Foreword -- Hillary Rodham Clinton

Together, we stand at a unique moment in history. In the coming months, we have an opportunity to accomplish what our nation has never done before: provide health security to every American - health care that can never be taken away.

The debate over health care reform that will unfold over the next several months touches all of our lives and the lives of our children, our parents and generations to come. Because this issue is so critical to all of our futures, it is important that all of us have the opportunity to understand the complex issues and difficult choices that lie behind the design of any comprehensive reform effort.

That is why we have written this book - to lay out the dimensions of the crisis that confronts our nation, explain its elements and complexities, and state the case for comprehensive reform as proposed in the Health Security Act.

Book after book has been written about the intricacies of the health care system and the difficulties of addressing these problems. But most of them have not been written for people like you and me - people who may not be experts in health care policy but need and want to understand an issue so vital to our nation and our future.

I invite each and every American to read this book, to listen to the stories told here, to think about the issues and grapple with this complex - but solvable - problem. Then I invite every American to join in the debate. Every month, two million Americans lose their insurance for some period of time. Every day, thousands of Americans discover that, despite years of working hard and paying for health insurance, they are no longer covered. Every hour, hundreds who need care walk into an emergency room because it is the only place they can go. And business owners, large and small, struggle to stay afloat while providing coverage for their families and employees. Each time someone loses health coverage or is denied insurance, their experience becomes another chapter in a growing national tragedy. Anxiety and fear about the cost of health care affect tens of millions of Americans - those with health insurance and those without. Even those with the very best benefits worry that their insurance

might not be there tomorrow or may no longer be affordable. Over the past months, I have had the extraordinary opportunity of listening to thousands of Americans talk about health care. I've sat in living rooms talking to farm families. I've stood on loading docks talking to people who have worked for 10, 15, and even 20 years without insurance. I've visited hospitals, talking to doctors and nurses. I have learned firsthand about the tragedies of hard-working families who simply cannot get the health care they deserve. I have read letter after letter of the more than 800,000 we have received at the White House from people all over our nation who took the time to sit down and share their concerns about health care. I have been moved by stories of parents who cannot afford a prescription for a child who is sick and hurting, of families barely hanging on financially and emotionally because of a health care crisis, of people trying to start a new business suffocated by skyrocketing insurance costs, of older Americans forced to choose between food and medicine, and of young people just leaving school unable to afford insurance.

I have carried their stories in my mind as we worked long and hard to devise solid answers to tough questions. The President's Health Security Act is a product of all the people who took the time to share their ideas, their research, and their personal experiences with us. And, as we move forward in this great national discussion, we must focus on these people, their health care, and their peace of mind - not solely on theories or statistics.

The concerns that were expressed again and again - from those who need care and those who give care - convinced me of one point: although America can still proudly boast the world's finest health professionals and astounding medical advances, our health care system is broken. If we go on without change, the consequences will be devastating for millions of Americans and disastrous for the nation in human and economic terms.

As a mother, I can understand the feeling of helplessness that must come when a parent cannot afford a vaccination or well-child exam. As a wife, I can imagine the fear that grips a couple whose health insurance vanishes because of a lost job, a layoff or an unexpected illness. As a sister, I can see the inequities and inconsistencies of a health care system that offers widely varying coverage, depending on where a family member lives or works. As a daughter, I can appreciate the suffering that comes when a parent's treatment is determined as much by bureaucratic rules and regulations as by doctors' expertise. And as a woman who has spent many years in the

workforce, I can empathize with those who labor for a lifetime and still cannot be assured they will always have health coverage.

As an American citizen concerned about the health of our nation, I stand with you as we confront this challenge that touches all of us. We can and will achieve lasting, meaningful change.

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Health Security, The President's Report to the American People

"You know, there's that old saying: If it ain't broke, don't fix it...This system is broken and desperately needs to be fixed...If I were talking about this as a patient, I would say that it is in intensive care and we're not seeing the kind of vital signs that would lead us to believe it will recover."

-A doctor at St. Agnes Hospital Philadelphia, PA

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In many ways, the American medical system represents our nation at its best, pioneering in the most noble of human pursuits, the healing of the sick. It is the result of five decades of national investment - investment in research into disease and prevention, training of doctors, nurses and technicians, and construction of hospitals and medical schools.

Today tens of thousands of dedicated health care professionals apply their unmatched skills to the world's most advanced technologies and procedures. They deliver some of the best health care on earth. No other health care system exceeds our level of scientific knowledge, professional skill and technical resources.

But America's health care system also presents our nation with one of its gravest challenges. Bring together any group of citizens and the dimensions of the health care crisis emerge from their stories. Stories about insurance coverage lost, policies cancelled, fear of financial ruin, better jobs not taken, endless forms filled out. They are stories of frustration and insecurity - and, too often, pain and fear.

Today, everything that is wrong with the American health care system threatens everything that is right. That is the reality that drives the call for fundamental reform, the reality from which President Clinton's Health Security Act arises.

Rising Insecurity

From the 1940s through the 1970s, the United States made steady progress toward broader health care coverage. Employment-based insurance and public programs expanded to reach more people and offer more benefits. Beginning in the 1980's, however, the number of Americans lacking health insurance has increased steadily - while health care costs have increased at ever-rising rates.

The result: growing insecurity. Today, according to estimates prepared by Families USA, more than two million Americans lose their health coverage every month. Many get it back within a few weeks or a few months, but every day a growing number of Americans are counted among the more than 37 million who go without health insurance - including 9.5 million children. Millions more have health coverage so inadequate that a serious illness will devastate their family savings and security.

Unlike other nations that have made health coverage a right of citizenship, the United States continues to treat it as a "fringe benefit" of employment, something that can be given or taken away. Over the course of any two-year period, one in four Americans learns how easily that privilege can be taken away, leaving them vulnerable to financial ruin. Others watch anxiously as their health benefits erode. Even those with the best benefits wonder what will happen if they lose a job or change jobs.

Americans value what health care can do for them; increasingly, many fear what the health care system can do to them. At the root of the problem lies our health insurance system, which gives insurance companies the right to pick and choose whom to cover. Risk selection and underwriting - the practice of identifying the healthiest people, who pose the least risk - divide consumers into rigid categories used to deny coverage to sick or old people, or set high premium rates.

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"The way the system works now, even employed, insured people are just one major illness away from financial disaster."

K.P. West Lafayette, Indiana _____

The result is a system that is stacked against individuals, families and small businesses. Millions of Americans have lost their insurance when they got sick and needed insurance most. People with pre-existing conditions - an insurance term for medical conditions or diseases diagnosed before people apply for coverage - either cannot obtain coverage or can often only obtain it at exorbitant prices. Many lose their insurance coverage when a spouse dies or they divorce.

Among the 37 million Americans who lack insurance, 85 percent belong to families that includes an employed adult. Those who work part-time or are self-employed, often cannot obtain group coverage. Fear of losing insurance locks millions of Americans into jobs they want to leave; changing jobs or starting a new business can mean losing health insurance. And many people stay on welfare to get government health benefits they could not obtain if they were employed in minimum wage jobs.

For small businesses, health security has become almost impossible to achieve. Insurance companies charge small businesses higher rates than they charge major corporations, while refusing to cover some industries considered high risk. Small business owners that want to provide insurance can find themselves priced out of the market, leaving them unable to protect their families or employees.

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"My husband and I own and operate a small business. This year we will make our employees pay for any increase in premiums and may drop [some benefits] altogether. Our company cannot shop around for lower cost health insurance because I am uninsurable."

B.M. Phoenix, Arizona _____

Prompted by ever-rising costs, employers of all sizes have reduced health coverage benefits, raised deductibles, limited coverage and switched to hiring more part-time and contract workers in part to avoid paying health benefits. Sometimes without realizing it, workers sacrifice wage increases for health benefits, making a tradeoff between what they deserve and what they need. What many Americans fear most about losing a job is losing their health insurance.

