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Roxy —

Per our conversation Wed.

Reference to Institute, p. C-9, col 2.

Dave

The Houston Post
MONDAY, July 6, 1992 C
BUSINESS HOUSTON
For people in the business of doing business

A LOOK AHEAD

TODAY

SONALITY PROFILE — "Dealing with e Customer Personalities" will be the dis- ion topic for the National Association of ice Managers, Gulf Coast chapter, begin- at 6 p.m. at Ryan's Family Steakhouse, 1 Dairy Ashford. Discussion leader: M member Bob Duncan. Officer elec- will also be held.

II TUESDAY

HNOLOGY TRANSFER — Two biotech- gy experts will discuss opportunities for ersity researchers and industry to bring technological advances into the marketplace. Where: Bio/Medical Technology Club, 7 a.m., Houston Plaza Hilton, 6633 Travis. Presenters: Malcolm Skolnick of UT Health Science Center professor and director of Office of Technology Management; and Frank Vazquez, a 15-year veter- an in medical and biosci- businesses and consultant on biotech- gy business development. Sign-up: 888- 0.

III WEDNESDAY

-ACTIVE PR — Rene Henry Jr., execu- director of university relations, Texas M University, will be featured at the Hous- Public Relations Society of America, 5 a.m., Junior League of Houston, 1811 r Oaks. Henry is a former Emmy judge, mpics promoter and pioneer in Hispanic keting. Reservations: 526-1089.

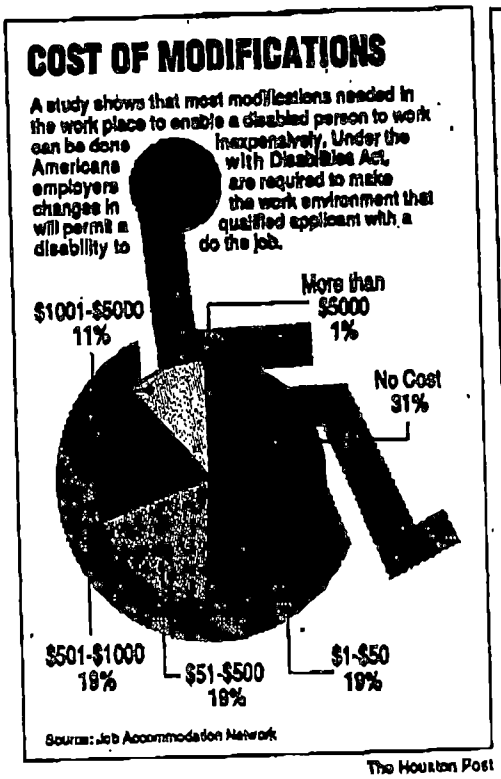
VIRONMENTAL CHECKS — Slide presen- ons documenting project work on the n-up of the recent Guadalajara gas leak of the Bayou Sorrel Superfund Site Re- diation project will be featured at an open se sponsored by environmental special- ERM-Southwest. Timing: 4-7 p.m., 16300 y Freeway, Suite 300. The program in- des demonstrations and discussion of new hnology. Information: 579-9999.

VIII THURSDAY

TIN PIPELINE — Members of ARPEL, the rnational organization of six Latin Ameri- Petroleum firms, will be recognized at a eting of the Houston Interamerican Cham- of Commerce, 6 p.m., Westin Galleria tel, 5060 W. Alabama. Keynote: Alvaro xeira, secretary general of ARPEL of Uru- y. Contact: 978-8171.

more events, see Page C-12.

A SQUARE DEAL AWAITS THE DISABLED



The Houston Post

King Chou Wong/The Houston Post
Tracy Reby hears information from her computer through a speaker because she cannot see the screen. Her employer, MMAR Group Inc., bought a scanner, voice synthesizer, voice software program and a speaker for her to do the job.

Ability now comes first at workplace under new statute

BY JANE BAIRD
OF THE HOUSTON POST STAFF

EMPLOYERS HAVE told Evan J. Kemp Jr. over the years that he could not advance because of a disability. He uses a wheelchair as the result of a rare neurological disease.

When he graduated near the top of his class from the University of Virginia in 1964, for example, he interviewed with 39 law firms around the county. All told him bluntly they wouldn't hire him because he was disabled.

When he was working for the Securities and Exchange Commission in 1977, Kemp was told he couldn't be a supervisor of two employees because of his disability.

None of this has stopped him. Kemp is now chairman of the Equal Employment Opportunity Commission, where he supervises about 2,500 people.

That job makes him the chief enforcer of the Americans with Disabilities Act, which prohibits employers from dis-

Please see ADA, C-9

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WEEKEND WRAPUP ..... Page C-8
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ENERGY ..... Page C-13,14
ON THE RECORD ..... Page C-12
STOCK MARKET ..... Page C-7,11
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SUCCESS

Checking and rechecking every detail is paying a big dividend for Howard Wayland, founder of First Home Mortgage. In November 1988, Wayland left a good job with a large Houston mortgage company to launch his own firm. First Home has grown rapidly, thanks to Wayland's innovations and a decline in activity by savings and loan associations in traditional home loans. Future plans: More recognition in the local market.

Page C-8

COVER STORY

Houston Post file photo

Harriet Ehrlich, district director for the Equal Employment Opportunity Commission, warns of "vultures trying to make a buck" off ADA.

Free ADA information is available

FROM STAFF REPORTS

Some lawy... ...ul-ants are f... ...n-ployers wit... ...s with Disa... ...ier to d... ...ald Har... ...irecto... ...ploym... ...Com... "T... ...ures ...nal ...h

ADA:

■ The EEOC will send one free copy of a comprehensive technical assistance manual on the ADA to anyone who calls. It includes a 214-page directory of resources, both government and non-governmental organizations. 1-800-669-EEOC.

■ The Job Accommodation Network, a service of the President's Committee on Employment of People with Disabilities, provides advice on the latest accommodation methods, devices and strategies as well as other ADA issues. 1-800-526-7234.

■ The Independent Living Research Utilization Program, part of The Institute for Rehabilitation and Research in Houston, provides a complimentary ADA hotline for employers and people with disabilities. 1-800-949-4232.

ADA: Disabled get fair chance to show ability

From C-1

criminating against people with disabilities. The EEOC plans to enforce the law vigorously, he told Houston employers at a recent conference.

The employment portion of the act goes into effect July 26 for employers with 25 or more employees and July 26, 1994, for those with 15 or more.

"The bottom line of the law is that you can't discriminate against any person who is qualified to do the essential functions of the job," said Harriet Ehrlich, EEOC district director in Houston. "You have to look at people's abilities first, not their disabilities."

"A lot of companies have not realized it is going to hit," said Robert McDonald, president of Accessibility Consultants Inc. Many "are afraid of the law. They think it is going to cost them tremendous amounts of money."

The law provides a broad definition of disability to include people not only with physical impairment but also with mental disorders such as manic depression, schizophrenia or retardation, people with AIDS, alcoholics and rehabilitated drug users.

The National Council on Disability estimated that 43 million Americans have disabilities. About 12 million disabled people are in the job market, but only about 4 million have jobs, said Lex Frieden, senior vice president of The Institute for Rehabilitation and Research in Houston.

The law applies from the moment a job applicant comes through the door. An employer no longer can require a medical exam. Nor can he ask whether the applicant is disabled or the nature of a disability.

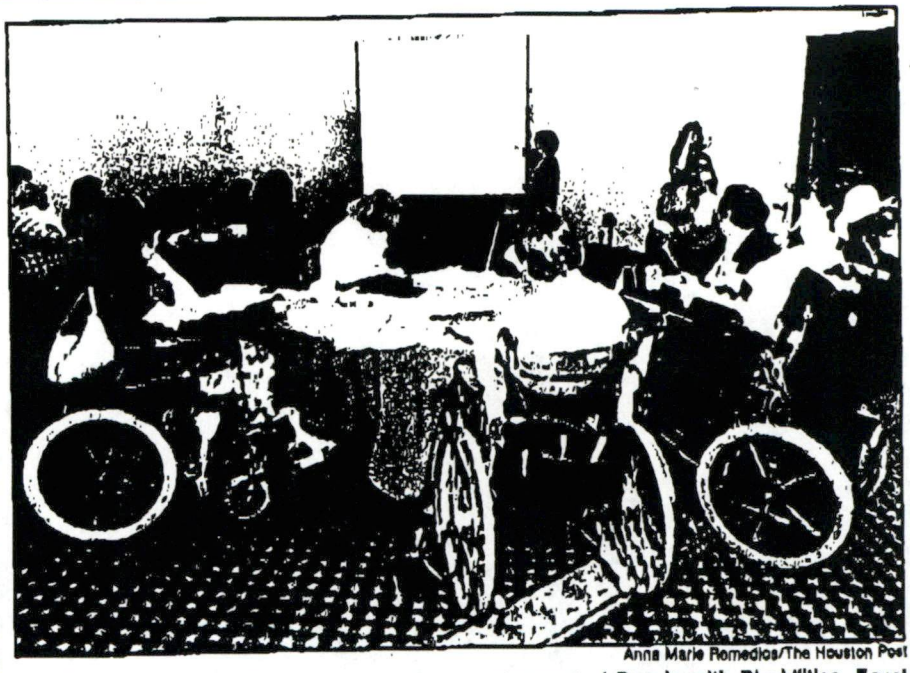
Only after making a job offer, the company may require a medical exam from all people in that job category. If the exam then reveals a disability, and the applicant is not hired, the employer must be able to show that the reasons were essential for the job and that no reasonable accommodation could have been made.

Reasonable accommodation is a key concept in the law.

Employers are required to make any change or adjustment to the work environment that will permit a qualified applicant with a disability to do the job. It is the employee's responsibility to ask for that accommodation.

Examples include erecting ramps and rearranging furniture to allow passage of a wheelchair, distributing marginal job functions to other employees, arranging part-time or modified work schedules or providing special equipment or devices.

The employer is excused from making these accommodations *only if they would cause an "undue hardship."*



Anna Marie Remedios/The Houston Post

Disabled people attend a conference that deals with ADA issues, sponsored by the Houston Mayor's Committee for the Employment of People with Disabilities, Equal Employment Opportunity Commission and Employment Management Association.

"The definition of a hardship is a lot different from what employers think," said Donna Guerrero, assistant to the EEOC director. A hardship can mean that the change would put a financial strain on the company. It also can mean that the accommodation affects operations, such as requiring a machine that uses up half the workspace or is too loud for other employees, she said.

Lowering the essential standards of the job would not be a reasonable accommodation.

For example, if a company wants to hire a maid to clean 18 rooms in an eight-hour shift, and a job applicant with a walker can only clean nine rooms in a day, that person would not be qualified for the job, explained Joe Bontke, vice president with Accessibility Consultants.

The size and resources of the company enter into the determination of what is an undue hardship, McDonald said.

But "in reality, most accommodations don't cost much," he said. When his consulting firm hired a person in a wheelchair, for example, all it needed to do was provide a parking space close to the building, remove the pencil drawer in the desk and select job assignments in wheelchair-accessible buildings, McDonald said.

The act does not require employers to provide a personal assistant to help the disabled person with personal needs, Ehrlich said. "That was a big controversy."

But it may require a company to provide a sign-language interpreter or a driver to help the employee carry out the job.

A signer or reader, however, does not have to be full time, Ehrlich said. "When there is a staff meeting and crucial information is given out, then a signer has to be present. But if the discussion is one on one, you can get away with writing notes."

Another defense permitted by the law occurs if the disabled person would pose a risk to health or safety in the workplace that could not be eliminated with a reasonable accommodation.

For example, a contractor who works in a petrochemical plant asked about hiring a secretary for a small office in the center of the plant. His fear was that she could not be evacuated quickly in the case of emergency, and he did not own the plant, Guerrero said. "I say that safety to self and others is another defense," she said.

But the potential that a person with AIDS will spread infection is remote enough that it does not apply, she said. Nor does the diagnosed epileptic who has had only one seizure in 20 years pose a direct threat, she said.

The disabled person who sues may seek back pay or to be placed in a job, but the law does not allow for punitive damages, McDonald said. "People are not going to get rich suing off this law."

The ADA section on public facilities went into effect in January. It was expected to generate lawsuits, but only about 160 complaints were filed nationwide by late-April, McDonald said.

"One of the weaknesses of the ADA is the lack of coverage of the health insurance problem. Congress understood it was not addressing the issue," said Frieden. As director of the National Council on Disability, he supervised the drafting of the ADA.

Insurance companies can legally deny coverage to persons with AIDS, mental illness, alcoholism and other disabilities. If an employer wants to hire a disabled person, but the employee can not get coverage, then it becomes the employee's decision whether to take the risk. The lack of coverage, therefore, becomes a disincentive to work, Frieden said.

EEOC's Houston office got a call recently from an employer who had run into a brick wall on health insurance, Guerrero said.

The employer had negotiated to switch insurance carriers, and the insurer asked the 38 employees to sign insurance cards. One employee with HIV refused to sign because he believed that the new plan was not as good. The insurer then refused to cover the company at all.

Even when the insurer provides coverage, "the employer is subconsciously afraid he is going to get re-rated and the cost of his insurance is going to go up," Frieden said.

Tracy Raby, 25, is one of many Houstonians whose disabilities have not prevented them from fitting into the work force.

Abnormal blood vessel growth in her eyes caused her to lose her eyesight in March 1991. After two medical operations and a leave of absence, she was ready to go back to work, but her former employer, a bank, dragged its feet, she said.

She soon found a better job doing research and other computer work for MMAR Group Inc., a Houston investment banking firm. Her father is an investment banker who knew people at the firm, she said.

Before she started work, the State Commission for the Blind analyzed the worksite and recommended the company add four pieces of equipment to her computer: a scanner that reads typewritten material, a voice synthesizer, a voice software program and a speaker, she said. "The company said, 'Whatever you need, we'll purchase.'"

Raby was not willing to sit and just watch life go by, she said. "I have never been around anyone who was not goal-oriented."

SECTION H

Bush Library Photocopy Preservation

BUSINESS

Sunday, July 19, 1992 Austin American-Statesman

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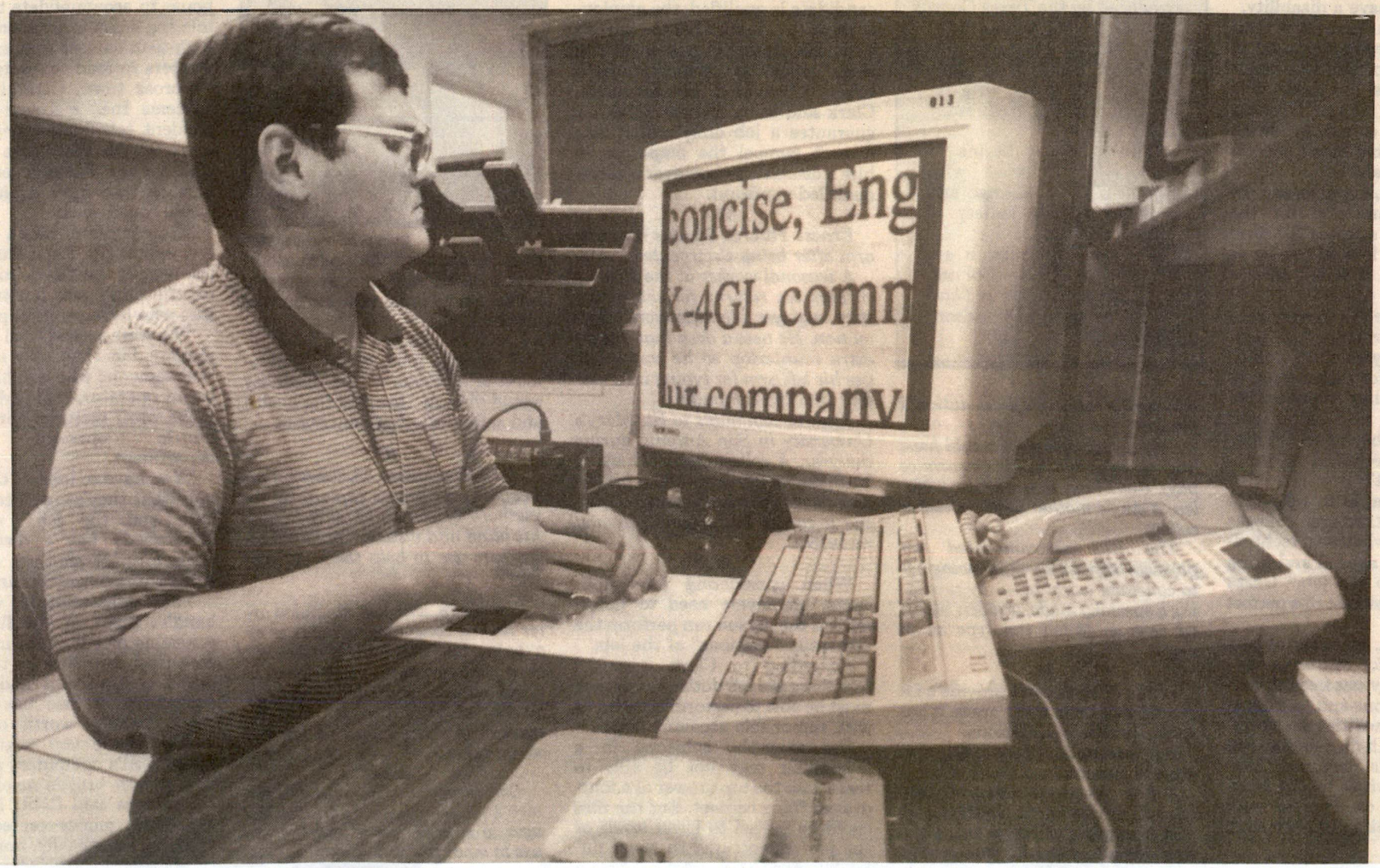


Rental advice: Become insured

By Diana Williams
American-Statesman Staff

With only one in four renters protected against personal property losses, the Texas Department of Insurance and the National Consumers League are working to increase local awareness about renter insurance policies.

