.

The Alabama legislature adjourns its 1993 session on Monday, May 17 and will decide the fate of several additional health care proposals before the close of business.

A. Physician Task Force / Created by the Alabama Medicaid Agency, 1989

The Task Force was designed to involve physicians in decisions regarding management issues that effect their practices

Arizona

Characteristics Impacting Health Care Reform:

1. As of 1992, 16% of Arizona's population was uninsured, a figure which places it above the national average. Also, it is estimated that close to 1 million residents (26%) will be without insurance at some point during 1993.

2. Arizona has large rural areas that are severely underserved for primary care.

3. Arizona has a relatively high concentration of small employers.

4. The political climate in Arizona has traditionally been conservative and, since it now has both a Republican Governor and Republican majorities in the House and Senate, that trend is likely to continue.

5. The budgetary constraints under which Arizona must operate could adversely affect the course of pending health legislation.

Health Care System Characteristics:

1. Arizona has nine HMO-style organizations (Health Care Service Organizations) which attract about 25% of the health care market.

2. Arizona's Medicaid program, (AHCCCS), provides for delivery of services through an HMO model.

3. Also administered by AHCCCS is a program called Health Care Group, a subdivision of Medicaid formed to address the needs of small businesses. It enables employers with 40 or fewer employees to obtain coverage under an AHCCCS managed care plan which protects them from medical underwriting and limits pre-existing conditions to 12 months for inpatient care.

Legislation:

1. House Bill 2027 / Passed-1991

   A. Prohibits employers from cancelling or not renewing coverage except in the event of nonpayment of premiums, fraud or misrepresentation.

B. Reduces the uninsured period from six months to days.

C. Establishes new criteria for " bare bones " packages, to include maternity and well-child benefits.

D. Expands eligibility requirements to groups of 40 or fewer employees.

2. Accountable Health Plans / Senate Bill 1109 / Passed by the legislature, May 1993

A. Establishes the Health Benefit Plan Committee appointed by the Governor. The Committees duties include:

-Developing a Basic Health Benefit Plan (BHBP)

-Recommending benefit and cost-sharing levels as well as any exclusions and limitations.

-Determining the list of licensed health providers who would be eligible for reimbursement under the BHBP.

B. Requires the certification of all health plans offered by insurers in Arizona. Accountable Health Plans (AHP) would operate under the following guidelines:

-AHPs must offer the BHBP to all qualified small employers with 25 to 40 employees. As of July 1996, AHPs must offer insurance to all small employers regardless of the number of employees. Employers filing for such coverage must not have provided an HBP to their employees for 90 days prior to applying for coverage with the AHP.

-An AHP may refuse to insure a given group if it can show that inclusion of this group would adversely affect its financial capacity to serve previously enrolled members.

-AHPs must guarantee issue, except in cases where eligible employees are located outside the AHP's service area.

-AHPs must guarantee renewability, except in cases of fraud or misrepresentation or when an enrollee has failed to pay his/her premium.

-An AHP may elect not to renew the HBP, but it will be prohibited from selling insurance in Arizona for five years following the termination of said plan.

-The maximum pre-existing condition exclusion is 12 months prior to the effective date of the plan.

-An AHP may vary premium rates by as much as 60% from the prescribed community-rating of an HBP due to the presence of high-risk circumstances.

-AHPs are required to use standard formats for billing and data collection.

-Quality Assurance and Utilization Reviews must be filed with the Department of Insurance to monitor the quality of services being provided by participating physicians and to gauge the satisfaction of enrolled individuals.

C. Provides for the creation of a Small Employer Reinsurance Program, which would pool the collective resources of small group carriers to protect against unexpected claims.

California

Factors Impacting Type and Bredth of Reform Initiatives:

1. California has an unusually large number of uninsured residents. 5.75 million residents (18.7% of the population) were without insurance in 1991, and an estimated 8.6 million (29% of the population) will be uninsured at some point in 1993.

2. The cost of purchasing health insurance for employees has become prohibitive, particularly for small businesses. The average cost of health care for California businesses was $35 billion in 1991 and is projected to reach over $81 billion by the year 2000. If costs continue unchecked, the trend would represent an increase of 810% in the twenty years between 1980 and 2000.

3. The average California family spent $1,666 for health care in 1980; by 1991, that figure had increased to $4,433 and, at the current rate of growth, would reach $9,765 by the year 2000. This would represent a 486% increase over the twenty year period.

4. There is a large percentage of people working in occupations that normally do not provide insurance (agriculture, forestry, retailing, etc.)

5. There is a large number of immigrants (54% of the nation's Immigration Reform and Control Act immigrants, 40% of the its refugees, and more than 50% of the its undocumented immigrants) who traditionally do not have access to adequate health coverage.

Health Care System Characteristics:

1. The CALpers program provides insurance for both active and retired state employees through managed care organizations. The CAlpers governing board has created a $1.3 billion purchasing pool through which it can negotiate with particpating HMOs for lower rates. It plans to standardize benefits for its members so they can choose plans based solely on service, quality, and price instead of level of benefits. The program has proven to be popular among state employees, and California has added a PPO system called PERScare for those who prefer a wider range of provider choices.

2. Medi-Cal (California's Medicaid program) has a portion of its membership enrolled in managed care organizations. It has plans

to expand the number of recipients from 600,000 to 2.5 million, or about half the elligible population.

Legislation:

1. Small Insurance Reform / Assembly Bill 1672 / Passed by the Assembly, 1992

   A. Small insurance carriers must issue premiums on a community-rated basis; they may vary rates according to age, family size, geographic location, etc., but premiums may not exceed the community-rating by more than 20%. After July 1, 1996, rates may not vary by more than 10%.

   B. Guaranteed issue is required, but only if a small employer has chosen to insure 100% of its employees and the employer agrees to pay the required premium payments.

   C. Renewability is guaranteed unless premiums are not paid or in cases of fraud or misrepresentation. Renewability is not guaranteed if the carrier chooses to exit the small insurance market.

   D. Pre-existing conditions clauses are limited to six months following the effective date of coverage. Any carrier choosing not to adhere to the pre-existing conditions rules may impose a waiting period of no longer than 60 days before coverage becomes effective.

   E. Carriers must disclose available plans and premiums as well as standard employee risk rates and any adjustments that might be made to an individual's premium.

   F. A reinsurance fund (The California Small Group Reinsurance Fund) for small insurers has been created to guard against high-risk groups which incur excessive medical bills.

   G. A purchasing pool to assist small employers in obtaining low-cost insurance for their employees has also been created.

2. Cost Containment Initiatives / Several passed by Governor Wilson, 1992

A. A federally acceptable uniform billing procedure is mandated for health providers.

B. The concept of coordinating general health insurance with worker's compensation will be tested in four new pilot projects. It is expected that costs will be reduced through elimination of duplicative coverage, and an overall reduction of administrative costs.

3. Managed Care Initiatives / Several passed by Governor Wilson, 1992

A. As mentioned previously, California will increase the number of Medicaid recipients who are enrolled in managed care plans by expanding existing contracts and making new ones.

B. Managed care programs will be introduced in ten new counties throughout the state, bringing the total number to 28.

4. The California Health Care for the Twentieth Century (The Garamendi Plan) / Passed by the legislature in 1992, Vetoed by the Governor / Reintroduced in 1993 as Senate Bill 38

A. The proposal calls for a government sponsored plan using Health Insurance Purchasing Cooperatives (HIPCs) focusing on managed competition through managed care. All existing insurance plans would be eliminated and their members would be incorporated into a single system, which would also seek to include those presently without coverage.

B. The plan will be financed by employer/ employee payroll based premiums for large businesses and exclusive employer premiums for small groups. The cost is estimated to be about $34.4 billion.

Connecticut

Characteristics Impacting Health Care Reform:

1. Relatively small number of uninsured individuals (Connecticut ranks 1st or 2nd in the country in lowest percentage uninsured). Still, an estimated 495,000 residents (15%) will be without insurance at some point in 1993.

2. High cost of insurance. The typical Connecticut family spent $2,015 on health care in 1980 and $5,420 just eleven years later in 1991. If current trends continue, the same family will pay $12,100 by the year 2000. This produces an increase of over 500% in twenty years.

3. When compared to per capita income, health payments rose 114 percent faster between 1980 and 1991.

4. Though Connecticut has a relatively low number of uninsured, figures indicate that the percentage of uninsured adults with full-time/full-year employment is significantly higher than the national average (47% vs. 35% nationally). This points to a large number of Connecticut businesses that do not offer coverage for their employees.

Health Care System Characteristics:

1. Connecticut has a number of large HMO's (Aetna, Cigna, US Healthcare) and PPO networks.

2. State employees are covered by an insurance plan, but it is not structured like a purchasing cooperative (Connecticut is currently considering the merits of forming at least one such cooperative).

3. Connecticut has a pilot program that provides for children's health insurance through a managed care system; the program is supported with funds from the state's uncompensated care pool.

Legislation:

1. Availability of Health Care Services and Insurance / Passed 1990

   A. The proposal provides for two health plan options for small employers who do not currently offer insurance: one to be

implemented by HMO's, the other by small insurance companies.

B. Both plans are required to include several basic criteria: benefits, deductibles, coinsurance, exclusions, and limitations considered appropriate for the small group market by the state's reinsurance pool board.

C. To market and sell the policies, insurance companies had to agree to a number of conditions:

-Limits on the duration and scope of pre-existing condition clauses.

-Mandatory renewability, except in cases of non-payment, fraud, or non-compliance with the terms of the plan.

-Limits on premium increases (they may not exceed 200% of the base premium amount).

2. Connecticut Small Employer Health Insurance Program

The program requires all insurers and HMOs offering small group insurance to adhere to the following guidelines:

A. Guaranteed issue of a statutory plan with an option to issue alternate plans containing traditional medical underwriting. In the event that an insurer rejects a group for the alternate plan, it must offer the prescribed statutory plan.

