M E M O R A N D U M

TO: First Lady Hillary Rodham Clinton February 4, 1993
FR: Chris Jennings
RE: Dole, Chafee Visit Following Senate Democrats Meeting
cc: Melanne, Steve R.

Following your Senate Democrats Meeting, you and your staff are scheduled to meeting with Senator Dole and Senator Chafee (R-RI), Chairman of the Republican Health Task Force. Steve Richetti has indicated that there may be others, in particular Senator Durenberger (R-MN).

ISSUES TO RAISE

* Consistent with the President's appointment of Senator Dole as one of the four lead Congressional health care representatives, will look forward to building on what you feel will be a close and productive working relationship.

* If there are problems, I want to know about it. I will be as responsive as possible. Based on our previous conversation, I know that this will be a two-way commitment.

* Will consult Senator Dole as frequently as possible. Interested in having a good relationship with not only Senator Dole, but with all Republicans committed to effective cost containment and universal coverage.

* Outline the structure and roles of Task Force and Working Groups. Omit ANY discussion of incorporation of staff into the work groups, however. (They should not know anything about the Democratic staff role at this time and we believe it is unwise to address unless raised by them).

ISSUES THEY MAY RAISE AND TO DANCE AROUND (as you have)

* They will suggest that the Administration needs Republicans to pass a bill and it would be best not to draw significant lines of destinction between the way Democrats and Republicans are treated.

* Raise questions about financing and how cost containment savings are allocated.

* Raise questions about legislative strategy, i.e. what will be timing and the likely legislative vehicle.

The Republican Health Care Task Force Proposal -- A Snapshot

Gradual universal coverage through an individual requirement

The Chafee proposal promises universal coverage by the year 2000. It mandates that all individuals purchase insurance, but has no requirement for employers to cover their workers. There are "vouchers" available for people who are low-income, phased in over 5 years. **If the program does not acheive the savings it envisions, the phase in would be slower, and universal coveage would take longer.**

Cost containment-- Medicare savings on the public side, weak on the private side

The Chafee proposal believes it can control costs by pooling small businesses into regional purchasing cooperatives and forcing plans to compete on quality and price, competition will bring about significant savings on the public side.

On the public side, the proposal caps Medicare and Medicaid at 7%, from a projected 12%.

Possible problems with this approach:

1. By making purchasing alliances both small (100 or fewer employees) and voluntary (no individual or employer must buy through an alliance), this proposal significantly weakens the bargaining muscle of the alliance, and their effectiveness in bargaining with plans.

2. Capping the growth of public programs without containing growth on the private side will further aggravate the "cost shift" that exists in the current system, and may weaken cost control efforts on the private sector side.

3. By making the pool voluntary, any employer that can get a better deal outside the alliance, or can keep their costs down by self-insuring, the pool left in the alliance may only be small employers with high risk, individuals, and subsidized people (who often have higher costs), and may have extremely high costs due to the adverse risks.

4. There is no portability-- the average person changes jobs 10 times in a lifetime, higher for people in small firms. If the pools are voluntary, workers will be in and out of plans, and may lose their work-based plan if they lose their job.

Cuts for senior programs with no new benefits

1. The Chafee proposal does nothing to help the millions of elderly Americans who want to remain at home in the community but can't get the care they need and are forced to move into nursing homes. While it does clarify tax treatment of long term care expenses and regulated private long-term care insurance, it doesn't support the long-term care seniors say they most want and need-- care at home. Nor does it strengthen the protections for Medicaid recipients in nursing homes, who are forced to spend down their assets to almost nothing before they qualify for help.

No clear guarantee of benefits

1. While the Chafee proposal does sketch out an outline for covered benefits, it does not say what specifically will be covered, nor what the level of cost sharing will be. It proposes two benefits packages-- one that is more broad, and one that is bare bones, with a very high deductible. It also leaves it up to the Board to cut back on benefits if the costs get too high-- so what you have this year, you might not have next. Americans can't be sure what they'll get, or what they'll be expected to pay.

Lets states go it alone

1. Chafee provides more latitude to states-- allowing them to set up basically whatever kind of system they want as long as a) costs in that state don't rise faster than in the rest of the country b) state plans generally cover the same percentage of people within the same timeframe as the national average c) the state plan is budget neutral to the federal government d) the state meets the federal quality and malpractice provisions, and provides similar benefits as the national plans. By contrast, the Clinton plan allows states to choose a single-payer option rather than a competitive/alliance structure,but allows no flexibility on insurance reforms, universal access, guaranteed benefits, cost control, or quality standards.

SUMMARY OF CHAFEE REPUBLICAN HEALTH PLAN

Overview

The current version of the plan establishes an individual mandate to purchase insurance coverage. Low-income individuals (up to 200 per cent of poverty) are assisted to purchase insurance by the provision of vouchers to help defray the cost of coverage. The vouchers are phased in according to a schedule established in the legislation, but only "as savings actually available". The program is financed by Medicare and Medicaid cuts and a tax cap. Insurance is provided to individuals and small businesses of fewer than 100 workers through health insurance purchasing cooperatives.

Universal Coverage

All Americans are required to obtain insurance conforming to the standards of a basic benefit package established by a national board according to parameters established in the legislation (benefit coverage is fairly broad, but specification of cost-sharing would be entirely left up to the board). A catastrophic coverage alternative will also be provided. No employer mandate is included in the bill, but large employers will be prohibited from dropping current coverage.

Vouchers will be provided to help low-income individuals meet the requirements of the mandate according to the following schedule: 1995 -- people below 90 per cent of poverty; 1996--120 per cent; 1997--140 per cent; 1998--170 per cent; 1999--per cent; 2000--240 per cent. As noted above, the availability of the vouchers is tied to the level of savings actually achieved. The intention seems to be to provide 100 per cent vouchers for people at the specified income levels if savings are achieved; if not, the vouchers will be provided at some per cent of the plan cost.

Financing

The document states that financing will be provided by reducing the growth rate in Medicare and Medicaid from 14 per cent per year to 9 per cent, and by a cap on deductibility. The specific cuts proposed in Medicare are:

Choice of plan will be by individuals, not by businesses. States will be allowed to establish competing HIPCs.

Topical outline

The topical outline of the plan is summarized below, including the provisions of the plan not described above.

I. Insurance market reform. Includes the standard insurance reform proposals, e.g., no pre-existing conditions, guaranteed acceptance, etc.

II. HIPCs.

III. Computerized, standardized and simplified information and data. A new Federal Administrative Standards Board will be established.

IV. Malpractice reform, including: mandatory alternative dispute resolution, limits on non-economic damages, limits on attorney's fees to 20 per cent of award, practice guidelines.

V. Individual mandate. Phased in based on the achievement of savings and the availability of low income vouchers.

VI. Larger employers.

VII. Tax cap. Cap applies to both the employer deduction and the employee exclusion.

VIII. State and Federal Certification of AHPs.

IX. Anti-trust reform.

X. Medicaid inclusion in the HIPCs. Phased-in according the recommendations of an HHS study.

XI. Ditto for Medicare.

XII. Low income vouchers, phase-in.

M E M O R A N D U M

TO: Hillary Rodham Clinton March 19, 1993
FR: Chris Jennings (CJ)
RE: Senator Chafee's statements on gun control
cc: Melanne, Kim Tilley, Steve R., Ira, Christine, Steve E.

Following up on your request, attached is a copy of Senator Chafee's complete April 30, 1992 Senate floor statement regarding guns and their impact on children, education, and health care. Also attached is a June 9, 1992 Washington Post Op Ed piece by Senator Chafee that nicely summarizes the much longer statement and outlines his intention to introduce legislation to ban the sale, manufacture and possession of ALL handguns.

Both statements cite a 1991 Advisory Council on Social Security estimate that concludes that the overall health care cost of firearm injuries (from initial emergency room care and accompanying hospital stays, amubalance services, follow-up visits, and rehabilitation) is more than $4 BILLION a year. Significantly, 86 percent of this health care treatment tab is underwritten by government sources. The dollars spent on each gun shot injury averages out, according to Chafee, to be approximately $16,700 per patient.

The two Chafee statements were faxed today to Congressman Reynolds' office. Judging from how quickly he was to jump to publicly recount your (personal and I thought private) general support of the concept behind his legislation (in particular, the provision to tax guns and ammunition), I am sure he will follow-up with your suggestion to hold a conversation with Senator Chafee.

STATEMENT BY SENATOR JOHN CHAFEE IN THE U.S. SENATE REGARDING GUNS AND CHILDREN, EDUCATION, AND HEALTH
April 30, 1992

On Tuesday, the Senate spent 4 hours debating the matter of whether or not to approve the minting of new coins. Yet on that day, as is the case every day, an average of 27 adults and children across the country were killed by handguns, and 39 went to the hospital to be treated for handgun wounds. Of these 39 patients, some will be permanently and severely disabled; others will go back to their homes and family, wondering what type of society they live in where handguns are so commonplace.

We have many demands, challenges, and problems facing the Senate and our nation; and we need to spend far more of our valuable time and resources focusing not on parochial or political matters, but on those which are the most critical to our national well-being.

Two among the most pressing issues before us stand out: 1) the need to improve the quality of our education; and 2) the need to reduce the costs of our health care. But tied inextricably to progress on both of these matters is recognition of the costs placed on each by our national firearms policy; and that is what I wish to spend some length of time discussing this afternoon.

If we hope to achieve progress on education, it is imperative that educators be able to spend their time and their resources on their principal task: educating our young people. Likewise, if we are to move forward on health care, it is critical that we ensure that our population is as healthy and fit as possible, and thus reduce the demands for expensive health care services.

Yet today, educators are distracted from educating, and pupils are distracted from learning, by the ever-increasing and frightening presence of handguns within our schools. And our efforts to hold down health care costs literally are being shot down by the more than $4 billion required to be spent every year on the ghastly woundings and deaths from handguns.

How many handguns are there in this country? It is estimated that there are roughly 66 million of these deadly weapons in the U.S. today. In 1982, there were "only" 53 million. That's a 25 percent increase in ten years! According to the Bureau of Alcohol, Tobacco, and Firearms (BATF), we can expect to add 2 million handguns every year. That is hardly a comforting thought!

Handguns -- these guns so easily concealed under a jacket or in a shoulderbag -- cause untold damage and suffering in this nation. The statistics are staggering, frightening, and shameful.

Every year, handguns are estimated to be involved in at least 10,000 murders and 15,000 woundings -- that translates to about 27 persons killed and 41 persons injured every day! Every year, we set a new record in handgun deaths: since 1988, handgun murders -- which represent 75 percent of all firearms murders -- have gone up each year by nearly 1,000 deaths.

Handguns are involved in an average of 33 rapes, 575 robberies, and 1,116 assaults every day. Handguns are responsible for 70 percent of all firearms suicides, about 3,200 of which every year are teen suicides; and it is a disgusting, terrible fact that these guns constitute the most efficient, effective, and lethal suicide method.

I. GUNS AND EDUCATION

Yet access to handguns has become easier, not more difficult; and their owners, younger. Children not yet old enough to drive are matter-of-factly carrying guns on their person every day. Children take guns to school as if they were lunchboxes; they go to gun-sellers, not to their teacher, to settle a fight with another student; and they bring guns, not toys, to classroom Show-and-Tell.

Can children obtain handguns? The answer clearly is "yes." In 1989, in a national student survey, nearly half of all tenth-grade boys and about one-third of eighth-grade boys said "yes," they could obtain a handgun. Eighth-graders are 12 years old!

Not only do these youngsters carry guns, they take these guns to school. Five years ago, an estimated 270,000 students carried handguns to school at least once; and roughly 135,000 boys -- whom research reveals are far more likely than girls to choose guns as their weapon -- carried guns to school every day.

Since then, the problem has become worse. According to a 1990 national survey, one out of every 5 eighth-graders says that he or she has witnessed weapons at school. That should come as no surprise, considering the number of youngsters that "pack a gun" to go to school. In Illinois, 33 percent of high school students have carried guns to school. Texas reports that 40 percent of eighth- and tenth-grade boys who were surveyed had carried a gun to school at least once.