Even for Americans employed by the largest corporations, rising health costs present an increasing competitive disadvantage, prompting renegotiation of benefits, reductions in coverage, higher deductibles, limits on choice of doctors, and attempts to shepherd employees into one health plan. As costs continue to rise, these trends become more pronounced - and increasing numbers of American families find health security beyond their reach.

This growing insecurity also has a great impact on older Americans. Any pharmacist will tell you that thousands of elderly people must decide every week between buying medicine and buying food. Doctors who care for the elderly know that cutting down on a dosage to stretch a prescription or skipping a refill has become commonplace, particularly among the elderly who live only a little above the poverty line.

At the same time, a second and perhaps more daunting challenge confronts us: the growing need for security against

the devastating costs of long-term care for the elderly and people with disabilities. With the number of Americans over age 85 projected to double by the year 2010, the need for long-term care is expected to rise dramatically as the next century begins, affecting not only those who need care but their families as well.

In the past, the United States has attempted to remedy the gaps in our health care system by expanding public programs or adding new programs aimed to fill specific needs. Community health centers, public health clinics, clinics for migrant workers, and public hospitals - all add up to a patchwork of services covering specific populations, but we have never met the growing need for reliable and secure health coverage.

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"When my two sons were 3 and 6, Spencer and Evan were diagnosed with cystic fibrosis. In the blink of an eye, my two beautiful, healthy boys became part of our worst nightmare. We had to face the fact that we could lose them to this dreadful disease. We live in constant fear of losing our medical coverage... Without the drug coverage that we now have, it would cost us at least $1500 a month for their medicine alone. These little boys are virtually uninsurable...As mothers we need to protect our children, and I don't want to feel frightened about this all my life."

A.B. Pleasanton, CA _____ Growing Complexity

American health care is choked by paperwork and strangled by bureaucracy. Administrative costs are higher in the American health care system than in any other country, and rising rapidly.

Confusion, complexity and increasing costs stem from the peculiarities of our health insurance system. Consumers experience it around the office or the kitchen table, when they are faced with piles of incomprehensible forms or when an insurance company refers them to the fine print in a policy to answer a question. A change in jobs or a move to another state can mean deciphering a whole new set of documents and learning a whole new set of rules.

_____ "While we go about our business caring for our patients, we are being buried in paperwork. Everyday, my mailbox is filled with directives, new regulations and papers to sign. The truth is, if I read all my mail, there

would be no time left to see my patients."

Dr. Jules Zysman _____

For small businesses, too many health care dollars go to administration not to actual care. Firms with fewer than five employees face administrative costs that absorb as much as forty cents of every premium dollar, compared to about five cents for larger companies - one reason why many small businesses do not have health insurance.

The sheer number of insurance companies and health plans also adds costs. Hospitals, clinics, doctors and other health providers must deal with hundreds of different insurance plans, each with its own benefit package, exclusions and limitations - and mountains of forms, rules, rates and payment procedures to follow. Each insurance carrier, federal program and type of policy - be it health insurance, auto insurance, or workers' compensation - has its own requirements. Hospitals have been forced to establish whole departments, create new occupational categories and hire special clerks to handle the paperwork.

In an attempt to control costs and improve quality, private insurance companies and government programs require doctors and other professionals to seek approval before providing treatment, and submit case records for reviews.

For example, a government program or insurance company considering a $30,000 hospital bill has no direct knowledge of the case or the services delivered. Reviewers want evidence that the care was necessary, that it was delivered, and that the bill is accurate and justified. Every doctor's office and hospital must hire staff to document every service delivered, enter record codes, send out bills, and process other paperwork. They must determine whether an individual qualifies for health coverage, which company carries the primary policy, whether the services are covered, whether another policy covers the same care, how much each company is willing to pay, and how forms need to be filled out. Those staff then spend hours on the telephone with insurers arguing about what's covered and what's not. In many cases, these steps are only the beginning; receiving payment can take weeks.

Doctors, nurses and other professionals feel frustrated by bureaucracy, and worry that outside controls compromise their ability to make decisions about treatment. The relationship between doctors, nurses and their patients cannot help but be strained when the "hassle factor" and paperwork drain time and

energy away from the delivery of care.

Rising Costs

Between 1980 and 1992, American health care spending rose from 9 percent of Gross Domestic Product (GDP) to 14 percent. Without reform, spending on health care will reach 19 percent of GDP by the year 2000. If we do nothing, almost one in every five dollars spent by Americans will go to health care by the end of the decade, robbing workers of wages, straining state budgets and adding tens of billions of dollars to the national debt.

American workers already feel the impact of rising health costs in their paychecks. Had the proportion that health care makes up of workers' wages and benefits held steady since 1975, the average American worker would be making $1,000 a year more today. If current trends continue, real wages will fall by almost $600 per year by the end of this decade.

For every American family and business that purchases health coverage, the real cost of health care is substantially higher than most of us realize. We pay insurance premiums, deductibles (the amount we pay each year before insurance kicks in), plus whatever co-payments or co-insurance (the amount we pay that insurance doesn't cover) our policies require. And ll those payments include a hidden 10 percent surcharge - in the form of higher bills - to cover the more than $25 billion in care that hospitals and doctors provide every year to people who cannot pay. Finally, we pay a payroll tax to cover the cost of Medicare, and other local, state and federal taxes to support the safety net of public programs that help fill in the gaps.

For America's employers, these costs put us at a disadvantage in international competition. Health costs in the United States, for example, add about $1,100 - about twice as much as in Japan - to the cost of every car made in America.

Rising health care costs deal the same blow to government budgets that they do to workers, families and businesses. If current rates continue, health spending will consume as much as 111 percent of the real increase in federal tax revenues during this decade. The same holds true at the state and local level, where increasing demands for public spending on health care, threaten state budgets and drain resources. For the first time in our history, state spending on health care now outstrips spending on education. Health care will consume a third of projected real increases in state and local budgets during this decade.

Rapidly escalating costs are particularly threatening to the security of two population groups - Americans older than age 65 and the severely disabled - for whom we decided decades ago to extend health security under the Medicare program. But with growth in Medicare spending running 23 percent higher than the rate of inflation over the last decade, calls to cut Medicare have become commonplace.

The excessively high cost of health care is not the result of forces beyond our control. Other advanced countries provide coverage for all their people at lower and more stable costs and with higher levels of consumer satisfaction (and, in some cases, life expectancy). The American health care system consumes enough money to provide health security to every citizen and legal resident over time. As in other countries, the financial discipline needed to make care affordable can also keep health costs in line with the rest of the economy.

The fundamental problem in America is not that we spend too little for health care. It is that we don't get good value for the billions of dollars we spend. Much research has demonstrated the waste and inefficiency of the health care system - as any doctor, nurse, patient or consumer can verify. First, we train too few doctors who provide the basic health care that most Americans need. Second, we neglect the basics of good medical care - such as preventive services - while investing too much in expensive, high-tech equipment that sits idle. Experts also estimate that health care fraud drains more than $80 billion each year from legitimate needs.

The incentives built into our health care system have also led to striking variations in the cost and frequency of medical treatments.

"Solutions must be found for spiraling health care costs that are eroding the competitiveness of U.S. companies in international markets and causing lower wages, higher prices for goods and services, and higher taxes here at home."

Kenneth L. Lay, Chairman and CEO of Enron Corporation

Working at the Dartmouth Medical School, one research team compared how often patients covered by the Medicare program went into the hospital. The team discovered that elderly patients who lived in Boston were 1.5 times as likely to be sent to the hospital as those in New Haven. As a result, the average cost of

care for Medicare beneficiaries living in Boston was twice as high as for those living in New Haven. But the researchers found no evidence that Medicare patients were any healthier in one city than in the other.

Other studies have documented similar variations. A study published recently in The New England Journal of Medicine found that after adjusting for differences in age and sex, Medicare payments for doctor care for patients varied from $822 in Minneapolis to $1,874 in Miami - with no discernible difference in health to justify the difference in cost. The current system offers few incentives to probe why these variations occur.

