Chron

April 5, 1993

**MEMORANDUM**

TO: Bob Lewis
Bob McAdam
Cal George

FROM: Susan Stuntz SM

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Attached are 21 pages of "talking points" currently being used by the White House to explain and promote its health care reform process and plan. Financing issues are not addressed in this document; there is no mention of excise taxes anywhere.

Those talking points that discuss the process make mention of a number of interest groups with whom the task force is working. Among those mentioned are a variety of groups with whom we have relationships, including the National Council of Senior Citizens, the AFL-CIO and SEIU, and Citizen Action.

Attachment

cc: Sam Chilcote

# HEALTH CARE TALKING POINTS

## THE STATUS QUO

- American families do not have the security they deserve. 100,000 people a month are losing their coverage, and those who switch jobs or have a pre-existing condition are not guaranteed coverage.

- Americans are getting killed by skyrocketing health costs. Without immediate reform, the annual cost of health care for American families will more than double by the end of the decade -- to a whopping $14,000 per family.

- The current system is broken -- and it threatens your family's future and the future of every American business.

- We must take action now.

## THE CLINTON PLAN

President Clinton will present a proposal for comprehensive health reform to the Congress in May. His plan will fundamentally overhaul the system while maintaining your high quality of care and choice of doctor.

The powerful lobbies of the special interests are already lining up to block the President's plan. But with your support, the President will break the gridlock.

The proposal will be based on the following principles:

1) Security: The Clinton plan will provide Americans with the security of knowing that they will have health coverage even if they switch jobs or have a preexisting condition.

2) Choice: The Clinton plan will allow you to choose your doctor. And most Americans will have more choice of health plans. Under the Clinton proposal, your employer or insurance company won't pick the kind of coverage you get -- you will.

3) Continuity: The Clinton plan will maintain the best of the current system: your ability to get the highest quality care in the world and go to a family doctor.

4) Affordability: The Clinton plan will make health care affordable again. And it will control the spiralling costs that are strangling American businesses.

5) Comprehensiveness: The Clinton plan will guarantee all Americans a comprehensive benefits package.

6) Simplicity: The Clinton plan will reduce paperwork for both doctors and patients, and it will eliminate fraud and abuse. The health care bureaucracy will shrink under the Clinton plan.

# AMERICA'S HEALTH CARE CRISIS: THE FACTS

## THE GROWING RANKS OF THE MIDDLE-CLASS UNINSURED:

- One hundred thousand Americans move into the ranks of the uninsured each month. More than half of the uninsured in 1990 were full-time workers and their families. [Washington Post, 1/26/93; CBO]

- More than one million of those who lost health insurance in 1991 were Americans earning between $25,000 and $49,000. [Himmelstein and Woolhandler, "The Growing Epidemic of Uninsurance", 12/92]

## AMERICANS WORRY ABOUT LOSING INSURANCE:

- **One out of every three** Americans who earns between $30,000 and $50,000 report that they or someone in their household stayed in jobs they wanted to leave because they were afraid of losing their health care coverage. [New York Times, 9/26/91]

- 61 percent of Americans worry a great deal that health insurance will become too expensive for them to afford. [Kaiser/Commonwealth/Harris, 4/92]

## AMERICAN FAMILIES HURT BY SKYROCKETING COSTS:

- Health care spending per person has almost **quadrupled** – from just over **$1,000** in 1980 to more than $3,100 last year. [HCFA, Bureau of Economic Analysis]

- If we do nothing, experts estimate that the annual cost of health care for an American family will **more than double** by the end of the decade – to a whopping $14,000 per family. **Workers will lose $655 in income each year if health care costs are allowed to continue to eat up wage increases.** [Families USA; OMB]

## SMALL BUSINESSES HIT HARDEST:

- **Two thirds of small businesses provide their employees with health insurance;** the rest would like to but can't afford the 20 to 50 percent premium increases that only small businesses face. [Washington Post, 1/26/93; National Small Business United]

- Small companies pay premiums that are one third higher on average than large employers and these premiums have continued to increase 50% faster than premiums for larger employers. [National Small Business United]