Nationwide, a full nineteen percent of some 11,000 students -- again, one in every 5 students -- surveyed by the Centers for Disease Control admitted that yes, they had carried a gun to school just in the past month.

I find these statistics to be absolutely stunning -- and incredibly depressing. We're talking about young children!

Given the number of gun-toting youngsters, it is no wonder that gun incidents at school are becoming far more frequent. California officials have reported a 200-percent increase in student gun possession incidents between 1986 and 1990; Florida, too, has reported a sharp jump in student gun incidents. Here in the Washington area, in nearby Prince George's County, 23 incidents -- more than twice the number of last year -- involving guns on school property have occurred since July, and this school year is not over yet.

In nearly every instance these guns were handguns.

Right now, there is so much violence, and so many guns, at schools that some students are scared to go to school. According to the Department of Justice, 37 percent of public school students nationwide fear they will be the subject of an attack at or on the way to school. So what do these children do?

One method of protection is simply to stay away from school, and some children do. An Illinois study reports that one in 12 students is so scared of someone hurting them at school that they are staying home to avoid facing that risk.

But students can't play hookey forever, and another, increasingly popular, way students conquer their fear is to carry a handgun for "protection." They take their new-found security blanket to school; and the presence of that gun in turn feeds the very fear it was meant to assuage. Other students are driven to take their own "protective" measures; and the horrible ripple effect goes on.

The end result? Our schools, designed as places of learning, now are becoming places of tension and violence. It has come to the point where many urban schools conduct random gun searches, and safety drills include dropping to the floor at the first sound of gunfire. Meager school budgets must find money for metal-detectors. That is the last thing on which our schools should have to spend limited resources -- those funds should be going toward textbooks, more teachers, or classroom and sports equipment!

But what choice do school administrators have? Children are learning to believe that guns are a way to resolve their problems. In earlier times, a student dispute might mean a fistfight after class. Now the quarrel often is settled -- quite openly -- with a gun. Just over a month ago, a 16-year-old boldly walked into a Potomac, Maryland, high school chemistry class and fired his handgun at point-blank range at his intended student victim, who somehow miraculously escaped the bullet.

This is an ever-more common pattern. Look at Jefferson High School in Brooklyn, where in the course of a dispute, a student killed one teen and another young "innocent bystander," bringing the death toll -- a death toll for schools?? -- for this school year to 56. Look at the Crosby, Texas, high school, where a 15-year-old girl shot a 17-year-old boy in the lunchroom for insulting her. Look at the third-grader in Chicago who pulled a handgun from his bookbag and shot a student in the spine. Look at the 11-year-old in Clinton, Maryland, who brought a fully loaded .38 caliber revolver to school to "impress his friends." And look at my own State of Rhode Island, where three weeks ago police confiscated a handgun from a 15-year-old junior high school boy who was waving it in front of other students in the school hallway.

"We've never seen a year like 1991-92," says the head of the National School Safety Center, referring to new highs in school gun violence.

No wonder 10 percent of parents at every income level worry about their children's physical safety. No wonder a recent "Dear Ann Landers" column on guns in schools provoked more than 12,000 responses from angry and worried parents, and resulted in a second day's column devoted solely to the printing some of these responses.

Children who are not yet 18 years old are becoming inured to the violence that is not only on the streets, but in their schools. They are becoming accustomed to the notion that guns help you get what you want -- be it an added measure of safety, new respect, or some quick cash. It's just business as usual.

That acceptance is dangerous. We cannot afford to bring up future generations who are hardened and deadened to a culture of violence.

Let me share with my colleagues a story so bizarre, so horrifying, that it seems more like a fiction than fact. In my State of Rhode Island, just a few weeks ago, a teenage boy was given a class assignment to "write an interesting story." The three-paragraph essay he turned in was entitled "Man Killer." It consisted of an interview with his 14-year-old friend about what it felt like to kill a local shopkeeper. Let me read (verbatim) the first few lines:

> "WHAT IT FEEL LIKE THINKING HOW A KILLER FEEL LIKE. WELL, IT FEEL NORMAL, SAID THE 'KILLER.' ITS JUST LIKE STEPPING ON A COCKROACH... I FEEL BAD FOR THE GUY SAID THE KILLER. BUT I HAD TO DO IT."

The boy's teacher, uneasy, and not sure that the story was

actually fiction, turned the paper over to the police. With it, they were able to arrest the 14-year-old suspect.

I warn my colleagues: increasingly in our schools children are exposed to guns, children are becoming used to guns, and children are using guns. And these are children -- gun use can start as early as at eight years old.

This is appalling. We are desperately trying to improve our educational system. Schools, already burdened with many responsibilities, have more than enough problems to deal with right now. We have youngsters with learning difficulties, youngsters who don't get enough to eat, youngsters with drug problems, youngsters from totally shattered families. And now it appears that we can't even guarantee children a safe place to work and learn. This is outrageous! And it is simply intolerable.

How exactly are children to learn anything if they live in fear of walking down the hall and walking into some fatal, senseless dispute? They can't. If we can't even guarantee children, parents, and teachers that they will be safe in school, any new and innovative ways of improving our education system will be useless.

Is this the way our nation becomes competitive? Is this the way we prepare for the next century? No.

II. GUNS AND HEALTH CARE

Let me turn to the cost exacted by guns to our health care system.

Gun-related violence is choking city emergency departments, hospital resources, and indeed our entire health care system. We pay dearly -- not only in terms of monies, but in terms of precious time and resources -- to patch up those who have been shot by a gun. Often, the more serious the wound, the higher the costs -- and the higher the likelihood that the person won't make it. Bone-shattering, nerve-cutting gunshot wounds and gunshot deaths place incredible stress on our health care system and are major contributors to its escalating costs.

What are the health care burdens and costs associated with gunshot wounds? Let's take a look at the number of firearms deaths and firearms injuries.

How many firearms-related DEATHS do we suffer each year? Thousands: about 60 percent of the 23,000 annual homocides are firearms-related, and 75 percent (or around 10,000) of these involve handguns. And these account only for those deaths that are willful and intentional; adding in the accidental firearms

deaths boosts the annual number by another 7 percent (or 1,500).

Now let's turn to firearms INJURIES. According to a 1991 General Accounting Office estimate, every year more than 65,000 persons -- 180 per day -- are injured seriously enough to be hospitalized for firearms injuries. About 12,250 of these are estimated to be victims of accidental injury; the remaining 53,000 or so are thought to have received intentional injury.

(I want to again emphasize here that handguns play a particularly prominent role in firearms deaths and injuries. In 1990, handguns were the weapon used in at least 10,000 murders, which is about 43 percent of ALL murders. As for handgun injuries, an estimated 15,000 persons are shot and injured by handguns during the course of a crime; virtually all -- 95.5 percent -- of those wounded required medical attention and care.)

These injuries place a huge burden on health care providers. "We used to see one or two major trauma victims a day... usually car accidents or falls," says the chairman of the emergency medicine department at a major California hospital. "Now, we see probably four to eight every day, and of those, 30-40 percent are gunshot wounds or stabbings... The other evening, we had five gunshot wounds in three hours, and the ages were 12, 15, 16, 19, and 22." An emergency room doctor in New York adds: "Knives are passe. Today, everybody has a gun... As proud as I am of the advances of trauma technology, I must tell you that the weapons technology has outstripped our therapeutic skills."

Emergency rooms and hospitals providing trauma care are reeling from the added demands of gunshot victims to the overwhelming caseload they already carry. One-third of community hospitals now are reporting "emergency department gridlock" at least weekly. Gun wounds increasingly contribute to this turmoil.

No wonder the American Medical Association, the American College of Emergency Physicians, and the Emergency Nurses Association all endorse handgun control provisions. Their members have the grisly job of cleaning up the bloody mess of gunshot wounds.

The financial drain caused by this carnage is staggering. A 1990 Bureau of Justice Statistics report concluded that 68 percent of victims of handgun injuries incurred during a crime required overnight hospital care; 32 percent remained in the hospital for 8 days or more. Hospitals are among the most expensive venues for health care services in our system!

Hence, the costs associated with gunshot wounds are tremendous. Eight years ago, data compiled by three researchers at San Francisco General Hospital calculated that the hospital

bill for patching up gunshot victims -- 80 percent of whom had handgun wounds -- ranged from $559 to $64,470 per patient. The average cost was $6,915; and the average stay, 6.2 days.

Recent data, compiled in the past few years, reveals even greater costs: the American College of Emergency Physicians reports that based on data collected at a major hospital during the 1989-91 period, the cost per gunshot victim ranged from $402 to $274,189. The average cost? $9,646. The average stay? About 7 days. Another study, conducted during 1988-90 at the University of Arizona Emergency Medical Research Center, concluded that gunshot costs ranged from $9,800 to $125,300 per victim. Again, the average cost per gunshot victim was high: $16,704.

Think of that: if the average cost is $16,704, and the estimated number of total gunshot injuries is 65,000, the annual cost of hospitalization for firearms injury is at least $1.1 billion. And this amount does not include additional charges, such as those for physician services, ambulance services, follow-up care, and rehabilitation.

This is an important point: health care for gunshot victims does not stop when they are discharged from the hospital. For some, it is just the beginning. In too many cases, the bullet or bullets cause permanent damage for which intensive rehabilitation is necessary.

Thus, up the costs go again. Since firearms are responsible for a substantial number of all traumatic spinal cord injuries, let's take as an example spinal cord injury rehabilitation. At one typical rehabilitation center specializing in spinal-injury treatment, a full 35 percent of the spinal patients are gunshot victims, second only to the 40 percent of auto victims. The center's daily -- DAILY -- per patient rate for care is $1,500.

How many days do these patients stay? Depending on how fully or cleanly the bullet has severed the spinal cord, the spinal injury patients suffer partial or complete paralysis. Paraplegic, or partially paralyzed, patients usually receive around 75 days of care, during which time they receive intensive occupational and physical therapy. Cost: $112,500. Quadriplegic patients, those paralyzed in all four limbs, usually stay for 5 months. Cost: $225,000. This cost is incurred in addition to the $100,000 that is commonly required for acute care of such serious injuries.

Amazingly, and sadly, fully half of the gunshot spinal injury patients are under age 25.

When you add up the costs, from the initial emergency room care and accompanying hospital stay, to the ambulance services, follow-up visits, and rehabiliation treatment, the overall cost of

firearms to our health care system is colossal: an estimated $4 billion, according to the Chair of the 1991 Advisory Council on Social Security.

Who pays this monumental bill? Who else? -- the taxpayers. An estimated 86 percent of the staggering costs associated with firearm injury are paid by government sources.

What people just don't seem to realize, or to think much about, is that guns are as significant a cause of harm, and expense, to individuals as are motor vehicles. We hear quite often that injuries are a leading cause of death in the U.S., and that motor vehicle injuries account for a significant portion of these injuries. Yet most don't realize that guns rank right up there with motor vehicles.

According to data compiled by the Injury Prevention Network, 32 percent of all fatal injuries are caused by motor vehicles; firearms follow in second place with 22 percent. Combined, the two account for over half of all injury-related fatalities in the United States.

In fact, in 1990, firearms overtook motor vehicles to claim the dubious honor of being the leading cause of injury-related death in Louisiana and (for the first time) in Texas. In other words, gunshot wounds in those two states cause more deaths than automobile accidents. And while the incidence of motor vehicle deaths is going down, that of firearms deaths is going up.

Let's face the facts: guns cause great physical damage. That damage, in turn, is forcing the ever-rising costs of health care up, up, up.

III. SUMMARY: WHAT CAN WE DO?

In sum, we have scared children, we have scared parents, we have terrible, bloody violence, and we have terrible gun-related health and societal costs.

It's time to wake up. This is a matter that affects all of us. There are many who think: "Well, that gun problem is limited to thuggish drug dealers killing other drug dealers, and anyway, it only happens in those low-income neighborhoods."