After years of attempting to slow the frightening rate of increase in health care costs by tinkering with the existing system, it is clear that only comprehensive reform will work. Only a fundamental change of direction - a change that reduces the waste and bureaucracy and turns today's upside down incentives right side up - can bring about the savings needed to make the promise of security real. States and communities across the country are proving that it can be done; now we must set the entire nation on this positive course.

Decreasing Quality

While the American health care system features some of the world's best quality care, the constant improvements in quality are now threatened. Today, we have no clear sense of what treatments work best and which treatments should be used in different situations. And our neglect of preventive care means that we are not as healthy as we could be. Traditionally, Americans have assured medical quality by setting standards and then sending regulatory agencies to search for those who fail to meet them. In its oldest form, federal and state laws require health professionals and institutions to satisfy minimum criteria for licensing and certification. But while these procedures are necessary to protect consumers from substandard care, they have done little to improve quality or reward excellence.

Government and private sector regulators have written thousands of pages of rules governing everything from the qualifications of nurses' aides to the square footage of hospital rooms. Review agencies require doctors, nurses and hospitals to document each step in treatment and scrutinize case records. For many health professionals, quality assurance has come to mean nothing more than outside reviewers poring over records in search of errors. Too often quality programs just

mean interference and punishment. _____

"The duplication of documentation, the authorization forms, the insurance claims forms and all of the complicated and often more contradictory instructions devised by the more than fifty insurance plans we accept are all overwhelming." Dr. Lillian Beard Pediatrician Children's Medical Center Washington, D.C.

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Traditional quality systems have not produced the information that would be most valuable to doctors, nurses or consumers. Doctors and health care managers are frequently unaware of what happens where they work - for example, how often surgeons perform various operations, at what costs and with what results. They are even less likely to know how their performance compares to that of other professionals in the same community, much less across the country.

Since doctors and hospitals don't know how they measure up, patients are in the dark on most medical decisions, unaware of risks and benefits of alternative treatments or settings. Information that would allow them to make meaningful comparisons does not exist. Making this information available would give consumers a way of knowing that the care they receive is high quality and cost-effective.

Declining Choices

Free choice of doctors and other health care providers cuts to the core of the American health care system and the center of the doctor-patient relationship. For patients, the ability to keep seeing their doctor - someone familiar with their medical history and their family - can mean the difference between a good experience and a frightening one, sometimes even the difference between successful and poor outcomes. Perhaps no issue is more important to patients.

But today even patients who have good private coverage increasingly have restricted choices. Almost every practicing doctor has had patients call the office upset because they had to transfer to another physician when their employer or a job change caused them to switch them to insurance carriers. And doctors often find themselves discouraged from joining all the health plans in which they want to participate, separating them from some of their patients.

Faced with rising costs, many American employers increasingly limit the health care choices workers once took for

granted. Today only one in three companies with fewer than 500 employees offers its workers a choice of health plans. Increasingly, the one plan available may limit choice of doctors, often disrupting valued relationships.

In one other sense, choices are limited in today's health care market. When the elderly or disabled need long-term care, they generally have only one place to go if they want coverage: the nursing home. Despite the fact that many would rather receive care in their homes and communities --- a choice that is usually less expensive than institutional care --- they are blocked from using federal health care dollars for such care. These peculiar rules and wrongheaded incentives single out for punishment those groups that deserve the security of guaranteed care.

Growing Irresponsibility

Irresponsible behavior in our current system begins with those who profit the most: insurance companies that search for only the healthiest people to cover while excluding the sick and the elderly; and pharmaceutical companies that sometimes charge Americans three times what they charge citizens of other nations for prescription drugs. The medical malpractice system also fosters irresponsible behavior. Although the direct costs of medical malpractice are not great - experts estimate that they account for no more than 2 percent of health care spending - the threat of frivolous lawsuits breeds distrust and fear among doctors and other health providers. Procedures that doctors and hospitals perform to protect themselves from lawsuits adds billions more in "defensive medicine" to our bills. This lack of responsibility can be seen throughout the system. Many people pay nothing for their health care, and in turn, contribute to skyrocketing costs. In the United States people who have no health insurance or who have inadequate coverage still receive care - but often it's the most expensive type of health care delivered in the most expensive place: the emergency room. Doctors, hospitals and clinics are forced to pass those costs along to everyone else - leading to what's known as "cost shifting" - which contributes to rapidly rising health spending.

Take the example of two businesses in a small town, a gas station and a car wash. Ever since he opened his business, the gas station owner has provided good health insurance coverage for his employees. Down the street, the owner of the car wash wants to provide insurance coverage, but he does not because he can't get a reasonable rate from an insurance company.

Not having health insurance doesn't protect the employees of the car wash from injury, of course. So when one of them gets hurt in an accident, he or she goes to the emergency room. The doctors provide treatment and the hospital sends the bill knowing full well that the patient cannot pay all or, in some cases, any of it. In turn, the hospital raises its rates for other patients to make up the difference. In effect, the gas station owner and his employees are paying for the health care of the car wash owner and his employees.

The bottom line is simple: every American pays when a company or individual fails to assume responsibility for health coverage or when insurance companies price people out of the market. Those who pay for health coverage end up paying for those who can't or don't. Restoring responsibility is vital to providing health security for every American.

An American Challenge

Like a patient denying the symptoms of serious illness, for decades America has put off confronting the crisis in health care. Comprehensive health care reform has long seemed so formidable, complex and costly that we have denied the threat that continuing on the same course poses to our own lives, the lives of our children, and the course of our nation.

The cost of doing nothing far outweighs the cost of reform. One of every four Americans stands to lose health coverage at some point in the next two years. By the year 2000, one of every five dollars earned by Americans will go to health care. The average worker will sacrifice more than $600 in annual wages to pay for health care coverage. Rising costs will force firms to cut back further on benefits and scale back choices.

Despite its many achievements, America's health care system is threatening millions of people each year, undermining security, the ability to compete, and economic strength. The challenge of health reform is to alter that course, to reverse the harm while improving the quality of care, to replace fear with guaranteed security.

Chapter 2 -- PRINCIPLES OF REFORM

"Some things, like universal access, are not negotiable. And

that's exactly the way it should be."

Former Surgeon General C. Everett Koop, M.D. September 1993

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Six principles underlie the Health Security Act: security, simplicity, savings, quality, choice and responsibility.

SECURITY

Guaranteeing comprehensive benefits to all Americans.

1) The Health Security Act guarantees all Americans comprehensive health benefits, including preventive care and prescription drugs, and ensures they can never be taken away.

2) The Health Security Act outlaws insurance company practices that hurt consumers and small businesses. Insurers will not be able to deny anyone coverage or impose a "lifetime limit" on people who are seriously ill. And the plan outlaws charging older people more than younger people, and sick people more than well people.

3) The Health Security Act sets limits on what consumers pay for health coverage. It limits how much health care premiums can go up each year, and sets maximum amounts that families will spend out-of-pocket each year, regardless of how much or how often they receive medical care. The Health Security Act removes "lifetime limits" on coverage, ensuring that benefits will always continue, no matter how much care you need. 4) The Health Security Act will preserve and strengthen Medicare, adding new coverage for prescription drugs. A new long-term care initiative will expand coverage of home and community-based care.5) Access to quality care will expand, so that people know that there will always be a doctor that they can get to and a hospital that will treat them. Particular attention will be paid to the needs of underserved rural and urban areas.

SIMPLICITY

Simplifying the system and cutting red tape.

1) The Health Security Act reduces paperwork by giving everyone a Health Security card and requiring all health plans to adopt a standard claim form to replace the hundreds that exist today. 2) The plan cuts insurance company red tape by creating a uniform, comprehensive benefits package, standardizing billing and

coding, and eliminating fine print.

