THE CHAFEE BILL

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When examined closely, the 850 page Chafee bill accomplishes much less than the rhetoric surrounding it suggests. It is described as providing universal coverage, but there is no requirement that individuals purchase coverage until 2005. It uses the tax code to discipline consumer behavior by denying tax deductions for health coverage costing more than the average of the bottom half of plans in an area. It maintains many features of the current insurance system.

The federal government plays a significant role in the proposal, from a Benefits Commission that develops and interprets the benefit packages and recommends cutbacks in the event of cost increases to IRS enforcement of the mandate and a tax cap. HHS would establish a nationwide eligibility determination structure to distribute vouchers to low-income individuals for health insurance.

Overview

The Chafee bill has the following major problems:

- There is no requirement for universal coverage until 2005. Even then, universal coverage is contingent upon funds being available for vouchers for those whose income is less than 240 percent of poverty, and may be expensive for those above 240 percent of poverty for whom no subsidies are available. Some families may be required to pay 15-20 percent of their income for health care.

- The tax cap, set at the average cost of the bottom 50 percent of health plans in a region, will mean increased taxes for millions of people, mostly middle-class Americans.

- The individual mandate will provide a significant disincentive for employers to continue to provide coverage, especially for low-wage employees (since the government will provide subsidies, or vouchers, to individuals with incomes less than 240 percent of poverty). This will increase program costs dramatically as companies drop coverage they now provide.

- The benefits package is not clearly defined.

- In the event that the costs of the voucher program, Medicare, and Medicaid exceed a baseline in the legislation, the Benefits Commission is required to recommend to Congress cuts in benefits, increases in out-of-pocket costs, or cuts in Medicare or Medicaid. Either through rationing benefits, increasing consumer costs, or cutting programs for

the poor or the elderly, the consumer pays for increases in costs beyond those specified in the legislation.

- There is no financing mechanism for the voucher system. The Chafee bill contains cuts in the Medicare and Medicaid programs, which make available some federal funding, and will produce additional revenue through the tax cap. But the funding is totally unrelated to the cost of the voucher system, and there is no other source of funding.

- There is a dramatic increase in federal control and bureaucracy.

  - A new commission determines benefits and specific cost sharing provisions.

  - The role of the IRS will be significant. The agency enforces the individual mandate and oversees the tax cap.

  - HHS would have to establish a national system to make voucher determinations for tens of millions of people.

- Much of the current insurance system is maintained. Individuals may still be denied coverage because they have preexisting illnesses, and insurance companies will be permitted to continue experience rating under certain circumstances.

Analysis

Failure to Provide Security

No Universal Access

The Chafee bill purports to phase in universal coverage by 2005 -- leaving millions of Americans uninsured for at least the next twelve years.

Even in 2005, universal coverage will not be achieved. Universal coverage is contingent upon cost savings in the Medicare and Medicaid programs -- if savings are not achieved, federal subsidies are cut, preventing low-income Americans from affording coverage. Subsidies for certain categories of people are not adequate, in any event, to make insurance affordable.

No Significant Insurance Reform

The Chafee bill includes only minor insurance reforms -- allowing the continuation of

modified experience rating and some pre-existing condition exclusions. Since the purchasing groups are voluntary, marketing to low-risk groups and individuals by insurance companies will continue.

By allowing insurance companies to charge different prices on the basis of age and administrative efficiencies, insurance companies will continue to market coverage to the young and healthy and to discriminate against older and sicker Americans who need health insurance the most.

Further, those individuals with illnesses who seek coverage may be excluded, since the bill permits insurance companies to deny coverage to individuals with preexisting conditions for six months under certain circumstances.

Comprehensive Benefits Not Guaranteed

The benefit package is not clearly defined in legislation; the benefits are listed in thirteen lines of the bill. At best it is unclear what the benefit package includes, with no mention, for example, of vision, dental or extended care services.

A Benefits Commission is charged with clarifying the benefit package through a recommendation to Congress, which must be affirmatively approved by the Congress. The clarification recommendation to the Congress may delete benefits, but may not add them.

The bill requires that all plans cover the listed benefits, through either a standard or a catastrophic cost sharing policy. The Commission must define covered services, deductibles, cost sharing and out-of-pocket limits, and submit them to Congress as part of the clarification report. The Benefits Commission could, for example, recommend a copayment or coinsurance payment of 50 percent or more of any payment.

Because the benefits will be defined later, there is no guarantee that the package will be comprehensive or that all Americans will be able to afford the cost-sharing.

The Benefits Commission may also recommend at any point that benefits be reduced. If health care spending for Medicare, Medicaid, and the voucher program exceed the baseline amount stated in the bill, the Commission may recommend benefit cuts, reductions in eligibility for the voucher program, Medicare or Medicaid cuts or a reduction in the tax cap. In the event that the Commission recommendations are not approved by the Congress, the funds available for the voucher program are reduced by the amount of any shortfall for the year, limiting the availability of coverage for low-income people.

Inadequate Financing Mechanisms

The federal government is responsible for providing vouchers for low-income individuals, but the cost to the government cannot be calculated without knowing the benefit

package. The bill does contain cuts in Medicare and Medicaid, but there is no connection with financing of the voucher system.

A baseline of federal health expenditures (projected Medicare, Medicaid, and voucher spending) is established. If spending is more than anticipated, the voucher phase-in is delayed (or benefits reduced) and, after phase-in, the voucher program must be reduced, meaning no real universal coverage.

Taxing the Middle Class

The Chafee plan removes tax deductibility for benefits contributions above the average cost of the bottom 50 percent of health plans in a region. This will mean increased taxes for millions of people, mostly middle-class Americans. We are currently calculating the amount of the tax increase.

Less Choice

The Chafee bill gives large, managed care plans a competitive advantage over community-based plans. Because of these advantages, individuals will have less choice of plans than they do today and may be forced to join managed care plans.

Health plans must cover an entire "health care coverage area", which may be as large as an entire state, may not be smaller than a metropolitan statistical area, and may include no fewer than 250,000 individuals.

There is no requirement that individuals be offered a fee-for-service plan or a point-of-service option in managed care plans.

Extensive Federal Control and Bureaucracy

The Chafee bill adds layers to the existing federal bureaucracy and gives broad new authorities to federal agencies to regulate the private sector.

- A new federal commission, the Benefits Commission, defines the benefit package through a long and complicated process requiring that a series of proposals be submitted to Congress.

- In addition, there will be an expansion of the role of existing agencies.