To those who comfort themselves that this is someone else's problem -- a low-income neighborhood's problem, an urban problem, a minority problem -- to them I say, "Wake up!" We all need to care, and not just because the problem is spreading, but because we're talking about children to whom we as a society have a responsibility.

Other industrialized nations do not tolerate handgun slaughter. Canada, which like the U.S. has a Wild West, pioneer heritage, has stronger gun control laws and an annual firearm-related death rate of around 1,400 -- only about 180 of which are gun homicides. Those statistics are much higher than those in European nations, but they are negligible in comparison to our 23,000 firearms murders. As for handguns, less than 300,000 Canadians own one. We Americans own 66 million, and if handgun manufacturers like the Jennings family have their way, we can look forward to being flooded with thousands more cheap $35 models in the near future.

Guns cause terrible damage in this country, yet we do little to prevent it. Have we simply become accustomed to the killings? Are we compliant witnesses to the "terrible stillness of death" -- as one witness to a violent shooting called it -- now being heard around the country?

I think -- I know -- that this country must not be. We are a caring nation; a nation of people who are appalled at these acts of devastation. We must not become inoculated to such violence.

I am going on record today to say that more must be done -- and I'm talking about measures to restrict the incredibly, insanely easy access to guns in this country. I am working on a proposal that I consider to be the best solution, and intend to present it to my colleagues shortly, in the coming weeks. It is time to act. We cannot go on this way.

John H. Chafee

Ban Handguns!

Recently, the Senate spent an entire day debating whether or not to mint new coins. By the end of that day, as on every day of the year, a total of 27 children and adults nationwide were murdered by handguns; and another 33 used a handgun to take their own lives. Dozens of others were grievously wounded by handguns.

What are we going to do about this slaughter? One suggestion—a good one—is a national waiting period before the purchase of a handgun. However, the situation we face demands much more than the screening of felons. We need to shut off the spigot that is pouring more than 2 million handguns each year into our society.

Few of us—including myself, until I had the opportunity to study it—realize the extraordinary extent to which handguns play havoc with our best policy efforts. We have a whopping 66 million handguns in the United States, more than twice the 31 million of 20 years ago; and 2 million more of these deadly guns are added to the arsenal each year. Handguns, so easily available and so easily concealed, are pushing our violent death rate to levels unheard of in this nation, let alone overseas; and each year they are involved in hundreds of thousands of rapes, robberies and assaults.

There isn't a citizen in this nation who isn't worried about two critical national needs: improving our education system and reducing the costs of our health care system. But it is well-nigh impossible to make progress on either matter without recognizing the costs placed on each by our current handgun policy. It is truly shocking—and intolerable. Today, educators and children are distracted by the frightening presence of handguns in our schools. And efforts to hold down health care costs are being shot down by the billions of dollars' worth of damage caused by handgun wounds.

Five years ago, an estimated 270,000 students carried handguns to school at least once; today, it is worse. There are so many handguns in school that some students are afraid to go to school. What do they do? Many turn to a handgun of their own, which feeds the very fear it was meant to assuage. This horrible ripple effect carries on up to school administrators, who must find monies in meager school budgets to purchase $4,000 metal detectors instead of textbooks.

But what choice do schools have? Earlier, a student dispute might mean a fistfight; now, the quarrel often is settled with a handgun on school grounds. No wonder a recent "Dear Ann Landers" column on guns in schools provoked more than 12,000 responses from angry, worried parents.

How ironic: We are desperately trying to improve our educational system, yet how can children learn if they are afraid of walking into some fatal dispute? If we can't guarantee safety in school, innovative ways of improving our education system will be useless. Is this the way our nation wants to prepare for the next century?

Health care, another national priority, suffers equally heavy costs. The tens of thousands of bone-shattering, nerve-cutting gunshot wounds place incredible stress on our health care system and are major contributors to its escalating costs. Urban emergency rooms are flooded with gunshots injuries. And despite emergency teams' hard work, weapons technology is outstripping advances in therapeutic skills, as one physicians noted.

The financial drain caused by this carnage is staggering: The cost of a gunshot injury averages $16,700 per patient. And costs don't stop upon discharge from the hospital; there are bills for follow-up care, medication and rehabilitation treatment (initial rehabilitation costs for spinal cord trauma, a common gunshot injury, range up to $271,000 per patient). When added up, the overall health care cost of firearms is colossal: more than $4 billion annually. Who pays? An estimated 86 percent of this bill is paid by government—i.e., the taxpayers.

I shortly will introduce legislation banning the sale, manufacture or possession of handguns (with exceptions for law enforcement and licensed target clubs). A radical proposal? Hardly. What I would call radical is allowing the terrible status quo to continue.

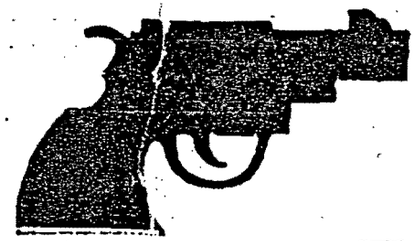
There will be those who will argue that there exists a fundamental constitutional right to bear arms. But if there is one argument that is utter nonsense, this is it. Not only have its proponents not read their Constitution lately, but they haven't followed more than 50 years of remarkably unanimous court holdings against that erroneous supposition.

As for those who will argue that handguns in the home are needed for protection, they haven't reviewed the horrific statistics detailing that handguns are far, far more likely to kill a loved one than an intruder.

Sooner or later (and I believe sooner rather than later), handgun violence will touch the life of someone in every American family. Handguns, when introduced into the already volatile mix of conditions that lead to violence, act as a match to dry powder.

It is time to act. We cannot go on like this. Ban them!

The writer is a Republican senator from Rhode Island.



SENATOR JOHN CHAFEE (R-RI)
HEALTH EQUITY AND ACCESS IMPROVEMENT ACT (S. 1936)

Overview:

Tax change for individuals and businesses, reformed insurance regulation for small businesses, purchasing groups for small businesses, pre-emption of State managed care laws, optional State expansion of Medicaid to cover low-income individuals, medical liability reforms.

Major Elements:

Would expand access through: tax credits for individuals to use to purchase health care services or insurance and for businesses which begin to cover employees and dependents; tax deductibility of health insurance premiums; State options to expand Medicaid to cover low-income individuals; expansion of funding to community health centers and to other rural health care delivery; reforms of insurance regulation.

Would reform the medical liability system through Federal pre-emption of State tort laws and would create systems to encourage early settlement of disputes.

Would encourage managed care arrangements through tax credits and preemption of State anti-managed care laws. Would emphasize primary and preventive care through tax credits to providers and increased authorizations to community and migrant health centers, which focus on primary care.

Would create purchasing groups and would reform regulation of insurance for small businesses. Would create a waiver board for Medicaid, Medicare, and PHS grants for State-wide demonstration programs to increase delivery of care, control costs, and assure quality.

Financing:

No financing mechanisms are included. During the 11/7/91 press conference, Senator Chafee estimated the cost of this bill to be $150 billion over 5 years, including the cost of the tax credits but not including off-sets from preventive services.

Groups Affected:

Small businesses and employees, insurance industry, low-income individuals currently not covered by state Medicaid programs, States, plaintiffs in malpractice claims.

Cost Containment:

No explicit limits on spending. Would contain costs through liability reforms, managed care arrangements, purchasing groups for small businesses, and preventive care.

Quality:

Would pre-empt State managed care laws that limit utilization review. Waiver board could approve demonstrations to assure quality. Would reallocate provider licensing fees to agencies responsible for licensing and discipline and would grant immunity for state health care practitioner board members. Would require States to have risk management programs and would redistribute awards for punitive damages to a fund to provide resources for disciplining and for consumer protections.

SPEECH BY SENATOR JOHN H. CHAFEE
The American Health Care Association
Washington, D.C. May 12, 1993

Thank you for including me in your symposium. Your agenda is an impressive one -- you should come away from this conference with a good sense of the direction health care reform is taking, as well as how nursing homes will be affected.

Health Care Reform will prove to be the most arduous and dramatic domestic policy undertaking in the last fifty years, and it will affect all Americans. The American health care system has considerable strengths, but it also has distressing flaws.

What are these flaws? Seems to me there are three. First, the cost of health care and health insurance is becoming a mounting burden on many individuals and our national budget. Individual premiums, copayments and charges are soaring. The government's share of the health care bill -- $230 billion in fiscal year 1993 -- represents a full one-sixth of all federal spending. Not an auspicious fact for deficit hawks.

You know the statistics: America spent $752 billion on health care in 1991 -- 13.2 percent of our GDP. The Health Care Financing Administration projects that, left unchecked, U.S. health care spending could climb to 32 percent of GDP by the year 2030. While in 1991, per capita spending on health care was $2,868 -- in 2030, it would could be as much as $48,000 for every man, woman and child in America! The nation cannot sustain these costs.

Second, appropriate medical care is simply unavailable to millions of Americans. We are pretty familiar with the discouraging gaps -- 37 million of our fellow citizens are without medical insurance. In addition, many poor and disabled who are covered by insurance -- I am referring to Medicaid -- have insufficient health care because there are no doctors to see, especially in rural and inner city areas.

And third, because businesses must include their large employee health benefit expenditures in the price of their products, health care costs are eroding our competitive position internationally. It was reported in last Thursday's (May 6) New York Times, Robert L. Ozment, director of insurance at Ford Motor Company, said his company spent $1.35 billion, or 19 percent of payroll, on health benefits for active workers, retirees and dependents last year. "That is more than the $1.1 billion that Ford spent on steel," he said in an interview.

What is the answer? The answer is that we all need to change. Providers will need to make changes in the way they practice medicine, and we as consumers will need to accept changes in the way we get medical care.

It is difficult for me to discuss the details of the

President's plan, as many key decisions have yet to be made. You are fortunate to have Judy Feder here later this morning, to shed some light on deliberations at the White House.

I will fill you in on the Republican plan.

You may know that in July 1990, I was asked by Senator Dole to establish and chair a Task Force to help all Republican Senators develop expertise on our nation's complicated health care system, and to begin the search for solutions to the problems that plague it. Thirty-five Republican members of the Senate are and have been participating in the endeavor.

After a year of work, in the fall of 1991, I was joined by twenty-three of my Republican colleagues in introducing legislation that we believed was an achievable first step in reforming our system. That program included insurance market reform, the establishment of small group purchasing organizations, medical liability reform, repeal of state mandated benefits, repeal of state anti-managed care laws, creating equity in the tax code, reduction of administrative costs, expansion of community health centers, and other elements.

Soon after introduction, however, I and many of my colleagues were concerned that our bill did not do enough to control health care costs. We have spent considerable time discussing cost containment options, and many of us believe that a managed competition approach is the route to take.

It is a bit awkward for me, as the leader of the Republican group, to divulge the precise details of our plan, while I am still trying to build and maintain consensus behind a strong idea. So I will avoid premature disclosure right now, but will give you an indication of what our proposal will look like by outlining the pitfalls likely to be encountered by any reform proposal. I do think it is fair to say that our bill will focus less on "managed," and more on "competition."

Obstacles to enacting a health care reform proposal will not be found on the Republican side of the aisle. The potential for trouble is evident in the fact that, although the Democrats have controlled both houses of Congress since 1986, any consensus on health care reform has and still eludes them. When the President's plan -- which we anticipate to be based on managed competition, with some form of external price controls -- is presented to the Senate, you will surely see objections from a number of Democrats. There may well be some in the liberal and some in the conservative wing of the party who will not be able to support it.

In neither house of Congress have the Democrats been able to coalesce around a single health care reform proposal. Although the Democratic leadership in the House and Senate, for the time being, are deferring to the President on this issue, there is still support among many Democrats for other types of reform.

In early March, a group of 4 Democratic Senators and 54 Democratic Members of the House introduced a Canadian-style, single-payor bill. This same group disavows the managed competition proposal which is the basis of the President's reform package.