"If you rent and you don't have renter insurance, you could be completely out-of-pocket if you suffer from fire or theft damage," said Rafael Ayuso, a state insurance department spokesman.

Ayuso said many Austin renters mistakenly believe their landlords' insurance policies will protect them from personal losses. Landlords, however, typically insure only against structural damage and liability — not their tenants' possessions.

Renter policies are designed to protect tenants' personal property in cases of fire, ,theft, vandal-

BREAKING WORKPLACE BARRIERS

ADA offers job access to people with disabilities

Using an Apple Macintosh computer, Susan Ilkenhans designs posters, signs and brochures for the Austin IRS Service Center.

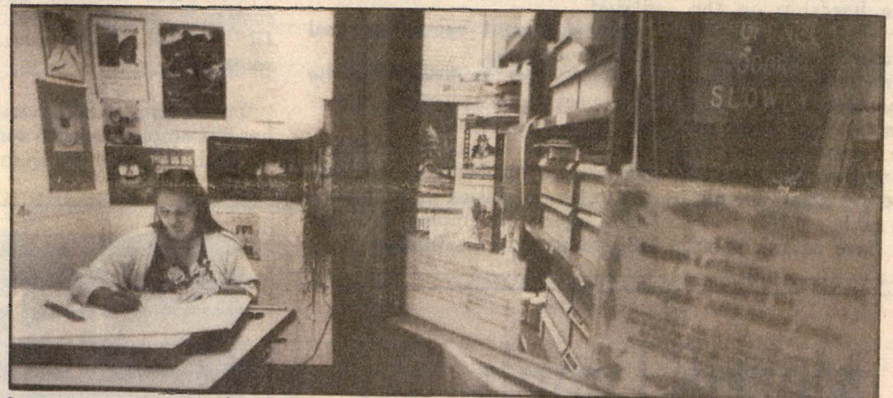
A light on the desk next to her computer screen tells her when the phone is ringing — just one of the devices the IRS has acquired to help the deaf illustrator get along better in her job.

A window added to her door allows her to see if someone is knocking, while a telecommunications device for the deaf sits on a desk outside her office so she can receive phone calls. A staff interpreter is available if she needs help communicating with a hearing person who doesn't know sign language.

Ilkenhans, a mother of four, has worked for the IRS eight years and says she loves her job and the chance to use her natural drawing ability.

"I'm not going to give it up for anything," she says.

Story by Kim Tyson
Photos by Karen Warren
American-Statesman Staff



Susan Ilkenhans, who is deaf, is an illustrator at the IRS. A light on her desk blinks when she has a phone call and a sign language interpreter is available to translate when she has to communicate with someone who does not know how to sign.

A week from today, a new federal law is expected to break down barriers and open doors to jobs for millions of persons with disabilities who are willing and able to work.

On July 26, the employment section of the Americans with Disabilities Act becomes law — affecting all companies that have 25 or more workers.

Hailed as the Civil Rights Act for persons with mental or physical disabilities, the ADA requires employers to end discriminatory hiring practices and make accommodations in the workplace so those with disabilities can use their skills to be employed.

The federal law, passed in 1990, is expected to help people who have sight, hearing, mobility and other physical or mental impairments move more easily into the mainstream of American life. Some 43 million Americans are believed to be disabled, including 15 percent of Texas' population.

Under ADA, employers are prohibited from discriminating against qualified individuals with disabilities in any aspect of employment and are required to make "reasonable accommodations" to enable workers with disabilities to perform the essential functions of their jobs, said Carol Clark, an attorney with Graves, Dougherty Hearon & Moody in Austin.

Companies with 15 to 24 employees must comply with the provisions of the law by July 1994.

Clark said the problem companies have with the new law is that it fails to tell them and persons with disabilities exactly what companies must do to meet it.

"The act basically says you can't discriminate against a person with a disability in that you have to make available accommodations for them to do the job, provided it doesn't create an undue hardship," Clark said. "What constitutes a 'reasonable accommodation' and 'undue hardship' isn't known.

"When is it that I need to hire someone with a serious disability and how much money will I have to spend? There just isn't an answer on what I think is a critical question," Clark said.

■

Telephone operator Dan Brown's fingers quickly scan the Braille coded keys. In the meantime he slips into fluent Spanish, responding to the language needs of a Capital Network Systems Inc. customer making a collect call.

Brown, 22, has been blind since birth. But with a $6,000 Navigator system provided by the Texas Commission for the Blind, he has no trouble keeping up with the dizzying pace of the other CNSI phone operators answering calls.

When it's time for a break or to head home, his guide dog Mac, who sleeps at his feet during the day, is ready to go.

■

"I think the idea of providing a law that prohibits discrimination makes an enormous amount of sense. You have people with tremendous job skills and they really ought to be in the market," Clark said.

"My only complaint is that the President and Congress should have told us the game rules rather than leaving it to the courts."

Federal officials did a better job with another major section of ADA that went into effect last January, Clark said.

That part of the law — which requires that physical barriers to the disabled be removed in public places so they will have equal access to facilities — is unclear in places, she said, but Congress made more of an effort to describe what must be done to make a property accessible and at

See Businesses, H2

Where to find information about ADA

More information about the Americans with Disabilities Act of 1990 is available from the following sources:

■ **The U.S. Chamber of Commerce** offers a manual: *What Business Must Know About The ADA: 1992 Compliance Guide.* U.S. Chamber, 1615 H Street NW, Washington, D.C. 20062-2000. Credit card orders: 800-638-6582. Other inquiries: 202-463-5503.

■ **Better Business Bureau** members can receive free copies of *The Americans with Disabilities Act: Questions and Answers* by the U.S. Equal Employment Opportunity Commission and Civil Rights Division of the U.S. Department of Justice, as well as a brochure called *The Americans With Disabilities Act: Your Responsibilities as an Employer* by the EEOC. Graves, Dougherty, Hearon & Moody is underwriting the mailings. Phone: 800-949-4232.

■ Specific questions about ADA requirements can be sent to: **Equal Employment Opportunity Commission**, 1801 L Street NW, Washington, DC 20507. Phone: 800-669-EEOC (voice) or 800-800-3302 (TDD).

■ **Job Accommodation Network**, a service of the President's Committee on Employment of People with Disabilities, is a free consulting service for business wanting to get up to speed on ADA.

■ **Texas Governor's Committee for Disabled Persons**, 4900 N. Lamar Blvd., Austin 78751-2316. Phone: 512-483-4380.

■ **Texas Rehabilitation Commission**, 4900 N. Lamar Blvd., Austin 78751-2316. Phone: 512-483-4425.

U.S. Census figures for 1990 showed that 59.4 percent of Austin dwellings were rented properties.

Ryan Robinson, a senior planner with the City of Austin, said the city has one of the highest rental percentages in the country. "There are many factors that cause this, especially with the universities and renting students we have in the area," Robinson said.

> "It is a necessity for everyone who rents to inquire about it."
> — Rafael Ayuso

Ayuso said the high percentage of rental properties — coupled with the low rate of tenants who have insurance — makes Austin renters a major target for property loss.

"We think it is a necessity for everyone who rents to inquire about it," Ayuso said. "I can't say as a blanket statement that it is right for everybody, but everybody should at least look into it."

Janet Karner, who works at the insurance department with Ayuso, said she decided against renter insurance.

"We felt safe where we lived," Karner said, referring to her Southwest Austin apartment. "We never thought something would happen to us."

But this summer, during a daytime robbery, Karner's television, video tape recorders, video games, camera equipment and jewelry were stolen. The stolen goods were valued at more than $1,000 — a cost Karner and her husband cannot afford.

"I wish we had the insurance now," she said.

"If people have invested their time and money in electronics and jewelry, they need to look into getting insurance," she said. "You might not be able to pay for new things without it."

Ayuso said some renters believe insurance premiums are expensive. "This is a myth," he said. "More people can afford it than they think."

Although premiums vary, most renters can find insurance for about $160 a year.

However, insurance policies for those who live in apartment units are generally higher than for those who rent houses, and

Businesses try to clear path through ADA requirements

Continued from H1

what cost.

Clark said the employment details are expected to be worked out after long, expensive court battles. The ADA allows judges to award fees to lawyers in ADA cases, a fact that some companies fear will promote lawsuits.

Belinda Carlton, executive director of the Coalition of Texans With Disabilities, said she expects legal action by activists in the disabled community will center on the employment section of ADA.

"I think the employment piece of it is critical to all the other aspects of ADA," she said. "The key to independence is employment.

"I think there is going to be some real blatant discrimination that's going to be real obvious on the employment side," Carlton said. "I think they will be the (lawsuits) to come first."

She said her organization, a statewide consumer rights coalition of 90 groups, has not been happy with the way the ADA has been followed so far.

"There have been some large businesses who really have embraced the ADA, but overall it's been a disaster," Carlton said. "They just think it's something that is too complex and too expensive. I think they're going to choose to wait until they see if somebody gets sued."

■

At Capital Network Systems Inc., operator Craig Garrells, who has cerebral palsy, needs no extra equipment to do his job. Unlike some with the disability, he has no difficulty with eye-hand coordination or speaking, although he walks a bit slower and with a limp.

Garrells, a 15-year veteran of the telecommunications industry, said he never encountered discrimina-

scrutinized for compliance.

"In the real world a company with 30 employees is a lot less likely to face an ADA lawsuit than a major Austin employer," Clark said.

She said larger firms also are expected to spend more to accommodate those who have a disability.

"It's pretty clear to me that IBM is big enough they're supposed to hire a reader (a person who reads written materials for those who can't)," she said. "It's pretty clear to me that the corner sandwich shop is so small they aren't expected to hire a reader."

Rolando Garza, a spokesman for the Texas Commission for the Blind, said ADA stresses the need for employers to look at people as individuals with different talents and needs.

"Sometimes we like to wrap people in one little wrapper," he said.

He said employers must consider what it takes for each person to do the job: Are they computer literate? Can they read better with large print? Do they know Braille? Can they read technical information and digest it?

"The ideal goal is to take that job, make the structural changes necessary and whatever technology changes are needed and bring that person into the job," Garza said. "That's what we call a perfect job match."

Ginger Byram, manager of personnel services for Motorola Inc., said the company has been updating job descriptions and looking at whether all its facilities are accessible to those with disabilities. But she said Motorola, previously honored for its activities by the Mayor's Committee on Persons with Disabilities, is fairly well prepared for the new law.

Several years ago Motorola be-

ADA on TV

Information on the new Americans with Disabilities Act will be featured this week in a Channel 33 showcase "Equal to the Challenge," produced by the Texas Commission for the Blind.

Individual programs will be shown primarily on Tuesday and Thursday, with repeat shows on Wednesday and Friday.

The showcase begins at 6:30 a.m. Tuesday with *Equal to the Challenge* and includes a wide variety of other programs.

For more information, see the Austin Access Column and television grids in *Show World* in today's *American-Statesman*.

mining the country's gross national product.

"My doctor told me I would have had to take disability (insurance pay). But I have to work," says Nolen, a single mother with a child in college.

The IRS accommodated her physical difficulties — allowing her to continue working — by providing a specially made, wooden, slanted desk so Nolen can type at an angle.

■

While ADA doesn't provide a lot of guidance on in some areas, it has some specific prohibitions.

For example, Clark said, employers cannot:

■ Ask questions about disabilities on employment applications.

■ Administer medical exams before extending employment offers.

■ Have selection criteria that

functions that are appropriately part of the job."

Clark said pamphlets from the U.S. Equal Employment Opportunity Commission offer good guidance on how employers should conduct interviews.

When trying to determine if the candidate is qualified, the employer must decide whether the person with the disability possesses the skill, experience, education and other job-related requirements. Clark said being disabled does not guarantee a job offer and it also doesn't compel the employer to hire a disabled person over a better qualified applicant.

■

Ernest Ytuarte, 26, lost his right arm after being electrocuted.

A seasonal worker at the IRS, he surveys tax returns for the necessary taxpayer identification information. He uses a desk that has an extra countertop so he can better use his left arm for typing information into the computer.

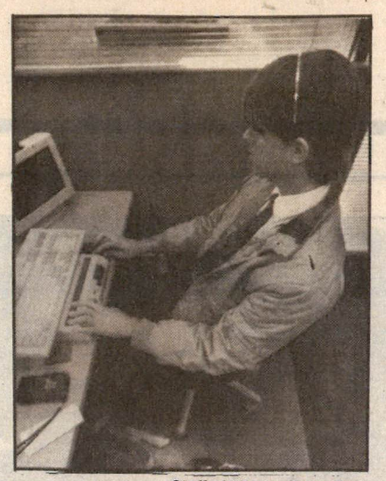
Ytuarte commutes to St. Mary's University in San Antonio during the year. A college junior studying business, he wants to finish his degree in the next two years and pursue a career in corporate human resources.

■

When considering job applicants, employers need to determine if the person can perform the "essential functions" of the job.

According to Clark, essential functions are job duties the person must be able to perform unaided or with reasonable accommodation.

For example, someone in a wheelchair may not be able to reach into the top drawer of a four-drawer filing cabinet. But the files could be moved to lower levels or the job restructured so those duties are handled by someone else.



Staff photo by Sung Park

Dan Brown, blind since birth, works with a $6,000 Navigator system that helps him keep up with the pace of calls at CNSI.

■ Identify jobs where employment of a person with a disability would directly threaten the health and safety of other employees.

■

Brad Trainham, 33, takes off his headset and begins explaining the plethora of electronic aids he and his blind and visually impaired coworkers use to help them do their jobs.

Trainham, who lost his vision after having congenital eye cancer as a baby, has a speech synthesizer that allows him to hear what is typed on his computer screen. A nearby scanner can be used to transfer printed material to the computer.

Colleague Paul Hunt uses a device that translates computer images to Braille "keys" that he can use to move the cursor and read the

of its 3,500 workers.

Throughout its building on South Interstate 35 are an array of simple and sophisticated ways the agency has made job accommodations so employees with disabilities can do their work better — from wooden desks fabricated in-house to accommodate those with missing limbs or problem backs to high-tech devices that allow blind workers to read computers.

Across town, Capital Network Systems Inc., a 4-year-old independent telephone company, has worked with the Texas Commission for the Blind to employ six persons who have some form of visual impairment.

The company, which was cited last year as the Texas Employer of the Year by the Texas Commission for the Blind, also has two operators who have cerebral palsy.

"We were so skeptical at the beginning, but then they showed us that someone who was blind could be an operator," said Marti Simmons, staff manager for the 170-person operator services department.

"You have to look at the person and what they're used to working with and the job," she said. "Everybody has a disability of some form or another, some just shine through more than others."

The Commission for the Blind handles much of the firm's prescreening of job applicants to ensure they can work in the quick-paced environment and use the equipment. It also has paid for about $40,000 worth of Braille reading equipment that is used with CNSI's computers and regularly repairs broken machines.

Simmons said CNSI has spent very little money on equipment used by its visually impaired or blind workers. And its two employ-

suits) to come first."

She said her organization, a statewide consumer rights coalition of 90 groups, has not been happy with the way the ADA has been followed so far.

"There have been some large businesses who really have embraced the ADA, but overall it's been a disaster," Carlton said. "They just think it's something that is too complex and too expensive. I think they're going to choose to wait until they see if somebody gets sued."

■

At Capital Network Systems Inc., operator Craig Garrells, who has cerebral palsy, needs no extra equipment to do his job. Unlike some with the disability, he has no difficulty with eye-hand coordination or speaking, although he walks a bit slower and with a limp.

Garrells, a 15-year veteran of the telecommunications industry, said he never encountered discrimination until he came to Texas three years ago and ran into what he calls the "Bubba syndrome."

"It's not what they say but how they look at you," he says. "You would expect employers in the '90s to be more receptive to people's abilities rather than the old stereotypes."

■

Many companies are still trying to understand the ramifications of ADA.

"I think that large companies with a department of human resources are very much aware of the law," Clark said. But companies with 30 or 50 employees are "probably not particularly up to speed," she said.

Although smaller firms may be less likely to be taking steps to meet the law, she said she expects large companies to be the ones

ple in one little wrapper," he said.

He said employers must consider what it takes for each person to do the job: Are they computer literate? Can they read better with large print? Do they know Braille? Can they read technical information and digest it?

"The ideal goal is to take that job, make the structural changes necessary and whatever technology changes are needed and bring that person into the job," Garza said. "That's what we call a perfect job match."

Ginger Byram, manager of personnel services for Motorola Inc., said the company has been updating job descriptions and looking at whether all its facilities are accessible to those with disabilities. But she said Motorola, previously honored for its activities by the Mayor's Committee on Persons with Disabilities, is fairly well prepared for the new law.

Several years ago Motorola began trying to meet rules spelled out in the Rehabilitation Act of 1974, which governs federal agencies and government contractors, she said.

"We just figured it was coming and went along with it then. That has pretty much gotten us ready for this," Byram said, noting the company has worked closely with state schools for the deaf and mentally retarded. "Throughout the years we've been very pro-active in hiring people with disabilities."

■

Kay Nolen, 51, suffered two ruptured discs in her back after an auto accident six years ago. Several of her vertebrae were fused together through surgery, a procedure that made it increasingly difficult for her to use a computer keyboard.

An 11-year employee of the IRS, Nolen develops statistics used by the federal government in determining the country's gross national product.

"My doctor told me I would have had to take disability (insurance pay). But I have to work," says Nolen, a single mother with a child in college.

The IRS accommodated her physical difficulties — allowing her to continue working — by providing a specially made, wooden, slanted desk so Nolen can type at an angle.

■

While ADA doesn't provide a lot of guidance on in some areas, it has some specific prohibitions.