SAVINGS

Controlling health care costs.

1) The Health Security Act increases competition, forcing health plans to compete on price and quality, instead of on who does the best job of excluding sick people or old people. Health plans will have an incentive to provide high-quality care and control costs to attract more patients.

2) The plan strengthens buying clout by bringing together consumers and businesses in Rhealth alliancesS to get good prices on health coverage. Today big businesses use their clout to get low prices; alliances will allow consumers and small businesses to get a good deal, too.

3) The plan lowers administrative costs by cutting paperwork and simplifying the system.

4) The plan places limits on how much premiums can rise, acting as an emergency brake to ensure that health care costs donUt spiral out of control.

5) The Health Security Act criminalizes health-care fraud, including overbilling, and imposes stiff penalties on those who cheat the system.

QUALITY

Making the world's best care better.

1) The Health Security Act arms doctors and hospitals with the best information, latest technology and feedback as it empowers consumers with information on quality Q forcing health plans to compete on quality in order to attract patients. 2) The Health Security Act also invests in new research initiatives -- into new ways to make prevention work, new treatments, and new cures for diseases.

3) The Health Security Act emphasizes preventive care -- putting a new emphasis on keeping people healthy, not just treating them after they get sick. The comprehensive benefits package pays fully for a wide range of preventive services not covered by most insurance plans today. And it builds a stronger health care work force -- training more primary care doctors, nurses and other health professionals to provide care into the

next century.

CHOICE

Preserving and increasing the options you have today.

1) The Health Security Act ensures that you can follow your doctor and his or her team into any plan they choose to join.

2) All Americans will be able to choose from at least three and likely many more kinds of health plans offered -- no matter where they work. The choice of plan will be yours -- not your employerUs. And every American will be able to switch plans every year if they're not satisfied with their care or service.

3) The Health Security Act makes it possible for more elderly and disabled Americans to continue to live in their homes and communities while receiving long-term care.

RESPONSIBILITY

Making everyone responsible for health care.

1) Without setting prices, the Health Security Act asks drug companies to take responsibility for keeping prices down.

2) To discourage frivolous medical malpractice lawsuits the plan requires patients and doctors to try and settle disputes before they end up in court, and it limits lawyers' fees.

3) Everybody -- employers and employees alike -- will be asked to pay something for health care coverage, even if the contribution is small. Low-wage small businesses and workers will get substantial discounts, but everyone must take responsibility. Chapter 3 -- HOW THE NEW SYSTEM WORKS

How Reform Will Affect You

After health reform goes into effect, every American citizen and legal resident will receive a Health Security card. Once you get your card, you will never lose your health coverage -- no matter what. If you get sick, you're covered. If you change jobs, you're covered. If you lose your job, you're covered. If you move, you're covered. If you start a small business, you're covered. The card guarantees you a comprehensive package of benefits that can never be taken away. Those benefits are as comprehensive as the ones that most Fortune 500 companies offer their employees. The package includes doctor and hospital care,

as most insurance plans do, and also covers prescription drugs and a host of other services. [See chapter 4] You will also receive something rarely found in today's insurance plans -- preventive care.

No matter which plan you choose, you will also receive something. The plan will pay 100 percent of the costs for a wide range of preventive care services, including prenatal care, well baby care; immunizations; disease screening for adults, such as mammograms, Pap smears, and cholesterol tests; and health promotion programs, like stop-smoking classes and nutrition counseling.

You will be able to choose your doctor. Every American will have a choice of health plans -- and plans will enroll everyone who applies, regardless of age, occupation or medical history. While prices will vary among plans, each health plan will charge everyone the same price for the guaranteed, comprehensive benefits package. Employers or insurance companies won't decide how or where or from whom individuals get their care -- you, the consumer, will decide. You will be able to follow your doctor into a traditional fee-for-service plan, join a network of doctors and hospitals, or become a member of a health maintenance organization (HMO). For older Americans, the Medicare program will be preserved and strengthened with new coverage of prescription drugs. There will also be expanded options for home and community-based long-term care.

Like today, almost all of us will be able to sign up for a health plan where we work. Brochures will give you easy-to-understand information on several health plans -- the doctors and hospitals involved, an evaluation of the quality of care, and prices. There will be regular "report cards" that measure quality and consumer satisfaction for each plan. Once a year, consumers will have a chance to choose a new plan. If you are not satisfied with your care or service, you can "vote with your feet" and pick a new plan, something most people can't do today.

If you're self-employed or unemployed, you can sign up through the health alliance in your area by phone or through the mail. Alliances, run by boards of consumers and local employers, will contract with and pay health plans, guarantee quality standards, provide information to help consumers choose plans, and collect premiums. They will, in effect, take on roles similar to major corporate benefits offices. The largest national corporations -- those employing 5000 workers or more -- have the option of continuing to self-insure their employees or joining regional alliances. For the consumer, particularly

people who work, the local alliance will be largely invisible. It will help you get good prices on insurance, but you'll still sign up for health care at work. In order to get care, most people will do what they've always done -- go to the same doctors, hospitals, pharmacies, or other providers. More providers will organize into "networks" -- groups of doctors, nurses, hospitals, and labs that cooperate together to coordinate the care of their patients and control costs. Once you've picked a plan, if you need to go to the doctor for a check-up or if you get sick, you'll simply take your Health Security card, show it at the doctor's office, and they'll take care of you. Then you'll fill out one standard form, and you're done. So when you get sick, you won't be buried in forms -- and neither will your doctor or hospital.

Unless your employer chooses to pay your entire premium, you will contribute about 20% of the cost. Your share of premiums will be deducted from your paycheck, the same way most people pay now. If your employer wants to pay the full cost of your premiums, that will always be an option. In addition, individuals will pay limited co-payments or deductibles to their health plans as part of their coverage. People who are either self-employed or unemployed, but still can afford to contribute, will send in a monthly check for insurance. (See charts at the end of the chapter.)

Today, most businesses offer health coverage to their workers. For these businesses, health care reform which provides universal coverage will mean a tremendous benefit. No longer will these businesses bear the costs of other businesses and their employees -- through higher premiums and higher taxes to pay for people without coverage, or by covering spouses working for other businesses. And no longer will premiums continue to rise out of control. This will mean that businesses will be more competitive and be able to create more jobs.

Currently, health care costs represent an increasingly large financial burden for businesses of all sizes. Firms now pay as much as 20 percent of their total payroll just to provide health care coverage for their workers. Under the Health Security Act, no business will ever pay more than 7.9 percent of their payroll for health insurance.

"Successful implementation of health care reform is one of the best pieces of news American business could receive."

Henry AaronHealth Economist, Brookings Institute

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Small Business in the New System

Today's health care system is stacked against small business owners, their families and employees. Small businesses, who are too small to have benefits departments, are burdened by high administrative costs -- as much as 40 cents of every dollar of their premiums -- compared to only 5 cents for large companies. They are charged higher premiums because they don't have the bargaining power that large companies do to get the best prices from insurance companies. And they are the most vulnerable to sudden rate hikes if even one employee gets sick.
Despite these obstacles, most small businesses -- particularly those with more than one or two employees -- do provide insurance for their workers. And most of those that do not cover their employees want to provide insurance but find it impossible in a health care system that discriminates against them.

The Health Security Act creates a level playing field that will finally allow small businesses to provide affordable coverage for their employees without being discriminated against because of their company size. The Wall Street Journal has said that the Health Security Act will be "an unexpected windfall" for many small businesses that currently provide insurance to their employees. These companies will likely pay substantially less under reform -- because of lower premiums and reduced administrative costs. And those small businesses who are charged far too much today to provide a "bare-bones" package for their families and employees will finally be able to afford to provide a comprehensive benefits package -- in many cases without spending much more than they currently pay for less coverage today. The Health Security Act will level the playing field for small businesses in the following ways:

* Small businesses will no longer face outrageous administrative costs because they will join together to get the same benefits -- in terms of bargaining power and administrative simplicity -- that big businesses have today.