On the other hand, price controls and mandatory employer contributions will cause rebellion amongst the conservative Democrats, with their small business constituents. Thus, for any program to succeed, bipartisan cooperation is required.

To me, the managed competition approach has appeal because it allows competition within set boundaries of benefits and with standards for insurance.

Proceeding with managed competition is going to present all of us with some extremely tough decisions, however.

For example, managed competition revolves around a single uniform benefit package which will be applied nationwide. Who will set that package -- Congress or a Federal Board? More importantly to you, however, is the issue of whether or not long-term care coverage will be included.

Both Democrats and Republicans would like to address the issue, and both parties are considering a number of options. Clearly, cost will be one of the biggest factors in deciding how or whether long-term care is included in reform. Republicans would like to see long-term care provided in the private sector for those who can afford to purchase long-term care insurance.

Toward that end, we are considering changes in the tax code and in insurance marketing practices in an effort to encourage individuals to purchase insurance, and to encourage insurers to market long-term care products. Can we deduct the cost of acute care insurance - it's not clear about the deductibility of long-term care insurance. Just how we will deal with low-income populations has not been resolved.

Back to managed competition...is Congress willing to limit the amount an employee can count as a tax-free fringe benefit? It is not so politically difficult to limit employer deductibility of health insurance premiums. But capping employees is a different story. The UAW will hardly rise and cheer for that! Yet tax exemptions only for the value of the standard benefit package is at the heart of managed competition.

What, if any, will be the contribution required from the employer? President Clinton seems to have advocated that employers pay a substantial amount of the premium, maybe 80%. That will have a serious impact on small businesses. We must be cautious in how we approach this issue.

More tough decisions. Will we be willing to undertake medical

liability reform, which is critical to bringing health care costs under control? I believe that it must be included.

Are Americans willing to accept a health care system which would limit choice through managed care?

What happens to Medicare, Medicaid, and Veterans health programs under managed competition? Are these all changed to conform to the standard package? My choice would be to phase these populations into the same program as private patients.

Are we willing to raise taxes to finance care to those who remain uninsured?

Many of us worry that the costs of health care reform are not being considered adequately as the President presses ahead with his economic recovery programs. He is tapping a variety of new or additional sources of revenue -- such as increasing the personal and corporate rates, extending the Medicare payroll tax, making cuts in Medicare benefits -- but none of this money is for health care reform, which has been projected to cost as much as $100 billion per year when fully implemented. It will all be absorbed by the time health care reform comes along.

On top of the great need to find a way to finance a health care reform proposal, Members of the Senate Finance Committee also must grapple with a budget reconciliation bill in the coming months. We are charged with finding $35 billion in spending cuts within our Committee's jurisdiction. The bulk of these cuts will likely come from Medicare, and to a lesser degree -- Medicaid.

According to the Congressional Budget Office, we can achieve $1.75 billion over the next five years by tightening Medicaid's estate-recovery processes, and limiting the ability of individuals to transfer assets in order to qualify for Medicaid long-term care coverage. I would like to be able to tell you not to worry about the elimination of return on equity payments, but given the level of cuts that must be achieved, I wouldn't count anything out until the ink from President Clinton's signature is dry.

In addition, there are a number of spending items that many of us would like to see included in a budget reconciliation package, not the least of which is the elimination of the 3-day hospital stay requirement. Needless to say, this is going to be a difficult year.

Back to the thorny issues of health care reform. Perhaps the most politically volatile issue of the health care reform debate will be how to contain costs. On one end of the spectrum we have pure regulation -- price setting for physicians, hospitals, and other providers. On the other end we have plans relying on pure competition and consumers to control costs.

Although President Clinton has embraced the concept of managed competition, he has stated that he will also use a nationwide

budget to contain health care costs. The Republicans oppose this.

If total medical expenditures are capped and the caps are enforced, difficult decisions would have to be made about what services would be covered, who would benefit and how quickly. The word "rationing" emerges. Clearly, under such a system, Americans who now enjoy unlimited coverage would experience some reduction in benefits or services.

There will be a big push this year to get health care reform enacted, but I fear one year may be an overly optimistic goal. However, I do think it is possible to get the details worked out and build a consensus and achieve passage in 1994.

Regardless of the complexion of the ultimate reform package -- whether the managed competition model survives, or we turn in some as yet unforeseen direction, one thing is certain. In order to bring national health spending down, we need to bring about a much greater emphasis on preventive medicine, including education about healthy behaviors. We absolutely have to convince people not to abuse alcohol and drugs, not to smoke, not to drive fast, not to own guns, always to wear seatbelts and motorcycle helmets. The gargantuan expenditures caused by these avoidable practices have to be curbed. Handgun injuries alone cost $4 billion a year, not including rehabilitation services! Any health care legislation will certainly reflect that shift in focus, to some degree.

I am one who has believed all along that it is possible -- in fact, imperative -- to put political partisanship aside and develop a sensible health reform package that will meet the compelling needs of our nation. This is a thrilling moment in our country's history. The political will do something momentous and worthwhile is there. We must not allow this opportunity to pass.

Thank you.

Speech by
Senator John H. Chafee
Rhode Island College - Department of Nursing
April 8, 1993

Thank you for giving me the opportunity to join you here this evening. Health care reform will be one of the most important issues we address in this decade. How we deal with the problem of rising costs and the availability of quality services will have a major impact on every aspect of our lives for decades to come.

The outcome of this debate will determine whether or not everyone has access to basic health care services, which services will be provided, when, and by whom. It may also determine the availability and application of technologies in our health care system.

Second, the outcome of this debate will significantly affect the economic future of our nation. For every dollar we spend on health care, we have one dollar less to spend on food, housing, education or other necessities. Unless we get control of health care costs and particularly, on federal spending on health care, we will never be able to control our growing federal deficit. And unless we control the deficit, our children and our grandchildren and great-grandchildren will be paying our bills for generations to come.

Clearly, if you look at the polls, there is a profound difference between reforms being discussed in Washington, and what the American public wants. According to polls, Americans do not want the government providing health care. They do want the government to control costs, but not if it means the government rations health services or limits their freedom to choose their own doctors and hospitals. In general, Americans would like to see employers pay for health insurance for their employees, but not if it means lost jobs.

No single proposal can meet all these expectations. A Canadian-style, single-payor proposal will provide universal access and will control costs, but gives the government more control than people are willing to accept. In addition, it may limit services to some individuals who currently have unlimited access to health care.

The Senate Democratic leadership introduced a bill last year which requires businesses to provide health insurance or pay a tax. That plan enjoyed little support because of the concern that such a proposal would hurt small businesses and could cost thousands of jobs. A further criticism was that it did little to control costs.

In July 1990, I was asked the Senate Minority Leader, Bob Dole, to establish and chair a Task

Force to help all Republican Senators develop expertise on our nation's complicated health care system, and to begin the search for solutions to the problems that plague it. Thirty-five Republican members of the Senate are and have been participating in the endeavor.

After a year work, in the fall of 1991, I was joined by twenty-three of my Republican colleagues in introducing legislation that we believed was an achievable first step in reforming our system. That program included a series of refoms that were intended to make health insurance more affordable to individuals and small businesses, to guarantee that when a person changes jobs he or she can still get covered, to reform medical malpractice laws, to encourage the use of primary and preventive care and to build on existing public programs such as our community health centers.

Soon after introduction, however, I and many of my colleagues were concerned that our bill did not do enough to control health care costs and to guarantee access to health care services. We have spent considerable time discussing cost containment options, and many of us believe that a managed competition approach is worth pursuing.

The political landscape has changed profoundly since last year. The need for affordable,

accessible, appropriate health care for all Americans has moved to the front burner, and is about to boil over. We now have a Democratic President. The Democrats continue to control both Houses of Congress. President Clinton has promised to have a health care reform proposal to Congress by May 1, although that date is slipping. The President is supporting a so-called managed competition bill and would limit total spending on health care.

What is managed competition? In general, individuals and small businesses would be able to purchase health insurance through large purchasing groups. They would therefore have the same purchasing power as large companies such as GM or Chrysler. Individuals such as the self-employed and employees of small business would select from a menu of health insurance plans that would be offered through the purchasing group.

To me, the managed competition approach has appeal because it allows competition within set boundaries of benefits and standards for insurance.

Proceeding with managed competition is going to present all of us with some extremely tough decisions, however.

For example, managed competition revolves around

a single uniform benefit package which will be applied nationwide. Who will set that package -- Congress or a Federal Board?

How will managed competition affect self-insured entities, which are currently exempt from any state-mandated benefit packages? Most of these entities are probably unionized. One of their most important collective bargaining chips -- the benefit package & cost sharing requirements -- will be threatened by the managed competition approach.

Is Congress willing to limit the amount an employee can count as a tax-free fringe benefit? It is not so politically difficult to limit employer deductibility of health insurance premiums. Under this approach if employees choose the most expensive plan, they will pay taxes on a portion of that premium.

More tough decisions. Will we be willing to undertake medical liability reform, which is critical to bringing health care costs under control?

What, if any, will be the contribution required from the employer? President Clinton has advocated that employers pay a substantial amount of the premium, maybe 80%. That will have a serious impact on small businesses. We must be cautious in how we

approach this issue. Given the state of our economy in Rhode Island, I do not think that we can afford health care reform at the cost of jobs.

Are we willing to raise taxes to finance care to those who remain uninsured?

What happens to Medicare, Medicaid, and Veterans health programs under managed competition? Are these all changed to conform to the standard package?

Perhaps the most politically volatile issue of the health care reform debate will be how to contain costs. On one end of the spectrum we have pure regulation -- price setting for physicians, hospitals, and other providers. On the other end we have plans relying on pure competition and consumers to control costs.

Although President Clinton has embraced the concept of managed competition, he has stated that it will also use a nationwide budget to contain health care costs. That presumably will be broken down into a maximum amount for each state. Coming from Rhode Island where we have traditionally received minimum federal allocation of funds, and low reimbursement rates under Medicare, I am very worried about the impact on our state.

Recently, we have heard the White House talk about price freezes on health care services. While it sounds appealing to freeze prices for doctors and hospitals, that translates to wage freezes for hospital staff, nurses, and ultimately could affect those who supply goods to doctors and hospitals. This could translate into a very real problem with respect to our fragile local economy.

The real test will come as people realize that if total medical expenditures are capped and the caps are enforced, difficult decisions would have to be made about what services would be covered, who would benefit and how quickly. The word "rationing" emerges. Clearly, under such a system, Americans who now enjoy unlimited coverage would experience some reduction in benefits or services.

There will be a big push this year to get health care reform enacted, but I fear one year may be an overly optimistic goal. However, I do think it is possible to get the details worked out and build a consensus and achieve passage within two years.

I am one who has believed all along that it is possible -- in fact, imperative -- to put political partisanship aside and develop a sensible health reform package that will meet at least some of our needs. Most in Congress agree that we should move forward on this issue. The political will is there,

and I believe that we will see significant health care reform ,if not this year, before Congress adjourns in 1994.

News from
SENATOR JOHN CHAFEE
RHODE ISLAND

567 DIRKSEN BUILDING WASHINGTON D.C. 20510-3902 (202) 224-2921

SPEECH BY SENATOR JOHN H. CHAFEE
Meet the Health Care Policy Makers
Washington, D.C. June 25, 1993

Good morning. I appreciate the opportunity to discuss my work on health care reform with you.

I have studied your program. The word comprehensive seems an understatement. To be honest, I am not sure I can think of twenty minutes concerning health care reform that won't be repetitive for you.

You have heard from two Administration representatives. You know, I would be curious whether you feel they agreed on anything!

You have heard from two of my Republican colleagues in the Senate, who have been deeply embroiled in the efforts of the Senate Republican Task Force on Health Care.

You are hearing from three Democratic Senators, who hold a wide range of positions on reform -- some are advocates of the Canadian-style, single-payer system.

You have heard from one of the leaders of the Conservative Democratic Forum in the House of Representatives, who has introduced a very credible proposal, based on managed competition.