  The Department of Health and Human Services will have the following new responsibilities:

  - A new apparatus within HHS must be created to determine eligibility for and to administer vouchers to everyone in the country whose income

is 240 percent of poverty or less. The eligibility determination process, though not spelled out in the bill, would be enormous.

- A new office within HHS, the Office of Health Care Competition Policy, implements health care antitrust policy.

- HHS, with the Department of Labor, regulates large employer plans. It develops standards to require that large employers: guarantee availability to all eligible employees; guarantee to all enrollees coverage for services; meet quality assurance criteria; and provide standardized information to evaluate the performance of the plan.

- HHS oversees the quality assurance system by:

  - Developing standards and measurements of quality with which the quality assurance programs must comply;

  - Publishing annual reports on expenditures, volumes and prices for procedures;

  - Developing comparative information regarding the relative performance of specialized centers of care;

  - Studying the feasibility of creating an Agency for Clinical Evaluations; and

  - Evaluating and disseminating information on research priorities and data about effectiveness trials.

- HHS develops and certifies models of alternative dispute resolution to be used by health plans.

- HHS establishes and coordinates a national health care fraud program.

- HHS creates a new program to administer grants to the states for low-income and medically underserved populations.

- A new office within HHS, the Office of Emergency Medical Services, provides technical assistance to state EMS programs.

- HHS develops and submits to Congress a proposal for the integration of Medicare beneficiaries into qualified health plans.

- HHS establishes a Health Insurance Coverage Data Bank.

- The Department of Labor develops standards for large employer plans, in addition to those imposed by HHS. Large employer plans must: meet financial solvency requirements; meet premium payment and collection criteria; provide mediation procedures for hearing and resolving malpractice claims; offer both the standard and catastrophic benefits packages; provide an alternative plan if more than 50 percent of the eligible employees so elect; and provide for equitable enrollment criteria.

- The IRS enforces the individual mandate and limitations on tax deductibility of benefits. These responsibilities require significant expansion of IRS oversight. To enforce the tax cap alone, the IRS must measure, for every family in the country, the cost of health insurance as compared to the low cost plan in the area and calculate the tax status of their health benefits.

Maintenance of Current Insurance Market Practices

The Chafee bill allows, but does not require, small employers (fewer than 100 employees) and individuals to join purchasing groups and does not permit employers with over 100 employees to join. Because risk is spread across an entire purchasing group, low-risk individuals and employers with low-risk employees -- who can find less expensive coverage outside the purchasing group -- will choose not to join the purchasing group.

The purchasing groups will become insurers of last resort, with a high-risk population and high premiums. The higher the premium, the more likely small employers and individuals will attempt to avoid joining the purchasing group.

With the continued ability of insurance companies to market to healthier populations, the high administrative costs in the current insurance system -- including substantial underwriting and marketing costs incurred in attempting to insure only low-risk individuals -- will continue.

Underserved Populations

The Chafee bill provides only limited funding for public health initiatives and investments in underserved areas. It eliminates current disproportionate share payments under Medicare and Medicaid, hurting facilities in underserved areas, at the same time as Medicaid payments are reduced. These reductions take place well before coverage of these populations can be achieved.

Constituents

The national constituents of the Chafee bill are:

- Smaller insurers who will continue to market to "good risks".
- Small businesses who will not be subject to mandates.
- Some big businesses because the bill leaves them more in the "drivers seat" as big purchasers, and because it is a federal rather than a state-based approach.

If its contents were fully understood, it would be opposed by virtually everyone else, including:

- The middle class because their benefits are taxed and they will be forced into restrictive managed care plans.
- Seniors because Medicare will be cut but no new benefits will be added.
- The poor and their advocates who will see a deterioration in benefits and in the health infrastructure now serving them.
- Low-wage workers who still will not be able to afford health care coverage.

PLAN COMPARISONS

I. Key Talking Points -- Clinton Plan vs. All Other Plans before Congress

II. Strengths of the Clinton Plan Compared with All Other Plans

- A. Summary (more rhetorical)
- B. Preserves What Works in the Current System
- C. New Benefits for Older Americans
- D. Coverage for All Americans

III. Alternative Proposals -- Summary, Some Concerns, Questions to Pose

- A. Republican Task Force Proposal (Chafee)
- B. Managed Competition Act (Cooper)
- C. Gramm/McCain
- D. Single Payer (McDermott/Wellstone)

IV. Typical Questions About Reform: Clinton Plan and the Alternatives

- A. Summary Answers
- B. Big new government bureaucracy?
- C. Drives small businesses under?
- D. Decreased quality and increased rationing?
- E. Reduced patient choice?
- F. Realistic Medicare savings?
- G. Does the plan include price controls?
- H. How is reform financed?

KEY TALKING POINTS ON THE CLINTON PLAN VERSUS ALL OTHER HEALTH CARE PLANS BEFORE CONGRESS

1. The Clinton Plan is the only plan that guarantees every single American a comprehensive set of benefits that can never be taken away-- without raising a billion dollars in new taxes or turning the system over to the government.

2. Leaving aside a government run solution, the Clinton Plan is the only plan that:

   * Defines a comprehensive set of benefits. The other plans leave it until after passage of the bill to have a government commission define the benefits package. We can't ask the American people to take that risk.

   * Guarantees comprehensive not barebones coverage. In market incentives to push people toward barebones coverage, for example, taxing people or employers who choose more than the lowest cost package. This could mean millions of middle class American losing benefits, rather than holding onto what they've got.

   * Ends lifetime limits. No other plan guarantees that lifetime limits will be ended and people can truly believe that their health care will be there when they need it.

   * Ends discrimination for pre-existing conditions. The other plans *say* they are ending discrimination in coverage for pre-existing conditions but they do not deal with the question of cost. In the other proposals insurers will have to cover people with past health problems, but they can continue to charge any premium price. That will leave millions of Americans still unable to get health coverage because of their pre-existing condition. Premiums in the Clinton Plan will be based on the number of working people in a family, geography, and the type of plan chosen -- not health status.

   * Guarantees prescription drugs for seniors. The other plans project savings in the growth of Medicare but do not reinvest those savings in senior citizens. The Clinton Plan expands Medicare benefits for senior with prescription drugs and the phase-in of long term care, as it realizes savings in the growth in Medicare.

3. The Clinton Plan achieves universal coverage in the most conservative way -- building on the existing system in which 9 out of 10 people get their insurance through their work.

The only other plans that accept universal coverage as a undamental goal do so in a way that could dramatically alter how most Americans get their health care. The single-payer option would shift all responsibility to the government. The Chafee plan would shift all responsibility to the individual. Either of these options would fundamentally change the current employer based system.