## U.S. COMPETITIVENESS AND U.S. WORKERS SUFFER:

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

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

# AMERICA'S HEALTH CARE CRISIS: THE FACTS (Page Two)

U.S. DEFICIT INCREASES WHILE OUR INVESTMENT FALLS:

- If we do nothing, health care spending will rise from 14% of GDP today to an astonishing 18% of GDP in the year 2000 -- meaning that **seven years from today, almost $1 out of every $5 earned by Americans will go to health spending.** More than half of the expected $738 billion increase in federal revenue in the next four years will be absorbed by health care cost increases. [OMB; Lewin-ICF]

- The potential "health dividend" is far larger than the "peace dividend". If America spent the same share of our national resources on health as our main international competitors -- who insure all their citizens -- $230 billion (or 4 percent of GDP) in 1992 could have been used for additional investment or to **almost completely eliminate our $290 billion deficit.** [OMB]

Academics describe the Clinton plan as a combination of "managed competition" and "global budgets". That means:

- Giving consumers the power to join together in local health alliances to obtain the highest quality care at affordable prices.
- Gradually bringing down health costs to ensure that costs stop rising four times faster than inflation.
- Providing a comprehensive benefits package to every American.

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. And it 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. Insted of avoiding risk, insurance companies manage risk. 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 the patient pays for each medical service received.

**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.

**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.

**GLOBAL BUDGET:**
An amount -- usually set by the government -- intended to cover all spending on specific health services. The global budget includes all potential spending -- public and private -- and is not to be exceeded.
Translation: A guarantee that health care costs won't spiral out of control. Measures to control costs are one option being discussed as part of the Clinton plan.

**LOCAL HEALTH ALLIANCE** (aka health insurance purchasing cooperative):
Organization set up to act as a collective purchasing agent for employers and individuals.
Translation: A local group whose job it is to get you and everybody in your region the best health care at the lowest possible price. Groups like this are likely to be included in the Clinton plan.

**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.

**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.

# TALKING POINTS ON HEALTH CARE TASK FORCE AND THE "TOLLGATE" POLICY DEVELOPMENT PROCESS

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. Their charge: prepare health care reform legislation to give American families the security they need and bring spiralling health care costs under control. President Clinton 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. As President Clinton said, the First Lady is both experienced and able to "bring people together around complex and difficult issues to hammer out consensus and get things done."

The President's health care reform process has two tiers: the first is the Task Force itself, which includes representation 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 -- including federal employees, outside experts and health-care professionals -- which have been 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 has 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, will guide their research efforts through a series of tests, or "tollgates", before a comprehensive set of options is presented 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 current phase, this broad group of options is being narrowed, after which the working groups will make draft recommendations which will be synthesized into a comprehensive set of proposals. At that point, outside auditors will check to ensure that all cost and savings projections are sound, and that all legal concerns have been addressed.

AN INCLUSIVE PROCESS . . .

To ensure that this process is open and inclusive, the President has 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 policymaking process in history, more than 500 people from all over the country are 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, there are **more than 100 health care professionals** -- including 60 doctors, 20 nurses and 6 social workers -- developing policy options for the Task Force. A Health Professionals Review Group of more than 40 people has begun to meet regularly to assess the policy options that are being discussed in light of their real-world applications. In addition, **diverse panels of consumers** -- many selected from letters they sent to the Task Force -- are brought in regularly to advise the working groups as they develop their recommendations.

. . . 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 First Lady, Ira Magaziner and other 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 50,000 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 officials or working groups.

The First Lady, Health and Human Services Secretary Donna 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. In the past month, they have attended several roundtable discussions across the country to listen to 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 will continue to be closely involved as policy options are narrowed and recommendations are prepared for the Task Force in May.

## . . . 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 experience and 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 weekly meetings with the House and Senate Leadership, Committee Chairmen, and other Members of Congress. The First Lady herself has discussed health care reform with more than **60 Senate Democrats and Republicans**, and well over **100 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;

- 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;

- In an unprecedented attempt to draft legislation in consultation with Congress, **more than 150 Congressional staff members** are actively involved in the day-to-day development of policy options taking place within the working groups.