And, you have heard from the Chairman of the Ways and Means Committee, who has been through numerous drills like this one before. He has a unique sense of history concerning how such contentious and far-reaching issues can be resolved through the Congressional process.

You have certainly gotten a thorough schooling. I must say I am grateful to the conference organizers for giving me this slot on the schedule. You have had a good night's sleep, and plenty of time to get a second cup of coffee -- so there may be some hope for my speech!

Now, to outline for you the Republican solution to the health care crisis in this country. You may know that twenty-three members of the Senate Republican Task Force on Health Care, which I chair, introduced an initial reform bill in 1991. We are firmly committed to many of the elements of that bill, and have included them in the measure that we are now poised to introduced. Among them are:

1. Insurance market reform. No longer will insurance companies be able to select only the healthy for coverage.

2. The establishment of small group purchasing organizations, to allow individuals and small businesses to pool their risks and resources -- giving them the same clout as large companies when buying health insurance.

3. Medical liability reform. Doctors and hospitals have to carry backbreaking malpractice premiums -- and we ultimately bear those costs in our health insurance or doctors' fees. We have to change the way malpractice litigation works.

4. Repeal of state mandated benefits and state anti-managed care laws, to encourage the development of managed care initiatives -- ranging from simple hospital pre-admission screening to full scale HMOs.

5. Creating equity in the tax code, to guarantee that all individuals, and the self-employed, can deduct 100% of their health insurance costs. As it stands, employer-provided health insurance is tax-free, while health insurance purchased individually must be bought with after-tax dollars. The self-employed can deduct only 25%. This is a glaring inequity which absolutely must be corrected.

6. Reduction of administrative costs. It is estimated that 17 cents on the health care dollar goes to paperwork, and the time health professionals spend filling out forms in triplicate. It stands to reason that we can save a bundle by paring down these costs -- even with a simple solution like creating a standard insurance form.

7. Expansion of community health centers -- to get needed care to those in underserved areas.

8. Greater emphasis on preventive care. This is the principle on which Health Maintenance Organizations operate: if you keep people healthy with routine check-ups, immunizations, and screenings, you avoid costly health crises.

Regardless of the complexion of the ultimate reform package, one thing is certain. In order to bring national health spending down, we need to bring about a much greater emphasis on preventive medicine, including education about healthy behaviors. I know you will agree with me that we absolutely have to convince people not to abuse alcohol and drugs, not to smoke, not to drive fast, not to own guns, always to wear seat belts and motorcycle helmets. The gargantuan expenditures caused by these avoidable practices have to be curbed. Any health care legislation must certainly reflect such a shift in focus.

Let me digress for a moment to discuss two areas of particular concern to me -- which I think we absolutely have to start thinking of in the context of health care reform.

First, let us recognize the alarming impact of handguns on the health care system.

Handgun violence is nothing less than a national public health emergency. More than any other weapon, easily concealed, readily available handguns are wreaking havoc on our society.

Each year, handguns are used to commit 80 percent (11,400) of gun homicides, and 70 percent (12,600) of gun suicides. Countless individuals, many of them children, are killed accidentally by handguns. Moreover, for each gun death, there are an estimated <u>seven</u> gun injuries.

The health care costs associated with gunshot wounds are staggering. Researchers calculate that the per-patient cost of hospitalization for gunshot wounds averages $13,200, with costs ranging from $800 all the way to $495,000. And there are additional costs: ambulance services, follow-up care, medication, and rehabilitation treatment. If the bullet nicks the spinal cord, and the patient suffers paralysis, costs can run $1,500 per day for basic rehabilitation. Depending on the extent of paralysis, three months of treatment can cost up to $270,000.

In each case, a staggering 80 percent of the charges for treatment of gunshot wounds are borne by government sources -- i.e., the taxpayer. The overall cost of firearms injury to the U.S. health care system? More than $4 billion, according to the Chair of the 1991 Advisory Council on Social Security. I believe that figure is low.

If we are serious about health care cost containment, then we should ban handguns altogether.

Let me turn your attention to another grave public safety matter: injuries related to motor vehicle accidents. The amount of public funds consumed by gun violence is surpassed only by the health care costs attributable to motor vehicle accidents -- which are estimated at $14 billion annually.

Most of those injuries -- and costs -- could be prevented. The National Highway Traffic Safety Administration estimates that, if we could increase seat belt use from the current 62% to 85%, and make some modest gains in motorcycle helmet and child restraint use, an additional 7,800 lives could be saved each year and innumerable injuries prevented.

Last year, I was successful in including language in the highway bill to pressure states to enact seat belt and motorcycle helmet laws. I considered that a major triumph in the area of prevention.

The statistics in my home state of Rhode Island make a compelling case for universal motorcycle helmet laws. The State Hospital in Rhode Island is now caring for five individuals who are comatose from head injuries suffered while riding motorcycles without a helmet, at a cost to the State of nearly $350 per patient, per day. That is $125,000 per patient, per year. One of these persons has been in this condition for over 18 years, at a total cost to taxpayers, thus far, of nearly $2 million.

This year, twenty of my Senate colleagues, even some who are involved in the health arena, have introduced legislation to repeal the mandatory seat belt and helmet law. To me, this is a discouraging development. This is no time to allow such a setback to prevention efforts. I could certainly use your help in defeating that measure.

Back to health care reform. The current Republican Health Care Task Force plan adopts a "managed competition" approach, as a way to contain health care costs even further. If you didn't know before you got to this conference, you certainly know now, that the term "managed competition" means different things to different people -- so I will describe briefly how it would work under the Republican plan.

A national, uniform health benefit package would be developed. Individuals and small businesses would be able to purchase this benefit package through large purchasing groups. They would therefore have the same purchasing power as do large companies such as GM or Chrysler. Individuals, the self-employed, and employees of small business, would select from a menu of health insurance plans that would be offered through the purchasing group.

These plans would all offer the same benefits, and would compete on the basis of price, and on the array of doctors and hospitals with whom they contract. But there would be an incentive to select a lower-cost plan, because of favorable tax treatment. Tax exemptions only for the value of the standard benefit package are at the heart of the managed competition model. Republicans are working on an acceptable way to implement that premise.

Thus, there would be strong competition among health plans and providers to keep costs low, in order to attract patients. Plans that were unable to do so, would be at a competitive disadvantage. Furthermore, information about the track record of a given plan -- or doctor -- would be much more readily available than it is now.

I know that many health care providers, particularly physicians, are opposed to the concept of managed competition, because managed competition could force providers into managed care. I'd like to warn those opponents, however, that if this fails, you will almost certainly see government price controls. The American public's perception of our health care crisis is that fees charged by physicians, hospitals, drug companies, and insurance companies must be controlled. They see the biggest problem as waste, fraud, and abuse. They want it cut from the hides of insurance companies, hospitals, doctors, and government.

Republicans are wary of many of the details of the Clinton plan as they become evident in the daily news leaks. But, we are eager to work with the Administration to fashion a plan that will be good for our country.

I have discerned some major differences between what we are working on, and what Mrs. Clinton's task force is rumored to be developing.

The first issue is whether a contribution will be required from the employer. President Clinton has advocated that employers pay the price of health insurance -- seven percent of payroll is what is usually mentioned. That will have a serious impact on small business. I do not think that we can afford health care reform at the cost of jobs. After all, one of the major reasons we need to reform the system is that health care costs are weighing down business, impeding job creation. Thus, Republicans are averse to levying what is, in effect, yet another payroll tax on business.

The second difference is the question of raising taxes to finance care to those who remain uninsured. This point is especially critical given the tax increases that are part of the Clinton budget plan, which Congress is in the midst of considering. That proposal envisions $270 billion in new taxes over the next five years. These increases do not include funding for health care reform, which has been projected to cost as much as $100 billion per year when fully implemented. Republicans are working with a "pay-as-you-go" concept: as the savings from the initial reforms are realized, we propose to use those funds to bring more people into the system. We worry that an abrupt, massive expenditure will be a disastrous jolt to the economy. Thus, we favor a long phase-in period.

Finally, although President Clinton has embraced the concept of managed competition, he has stated that he will also use a nationwide budget to contain health care costs. One concern Republicans have about price-setting is that it conjures up the word "rationing." Furthermore, Republicans do not believe that global budgets or price freezes will necessarily achieve the goal of keeping costs down. As we have seen with Medicare reimbursement -- providers will charge as much as they know they can get back from the government. It's hardly the incentive to keep costs low that managed competition is supposed to create.

I am one who has believed all along that it is possible -- in fact, imperative -- to put political partisanship aside, in order to develop a sensible health reform package that will meet the compelling needs of our nation. This is a thrilling moment in our country's history. There is a clear will to do something momentous and worthwhile -- we must not allow this opportunity to pass. Thank you.

cc: STEVE
MELANNE
CHRIS

SPEECH BY SENATOR JOHN H. CHAFEE
HEALTH CARE REFORM: WHERE DO WE GO FROM HERE?
National Press Club Washington, D.C.
September 23, 1993

Last night, President Clinton presented his health care reform proposal to the nation. I congratulate him, and Mrs. Clinton, for their willingness to tackle the toughest domestic challenge in decades -- ensuring that every American has health care and putting the brakes on escalating costs.

A week ago, 23 Senate Republicans unveiled a proposal for universal health insurance coverage and cost control. We call it HEART -- Health Equity And Access Reform, Today. We believe it is a comprehensive and responsible solution to our health care challenge.

HEART is a product of three years of effort by a Republican Task Force on Health Care. I am grateful to Senator Dole for his vision in establishing the Task Force, his steadfast commitment to its efforts and its product, and, of course, his decision to appoint me as chair.

There are other serious proposals as well. Congressman Jim Cooper and the Conservative Democratic Forum have a good package; the House Republicans have introduced a thoughtful proposal, and there are likely to be other helpful ideas put forth before this debate is completed.

But now the real challenge begins -- forging a consensus among Americans and in Congress.

Health care reform is a mammoth legislative undertaking -- one which will touch every American, and affect one out of every seven dollars in our country's economy. We must move this complex issue through a

veritable maze of Congressional Committees, each of which will want to put its own stamp on the final product. As many as sixteen House and Senate committees -- and some two dozen subcommittees -- will claim jurisdiction over some part of it.

In the Senate, the Finance Committee will have a large responsibility -- encompassing Medicare and Medicaid, taxation, and probably insurance reform issues. The Judiciary Committee will be responsible for antitrust and medical liability reforms. Other portions will go to the Labor and Human Resources, Government Affairs, Veterans, Indian Affairs, and Armed Services Committees. The Budget Committee will get a crack at it as well.

Health care reform is too important to fall victim to business as usual in Washington. We must somehow strike a balance between a considered, deliberative Committee review process, and the possibility of any one, or several committees stalling action.

I will concentrate my remarks on the Senate.

I believe that setting at least an informal timetable for action is the answer. It is my hope that the Senate Majority Leader and the Republican Leader would confer, allocate the pertinent sections to the respective Committees and set forth a number of target dates. Perhaps the House leadership will pursue a similar approach.

I would suggest that this timetable provide that Committees complete a first round of hearings by Thanksgiving of this year, when Congress is scheduled to adjourn. Senators would then return to their states for two months, and hold field hearings and constituent meetings, to explain the plans under consideration and invite comment.

Committees would hold another round of hearings when we reconvene in January, and would then be asked to report out their sections sometime in early Spring -- I would suggest April 21. By early June, we should be able to complete debate on a health care reform bill on the Senate floor. The hope would be the conference report could be considered before August, thus the bill would be on the Presidents desk by August.

There is nothing magic about these proposed dates. But I believe it is important that we have goals that we shoot for.

I also envision an important, immediate role for consultations between the Administration and those of us in Senate who have presented alternatives. We can speed up the process by spending the next few weeks together discussing and clarifying the provisions in each of the major proposals. While we have been briefed by members of the Administration on the options they considered in developing their proposal, we have not had the opportunity to have any in-depth, detailed discussions to clarify their proposal. Likewise, the Administration needs to have a chance to question us about our approach.