B. Renewability is guaranteed for both statutory and alternate plans.

C. Rate increases are limited by using the established community-rating and a demographic figure to determine an appropriate adjustment.

D. In order to insure high-risk groups with some measure of confidence, insurers may form and participate in a reinsurance pool funded by the industry. Provisions include:

-Reinsurance premiums

-Assessments on small group premiums (up to 5%)

-Assessments on all other health premiums

E. A special statutory plan has been developed for employers who have not offered insurance for two years. It targets low income individuals (those who fall below 200% of poverty) and requires health care providers to accept 75% of the established Medicare reimbursement rate.

2. Health Insurance for Low Income Children / Established, September 1992

A. A pilot program has been established to provide subsidized insurance for children in families with incomes between 133% and 200% of poverty.

B. The program also incorporates managed care initiatives for school age children.

C. An expanded version of the program is currently under consideration in which children age 1-5 would enter the same managed care system and complete coverage would be provided for those in families living between 133% and 185% of poverty.

Delaware

Factors Impacting Health Care Reform:

1. In 1991, 94,000 Delaware residents (13.2%) were uninsured. Projections for 1993 indicate that 150,000 Delawareans (21.7%) will be uninsured at some point during the year.

2. The average Delaware family spent $1,913 on health care in 1980. By 1991, costs had risen to $4,393. They are expected to reach $9,055 by the year 2000, for a total increase of 373 percent in twenty years.

3. In the last ten years, health care payments for Delaware families rose 165% faster than their wages.

4. Delaware businesses spent $164 million on health care in 1980 and about $667 million in 1991. That figure could reach as high as $1.3 billion by the year 2000, producing an overall increase of 693 percent.

5. Interestingly, the percentage of Delaware residents living in rural areas is a full eleven points higher than the national average (33.7% vs. 22.5%). This may indicate a need for increased access in these areas.

Legislation:

1. Children's Health Care Initiative / Passed 1992

   A. Under a collaborative effort between the state and the Nemours Foundation, Delaware will establish children's health care clinics throughout the state; emphasis will be on opening new centers in notably underserved areas.

   B. The program will provide state-funded health coverage to all children ages 0-18 living in poverty.

   C. Medicaid elligibility will be extended to allow pregnant women and infants up to 185% of the federal poverty level to receive the benefits provided therein.

   D. Coverage will be extended to children ages 0-18 who are living below 175% of the federal poverty level.

E. Children above the 175% level will be offered coverage on a sliding-scale basis.

2. Health Care Delivery / Passed 1992

A. Provides for development of a managed care pilot project targeting the needs of the working uninsured; based on the success of the program, subsequent recommendations can be made to provide more effective coverage for working people, as well as for other special populations.

B. Allows for an increase in Medicaid reimbursement fees for physicians. This, combined with the establishment of a Voluntary Initiative Program by the Medical Society of Delaware, encourages doctors to treat Medicaid patients and otherwise indigent populations.

3. Small Group Insurance Reform / Passed 1992

A. Provides for guaranteed issue regardless of age or health status.

B. Establishment of rating bands to limit premium increases.

C. Establishment of standard benefits package.

D. Complete portability of coverage in case of a change in jobs or unemployment.

4. Cost Containment Committee / Passed 1992

A. The Committee will recommendation ways to control health care costs and is scheduled to release its initial findings by December 31, 1993.

Florida

Factors Impacting Health Care Reform:

1. Approximately 2.5 million Floridians (18% of the population) are uninsured. Many of these people are young, unskilled workers, retired persons, or migrant farmers.

2. Almost 75% of this 2.5 million are workers and their dependents, and nearly 23% are children.

3. There are 2 million Floridians who work but whose earnings place them below the federal poverty level; accordingly, about 1/2 of the uninsured are below poverty and cannot afford the rising cost of health care.

4. Florida has a large number of small businesses, with 95% employing 25 or fewer. 32.3% of those employed in businesses with 5 to 9 employees are without insurance. Firms with fewer than 5 employees generally leave 60% of their employees uninsured.

5. Workers in the service industries or in retail tend to be uninsured, and statistics show that nearly 49% of the state's workforce falls into this catagory.

6. Florida ranks second only to California in Medicare spending, with total expenditures reaching $32 billion in 1990. It is projected that spending will hit $90 billion by the year 2000 without a comprehensive plan for health care reform.

Legislation:

1. Florida Health Care Reform Act / Enacted March 24, 1992

   A. Ensures universal access to Florida residents regardless of age, employment, health condition, or economic status.

   B. Ensures coverage for those unable to afford insurance as a result of chronic illness.

   C. Provides for a mandatory health insurance program for all employees and their dependents by December 31, 1993, with employers covering those who are left behind after the prescribed target date.

D. Ensures an appropriate number and distribution of health care facilities throughout the state by January 1, 1996, with particular emphasis on rural and underserved areas.

2. Florida Health Care and Insurance Reform Act / Enacted April 1993

A. Requires small insurance carriers to offer a standard benefits package to all businesses employing 1-50 people and prohibits discrimination on the basis of age, sex, health status, or claims history.

B. Allows for modified community rating of small business policies where factors such as age, gender, tobacco usage, and geographic location are concerned.

C. Establishes Community Health Purchasing Alliances (CHPA's) for the purpose of pooling the purchasing power of small business; membership is also offered to state employees, their dependents, and Medicaid recipients.

D. Requires hospitals to collect patient outcome data by diagnosis and forward it to the Agency for Health Care Administration (AHCA) beginning in June of 1994. AHCA will evaluate the effectiveness and cost of care for each diagnosis and develop reports for public use beginning in December 1994.

E. Creates rural health networks that coordinate health service planning among providers and link newly constructed rural facilities with urban health centers. Also provides certificate of need preferences and a rural hospital financial assistance program if federal funding is not available.

F. Creates the MedAccess Program for Floridians with incomes up to 250% of the federal poverty level. The program will be funded soley by the individual or the individual and the employer, and providers will be compensated at the Medicaid reimbursement rate.

G. Creates a physician fee schedule based on a resource-based relative value scale.

Georgia

Factors prompting health care reform:

1. A large number of uninsured Georgians (approximately 1.2 million).

2. Rigid underwriting practices of insurers, which often exclude those with pre-existing conditions.

3. An increase in health spending from $1,666 in 1980 to $4,159 in 1991 for a typical Georgia family, with an estimated cost of $8,880 by the year 2000. This represents a 433 percent increase.

4. Payments for a typical family have risen 168 percent faster than wages in the last decade.

Health Care System Characteristics:

1. Georgia has established successful managed care programs through a variety of HMO's, PPO's, and Blue Cross/Blue Shield. These managed care systems can now be used to implement the newly passed health care legislation.

2. Georgia state employees are currently covered under a benefit plan administered by the State Merit System.

3. In the Georgia Reform Insurance Plan passed by the Georgia state legislature in 1993, insurers will be required to use their combined enrollments to obtain the best prices for medical care, equipment, and services.

Legislation:

1. The Georgia Reform Insurance Plan (GRIP) / Passed by the Georgia State Senate, 1993

   A. The GRIP can only be provided through existing managed care plans which meet the qualifications established by the Commissioner of Insurance.

   B. Price controls will be negotiated and agreed upon by health care providers and may not be exceeded under any circumstances.

C. Coverage of newly born or adopted children, handicapped children beyond the limiting age, and mammograms, Pap smears, and prostate-related procedures is guaranteed.

D. The legislation provides for a "guaranteed issue" clause, which extends full coverage to all Georgia residents up to age 65 regardless of age, sex, past health experience, or occupation.

E. There are no pre-existing condition limitations in the GRIP with the exception of a mandatory 12 month period following the effective date of coverage; this measure was deemed necessary to guard against indivduals who suddenly claim a pre-existing condition, receive treatment, and then discontinue coverage.

F. Portability of coverage is guaranteed regardless of changes in employment or terms of policy.

G. Qualified insurers must offer at least three plans which reflect differences in an individual's ability to pay, including a low cost, mid-range, and higher cost plan. Also, insurers are required to offer a basic, minimum benefits package for those whose annual income places them below 250% of the federal poverty level.

H. All plans must include substantive primary and preventive care measures.

I. Community rating will be established so that all insureds in the same class will pay comparable premiums.

J. The legislation also includes provisions for the standardization of billing and claims forms in an effort to reduce administrative costs.

Kansas

Factors Prompting Health Care Reform:

1. Large number of small employers.

2. Prohibitively high cost of health care services / rising cost of health insurance; (during the last decade, the typical Kansas family's insurance costs rose 263 percent faster than wages and, while Kansas businesses experienced a rise in corporate profits of about 130 percent, they also saw an increase in health payments of nearly 215 percent.

3. Over 300,000 non-elderly Kansas residents (12.6 percent) had no health insurance in 1991.

Health Care System Characteristics:

1. Kansas has several managed care networks, including Kaiser Permanente, Humana, and Blue Cross/ Blue Shield of Kansas.

2. Kansas state employees are eligible for coverage under the State employees group health insurance plan.

3. Kansas currently has no programs to address the health concerns of specific populations such as children and/or the elderly.

Legislation:

1. Small Employer Health Benefit Plan / House Bill 2610 / Passed 1990

   A. Designed to encourage small businesses to offer health insurance to their employees.

   B. Permits 2 or more small employers to pool their risk.

   C. Exempts plans from any mandated benefits established in subsequent reform initiatives.

   D. Provides credit for state income taxes based on premium payments.

   E. Limits amount the employer must pay / mandates co-payments for employees.

2. Group Health / House Bill 2001 / Passed 1991

   A. Prohibits exclusion or restriction of coverage for specific, pre-existing medical conditions.

   B. Requires that group health insurance rates be filed with the Commissioner of Insurance and that they not be unreasonable, excessive, or discriminatory.