The other proposals do not achieve universal coverage. Despite their talk about "universal *access*," the other plans essentially perpetuate the problems in the current system. People have "universal access" today, if they have enough money. The Cooper, Gramm, and Michel proposals do nothing to guarantee coverage to every American.

COMPARING THE PRESIDENT'S HEALTH CARE REFORM PLAN WITH OTHER PROPOSALS

ISSUES	CLINTON	STATUS QUO	WELLSTONE	CHAFEE	MICHEL	COOPER	GRAMM
Security	**YES.** All citizens covered by Jan. 1, 1997. Medicare remains a separate program. Comprehensive medical benefits package administered by regional alliances. Provides health care that's always there — that can never be taken away. Not when you change jobs, lose your job, or get sick. You'll never lose it.	**NO.** Thirty four million Americans have no health insurance — and too many of those currently covered are in jeopardy. One out of four Americans will be without health coverage at some time in the next two years. American families are one layoff or sickness away from losing health security.	**YES.** All citizens covered by Jan. 1, 1996. Standard medical benefits package, with government footing the bill. Everyone is covered — but a huge tax will be required to pay for it.	**DEPENDS.** A step in the right direction, but requires mandate on individual, but not on business. Individual mandate might prompt employers who now supply insurance to drop it.	**NO.** Employers required to offer — but not required to pay for — health insurance coverage. Tax-free medical savings accounts provide only limited protection. Universal coverage is not goal of plan.	**NO.** Plan offers no provision for universal coverage and no guarantee that coverage won't be lost. Government pays for insurance premiums for the poor and subsidizes premiums for the near-poor. Employers and insurance company can continue to drop workers. If you lose your job, you're out of luck.	**NO.** Does not provide universal coverage, leaving many uninsured or with bare bones coverage. Those with good coverage will continue to pick up the tab for those without. Takes unfair, punitive approach to those most in need of health care coverage.
Savings	**YES.** Establishes annual national health budget. Growth limited by annual inflation factors. Insurance premium increases limited by national board. Controls costs by spending smarter, encouraging competition, capping how fast premiums can go up, and eliminating wasteful spending.	**NO.** Without effective controls, our Nation's health costs have quadrupled since 1980. Without further action, they'll double again by the year 2000. Skyrocketing health care costs are busting family budgets and hindering the growth of our economy.	**YES.** Establishes annual national health budget. Growth based on changes in gross domestic budget. National board establishes pricing for all services. Shifts financial responsibility to Federal government.	**PARTIAL.** While this proposal includes no system-wide controls on costs, insurance market reforms would result in some savings. Without system-wide controls, health care costs can never be truly brought under control.	**PARTIAL.** No system-wide controls; relies on competition to produce savings. Emphasis is on accumulating savings in medical IRAs, rather than on acquiring affordable health care. Competition without a national budget leaves consumers vulnerable.	**NO.** Relies totally on competition to produce savings. Personal cost savings occur only if one chooses lowest cost plan. No guarantee that costs will be lowered. Consumers could face significant new tax.	**NO.** Fosters choice of bare bones coverage — catastrophic health costs only. Doctor visits will keep draining consumer pockets. People with pre-existing conditions pay at least 50 percent more than others in their area. Legalizes discrimination against those with pre-existing conditions.
Comprehensive Coverage	**YES.** Complete coverage of hospital, doctors, and prescription drugs. Some mental health and substance abuse. Expands long-term care coverage.	**FOR SOME.** Coverage varies widely.	**YES.** Complete coverage for doctors, and hospitals, prescription drugs, mental health, and other medically necessary treatments. No long-term care.	**UNDEFINED.** Benefits would be determined by Benefits Commission and later adopted by Congress. Consumers could opt for bare bones coverage under catastrophic coverage.	**NO.** National Association of Insurance Commissioners sets uniform guidelines for the benefits. Small companies (from 2 to 50 employees) have flexibility in offering lesser benefits than set by NAIC. Too many Americans would find only bare bones coverage available under this plan.	**UNDEFINED.** Quality and range of benefits depends on ability to pay. Only those seeking lowest cost health plan enjoy full tax benefits. Benefits would be set by a national health board for those using a purchasing cooperative.	**NO.** Leaves the benefits Americans need to count on up for grabs. Makes those needing health services pay more.
Quality	**YES.** An advisory council develops quality and performance measures to assure highest quality care.	**NO.** No quality control.	**YES.** Requires States to develop data and information systems for oversight purposes.	**LIMITED.** Establishes nationally linked health care information data base, but doesn't require States to use information.	**NO.** No quality control.	**NO.** No quality control.	**NO.** No quality control.
Choice	**YES.** For most Americans, more choice. Consumer chooses plan, not employer. Alliances must offer a fee-for-service option.	**NO.** Only three of every 10 employers with fewer than 500 employees offer any choice of health plans. Millions of Americans have almost no choice today.	**CHOICE OF DOCTORS BUT NOT OF PLAN.** A single government system would allow States to provide and structure the individual plans for health service. All providers would operate in one system.	**LIMITED.** Individuals must buy either catastrophic or a basic benefit plan. Employers not required to join alliances and may continue to determine what plans worker gets.	**LIMITED.** Requires insurers to sell a standard catastrophic plan and a Medisave plan.	**NO.** All incentives in program are aimed at moving people into a low-cost health maintenance plan. Consumers face tax penalty if they choose plan outside of the HMO.	**NO CHANGE.** Program really leaves it up to consumers to find a plan for themselves or invest in a medical IRA account. Millions still will be without coverage.
Simplicity	**YES.** Reduces the burden of paperwork by utilizing standardized forms, electronic billing, and uniform reporting standards. Simplifying forms and cutting back on regulations will give doctors more time with patients.	**NO.** Twenty-five cents out of every dollar on a hospital bill goes to bureaucracy and paperwork — not patient care. Hospital administrators are increasing four times faster than the number of doctors.	**DEPENDS.** There are claims that the single payer system would be simpler. But multiple layers of review, inspection, and oversight are needed to run a single system.	**YES.** Utilizes standardized forms, electronic billing, and reporting practices. Establishes nationally linked health care data base.	**NOT SPECIFIC.** States given the authority to regulate insurance market, like today, and develop competitive cost information. Would give HHS Secretary authority to set standards on billing and electronic forms.	**LIMITED.** A national board establishes goals to eliminate paperwork and standardize electronic claims and eligibility certification. But brings in IRS to help regulate.	**ALMOST NONE.** Calls for standardized forms for Federal agencies involved in funding or delivery of health care services.
Financing	Requires everyone to contribute to system through premiums. New taxes of $105 billion primarily on tobacco plus assessment on large corporate employers that stay out of regional purchasing alliances. Reductions of $238 billion in anticipated growth of Medicare and Medicaid from 1995 to 2000.	Rapidly rising health care costs are fueling government deficit, eroding employee wages, and increasing the ranks of the uninsured.	Plan being developed to raise the money needed to finance. Has been estimated at as much as a half-trillion dollars.	Reduction of $213 billion in growth of Medicare and Medicaid from 1995 to 2000. Taxes a portion of health insurance benefits.	Would save $17 billion by reducing Medicare subsidies and altering Federal retirement rules.	Would raise $16 billion by preventing employers from deducting costs of insurance beyond the cost of basic plans and $6.5 billion by slowing Medicare increases.	Reductions of $175 billion in growth of Medicaid and Medicare from 1994 to 1998. Assumes $16 billion in additional taxes with lower business expenses.