* Small businesses will be charged the same rate as large businesses to provide coverage to their workers.

* Small businesses that now provide insurance will see their

premiums decrease when they no longer have to pay for uninsured workers.

* The Health Security Act will outlaw insurance company practices -- ranging from price gouging to refusing to insure entire industries -- that make it impossible for small business owners to get insurance today for their families or employees.

* Reform will also streamline the workers' compensation system -- which is a never-ending source of frustration, fraud, and high costs for small businesses today.

* Self-employed Americans will now be able to deduct 100% of their premiums -- instead of the 25% allowed by law today.

Discounts for the Smallest Companies

Those small businesses that provide no health coverage today will have to help pay for their employees' health care. The Health Security Act is specifically designed to protect small businesses and help them make the transition to a system that guarantees their families and employees the health security they deserve. Those low-wage businesses with 75 or fewer employees will receive substantial discounts on the price of insurance, depending on the size of the company and the average wage.

* For the smallest firms that pay the lowest wages -- such as restaurants -- the percent of payroll devoted to health care may be as low as 3.5 percent. That amounts to $350 a year for a company with average wages of $10,000 -- or less than $1 a day per employee.

* These discounts apply to most small businesses with less than 75 employees, even those that currently provide health insurance to their workers.

* The vast majority of small businesses -- especially the "Mom and Pop" firms that are so vital to the American economy -- will find that the savings they reap in the cost of health insurance for their own families will substantially offset any new spending required to cover employees.

An Overview of the New System

The Health Security Act rejects the idea of a government-run health care system. Health care will remain rooted in the private sector. Most people will get insurance through their

employers, as nine out of ten people do today. The plan achieves universal coverage and recognizes that some direction from the government -- including asking everyone to pay their fair share -- will be necessary to achieve that goal. But it leaves the tasks of delivering care and controlling costs to the private market. The Health Security Act seeks to build on what works best in the American economy and fix what is broken. What works best is a competitive market that provides products and services to Americans at the highest quality and lowest price.

But the competitive power of the market is not working in today's health care industry. Today, insurance companies compete not on the basis of price and quality, but by excluding people who might become sick.

The system is also broken in another fundamental way: small and mid-sized businesses, the self-employed, and average American families are powerless to bargain with insurance companies. Today, only big business has the clout to negotiate lower prices. The little guy -- the local hardware store, the entrepreneur, the young family -- ends up getting stuck with high prices and excessive cost increases.

The Health Security Act seeks to fix these problems so that all Americans benefit from a truly competitive health care marketplace. First, the Health Security Act outlaws insurance company discrimination based on age, sex, or medical condition. Instead, it makes insurance companies compete based on how well they cover all of us, and not how well they exclude some of us.

The Health Security Act joins consumers and small businesses together in health alliances so that they can have the same bargaining power that the largest companies get. After reform, every American will have bargaining strength to get low prices and high quality care.

For the first time, consumers will be in the driver's seat when it comes to finding quality health care. Health plans will be forced to compete on providing the best care at the most affordable prices. This will provide incentives for everyone in the health care business to operate more efficiently -- incentives that don't exist today.

Flexibility

Realizing the goals of the Health Security Act requires that we build in flexibility. National reform establishes a framework within which states and local communities make their

own choices. Americans cannot, and need not, come to one vision of the single best approach to health care.

Consequently the pace of reform will vary across the country. Some states are already well along in addressing the need for health reform. Some have served as models, forging paths that other states will follow as they implement reform. Under the Health Security Act states will begin implementing reform in 1996, and all states are to begin implementing reform by the end of 1997.

Reflecting the geographic diversity of our nation, the Health Security Act allows for each state to tailor health reform to its unique needs and characteristics as long as it meets national guarantees and standards for quality and access to care. Certain states, in fact, may choose to set up a single-payer system, where one agency collects and distributes all health care dollars for that state. Flexibility is essential because we know that what works in North Dakota may not work in North Carolina.

Although the Health Security Act establishes a national framework to achieve the goals of reform by spelling out standards and the comprehensive benefits that every American must receive, it does not prescribe how to deliver care or organize services. It leaves those decisions to consumers, doctors, nurses, hospitals and managers of health plans, rather than to the government. The Health Security Act establishes protection at the national level to ensure security -- the solid foundation upon which American communities are free to build. Then it gets government out of the way to allow the reformed, private market to work. Chapter 4 -- SECURITY

"Six months ago, my sister-in-law, Pam, had a disabling stroke. Pam is only 39 years old, and she's a severe diabetic. Six months have passed, her short-term memory has deteriorated, her vision is leaving, and it looks as if my brother will either have to hire someone to come into their home full time to care for her, or put her in a nursing home, which his medical plan does not cover.

My brother's attorney has advised him to divorce Pam so that her medical bills don't pull him into financial ruin. My brother has two young sons that he's caring for and in order to continue to provide for them, he is giving this consideration...

A man who loves his wife must divorce her so that her misfortune

(in sickness and in health) does not leave him with the inability to raise their family."

A.P. Toledo, Ohio _____

Americans buy health insurance to provide security for themselves and their families. Security, in its full sense, is what health care reform must give us all. We must be secure that no American will face exclusion from coverage because of illness, occupation or age. We must be secure that health benefits will be comprehensive enough to keep us healthy and cover our health care needs throughout life.

Comprehensive Benefits

Under the Health Security Act, all American citizens and legal residents will be guaranteed a comprehensive package of health benefits that can never be taken away. They will receive a Health Security card entitling them to enroll in a health plan.

Everyone will have a choice of at least three -- and, in most communities, many more -- health plans. And no matter which plan people choose, they will receive the comprehensive benefits package.

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Sidebar - Pg 34-35

Covered Benefits

Benefits covered under the nationally guaranteed comprehensive package carry no lifetime limits. The package covers the following health services when they are medically necessary or appropriate: * Hospital services, including bed and board, routine care, therapeutics, laboratory and diagnostic and radiology services and professional services. * Emergency services. * Services of health professionals delivered in professional offices, clinics and other sites. * Clinical preventive services. * Mental health and substance-abuse services (for details, see box on mental health and substance abuse). * Family planning services. * Pregnancy-related services. * Hospice care during the last six months of life. * Home health care, including skilled nursing care,

physical, occupational and speech therapy, prescribed social services and home-infusion therapy after an acute illness to prevent institutional care. * Extended-care services, including inpatient care in a skilled nursing home or rehabilitation center following an acute illness for up to 100 days each year. * Ambulance services. * Outpatient laboratory and diagnostic services. * Outpatient prescription drugs and biologicals, including insulin. * Outpatient rehabilitation services including physical therapy and speech pathology to restore function or minimize limitations as a result of illness or injury. * Durable medical equipment, prosthetic and orthotic devices. * Routine ear and eye examinations every two years. * Eyeglasses for children under age 18. * Dental care for children under age 18.

Planned Expansion of Benefits

Beginning in the year 2001, the nationally guaranteed benefits package will expand to include the following:

* Preventive Dental care for adults. * Orthodontia if necessary to prevent reconstructive surgery for children. * Expanded coverage for mental health and substance abuse treatment.

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The coverage provided by the comprehensive benefits package equals that provided by America's major employers, such as Fortune 500 companies. It covers a full array of clinical services, from doctors' offices, to clinics, to hospitals, to rehabilitation centers, to laboratories, hospices, home-health agencies and other professional offices. The comprehensive benefits package provides far more coverage for clinical preventive services than traditional insurance. It waives the usual co-payments and deductibles for a wide range of preventive services that are vital to keeping people healthy. Preventive services covered without co-payments include prenatal, well-baby and well-child checkups, physicals for adults, immunizations and regular screening tests such as mammograms and Pap smears. The Health Security Act particularly expands preventive services for certain low-income women and children. By fully funding the Special Supplemental Food Program for Women, Infants and Children (WIC), more families will be able to receive nutrition

counseling and get nutritious food -- part of the overall strategy for keeping people healthy rather than waiting until they get sick.