# SMALL BUSINESSES AND HEALTH CARE

- Small businesses want to cover their employees, and many of them do. In fact, **nearly two-thirds of small businesses currently provide health insurance to their employees.**

- But as small business premiums continue to skyrocket, it becomes more and more difficult for small businesses to cover their employees.

- In today's system, the fewer employees you have, the more you're likely to pay. And if your employees are older, or if one or two have pre-existing conditions, insurance companies will either charge you exorbitant rates, cancel your coverage, or refuse to cover your employees.

- **The President's plan will help small businesses by enabling them to join large purchasing pools with the power to negotiate for high-quality care at an affordable price.**

- **The President's plan will cut health costs for small businesses** that provide coverage and provide financial help that makes it possible for other small businesses to cover their employees.

- **By moving insurance companies toward community rating, the President's plan will cut the underwriting costs that drive small business premiums up.**

- Critics are already charging that the President's health plan will drive small businesses under. In fact, the plan will control their skyrocketing costs and help them cover their employees. **Remember, this is a President who offered an unpredecented set of incentives for small business in his economic package.** He recognizes the vital role that small business plays in the American economy.

<u>The Task Force Process:</u>

- Ira Magaziner, head of the Task Force effort and a former small business owner, has personally met with almost all of the major groups representing small business. He has also spoken before the Retail Federation, the Washington Business Group on Health and the Small Business Legislative Council.

- At the March 29 Task Force hearing, representatives of small businesses -- including the Small Business Legislative Council, National Small Business United, National Association of Women Business Owners, and Chamber of Commerce -- all testified. The National Federation of Independent Business was invited but declined to testify.

- Mrs. Clinton has visited small businesspeople in Boston and other communities to hear their concerns about health care.

# OLDER AMERICANS AND HEALTH CARE

- We know that prescription drugs are the largest cost of daily living for almost half of all people over 65. And more than 5 million Americans over 55 say they have to choose between buying food and paying for medication. That's wrong.

- The President has been very strong in taking on the drug companies that charge outrageous prices for prescription drugs. We believe that **making prescription drugs affordable for all Americans must be a priority of any health reform package.**

- The President and I believe that **long-term care reform must be included** as part of any comprehensive health reform package. We understand **the need for greater flexibility for home and community-based services for long-term care patients.**

- We need to change the way government reimburses for care. If home care is more cost-effective and preferable for people, it should be made more available and affordable.

- However, we must be realistic. Given the need to control costs, **an immediate solution to all the challenges of long-term care is unlikely.**

- No matter what changes are made, older Americans can be sure that **the fundamental contract between older Americans and the government will be preserved.** Older Americans who currently rely on Medicare will continue to have the health security they deserve. But the details of how Medicare will fit with the President's health reform proposal remain undetermined.

Task Force Process:

- The President has met with the AARP and the National Council of Senior Citizens (NCSC).

- Ira Magaziner, the head of the Task Force effort, has met individually with the AARP, NCSC, Families USA and the National Committee to Preserve Social Security and Medicare.

- Representatives of seniors' groups have been in White House roundtable discussions about health care, and the long-term care working group has met with several seniors' groups.

- Mrs. Clinton attended Florida's Robert Wood Johnson forum that focused on the needs of older Americans.

- At the March 29 Task Force hearing, representatives of the National Council of Senior Citizens, Families USA, AARP, National Committee to Preserve Social Security/Medicare and Long-Term Care Campaign testified.

# PEOPLE WITH DISABILITIES AND HEALTH CARE

- I understand -- and the President understands -- that allowing people to choose **their own doctor is a hallmark of American medicine.** The President and I believe that we must preserve this right for all Americans -- and we understand how important this is to people with disabilities.

- **We understand the importance of services such as home and community-based long-term care, which help people with disabilities to lead independent and productive lives.**

- Because home or community-based care can help patients, save money and allow individuals to be more independent, the President and I agree that it must be an integral part of any health reform package.