For example, Clark said, employers cannot:

■ Ask questions about disabilities on employment applications.

■ Administer medical exams before extending employment offers.

■ Have selection criteria that screens out individuals with a disability unless the employer demonstrates that the criteria are related to the job.

■ Give preference to a qualified individual without a disability over an equally qualified person with a disability merely because the person with a disability would require reasonable accommodations, unless the accommodation would impose an undue hardship on the company.

"You can't inquire about prior workers' compensation claims, about prior absenteeism; you really can't inquire about past drug-related problems because you may be asking questions that are a veiled attempt to find out about the disability," Clark said.

"You really have to ask about

extra countertop so he can better use his left arm for typing information into the computer.

Ytuarte commutes to St. Mary's University in San Antonio during the year. A college junior studying business, he wants to finish his degree in the next two years and pursue a career in corporate human resources.

■

When considering job applicants, employers need to determine if the person can perform the "essential functions" of the job.

According to Clark, essential functions are job duties the person must be able to perform unaided or with reasonable accommodation.

For example, someone in a wheelchair may not be able to reach into the top drawer of a four-drawer filing cabinet. But the files could be moved to lower levels or the job restructured so those duties are handled by someone else.

Clark suggests employers do several things to prepare for ADA:

■ Review and revise job application forms, describing duties by their essential functions.

■ Train supervisors on the proper way to handle job interviews and the confidentiality of medical records.

■ Review employment testing procedures to see that they are job-related.

■ Review and revise medical exam procedures.

■ Make the facilities used by employees easily accessible to persons with disabilities.

■ Analyze whether auxiliary aids, job restructuring or reassignment of some duties would enable the company to employ qualified individuals with disabilities.

■ Identify jobs where employment of a person with a disability would directly threaten the health and safety of other employees.

■

Brad Trainham, 33, takes off his headset and begins explaining the plethora of electronic aids he and his blind and visually impaired coworkers use to help them do their jobs.

Trainham, who lost his vision after having congenital eye cancer as a baby, has a speech synthesizer that allows him to hear what is typed on his computer screen. A nearby scanner can be used to transfer printed material to the computer.

Colleague Paul Hunt uses a device that translates computer images to Braille "keys" that he can use to move the cursor and read the computer screen.

Around the corner, Steven Ray has an oversized computer screen that allows him to magnify script. Ray, 37, whose vision was impaired by congenital contaracts, also has a miniature hand-held television camera that he can use to scan the latest technology manuals on his computer screen. The system, he calculates, cost upwards of $8,000.

The three work in a national computer coaching center used by IRS service centers around the country.

■

The Austin IRS Service Center has 431 employees with some form of disability, or more than 1 in 10

ginning, but then they showed us that someone who was blind could be an operator," said Marti Simmons, staff manager for the 170-person operator services department.

"You have to look at the person and what they're used to working with and the job," she said. "Everybody has a disability of some form or another, some just shine through more than others."

The Commission for the Blind handles much of the firm's prescreening of job applicants to ensure they can work in the quick-paced environment and use the equipment. It also has paid for about $40,000 worth of Braille reading equipment that is used with CNSI's computers and regularly repairs broken machines.

Simmons said CNSI has spent very little money on equipment used by its visually impaired or blind workers. And its two employees with cerebral palsy have needed no special equipment or other accommodations to do their jobs.

She said CNSI has learned that being open to hiring those with disabilities has its advantages.

"If just given a chance, the people we have working here are doing a better job than some of those who can see," she said.

"I'm just glad it didn't take a law to make us realize that people with a disability are more than capable or just as capable as you and I are.

"It really frustrates me," Simmons said. "They don't enjoy sitting at home collecting welfare. They want to work just like you and I do."

NationsBank invests in MNC

Knight-Ridder Tribune News Service

CHARLOTTE, N.C. — NationsBank Corp. said Friday that it will invest $200 million in ailing MNC Financial Inc., Maryland's

dent and chief executive Hugh McColl Jr., "not an acquisition. This structure gives us time to see how things play out at MNC."

If MNC rebounds, NationsBank can buy MNC for between $1.25

Merrill Lynch
has a lot to say about
low short-term rates

IF INTEREST
RATES
ARE MAKING YOU

Roxie,

Here additional info for Lex on the health care issue – no need to fax. he can see this when he gets back to town

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HOUSTON POST 9/27/92

Boiling down the health care issue

By Rosalind Jackler
WASHINGTON BUREAU

WASHINGTON — When George Bush and Bill Clinton talk about health-care reform, they spend more time bashing each other's plans than boosting their own.

It has taken more than a while for both of them to finally talk specifics on how each would make health care more affordable and accessible.

Bush had mentioned the need for health-care reform early in his term, but it was last year's election of Pennsylvania Democrat Harris Wofford to the U.S. Senate that thrust the issue into the spotlight. Wofford successfully used the health-care issue to defeat former U.S. Attorney General Dick Thornburgh.

The defeat of a former Cabinet member sent the administration scrambling to put together a health-care package that was supposed to be announced during Bush's State of the Union address. But it got pushed back to Feb. 6.

Clinton also was slow entering the health-care fray and was bruised on the issue during the Democratic primary race, especially by Sen. Bob Kerrey of Nebraska, whose main issue in his short-lived campaign for the Democratic Party's nomination was health-care reform.

Even after proposing their distinctively different plans, health-care reform has been slow to catch fire as an election issue. For starters, it's incredibly complicated and doesn't easily boil down into a television sound bite.

Congress hasn't handled it well, either. Democrats wanted to make health-care reform their pet cause and held a series of town meetings around the country last December to let voters know the lawmakers plan to do something.

But the Democrats have been unable to reach a consensus on what to do. Their own re-election fears — as well as concern over the presidential race — have left the issue dormant, despite myriad bills that have been introduced.

Everyone is for health care. The question is how to provide adequate medical treatment for a nation and hold down costs without driving up taxes or the deficit. Health-care experts don't even agree on how to fix the system.

That's why it's easier to attack the opponent or distort his plan, such as Bush saying Clinton favors an additional payroll tax for businesses to cover health care for workers or Clinton claiming Bush would reduce Medicare benefits. Both candidates have been rebutting the other's descriptions of their health plans.

Bush and Clinton actually agree on a few health-care issues, such as malpractice reform, reducing hospital paperwork and encouraging preventive care. But they have different approaches to solving the spiraling costs of providing health care.

Here are highlights of their plans:

Obtaining insurance

The cornerstone of Bush's plan is to provide a tax credit or tax deduction up to $3,750 for a family to obtain health insurance. The administration says this would benefit more than 90 million Americans and make insurance available to those with low incomes and more affordable for middle-income Americans.

For example, a family of four with an adjusted gross income of up to $14,300 would be able to use the maximum $3,750 to purchase health insurance. A family of four with an income up to $60,000 and without employer-sponsored insurance could claim the full tax deduction of $3,750 that would provide about $1,050 to help buy insurance. If an employer pays part of the insurance cost, that amount is deducted from what the worker can claim on his income tax.

States would be required to develop a basic health insurance package that could be purchased with the tax credit, but people would be free to purchase alternative insurance.

Clinton wants to guarantee a basic health insurance package for all Americans either through private or public plans. Businesses would be required to insure their workers or to buy into a public program that provides insurance. Tax credits would ease the burden for small businesses. The unemployed would be covered through a public plan and pay on a sliding scale based on income.

Clinton disputes criticisms from the Bush administration that his proposal is a type of "play or pay" program that would raise payroll taxes for business. He said it will not require new taxes and preserves private sector competition.

Both Bush and Clinton would allow the self-employed to deduct 100 percent of their health insurance costs, an increase from the current 25 percent deduction.

Cost controls

Clinton would establish a national health-care board made up of consumers, providers, business, labor and government to set overall caps on national and state medical costs, as well as government spending.

The spending limits would be designed to create incentives for health-care providers to form networks and find ways to reduce bureaucracy, eliminate duplicate technology and stop waste.

He also calls for establishing insurance purchasing pools across the country that small businesses and private insurers could join to lower premiums.

Clinton argues that his major reforms of the insurance system combined with a revised governmental role will foster competition among health-care providers and insurance companies to offer a variety of affordable health-care packages for Americans to choose.

Boiling down the health care issues
Page 2

Bush says Clinton's plan would involve massive new government intervention into health care and eventually would leave to government takeover of American health care. He also argues that Clinton's overall spending caps would lead to price controls.

Both Bush and Clinton advocate streamlining hospital paperwork, billing and insurance claims to cut red tape and hold down administrative costs.

Core benefits

Both Bush and Clinton favor establishing a core benefits package that would be available to everyone and would not restrict coverage for pre-existing conditions.

Health networks

Both Bush and Clinton favor strong incentives for insurers, physicians and health-care institutions to collaborate to form local health networks, a type of giant health maintenance organization, to provide competitive benefits and hold down costs.

Malpractice reform

Both candidates call for malpractice reform as a way to hold down costs, including developing alternative mechanisms for resolving disputes out of court and establishing medical care guidelines.

Medicare

Clinton wants to expand Medicare for the elderly and disabled to include more long-term care, placing emphasis on home- and community-based care.

Bush's health-care reform plan makes no substantial change in existing Medicare coverage.

Costs

Bush's plan would cost $100 billion over five years with the money coming from what is now spent on Medicaid as well as cost reductions within the reforms.

Clinton doesn't specify a price tag but says the costs would come from savings in the insurance reforms and through the spending caps.

Special election reports

This is the second in a series of Sunday reports on key issues in the presidential campaign. Today we examine where the candidates stand on health care. Also, eight Houstonians with a daily interest in the issue offer their suggestions. /A-26

Lex

NATION & WORLD

The Houston Post/Sunday, September 27, 1992

Canada offers possible model for health care

By Kathy Kiely
Post Washington Bureau

MONTREAL — The U.S. presidential election is causing a certain amount of heartburn up here. But if anyone gets ulcers over it, there's one comfort:

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That's the remarkable fact that has made Canada, of all places, something of an issue in this year's campaign for the White House. Perhaps for the first time since the Vietnam War sent draft resisters scrambling across the border, Americans are taking an "uncharacteristically nervous glance northward.

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It seems that Canadians already have something more and more Americans are coming to believe they need: Universal health care, insured by the government and available free of charge.

Critics of the Canadian system — among them President Bush and former Democratic presidential contender Paul Tsongas — caution that our neighbors to the north are not necessarily as well off as they seem to be, that Americans could lose more than they'd gain by following Canada's lead.

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There is much about health care in Canada that is reassuringly familiar to middle-class Americans — patients pick their own doctors, hospitals are privately run. Other aspects of the program are refreshingly different. No one asks about insurance when you go to a hospital. At doctors' offices, there are no endless forms to fill out.

Most stunningly, there is usually no bill, no co-payment and no deductible.

That's pretty much the way it's worked for the last two decades in Canada, which covers its citizens' medical expenses through a government-run, government-funded insurance program administered by governments of the nation's 10 provinces and 2 territories.

In a year when the 37 million Americans who are without medical insurance either because they or their companies can't afford it are one of the presidential campaign's hottest topics, it was inevitable that the seemingly greener pastures north of the border would get some attention.

Not all of it has been welcome.

While Canada's health system has won some admirers in the United States — a 1991 study the U.S. General Accounting Office did for a U.S. House subcommittee was positively glowing — the criticisms have set many Canadians' teeth on edge.

At a recent conference of U.S. and Canadian journalists near here, the Canadians laughed off some of the criticisms of their health system as the wild exaggerations of a jealous neighbor. Privately, U.S. Embassy officials attending the conference seconded the Canadian assessment.

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In 1989, Canada spent 8.9 percent of its gross national product on health care, while the U.S. was shelling out 11.6 percent. It cost $1,805 per person to provide health care in Canada, $2,354 for every citizen in the United States — even though not all U.S. citizens are covered.

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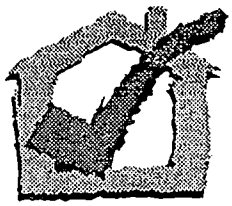
THE POST'S PANEL ON HEALTH AND MEDICAL ISSUES



BRINGING HOME THE CAMPAIGN

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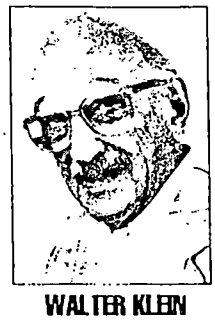


WALTER KLEIN

American Association of Retired Persons official

A health care system that's "affordable to everyone" is what the country needs. He feels it may be possible only through some form of nationalization. But, neither presidential candidate has been specific enough in his health care proposals to make Klein confident about reforms.

MIKE MCGUIRE

Spokesman for William M. Mercer Inc., an employee benefits consulting firm

The spiraling cost of health care can be controlled without nationalizing and weeding out those who provide poor quality care. Limiting liability physicians face would reduce excessive testing and treatment.

DR. RONALD MERRELL

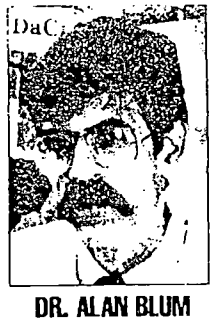
UT Medical School at Houston associate dean for clinical affairs

The country needs a policy that includes universal access to health care and some form of cost caps. Part of the current system works very well and should be preserved but more public involvement is needed.

TRISTRAM ENGLEHARDT

Baylor College of Medicine professor of medicine and ethics

The nation must spend more time identifying, in a very open, democratic way, what an appropriate level of basic health care is and then find a way to make that care accessible to everyone. That type of system is likely to include rationing of some care.



DR. ALAN BLUM

Health activist

Blum would like the country to shift its focus from high-cost technologies, and subspecialists to personal care. The country should spend more on preventative medicine

The Houston Post/Doug Mills

Canada offers possible model for health care

By Kathy Kiely
Post Washington Bureau

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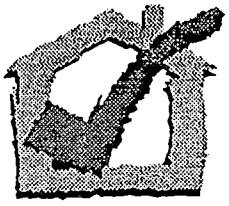

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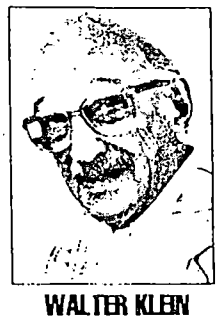


WALTER KLEIN
American Association of Retired Persons official

A health care system that's "affordable to everyone" is what the country needs. He feels it may be possible only through some form of nationalization. But, neither presidential candidate has been specific enough in his health care proposals to make Klein confident about reforms.

MIKE MCGUIRE
Spokesman for William M. Mercer Inc., an employee benefits consulting firm

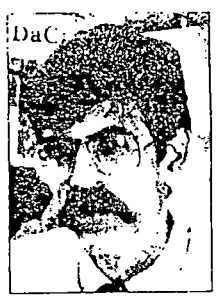
The spiraling cost of health care can be controlled without nationalizing and weeding out those who provide poor quality care. Limiting liability physicians face would reduce excessive testing and treatment

DR. RONALD MERRELL
UT Medical School at Houston associate dean for clinical affairs

The country needs a policy that includes universal access to health care and some form of cost caps. Part of the current system works very well and should be preserved but more public involvement is needed.

TRISTRAM ENGLEHARDT
Baylor College of Medicine professor of medicine and ethics

The nation must spend more time identifying, in a very open, democratic way, what an appropriate level of basic health care is and then find a way to make that care accessible to everyone. That type of system is likely to include rationing of some care.



DR. ALAN BLUM
Health activist

Blum would like the country to shift its focus from high-cost technologies, and subspecialists to personal care. The country should spend more on preventative medicine

From Marie -
Quentin has also read & both think its good - did not send to Kinko's - we have the article at home & will use that to copy if this is a yes

Document Originally
Attached to
Following Page

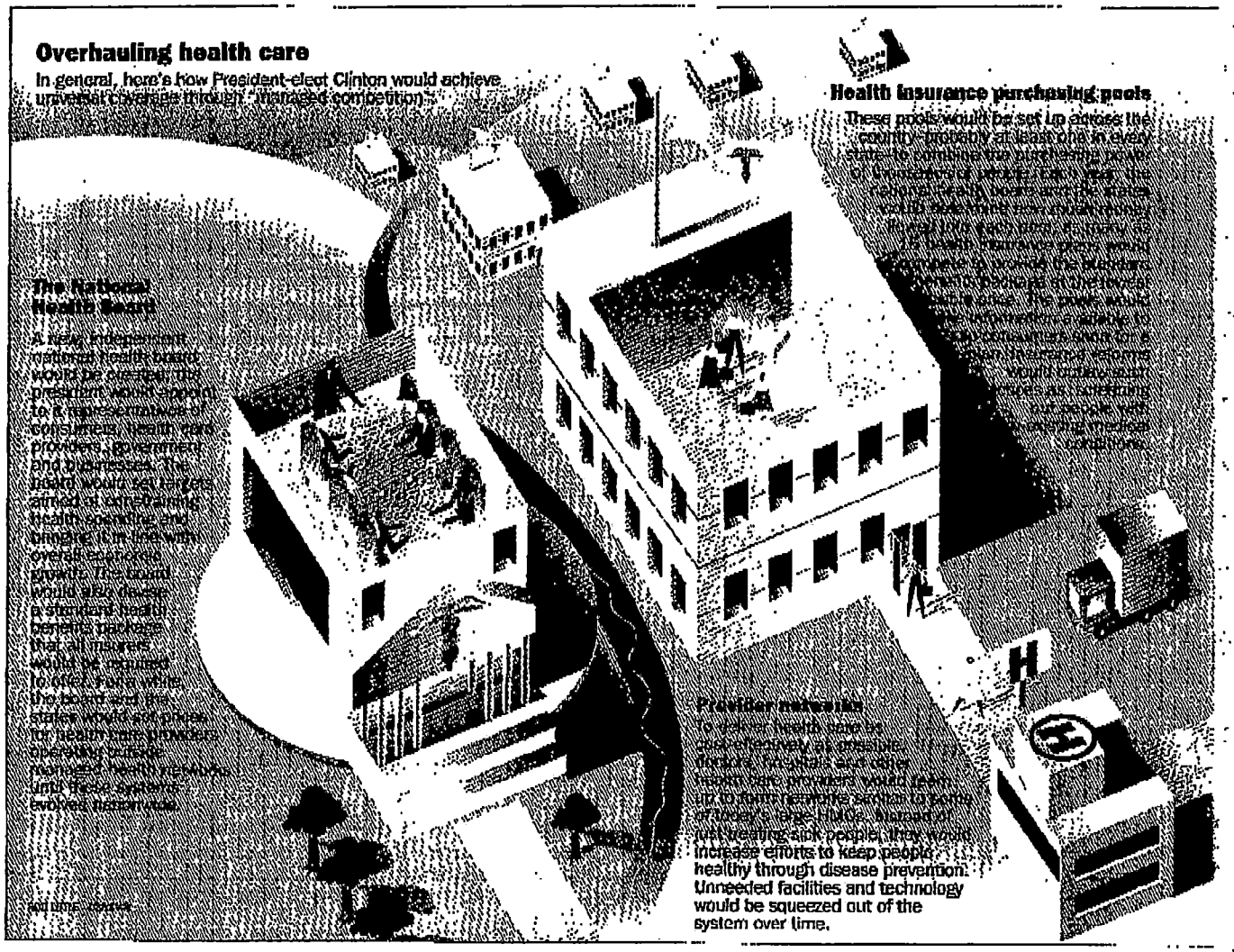
U.S. NEWS

CLINTON'S BIG TEST

The fate of the budget, the economy and his first term rests on containing medical costs

It may be the fate of every U.S. president to become bogged down in a dismal swamp. Lyndon Johnson had Vietnam. Richard Nixon had Watergate. George Bush wrestled with the double-dip recession. And Bill Clinton will have the U.S. health care system.