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Sidebar - Pg 36

Preventive services

The Health Security Act offers comprehensive coverage for a specific set of preventive screenings, laboratory tests and periodic checkups. Included in the benefit package, at no cost to the consumer, is coverage for preventive care such as immunizations and specific screening tests. Some preventive services will be targeted to groups that have a high risk for certain diseases, such as men considered especially vulnerable to cardiac problems and women with a close family history of breast cancer. Children will receive a full range of prevention services, including immunizations, well-baby checkups and developmental screenings at no extra charge.

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"We believe reform will enhance both medical security for the nation's 65 million children and peace of mind for their parents. We are especially impressed by the commitment of yourself and the First Lady to ensuring all children have access to appropriate health care, because it is such an important investment in the nation's future"

Lawrence A. McAndrews, President and CEO National Association of Children's Hospitals and related institutions. September 21, 1993 _____

The benefit package also expands traditional coverage of mental health and substance abuse treatment. Insurance companies often tightly limit their coverage of mental health; they adopt that policy partly because they depend on the public mental health system -- and the taxpayers who pick up the bills -- to serve millions of people who lack coverage for even basic treatment, or who suffer from chronic or serious illness. The Health Security Act eliminates the lifetime limits on mental illness that can devestate family savings; and it provides coverage for regular clinical visits, and offers more flexible care. For millions of Americans, the comprehensive

benefits package will provide a significant expansion of coverage. Those whose current benefits are more generous -- a much smaller number -- will have every right to continue receiving richer benefits. Nothing in the Health Security Act prevents employers from providing more extensive benefits, with no strings attached.

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Sidebar - Pg 38

Mental health and substance abuse

The Health Security Act offers Americans guaranteed coverage for mental illness and substance abuse, ending the agony that families confront when a serious mental illness occurs.

The benefit package gradually expands coverage for mental illness and substance abuse, both for inpatient and outpatient therapy. Out-patient services will include diagnostic office visits for medical management, substance abuse counseling, and relapse prevention. The benefit package also provides coverage for a wide range of new approaches, such as intensive care delivered outside the hospital. The Health Security Act eliminates lifetime limits on mental health and substance abuse treatments. Initially it contains limits on the number of days of inpatient and outpatient treatment, but it commits to removing those limits by the year 2001.

Types of services covered:

* Inpatient care * Alternative treatment programs which provide intensive care outside hospitals * Outpatient therapy with requirements for patients to share part of the cost. * Brief office visits and medical management for patients who take medication.

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Not everything is covered in the benefits package. It would just be too expensive. Examples of services that are not covered include: * Services that are not medically necessary or appropriate * A private room in a hospital * Adult eyeglasses and contact lenses *

Hearing aids * Cosmetic surgery

Individuals will be free to purchase supplementary insurance, although the comprehensive benefits package leaves little need for additional coverage. Employers are also free to offer additional benefits or absorb co-payments and deductibles.

However people choose to receive health care, the Health Security Act guarantees all Americans something no amount of money can buy in today's insurance market: the knowledge that they will always have comprehensive health benefits that can never be taken away -- no matter what happens in their lives or their jobs. If they lose a job or change employers, coverage will continue without interruption. If they move, get married, separate from a spouse, experience a catastrophic illness or confront any other crisis, their health coverage will continue uninterrupted.

Insurance Reform

The Health Security Act outlaws discriminatory insurance practices that prevent millions from obtaining health coverage today. It will return the concept of health insurance to its roots: offering protection to everyone whether they're healthy or sick, young or old. It will put an end to the practice of underwriting -- searching for only the healthiest people to insure. Under the Health Security Act, health plans will be required to:

* Enroll everyone who applies, whether they're healthy or sick, young or old; * Charge everyone the same price for the comprehensive benefits -- no more charging higher rates to sick people, older people, or people with pre-existing conditions; * Provide coverage without resorting to "lifetime limits" that cut off coverage when people need it most; and * Limit deductibles in fee-for-service plans to $200 for an individual and $400 for a family.

By establishing a uniform, comprehensive benefits package, the Health Security Act no longer makes it advantageous for insurance companies to shape benefits and policies that attract the healthy and avoid the sick. Health alliances, in turn, will help organize the private market so that consumers -- for the first time -- can compare plans and providers and make informed choices. Their mission will be to promote competition among health plans based on quality and price -- not on who can screen out sick patients. Limits on What Consumers and Businesses Pay

The Health Security Act also takes several important steps to protect families and businesses from rising health costs and financial ruin. To provide secure financial protection against the most devastating illnesses and injuries, it prohibits so-called "lifetime limits" and restrictions on the amount of medically necessary or appropriate care. The limits, which are included in six out of every ten insurance policies today, can mean bankruptcy for families in which catastrophic illness strikes. The Act also sets maximum annual out-of-pocket limits; even those who select the most expensive plans can spend no more than $1,500 a year for an individual, or $3,000 for a family. Insurance picks up the full cost of any medical care that exceeds those limits.

The Health Security Act also limits deductibles -- the amount people pay each year before insurance kicks in, which can run into the thousands today -- to $200 for individual's and $400 for families who choose traditional fee-for-service plans. Employers will pay a maximum of 7.9 percent of their payroll for health care. Small businesses -- those with fewer than 75 employees -- will receive discounts of between 30 and 80 percent, compared to what the average large business pays. And the self-employed will be able to deduct from their taxes 100 percent of their health care, up from today's 25 percent.

PROTECTING OLDER AMERICANS

The Health Security Act preserves and protects the Medicare program, providing older Americans with the health security they deserve. People covered by Medicare will see little difference in how, where or from whom they receive their health care, but they will receive new prescription drug benefits.
Americans eligible for Medicare will automatically receive the new prescription drug benefit -- which will cover drugs and biological products, including insulin, approved by the Food and Drug Administration -- when they enroll in the Part B benefit, which covers physician and other outpatient services. Under the drug benefit, there will be a $250 annual deductible for each person. Individuals on Medicare will also pay 20 percent of the cost of each prescription up to a maximum of $1,000 over the course of a year.

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Early Retirees

When Americans over age 55 find that health problems or other events require them to stop working, they often confront the worst possibilities in the current health insurance market: because of age, or medical conditions, individual coverage is difficult to obtain or very expensive. Under health care reform, American workers who retire between the ages of 55 and 64 will never have to worry about losing their health coverage.

Under the Health Security Act, individuals over age 55 who retire before they are eligible for Medicare will pay for their coverage like other people who do not work and will be eligible for discounts based on income.

When reform is fully implemented, at the end of this decade, early retirees will become eligible for greater discounts requiring them to pay only the portion of their insurance premium that they paid as employees, unless they have an annual income higher than $100,000 for an individual, or $125,000 for a couple.

To be eligible for this greater discount, early retirees will have to have worked for ten years, the same standard used for eligibility under the Social Security Act.

The coverage for early retirees in the Health Security Act will provide a major financial benefit to employers who traditionally cover the cost of retirees' health premiums.

Employers who wish to provide coverage for any or all of the retired employee's share of the premium or for cost sharing required by health plans will continue to do so, as they do today.

When they reach age 65, retired workers have the choice of staying in their health plan or enrolling in Medicare, just as they do today.

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Part B premiums will increase about $11 a month to cover 25 percent of the cost of this new benefit. But for seniors who have Medigap policies, which cover services not provided by Medicare, premiums for those policies should decline since they will no longer cover prescription drugs. As Americans enrolled in health plans through alliances turn sixty-five, they can choose between remaining in their health plan or entering the Medicare system. Older Americans will also see

their long-term care options expand and improve under health care reform. The Health Security Act creates a new home and community-based care program and expands the range of choices for disabled individuals who require long-term care.