- We recognize that health care for people with disabilities is not just a long term care issue. **The comprehensive benefits package in the President's health care plan will recognize the importance of preventive interventions to disabled Americans.** This will both promote independence and decrease costs over the long-term.

- In the Oregon Medicaid case, the Administration worked with Oregon officials to revise its proposal to ensure full compliance with the Americans with Disabilities Act. **But Oregon's Medicaid program carries no implications for the President's comprehensive health reform proposal.**

Task Force Process:

- The White House held a roundtable discussion with representatives from the nation's major disability groups.

- The Task Force working group looking at long-term care has met at least twice with several disability groups.

- In addition, Secretary Shalala has met with representatives of Consortium of Citizens with Disabilities (CCD).

- The March 29 Task Force hearing was addressed by the CCD and National Association of Developmental Disability Councils.

# VETERANS AND HEALTH CARE

- The President and I believe that America's veterans have demonstrated the service to country that has kept our country secure, and they deserve the security of knowing that they will never go without the health care services they need. This Administration will not leave the men and women who won the Cold War out in the cold.
- In today's system, the Veterans Administration covers all costs for providing care to service-connected and low-income veterans. **Under the President's plan, they will still be guaranteed these benefits, and may have a broader range of choices of where they can get their care.**

- In today's system, other veterans receive some health services from the VA. Under the President's plan, this will still be the case, but **all veterans will have the security of knowing that they are guaranteed a comprehensive package of benefits and access to the highest quality care.**

- In today's system, the Veterans' Administration is also an important provider of long-term care services and has special expertise in other areas -- like spinal cord injury and prosthesis. And the VA will continue to play that role.

Task Force Process:

- The VA has been meeting on an ongoing basis with the major veterans' organizations on the health care issue.

- Jesse Brown is a member of the Task Force, and members of his staff are a part of the Task Force's working groups.

- In the midst of government spending cuts, the VA received an increase of over $1 billion in funds in part because of the importance of the VA's health-care system to the administration.

- The Administration has been working closely with the House and Senate Chairmen of the Veterans' Affairs Committees, Rep. Sonny Montgomery and Sen. Jay Rockefeller, on this issue.

## PROVIDERS AND HEALTH CARE

- The President and I are determined to maintain the best of the American health care system -- the highest-quality care in the world and an individual's right to choose a doctor.

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

- **The President's plan will reduce paperwork by standardizing forms and reducing insurance company micromanagement.**

- We understand that malpractice reform is essential to **giving physicians back professional autonomy and lowering health care costs caused by "defensive medicine".**

Helping Specialists:

- The President's plan will reform malpractice laws in order to let doctors determine what course of treatment is best for their patients, not what tests or procedures have to be done to avoid getting sued.

- The President's plan will recognize the importance of preserving and promoting the unique and important relationship between doctor and patient.

Helping Primary Care Physicians:

- The President's plan will provide incentives for more medical students to become primary care physicians. By emphasizing preventive health care services, the plan will place increased importance on the family physician.

Task Force Process:

- More than 100 health professionals -- including more than 60 doctors -- are on the Task Force's working groups that are developing policy options. In addition, a health professionals review panel of more than 40 people, including family practitioners and specialists, has been charged with reviewing the options developed by the Task Force.

- White House officials have also held separate roundtable discussions with both physicians and nurses. In total, Administration officials have met with more than 30 groups representing health professionals.

- Ira Magaziner, the head of the Task Force effort, has met repeatedly with the American Academy of Family Physicians, the American College of Physicians and the American Medical Association.

- Mrs. Clinton held a meeting with representatives of several nurses' groups, including the American Nurses Association.

# UNIONS AND HEALTH CARE

- **Health care costs are the number one cause of labor-management disputes in the country.**

- With a guaranteed, comprehensive benefits package, **unions will no longer face the tradeoff between health benefits and wage increases.**

- Some fear that what academics call "managed competition" will result in worse benefits for workers that have done a good job negotiating for comprehensive benefits from their employers. While the specifics of the President's plan are not yet decided, this will not be the case:

  - **Workers, in fact, will likely have a broader range of choices for health care plans,** many of which will be more cost effective than today's plans.