Consider the treacherous terrain that lies ahead for the president-elect. Exploding government health care programs are driving the federal budget deficit skyward. Left unchecked, they could add almost $1 trillion to the national debt by 2001. Spiraling health costs are breaking the backs of thousands of businesses and depressing workers' wages; at Ford, covering workers' health costs now runs to $800 per vehicle, roughly double the per-car cost of steel. At least 35 million Americans now lack health insurance and Clinton says 100,000 more are losing their coverage each month.



FROM P. 028

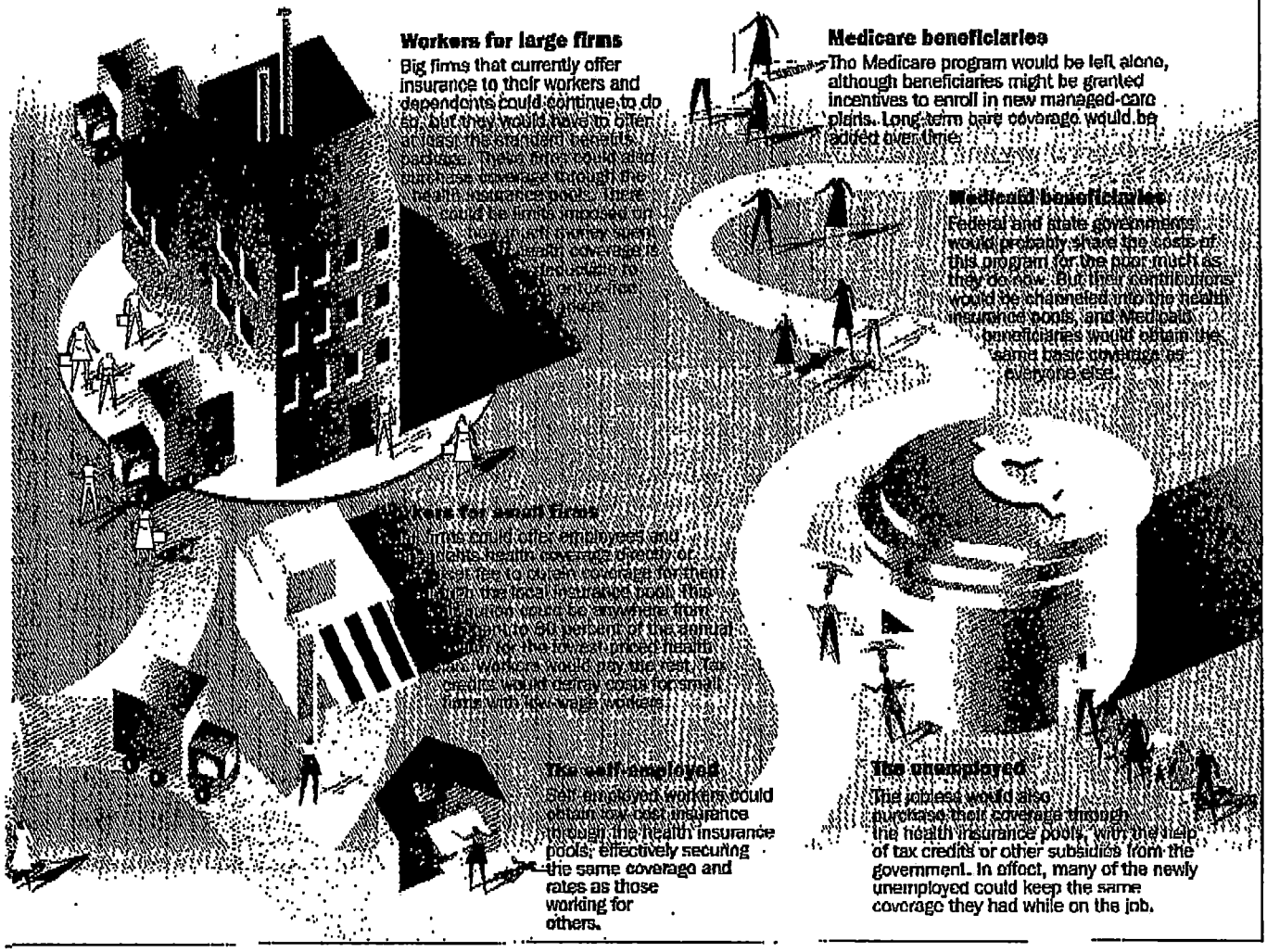
Polls suggest that many voters badly want change; nearly 7 out of 10 who cast their ballots for Clinton rated health care as an issue that mattered most. Yet few may have comprehended what a herculean task they were handing their next president. Clinton has vowed to produce a complete health care reform plan in his first 100 days as president, but restructuring the roughly $800 billion health care system will be a protracted process comparable with overhauling the old Soviet planned economy. Moreover, given the diverse set of interests at stake, getting intricate reform legislation through Congress could devour Clinton's precious political capital.

Last week, Clinton named a transition group headed by Washington health policy expert Judith Feder to assemble his eventual health care team and to help shape his reform strategy. Now they must put meat on the skeletal health plan that the president-elect sketched during his campaign. As it stands, the plan is a variation of so-called play-or-pay schemes: It would require all employers to provide health insurance to their full-time workers or to pay a portion of the cost of obtaining coverage for workers and dependents through newly created health insurance purchasing pools (graphic below). The plan is also based on an untested theory called managed competition, designed to reap savings by restructuring the health care market with new incentives to manage costs.

Aside from literally hundreds of technical questions that must be settled, Clinton and his team face daunting political ones. A battle looms in Congress among lawmakers who favor tougher regulation to contain health costs and those who prefer to bet on a restructured market; currently, Clinton's plan contains a schizophrenic mixture of both. Then there's the powerful small-business lobby. It's hardly certain that Clinton can persuade thousands of tiny firms to accept a costly mandate to help cover their workers—even with billions of dollars of tax breaks dangled over them like candy.

Elusive savings. A slew of other issues surround Clinton's plans to spread coverage to the uninsured. His current goal is to contain health costs first—then use billions of dollars in hoped-for savings to help subsidize full coverage for the uninsured by 1999. But what happens if those savings never materialize, as many experts fear? Would the pressing need to extend health insurance to those who lack it argue for enacting tax hikes to help pay for it sooner?

Clinton's primary challenge is waging



LOGO: RICHARD GAGE USNWR

FROM P. 029

an assault on health costs, since containing those outlays is the linchpin to virtually all his other economic plans. For example, boosting workers' wages, a top Clinton goal, requires raising the rate of productivity, or output per worker. That depends in turn on making private funds available for investments in infrastructure, plants and equipment. But the annual federal deficits are absorbing the bulk of those funds—and key forces behind those deficits are the government health care programs, Medicare and Medicaid. Without the savings generated by health cost containment, there is no chance for other good news—no deficit reduction, no productivity boost, no rising real wages.

The incentives to act are enormous. National health spending is rising about 10 percent a year, or about 1⅔ times the rate of nominal economic growth. If that trend continues, health care will absorb an ever growing share of the economy - from just under 14 percent now to 18 percent by the year 2000. But if the rise in health spending could be brought down in line with nominal economic growth—in other words, to about 7 percent a year—the savings would be extraordinary. Washington health economist Jack Meyer calculates that trimming overall health spending to that level could produce nearly $1 trillion in savings—and perhaps as much as $4 trillion—over the course of this decade.

Making a market. But how can Clinton reap such savings given the prevailing trends in health care, such as an explosion in costly medical technology and the aging of the U.S. population? His plan nudges toward a strategy known as managed competition, long advocated by a group of health policy experts including Stanford University economist Alain Enthoven and Paul Ellwood, an early proponent of health maintenance organizations. The underlying premise is that, for a variety of reasons, health care lacks the necessary ingredients of an efficient market. For example, the fact that health insurance pays most health care bills means people do not shop carefully for health care—nor do they make the cost-benefit calculations that they do in buying other goods. Combined with scant information about what really works in medicine, the result is an explosion of health services of dubious necessity or quality.

Moreover, since most small businesses buy health insurance separately, they are deprived of the big underwriting discounts available to large firms that cover far more employees. And instead of managing the risks, many insurers simply compete to screen out sick people to duck the costs of treating them.

The solution proposed by Clinton and managed-competition advocates is to have the government lay the ground rules for an entirely new market—one in which the incentives motivate everyone to pursue or provide cost-effective medical care. Health insurance purchasing cooperatives, or HIPCs, would be set up across the country, pooling together small businesses and other purchasers to obtain lower insurance rates. Strict new laws would compel insurers to charge comparable rates for everyone in a given area and would bar them from such practices as denying coverage to people with pre-existing medical conditions. Networks of insurers and health care providers, organized much like today's large HMOs, would be required to offer at least a standard benefits package determined by the government. These networks would compete on the basis of the price they charged for the standard insurance package—and in turn, on how well they managed the health care of the people they enrolled.

It sounds great, in theory. But aside from the sheer difficulty of putting such a plan in place, no one knows whether it would work. University of Pennsylvania economist Mark Pauly contends that while managed competition could lower the rate of growth in health costs, it might not do so by very much. That would be a serious setback. Clinton currently intends to use savings from slower-growing government health programs to pay for tax breaks to help small, low-wage businesses cover their workers. But if the savings don't show up, many of the uninsured wouldn't get coverage—unless Clinton proposed raising billions of dollars in new taxes.

Some analysts question how many competing health networks would actually spring up in less populated areas like Mississippi, which at present doesn't have even a single HMO. And still others are troubled by the odd mix in Clinton's scheme of the market and the heavy hand of government. "Managed competition has the ring of oxymoron, like 'socialist profits,'" argues Robert Reischauer, who heads the Congressional Budget Office. "I want to see it in operation."

There are also widespread concerns that Clinton hasn't quite got the basic recipe right—partly because his plan entails far more regulation than even many

Tough calls. *Clinton has to settle on the specifics of his plan; then he faces a long legislative war.*

SCOTT GOLDSMITH FOR USN&WR

THE BILL COLLECTOR. *"People never used to ask why their bill was so high because they were not paying for it themselves," says Keith Alltop, Riverside's chief of patient accounting. "Now that they're paying part of it, they complain. And we're the last to get paid."*

less competition, widespread duplication of technology and services and, inevitably, soaring costs. To admirers, she epitomizes a new generation of hospital boss, whose financial acumen and consensus-building skills are critical to an institution's ability to provide high-quality care in an era of unprecedented financial pressure. Her world represents a sobering reality check on how intractable the problems of the system are. "Everyone is going to have to give up something for it to happen," she says. "So far, I see a lot of groups, hospitals included, fighting to protect their own interests. And the fight hasn't even begun. So, I'm not going to blow the whistle and stop the game as long as everyone else is playing."

Conflicts of interest. Though Schlichting voted for Bill Clinton and believes major reforms are necessary, she sees every day the conflicting interests and expectations of patients and their families, hospitals, physicians and insurance companies, as well as business and political leaders—all of which must be overcome if comprehensive reform is to be achieved. She fears that many, including Clinton, underestimate how difficult it will be.

Columbus and Riverside Methodist provide an all-American view of what makes the system plug along and what its shortcomings are. The soaring local cost of health care has become a staple of dinner-table conversations. And while its health care problems are not as extreme as those of most larger American cities, as a metropolitan area with 1.4 million people, Columbus has plenty of pain to go around. "We have first-class medical care but we also have major systems failure," says Jackie Fullerton, president of the Health Coalition of Central Ohio, a business and community advocacy organization.

Only 30 percent of the children in Franklin County, which includes Columbus, are immunized before entering kindergarten. The county's infant mortality rate is 10.8 per 1,000 live births, a full point higher than the rate for the United States. In Columbus, 16 percent of the population is uninsured, compared with 14.7 percent nationally and 11.4 percent in Ohio. In addition, tens of thousands more people are underinsured. Many of them work in service-industry jobs where health insurance benefits are traditionally less comprehensive than in other sectors, such as manufacturing. For cost reasons, many of these people delay seeking treatment, and others use hospital emergency rooms in place of a visit to primary-care doctors. In Columbus, as elsewhere, preventive medicine like prenatal care usually takes a back seat to treating acute illnesses. The area hospitals are part of both the problem and the solution.

Riverside Methodist, a nonprofit institution, is the flagship of U.S. Health, which owns or manages six other hospitals in Ohio. In the past 25 years, Riverside has more than doubled in size, and it is widely perceived as the most prosperous hospital in central Ohio. It commands nearly a quarter of the market in the greater Columbus area, and from a business perspective, its patient mix—30 percent private pay, 15 percent managed care, 47 percent Medicare, 5 to 8 percent Medicaid and about 3 percent charity—is good compared with many hospitals whose private-insurance patient loads are much lower and whose indigent caseloads are higher. The hospital has a $160 million annual payroll, and it spends an additional $100 million annually for goods and services.

During the presidential campaign, Clinton said repeatedly that "runaway administrative costs" are at the root of the nation's health care cost crisis. His proposal, which would encourage people to switch from fee-for-service insurance schemes to prepaid health plans such as health maintenance organizations, could ease the paperwork burden for some, but unraveling the system that has grown up in this era of cost consciousness and high fees is still daunting.

SCOTT GOLDSMITH FOR USN&WR

THE RECORD KEEPER. *"To insurance companies, we're guilty until proven innocent," says Jill Lora, head of medical records. "There must be a better way."*

"What we have to go through to get paid is nothing short of incredible," says Schlichting. Riverside's medical-records department has 66 employees, more than twice as many as it had a decade ago. Twenty-two of them work full time storing and maintaining the records, while 35 more in the data-

quality section process patient bills beginning the day after discharge. It used to take about two weeks to train a new employee for that task. Now, says Jill Lora, the department head, it takes a full year for a worker to become proficient in deconstructing a patient's chart—which may contain as many as 200 different forms—and then assigning codes and charges based on a myriad of rules and regulations from as many as 1,000 different private insurance companies and a dozen separate government agencies.

Inevitably, the relationship between Riverside and private insurance companies has grown more adversarial. "They're out to protect themselves, and we're out to protect ourselves," says Lora. "We're certainly not working as a team on the patient's behalf." The most common complaint from insurers, sometimes valid, is that the hospital has double charged for a procedure or that supporting documentation is missing or incomplete. The scrutiny has increased significantly in recent years because of competition among insurers and among hospitals for managed-care contracts—the kind Clinton wants to create nationwide. Riverside has half a dozen employees assigned exclusively to respond to insurers' challenges of patient bills. "We can't afford to back down just because a carrier challenges us," says Lora. "There's too much money involved."

Keeping tabs. Not surprisingly, insurance companies feel the same way, and they are sure to resist fiercely any attempts by Clinton and Congress to radically reduce the number of private insurers. "Everyone agrees we place an administrative burden on hospitals," says Ron Hunt, a vice president of Nationwide Insurance Co. in Columbus. "But over time there is ample evidence that many services have been overutilized and hospital bills aren't always accurate. Companies want to know what we're doing to control their costs."

For Schlichting, this is another example of conflicting expectations. "Insurance companies want us to reduce costs, and that's a valid concern. But they impose so many requirements that we have to increase costs just to keep up." Eventually, those costs are paid by patients.

Riverside's experience with its patients and the Columbus community is instructive because the success of whatever health care reform package the Clinton administration eventually puts forward will depend in no small measure on building a public consensus. For Clinton, the fact that far more Americans now pay a share of their health costs could be a mixed blessing. They are paying close attention to the issue. But if Clinton's plan means higher taxes to pay for universal access, for example, opposition could be high.

"There's a lot more sticker shock these days," says Keith Alltop, Riverside's director of patient accounting. Once again, Schlichting sees potential pitfalls because of conflicting expectations. "Collectively, we're cheap; individually, we're generous," she says. "We complain about the system and the costs. But when it's us or our family, we want everything and we don't care about the costs."