Source: SENATE DEMOCRATIC POLICY COMMITTEE
October 20, 1993

THE CLINTON PLAN MOST CLOSELY PRESERVES WHAT WORKS IN THE CURRENT SYSTEM

The President's proposal builds on what works. Unlike most of the proposals on Capitol Hill, it doesn't dramatically restructure the way health care is delivered and paid for, or completely alter the health benefits people get through their insurance. Most people are happy with the way they get their health care; they just want to know it will be there for them when they need it.

9 out of 10 Americans with private insurance get coverage through their employer -- the fact is an employer-based system works well for most people. The President's plan preserves and builds on the employer based system by requiring all employers to contribute to a portion of their worker's health insurance, and by spreading risks and responsibilities among all employers to make health insurance more affordable for all companies. Most people will get their health care from the same doctors and hospitals they do now, and, like today, most will contribute something to the cost of their care. Most importantly, most people will get the same or better benefits than they have today, and under the President's plan those benefits will never be taken away.

The other plans:

Chafee

Senator Chafee's proposal shifts responsibility for health care from employers to individuals with an individual mandate. Under this plan, individuals would have no choice but to buy health insurance, but employers have no responsibility whatsoever to chip in. They'll tell you employers will probably keep on contributing, but if they don't middleclass families would be required by law to pay the full cost of their health insurance. But insurance isn't cheap, especially for decent benefits. The Chafee bill says that people who can't afford to pay the full cost of benefits they have now will have the option of buying bare-bones coverage. If people are forced to bear the full cost, any people will find that's all they can afford, and will end up with far fewer benefits than they have today.

Cooper

Congressman Cooper's plan also changes the responsibility of the employer. This proposal encourages plans to offer low prices, because under this system only the cheapest plan is tax deductible. That means that many companies would have to scale back benefits they now offer their workers or else pay new taxes to keep providing them.

Gramm/ Michel

The proposals put forth by Senator Gramm and Congressman Michel are the worst of all worlds-- they keep in place the things about our health care care system that virtually everyone thinks should be changed and put at risk the things about our system people want protected. Senator Gramm's proposal leaves in place insurance company practices that drop people without clear reason, overcharge people because they once were sick, and refuse to pay for illnesses they label "pre-existing conditions". And both Senator Gramm's bill and Congressman Michel's bill toss aside the elements of our health care system most people really like-- coverage to see your own doctor, and comprehensive benefits. These proposals say that if you want to still see your doctor that's fine, but you should pay for it, not your insurance company. Not only does it do nothing to bring coverage to the 37 million Americans with no health insurance, but it puts in jeopardy the people who have good benefits today by repealing state insurance laws that guarantee a minimum level of benefits for all those with insurance.

McDermott/Wellstone

Perhaps the most dramatic changes to American health care are proposed by Congressman McDermott and Senator Wellstone, and the dozens of other Members of Congress who favor a "single-payer" system where the government raises money through taxes and pays all the country's health care bills. They argue this approach works in Canada and could work well here. Certainly it is a more simple system, and does achieve universal coverage. But it would involve replacing our existing private sector system paid for by individuals and companies with a public system paid for with a half a trillion dollars in new taxes.

The President's goal is to preserve our uniquely American approach to health care-- employer-based coverage for private-sector health care-- and make it better by making it work for everyone.

THE PRESIDENT'S PLAN GUARANTEES COMPREHENSIVE BENEFITS THAT ARE SPELLED OUT AND GUARANTEED

The President's proposal provides a clear and explicit guarantee of comprehensive benefits. His proposal spells out in detail an extensive list of covered services, including hospital care, physician services, prescription drugs, mental health care, and diagnostic tests. It also offers unprecedented coverage of preventive care -- such as mammograms, cholesterol screenings and immunizations -- to help keep you and your family healthy. It says exactly what the co-pays are, and exactly what the deductible is for both individuals and families. It sets an exact dollar limit on how much any family will have to pay for health care in a given year, and specifies in law that no insurance plan can impose a "lifetime limit" on benefits.

Chafee

Senator Chafee's proposal doesn't spell out benefits. Congressman Cooper's doesn't spell out benefits either. Both plans propose that the decisions about what you're covered for should be decided by a government commission. And both say that if the benefits decided on by the commission end up costing more than they thought, the commission can cut them back.

Senator Chafee's bill acknowledges that without the help of employers, not everybody will be able to afford the benefits package eventually specified. They propose offering a second, reduced benefits package, so that people who can only afford bare bones coverage get only a bare bones package.

Cooper

Congressman Cooper's basic benefits package will be the same for everyone -- but will only be deductible to those who choose the cheapest versions. That will mean that employees who've given up wage increases for comprehensive benefits willeither have scaled back coverage, or pay new taxes to keep the same benefits.

Gramm/Michel

Senator Gramm's bill, and Senator Michel's similar proposal, suggest that insurance benefits be dramatically scaled back to a bare bones package, and that insurance plans be made cheaper by including a $3,000 deductible per family before the insurance even kicks in. Under their proposals, the routine care most of us need in a given year -- check-ups, eye exams, broken arms, etc -- would be paid for not by our insurance, but out of our own savings. Some states have insurance laws on the books today that prohibit insurance benefits from being scaled back that far, but these plans get around that by repealing those protections.

McDermott/Wellstone
By contrast, the single payer proposals specify a detailed and comprehensive benefits package -- some even go as far as to include a broad range of long-term care services. The goal is the same -- comprehensive benefits for all -- but the President's plan keeps the private insurance market in place and the single payer plans replace it with a public program financed by taxes.