  - **The comprehensive benefits package available to every American will be based on the best of today's benefit plans.**

  - **American workers will no longer have to fear that losing their job or switching jobs will mean losing their health care coverage.**

- Skyrocketing health costs also make it harder for American companies to compete in a global marketplace:

  - Health care costs add more than $1100 to the price of every car made in America; that's more than double what the Japanese spend.

  - The U.S. spends twice as much on health care than the average total costs of the 24 industrialized countries in Europe and North America.

- Many labor unions support the single-payer approach to controlling costs. And **single-payer advocates and the President agree: there is an urgent need for a fundamental overhaul of our health-care system.**

Task Force Process:

- Many unions have been included in White House roundtable discussions on health care.

- Mrs. Clinton has met with the AFL-CIO executive board to discuss health care reform.

- Ira Magaziner, the head of the Task Force effort, has met regularly with representatives of the AFL-CIO. He has also met with the SEIU and spoken at an AFSCME meeting.

## SINGLE-PAYER ADVOCATES AND HEALTH CARE

- Single-payer advocates and the President agree: there is an urgent need for a fundamental overhaul of our health-care system.

- Many elements of single-payer models -- cost containment, simplification, reduced paperwork, a guaranteed, comprehensive benefit package and universal access -- are things which the President strongly supports and which will be central to his plan.

- Like single-payer plans, President Clinton's health reform plan will squeeze the waste, excess and inefficiency out of our present system and use those savings for health care reform.

- But the President believes that by putting the government in charge of the health-care system, a single-payer system might create too much government.

- **The President is committed to maintaining a uniquely American system** -- one that is rooted in the private sector, provides the highest-quality care in the world and preserves the right to choose your doctor.

- The Clinton plan is likely to provide states with enough flexibility to design a single-payer system within the framework of the national system if states so choose.

Task Force Process:

- The White House held a roundtable discussion with single-payer advocates, including AFSCME, Citizen Action, National Council of Senior Citizens.

- White House officials have met with representatives of more than 20 single-payer advocate groups.

- Ira Magaziner, head of the Task Force effort, spoke at AFSCME's annual convention and has met with several groups who have traditionally supported a single-payer approach.

- The March 29 Task Force hearing was addressed by the Ntaional Council of Senior Citizens, AFSCME, Teamsters, Citizen Action and National Council of Churches -- all traditional single-payer advocates.

# SUCCESSFUL MODEL PROGRAMS

To prepare its health care reform proposal, the Task Force has been examining the many successful reforms that have been implemented by states, cities, and companies around the country. These reforms share several crucial characteristics: all allow choice of doctors; all are market-based reforms; and all provide a comprehensive package of benefits while controlling costs and eliminating administrative waste.

## CALIFORNIA PUBLIC EMPLOYEES RETIREMENT SYSTEM (CALPERS)

The California Public Employees Retirement System (or Calpers) administers health care plans for almost 900,000 state and local government employees and their families across California. In response to premium increases of 21% in 1990, the agency embarked on an ambitious program to lower costs and eliminate administrative waste.

Calpers -- which buys $1.3 billion of health care each year -- demonstrated how large groups of consumers can use their size for bargaining power when negotiating coverage from competing plans. Many smaller companies and individuals join Calpers because it gives them leverage they would otherwise lack. Calpers offers its members **a choice among 19 plans,** with which it negotiates rates and comprehensive packages of services. Patients then choose a personal physician within the plan they select. Calpers offers traditional health insurance plans for members in remote areas.

By pooling large groups of consumers to negotiate among providers, **Calpers has been able to hold annual premium increases in 1992 to 3.1 percent** -- compared to a state industry average of 13.2 percent. It has also forced its insurers to root out wasteful administrative costs, reduce inappropriate care, and encourage hospitals and doctors' groups to moderate their rates.

## CITY OF ROCHESTER, NEW YORK

Called "a jewel in a sea of health care despair," Rochester is one of the few American cities that have health care systems that work. The city's doctors, hospitals and local businesses have cooperated to keep the quality of care high, while implementing incentives to control costs.