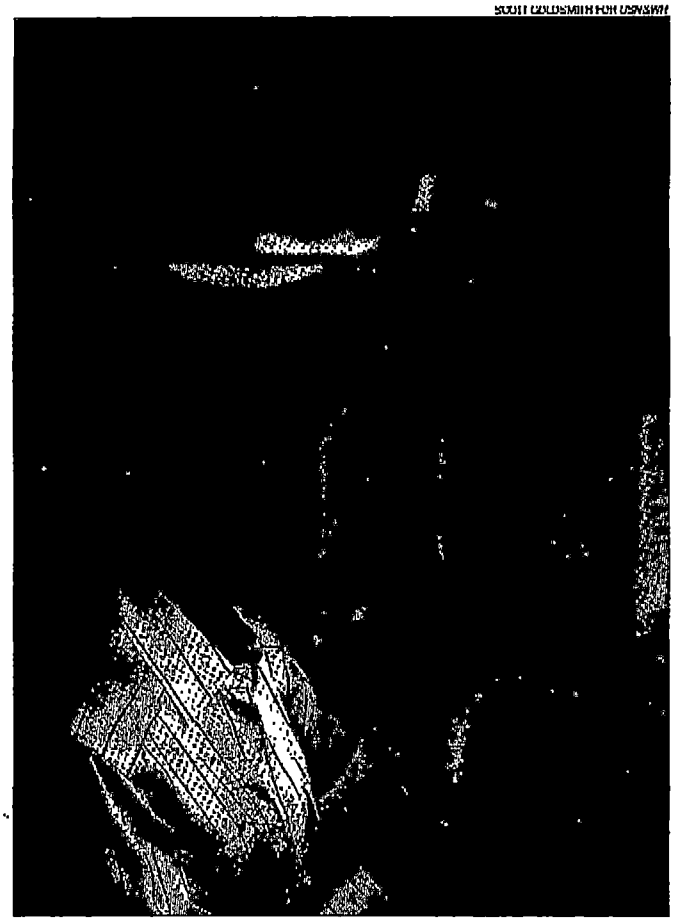
These days especially, Schlichting detects the same kind of community ambivalence when it comes to Riverside's facilities. Last January, Riverside opened a new outpatient care center across the road from the main hospital. With outpatient services growing at a 10 percent annual rate for the past five years—they now account for 22 percent of Riverside's revenue—few disagreed with the need for a new facility. But to many critics and admirers alike, Riverside's $23 million outpatient building, complete with four-story atrium, indoor fountain and handsome woodwork, comes at too high a cost. Concedes Jerry Clark, Riverside's vice president of finance, "It looks a little too good. Patients like the atrium, but they say, 'It's not going to help me pay my bill.'" But, Clark adds, "patients like it a lot better than the old space."

Building to compete. Now, Riverside is in the middle of an $85 million, 280,000-square-foot expansion and renovation of the main hospital. Schlichting argues that its 30-year-old physical plant needs upgrading and that the hospital's growth and new technology justify the new facilities. "Some of the critics are the first ones to use the new quarters," she says.

The hospital-building frenzy, in Columbus and around the country, is a reflection of the intense competition among hospitals for patients, especially those who are covered by private insurance. Such competition is one reason why nine of the 12 hospitals in Franklin County have a combined debt of $600 million—$300 million of which has been incurred in the past six years for new technology and new and renovated facilities. To pay off that kind of debt, the hospitals increase the price of the daily room rate and medical procedures.

The competition results in significant duplication in areas such as cardiac care, cancer treatment, women's health, and rehabilitation services. A source of considerable envy these days is cardiac-catheterization laboratories, where potentially fatal heart ailments are detected and sometimes treated. "Cath labs," as they are called, cost between $1 million and $2 million each, and according to the Health Coalition, eight of the 12 Franklin County hospitals have at least one lab and two more institutions have each applied for one.

It's not hard to figure out why. At Riverside, the average per-patient charge for a cardiac-catheterization pro-



SCOTT GOLDSMITH FOR USN&WR

THE DOCTOR IN THE MIDDLE. *"Unless we start rationing of some kind, we won't get where we need to go," says Dr. Mary Pat Borgess, a radiologist. "We use the technology too much."*

P. 032

FROM

THE VETERAN PRESIDENT. *"Our ability to get doctors' cooperation depends on how well we can meet their patients' needs," says Albert Gilbert of Akron City Hospital. "We depend on the doctors for our revenue, and thus our success. If you don't have that relationship, you're sunk."*

cedure is $4,049, even though the actual cost to the hospital is only $1,977. That profit margin is in line with the national average for such procedures. Hospital executives like Schlichting defend the price by saying the revenue is used to offset money-losing procedures and services elsewhere in the hospital, such as the emergency department. And while experts agree the new technology is a major breakthrough in cardiac care, they say its widespread availability inevitably leads to its overuse, and not always by the most proficient practitioners.

Can we talk? Schlichting agrees, but she warns that federal efforts to persuade hospitals to cooperate more and compete less will meet considerable resistance in an industry where all the incentives in the past decade have encouraged hospitals to be all things to all people. Clinton would change that—urging hospitals and other providers to form coordinated networks in which each player specializes in different services. Such collaboration, Schlichting says, "requires different skills, and I'm not sure how many administrators are ready for that."

But there are hopeful signs. The American Hospital Association has begun campaigning for relief from antitrust laws to allow hospitals to cooperate more easily, especially in forming so-called health care networks. Earlier this year, Ohio passed a law giving hospital trustees some antitrust relief as a way to encourage more joint planning.

More cooperation within hospitals, especially between administrators and doctors, will be crucial to any national effort to control costs. Like many hospital CEOs, Schlichting spends about half her time dealing with Riverside's medical staff and related issues. Of all the constituent groups she must face every day, doctors present the most difficult challenge. "Many hospital administrators have an innate distrust of doctors, and often the feeling is mutual," she says.

Schlichting has never included herself in that equation, and since coming to Riverside four years ago as the No. 2 administrator, she has won wide praise for improving relations with the physicians. "The doctor's ordering pen is the most potent weapon in a hospital," she says in a refrain that is repeated frequently by her colleagues around the country. "Doctors order the tests, the operations, medications. We just carry out those orders." Schlichting admits she doesn't confront doctors so much as try to "educate" them about how their actions affect the hospital's overall budget. Two years ago, she formed a physician's advisory budget council to bring doctors into the capital-budgeting process. She showed the doctors data that Riverside's administration had never before divulged—how much average profit the hospital makes on each cardiac surgery case, for example ($2,350), and how much it loses on each Medicare patient ($2,000). "It opened our eyes to the hospital's perspective," says Dr. John Baumert, a medical staff officer.

Despite such progress, Schlichting still tangles with high-powered doctors. "I get threats all the time from doctors who say if I don't give them what they want, they'll go across town to Ohio State or Mount Carmel," she says.

Ultimately, for Schlichting and others at Riverside, any proposed changes from Washington will depend on the willingness of elected officials as well as citizens to confront tough choices. Schlichting is proud of Riverside's cardiac care, for example, but she points out that 5 percent of open-heart surgery is performed on patients 80 years or older. She is equally proud of the critical care at Riverside, but she knows that the $1,500-a-day ICU beds are often occupied by patients with little or no chance of recovery. "I give Oregon credit for trying," she says, referring to that state's proposal, put on hold by the Bush administration, to provide universal care by rationing coverage for procedures like those routinely performed on terminally ill patients. "Most of us shy away from the tough decisions. As a society, we are not willing to face reality when it comes to health care." She quickly adds, "And as hospitals, we have to stop trying to be all things to all people."

AKRON, OHIO

Where competition has cost the community

■ Anyone who believes that old-style competition among hospitals has helped

SCOTT GOLDSMITH FOR USN&WR

new outpatient care center across the road from the main

cut health care costs should visit Akron. Competition may have worked with tires in years gone by, but in Akron these days, the battle between its two main hospitals for prestige and patients has not put a dent in costs and has more likely made matters worse for the poor and underinsured. Primary care and preventive medicine, such as childhood immunizations and prenatal care, are often lacking. "As long as we are chasing the paying patients, we will continue to miss the rest of the picture," says Albert Gilbert, president of Summa Health System, which includes Akron City Hospital, one of the city's two main medical centers.

Turf wars. Gilbert speaks from experience. Since 1974 he has led Akron City in a head-to-head competition against Akron General Medical Center a few miles across town. The hospitals are a lot alike—each has about 500 beds and 125 medical residents in training. Last year, City had 24,000 admissions and 65,000 visits to its emergency department, while General had about 20,000 admissions and 41,000 emergency visits. Both are considered to be high-quality institutions that serve Akron, a city of 223,000, and 427,000 more people in surrounding counties. Gilbert says he has high respect for his counterpart at General, Michael West, and West says the feeling is mutual.

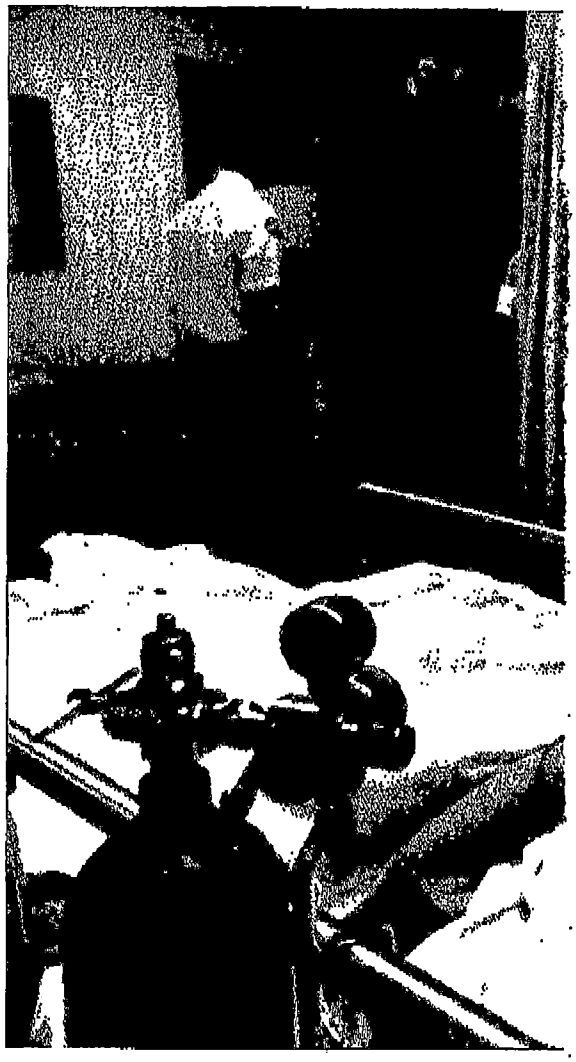
So why is it that the two hospitals often can't agree on much of consequence? Federal policy promoting "competition" is part of it—not real economic competition, such as Clinton wants to create through competing managed-care plans, but the kind of wasteful incentives to accumulate more technology and buildings that have long dominated the U.S. health system. Ego enters in, too. Consider the decision seven years ago about where to put a regional burn center. City and General both wanted it, but neither would agree to let the other have it. So after much discussion and some acrimony, the burn center was located at the city's children's hospital. "It's not the most logical place, but it was the least explosive politically," says Gilbert.

Such turf battles, which consume an inordinate amount of time and often contribute to substandard care, are common in American cities. Clinton and his reformers will find that this give-no-quarter attitude will make health care reform a bitter and lengthy battle.

In Akron, as in Columbus, duplication of services and medical-training programs is rampant, and the hospitals are keeping the construction industry busy. City has a $40 million expansion project underway, and General is spending $32 million for a similar capital project. In recent years each hospital has tried to block parts of the other's expansion plans through Ohio's certificate-of-need process. "When you challenge the other guy's application you cloak it in motherhood and the good of the community," says Dr. Thomas Bear, an orthopedic surgeon at City. "But mainly you're concerned with the other guy getting a competitive edge."

Akron's competition is also heightened because both City and General are afraid of losing patients, especially those with higher incomes, to the highly respected Cleveland Clinic less than an hour to the north.

In 1979, a blue-ribbon commission of corporate executives tried but failed to change the pattern, as did a similar effort in 1983, in part because of antitrust concerns. A new civic group studying the city's future, called "Akron Tomorrow," is making health care a top priority. And there has been some recent success in forging cooperation to provide more immunization and prenatal care through the city's health department. But there is a growing consensus in Akron that if the high-stakes hospital competition is to end or be reduced, it will only come in concert with major changes initiated by the federal government.



ROCHESTER, N.Y.

Clinton's model system doesn't have all the answers

■ During the presidential campaign, when Bill Clinton talked about the few places where the health care system seemed to work, he usually mentioned Rochester. With good reason. For more than a generation, Rochester has followed an innovative course in which hospitals, doctors, businesses and insurers have cooperated to keep costs down while providing wide access to high-quality care.

In Rochester, the per capita cost of health coverage in 1991 was $2,378, one third less than the national average of $3,573. For Eastman Kodak Co., which

Health-care lobby sees election as mandate for major changes

By ROBERT PEAR
New York Times

WASHINGTON — Bill Clinton's election has been interpreted by the health-care industry as a referendum for sweeping change.

Factions recently at war now seem to be falling into line. But the growing consensus is on general principles, not the details, which still present big obstacles to final agreement on how to provide health care to everyone at reasonable cost.

On Nov. 9, six days after the election, business executives, hospital trustees and leaders of the Blue Cross and Blue Shield Association offered to cooperate with Clinton in writing legislation to revamp the health-care system.

On Wednesday, in a break from past practice, the Health Insurance Association of America, representing 270 commercial insurers, called for a new law requiring insurance coverage of all Americans. As a way to control costs, the insurers said they would welcome a limit on the open-ended tax subsidy for health insurance bought by employers for their employees.

The insurers' new position, unlike the old one, would require health insurance coverage for all Americans and limit the amount of tax-free health benefits that employees could get from their employers.

The proposal would require employees to pay a tax on the value of health insurance exceeding the standard package of benefits. This proposal is noteworthy because companies rarely propose a new tax on their own goods and services. Revenue from the health insurance tax would be used to help finance additional coverage for poor people.

After the promise of jobs and economic growth, health care was the biggest issue in Clinton's campaign, and his election has changed the political landscape for action. In the last Congress, Democrats could not agree among themselves on a national health plan, and there was even more disagreement between Congress and the White House.

But now the sounds emanating from Washington are harmonious. Frederick Graefe, a lawyer who specializes in health-care policy, said: "The vote by the directors of the Health Insurance Association is a simple reflection of political reality. They're reading the tea leaves after they got hit with a 2-by-4."

The political reality is complex and elusive. For consumers, health care is a pocketbook issue. The cost of health care and health insurance has been rising twice as fast as other consumer prices. But for middle-income families with health insurance, there is no prospect of immediate relief under the changes proposed by Clinton and the health insurance industry. Indeed, the middle class might be asked to make some sacrifices for which it has not been politically prepared.

The changes would be gradual. Prices would rise more slowly. Some consumers would have to sacrifice some of their freedom to choose doctors and hospitals. Under the industry proposal, millions who get health insurance from their employers would have to pay higher taxes.

Karen Ignagni, director of employee benefits at the AFL-CIO, said: "Middle-class workers with comprehensive health benefits will just say no to higher taxes. They have borne the burden of rising health-care costs for too long to accept this solution. They paid very dearly for the health benefits they now have. They sacrificed wages to get and maintain those health benefits."

Clinton has not said whether he wants to tax a portion of employee health benefits, as many economists recommend. Doing so would fracture the coalition of his supporters.

Economic theorists say the tax code encourages employers to buy too much health insurance and encourages workers to use too much health care. Employees see the problem differently. Many workers are now paying more for less coverage than they once had.

There are hundreds of unanswered questions, including these:

- What will be in the basic package of benefits promised to all?
- Will elderly people be entitled to all the benefits they now get under Medicare?
- Will the government regulate drug prices? Will a new agency be needed to regulate health insurance?
- Must antitrust laws be amended to let hospitals cooperate in eliminating duplication of services?
- If every American must buy private health insurance, what becomes of Medicaid, the program for poor people? What becomes of veterans' hospitals?

Analysis

Universal coverage

The Health Insurance Association of America's plan for universal coverage includes:

- Private insurers would agree to provide coverage to every American.
- People would be covered either through their employers or "their own means."
- Essential-benefits package would pay for catastrophic illness as well as primary and preventive care.
- Insurers would accept people with pre-existing conditions — everything from heart attacks to AIDS — which are typically rejected for coverage because they are considered expensive risks.
- Cost controls would discourage excessive doctor visits as well as unnecessary testing and hospitalizations.
- Employed Americans who continue to receive generous benefits — anything beyond the value of the essential-benefits package — would be taxed as income.
- Tax revenues would help the government pay for the poor. Private insurers and health providers would give people below the poverty line primary and preventive care.