Clearly defined, comprehensive benefits should be a prerequisite to any health reform proposal. Every proposal -- including the President's -- asks individuals to pay some of the costs of their health care. The President believes that if you ask people to contribute, they deserve to know what their getting. The President guarantees a broad range of comprehensive benefits which can never be taken away.

THE CLINTON PLAN PROVIDES NEW BENEFITS FOR OLDER AMERICANS

Virtually every health reform proposal being considered on Capitol Hill calls for slowing the growth in spending on Medicare and Medicaid and using the savings as a source of financing for reform. But unlike most of the other proposals, the President's plan reinvests that money in new benefits for older Americans and the disabled.

The President's plan preserves the Medicare program, and protects Medicare beneficiaries by providing them with a new benefit so important to millions of seniors-- coverage for prescription drugs. It also uses Medicare savings to begin funding a new home and community-based long-term care program, which will provide needed services to elderly and disabled Americans who would otherwise be at risk for entering a nursing home. Finally, it increases financial protection for seniors who do enter nursing homes by increasing the asset protection limit so seniors don't have to spend themselves to destitution before they can get help paying for their care, and by increasing the amount of spending money seniors in nursing homes have each month.

Chafee

The Chafee proposal trims roughly $200 billion from the Medicare and Medicaid programs, but it earmarks the savings to pay for government vouchers for the poor. The proposal does nothing to provide new benefits to older Americans. It does not guarantee any help with the cost of prescription drugs, though Senator Chafee said in a recent television broadcast that he thought it was a good idea. It does nothing to give new options to the millions of older Americans who want to remain at home rather than move to a nursing home.

Cooper

Congressman Cooper also proposes we pare back spending on Medicare and Medicaid, raising the Medicare premiums many elderly Americans now pay, but adding no help with costly prescription drugs, no help with long-term care, and no greater protections against impoverishment that now grips too many elderly in nursing homes. Perhaps the greatest risk to older Americans under this proposal would be the plan to shift spending for long-term care services currently shared by the state and federal governments completely to the states. Governors and other state officials dismiss this approach out of hand, saying they are already being bankrupted by their contribution to escalating long-term care costs, and could never bear the full burden of long-term care. Nonetheless, that's just what Congressman Cooper proposes, and if his bill became law, it could put the long-term care services many vulnerable elderly now receive in jeopardy, despite the best efforts of the states.

Gramm/Michel
Senators Gramm and McCain, and Congressmen Michel and Hastert, all have used their health care proposals as a reason to save money from Medicare and Medicaid. They propose capping Medicaid spending, giving states a per-person amount and no more, regardless of how much care actually costs. They also gives states that want to cut back on the long-term care services that option, which could jeopardize access to long-term care services for millions of older Americans.

McDermott/Wellstone
Congressman McDermott and Senator Wellstone's "single-payer" bills include coverage of long-term care as part of the benefits package all Americans receive. Under these plans, seniors would pay a premium for this new benefit. Under the President's plan, disabled seniors would be eligible for a new home and community-based program, including personal care services, home health care, and respite care. While there would be payments for these services, based on income, there would be no new premium for seniors.

Older Americans have worked hard and contributed to the system all their lives. The President agrees with the members of Congress who think there is room to save in the Medicare and Medicaid programs as part of reform, but believes that the elderly will not truly have health security until they have some protection against high-cost prescriptions, and that increased choice for older Americans must mean increased options for care at home. His proposal stands alone with single-payer plans in providing elderly Americans with these benefits, and is the only plan to provide long-term care without a new premium.

THE PRESIDENTS PLAN ACHIEVES THE MOST IMPORTANT OBJECTIVE OF REFORM: COVERAGE FOR ALL AMERICANS.

Under the President's proposal, all Americans have health security-- a guaranteed set of comprehensive benefits that can never be taken away. Every American-- no exceptions-- gets a health security card guaranteeing them coverage regardless of where they live, how much money they have, who they work for, and whether or not they've ever been sick. All Americans are asked to contribute to the cost of their care if they can afford it, but in return everyone has coverage, no matter what.

There are only three ways to achieve universal coverage: requiring businesses to buy coverage for their workers, requiring individuals to buy insurance for themselves, or requiring everyone to contribute to a government-run health care system buy paying new health care taxes. Any of these are tough choices-- but universal coverage for all Americans is a worthy goal.

The President's proposal achieves universal coverage by taking the most conservative approach: building on the employer-based system, requiring all employers to contribute to a portion of their workers' coverage. To make sure this remains affordable for businesses, the President's plan does three things: first, it asks that workers share in the cost of their health plan premiums. Second, it gives big discounts to small, low-wage firms to make their cost of insurance as low as possible. Finally, it pools all but the biggest corporations into large groups, giving them greater bargaining leverage with health plans.

Chafee

Senator Chafee's proposal on the other hand, achieves universal coverage by requiring that all individuals buy themselves insurance. The potential problem with this approach is that with no similar requirement on employers, our health care system could shift from one paid primarily by companies to one paid primarily by workers. While this approach does achieve universal coverage, some worry that many employers will stop providing coverage to their workers if individuals are required by law to buy it themselves, and that it will be difficult for many Americans to bear the full cost of insurance. Discounts of the poor are not guaranteed and their aare no discounts available to the middle class.

McDermott/Wellstone

Single-payer proposals achieve universal coverage by creating a government-run health care system. All Americans pay new health care taxes, and all Americans get health care though a public program. This approach gives all Americans coverage through the same universal system. The concerns about this approach center around how large a role government should have in

health care, and around whether or not such large, widespread tax increases are necessary or reasonable.

But Senator Chafee's group and the single-payer sponsors should be commended for putting forth proposals that do achieve the most fundamental principle of health care reform: coverage for all Americans. These plans recognize that Americans are demanding a system that includes everyone, so that those with coverage no longer pay for those without, and so everyone has the comfort of knowing that they could never become uninsured, regardless of circumstance.

Most other proposals before the Congress fail to meet this most basic principle.

Cooper

Congressman Cooper and his colleagues reorient the health care system toward cost-conscious delivery, and provide a mechanism for pooling businesses and individuals to bargain as big groups with health plans. But it does not achieve universal coverage. Every business and family that wants more expensive health care than the cheapest plan is obligated to pay new taxes on those benefits, but no one is obligated to buy coverage-- not businesses, not individuals, not the government. Under this plan millions will remain uninsured, and the cost of their care will be shifted to those with insurance.