   C. Prohibits the creation of rating classifications based on medical condition.

   D. Prohibits rate increases of more than 75% in any one year for group insurance.

   E. Guarantees portablility of health coverage.

3. Guaranteed Issue for Small Employer Groups / Senate Bill 561 / Passed 1992

   A. Establishes a reinsurance pool so that insurers may evenly distribute the risk presented by small groups which would not normally be insurable at reasonable rates.

   B. Mandates a discrepancy of no more than 25% between the highest rates charged a given group and the lowest rates charged a given group.

   C. Prohibits forcing an employer to transfer from one rating classifcation to another.

4. Individual Health Risk Pool / House Bill 2511 / Pending

   A. Establishes a health risk pool for the purpose of extending coverage to those who would not otherwise be eligible for basic health insurance.

   B. Requires that providers be reimbursed at the same rate they receive for those in the Medicaid program.

   C. Permit insurers to take a credit against premium taxes equal to 80% of the difference between premiums paid for coverage and the claims incurred by those insured in the pool.

D. Mandates co-payments for each service in the plan so that the individual takes partial responsibility for making rational medical choices.

E. Plan is exempt from mandated benefit provisions.

Kentucky

Factors Prompting Health Care Reform:

1. Between 1980 and 1991, health care payments for a typical Kentucky family jumped from $1,524 to over $3,200, an increase which is about 197% more than the average increase in wages for the same period.

2. Over 500,000 non-elderly Kentuckians (15.6%) had no health insurance as of 1991.

Legislation:

1. Health Care Reform Plan for Universal Access / Proposed by Governor Brereton Jones, September 1992 / Pending in Kentucky legislature

   A. Establishes a Mega-Pool Insurance Plan which could potentially cover 2 million uninsured residents. Elligible individuals include:

      -Public Employees, Uninsured and Unemployed Individuals, Individual and Business Participants, Medicare Recipients, Prison Inmates, Wards of the State, and Worker's Compensation Recipients.

      -The Medicaid program would be kept in tact and would continue to cover those who meet the proper criteria.

      -Payment options for the pool were also discussed and include competitive bidding, capitation, and modified fee for service.

   B. Establishes mandatory employer-sponsored health insurance, with the state providing a subsidy for small businesses. If the Reform Plan is not passed, a play or pay system would take effect in which employers refusing to offer health insurance would pay an estimated $120 per month per employee.

   C. Provides state financial assistance for children in families with incomes below 200% of the poverty level and partial assistance for unemployed adults below 200% (sliding-scale basis).

D. Proposes establishment of a Health Care Authority to administer reform initiatives.

E. Provides for health insurance reform with the following proposals:

-Community-rated insurance.

-Standardized billing and a single insurance card.

-Assured portability.

-Assured renewability.

-No pre-existing condition limitations.

-Financial incentives for rural practitioners.

-Recruitment of rural practitioners through the Kentucky Health Services Corps.

F. Proposes Regional Health Care Delivery System consisting of:

-One full-service regional hospital.

-Several primary and emergency care facilities per region.

-County health departments.

G. Proposes physician extender clause which grants presciption authority to physician assistants and nurses in underserved areas.

Louisiana

Factors prompting health care reform:

1. Large number of uninsured residents; estimates indicate the nearly 25% of the state's population (963,000 people) is uninsured. This is the third highest percentage in the country behind New Mexico and Texas (26%).

2. Large portion of population (10%) living in rural areas which are generally severely underserved.

Health Care System Characteristics:

1. Louisiana has a State Employees Group Benefits Program similar to a group purchasing cooperative, but it is currently having problems neutralizing rising health costs and must find a way to balance claims costs with premium payments.

2. The Louisiana Health Care Authority has established a charity hospital system, which ensures the availability of acute and primary care services for the uninsured and underinsured.

3. Louisiana currently has very few sophisticated managed care organizations, and virtually all of them located in the cities of Shreveport, Baton Rouge, and New Orleans.

Legislation:

The following are recommendations of the Louisiana Health Care Commission, which was formed by Legislative Act 1068 in July of 1992.

1. Creation of Health Insuring Organizations (HIO)

   A. Louisiana is proposing the use of HIO's to affect an expansion of the Medicaid program. The expansion would cover an additional 500,000 people through the implementation of managed care initiatives authorized and controlled by HIO's.

2. Basic Health Plan

   A. Attempts to provide universal access to health services in Louisiana through the negotiation (with insurers) of low-cost

insurance options for those currently below the poverty level and without any form of insurance.

3. Assured Portability of Coverage

4. Community Rating of Insurance Premiums

5. State Mandate Justification

   A. This provision would require that all state legislation outlining health care reform initiatives have a detailed benefit cost analysis to prove its merits and necessity.

6. Restrictions on Physician Self-Referrals

7. Elimination of Administrative Waste

   A. Proposes the creation of a Department of Insurance, which would be responsible for standardizing claims and billing procedures and substantially reducing the costliness and inefficiency of excessive paperwork.

Minnesota

Factors impacting health care reform:

1. Large number of uninsured (406,000 individuals, or 9.3% of the population); it is estimated that 1/3 of this group had outstanding medical debts averaging $826.

2. As of 1989, roughly 366,000 Minnesotans had individual health insurance policies which had high premiums or deductibles and sometimes excluded significant health conditions.

3. Also as of 1989, 11,000 people were refused medical care because they lacked insurance, and an additional 50,000 postponed necessary medical attention because of what they perceived to be prohibitive costs.

4. Rural health care has surfaced as a primary point of contention, with those in rural areas being 38% less likely to have insurance than those in urban centers.

5. It was also found that rural residents paid 60% more in out-of-pocket expenses than did urban residents.

6. Generally, those who had some form of insurance were more concerned about securing coverage for catastrophic conditions, while those who had no insurance emphasized the need for primary care.

Health Care System Characteristics:

1. Minnesota has developed a Children's Health Plan which, at the time of initial passage in July of 1988, provided coverage to children ages 1-18 living in families with incomes below 185% of the poverty level. The plan, which is financed through a restructuring of Medicaid eligibility requirements, has since been expanded as follows:

   A. As of October 1, 1992, the Children's Health Plan was expanded to include outpatient benefits for families of the children enrolled.

   B. As of January 1993, the Plan was further expanded to include outpatient benefits for families with children at or below 275% of poverty.

C. In July 1993, inpatient benefits will be covered for the aforementioned low-income populations.

D. Finally, by January 1, 1994, single adults and families with incomes up to 275% of poverty will be eligible for coverage under the Children's Health Plan.

2. The Minnesota State Employee Insurance Program covers state workers under a managed care system and is currently the model for a new health purchasing cooperative for private-sector employers set to take effect in July 1993. The plan will feature voluntary participation with a two year minimum and guaranteed issue for all applicant groups. Like the program for state employees, it will be sponsored by the state government.

3. One unique feature of Minnesota's pending health care reform legislation has been the proposed development of Integrated Service Networks. The networks would be similar to HMO's in that they involve cooperation among groups of providers and/or insurers to provide an established set of health services at a fixed price. The primary difference would involve more flexibility in the nature of the partnerships, so that providers and insurers, just providers, or just insurers could form an alliance whose only requirement would be to share the risk of extending care to a given group of individuals.

Legislation:

1. Minnesota Health Care Commission / HealthRight Act / Passed 1992

   A. The HealthRight Act charges the Commission with developing a plan to slow the growth in health care spending by at least 10 percent a year for each of the next five years.

   B. The Commission will also become involved with issues related to access, quality, and affordability following the implementation of the initial cost containment phase.

   C. Cost Containment Measures

   -Integrated Service Networks have been developed to provide a continuum of services for a fixed price through networks of providers. ISNs would compete on the basis of cost and quality, operating much the same way HMOs do, except that

there would be increased flexibility in choosing providers and forming health care partnerships.

-Global budgeting will be used to control all public and private expenditures without interfering directly in the financial matters of providers and health plans.

-A balance of competition and collaboration will be used induce ISNs to provide better quality services at lower prices. Data collection and distribution will be vehicle through which competition is spurred and, in the event that competition becomes counterproductive, the plan facilitates collaboration of providers and networks.

2. MinnesotaCare / House File Number 2800 / Signed into law by Governor Carlson, 1992

   A. All uninsured low-income families with children and individuals will be phased into the plan in accordance with their respective financial standing starting on October 1, 1992.

   B. Enrollees will contribute to the cost of health care on a sliding-scale based on income.

   C. Financing will be achieved through additional taxes on cigarettes and health providers. Taxes include:

      -A 2 percent tax on gross patient revenues in hospitals beginning in January 1993

      -A 2 percent tax on gross revenues of all other providers.

      -A 2 percent tax on the wholesale price of prescription drugs

      -A 1 percent tax imposed on non-profit health insurers (such as Blue Cross/Blue Shield and HMOs)

   D. Small Employer Insurance Reforms include:

      -Insurers must offer two small employer plans.

      -Guaranteed issue and renewability.

      -Insurers must require the contribution of at least 50% of the premium for small employer plans.

-Twelve month pre-existing conditions clauses.

-Eliminates medical underwriting for such reasons as gender and family medical history.

Maine

Factors prompting health care reform:

1. Maine has substantial rural areas which have not developed the kind of sophisticated facilities necessary to provide comprehensive care to residents living there.

2. Rising costs have become excessive for all state residents, and prohibitive to those with lower incomes.

3. Maine is currently experiencing fiscal difficulties, which prohibit the use of state funds to fuel an expansion of health benefits.

4. Lack of practitioners in rural areas.

Health Care System Characteristics:

1. Maine's state employees are currently covered by a conventional Blue Cross plan, but will begin receiving coverage through a newly conceived primary care, point of service plan in April of 1993. The new plan will continue to be administered by Blue Cross/Blue Shield.