Source: Associated Press

Chronicle

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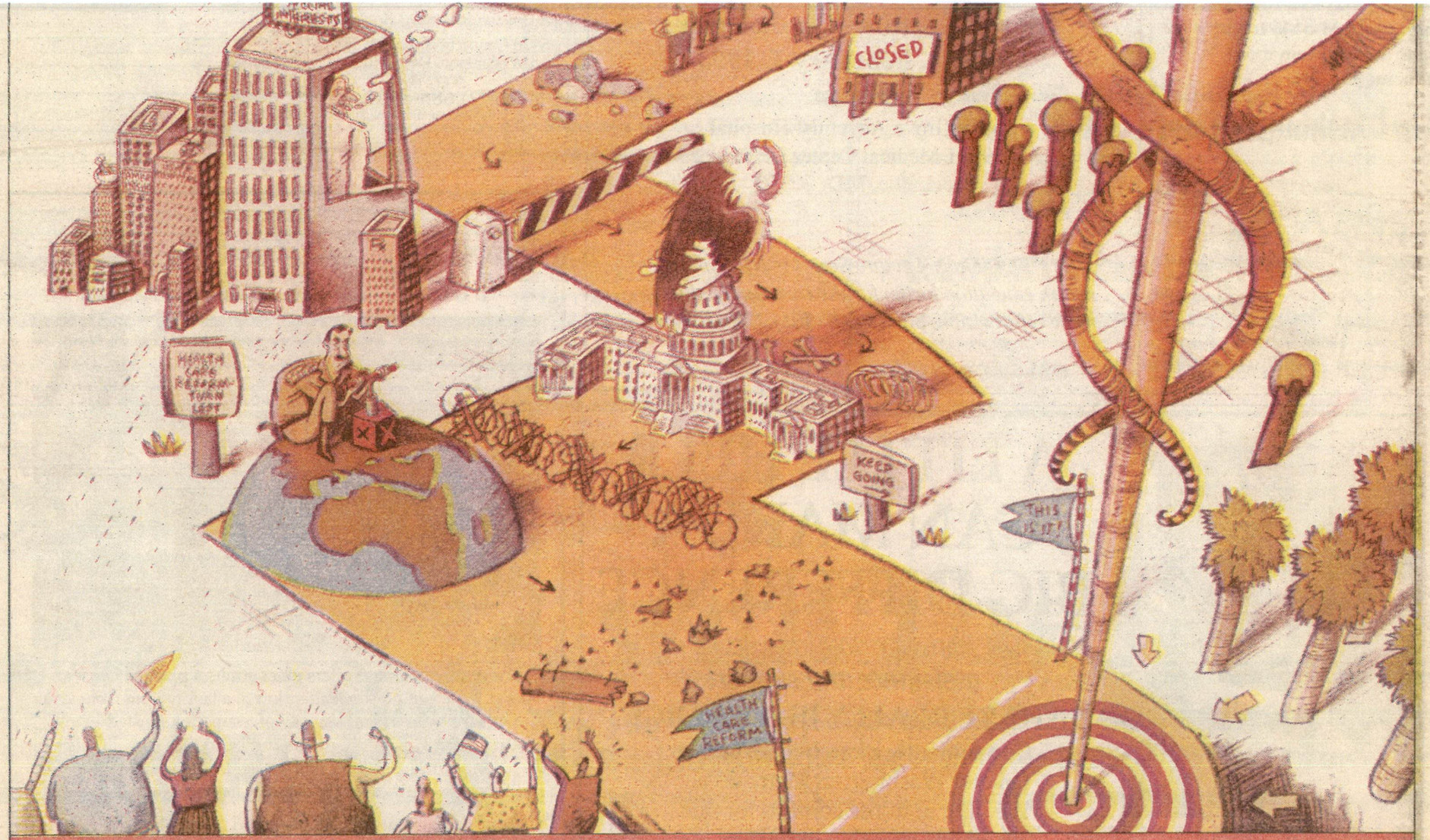
The Washington Post

TUESDAY, JANUARY 26, 1993

HEALTH



The Road to Health Care Reform

Small Pox ■ AIDS Scams ■ Eating Habits

A GUIDE TO THE COMING DEBATE

The Road to Health

BY DANA PRIEST

The statistic is straightforward: one in every seven dollars spent in this country each year—an estimated $939 billion in 1993—goes to hospitals, doctors, insurance and drug companies, equipment makers, bureaucrats and others in the U.S. health care system.

But that is where straightforwardness stops. The "system" is not a system at all. It is a collection of dissimilar and often wasteful practices that has left 37 million Americans uninsured. Unrestrained health spending has climbed to 14 percent of the Gross Domestic Product.

The call for reforming the U.S. health care system—the

PERCENTAGE OF U.S. GROSS NATIONAL PRODUCT SPENT ON HEALTH CARE

The reasons health care in the United States costs so much are numerous and interconnected. They include ever more complicated medical procedures, a largely unfettered consumer demand for services, an aging population that requires more care, fraud and abuse in programs like Medicare and Medicaid, wasteful and overlapping administration costs among hospitals, doctors and insurers. Most important, the incentives for those providing care are to spend more rather than less in every area of medicine and in almost every case.

"These incentives, moreover, have influenced the everyday rules of thumb that doctors use in deciding about tests, hospitalization, operations, and so on," writes Princeton University sociologist and Pulitzer Prize-winning author Paul Starr in his book, *The Logic of Health Care Reform.* ". . .American physicians' practice styles are partly the product of financial arrangements that for decades rewarded the decision to treat even if there was no good evidence the treatment would work."

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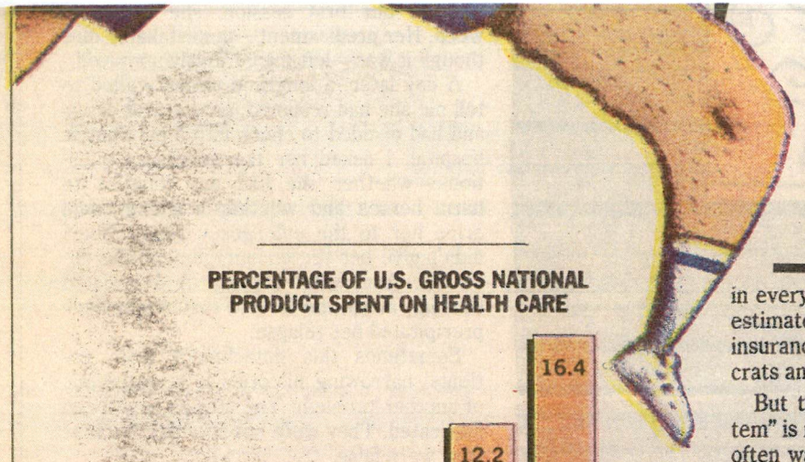

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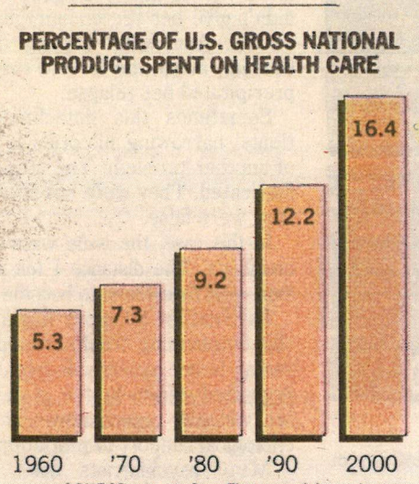
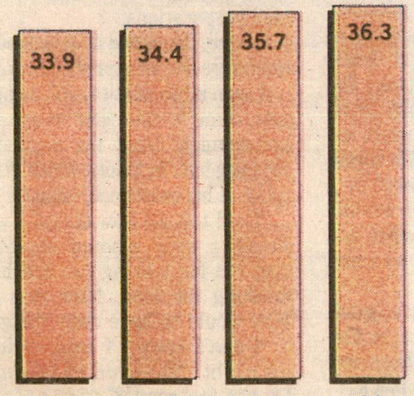


SOURCE: Health Care Financing Administration

NUMBER OF NONELDERLY AMERICANS WITHOUT HEALTH COVERAGE, IN MILLIONS



SOURCE: Employee Benefit Research Institute tabulations of the Current Population Survey, March '89, '90, '91, '92

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The call for reforming the U.S. health care system—the most costly and advanced in the world—is fueled by startling contradictions:

While individuals, corporations and federal and state governments continue to spend an ever-increasing amount of money on health care—costs grew 11.5 percent last year— 100,000 individuals a month continue to move into the ranks of the uninsured. They lack coverage because their jobs do not offer it or because they can no longer afford to buy it on their own, or are dumped by insurers when they become ill or old.

While the United States spends more per capita on health care than any other country, its infant mortality rate is the among the highest in the industrialized world, and publicized personal appeals for money too often determine whether someone can afford a life-saving procedure such as a transplant.

While private companies and the Medicare and Medicaid programs have set price controls on medical services and negotiated volume discounts from hospitals and insurers, spending on health care has risen from $250 billion in 1980 to $838 billion in 1992. Family spending on health care has tripled in the past decade.

As candidate Bill Clinton said in his major health care address during the presidential campaign: "We are the only advanced nation in the world that does not provide basic health care to all its citizens. We spend 30 percent more of our income than any other country in the world on health care at a time when we desperately need to spend more on new plants, new equipment, new businesses, reinvesting in education and training of our citizens. . .We cannot go on like this."

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For these reasons many policy experts, and Clinton, believe that only comprehensive reform can solve the twin problems of containing costs and financing universal access to affordable, high quality services.

Piecemeal legislation, argue experts, will only result in piecemeal changes that will not go far enough to reverse the systemic problems in the health care system. A piecemeal approach may also dampen the momentum in Congress and the public for more complete reform—momentum that Clinton created by highlighting the issue during and after the campaign.

But systemic reform means taking on the powerful, effective and diverse special interests all at once. Registered lobbyists are already at work for more than 750 different health care organizations, from the largest medical societies to the smallest manufacturers of disposable medical equipment. Industry giants are already mounting their media campaign to shape public opinion in their favor. Business groups have begun meeting with new members of Congress to express their concerns.

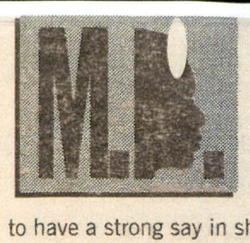
It is not only the lobbyists and industry leaders that Clinton and Congress will have to contend with, however. About 10 million people work in the health care field and can be counted on to make their feelings known to any legislator who supports changes that would close a local hospital or put the local insurance agents out of work. Reducing health care spending means reducing health care jobs.

So how has Clinton promised to fix such a mess?

He has said repeatedly that he would propose a reform plan within the first 100 days of his administration. During his pre-inaugural economic summit, he emphasized the need to get health costs under control in order to reduce the federal deficit, heightening public expectations that real reform is around the corner.

The two primary goals of his campaign proposal were to provide everyone access to health care and to contain sky-

See HEALTH CARE, Page 15



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GUIDE TO THE COMING DEBATE

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SPECIAL INTEREST GROUPS

There are so many special interests involved in health care that trying to sort them all out can be like traveling through a maze made of distorted mirrors: nothing appears as it really is and the political path from the current system to a reformed one is not at all straightforward. While most groups by now have jumped on the rhetorical reform bandwagon, the positions they take on the toughest issues—guaranteeing access and controlling costs —are based largely on their economic interests.

DOCTORS: The American Medical Association, the largest physicians' group, opposes price controls of any form. It supports an employer mandate to require coverage and major changes in health insurance to prohibit abusive practices. It also wants to have a strong say in shaping a standard benefit package and in developing ways to monitor and measure physician performance. Managed competition worries many doctors because they fear it will lead to more regulation by non-physicians over what they do. Physicians are not a unified front; some speciality groups differ from the AMA, and the American College of Physicians endorsed a plan similar to Clinton's.

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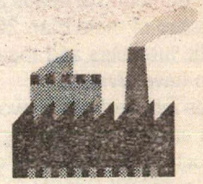
prohibition on charging lower rates to healthy young people and excluding coverage for pre-existing illnesses. The large companies, which already have moved into the managed care business, would prosper under Clinton's campaign proposal. Many small companies will likely go out of business altogether, a threat many of them will fight.

- The average monthly cost of a family policy has gone from $210 in 1987 to $355 in 1991. The industry employs about 900,000 people.

DRUG COMPANIES: Frequently criticized for its prices and profits, the drug industry is preparing for a major fight to stave off price controls. A few large companies voluntarily have been holding their price increases to the inflation rate to show they can police themselves. But influential critics on the hill, mainly Sen. David Pryor (D-Ark.), a Clinton friend, believe the government must limit prices. The



elements of Clinton's proposals, including reform of health insurance. Most oppose employer mandates, government price regulation and limiting the tax deductibility of health benefits. Most companies that are self-insured would also oppose government regulations requiring their employees to purchase coverage from regional purchasing cooperatives.

- About 140 million people, 57 percent of the U.S. population, get health insurance from their employers. About 83 percent of full-time employees at firms with more than 100 workers get health insurance from their employers. Large employers have experienced annual increases in health premiums of 15 to 20 percent.

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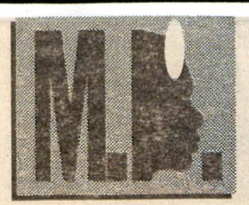

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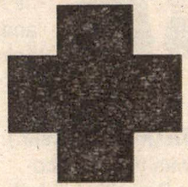
HOSPITALS: They oppose price controls and other government-imposed cost controls. Hospitals support employer mandates; they are especially concerned about the growing number of people they treat who have no one to pick up the tab. They favor most other Clinton proposals and want to make sure hospitals have a large role in organizing community-based health networks that would provide people with a complete range of medical care.



● There are 738 for-profit hospitals, most represented by the Federation of American Health Systems, and 5,342 not-for-profit hospitals. The largest hospital group, the American Hospital Association, represents about 4,500 for-profit and not-for-profit facilities. Hospitals earned $235 billion last year. They were not compensated for $10.8 billion worth of care to indigent patients. Hospital care is the single largest category of national health care spending. About 3.5 million people work for hospitals.

INSURANCE COMPANIES: This is a fractious group. Generally, they oppose government-imposed price controls, especially on insurance premiums. They also will oppose a comprehensive standard benefit package, which they believe to be too costly to provide. The largest companies are resigned to significant regulation of insurance practices, including a prohibition on charging lower rates to healthy young people and excluding coverage for pre-existing illnesses. The large companies, which already have moved into the managed care business, would prosper under Clinton's campaign proposal. Many small companies will likely go out of business altogether, a threat many of them will fight.

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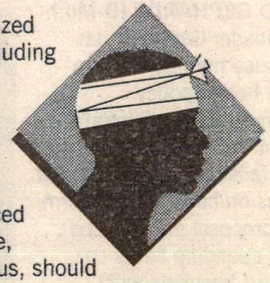
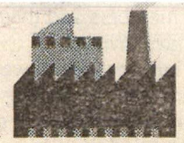
● Spending on pharmaceuticals reached $51.3 billion in 1992. Drug companies spent about $10 billion on research. The industry employs about 300,000 people.

CONSUMERS: The main organized consumer advocacy groups, including Families USA, Citizen Action, Public Citizen, Consumers Union, the Consumer Federation of American and Neighbor to Neighbor, back a single-payer, government-financed plan. They believe that everyone, regardless of income or job status, should have access to quality health care. They criticize Clinton's proposal because insurance companies would continue to play a major role, the system would still be market-based and there is no guarantee everyone would be covered immediately.



● About 37 million people have no insurance and many more have policies with exceedingly high deductibles and copayments.

BIG BUSINESS: By no means monolithic, important business coalitions, including the Washington Business Group on Health and the Business Roundtable, back elements of Clinton's proposals, including reform of health insurance. Most oppose employer mandates, government price regulation and limiting the tax deductibility of health benefits. Most companies that are self-insured would also oppose government regulations requiring their employees to purchase coverage from regional purchasing cooperatives.



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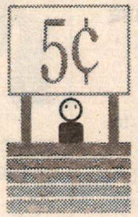
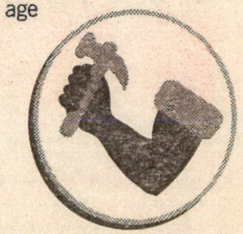


SMALL BUSINESS: Represented by such national grassroots organizations as the National Federation of Independent Businesses and the National Association of Manufacturers, small businesses are poised to mount a major fight against an employer mandate or other forms of health care taxes. They support other aspects of Clinton's proposal and welcome insurance purchasing arrangements and insurance industry reforms that will make it less expensive for them to buy insurance. But NFIB members generally oppose any regulation on businesses.

● About 69 percent of full-time employees at firms with fewer than 100 workers get health insurance from the companies. Small firms have experienced annual health benefit cost increases of 20 to 50 percent recently.

LABOR: Lucrative labor union agreements on health benefits have been the benchmark for most large employer-provided benefit packages and the AFL-CIO is determined to hang on to them. Corporate give-back requests were at the heart of several recent major strikes. Some unions favor a single-payer system and others support parts of Clinton's general proposal. But they oppose taxing health benefits because it would likely mean employees would pay higher taxes or see their benefit packages shrink. They favor an employer mandate and want to drop the Medicare eligibility age to 60, which would lighten the financial burden on companies' and unions' retiree health plans.



About 15 million workers, 18 percent of the labor force belong to unions.

convincing the candidate to adopt a more market-oriented approach to reform.

DONNA E. SHALALA: The new secretary of the Department of Health and Human Services is a longtime friend of Hillary Clinton. Her last job was as chancellor of the University of Wisconsin at Madison. While familiar with health care matters, she too, is not a policy expert on the subject. HHS has traditionally been in charge of health policy; it has jurisdiction over Medicare and Medicaid as well as the National Institutes of Health and the Food and Drug Administration. Shalala has made it clear she intends to be prominent in health care reform.

CAROL RASCO: Also a longtime associate of both the Clintons, Rasco is assistant to the president for domestic policy, a large portfolio. She has said her priority will be "health, health, health." Rasco was an adviser to Clinton for 10 of his 12 years as Arkansas governor.

JUDITH FEDER: Feder is the only professional health care policy expert in the group. Before joining the campaign as an adviser, and then heading the health care transition team, she co-chaired the Center for Health Policy Studies at Georgetown University. Feder is Shalala's principal deputy for health care. She became well known on the Hill and elsewhere as the staff director of the Pepper Commission, a bipartisan congressional commission that studied health care reform. She has close ties to Sen. Jay Rockefeller (D-W.Va.), who headed the commission after Sen. Claude Pepper (D-Fla.) died.

—Dana Priest

The call for reforming the U.S. health care system—the most costly and advanced in the world—is fueled by startling contradictions.

HEALTH CARE, *From Page 12*

rocketing costs. He also embraced the managed competition model as the way to structure the system.