Gramm/Michel

Senator Gramm and Congressman Michel have both submitted health care proposals on behalf of the conservative Republicans they represent, but neither of their proposals involve providing coverage to all, or even changing the insurance system that has refused coverage to so many Americans. Worse, by proposing a system in which insurance is scaled back to cover only major illnesses and most medical care is paid for from savings, even those currently insured may find themselves with less under their plan.

The President's is the only proposal that keeps everything that's right about the current system in place– private sector health care, employer-based coverage, choice of doctors and plans, and high quality American medicine. And it fixes what's wrong without any new broad-based taxes.

It's the only proposal that achieves universal coverage without shifting the full cost of health care to American families, like Senator Chafee's plan, or turning American health care over to the federal government, like single-payer plans.

Most other proposals leave millions uncovered. In fact some plans, like Congressman Cooper's, actually encourage companies to drop the coverage they now provide their workers. By setting up a government program to pay for poor people, including those who work, this plan essentially tell firms: don't worry about your low-wage workers-- the government will pick them up. And the other Republican proposals don't do anything to expand coverage, while paving the way for discriminatory insurance practices to continue. One thing is clear, under these plans, millions of Americans will continue to lose their health insurance, and the rest of us will foot the bill for their care.

The President's is the only plan that guarantees clearly defined, comprehensive benefits without raising a half a trillion dollars in new taxes.

Most proposals leave decisions about benefits to government commissions, or set out to provide only bare bones coverage. Many of them actually encourage firms to reduce the benefits they now provide their employees, either by levying new taxes on benefits that cost more than the cheapest plan, or by driving a change in insurance so that barebones policies replace more comprehensive coverage, and most routine care is paid for from savings.

The President's is the only plan that invests Medicare savings in new benefits for older Americans– coverage for prescription drugs under Medicare and a new community-based long-term care program.

Every other proposal uses money from Medicare savings to expand access for the poor. And by clamping down on Medicare and Medicaid while doing nothing to control spending on the private side, these plans will likely result in an even bigger gap in rates between Medicare and Medicaid, and could mean more doctors would decide to stop seeing Medicare patients altogether.

The President has put forth a thorough and explicit proposal that answers the tough questions: it spells out what's covered, how the system works, and most importantly, how it's paid for. These other proposals are long on rhetoric, short on specifics. On all the decisions that affect Americans most-- who's in, who's out, what's covered, who pays-- they basically punt.

The single-payer plans answer the tough questions, problem is, there answers are tough to swallow. They deserve credit for leveling with people about how they think everyone should get covered and how the program should be financed, but let's face it-- government-run health care and a half a trillion dollars in new taxes are political non-starters.

If these other plans want to be a part of the debate, then fine, let's debate. But first tell us what your plan will do for people. Under your plan, who can feel sure they'll have coverage? What will they be covered for? Which services will be covered and which will be denied? And most importantly, what will the whole thing cost, and who'll get stuck with the bill? If they really think their plans are better, it's time they come forward with some specifics.

The President's plan stands alone as the only proposal that is universal, comprehensive, logistically feasible and politically realistic.

REPUBLICAN HEALTH CARE TASK FORCE PROPOSAL (CHAFEE/DOLE) SUMMARY

The Republican Health Care Task Force has proposed a health care reform plan which would gradually phase-in coverage. The program is based on mandating that all individuals buy health insurance. A national board would establish two benefits packages, standard and "bare bones" with a high deductible. Government vouchers, paid for with Medicare and Medicaid savings, would be provided to help poor people buy insurance. The level of benefits included in the package and the availability of the vouchers would depend on the savings generated from Medicare and Medicaid.

The plan would establish cooperatives within each state to help small businesses and individuals purchase coverage. It would continue to permit -- but would not require -- that employers contribute toward coverage for their employees. By allowing employers to decide whether or not to provide insurance and giving them the option of purchasing coverage through the alliance or on their own, employers would still determine the kind of health care plan their workers would receive. The health cooperatives will be small and voluntary, weakening their bargaining power with health care plans and limiting their ability to bargain for affordable rates.

The Republican Health Task Force plan would control costs by encouraging competition between plans within the alliances and by taxing individuals and employers who buy benefits that cost more than an established cap. The plan also includes measures to reduce administration and bureaucracy, and reforms malpractice laws.

REPUBLICAN HEALTH CARE TASK FORCE PROPOSAL
(CHAFEE/DOLE)
SOME CONCERNS

The proposal put forth by the Republican Health Care Task Force indicates that we are closer than ever before to a bi-partisan approach to comprehensive health care reform. For the first time, 23 Republican Senators have committed themselves to guaranteeing comprehensive coverage for all Americans, and have put forth a serious proposal. We agree with much of their approach. We agree that coverage for all Americans is the first and most important goal of health reform. We agree that market forces and changed incentives can bring down health care costs, and that competing health plans and health alliances will make it happen . We agree that individuals should take responsibility and contribute toward their care.

But we cannot support the Republican plan because it does not go far enough. It says that individuals have an obligation to buy health insurance, but that the companies they work for don't need to contribute. It says that small businesses and individuals deserve the better bargaining power of a health alliance, but doesn't guarantee they'll get that clout. It says that comprehensive benefits are a must, but fails to say what's covered. It limits spending for public programs, but has no similar protections on the private side. It says that we can slow spending in Medicare and Medicaid, but doesn't use that money to buy new benefits for seniors. This plan is like a car that heads down the right road, but runs out of gas half way there.

Does Not Achieve Universal Coverage in this Century

The Chafee proposal promises universal coverage for comprehensive benefits by the year 2000.....if. If the savings they project materialize. If savings don't come as quickly, they' will extend coverage more slowly, leaving more people without coverage for longer.

Does Not Guarantee Comprehensive Benefits

The proposal promises that the benefits package will cover a broad range of services.....if. If the Commission the Republican plan sets up decides those benefits are affordable. And if costs go up faster than they expect, the benefits could be cut back. These are big ifs. People need the security of knowing what's covered, and knowing that those services won't be watered down over time.

Shifts Costs to Businesses and Individuals

The Chafee proposal controls costs by pooling small businesses into regional purchasing cooperatives and forcing plans to compete on quality and price. The evidence suggests that competition and better incentives will control costs-- but it doesn't guarantee it. By contrast, public sector savings are guaranteed in this proposal--it caps Medicare and Medicaid growth at 7%, from a projected 12%.