2. The Rural Medical Access Program provides malpractice insurance assistance to doctors offering obstetric services in rural areas.

3. General health services are provided by an array of small Community Health Centers.

4. Maine currently has two HMO's operating in several of its major cities.

Legislation:

1. Medicaid Elligibility Reform / Passed 1988

   A. Medicaid expanded to include incomes of up to 185% of the poverty level for pregnant women and children; expanded to 100% for older persons and those with disabilities.

2. Maine Health Program / Passed 1989

   A. Established to provide coverage to low income individuals who do not qualify for Medicaid.

-To implement the program, Maine obtained two federal demonstration grants from the Health Care Financing Administration which provide federal matching funds for all children in families below 125% of poverty and a limited number of adults with incomes up to 100%.

3. MaineCare Program / Passed 1989

   A. Assists small businesses by offering sliding-scale premiums to individuals in firms with 15 or fewer employees who previously lacked any form of insurance coverage.

      -Employers must pay 50% of the premium, and all employees not covered under an alternate plan must participate. Program is administered by a Maine based HMO.

      -Program originated as a pilot project under the Robert Wood Johnson Foundation and is currently being implemented in two target areas.

4. Rural Medical Access Program / Passed 1990

   A. Provides malpractice insurance subsidies of $5,000 to $10,000 to physicians providing pre-natal and obstetrical care in medically underserved regions. The program is funded by savings achieved in the Collateral Source Reform Initiative, which prohibits plantiffs from collecting from multiple sources in malpractice cases (also enacted in 1990).

5. Medicaid Reimbursement Initiative / Passed 1990

   A. Provides for a resource-based relative value scale for physician fees, so that Medicaid reimbursement for primary care doctors is balanced with that of specialty providers.

6. Community Health Program / Passed 1990

   A. Provides funding for rural community health centers.

7. Assured Continuity / Passed 1990

   A. Provides most group policy-holders with a three month transition period from one policy to another without pre-existing condition limitations.

8. Medicaid Expansion / Passed 1991

   A. Medicaid expanded to insure those children living below 125% of poverty who were previously covered under the Maine Health Program of 1989.

9. Medical Liability Demonstration Project / Passed 1991

   A. Established to reduce the practice of defensive medicine by devising a prescribed set of guidelines which, if adhered to by providers, protects them from unreasonable medical liability.

10. Insurance Reform Package / Passed 1992

   A. Introduced mandatory community rating for insurers as well as guaranteed issuance and renewal in the small group market.

11. Standard Benefits Package / Passed 1993

   A. Bureau of Insurance established both a comprehensive package of services and a lower cost, basic package for the small group market.

12. L.D. 182 - An Act to Implement the Recommendations of the Joint Committee to Study the Feasibility of a Statewide Health Program / Pending

   A. Extends community rating to groups of 50 (from 25) and to individual health policies.

   B. Provides for guaranteed issue for individuals and greater portability for both groups and individuals.

13. L.R. 16 - An Act to Provide Family Security Through Quality, Affordable Health Care / Pending

   A. Establishes the Maine Health Plan and Maine Health Fund to set spending and price controls.

14. Governor's Health Care Reform Proposal / Pending

   Details Not Final.

Missouri

Legislation:

1. Revision of House Bill 564 / Passed March, 1993

   A. Establishes a State Legal Expense Fund to protect from malpractice claims those physicians who choose to provide primary or preventive care in a city or county health department, a non-profit medical facility, or public elementary and secondary schools. Coverage will pay up to $500,000 for any one claim, and doctors may purchase additional insurance for claims which may exceed said amount.

   B. Encourages physicians to practice in underserved areas by providing financial incentives drawn from a "Health Access Incentive Fund". The fund may be used for loan repayments, professional liability insurance, practice subsidies, annuities, technical assistance, and start-up grants. Doctors receiving such financial support must agree to treat all patients regardless of their ability to pay.

   C. Medical School loans may be granted by the Missouri Department of Health up to $7,5000 per student per academic year. Repayment of the loan may be reduced by 1/4 for every year a physician practices in an underserved area.

   D. Permits physicians to delegate to a registered professional nurse the authority to dispense presciptions and administer appropriate medical care under established collaborative practice arrangements.

   E. Permits public schools to contract with health care providers to provide primary care and childhood screenings to children in Medicaid families who may not otherwise receive adequate health care services.

   F. As of July 1, 1995, the Department of Social Services may offer a health insurance policy through the Medicaid program. Those elligible for the plan include: surviving spouses unable to afford continuation of previously purchased group coverage, adults over 21 who are not pregnant and reside in households with incomes up to

185% of poverty, and dependents of an insured person residing in households with incomes up to 185% of poverty.

G. As of July 1, 1994, Missouri will implement a pilot project to provide a special set of benefits for the treatment of chemical dependency. The plan will be voluntary (because it will involve additional cost on the part of the insured individual) and will be evaluated as to the relative costs and benefits of alternative coverage.

H. Requires that employers identify employees who are elligible for a federal earned income credit and assist them in completing the forms necessary to ensure processing of the credit. Additional income accrued as a result of the credit may be used for the purpose of purchasing health insurance for children in elligible families.

I. Permits Missouri residents to claim a state income tax deduction of up to $2000 for amounts deposited in an Individual Medical Account. Money drawn from the account must be used exclusively for the purchase of medical care and will be subject to a 10% penalty in case of withdrawal for other purposes. Accrued interest will not be subject to state income tax.

J. Initiates a pilot project providing funds for the purchase of health benefits for up to 1000 residents currently receiving unemployment compensation.

K. As of January 1, 1994, physicians, dentists, chiropractors, and podiatrists will be required to post notices indicating the ten services most frequently provided and the corresponding fees for said services.

New Mexico

Factors Prompting Health Care Reform:

1. A large percentage of New Mexico's population (51.6%) resides in rural areas.

2. New Mexico has the highest percentage of people unserved for primary care in the country with 16.8%

3. In 1990, 20.9% of the population was living below the federal poverty level, as compared to 13.5% nationally. Currently, New Mexico ranks about 46th in both per-capita income and population above poverty.

4. 26.4% of non-elderly New Mexicans are without health insurance; this is the highest percentage of uninsureds in the country.

Health Care System Characteristics:

1. The University of New Mexico's Medical Center has been the focal point of an effort to strengthen the quality of emergency services for all state residents. Its key components include a Lifeguard helicopter and specialized centers for trauma situations and burns.

2. In addition to the hospital run by the University, Alburquerque has three other large hospitals which feature a Level III trauma center, a Neonatal Intensive Care Unit, several cardiac catherization labs and transplant units, and about a dozen MRIs. Again, these facilities have been designed to transport and serve even those residents who may not live in the immediate vicinity.

3. The northeastern portion of the state has a strong network of primary care clinics as a result of close-knit communities inhabited by Hispanic families. Primary care in other parts of the state is more sparse and therefore less effective.

4. New Mexico's three largest cities (Alburquerque, Snata Fe, and Las Cruces) have well established HMOs with reasonably high participation.

5. Purchasing cooperatives are in place for public employees and public school employees.

6. New Mexico was the first state to establish a policy of peer review for physicians, and one of the first to have a statewide Medicaid Primary Care Network.

Legislation:

1. The New Mexico Health Policy Commission / Passed by the State Legislature, 1991. Since its creation in 1991, the Commission has developed the New Mexico Health Care Initiative, a proposal which includes a statewide Health Cooperative designed to phase in universal access. Elements of the plan are as follows:

   A. State and local employees will be members from the start.

   B. The Cooperative will apply for Medicaid and Medicare waivers so that persons currently covered under those programs can be incorporated.

   C. The Cooperative will also try to include other programs, such as the Veterans Administration, the Indian Health Service and CHAMPUS, through contracts.

   D. Employers must provide coverage for their employees, either through the Cooperative or private insurance.

   E. Unemployed individuals not qualifying for Medicaid will automatically be covered by the Cooperative.

   F. The Cooperative will eliminate medical underwriting and exclusions for pre-existing conditions. It will also consider the merits of a single community rating system vs. regional rating.

   G. The plan will be financed through a number of sources, including:

      -premiums payed by employers and employees

      -federal funds now used for Medicaid and Medicare

      -additional state funds to cover those who do not qualify for assistance under any of the aforementioned programs

2. New Mexicare / Not passed by the 1993 Legislature

New Mexicare would have introduced a radical, single-payer plan administered by the state. It would have imposed an 8% income tax charge on all state residents and an additional 3.5% payroll tax on businesses. The public reaction to these tax increases resulted in the death of the proposal in committee.

New York

Characteristics impacting health care reform:

1. Cost of health care tends to be high
2. Population density is high, therefore utilization is high
3. Litigation is greater
4. Incidence of fraud is greater
5. Corporations can move to near-by states fairly easily in event that health care costs become too high
6. Presently, few commercial companies are writing individual coverages; costs are high for individual / small group coverages

Health Care System Characteristics:

1. New York has specific proposals designed to improve services and delivery for Medicaid recipients and small groups and individuals in a commercial setting

2. New York has thirty-one (31) HMO's, 30 of which will be offering open enrollment for small groups and individuals

Legislation:

1. Children's Health Insurance Program (CHIP) / Passed 1990, Effective 1991

   A. Provides primary and preventive health insurance to children without family insurance or with inadequate coverage up to the age of 13

2. Community Rating-Open Enrollment / Passed July 1992, Effective April 1, 1993

   A. Requires insurers offering coverage to individuals and small groups to accept all applicants regardless of age, sex, occupation, or health status

   B. Rates are based on insurer's aggregate experience in a given area

3. Standardized Policies / Pending

   A. Establishes standard insurance policies designed to adequately cover those who are at greater risk of incurring claims (eliminates underwriting)

   B. Also ensures the creation of competing plans that are truly comparable, allowing the consumer to make meaningful decisions

   C. For insurers offering individual or small group insurance, pre-existing condition exclusions cannot extend beyond twelve months from the effective date of coverage

   D. Individuals who lose their insurance due to termination or exclusion from a particular class may, without evidence of insurability, continue coverage for himself or herself and his or her family

   E. Individuals may also convert insurance policies without evidence of insurability if he or she has been covered continuously for more than two years

4. Long-Term Care Security Demonstration Program / Passed 1989, Effective Spring 1993

   A. Proposes long-term care insurance that guarantees access to Medicaid without forcing individuals to "spend down" their assets in the event that long-term benefits are exhausted

5. UNYCARE / Proposed 1989

   A. Proposes a single-payer authority which would control costs through development of uniform reimbursement schedules and reduce and simplify administrative procedures

Oklahoma

Factors Prompting Health Care Reform:

1. Oklahoma has a large rural population (40.6% vs. a national average of 22.5%) and contains only two major metropolitan areas.