In the past weeks, we have heard about the differences among the various plans, but there are also some significant similarities. That is not to say we should underestimate the challenge that looms before us. Even the provisions which have tremendous support, have detractors in Congress.

Nonetheless, it is certainly possible that such serious discussions would bring us closer to agreement on those issues we have in common -- specifically those on the chart behind me.

Let me use the areas of similarities as an example, to illustrate why we need early consultation as well as a clear time table for action. We face a daunting task. Even on common ground the pitfalls are many.

Insurance market reform -- The different proposals move toward a so-called "community rate" in dramatically different ways.

Reduction of cumbersome paperwork -- now estimated to eat 17 cents on the health care dollar. Most of us think administrative simplification will save money and time. But concerns about privacy and overregulation are beginning to be heard.

Medical liability reform -- so that doctors and hospitals will not have to pass along their backbreaking malpractice premium costs to us, their patients. Last year, ob-gyns in Rhode Island had to pay an average of $52,800 in liability insurance. That's $21 per billable hour!

Although the case for tort reform is compelling, and every proposal mentions reform, the Republican approach is comprehensive, while others are timid.

Antitrust reform -- so that it will no longer be a crime for two hospitals to share a $2.3 million MRI machine. In a May 7 Finance Committee hearing, we got a taste of how contentious this issue can be.

Special assistance to rural and inner-city areas. We understand that giving an insurance card to folks in rural Alaska or inner-city Detroit does not mean that physicians will flock there to set up practice. Additional incentives need to be built into the system.
But who will pay for those incentives and how they will be implemented will be hotly debated.

Establishment of purchasing groups. The similarity on this issue begins and ends with the word purchasing. The debate over governance, authority, and membership will cut to the heart of the reform debate.

Setting quality assurance standards -- so that people can have confidence that their care and coverage are top-notch. But the extent and nature of such standards vary greatly.

Creation of a standard benefit package -- to ensure people have adequate coverage, and to provide a basis for comparison of health insurance plans. But what's in and what's out is already the source of intense discussion

100% deductibility of reasonable health expenditures for all Americans. But up to what amount?

Long-term care tax clarification.

Federal subsidies to low-income individuals who otherwise cannot afford health insurance.

Expansion of outcomes research -- so that we know what works and what doesn't, and can begin to base our health care choices on that information.

Encouragement of managed care -- Health Maintenance Organizations and the like -- as a way of keeping costs low. Yet at the same time, the Administration is talking of a guaranteed fee-for-service plan.

Emphasis on primary and preventive care. Regular visits to the family physician, the internist, the pediatrician, the nurse practitioner, the ob-gyn -- keep us healthy -- and save us a bundle of money. All agree on this.

Preemption of state mandated benefits.

That makes fifteen points on which some might say we are close to consensus. Yet, as you can see, even these have the potential of exploding.

Intense and early consultation and discussion between Senate Republicans and the Administration on these issues may give us the foundation of a bipartisan proposal. It will also make it easier to resolve the major, defining differences between the Administration's and the Senate Republican proposals.

THOSE DIFFERENCES ARE:

EMPLOYER versus INDIVIDUAL MANDATES -- The Administration proposal requires employers to pay 80% of the health insurance premium for their employees, while and employees must pay at least 20% of the cost. Republicans believe that the appropriate reforms and federal assistance to low-income employees and individuals will make insurance affordable and accessible to all Americans so that additional payroll burdens of this magnitude will not be required.

PRICE CONTROLS -- The Administration establishes a national health care budget, by capping the cost of the premiums that can be negotiated by the Alliances. Republicans, instead, believe that realigning incentives and reducing bureaucracy will lead to lower costs, better service, and higher quality.

LARGE NEW ROLE FOR GOVERNMENT

Mandatory Single Health Alliances -- The Administration requires all businesses with fewer than 5000 employees to purchase their health insurance through their region's health alliance, which would be state-run under federal guidelines. Some estimate that as much as 90% of Americans would be forced to purchase coverage through a large bureaucratic entity. According to estimates we have seen, most Health Alliances will control larger budgets than do many state governments. For example, in California, the health budget would exceed the state's by 26%, and in Texas, by 59%. The Republican plan allows multiple purchasing cooperatives in a region and leaves customers free to continue to purchase outside the cooperatives. The cooperatives must be non-profit and member run. They will have to provide valuable service in order to attract customers.

National Health Board with Broad Powers -- The Administration's plan sets up a federal board with the responsibility to set and amend the standard benefit package; establish premium caps; and enforce individual, business, insurance and state adherence to Alliance rules.

The role of the federal benefits commission under the Republican plan is limited to refining the standard package. Insurance plans will be certified by the states.

FINANCING -- The Clinton proposal envisions raising certain taxes and making program cuts, but does not tie implementation of new Medicare entitlements and universal coverage to availability of revenues. If the anticipated savings are not achieved, it will be a serious new hit on the budget, increasing the pressure for new taxes and additional spending cuts, or leaving the bill for our

children to pay. Republicans favor reducing the rate of growth in federal health programs, as well as tying an accelerated phase-in of coverage to demonstrated savings -- a "pay-as-you-save " approach.

So there you have my thoughts. There is much hard work ahead. Let's begin serious discussions between the Administration and Republicans immediately, let's set forth an realistic timetable for consideration of health care reform bill at least in the Senate, and let's get this thing done. There is no time to waste. Thank you.

September 14, 1993

INTRODUCTION

Over three years ago, Senate Republicans formed a Task Force to study our health care system. Since its formation, the Task Force has been meeting regularly to examine our current system, its problems, and the myriad proposed solutions.

We have directed our efforts toward creating a reform proposal that reflects the views of an ideologically and regionally diverse group of Republican Senators. We are united on the goals of maintaining and improving the high quality of our current system, controlling the escalating costs borne both by the private sector and government, and ensuring that all Americans have the security of access to stable and affordable health insurance. We believe we have developed a proposal that meets these goals by building on the private health care system.

The Senate GOP Task Force proposal is based on the premise that, on the whole, our health care system works. The 85% of Americans with insurance have access to high quality care - the finest in the world. For most of them, health insurance premiums are affordable right now. But there are serious problems that if not corrected will threaten the security of all Americans.

The intent of our proposal is to minimize disruption to the working parts of our system, while seeking to correct the problems that jeopardize even its most successful facets: the spiraling rate of growth in health care spending and the hidden costs of providing care to those who do not have health care coverage.

In examining this issue, members of the Task Force have concluded that while our system does not need radical revision, it does need comprehensive reform. Our proposal makes a number of changes to facilitate and enhance competition in the health care marketplace. These changes, combined with provisions to give consumers information that will help them make cost-effective choices, will lead to improved quality of health care and a significantly reduced rate of growth in costs. In addition, our proposal will ensure that all Americans gain access to affordable health care without adding to the federal deficit.

Our proposal is divided into two sections. The first consists of the structural reforms in our health care system designed to improve the availability, security, and affordability of health insurance, and to improve the efficiency of health care

while holding down escalating health costs. These changes can be enacted immediately. The second provides federal financial assistance on a phased-in basis to those for whom insurance remains out of financial reach, even after the changes outlined in the first section are completed.

STRUCTURAL REFORMS

Current insurance market practices favor large employers and give these employers some measure of control over the health care costs of their workforce. Their large number of employees enables them to negotiate better insurance premium rates with insurers, or to negotiate reasonable prices directly with health care providers. In addition, with few exceptions, all of their employees pay the same premium and are not denied coverage on the basis of health status. Employers also are able to deduct 100% of the cost of health care coverage, and employees receive these benefits tax-free.

The Senate GOP Task Force proposal extends these same advantages to individuals, to small businesses and their employees, and to the self-employed. First, the proposal requires insurers to provide coverage to everyone regardless of health status and limits insurers' ability to charge higher premiums to those who are sick. It prevents insurance companies from marketing and selling only to healthy individuals and groups by reforming the private system, establishing purchasing cooperatives, and making risk adjustments between plans.

Second, the proposal allows individuals (such as workers with no employer-paid insurance) and the self-employed to deduct the cost of their health insurance premiums. Today, the self-employed can deduct only 25% of their premiums and individuals, none at all.

Throughout our proposal, we have remained sensitive to the notion that "one size does <u>not</u> fit all." The proposal sets broad federal guidelines within which states, communities, insurers, providers, and businesses can operate. We include options and special incentives to expand and improve the availability of quality medical care in frontier, rural, and inner city America. We also realize that in some instances, states may want to go in a completely different direction in delivering health care to their residents. We give states the ability to move forward on their own versions of health care reform without subjecting them to unreasonable federal restraints.

The proposal also restructures the treatment of health insurance premiums in the federal tax code. Current tax subsidies of employer contributions to health plans over the next five years will amount to about $60 billion annually. These subsidies are available only for employer-paid health premiums and not for the individual or the self-employed. They provide for full tax preference regardless of the quality, cost, or efficiency of the plan. We spread this benefit more fairly by making it available to individuals and the self-employed. In order to make consumers more cost-concious in their selection of plans, the proposal limits the amount of premium costs that can be tax-free to individuals and deductible to employers.

Our proposal also makes a variety of changes to the system that we believe will stop the uncontrolled growth of health care costs and improve the quality of care.

It reforms medical liability laws to reduce the unwarranted lawsuits and irrational damage awards that have led providers to order unnecessary tests and procedures and to practice defensive medicine.

It reforms anti-trust laws which prohibit hospitals and physicians from sharing costly medical equipment and capital to make more efficient use of health care resources.

It establishes standardized forms and electronic information reporting and exchange requirements to eliminate bureaucratic red tape and reduce administrative costs and burdens.

We believe that we will reduce costs and improve quality by providing consumers and health care providers with more information. With better information, consumers can make informed choices about health insurance plans, providers and treatment options. In addition, by expanding outcomes research and practice guidelines, health care providers can remain informed about the most cost-effective procedures and treatments.

COVERING THE UNINSURED

Of those who are uninsured, at least 40% have incomes greater than 200% of poverty. The structural changes outlined earlier will significantly increase the availability, security, and affordability of high quality health care for most of these Americans. In addition, we believe these changes will slow the

rate of growth in health care expenditures, in both the private and public sectors.

There will, however, be some Americans who will not be able to afford even reasonably priced health insurance. The second section of our proposal lays out a plan to make available a federal voucher for those individuals and families who, without financial assistance, cannot afford coverage. The voucher will be equal to an income-adjusted percentage of the cost of the standard benefit package, and will be used to purchase coverage from a certified health plan.

As was indicated earlier in this paper, we believe that our proposed structural changes will lead to substantial federal savings. It is our understanding, however, that, at this point, the Congressional Budget Office (CBO) will credit only limited savings to any reform proposal other than a highly regulatory; Canadian-style, single-payor system.

Moreover, we also are mindful of the admonition of the Office of Technology Assessment (OTA) that, "There is a startlingly wide range of estimates of the impact of the selected approaches to health care reform on the areas of the economy examined." In light of these points, we have concluded that the most prudent approach is to pursue reforms in federal health care programs that will slow the rate of growth in federal spending and then use those savings to pay for a schedule of increased access for the poor. Our proposal contains plans for an accelerated phase-in if structural changes in the health care marketplace result in greater or earlier savings than currently scored by CBO.

We are very mindful of the fact that budget savings estimates are, in fact, just estimates. They are based on assumptions about future behavior of consumers and providers and the efficiencies of the markets they impact. Our experience with budget estimates tells us that for major program changes, these estimates have been an imprecise predictor of actual savings. We do not believe that we should promise the American people a new entitlement program that we are not certain we can pay for.