His promises include the following elements:

- Require insurance companies to provide the same coverage to everyone in the same region for about the same price (called "community rating") and prohibit them from denying coverage to individuals because they have pre-existing illnesses.
- Create a government board that would set annual national spending targets for public and private health care. The goal is to limit health cost increases to the rate of inflation.
- Instruct the board to establish a comprehensive, standard benefit package that all insurers would have to offer.
- Adopt an employer mandate that would require employers to provide part of their employees' health premium. This requirement would be phased in to lighten the burden on small businesses, and government subsidies would be available to some businesses.
- Expand government health care subsidies for the unemployed and poor.
- Create insurance-purchasing cooperatives through which companies and individuals could purchase a health plan. The cooperatives would negotiate the best price and quality from competing plans.
- Create incentives—most likely lower costs and special tax benefits—for people to join managed care networks, which are more cost-effective.
- Establish primary and preventive health care clinics in the inner cities and rural areas.
- Emphasize health education and prevention in schools and the workplace.
- Invest more in health care research. ■

Gearing Up for the Fights

The status quo is out. Change is in. Just about every health care group imaginable now says it endorses change and most say they endorse reform "similar" to President Clinton's proposals. That's the hitch. "Similar" but not quite the same. In fact, major knock-down-drag-out fights are expected in some critical areas, including:

GLOBAL BUDGETS. There is not a health care business group around, including doctors, hospitals, insurers, etc., that supports a government-imposed annual health care budget that might require price controls. The architects of managed competition, such as Stanford University professor Alain Enthoven, believe government price-setting is incompatible with their model and will significantly distort the market's ability to weed out inefficient health providers and drive down costs. Others believe savings are not possible without government-imposed controls.

TAXING EMPLOYEE BENEFITS. Labor unions, consumers and many business groups are opposed to changing the tax treatment of health benefits. It is a lucrative benefit they do not want to give up.

MANDATING THAT EMPLOYERS PROVIDE COVERAGE. Employers of all stripes, and most federations that represent them, oppose such a mandate, as do proponents of a single-payer system who say coverage should not be employer-based.

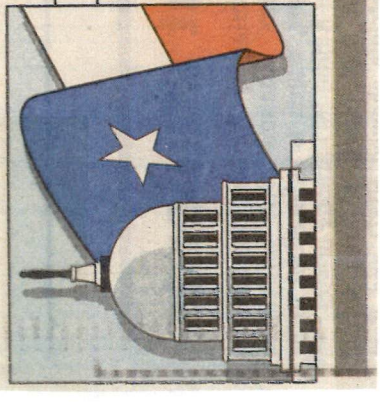
HOW TO FINANCE UNIVERSAL COVERAGE. Even with an employer mandate, major disagreement is expected over how fast the government should commit new resources to financing universal coverage.

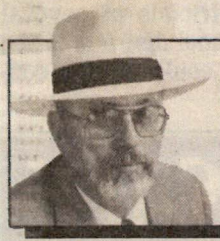
The problem is linked to how Clinton deals with the federal deficit. If he decides to wait and use the savings from reforming the entire health care system to help subsidize expanded access, then it will be several years before the government can do much. If he decides to use savings to reduce the deficit, an even longer wait is ahead. On the other hand, he could impose strict price caps to achieve quick savings or increase deficit spending and pay for expanded access more quickly.

The Houston Post
★ FRIDAY, September 3, 1993

HOUSTON/TEXAS

ROAD TRIP: Gov. Ann Richards takes state government to the people in a visit to Carthage —





Paul Harasim

Disabling views on the disabled

WE'RE JUST NOT thinking. If we were, change would come faster.

Once we come to fully understand that the only thing that separates us from a wheelchair is a split-second, grinding collision on Main Street or a swimming accident or a fall from a ladder, then a nation built for "normal" people over the last 200 years will truly come to realize that both the physical and mental obstacles created for the disabled must come down NOW.

If you think about it, what happened to Pam Mackie the other day at the Muncipal Courts building should have never happened.

Like many who use wheelchairs, she drives a van equipped with a lift. That means the usual handicapped parking space isn't big enough — a space the size of 1½ spaces is needed.

To ensure that she wouldn't get boxed in after helping a friend at the Municipal Courts building, she took up two spaces.

That got her ticketed.

It's the kind of frequent aggravation — Mackie says it makes some disabled people want to give up — that reminds Lex Frieden, one of the most effective civil rights activists in America, just how much more work there is to do.

First things first

We have met for lunch at the Texas Institute for Rehabilitation and Research, and Frieden, the chief architect of the Americans with Disabilities Act, lets his enchiladas get cold.

It is quickly apparent the 43-year-old Frieden appreciates food for thought far more than for the belly.

He's trim, sitting in a wheelchair as a result of an auto accident during his freshman year at college.

A senior vice president of TIRR who worked in Washington, D.C., for years conceiving the ADA legislation, he was awarded a Presidential Citation by George Bush for his work.

For a man whose work will radically change America — the effects of ADA are only now beginning to be felt across the country — Frieden is remarkably modest.

"The drive for what has been done and what needs to be done comes from millions," he says.

And yet when you talk with government leaders on either the national or local level, he's credited as being the driving force behind the disability rights movement.

In March, Hillary Rodham Clinton had him address leaders of the Western Hemisphere on how to bring those with disabilities into the mainstream, instead of shunting them into dead-end jobs.

Houston firsts

It was Frieden who got Mayor Bob Lanier to create the city's first commission for the disabled as well as the first city program to streamline mainstreaming.

Frieden's intellect and ability to speak off the cuff remind you of newsman Ted Koppel.

The transplant from Oklahoma will talk forever about the need for more contact between the able-bodied and those with disabilities.

"We have goals, too," he says. "Once people see that, the 'us and them' mentality disappears."

And then it becomes easier to understand why there's a need, say, for some wider handicapped parking spaces (now mandated by ADA).

As Frieden says, there's no question that attitudes about the disabled have evolved for the better.

Otherwise, the ADA, which is supposed to guarantee equal treatment and access for those with disabilities, could not have passed Congress in 1990.

But we've got a long way to go.

As renowned as he has become, Frieden realizes how far too many still view someone in a wheelchair.

When he was sitting recently at a bus stop with a cup of water in his hand, people threw change his way.

"I made a dollar," he says.

Bush Library Photocopy Preservation

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Post 9/7/93

A Republican Health Care Position

MORE THAN half the Senate Republicans signed a "statement of principles" on health care reform as Congress was leaving town last month. The statement got less attention than it deserves. Republicans divide roughly into those who want to use health care reform as a trampoline for scoring political points and those who genuinely want to deal. Those who signed this statement fall for the most part in the latter, serious category. Their go-slow views are shared by a large enough group of moderate-to-conservative Democrats to make a major difference. They need to be heard; they're going to affect the outcome.

The 24 senators who signed the statement include Minority Leader Bob Dole, John Chafee, steady chairman of a Senate Republican health care task force, and majorities of the Republicans on both the Finance and Health and Human Resources committees, which have most of the jurisdiction over health care. The statement, a kind of Republican place-holder meant to keep the administration from having the policy field to itself while Congress was out, was deliberately vague in some respects; there isn't total agreement. But it's a clear enough outline.

(1) The senators say they share the goal of making health care coverage universal. But they'd do it only as funds became available from various, mostly modest steps they are also proposing to reduce projected health care costs. Candidate Bill Clinton had a similar position in last year's campaign; he said he would phase in universal coverage only as savings occurred. It's not clear to what extent his plan as president will now follow that rule, but this is not just a timing question. It's whether or not to give a guarantee that at least some Democrats want to give up front. It could well become a point of contention.

(2) As an interim step toward broader and equal coverage for all, the Republicans suggest a spreading-out of the tax subsidy that goes to employer-paid health insurance. The familiar idea is to let employers deduct the cost of premiums paid for employees only up to an amount deemed sufficient to buy a basic amount of insurance. Beyond that, not only would the deduction cease but the employee also would have to count any premium paid as taxable income. Yes, these are Republicans suggesting what would amount to a tax increase for some. The proceeds, the statement says, could be used to give the self-employed and workers not covered by their employers a deduction up to the same amount when they go out to buy their own insurance.

Organized labor has traditionally opposed such a cap; many unions have generous employer-paid plans. The administration, despite the labor objection, has apparently adopted the concept, but would set the cap at a point where it wouldn't bite much, nor raise much revenue. It would present a political problem for the Democrats to tighten it as much as the Senate Republicans seem to have in mind. But a cap that bit would be a more progressive way of raising the funds to broaden coverage than a lot of others that have been proposed—and than some of those that are said to be included in the administration plan. It would have the theoretical advantage of making health care consumers more cost-conscious as well. You'll hear more about this.

(3) In trying to broaden access to care yet cut the cost, the Republicans seem willing to regulate the insurance industry much more heavily than now. But they're leery of other regulatory steps. They particularly oppose as too great a burden on business the employer mandate that will apparently be at the heart of the president's plan—a requirement that all employers eventually help pay the cost of insurance for all employees. The senators say it would be a mistake to add that much to labor costs. (For similar reasons they also warn against too narrow a focus on cutting federal health care spending under Medicare and Medicaid because providers will simply shift the costs to "businesses and workers." You wonder where they were with that argument during the clamor for spending cuts in the budget fight.)

To lower projected health care costs, the Republicans propose a range of mostly mild steps from "private-sector purchasing cooperatives" to paperwork savings and "reform" of the medical liability laws, but they oppose what they call "arbitrary . . . global budgets and bureaucratic price controls." It's a fair question whether their proposals are powerful enough to achieve the lower rates of cost increase they seek—and if they don't save the money, under their plan they don't achieve universal coverage either. But that's an argument they seem to be prepared to have. The House Republican Conference put out the opposite kind of position paper on the still unsighted Clinton plan last month. It was a bombastic, take-no-prisoners document, the budget fight all over again—"a Dr. Kevorkian plan for jobs," it called the Clinton approach. The senators seem to want to do it differently this time around. Good for them.

Clinton Health Package Combines Cost

Controls, Market Incentives

By Dana Priest
Washington Post Staff Writer

President Clinton's health care reform proposal includes nationwide, long-term cost controls on health premiums and the creation of a new structure for buying and selling health care services that is supposed to make health care providers more competitive and cost-efficient.

The unusual—many critics would say counterproductive—combination of government regulation and market incentives is an attempt to push the $900 billion health care industry in a new direction, according to senior government officials, who yesterday revealed further details of the plan.

"We are sailing into some uncharted waters," a senior adviser said yesterday. Dealing with such a large part of the economy, "we're very humbled by that."

The goals, which Clinton stated time and again during the presidential campaign, are to guarantee that all Americans have health coverage and to stop ballooning inflation of health care costs, which diverts corporate and private spending away from more productive uses.

Clinton has ruled out any controls to hold down medical care prices before the plan took effect. But once the plan was implemented, it would limit the amount health premiums could grow to the rate of growth in the economy, as measured by the gross domestic product. Not since the Nixon administration, from 1971 to 1973, have controls been placed on a large sector of the economy. Those controls were ended after several years.

The president is relying on the belief that the package would increase competition among health care providers—for example, forcing providers to worry whether consumers were satisfied with their care because they could switch plans every year.

At the same time, the president and his advisers believe the market would become so competitive that health care costs would increase at a rate less than the allowable limit, eventually making the cap irrelevant. This is a point of dispute in the private sector and among Republicans and conservative Democrats who oppose cost controls.

Clinton is betting not only that the controls would be effective but also that they will be politically acceptable to members of Congress and interest groups, such as senior citizens, who worry about Medicare cuts, and insurance companies, which fret over caps on premiums.

In the public sector, Clinton will propose unprecedented limits on Medicaid and Medicare spending, beginning in 1998 or 1999.

For the American public, he is betting that most people will look at the plan, compare it to what they have now and decide that the package of guaranteed benefits is as comprehensive as the coverage they have now; that the new proposals would not cost them more than they pay now; and that they still would have the freedom to choose their own physicians, if that is important to them now.

The standard benefits package, the details of which were outlined in The Washington Post on Saturday, is as comprehensive as health plans now offered by most employers. But the proposed benefits are not as extensive as some offered by large companies, often under union contracts. Although the administration's standard benefits package includes some nonstandard services, such as mental health care, other common coverage, such as dental care and eyeglasses for adults, is excluded.

Comparisons between current health costs and those under the Clinton proposal will be hard for individuals and businesses to assess before the plan is implemented because the price of enrollment in a health plan would vary from region to region and because no one is certain how the private market would respond to the new rules.

For now, the administration estimates that the average cost of a family policy under the new system would be $4,200 a year. The employee would have to pay up to 20 percent of the premium's cost, with the rest coming from his or her employer (although the government would subsidize low-income workers and employers). According to recent data from the Health Insurance Association of America, family coverage now costs $4,300 or more a year, and employees generally pay up to 28 percent of the total cost of the premiums.

As for the freedom to choose physicians, the administration has said it would guarantee that a traditional fee-for-service plan was available in each region. But for this option to be available, groups of physicians would have to be willing to organize themselves into a network and abide by a fee schedule. Health experts believe that under the Clinton plan, many more people would receive their care from health maintenance organizations.

The question of how much the government should regulate such a huge part of the national economy and how much it should try to correct problems of inflation and consumer access through market forces has been a source of tension among Clinton's own advisers. Part of the tension has arisen from a desire by Cabinet members to guard their own turf, a top administration official said.

For example, Health and Human Services Secretary Donna E. Shalala, who has jurisdiction over the Medicare and Medicaid programs, has fought hard to make sure those programs do not receive heavy hits.

Laura D'Andrea Tyson, who heads the Council of Economic Advisers, and Treasury Secretary Lloyd Bentsen have reminded those drafting the president's plan to keep in mind possible market con-

Sunday
Sept. 5, 1993
Post

HIGHLIGHTS OF THE PRESIDENT'S HEALTH CARE PLAN

Under President Clinton's health care proposal, all Americans and legal residents would be guaranteed a comprehensive standard benefits package by the end of 1997. No one could be denied coverage because of age or preexisting illness. The plan also is designed to limit the rate of increase in the cost of health care.

STANDARD BENEFITS PACKAGE

Standard health care benefits, with some limitations, would include:

- Inpatient hospital care.
- Professional services and outpatient hospital services, including emergency care.
- Preventive services, including well-baby and prenatal care.
- Hospital alternatives: hospices, home health care and extended-care facilities.
- Outpatient physical, occupational and speech therapy.
- Medical equipment, outpatient lab services and ambulance use.
- Routine eye and ear exams; eyeglasses for children.
- Limited mental health and drug and alcohol treatment.

Most standard benefits would become available before a state implemented the plan. Additional benefits, including adult dental care, unlimited mental health coverage and long-term care, would be added as savings in health care were realized.

SOURCE: Senior White House Officials

WHO PAYS

Employers would pay 80 percent and employees would pay 20 percent of the average cost of a health care premium.

- Maximum employer contributions for low-wage firms—those whose average worker salary is $24,000 or less per year—would be capped at 3.5 percent to 7.5 percent of total payroll. The actual percentage would be based on variations in the size of a firm's work force and average payroll.

PAYING FOR LOW-INCOME AND UNINSURED

The estimated cost of covering uninsured and low-wage workers in small firms is $60 billion to $70 billion annually. The money would be raised from:

- New taxes on cigarettes and alcohol; estimated revenue $12 billion to $16 billion per year in the initial years.
- Medicaid and Medicare savings from enrollees whose health care premiums would be partially covered by employers; estimated revenue $19 billion per year.
- Money now spent on Medicaid for individuals who would be covered under the plan: estimated total revenue $40 billion to $50 billion per year—$20 billion from states, $20 billion to $30 billion from federal government.
- Taxable profits would increase as companies' health care expenditures slowed; estimated revenue $2 billion to $15 billion per year by the year 2000.

COST CONTROLS

- Public sector. Medicare and Medicaid spending increases would be limited to about the annual increase in the consumer price index, plus population growth, plus 1 percentage point. To be implemented by 1999 and possibly as early as 1998.
- Private sector. In the first year the federal government and health plans would set an average cost for premiums in each region. The premium would then be allowed to increase according to the average growth of the gross domestic product.

TAX CAPS

- Employers could deduct the cost of providing the standard benefits package.
- Employers could continue to deduct the cost of higher benefit levels under existing labor contracts for up to eight to 10 years, but then would be required to adopt the standard benefits package.
- Self-employed individuals could deduct 100 percent of the cost of the standard benefits package.
- Employees would have to pay federal income taxes on employer-provided benefits that exceed the standard package.

TIME FRAME

- If legislation passed next spring, states could begin implementing the program in 1995.
- By the end of 1997 all states would be required to mandate universal coverage and make other structural changes.

Compiled by Megan Gar

Clinton Health Package 9/5/93 A9

The tensions are felt "every day," said a senior government official who has attended most of the discussions on health care reform. If Shalala had her way, she would regulate it extensively, he said. If Bentsen had his way, the official said, he would settle for more incremental changes in how the insurance market operates.

Melding the proponents of certain positions and making Clinton's hybrid vision of health care reform work "is a challenge," the official said, "but no greater challenge than had we gone to one extreme or the other."

One official who has been involved in the daily debate characterized the disagreements as "differences in judgment about how fast you can change fundamental institutions. . . . What we're debating is how slow or how fast you should move this along."

That debate is reflected in the proposed timetables, each of which is meant to cushion the transition for health care providers, state governments and federal budgetary requirements.

For instance, although the plan would be a federal program, the regional alliances through which consumers would purchase health care services from local health plans would be put in place state by state. States would be allowed to implement the changes as they became prepared to do so, but no later than by the end of 1997.

Some benefits, such as mental health and long-term care, would be phased in as savings from existing federally funded and state-funded programs became available to help pay for them.

The phasing in of the program also reflects Clinton's reluctance—perhaps because of his troubles getting a budget agreement through Congress—to propose any major new taxes or a plan that would appear to redistribute income from high-wage earners to low-wage earners.