2. While the percentage of the population unserved by primary care physicians is only slightly lower than the national average (4.0% vs. 4.8%), there appears to be an uneven distribution of primary care facilities.

3. High percentage of small businesses unable to provide insurance.

4. 15.6% of Oklahoma's population lives below the poverty level (vs. 13.5% nationally), with the average per-capita income standing at $14,154 as of 1989 (vs. $17,596 nationally).

5. 27% of all Oklahomans working full-time year round were uninsured as of 1988 (vs. national average of 35%). The total number of uninsured residents is about 600,000.

Health Care System Characteristics:

1. Oklahoma has several large HMOs located in the metropolitan areas of Oklahoma City and Tulsa; they insure a relatively low 5.8% of the state's population (compared to a 14.6% average nationally).

2. There is a program currently in existence which provides coverage for over 70,000 state employees and teachers; members may choose from an insurance plan offered by the state or one of several HMOs.

Legislation:

1. The Oklahoma Health Care Authority / House Bill 1573 / Pending

   A. The Authority would be required to submit recommendations and proposals to the Governor on each of the following issues:

   -a standardized benefits package to be offered by insurers

-a plan for more even distribution of health care services and facilities

-cost containment, including certificates of need and global budgeting proposals

-parameters for physician practice guidelines based on outcomes research

-a health services rate schedule based on a Resource-Based Relative Value System

2. The Health Care Benefits Reform Act / Senate Bill 525 / Dormant for this legislative session

The bill calls for several standard insurance reform measures designed to shift the focus from defensive insurance practices to cost containment and quality of services. Theoretically, such a shift would benefit both consumers and insurers. The proposed reforms include community rating, guaranteed issue, portability, and a general standardization of policies to ensure competition based solely on price and quality.

2. Medicaid Managed Care / Senate Bill 76 / Pending

A. The bill proposes a managed care delivery system for current Medicaid recipients to induce cost savings while maintaining an appropriate level of care.

3. Individual Medical Account Act / House Bill 1436 / Committee report submitted

A. Establishes a system in which individuals, employers, and the government would deposit pre-tax dollars into Family Health Accounts for the purchase of health insurance.

B. Individuals would choose their own health plans based on cost and quality of service and would deposit their share of the premium into the Health Account; this would provide incentives for both consumers and insurers to control costs.

C. The creation of a standard benefits package, uniform claims and billing procedures, and the elimination of pre-existing condition measures would increase competitiveness in the

market and provide further incentive for insurers to control the cost of their policies.

D. After an individual's premiums are paid, any remaining funds in the account could be used to purchase benefits not covered by the basic benefits package.

E. Income or interest that accumulated on the accounts would be used by the State to expand eligibility for Medicaid, assist small employers with their contributions to the Accounts of their employees, and provide basic coverage for those who cannot afford insurance and do not qualify for public assistance.

F. The accounts would be maintained and administered by the Oklahoma Health Care Authority.

4. Guaranteed Portability / House Bill 1302 / Signed by Governor David Walters, April 18, 1993

   A. Provides for guaranteed portability of health coverage when an employee changes jobs.

5. Uniform Claim Forms / House Bill 1570 / Pending

   A. Requires uniform standards and procedures for processing claims, including electronic claim form submission, to produce administrative cost savings.

6. Health Insurance Assigned Risk Pool Act / House Bill 1585 / Pending

   A. All insurers providing insurance in Oklahoma are required to participate in the pool, which serves to cooperatively assume risk for heavy medical claims. Premiums equal 200% of the average standard risk.

7. Long Term Care / Senate Bill 50 / Signed by Governor Walters, May 4, 1993

Oregon

Factors Prompting Health Care Reform:

1. 450,000 Oregonians were uninsured prior to the implementation of the Oregon Health Plan in 1993.

2. Many of Oregons businesses are small businesses employing between 3-25 people.

3. Oregonians just above the poverty level have problems accessing basic health insurance because of the general increase in the cost of health services and insurance.

Health Care System Characteristics:

1. Oregon has nine HMOs which provide managed care for almost 27% of the population.

2. There are also pre-paid health plans called PCOs which cover a specialized package of services exclusive of inpatient hospital treatment.

3. A community based plan is in place to address the needs of senior citizens and people with physical disabilities. The Home and Community Based Waiver permits 11,000 of the 19,000 people with physical hardships to live in their own homes or residential care facilities.

4. There have also been efforts to expand services for people with serious mental and developmental deficiencies. Successful implementation of the Oregon Health Plan will provide preventive screenings for mental illness and chemical dependency.

5. Oregon also has a plan to increase the number of managed care facilities throughout the state and especially in extremely rural areas where populations are generally underserved.

Legislation:

Oregon has recently received the long-sought Medicaid waiver it needs to implement the Oregon Health Care Plan (Senate Bill 27, first proposed and signed into law in 1989). A summary of the Oregon Health Plan's three main components follows:

1. Medicaid Expansion

A. Proposes changing Medicaid elligibility requirements to enable an additional 120,000 individuals to qualify for assistance. The expansion will be financed through savings from the implementation of managed care procedures and prioritizing services to create a basic benefits package.

2. High Risk Pool

A. Combines the purchasing power of individuals who are currently without insurance because of pre-existing conditions or costly medical history and ensures more affordable premiums.

3. Employer Mandates

A. Institutes a "play or pay" system in which employers provide insurance for all full-time employees (17.5 hours per week) or pay a payroll tax which would support their workers in a state insurance pool.

4. Small Employer Program

A. Creates a benefits plan for small business employees similar to the Medicaid package; plan must be offered by all small group insurers, with provisions for rate banding, limited pre-existing conditions exclusions, and guaranteed issuance and renewal.

Pennsylvania

Factors Prompting Health Care Reform:

1. Pennsylvania has the largest rural population in the nation, which creates the usual problems concerning the lack of primary care physicians and full service health clinics in these areas.

2. The number of uninsured Pennsylvanians is currently 1.3 million.

3. It is estimated that about 402,000 children in Pennsylvania (1 in 5) lack health insurance; of this number, four of ten live in households where at least one parent is employed on a full-time basis and an additional four have at least one parent who works part-time.

4. 19% of the state's businesses employ 50 or fewer employees.

5. Only 12.9% of Pennsylvanians were enrolled in HMOs as of 1990.

Health Care System Characteristics:

1. There are currently no purchasing cooperatives in Pennsylvania to defray the cost of insurance. Employers generally purchase insurance individually, with large employers possessing a distinct advantage. State employees receive benefits through a trust arrangement with insurers and HMOs.

2. Pennsylvania has numerous programs which target special populations. They include: a network of EPSDT providers for low income residents, state health clinics that emphasize immunization and screening services for low income residents, a health insurance program for children of working, uninsured adults, and a program initiated by the state's insurers to provide low cost, basic benefits packages on a sliding-scale.

3. There are currently 18 operational HMOs in Pennsylvania serving about 1.5 million residents, as well as numerous PPO arrangements.

Legislation:

1. Pennsycare / Introduced by the Health Care Reform Committee, November 1992 / Pending

A. A Health Care Policy Board would establish a Basic Health Care Package to be offered by competing Managed Care Networks.

B. MCNs would be organized to suit the needs of residents in the region of operation and would be certified by the Policy Board on that basis.

C. MCNs would be authorized to design their own benefit plans emphasizing certain services but would be required to offer, as part of each option package, the prescribed Basic Health Care Package.

D. MCNs in each region would compete to offer the BHCP at the lowest rate. The low bidder would be selected to offer the BHCP at that rate. Persons wishing to subscribe to other MCNs offering a larger array of services could do so, but they would pay out-of-pocket for services beyond the BHCP.

E. Payments for the plans would be made by individuals, employers, and, when applicable, the government. They would be made on a capitated basis, so that a fixed price is established for each individual regardless of the extent of care received.

Rhode Island

Factors Prompting Health Care Reform:

1. In 1990, Rhode Island spent $2,707 per person, or 3.3% of all state and local expenditures, on health care. The average cost nationwide stood well below that figure at 2.5%.

2. The average Rhode Island family spent 13% of its income or about $2,363 on health care (vs. 11.7% or $2,101 nationally).

3. In 1990, 13.9% of Rhode Island's population was without health insurance and 11.2% was found to be medically underserved.

4. Virtually all of Rhode Island's medically underserved population (112,080) is located in Providence County.

Legislation:

The initiative proposed by Governor Sundlun is designed to provide comprehensive health coverage all uninsured pregnant women and uninsured children up to age 6. It would be jointly implemented and administered by the Departments of Health and Human Services and would begin no later than Jan 1, 1994.

1. Rhode Island Health Care Initiative / Introduced by Governor Bruce Sundlun, October 1992 / Pending

   A. Children in families with incomes below 250% of poverty would qualify for the same services now offered by Medical Assistance. Those above this level would qualify for a basic set of primary care services as well as special "at-risk" services when necessary.