Among other things, the Health Security Act will:

* Expand home and community-based services; * Improve Medicaid coverage for people in nursing homes; * Improve the quality and reliability of private long-term care insurance and provide tax incentives to encourage people to buy it; and * Provide tax incentives to help people with disabilities work.

ACCESS TO CARE IN RURAL AND URBAN AREAS

The challenges of guaranteeing health security in rural and inner-city communities are essentially similar: both include unusually high numbers of people without health insurance, making it difficult to attract doctors. Scarce economic resources create barriers to organizing effective networks of care.

Greater incidence of poverty aggravates health problems. Many people in these areas require special services -- rides to the doctor, babysitting and translators, just to get access to health care services.

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Long-Term Care

Beginning in 1996, a new home and community-based care program will enable older Americans with severe disabilities to remain in their own homes or with their loved ones, yet still receive the care and assistance they need.

Medicaid nursing home coverage will be enhanced, allowing nursing home residents to keep $70 per month for living expenses. States will have the option to provide even greater financial protection by allowing individuals to retain up to $12,000 in assets, instead of today's $2,000.

The Health Security Act also provides tax incentives to encourage people to buy private long-term care insurance that meets new standards, and tax incentives to help individuals with

disabilities to work.

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Although urban and rural areas have some of the same problems, the circumstances that cause them are often very different. In rural areas, geography is the main obstacle. With a relatively small population spread over a large area and health care professionals in short supply, patients often have to travel long distances to see a doctor. Doctors are reluctant to practice in rural areas because they have no help or support from peers. Without enough doctors, nurses and health facilities, building networks of care becomes more difficult, as does the task of attracting enough health plans to foster competition. In inner-city communities, the challenge is almost the opposite: crowded cities with culturally diverse populations. Only a few blocks away from world famous academic health centers, residents of low-income neighborhoods contend with a laundry list of health care problems too few doctors and nurses; little or no access to culturally-sensitive care; high rates of infant mortality and low-birthweight babies; frequent violence; and serious health epidemics such as AIDS.

To serve both communities, the goals of health care reform are similar: increase the economic base for health care through universal coverage, provide discounts to make care affordable, and create incentives to attract health care providers to the area. The Health Security Act includes new loan programs and investments to increase the level of service available in underserved urban and rural areas. Expansion of the National Health Service Corps will send new physicians and other health professionals into underserved rural and inner-city communities, substantially increasing the supply of doctors and nurses. Successful programs, such as community and migrant health centers, will expand to increase the number of places where people can find care.

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THE MAYO CLINIC A Model for Reform

If you went searching for the highest-quality medical care in the world, you might not immediately think to head to rural Minnesota. But there in Rochester, you'd find the Mayo Clinic, a magnet for patients all across America.

The largest managed care practice in the United States, the Mayo Clinic is known worldwide for its effectiveness at diagnosing and treating illness, and for the excellent physicians who work there. And they've proved that you can control costs and provide top-flight care, holding cost increases well below national averages.

The Mayo Clinic has led the way in encouraging the development of networks of doctors in rural areas, and linking rural physicians and regional health centers in order to increase the availability of high-quality care. These kinds of rural networks serve as the cornerstone for the Health Security plan's strategy to make care more available for residents of rural and remote areas.

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A new program of federal grants and loans will support doctors and hospitals in rural and inner-city communities form their own networks and compete with other health plans. This program will link federally funded clinics with other community providers bolstering their skills to coordinate care, negotiate with health plans, and form their own health plans.

The Health Security plan -- by supporting the creation of new clinics and offices and renovating and converting existing clinics and offices -- will ensure more and better places to seek care in these areas. In addition, it will improve the level of care -- and reduce isolation -- for urban and rural residents. This will be done by linking members of the practice networks with each other and with regional and academic health centers through the development of more sophisticated information systems.

Two new programs will overcome barriers to care for hard-to-reach, isolated, or culturally-diverse populations. One will support school health services for adolescents. Another will support transportation, child-care, translation, outreach and follow-up services for those in need of care but who are not being served by current programs.

Hospitals, clinics, doctors and health professionals who traditionally serve in these areas are also eligible for designation as "essential community providers", gaining special protections during the implementation of health reform. To help these key providers adapt to the changes in the system after reform, the Health Security Act requires health plans to

contract with essential community providers for five years to enable them to continue to serve the residents in these rural and urban communities who depend on them.

Chapter 5 -- SIMPLICITY

"Each of our medical insurance policies requires separate and different applications for reimbursement, each of which have to be mailed to different addresses. This mountain of paperwork places an undue burden on older Americans . . ." J.H. Venice, Florida _____

In order to simplify American health care, we must move forward on two fronts. First, we must reduce paperwork by adopting standard insurance forms and clarifying administrative rules. Second, we must strip away the unnecessary layers of regulation and oversight as we hold health plans and providers accountable for results. Streamlining administrative burdens will make our system less daunting and frustrating for consumers and more supportive and flexible for the doctors, nurses, and hospitals on the front lines.

REDUCING PAPERWORK

Guaranteeing all Americans health coverage and establishing a uniform, comprehensive set of benefits represent the first, vital steps toward simplifying health care. If all Americans have guaranteed coverage for comprehensive health benefits, then doctors, hospitals and clinics have less paperwork to do when a patient walks in the door. Doctors, nurses and other health professionals will no longer have to worry which patients are covered for what services. Patients no longer will have to deal with confusing sets of insurance requirements, and will no longer be stuck with huge medical bills because they didn't read the fine print.

The Health Security Card that every citizen and legal resident receives will guarantee that health coverage travels with you as circumstances change, whether you switch jobs or move to another state. Like the cards that activate bank-teller machines, a magnetic strip will provide basic registration information, including identifying the health plan in which you are enrolled. A personal identification number will authorize access to insurance information, reducing the process of registering and billing, but maintaining your privacy.

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Protection of Privacy

The Health Security Act establishes the first national privacy protection laws specifically aimed at protecting the medical records of patients.

Under reform, new security standards will protect computer information, ensuring that medical records will be available only to health professionals who have a legitimate need to see them. For example, the bill clerk in the hospital's financial department won't have access to medical information. This is an assurance that few insurers, or hospitals, can offer consumers now.

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The Health Security Card will not be a "smart card" -- which carries information in a computer chip -- a national identification card, or a credit card. It does not hold sensitive information such as medical records. It's simply a way to streamline the billing process, reduce paperwork for doctors and patients, and assure people that they have a comprehensive set of benefits that can never be taken away. All health plans will adopt a standard form that providers file for services. Replacing the hundreds of different claim and billing forms and codes insurance companies use today will allow health professionals to collect and send the same information to all health plans and alliances. Uniform claim forms will reduce the work that doctors, nurses, and hospitals must do and save an estimated 75 cents for each claim. In the long run we will save billions of dollars and free health professionals to spend more time caring for patients.

Today, different types of insurance often overlap, causing confusion, duplication, and waste. Under the Health Security Act, the health care portion of both workers compensation and auto insurance will be covered through regular health insurance. The need to coordinate benefits will decline and small businesses will be rewarded with less confusion and lower administrative costs.

CUTTING RED TAPE

Simplifying health care also requires aggressive steps to reduce unnecessary regulation. The Health Security Act frees hospitals and other health care institutions from excessive regulations. The federal government will develop national standards for quality which will use them as the basis for licensing hospitals and other health care institutions.

Today, dozens of public and private agencies, inspectors and outside groups inspect hospitals every year to make sure they meet quality standards. Although they all check the same things, they make their visits separately, and hospitals must spend time and money preparing for each visit. Under the Health Security Act, these groups will coordinate their visits, reducing preparation and follow-up time. Rather than routinely examining every hospital each year, inspections will concentrate on institutions with poor histories, following up on complaints and responding to problems.