Our proposal sets in place the following phase-in of federal assistance. By the end of 1995, all individuals with incomes of below 90% of the federal poverty level will receive federal assistance. By 1996 it will increase to 120%; 1997 to 140%; by 1998 to 70%; by 1999 to 200%; by 2000 to 240%. This coverage will be financed by limiting the rate of growth in Medicare and

Medicaid from 12% to 7%. In addition, our proposal requires the Congressional Budget Office, or other appropriate entity, to make an annual assessment of whether or not the structural changes have achieved greater savings than originally projected. If so, the phase-in will be accelerated accordingly. If, on the other hand, the savings in a given year are inadequate to finance either an acceleration or a scheduled step, the phase-in of assistance will be delayed unless Congress finds an alternative financing mechanism.

SECTION I: BASIC AND STRUCTURAL REFORMS

PART A: BASIC REFORMS

1. Insurance Market Reform

Purpose: to eliminate competition between insurers based upon selection of low-risk consumers; to ensure competition based upon quality, price, service, and choice.

Intended result: to increase availability of insurance to individuals and small business employees; to provide health security, control costs, and improve quality of care.

A. Qualified Health Insurance Plans will:

1. Guarantee eligibility to all applicants.
2. Guarantee availability throughout the geographic region in which the plan is offered.
3. Guarantee renewal to all participants except in instances of non-payment of premiums or fraud.
4. Not discriminate on the basis of health status.
5. Offer the standard or catastrophic benefit package.
6. Offer an adjusted community rate premium (after a transition) for individuals and small businesses defined as 100 or fewer employees who purchase through a purchasing cooperative. During the transition:
   a. rating bands will be applied in the first year; over the following years they will be narrowed to an adjusted community rate. States may shorten the phase-in.
   b. individuals who cannot demonstrate coverage in the previous year may be subject to a six-month pre-existing condition exclusion for expenses related to an illness that was evident within the previous three months.
7. Offer a community rate to individuals and small businesses who do not purchase insurance through a cooperative.
8. Participate in risk-adjustment.
9. Meet quality standards.
10. Comply with administrative standards and reporting requirements.
11. Meet solvency criteria.

2. Administrative Simplification

Purpose: to provide uniform federal guidelines for standardization of electronic data exchange and reporting to reduce red tape and bureaucracy and to eliminate duplicative forms.

Intended result: to lower costs, streamline operations, provide information on technology and quality, and generate a "report card" for consumers to compare quality of plans.

A. The Secretaries of Health and Human Services (HHS), Department of Defense (DoD), and Veterans Affairs (VA), and others appointed by the President, will make up a Federal Administrative Standards Panel. A Commission composed of private sector experts will advise the panel.

B. Duties of the Panel

1. Adopt data standards, within two years, for the electronic reporting and exchange of health care information. Such standards should be:
   a. based on existing, widely-used criteria.
   b. designed to include data related to enrollment, eligibility, quality measurement, utilization management, risk assessment, patient satisfaction, outcomes, appropriate data to monitor access to health care services, and other data sets as deemed appropriate by the panel.
   c. contain strict measures to ensure confidentiality of data.
2. Establish business practices for operation of a nationally-linked health care information database system.
3. Develop appropriate civil and criminal penalties for non-compliance.

C. Oversight and implementation of standards
HHS is responsible for oversight, enforcement, and implementation of data standards; and for establishment of a certification procedure for database, computer and network vendors.

3. Medical Liability Reform

Purpose: to resolve disputes more effectively and efficiently; to reduce the practice of defensive

medicine, unnecessary tests and procedures; to identify and correct bad practices; and to ensure that those who are the victims of negligence are fairly compensated.

Intended result: to lower medical costs and to improve quality of care.

A. Mandatory, non-binding Alternative Dispute Resolution (ADR)
   1. Parties must participate in an alternative dispute resolution system established by the state.
   2. Plans are required to explain this process in their descriptive materials to beneficiaries.

B. Litigation
   1. If one of the parties in the dispute wishes to challenge the result of ADR, he/she may do so
   2. If the decision rendered in court is less favorable to him/her than in ADR, he/she shall pay all legal fees subsequent to ADR.

C. Damages
   1. Non-economic damages are capped at $250,000.
   2. Malpractice awards shall be reduced for any collateral source payments to which the claimant is entitled.
   3. Periodic Payments
      Claimant will be required to accept periodic payment as opposed to lump sum on awards exceeding $100,000.
   4. Punitive damages
      50% of a punitive damage award shall be paid to the State for activities approved by the Secretary of HHS to improve monitoring, education, and disciplining of health care providers in that State.

D. Reform of Procedures
   1. Statute of Limitations
      a. except for minors, no health malpractice action may be initiated more than two years after the date on which the alleged injury should have been discovered, and in no event later than four years after the date of the occurrence.
      b. with respect to injuries alleged to have occurred to minors (under 6 years of age), no health malpractice action may be brought after reaching 12 years of age.

2. Joint and Several Liability
   For non-economic and punitive damages, liability for payment of damages shall be based on the degree of contribution to the negligent act.

E. Practice Guidelines Rebuttable Presumption
Providers following practice guidelines approved by the Agency for Health Care Policy and Research (AHCPR) shall have a presumptive defense against malpractice claims.

F. Products: drugs and devices
   1. All medical liability reforms listed above apply.
   2. If approved by the Food and Drug Administration (FDA) and used properly, no punitive damages will be allowed.
   3. If FDA approval was based upon misleading or false information, the prohibition on punitive damages will not apply.

4. Quality Assurance

Purpose: to ensure that health plans have an approved quality assurance plan, to establish national standards for reporting quality information, and to expand the availability of information available to health plans and health care providers on practice guidelines and outcomes.

Intended result: to maintain the high quality of care in our current health care system and to provide information to consumers on the quality of each health plan to assist in selecting a health care plan.

A. Health insurance plans must have a recognized quality assurance program as defined by the Secretary of HHS. In developing such standards, HHS must consult with recognized private sector entities engaged in quality assurance, such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, or other recognized organizations.

B. Plans must provide quality data including information on outcomes and effectiveness in the format developed by the Secretary of HHS in conjunction with the Federal Administrative Standards Panel.

C. AHCPR is directed to expand its present research agenda to include the following:
   1. A fund investigator to initiate research on the relationship between treatments and outcomes.
   2. Priorities for the research community to strengthen

the research base.
3. Effectiveness trials in collaboration with medical specialty societies and qualified health plans.
4. A clearinghouse and other registries on clinical trials research data.
5. Continued and expanded development of practice guidelines to provide information to health care practitioners and plans.

D. Establishes a Medical Research Trust fund to guarantee funding for medical research.

5. Anti-Fraud and Abuse

Purpose: to expand criminal and civil penalties for fraud and abuse in our health care system.

Intended result: to provide a stronger deterrent to the billing of fraudulent claims and to eliminate the waste in our health care system due to these practices.

A. Requires the Secretary of HHS to establish and coordinate a national health care fraud program, and establishes the Anti-Fraud and Abuse Trust Fund to finance these efforts. Monies from penalties, fines, and damages assessed for health care fraud would be deposited into the trust fund.
B. Increases and applies civil money penalties now available under Medicare and Medicaid to fraud in all health care programs.
C. Allows competitors to sue health care providers who defraud Medicare and Medicaid for damages if the government does not bring charges against the fraudulent provider.
D. Requires health care providers who are convicted of health care fraud felonies to be excluded from the Medicare program.
E. Requires HHS to publish the names of providers and suppliers who have had final adverse actions taken against them for health care fraud.

6. Antitrust Reform

Purpose: to reduce unnecessary duplication in our health care system and to allow providers to share resources.

Intended result: to reduce costs in, and increase access to, our health care system.

A. The Attorney General, in consultation with the Federal Trade Commission (FTC) and the Secretary of HHS, shall establish competition guidelines and safe harbors for state-licensed health care providers and for qualified health plans and buying cooperatives, including guidelines for areas where competition cannot function effectively, e.g., certain rural areas.

B. The Attorney General, in consultation with the FTC and the Secretary of HHS, shall promulgate standards and procedures to issue on an expedited basis waivers, which shall exempt persons and organizations in the health care market from all penalties (civil and criminal) under the anti trust laws. The Departments of Justice and HHS, and the FTC, shall establish procedures for expedited waiver review.

C. Cooperative ventures in the health care industry, when not deemed approved by certificate or other public license, shall be subject to the rule of reason analysis.

D. Buying cooperatives may be organized to represent consumers.
   1. Such cooperatives shall be deemed single entities under the antitrust laws and shall not be found to be illegal combinations in restraint of trade under the antitrust laws.
   2. Such cooperatives shall be subject to the antitrust laws for any anticompetitive use of buying power, unless subject to safe harbor or approved certificate.

7. Rural and Inner City Special Assistance

Purpose: to acknowledge that pure competition may not work in certain areas of the nation, particularly medically underserved areas, both urban and rural; that additional funds and services need to be provided for these special needs populations.

Intended result: to assure that persons living in rural and inner city areas have access to high quality health care.

A. Grants to States for Coordination of Health Care Services

1. A block grant to states will be established to assist in the delivery of health care to populations residing in rural and inner city urban areas.
2. States will develop a plan for expanding and /or coordinating existing state and federal health programs, or could use funds to provide services for which federal funds are not currently available.

B. Additional Requirements for Health Plans serving Special Needs Populations
1. Health plans will be required to provide additional benefits to populations in defined geographic areas.
2. Health plans will be compensated for these services either through a method of enhanced reimbursement or through a grant program.

8. Primary Care Provider Education

Purpose: to increase the number of health care providers who choose the field of primary care as opposed to specialty care.

Intended result: to increase the number of primary care providers in medically underserved areas.

A. In order to increase the number of primary care providers
1. Medicare graduate medical education (GME) demonstration authority would be established.
   a. Under this authority, seven states and seven health care training consortia would pool GME funds, which would have otherwise been paid directly to hospitals by Medicare.
   b. This would allow states or consortia to experiment with methods of changing the physician specialty-mix.
2. National Health Service Corps funds would be increased.
3. Health professions funding through the Public Health Service for primary care provider education would be increased.

9. Long-Term Care

Purpose: to clarify tax treatment of long-term care expenditures vis-à-vis other health care expenditures and to establish consumer protection standards in long-term care insurance.

Intended result: to provide the same federal tax treatment to long-term care expenditures as applies to other health care expenditures; to encourage greater participation in providing for long-term care needs.

A. Tax Clarification/Insurance Reform
   1. Clarifies that all long-term care services (institutional, home, and community-based care) are treated as medical expenses under current tax law:
      a. long-term care expenses and insurance will be tax deductible (above 7.5% of Adjusted Gross Income).
      b. payments under long-term care insurance policies will not be taxable when received.
      c. employer contributions to long-term care insurance will be tax-free fringe benefits.
   2. Clarifies that insurance companies can deduct reserves they set aside to pay benefits under long-term care policies.
   3. Requires that long-term care insurance policies meet certain minimum consumer protection standards to receive favorable tax treatment.

PART B: ESSENTIAL STRUCTURAL REFORMS

1. Establishment of Small Business and Individual Purchasing Cooperatives

Purpose: to provide the market advantages of large employers to individuals and employees of small businesses and to provide more information to the consumer.

Intended result: to lower the cost of health care coverage, to lower administrative costs; to provide more information to the consumer, and to achieve better service and quality.

A. States will establish geographic areas in which individuals and small businesses may form purchasing cooperatives.
   1. The State may authorize one or more purchasing cooperatives in a geographic area.
   2. Interstate agreements for geographic regions encompassing more than one state can be established.
   3. States will be responsible for making risk adjustments between all health plans operating in a given geographic region, in accordance with federal guidelines.