Capping the growth of public programs with no control on the private side will continue the same "cost shift" we have today, where prices go up slower in the Medicare and Medicaid programs, and doctors and hospitals raise prices higher and faster in the private sector to make up for it. Individuals and businesses will keep paying more, weakening the cost-slowing effects of competition.

Shifts Responsibility from Businesses to Individuals

Under the Republican Health Task Force plan, individuals would be required by law to buy insurance. While employers would still be free to contribute for insurance coverage, they would have no responsibility to do so. That means that middle-class families will bear the full cost of their insurance, if employers choose not to help pay for health coverage. For the same price you pay to cover part of the cost of good benefits today, you may pay the full cost for bare-bones coverage under reform. And if you want the protection of comprehensive benefits even if it's beyond your means, you'll just have to tighten up elsewhere in your family budget and forgo other necessities.

No Guaranteed Bargaining Leverage for Small Businesses

By making purchasing alliances both small and voluntary, this proposal significantly weakens the bargaining muscle of the alliance, and their effectiveness in bargaining with plans.

And what's worse, it keeps in place an insurance system which avoids risk by "cherry picking" firms with young healthy employees and rewarding them with lower rates. Any group that can get a better deal outside the alliance will stay outside. This approach pools vulnerable small businesses with the poor and uninsured, and will almost certainly mean that premiums in the alliances are higher than outside. That's no help at all to small businesses.

Continuous Disruption for Many Americans

The average person changes jobs 10 times in a lifetime, more for people in small firms. If the pools are voluntary, workers will be in and out of different plans based on their employer, and may lose their work-based plan if they lose their job.

Allows Huge Variations Among States

It's one thing to give states flexibility, it's another thing to tell them they can set up a whole different system than their neighbors. The Chafee plan tells lets set up basically whatever kind of system they want as long as they meet certain federal rules. That could mean a single-payer program in Vermont, an individual mandate in New Hampshire, pay-or-play in Massachusetts, an employer mandate in Rhode Island, and Med-Save accounts in Connecticut.

Such vastly different approaches in such close proximity could guide business decisions and other factors that skew economic development and have differing effects on state economies. And states that want to build on the current system through an employer requirement can't do so without worrying that businesses could move to the state across the border -- tying the hands of governors who support employer-based reforms.

"THE MANAGED COMPETITION ACT OF 1993" (COOPER) SUMMARY

Congressman Cooper's plan, The Managed Competition Act of 1993, attempts to control costs and improve access to health insurance by coupling the market forces of the private sector with government regulations. The health insurance market would be reformed, combining insurance companies and health care providers into Accountable Health Plans (AHP's). These AHP's would be prohibited from medical underwriting, excluding individuals for pre-existing conditions, and setting premiums based on health status. Health plan purchasing cooperatives (HPPC's) would be established by the states and would organize individuals and small group purchasers into pools. These pools, now with the larger economic clout of several purchasers, would negotiate with the AHP's for health insurance in a competitive marketplace.

A national health board would be established to oversee the creation of the AHP's and HCCP's. The board would be in charge of specifying the uniform set of health benefits along with providing standard deductibles and cost sharing. Standards for reporting prices, health outcomes, and measures of consumer satisfaction would also be established by the board, and plans which met these standards would be certified as AHP's.

The Managed Competition Act would modify the tax code to encourage the use of the board certified AHP's. Tax deductibility would be limited to the cost of the least expensive AHP in the region for both employers and individuals. There would be no tax deductibility for plans not certified by the board. Medicaid would be replaced with a new federal program which would assist low income individuals to purchase health care insurance though their HCCP's.

In addition, this bill contains provisions to improve access to rural and underserved populations, increase programs to promote preventive health care, simplify the paperwork involved in the administration of health insurance, and implement malpractice reforms.

"THE MANAGED COMPETITION ACT OF 1993" (COOPER) SOME CONCERNS

There are many components of this approach we agree with. Like Congressman Cooper, we believe community rating returns insurance to a community responsibility, not an exercise in profit making and risk avoidance. Like Congressman Cooper, we believe that an increased emphasis on competition will promote efficiency, reduce waste, and lower costs. And finally, like Congressman Cooper, we believe increased cost-consciousness is an important aspect of health care reform, and a necessary ingredient for cost control.

But we cannot support the Cooper bill because it does not provide health security for all Americans. We believe all Americans need and deserve health care security; this plan just doesn't provide that. We believe that comprehensive benefits should be spelled out and guaranteed; this plan doesn't provide that. We believe choice of doctor is a right; this plan considers choice a taxable luxury. We believe HMOs are one alternative; this plan believes HMOs are for everyone.

Does Not Achieve Universal Coverage

The Cooper plan assumes that between better incentives and government help for the poor, more Americans will be covered. But individuals can still decide that health care isn't their responsibility-- it's yours and mine. Employers can continue to drop workers who are costly, or decide not offer coverage. In fact, this plan encourages employers with low wage workers to drop the coverage they now provide and let the government pay for their care. The result? After Cooper-style health reform, 22 million Americans will still be uncovered. [Congressional Budget Office, July 1993] And with incentives for employers to drop coverage, CBO warns of 6 million newly uninsured Americans.

Encourages "Bare-Bones" Coverage

This plan does not even specify -- much less guarantee -- a comprehensive set of benefits, nor does it protect American families from exorbitant out-of-pocket costs. And because it does not eliminate lifetime limits, it cannot assure that your insurance coverage never run out . The Cooper proposal shifts the responsibility for defining the benefits package to a National Board -- to be determined after the legislation has passed and become law. The plan encourages employers to reduce benefits by levying tax penalties on employers that give their workers comprehensive coverage. The Cooper proposal would set a "tax cap" at the lowest cost plan in the area -- a plan with benefits that are less generous than what most people have today.

Americans Will Pay a Choice Tax

You could be penalized if you pick your own doctor and pay a "choice tax" to belong to certain plans or see certain doctors. Millions of Americans will pay new taxes for the same benefits. By trying to reward consumers for choosing tightly managed, cost-efficient plans like HMOs, the proposal punishes individuals and their employers for any other choices. If you want to continue to get health care the way you do now -- or to see the same doctor you've always seen outside of an HMO -- you get taxed. If you choose not to go into an HMO or HMO-type organization, you and your employer both pay new taxes on your health care premiums.