To reduce frustration and delay, all health plans will have to make clear to participating consumers and doctors precisely how they perform "utilization review" -- how the plan determines whether appropriate and effective care was given. Health professionals and industry groups will establish new performance standards, eventually reducing reliance on obtrusive methods of control. Chapter 6 -- SAVINGS

The Health Security Act creates a new framework that will ensure all Americans secure, affordable coverage -- and ensure that we spend our health care dollars wisely. Serious health care initiatives must take aim at the waste, inefficiency, and fraud that bloat our health care system. But the key to achieving the savings that lie at the heart of health reform is to release the American spirit of competition.

Competition, after all, drives the price and quality of most products we buy. Think about a car -- different companies build their automobiles, set their prices, and try to win our business. We shop around, kick the tires, make comparisons. Magazines like Consumer Reports help us judge what we can't see -- safety records and the satisfaction of those who've driven a particular model. Armed with information, we take our pick. We buy the car that best meets our needs for quality, performance, and price.

Health care has never worked that way. Consumers often

haven't had any bargaining power, they haven't had good choices, and they haven't had good information to make comparisons. Bringing competition to health care will give consumers the same buying clout in health care they've always had in other arenas. The Health Security Act will improve quality and control costs. Bringing about savings also requires action on several fronts. Savings requires changing incentives. Savings requires streamlining and simplifying regulations and requirements. And it requires taking aggressive steps to stamp out health care fraud, which drains $80 billion each year from real health needs.

INCREASING COMPETITION

The Health Security Act controls rising costs primarily through the power of a competitive market -- empowering consumers to make choices and giving health plans the incentive to compete for their business. Reform will change incentives so that health plans compete on the basis of quality, service and cost -- not on screening out sick patients. Physicians, hospitals and other health professionals will be given opportunities to shape a health care system that works for patients.

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Sidebar - Pg 55

CONTROLLING PRESCRIPTION DRUG PRICES

In the 1980's, the prices of prescription drug prices rose at quadruple the general rate of inflation. In recent years, several attempts have been made to control drug costs -- often involving the use of buying clout to bring down prices.

For example, HMOs and managed care groups are successfully using their bargaining power to negotiate substantial discounts from drug companies. Because they often control the brand of drugs prescribed by doctors, health plans have the power to drive down prices.

Under reform, with the addition of prescription drug coverage, Medicare will become the world's largest purchaser of drugs. And the Medicare program will use its negotiating power to get discounts from the pharmaceutical companies. In addition, with competing health plans trying to become more efficient, more and more buyers will use the same successful negotiating

techniques.

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Consumers will take their pick among health plans, based on what they have to offer. Which doctors are members of the plan? Are the offices and hospitals convenient? How much do they charge? Since all plans will offer the same comprehensive benefits, people will be better able to compare than they are today. Consumers will reap the savings from enrolling in health plans that deliver high-quality care most efficiently -- and, therefore, charge lower premiums. Better incentives for health plans will give consumers better value. In the current system, doctors and hospitals get paid extra for each service they perform, necessary or unnecessary. Under reform, health plans and providers make money by keeping their patients healthy -- not doing more tests, but giving better care.

It will be in the interest of each health plan to operate efficiently -- providing the best quality care at an affordable price. If health plans operate inefficiently, they will lose money. If they start cutting corners, they'll lose patients -- and the business that those patients bring. Competition is about finding the balance -- providing high-quality care while controlling costs.

STRENGTHENING BUYING CLOUT Increased buying clout can bring down costs. In today's health insurance market, for example, big companies can go to an insurance company and say, "Look, if you want the business of our 100,000 employees, you've got to give us a good deal." And they get a good deal -- comprehensive benefits, high-quality care and affordable prices. But if you don't work for a large employer you're not in a position to bargain, so you're more likely to get high premiums, bare-bones coverage or nothing at all. The Health Security Act will change that -- putting consumers and small businesses in the driver's seat. It's based on the simple idea that bigger buyers get better deals. By bringing consumers and small businesses together in health alliances, the Health Security Act gives everybody else the same buying clout as the big companies.

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CALPERS A Model for Reform

The state employees in California are getting a good deal on insurance -- using their buying clout to bring down prices and cut administrative costs.

Adopting a role similar to the one that health alliances will play under health reform, the California Public Employees Retirement System -- usually referred to as CALPERS -- negotiates with health plans on behalf of almost 900,000 state and local government employees and their families in California. And CALPERS offers its members a choice of 24 different plans. Prices for health plans vary, although all plans provide coverage for the same package of health benefits -- just as all plans will offer the same comprehensive benefits package under the Health Security Act.

Because they buy approximately $1.3 billion of health care each year, CALPERS -- like the alliances under the Health Security Act -- is in a strong position to get a good deal from health plans. Along with holding premium increases well below national averages for the last two years, CALPERS has also succeeded in reducing administrative costs.

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Today, a major insurance carrier doesn't have to give any kind of deal to the Mom and Pop store in Peoria. But they will not be able to ignore 5000 Mom and Pop stores brought together in an alliance from Central Illinois. That alliance will have more complete information on the costs of health plans, quality of care, service and consumer satisfaction than any buyer in today's market. It will keep enrollment records and collect premiums for many people, not just a few, and do it more efficiently as a result. Everyone -- not just employees of large companies -- will be able to get access to high-quality care at an affordable price. LOWERING ADMINISTRATIVE COSTS

The Health Security Act simplifies the business side of health care by cutting through the paper jungle generated by some 1,500 insurance companies, and stripping away conflicting regulations imposed by a variety of federal, state, local and private agencies. Administrative costs take up 40 percent of every health care dollar spent by small firms and the self-employed, with only 60 percent going to buy care. Meanwhile, large purchasers pay only 5 to 7 percent for administrative overhead; 95 percent of their health dollars go to care, as they should. For all private health insurance, the cost of administration totalled $44 billion in 1991, an average

of 16 percent of the benefits paid out.

"What the insurance industry burns up in commissions, marketing and claims processing costs is almost unspeakable. [President] Clinton would reduce those costs."

Professor Uwe Reinhardt Health Economist, Princeton University

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Similarly, eliminating some of the duplication among different kinds of insurance -- folding the health benefits of auto insurance and workers compensation into one unified health insurance policy, for example -- will produce savings. Today, doctors and hospitals often submit separate claims for payment to two or more insurers. Under the new system, everyone will have coverage, and most people will have one and only one source of insurance. Doctors and hospitals will no longer have to sort out conflicting coverage.

LIMITING PREMIUM INCREASES

The increased competition from health care reform will squeeze the waste and excess out of the health care industry that nearly every doctor, nurse, patient, consumer and insurance carrier knows exists. In order to reinforce the the competitive power of the market, the Health Security Act also creates an enforceable, fail-safe limit on the growth of insurance premiums. This limit reinforces the new incentives that slow the rate of growth in costs and acts as an emergency brake to back up competition. It serves to build in some discipline and certainty so that businesses and families will know their health care costs will not suddenly spiral out of control. It also ensures that the federal government is serious about living within its means. Once American consumers and employers have reaped the gains from savings, the limits on premium growth will be reassessed, based on experience under reform.

REDUCING HEALTH CARE FRAUD

The Health Security Act makes health care fraud a specific crime. The Act takes aggressive steps to combat health care fraud, increase penalties for those who cheat the system and expand enforcement activities. It imposes new prohibitions

against kickbacks and conflicts of interest, such as doctors who refer patients to laboratories in which they have a financial stake. And health care providers convicted of fraud and related crimes will be excluded from participation in health plans. The Departments of Justice and Health and Human Services will lead the anti-fraud effort, organizing an All-Payer Health Care Fraud and Abuse Enforcement Program to coordinate federal, state and local law-enforcement activities. The effort will target practices such as overcharging for services, charging for medical care that was never delivered, giving kickbacks to doctors who refer their patients to certain clinics or pharmacies, and delivering unnecessary services. If providers file false claims against health plans, their assets can be seized and criminal penalties for health care fraud can be imposed. The revenues from seized assets will be funneled back to support anti-fraud efforts.