   B. Pregnant women below 250% of poverty would receive the same services provided by Medical Assistance. Those above that level would be elligible for coverage under an expanded RITE start program. At-risk women would also receive enhanced services.

   C. The plan would use managed care concepts to ensure efficient delivery and would develop community health care networks to provide sufficient access and uniform quality to all parts of the state.

   D. The plan would also be used as a model to expand health

coverage to the entire population.

South Carolina

Factors determining type and bredth of health care reform:

1. There are currently 491,000 South Carolina residents without any form of health insurance.

2. An April 1990 census has yielded the following statistics concerning South Carolina's health care shortcomings:

   -South Carolina ranked 1st in the nation in percentage of low birth weight babies and 3rd in infant mortality rate

   -It ranked 8th in percentage of residents below the poverty level and 21st in percentage receiving public assistance

   -Finally, it ranked 28th in Medicare enrollment

   These figures indicate that because many South Carolinians live below the federal poverty level and cannot afford health insurance, a large portion of them should be elligible for public assistance. Health officials suspect that there may also be socioeconomic and educational factors which make health coverage elusive.

Health Care System Charactersitics:

1. An insurance program for state employees is in place and is administered by Blue Cross/Blue Shield.

2. Another plan sponsored by Blue Cross/Blue Shield addresses the specific problem of low birth weight and infant mortality by providing financial incentives for expectant mothers to visit a physician on a monthly basis. The incentives come in the form of discounts on consumer items.

3. There are currently four HMO's in South Carolina with a total enrollment of 98,220.

Legislation:

1. South Carolina Health Insurance Pool / Passed

A. Pool was formed to provide health insurance to individuals who cannot obtain coverage from an insurance company because of past or current medical history.

2. Small Group Insurance Reform / Passed by the South Carolina General Assembly, 1991

   A. Requires that if insurance is issued to a small group (25 or less), all members of the group must be accepted and covered.

   B. Restricts the amount by which small group premiums can increase each year.

   C. Places limits on cancellation and/or nonrenewal of small group policies.

   D. Ensures portability.

   E. Requires small group insurers to offer a pre-determined basic benefits package to small employers (50 employees or less) wishing to purchase it.

   F. Requires small group insurers to participate as either risk-assuming insurers or reinsuring insurers.

3. Health Services Cost Review Commission / House Bill 4244 / Not Passed, 1992 *

   A. Would have created uniformity and cost containment measures for the health care delivery system in South Carolina. The provisions under consideration included:

      -Global Budgeting

      -Uniform, all-payor rates

      -Regulation of medical procedures, equipment, and technology so as to affect appropriate cost savings.

*(A similar bill known as the Certificate of Need and Health Licensure Act was passed on July 10, 1992. See attached material for detailed description of provisions.)

4. Health Care Reform Package / Presented by the Joint Legislative Health Care Planning and Oversight Committee, March 1993 / Pending

   A. Calls for the creation of a health insurance purchasing cooperative in which state employees and Medicaid recipients would participate; smalland large groups could join the organization in 1995, and individuals would be elligible in 1996.

   B. Establishes a data collection center where all providers and purchasers would be required to submit period reports on costs and services.

   C. Prohibits the practice of self-referral.

   D. Mandates non-binding arbitration for all medical malpractice claims before proceeding to a court of law.

   E. Establishes practice guidelines for providers as a protection against malpractice claims.

Texas

Legislation:

1. Texas Health Policy Task Force / Created by proclamation by Governor Ann Richards, November 1991

   The recommendations of the Task Force have been structured so as to introduce new initiatives for cost containment and universal access while simultaneously preserving many aspects of the current system.

   The first step in initiating comprehensive health care reform was to introduce a proposal providing universal access to all children ages 0-18 through an expansion of Medicaid elligibility. Provisions for the program are as follows:

   A. A Children's Health Board in the Health and Human Services Commission would administer the program; it would include children ages 0-18 as well as pregnant women.

   B. The freedom to choose providers would be preserved.

   C. Uniform rates would be negotiated with providers, with the state playing an active role in the process.

   D. Standardized billing would be established and administrative costs would be limited to 10% through extensive data collection and utilization review procedures.

   Additional recommendations offered by the Task Force to address the needs of individuals and small businesses include:

   A. Establishing a non-profit corporation to help small groups purchase in pools.

   B. Insurance reforms similar to those being enacted in other states, including:

      - Guaranteed coverage, regardless of age, health status, or industry

      - Creation of a reinsurance pool to spread risk

- Standardized pre-existing condition limits

- Standardized caps on premium rate increases

- Setting insurance rates using a modified community rating model which prohibits underwriting but allows for limited variations according to industry, age, and gender

C. Establishing a state health care human resource plan to improve primary care and identify needed providers in different areas. This would include:

- Enlisting the help of educational institutions to encourage individuals in under-represented groups to enter the health profession; these efforts would emphasize the need for rural residents and minorities to become health care professionals who recognize the importance of practicing in the underserved areas in which they were raised.

- Programs providing substitutes to allow rural doctors time off

- Loan forgiveness programs to increase financial incentives

- Community/Provider matching in a state clearinghouse

- Increased use of non-physician personnel

- More equitable reimbursement for all providers, regardless of location

- Subsidizing the construction of new primary care clinics in typically underserved areas

- A program requiring hospitals to provide levels of charity care based on the economic benefits accrued through tax exemptions; private, non-profit hospitals would file estimates for charity care with their annual financial statements

D. Reducing administrative costs by standardizing health benefit packages and claims forms and by implementing utilization review systems.

E. Establishing a system of negotiated rate regulation to control costs, with extensive data collection and full participation of providers in determining appropriate expenditure limits.

Vermont

Factors Prompting Health Care Reform:

1. 76% of Vermont's population live in rural areas.

2. In 1980, Vermont families spent an average of $1,329 on all its health care. As of 1991, that figure had more than tripled to $3,649 and by the year 2000, it is projected to be more than $7,970; this would represent a 500 percent increase in the twenty year period.

3. During the period 10 year period between 1980 and 1990, the average Vermont family's health payments rose 200% faster than its wages.

4. The percentage of uninsured adults with full-time, full-year employment stood at 44% as of 1989 (vs. 35% nationally).

5. Vermont businesses spent an average of $135 million on health care in 1980. By 1991, this figure had increased by more than 225% to $483 million. By the year 2000, it is expected to eclipse the $1 billion mark, which would represent a 20 year increase of 635%.

6. It is estimated that 110,000 Vermonters (19.5%) will have no health insurance at some point during 1993.

Legislation:

1. Act 160-An Act Relating to A Health Care Authority / Passed by the General Assembly, 1992

   The Vermont Health Care Authority is comprised of a three member Authority Board appointed by the Governor and confirmed by the Senate. It effectively combines and oversees the functions of the Department of Health, the Hospital Data Council, and the Health Policy Council. Its mandate is as follows:

   A. Control the growth in health care expenditures through the use of global budgets, the certificate of need program, hospital budget review, and a health resource management plan (to be drafted every three years for the purpose of assessing the supply and appropriate distribution of health resources).

B. Design a Health Care Purchasing Pool which would negotiate with insurers to produce lower insurance rates. The pool would initially cover state employees and would be extended any employer, group, or association that wishes to participate beginning in October 1993.

C. Design comprehensive plans for both a single-payer system and a regulated multiple-payer approach, both of which would ensure financial access to health care for all Vermonters. The plans will be submitted to the legislature in November 1993 and must contain the following elements:

-a uniform set of health benefits offered without income or employment status restrictions

-an integrated system of health care delivery

-incentives to control costs

-reimbursement mechanisms for health care providers

-global budgeting and centralized planning that is consistent with the budget

D. Develop a health care data base to improve public awareness of the cost and use of health care resources in Vermont.

E. Develop guidelines for insurer cost management plans, require that every insurer submit a cost management plan adhering to these guidelines, and analyze the plans to ensure the release of health insurance policies that are both comprehensive and affordable.

F. Reduce administrative burdens through the standardization of claims and billing procedures.

G. Increase incentives for medical residents to serve on a rotating basis in underserved areas.

2. Act 52-An Act Related To Small Group Insurance / Passed by the General Assembly, 1991

A. Requires that participating small group carriers offer one or more health plans, each of which must be in compliance with standards established by the insurance commissioner.

B. Requires guaranteed acceptance for all members of an insured group.

C. Requires that small group carriers devise a rate structure which differentiates between single person, two person, and family rates.

D. Allows insurers to establish a 12 month pre-existing condition clause for conditions which existed during the 12 month period prior to the effective date of coverage.

E. Requires that policy premiums be established on a community-rated basis. One or more risk classifications may be used to lower the insurer's risk, but the premium charged cannot exceed the prescribed community-rating by more than 20%.

Washington

Factors Impacting Health Care Reform:

1. As of November 1992, Washington estimated that between 550,000 and 680,000 residents were without health insurance at any point in time. This represents 11 to 14 percent of the state's population.

2. There is a conspicuous lack of health care providers and hospitals/clinics in Washington's rural areas.

3. Demographic and cultural differences appear to present problems with regard to the delivery of services. For example, African Americans are at high risk for infant mortality compared to most other groups in Washington. The Hispanic population does poorly in many areas, but is at a much lower risk for infant mortality than is considered normal. Appropriate service delivery for these ethnic groups is not universally available.

4. Access may be impeded as a result of insufficient information on elligibility, providers, and services.

5. About 27% (148,000 to 184,000) of the uninsured population are children.

6. About 55% (302,000 to 374,000) of the uninsured have incomes less than 200% of the poverty level.

7. Almost half of the uninsured (46% or 253,000 to 313,000) are employed.

8. 65% of the uninsured work for small businesses (1-99 employees).