Older Americans Pay the Price

The Cooper plan worsens today's cost shifting, rising private sector costs and endangers access for Medicare beneficiaries. It slows Medicare spending, both by reducing rates to providers and by dramatically increasing Part B premiums for upper-income recipients. And yet it doesn't reinvest any of that money to new benefits or increased protections for seniors. By slowing Medicare spending without controlling private health spending, the unrestricted private sector will continue to be threatened by ever-rising costs shifted to it from budgeted public programs. The widening gap between Medicare rates and private rates will result in more and more doctors deciding not to see Medicare patients, limiting choices for older Americans.

"The IRS Full Employment Bill"

This plan is an administrative nightmare; it might as well be called "the IRS full employment bill." This plan significantly expands the reach of government bureaucracies and government involvement in the workplace. It requires the IRS to determine and monitor the low-cost plan in every HPPC region, and match that against spending on health care by every employer for every employee. And this adds a tremendous new administrative burden for businesses -- particularly small businesses who now suffer tremendous administrative burdens -- by forcing them to keep on top of the "lowest cost plan" the way an investor would follow changes in the stock market.

Increases the Deficit

The Cooper Plan increases the deficit by $70 billion. This proposal doesn't even pay for itself. In fact, the CBO/Joint Tax Committee analysis of the plan found that it increases the deficit by $70 billion in the first 5 years alone.

Shifts Financial Burden to the States

The Cooper plan does not address long term care other than shifting enormous federal costs onto the states. The Cooper plan says that states should bear those costs completely on their own. This unfunded mandate would bankrupt many states.

"THE COMPREHENSIVE FAMILY HEALTH ACCESS AND SAVINGS ACT" (GRAMM-MCCAIN): SUMMARY

The Gramm/McCain bill attempts to make health care insurance more portable and affordable by eliminating state requirements for minimum insurance benefits to create a market for "bare bones" health plans which would cover only major medical expenses. Tax incentives and government assistance would encourage the purchase of such plans. The bill would also create tax free "Medisave" accounts, much like Individual Retirement Accounts, which individuals would use to pay small medical bills. Individuals would pay for routine care and deductibles out of "Medisave" accounts, only using insurance for serious or catastrophic care. All "Medisave" funds not used for routine treatment would be retained by the individual for future medical expenses, creating an incentive to keep unnecessary health care use down.

In addition, employers who currently provide health insurance would be required to offer the employee an option of a "Medisave" account, an HMO, or continue their current coverage. The self-employed and uninsured would be allowed to exclude from their income the percentage of medical insurance coverage costs equal to the national average contributed by employers. This would also create an incentive to choose lower cost "bare bones" or HMO plans.

Under the Gramm/McCain bill, health care insurance companies would be prohibited from excluding individuals with pre-existing conditions from coverage but could charge a higher rate. There would be no limit on how much higher the premiums could be, but federal subsidies would be available if the cost exceeded a percentage of family income. Insurance discounts would be offered to individuals who engage in activities determined to constitute a "healthy" lifestyle. Federal assistance would be reduced for individuals who engage in "unhealthy" activities.

SINGLE PAYER (MCDERMOTT/WELLSTONE): SUMMARY

Under the McDermott/Wellstone single payer proposal the government would take full responsibility as the sole purchaser of health care services for all legal residents. The government would replace all other public and private health care coverage. The plan would be administered by the states under a fee-for-service program. States would also have the option of enrolling their residents, through capitated managed care, in health service organizations meeting federal requirements.

The program would be funded through $500 billion in increased taxes on individuals and businesses, including payroll taxes and income taxes. A trust fund would be established by combining new taxes with funds from existing federal programs (with the exceptions of IHS and VA.)

The government would establish payment rates for all physicians and other providers. The Secretary of Health and Human Services would establish annual state and national budgets. In order to contain costs, total spending would be strictly limited by this national health budget and would grow no more rapidly than the annual percentage increase in the gross domestic economy. Providers would not be able to bill their patients for covered services.

SINGLE PAYER (MCDERMOTT/WELLSTONE): SOME CONCERNS

Many elements of the single payer bills are central features of our plan. For example, both plans guarantee a comprehensive package of benefits for all Americans. Both simplify administration and reduce paperwork. We also agree on the need to control costs. We also provide states with the flexibility to adopt a single payer plan for their citizens.

But we cannot support the McDermott/Wellstone bill because, among other reasons, it would require raising and redistributing as much as half a trillion dollars in new federal taxes. Not only would this approach add further strain to our recovering economy, but it doesn't make sense to change our health care system so radically when it is possible to build on our current system -- to take the finest private health care system in the world and make it work better.

A New Half A Trillion Dollar Tax

Of the Americans that are covered under today's system, 9 out of 10 receive their coverage through the workplace. While we agree there are major problems with the current system that need to be addressed that there are many positive aspects as well. We believe that our goal should be to change what's wrong while preserving what's right. Our plan is uniquely American plan rooted in the private sector. Asking Americans to support a half a trillion dollar tax hike to support a system whose costs are already out of control is unfair. Without an effective mechanism for containing costs, their plan would compromise the quality of American health care and would limit consumer choices.

Government Dream? Providers Nightmare?

While single payer advocates claim that their system would be simpler, providers say that our current government programs are a bureaucratic nightmare. Doctors and nurses must deal with an ever-growing set of regulation, a blizzard of paperwork and multiple layers of reviews, inspections and oversight. In a government-run health care system with no competition, there aren't any incentives to increase efficiency, to develop systems that works better and improves quality.

We believe that the government should set standards, guarantee security then get out of the way. It will simplify the system, reduce paperwork, and streamline government oversight. Doctors and nurses will be able to spend less

time filling out forms and fighting bureaucrats and more time taking care of patients.

A One Size Fits All Approach

The McDermott/Wellstone bill is based on the premise that "one size fits all" -- that a single health plan would meet everyone's health needs and work as well everywhere. Our plan recognizes the unique differences of our states. What works in New York, may not work in New Mexico. Our plan allows states the flexibility to tailor their reform plan to meet the needs of the citizens of their state.

Ineffective Cost Control

The McDermott/Wellstone plan contains costs by setting fee schedules -- controlling the cost by controlling the payment rates for doctors and other providers. Under this approach, its easy for providers to game the system by ordering more tests and more procedures. Canada's health care costs are rising as fast as ours. We do not believe that Americans should be asked to spend their money on a system with skyrocketing costs with a containment mechanism that is ineffective.

Our plan is based on proven approaches -- here and around the world -- that are successful in containing costs. Costs will be controlled by bringing competition to the health care marketplace, strengthening the buying power of consumers and businesses by pooling them into large groups to bargain for lower prices. It will put consumers in the driver's seat by providing them with the information they need to choose plans on price and quality