Through insurance reform, Rochester has been able to serve the needs of its large businesses -- by keeping costs down -- while also establishing a structure that enables small businesses and families to purchase competitively priced insurance. A cornerstone of the Rochester plan is the single price approach -- small and large businesses pay the same monthly premium per person for equal benefits. **No one pays more or is refused coverage because of age, sex or a previous medical condition.** Another central element of the Rochester plan is the involvement of local industry. Led by regional-giant Eastman Kodak, Rochester's small and large businesses cooperate closely in this unified regional insurance program. This cooperation has also been extended to the area's hospitals, which have agreed over the years on which institutions should perform certain specialized services -- like organ transplants -- to prevent expensive duplication.

As a result of these reforms, **Rochester's medical costs are 25 percent lower** per capita than national levels, administrative costs are half national averages, and **94% of the population is insured.**

# SUCCESSFUL MODEL PROGRAMS (Page Two)

## XEROX CORPORATION

Before it reformed its health benefits system, Xerox experienced 20% increases every year in its health care costs -- which were rising uncontrollably because their employees, isolated from the costs of their health care, chose very expensive and inefficient health care packages. In what's been described as "an unheralded breakthrough," Xerox began pegging its contribution to its employees' health care packages to the cost of the most efficient, or "benchmark", health care plans.

Xerox offers a menu of health care options and then makes sure that employees either pocket the savings offered by more efficient plans -- or pay for choosing more expensive ones. Competition among health care plans at each of Xerox's 250 sites across the country is the cornerstone of their plan. All plans are screened each year to ensure that they meet high quality standards and offer comprehensive benefits packages. Annual patient satisfaction surveys are conducted on a broad slice of the work force. **Customer satisfaction ranges from 70% to 95% for a plan in Rochester.**

As Xerox hoped, premium increases for all health care plans -- especially the benchmarks -- have fallen significantly. Many employees have switched to the benchmark plans, whose average premium rose only 7.7% in 1992 and will rise a mere 5.5% in 1993.

# STATE REFORM EFFORTS

In recent years, many states have developed innovative solutions to the health care crisis faced by their citizens. Several of these, such as Minnesota and Hawaii, have moved far beyond the pilot stage -- enacting comprehensive new laws aimed at providing security to more people and controlling their health care costs. Well over half of the states have enacted smaller scale changes -- including initiatives for controlling costs, reforming medical malpractice laws, and changing insurance laws. For example, New York State has already enacted a law to make it easier for small businesses to purchase health insurance and is now considering fundamental health care reform. In March, Louisiana unveiled a program to bring medical insurance within reach of 600,000 people who earn too little to afford insurance.

## OREGON

Oregon's Medicaid waiver is an effort to give one state the flexibility to design a Medicaid program that meets the needs of its citizens. Their plan is fundamentally different from the Clinton proposal because Oregon attempts to extend coverage to more citizens by reducing benefits. The Clinton plan **will not ration health care** but will overhaul our health care system and use these savings to provide security to all Americans.

In March 1993, Oregon was granted a waiver to modify its Medicaid coverage and allow it to expand health care coverage to more than 120,000 of its working poor -- people who have full time jobs but remain below the poverty level. These families will now be eligible for a standard benefit package under Medicaid -- including doctor care, medication and hospital services. To provide for this increased coverage, the state ranked 688 medical treatments and conditions currently covered by Medicaid according to such factors as "seriousness" and "ability of treatments to improve the quality of life". 568 of these treatments -- such as pneumonia, flu, appendicitis and some cancers, and most organ transplants -- are covered, both for current Medicaid beneficiaries and the additional 120,000. The remaining treatments -- such as expensive treatments for incurable cancer -- will no longer be covered.

## HAWAII

Hawaii has moved closer to universal access than any other state through reforming and strengthening its traditional system of private, employer-based health care coverage. It is estimated that only about 2 percent of Hawaii's population remains uninsured -- compared to estimates of 15.3 percent nationwide. State officials note that while Hawaii's health care spending has mirrored the national average, it has continued to provide increased access to health care for its citizens.