9. Per capita expenditures for health care rose at an annual rate of 9.7%, from $1,081 in 1980 to $2,737 in 1990. This ten year increase is more than twice the increase in per capita income for the same period.

Legislation:

1. Health Services Act of 1993 / Passed by state legislature, May 1993

A. Creates permanent five member Health Services Commission to do the following:

-Design a Uniform Benefits Package (UBP) which provides a minimum level of coverage to all Washingtonians. The package must be offered by all insurers and must be purchased by all state residents by 1999.

-Establish a maximum amount that can be charged for the UBP and reduce the rate of premium inflation by 2% each year until it matches the rate of general inflation.

-Set standards for managed competition and competing certified health plans.

B. Consolidates state health care purchasing under a single agency, the Washington State Health Care Authority, by 1997.

-Saves money by streamlining and standardizing administrative procedures and eliminating unnecessary duplication.

-Saves money by grouping the buying power of state workers, public school employees, and low-income residents currently enrolled in state program. In addition to the above categories, the following groups will participate in a single, community-rated pool by 1997:

-Basic Health Plan beneficiaries

-Medicaid and Medicare recipients (federal waivers required)

-Worker's Compensation recipients

-Small businesses and non-profit agencies (through a Washington State Health Insurance Purchasing Cooperative developed within the HCA)

-As in all other phases of Washington's proposal, managed competition will be a feature of the state health care purchasing plan. Efforts to this end will include:

-Developing a standard benefits package

-Soliciting bids from managed care organizations

-Limiting the state's contribution to a percentage of the lowest priced plan

C. Provides access to health insurance for an additional 210,000 people by:

-Expanding the Washington Basic Health Plan, which provides basic health services to residents who fall below 200% of the poverty level. Until now, the program has been limited to 24,000 people.

-Expanding Medicaid to cover children in households with incomes up to 200% of poverty.

-Allowing all Medicare recipients to purchase supplemental coverage by 1995.

-Increasing the number and quality of primary care physicians and clinics in underserved areas.

-Allowing private employers to provide insurance in one of the following ways:

-Self-insure under their own certified health plan if they have more than 7000 employees

-Contract directly with certified health plans

-Purchase Basic Health Plan coverage at full cost if they do not already have more comprehensive coverage

-Join one of four regional HIPCs

-Requiring insurers to be certified by the Health Services Commission. Certification is dependent on the insurer's willingness to provide guaranteed issue, guaranteed renewability, community-rating, portability, and pre-existing conditions clauses limited to six months from the effective date of coverage.

D. Distributes Costs Fairly

-Employers are required to pay at least 50% of the UBP premium for each employee and their dependents. The requirement will be phased in over a three year period (beginning in 1995) depending on how many employees a company has.

-Small businesses will be granted short-term subsidies to help them purchase coverage in the first several years of implementation.

-Various tax increases will raise an estimated $251 million in the next two years to finance the plan. They include increases in the cost of hard liquor, beer, and tobacco products, as well as charges imposed on non-profit hospitals and HMOs.

GLOSSARY OF HEALTH CARE TERMS

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The Clinton plan will provide security and peace of mind to American families, so that you don't have to worry about losing your insurance when you switch jobs or being denied coverage because you're sick. The proposal will control rapidly rising health costs, and guarantee Americans a comprehensive benefits package. And the plan will maintain the highest quality care in the world and the right to choose your doctor.

Below are definitions of some of the terms often used in talking about health care. We provide a comprehensive explanation followed by a simple explanation that people can relate to.

COMMUNITY RATING:

Setting health insurance premiums based on the average cost of paying for services for all covered people in a geographical area, regardless of their history of (or potential for) using health services. Although this was the system used successfully by Blue Cross & Blue Shield for years, insurance companies do not currently cover people this way.
Translation: Everyone who lives in the same area pays an equal amount for health insurance. Instead of letting insurance companies make a lot of money off a small number of people, they will make a little money off a lot of people -- doing business like a supermarket. Moving insurance companies toward community rating is one option being discussed for inclusion in the Clinton plan.

COINSURANCE (COPAYMENT):

The portion of the bill for a medical service that must be paid by the patient (coinsurance refers to a percentage; co-payments are stated as flat amounts).
Translation: What you pay for each medical service you get.

COMPREHENSIVE BENEFITS PACKAGE:

The health care services that will be covered by every American's insurance.
Translation: The Clinton plan will guarantee a comprehensive benefits package for every American.

COST-SHIFTING:

The practice by which a seller of a health service, such as a hospital, makes up for charging a particular payer less than normal -- usually because of that payer's bargaining power -- by charging other customers more. This also applies to sellers who provide services to those with no way of paying, such as the uninsured poor.
Translation:
If you have good insurance, hospitals and doctors will charge you more to make up for the costs of caring for your neighbor, who works for a small business and can't get good insurance. The Clinton plan will limit this by asking all employers to take responsibility for covering their employees.

DEDUCTIBLE:

The amount that the patient must pay to the provider directly (usually each year) before the insurance plan begins paying for benefits. An example is the $100 annual deductible for doctor's services under Medicare.
Translation: What you have to pay out of your pocket each year before your insurance kicks in -- like auto insurance.

FEE-FOR-SERVICE:

A way of paying a health-care provider -- i.e. a physician -- an amount (fee) for each service rendered. Under this arrangement, spending rises with more services, higher-priced services or increased fees.
Translation: Paying for each service or visit separately; encourages doctors to see more patients, do more tests and perform more procedures. This will still be an option for payment under the Clinton plan.

HEALTH ALLIANCE:

Organization set up to act as a collective purchasing agent for employers and individuals.
Translation: A local group of businesses and individuals who band together to negotiate for high-quality care at an affordable price.

MANAGED CARE:

General term for any system of health care delivery -- such as an HMO -- organized to enhance cost-effectiveness. Managed care networks -- different types of providers that agree to provide services to those covered under the

plan -- are usually organized by insurance carriers, but also can be organized by employers, hospitals or hospital chains. Payment is made on a fixed basis, which provides incentives to control costs.
Translation: A system that gives everybody the care they need, keeps cost down and improves quality. More integrated networks are likely to appear under the Clinton plan.

MANAGED COMPETITION:

An economic theory that organizes health care delivery and financing in an attempt to combine the best elements of government regulation and free-market competition. Those paying for care are organized into large groups, and providers then compete for their business.
Translation: A way to put people in the driver's seat so that they can get the care they want at an affordable price. This idea is influential in the Clinton plan.

PAY-OR-PLAY:

An approach to increasing insurance coverage by requiring employers to make a contribution toward covering workers and their families. They may choose either to "play" -- buy private insurance for their workers -- or "pay" a set amount, usually a percentage of payroll, to help pay for covering the workers in a government-sponsored plan like Medicare. This is one form of an employer mandate.
Translation: Not the Clinton plan -- this tells employers they must either cover the employees or pay the government to do it for them. Makes employers pay more without controlling costs.

PRE-EXISTING CONDITION:

A medical condition of an insured individual that first becomes known before the policy is issued. Insurers often choose not to cover such a condition, at least for a period, or may raise rates because of it. Pre-existing conditions include such conditions as asthma, mental illness or allergies.
Translation: A medical problem that insurers often use as an excuse to deny you coverage under the current system. The Clinton plan is likely to include a way to prevent people from being denied coverage because of pre-existing conditions.

PREMIUM:

The money paid for your insurance. Often, both employers and employees pay a premium. And there are different kinds of premiums -- a per-person premium, which is a fixed amount of money paid by employers and employees for insurance, or a wage-based premium, which is a percentage of payroll paid by employers and employees for insurance.
Translation:
What you pay for your insurance; and what your employer pays for your insurance.

SINGLE PAYER:

A health system -- like Canada's -- that would designate one entity (usually the government) to function as the only purchaser of health care services.
Translation: Not the design of the Clinton plan. This is health care paid for and supervised by the government; the Clinton plan is based in the private sector. However, states that wish to experiment with this approach may well have the option to do so.