B. The membership of these purchasing cooperatives will be limited to employers and employees in businesses of 100 employees or fewer, and to all other individuals not enrolled in an employer health benefit plan who live or work in the geographic area.
   1. Purchasing cooperatives must allow all eligible businesses or individuals to join.
   2. Purchasing cooperatives may be governed only by the members.
   3. Purchasing cooperatives will collect premiums from members and forward them to the appropriate plan.
   4. Purchasing cooperatives must offer eligible individuals the opportunity to enroll in a health benefit plan within thirty days for new enrollees, or after first becoming eligible to enroll in the purchasing cooperative. Each fall an open-season date will be set by the Secretary of Health and Human Services. During that time, purchasing cooperatives will allow eligible individuals to enroll in a benefit plan or to change the plan in which they are enrolled. In addition, they will maintain a special enrollment process for individuals who experience a change in family status during the year.
   5. Purchasing cooperatives can charge members a limited fee to pay for operating expenses.
   6. Purchasing cooperatives will distribute to their members information regarding prices, outcomes, enrollee satisfaction, and other information pertaining to the quality of the plans offered within the purchasing cooperative.

C. Small business associations that currently offer health insurance to their members, and that exist for reasons other than to offer health insurance, will be allowed to

continue to offer health insurance plans to their members, but will be subject to the same insurance market reform requirements as the purchasing cooperatives.

2. Responsibility for Coverage

A. Individual Responsibility

Purpose: to ensure that all Americans have health care coverage.

Intended result: to require individual responsibility, increase consumer awareness of costs, reduce cost-shifting and bad debt due to uncompensated care.

1. A requirement for individuals to obtain health insurance coverage is phased-in based upon an individual's ability to purchase the standard health plan, and will be tied to the phase-in of federal assistance for low-income, uninsured individuals. The requirement also can be met through enrollment in Medicare, Medicaid, VA, or CHAMPUS.
2. The penalty for non-compliance, once the proposal is fully implemented, will be equal to the average yearly premium in the local area plus 20%.

B. Small Employer Responsibility

Purpose: to ensure employees of small business are given an opportunity to make informed health care choices.

Intended result: to increased choice and to increase awareness of quality and cost issues.

1. An employer with 100 or fewer employees may either join a purchasing cooperative in the geographic area in which it does business or offer a standard benefit plan through a qualified health plan.
2. The employer will collect and send premiums and any operating fees to the purchasing cooperative or health insurance plan on behalf of its employees.

An employer is not required to contribute to the cost of premiums or operating fees.

3. In an area with multiple, competing purchasing cooperatives, the employer will select the purchasing cooperative.
4. The purchasing cooperative will supply the employer with information for his or her employees.
5. For the purpose of this provision, an employee is defined as any individual receiving a salary from the employer.

C. Large Employer Responsibility

Purpose: to maintain participation of large companies to control costs.

Intended result: to maintain a competitive marketplace, to increase potential for quality improvements, and to increase awareness of cost issues.

1. Employers with greater than 100 employees may form cooperatives or other entities for the purpose of purchasing health insurance.
2. Multi-state employers may make a decision whether to treat each employment entity or location as a single entity for the purpose of determining whether or not it may obtain coverage through a purchasing cooperative in its geographic area.

3. Tax Treatment of Health Care Costs

Purpose: to create equity in the tax code.

Intended result: to increase the number of Americans with insurance.

Purchasers of certified health insurance plans will receive favorable tax treatment up to a limit - the so-called "tax cap."

A. Tax-free fringe benefits

1. employer-paid health insurance premiums up to the amount of the tax cap will be tax-free to the employee.
2. employer-paid health insurance premiums in excess of the tax cap will be taxable to the employee as income.

B. Deductibility
   1. the cost - up to the tax cap - of a plan will be fully deductible to individuals and the self-employed, regardless of employment status.
   2. the deductibility of health insurance premiums paid by individuals for certified health insurance plans will not be limited by the 7.5% medical expense deductibility floor; all cost-sharing, co-payments, co-insurance, deductibles, and other out-of-pocket costs will continue to be deductible only to the extent they exceed 7.5% of Adjusted Gross Income.

C. Employer deduction
   1. the cost - up to the tax cap - of providing a certified health insurance plan can be deducted by the employer.

D. Tax Cap
   1. the tax cap applies both to the excludibility of health insurance provided to an employee by an employer and to the deductibility of health insurance premiums paid by an individual.
   2. the cap is calculated as the average cost of the lowest priced one-third of the certified health insurance plans offered in the purchasing cooperative area in which an individual lives or works.

E. Medical Savings Accounts (MSAs)
   1. an MSA will be available for those individuals electing the catastrophic benefit plan option.
   2. contributions to an MSA will be tax-favored up to the amount of the tax cap, i.e., they will be fully deductible if made by the individual and excludible from taxable income if made by the employer.
   3. the cost of the catastrophic benefit plan premiums must be subtracted from the tax cap in determining the amount of contributions to an MSA that will receive tax-favored treatment.
   4. funds remaining in an MSA at the end of the year can be carried forward to the subsequent year. Amounts carried over from a previous year will be subtracted in computing the applicable tax cap for the individual in the subsequent year.

4. State and Federal Certification of Health Insurance Plans

Purpose: to ensure plans are of high quality.

Intended result: to ensure high quality care, fair competition, consumer security, and standardization sufficient to allow consumer evaluations.

A. Plans must be certified, by the state in which they are offered, as meeting the following federal guidelines, in order for a purchaser of a plan to receive favorable tax treatment under the Internal Revenue Code:

1. demonstrate the ability to deliver the full range of services required by the standard benefit plan throughout the geographic area in which they are offered, as defined by the State. States may not require plans to cover specific providers or types of providers.
2. comply with special requirements for designated underserved areas.
3. provide the required arbitration procedures and information about alternative dispute resolution (as defined in the benefits and malpractice sections).
4. establish a provider risk management program to prevent or provide early warning of practices that may result in injury.
5. comply with risk adjustment requirements defined by the state.
6. comply with the standard administrative reforms.
7. meet quality criteria.
8. demonstrate insurance market reform (outlined earlier).
9. meet solvency criteria as defined by the Secretary of HHS.

B. The Secretary of HHS will establish a federal procedure to approve any plan offered by a multi-state employer.

5. Benefit Package

Purpose: to meet basic health care needs; to limit the ability of insurers to use benefit plan design to attract only the lowest risk individuals; to ensure that

plans compete based primarily on product - service, quality, price - rather than on the health of their subscribers; and to make equitable tax subsidies available to all Americans.

Intended result: to ensure that consumers can draw comparisons between plans; costs are controlled; access, quality, and services delivery are improved.

A. Standard Benefit Package Guidelines:
   1. Medical and surgical services and equipment.
   2. Prescription drugs and biologicals.
   3. Preventive health services.
   4. Rehabilitation and home health services related to an acute care episode.
   5. Severe mental health services (narrowly defined).
   6. Substance abuse services.
   7. Co-payments and deductibles for all but certain preventive health services.
   8. Plans are required to cover the cost of a service only if it is medically necessary. The benefit plan does not create an entitlement to each benefit. Other benefits may be purchased, but will not receive favorable tax treatment.

B. Alternative catastrophic benefit plan with an integrated cash value medical expense account or income-related deductible.
   1. Same benefit parameters as above.
   2. High cost sharing, including deductibles (Amount rolled over from year to year)

C. Benefit disputes
   1. Plans and enrollees are required to resolve such disputes through a timely, mandatory, binding-arbitration process.
   2. Enrollees must show by a preponderance of the evidence standard that the plan's decision to decline the service is inappropriate based upon available scientific evidence.

6. Benefits Commission

Purpose: to ensure members of Congress will not become embroiled in debates about whether to include specific types of benefits, procedures, providers or treatments under pressure from special interests. To allow for adjustment of the standard benefit package while

ensuring that the cost of the package can be covered with a reasonable, affordable premium.

Intended result: to set a rational, appropriate benefit structure, to control costs, to increase focus on efficiency and effectiveness.

A. Appointed by the President, and Majority and Minority leadership in the House and Senate.
B. Charged with clarifications in benefit plan.
   1. Required to report a clarified benefit plan to Congress within six months; is precluded from adding, but may reduce benefits. Congress will vote on the proposed changes within 60 days of its submission en bloc - no amendments (similar to the base closing process).
   2. After year one, changes (additions as well as deletions) to the package can be recommended to Congress by the commission once a year; those changes must be voted on en bloc.
   3. Coverage decisions about new procedures or technologies generally are made by individual health plans. Plans may petition the Commission for a coverage decision under the following conditions:
      a. in the event a new technology or procedure shows evidence of substantial benefit <u>and</u> substantial cost, the Commission can exercise its discretion to make a national coverage decision, including an evaluation of the cost consequences of the decision.
      b. in the event a new technology or procedure becomes highly contentious, the Commission can make a national coverage decision in order to minimize disruption and dissent among the public.
      c. in both of the above circumstances, if the Commission acts to allow coverage, the decision must be voted upon by Congress.
C. Prohibited from specifying providers and provider-specific services.
D. Required to treat severe mental illnesses in the same manner as physical health services and subject to the same limitations and cost-sharing.

7. Ability of States to establish an alternative system

Purpose: to permit states flexibility to enact reforms to reflect alternative proposals.

Intended result: to allow experimentation in health care reform to more effectively meet the needs of the American people.

A. Any State may choose to establish its own system, by submitting a plan to the Secretary of HHS that demonstrates it can meet reasonable standards.
B. Such a plan must be reviewed, and either accepted or rejected, by the Secretary of HHS within 90 days.
C. The plan must show that generally the same percentage of individuals will be covered within the same time frame as the national average.
D. The State's annual rate of increase in health care spending must equal to, or lower than, the national, annual health care cost growth rate.
E The plan must be budget-neutral to the federal government.
F. The State is required to:
    1. meet all federal data collection standards and requirements.
    2. comply with federal medical liability reforms.
    3. offer a health benefit plan that has similar benefits and is actuarially equivalent to the standard benefit package or the catastrophic alternative.

PART C: TREATMENT OF EXISTING FEDERAL PROGRAMS

1. Medicaid

The Secretary shall establish a per-capita federal payment based on historical Medicaid costs. States may provide coverage to beneficiaries through a private purchasing cooperative, a managed care plan, or other alternative. The per capita rate of growth will be limited to the national average.

2. Medicare

A. Within one year of enactment, the Secretary of HHS will conduct a study and report to Congress on the phase-in of current Medicare enrollees into regionally-based

purchasing cooperatives. Current enrollees will have the option of remaining in the existing Medicare fee-for-service plan or entering into a revised Medicare risk contract until the phase-in plan is approved by Congress.

B. Medicare risk contracts will be revised and expanded to experiment with new models of service for the elderly.

3. **Federal Employees**
The Office of Personnel Management (OPM) will have the option of allowing federal employees in some areas to join the purchasing cooperative and of forming purchasing cooperatives with small businesses.

4. **Public Health Service**
No change in existing program.

5. **Veterans Administration health benefits**
No change in existing program.

6. **Department of Defense and CHAMPUS**
No change in existing program.

7. **Indian Health Service**
No change in existing program.

SECTION II
COVERAGE AND FINANCING FOR POOR AND WORKING POOR AMERICANS

PART A: GUARANTEED COVERAGE PHASE-IN

1. **By 1995**
By 1995, those with incomes below 90% of the federal poverty level (who are not eligible for Medicaid) will be provided with a voucher to purchase health care insurance through the individual and small group purchasing cooperatives.

2. **By 1996**
By 1996, the coverage for individuals will increase to 120% of poverty level; by 1997 to 140%; by 1998 170%; by 1999 to 200%; and by 2000 to 240% of poverty.

3. **Vouchers**
The vouchers for those eligible for assistance will be financed by reducing the combined average rate of growth in

Medicare and Medicaid from 12% to 7% over six years. The program changes made to reduce the average growth rate are:

A. Medicare
   1. Increase Part B co-insurance.
   2. Means Test Part B premium.
   3. Eliminate disproportionate share adjustment.
   4. Eliminate payments to hospitals for enrollee bad debt.
   5. Reduce IME and GME.
   6. Impose modest co-payments for labs and SNF.

B. Medicaid
   1. Eliminate Disproportionate share payments.
   2. Managed care.

PART B: ACCELERATED PHASE-IN

The guaranteed phase-in will be accelerated in the event the Congressional Budget Office (CBO) certifies additional federal savings from other structural reforms.