88 percent of Hawaii's non-elderly population receives insurance from their employers as is required by state law. Hawaii's remaining citizens are either insured by Hawaii's expansive Medicaid program (which accepts a greater percentage of its low-income population than most states) or through state-subsidized private health insurance (which is fully paid by the state for those whose income is under the poverty level). All three programs -- employer-funded, Medicaid and state-subsidized -- offer comprehensive benefit packages including medical, hospital, and laboratory services. Although Hawaii established a "rainy day fund" for small businesses who were unable to pay for their employees' insurance (as required by law), only 2% of small businesses have had to use these funds.

## MINNESOTA -- EMPLOYEE GROUP INSURANCE PROGRAM

In the late 1980s, Minnesota's Employee Group Insurance Program faced a crisis in health care costs. Most of its employees were enrolled in a traditional Blue Cross/Blue Shield self-insured health plan, which faced a $50 million deficit in 1988 and demanded a 1989 premium increase of 67 percent. To bring costs under control, the State reformed its approach to health insurance purchasing.

The Minnesota program now offers six health plans -- for which it negotiates rates and comparable comprehensive benefit packages -- to its 140,000 members. The employer contribution toward the cost of coverage is based on the health plan that offers the lowest family premium in each county; that plan is available at no cost to any employee. Employees who choose the most expensive plans, however, must pay the difference. The Program conducts patient satisfaction surveys to provide employees with information on the relative quality of health plans.

Since the reforms were initiated, the rate of increase for health insurance premiums has dropped dramatically -- from 42% in 1989 to only 6% in 1992 and 1993. At the same time, the health plans with the best premium rates have experienced significant enrollment increases.

# FOREIGN HEALTH CARE SYSTEMS

## GERMANY

The German health care system has provided cradle-to-grave health care for all its citizens for more than a century while controlling health care costs. Germany's system is rooted in the private sector -- not the government -- and is based on a publicly-supervised partnership between doctors and insurers. These are characteristics which will also be part of the Clinton reform plan.

Everybody living in Germany -- including the elderly and unemployed -- is covered by health insurance that allows them to choose their own doctor. Coverage is permanent; workers don't lose insurance if they change jobs or become unemployed and insurance companies can't refuse to insure a person because of a pre-existing condition. The system is financed by contributions from employers and employees -- each of which pay 6.5% of the worker's monthly salary. There are no "hidden costs" -- such as deductibles or co-payments. Fees for doctors and hospitals are negotiated by non-profit, independent "sickness funds" -- health insurance agencies for each area. The government sets a yearly limit for the nation's health care spending which has helped to keep health care cost per person to almost half U.S. levels.

## CANADA

The Clinton plan shares many of the goals -- cost containment, simplification, guaranteed benefit package -- of Canada's system, but will be significantly different. We are committed to maintaining a uniquely American system -- one that builds on its employer-based system and maintains the highest quality health care in the world, based on state of the art technology.

Canada's "single-payer" -- or government funded -- health care system consists of 10 separate provincial plans with certain mandated features. Health insurance is universal -- covering all medically necessary hospital and physician services. To control costs, the government determines hospital budgets and regulates both the technology and the prices of physician services. The federal and provincial governments share the costs, financing the system primarily through taxes. There are no deductibles or co-payments, so Canadians only pay extra for services that are not covered, such as cosmetic surgery. Critics charge that this system has limited the use of high-technology diagnostic and surgical procedures, producing waiting lists for some specialty care services.

## THE UNITED KINGDOM

The Clinton plan is not modeled on the top-heavy British system, which is run entirely by their government. The Clinton plan will maintain a system based in the private sector and ensure that doctors make health care decisions.

England has a system of socialized medicine. Doctors, dentists and other health care professionals are employees of the state, which owns and operates more than 2,000 hospitals nationwide. This federal National Health Service offers free cradle-to-grave medical care to all Britons, and finances it through general taxation. Each person enrolls with a general practitioner, who determines when to send the patient to a specialist. A new market of private hospitals and commercial insurers has sprung up for people seeking care outside the NHS; these compete on price and quality and advertise prices for various procedures.