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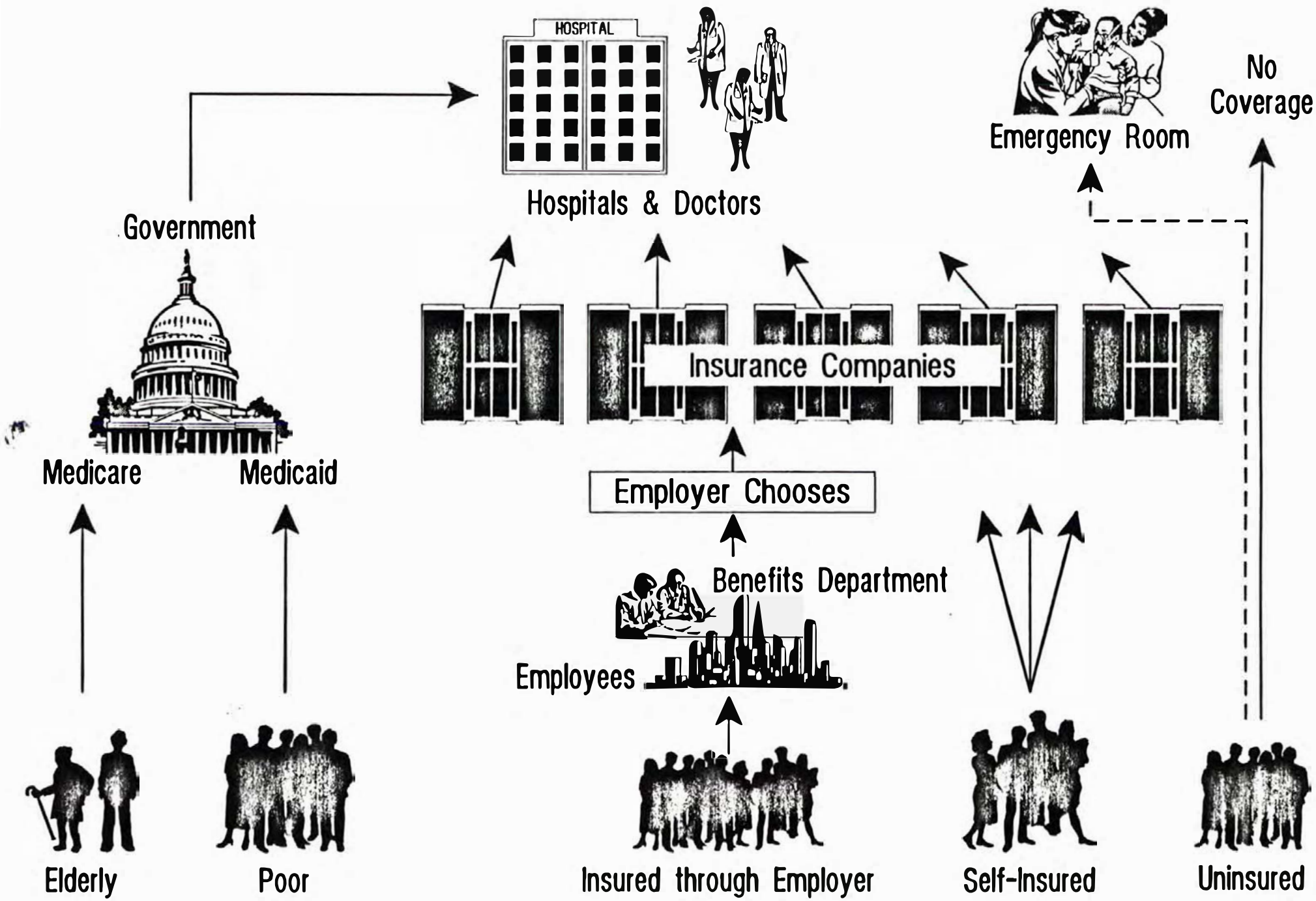
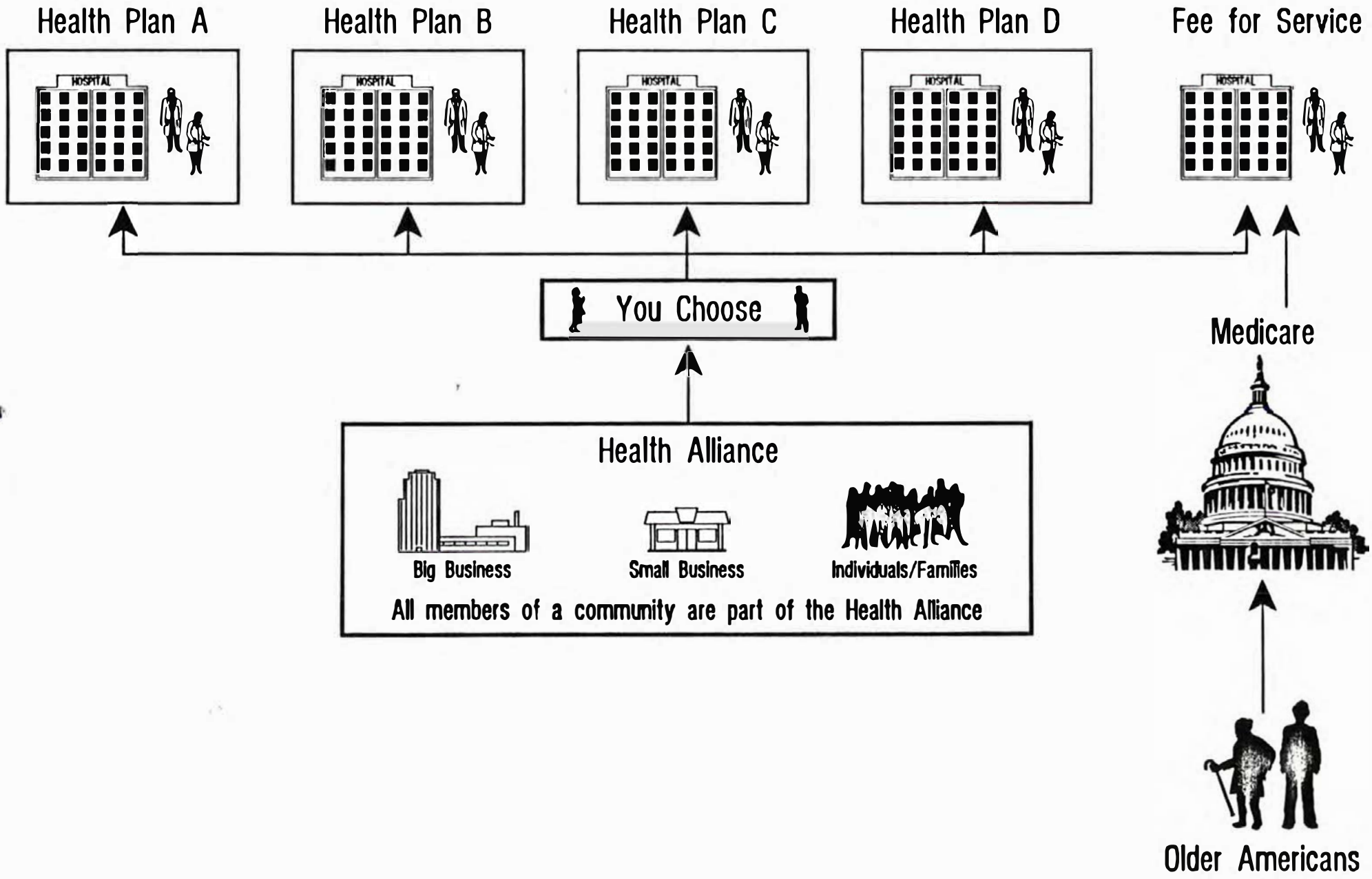


How You Get Coverage: The New System



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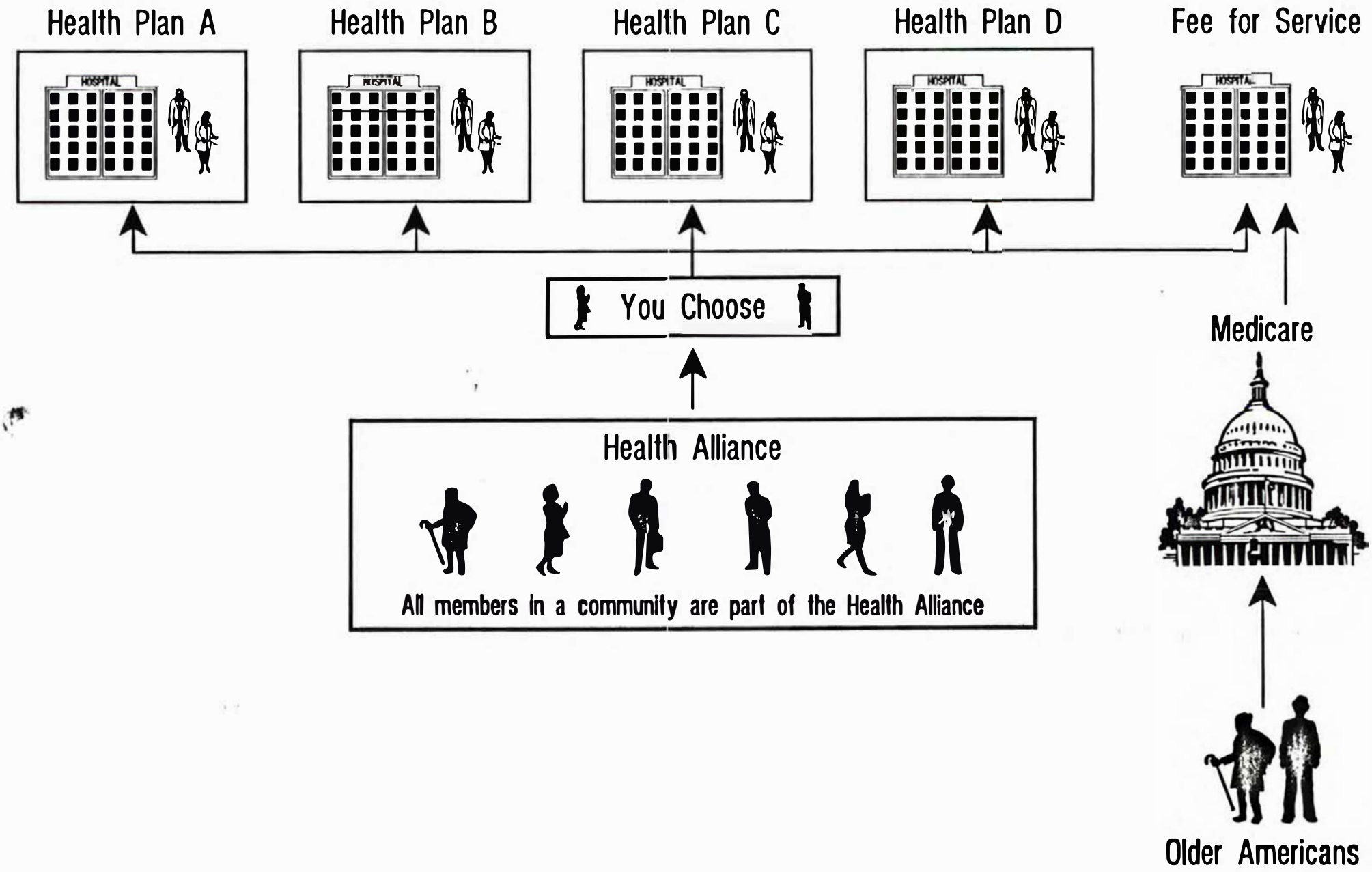

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