Taxes on cigarettes and alcohol are the only new taxes now envisioned; a payroll tax, once under consideration, was scrapped because it was thought to redistribute income too transparently from high-wage earners to low-wage earners and the uninsured.

The plan proposes picking up the estimated $70 billion a year needed to subsidize these groups by using a two-fold approach. First, the bulk of the new funding would have been required to cover an estimated 37 million uninsured Americans would come from the new mandate that employers cover employees. About 85 percent of the uninsured are working people and their families.

Much of the rest of the financing would come from existing government programs—$40 billion to $50 billion now being spent by governments on Medicare and Medicaid patients, and an additional $19 billion from employers of Medicare and Medicaid enrollees. The government also would pick up $12 billion to $16 billion from taxes on alcohol and cigarettes.

Another $2 billion to $15 billion (by the year 2000) would come from new tax revenue because taxable profits would likely rise as company health care expenditures slowed.

The process Clinton used to develop his plan, which he intends to unveil during the week of Sept. 19, has no rival in its complexity and in the number of people involved. On Friday, the administration's lead economist for health care, Kenneth Thorpe, completed the 100th run of computer models that have been used to analyze how all the numbers and all the options might fit together.

White House officials said the process will not end when the final policy is written, which they hoped to complete this weekend. The next stage is to begin Tuesday, when the president and Hillary Rodham Clinton are to brief key members of Congress on the plan. Further revisions may be made after those briefings, according to advisers, who said they have been consulting with Congress throughout the planning process.

"When the president goes to the nation, we're not going to pretend we have just come down from the mountain with the tablets," a senior adviser said. "Where there are better ideas, we'll try to be flexible."

Legislative language for a bill will be submitted about two weeks after Clinton unveils the proposal, an administration official said.

The Washington Post

Clinton Health Plan Includes Broad 'Standard' Benefits

Anticipated Basic Coverage Spans Pregnancy to Hospices

SATURDAY, SEPTEMBER 4, 1993

By Dana Priest
Washington Post Staff Writer

President Clinton will propose a standard health benefits package for all Americans that is as comprehensive as those most corporate employees have today and includes coverage of most conventional medical procedures and care, from pregnancy-related services to hospices.

This "standard package," which under Clinton's health care reform plan would become the mandatory minimum coverage that all health plans would be required to provide, includes a significant expansion in mental health benefits and drug and alcohol abuse treatment coverage over what most Americans have.

It also provides coverage for regular preventive exams, including routine childhood immunizations and lead tests, cholesterol screening, mammograms and pelvic exams to detect cervical cancer, according to a detailed White House document describing the package.

Long-term care coverage extends to 100 days per year. Dental coverage is limited to dental care for children under 18 and only emergency dental coverage for adults, although the plan envisions that coverage would expand to include adult dental care in the year 2000. Children would be covered for eyeglasses and routine eye and ear exams; adults would not.

In the areas of mental health and long-term care, Clinton opted for a more modest approach than some of his high-ranking advisers wanted. Tipper Gore, for example, argued that mental health benefits should be as broad as those for physical illnesses. But in general, the plan appears to satisfy Clinton's campaign promise that the package should be comprehensive with an emphasis on primary and preventive care.

The standard benefits package is a key element in Clinton's overall health reform plan, which he is scheduled to announce the week of Sept. 20. It would replace what most Americans know as their insurance policy. Under the terms of the program, which would have to be enacted by Congress to become law, the standard package would determine not only the minimum level of care, but also how much consumers would have to pay out of pocket—or with the help of their employers—to buy additional benefits.

According to the administration proposal, competing health care plans could include extra benefits as a way to attract customers. Prices could vary between competing plans in a given region; but plans would not be allowed to charge different people different prices for the same standard benefits, except for some permitted variation in charges for the elderly who use more medical services.

Currently, the health insurance policies that most people get through their employers vary extensively, both in the range of services offered and in the amount of out-of-pocket costs to employees and their families. Some policies exclude coverage of services for preexisting illnesses, a practice that would be abolished under the administration plan.

See HEALTH, A16, Col. 3

WHAT THE PATIENT GETS AND PAYS

The table below details the package of health benefits that would be guaranteed to every American and legal resident under the Clinton administration plan.

COSTS

HMOs and other managed care plans	Fee-for-service plans
Not yet finalized Under consideration: $10 a visit and same limits as fee-for-service (but HMOs traditionally have charged low or no out-of-pocket expenses for most services)	■ Deductible: $200 a person, $400 a family ■ After deductible, out-of-pocket expenses (co-payment): 20 percent per service, up to an annual maximum of $1,500 a person or $3,000 a family

BENEFITS

Type	Limitations	Co-payment
Inpatient hospital	Private room only when medically necessary	20 percent
Professional services, outpatient hospital services, including emergency		20 percent
Preventive services, including well-baby, prenatal	Preventive adult services include pelvic exams, cholesterol screening, and mammograms every 2-5 years	No co-payment or deductible
Hospice	As hospital alternative for terminally ill	20 percent
Home health care	As inpatient alternative; coverage reassessed at 60 days; added coverage only to prevent institutional care	20 percent
Extended care facilities (skilled nursing, rehabilitation facilities)	As hospital alternative; 150-day limit	20 percent
Outpatient physical, occupational, speech therapy	Only to restore function or minimize limitations from illness or injury; reassessment at 60 days; additional coverage only if improving	20 percent
Medical equipment, outpatient lab, ambulance		20 percent
Routine eye and ear exams, eyeglasses	Eyeglasses for children only	20 percent
Dental services ■ Initial: Prevention ■ Additions in year 2000: Restoration Orthodontia	Only for under 18 Remove age limit on prevention $1,500 annual maximum Only to avoid reconstructive surgery; $2,500 lifetime maximum	20 percent 50 deductible and 40 percent 40 percent
Prescription drugs		$250/year deductible 20 percent
Mental health, substance abuse ■ Initial: Inpatient services: Hospital alternatives: All outpatient except psychotherapy: Psychotherapy: ■ Year 2000: Inpatient services: Hospital alt.: Outpatient, incl. psychotherapy: 12 or more psychotherapy visits:	 30 days per episode; 60 days per year maximum 120 days maximum No limits 30 visits maximum No limits 120 days maximum No limits No limits	 One-day deductible; 20 percent One-day deductible; 20 percent 20 percent 50 percent cost sharing 20 percent 20 percent 20 percent 50 percent cost sharing

SOURCE: White House Documents

Clinton Plan to Set Health Care Minimums

HEALTH, From A1

Administration officials estimate that an average standard package for an individual would cost about $1,800, and $4,200 for a family with at least one child. But they cautioned that the price could vary from region to region according to local market conditions and the number and type of health plans that compete for consumers' business.

Clinton, who is in the midst of a round of high-level meetings to finalize the plan, also will propose standardizing the maximum amount individuals would have to pay out of pocket every year. In order to provide more freedom of choice among different kinds of health care plans, the administration proposal will include three options for such payments, depending on the kind of care a person chooses.

For managed-care plans, such as health maintenance organizations (HMOs), the administration is considering a $10 per visit charge, but has not made a decision. At present, most such plans require minimal or no out-of-pocket charges for most services. Many health experts believe that, if the Clinton plan were put into effect, most Americans would end up in managed-care programs.

For fee-for-service plans—currently the most common form of health care, in which individuals choose their own physicians—Clinton will propose that individuals would pay the first $200 of medical expenses per year and 20 percent of the cost of subsequent charges, up to a maximum of $1,500 a year. Families would pay the first $400 of charges and 20 percent of the cost of subsequent expenses, but no more than $3,000 a year.

The administration's "standard package" includes coverage for: hospital charges and physicians' fees; home health care; emergency and ambulance services; family planning services; outpatient laboratory and diagnostic services; outpatient prescription drugs; and rehabilitation services. It also includes durable medical equipment, prosthetic and orthotic devices, vision and hearing care, and health education classes.

There is no lifetime dollar limit on benefits except for orthodontia, which would be limited to $2,500. Several kinds of services, however, have other restrictions under the plan.

Coverage for inpatient and residential mental health and drug and alcohol abuse treatment would be limited to 30 days per episode and 60 days per year. Hospital care is available "only when less restrictive nonresidential or residential services are ineffective or inappropriate," the document states. Limits would be lifted by the year 2000.

People would be eligible for coverage "if they have, or have had in the past year, a diagnosable mental or substance abuse disorder . . . that results in or poses a significant risk for functional impairment in family, work, school, or community activities."

Administration officials said incarcerated persons, many of whom are drug addicts, are not eligible for the services in the standard benefits package. Their care is determined by Justice Department guidelines.

Psychotherapy is limited to 30 visits a year; other nonresidential treatment services, such as detoxification and home-based services for severely mentally ill children, are limited to 120 days per year.

The plan includes unlimited visits to psychiatrists and psychopharmacologists to adjust and monitor drug prescriptions for the mentally ill, a major part of the cost of their care.

Home health care, including skilled nursing, physical, occupational and speech therapy, is limited to 60 days and may be extended "only if the risk of hospitalization or institutionalization exists."

Coverage of long-term care in a skilled nursing or rehabilitation facility would be available only after an acute illness or injury—as an alternative to continued hospitalization—and is limited to 100 days per calendar year.

Just as the plan provides a minimum set of benefits for all Americans and legal residents, it also sets out minimum obligations for health care plans. The scope of the package determines how much some insurance companies, hospitals and group practices that offer limited services will have to adjust to remain in business. Many HMOs already provide a broad range of services with minimal out-of-pocket costs; but only 14 percent of the U.S. population is enrolled in HMOs and many companies have been criticized for unduly restricting care.

Clinton would require that employers pay 80 percent of the annual prepaid cost of a standard benefits package with some financial limits for small firms. That cost would remain tax deductible. But as a way to discourage what the administration considers excessive benefits that drive up total health care costs, the plan would impose a limit on the tax-exempt status of benefits above the basic package.

States Become Health Reform Labs

THE PATIENT'S ADVOCATE

BY VICTOR COHN

The Washington Post August 1993

Health care reform is happening, but not here in the nation's capital.

This is happening while experts and pundits here talk about reform's vast problems, the interests sure to combat it, the impossibility of doing anything before 1994 and a growing uneasiness about accomplishing much even then.

The lesson for the administration and Congress seems to be:

COMMENTARY

"The states spent a decade bemoaning their fate" as the high cost of Medicaid and other care for the poor and uninsured devoured their treasuries, "but now they recognize an opportunity," said Paul Ogren—a former Minnesota legislator and an architect of that state's plan—at a conference here this month.

It's more than an opportunity, it's a "must," Florida Gov. Lawton Chiles told the conference, organized by the Kaiser Family Foundation and the Alliance for Health Care Reform. "I had no choice. I found state policy being driven by health care" so expensive "there was nothing I could do with education or other reforms."

Many states are passing measures to expand care or control costs. Seven states lead:

- A [redacted] health authority set December 1994 as a target date for employers and managed care plans—HMOs and the like—to provide affordable coverage. Purchasing alliances will help employers buy coverage. The uninsured will be offered low-rate coverage. Employer participation is voluntary, but if the voluntary program doesn't work, "we have a big club," Chiles said, a mandatory program by 1995.
- [redacted] regulating insurers, making employers cover workers and creating a state program to cover the uninsured—now covers all but 1 or 2 percent of its population. A federal waiver will let it use managed care plans to try to cut Medicaid costs and cover everyone.
- [redacted] voted in 1988 to require employers either to insure workers or pay into a state insurance program. Hard times have forced a delay to earliest, 1995.
- [redacted] tax cigarettes and health care insurers and providers—doctors, hospitals and others—to subsidize coverage for low-income citizens and help others buy coverage on a sliding scale. Doctors and hospitals must form or join networks to provide economical care for all or face rate regulation. A purchasing pool will help small businesses buy coverage.
- [redacted] employers must cover workers by 1998 or pay into a state insurance pool. A cigarette tax will finance expanded Medicaid coverage, and the state—in a plan attacked as "rationing" but approved by the Clinton administration—will try to cover more citizens by reducing Medicaid services given low priority.
- The [redacted] legislature will choose between two plans —either a single entity to collect a new payroll tax and pay doctors and hospitals, or a system relying partly on managed care to control costs and partly on state regulation of prices. A statewide health spending target will later become an annual limit.
- [redacted] require employers to cover employees and dependents. Costs are to be controlled by caps on premiums and competition between managed care plans.

Almost all these plans face federal or other hurdles. Some require federal waivers or changes in laws or regulations that limit state action, for example, restrictions on moving Medicaid patients into managed care.

Over-reliance on state action could prevent effective nationwide action and leave millions of people uncovered. A past lesson, said Drew Altman, president of the Kaiser Family Foundation, is that often "five states will do great things, five will do horrible things, and most will be someplace in the middle."

Nonetheless, "we need to feel our way . . .," former Colorado Gov. Richard Lamm wrote in Health Management Quarterly. "It would be reckless to develop a system for 250 million Americans without more practical information on alternatives."

Clinton health planner Ira Magaziner told the recent conference, "We will encourage states to follow their own course" within national guidelines, setting some rules for effective cost control, universal coverage, minimum benefits and so on. And President Clinton last week promised states flexibility in meeting national goals.

The future, then?

Sidney Wolfe, physician-head of the Public Citizen Health Research Group, said managed care and competition—keystones of both the federal and most of the state plans—"won't work;" some state will start a system more like Canada's—covering everyone by taxing everyone and controlling payments to doctors and hospitals—"and in three years or so the whole thing will go that way."

Vermont's Democratic Gov. Howard Dean, also a physician, said all the present efforts, state and federal, could lead to a single payer system—in effect, something like Canada's—"15 or 20 years from now."

On the other hand, said Florida's Chiles, "what we are seeing now is an unshackling of many forces"—cooperating to deliver care at controlled costs—and "I think the market will operate in astounding ways we don't even know about."

Supreme Court Justice Louis Brandeis called the states superb laboratories of democracy that can "try novel social and economic experiments without the risk of the rest of the country."

The health reform laboratories are beginning to emerge. ■

Investor's Business Daily
July 14, 1994

NATIONAL ISSUE

DENYING HEALTH CARE FOR PROFIT

How Managed Care Rations Services To Enrollees

By John Merline
Investor's Business Daily

It is a story certain to make health-care reformers' blood boil.

Nelene Fox developed breast cancer that, despite chemotherapy, spread to her bone marrow.

Her HMO plan, Health Net, denied her coverage for a bone marrow transplant, claiming that the procedure was experimental.

The decision forced Fox to raise the money herself, delaying treatment that, the family believes, cost Fox her life.

A jury agreed, awarding the family $89 million. The jury was particularly incensed by the fact that Health Net, a highly profitable company, appeared to make the decision based more on making money than saving a life.

To reformers, this case — complete with denial of needed care to boost profits — is a perfect example of the need for changes in the health-care system.

Ironically, however, the woman got her care through a kind of insurance plan that would be encouraged by most health reform proposals.

"Most reform proposals put the trillion-dollar health-care system in the hands of the very institutions that have already proved their expertise at selecting indirect risks, limiting coverage, and denying or delaying payments," noted Donald Light, professor at the University of Medicine and Dentistry of New Jersey in Camden, in an article published in a recent New England Journal of Medicine.

Deadly Cure?

Proposed "Optimal Recovery Guidelines" under Blue Cross of Rhode Island

	Days In Hospital	
	National Average*	Proposed Guidelines
Above-knee amputation	15.7	2
Vaginal delivery	2.0	1
C-section	6.7	2
Cholecystectomy	7.9	1
Heart attack	9.7	4
Coronary bypass	10-13	4

*Non-Medicare patients, 1992
Source: American Medical News

In fact, while critics of the Clinton administration's plan decry elements they say will lead to rationing of care, plenty of rationing already takes place among those insured through the private sector's managed care industry.

"Managed care denies needed treatment, no doubt about it at all in my mind," said Dr. Michael Schlitt, a neurologist in Seattle. "And it happens all the time."

The outright denial of care is only the most obvious form of rationing.

Managed care plans employ a panoply of far more subtle rationing techniques, such as delaying treatment, failing to inform patients about more expensive treatment options, limiting access to expensive treatments, restricting access to doctors, and so forth.

"I suspect people understand those things happen, but think of rationing as being more dire," said Steven Schroeder, president of the Robert Wood Johnson Foundation, a Princeton, N.J., health-care philanthropy.

"You wouldn't see millions of people enrolling in HMOs if they were these evil health-care providers," said Geraldine Dallek, executive director of the Center for Health Care Rights in Los Angeles. "But, the financial incentives under which these plans operate do give providers incentives to deny care, especially expensive referral services."

The managed care industry employs a host of euphemisms to avoid the dreaded R-word. Utilization review, practice guidelines and drug formularies, are among the technical sounding terms used to describe managed care's rationing techniques.

"Most managed care plans will say that they are being 'cost effective,'" said William Schwartz, a physician and

Continued on Next Page

DENYING HEALTH CARE FOR PROFIT

From page 1

economist at the University of Southern California.

"What is the difference between cost-effective and rationing? To me that distinction is one virtually without meaning," he said.

Delaying treatment is perhaps the most subtle, and most common, form of rationing used by managed care plans.

"Delays are especially important for insurance companies, because they can garner high rates from investing the premiums for as long as they can hold on to them," noted Light.

Time And Worry

Unfortunately, while the plan may save some money, the patients, or their families, often pay in time and worry.

For example, when a 14-year-old Maryland boy developed a lump on his rib cage, the family's HMO doctor recommended a CAT scan, which took two weeks to schedule.

Nearly two more weeks passed before the results came in.

At one point, plan administrators said they had no record of the CAT scan.

"I was physically ill waiting for the results," said the mother, who asked not to be identified.

She concluded from her experience that HMOs "are wonderful for general physicals. But for anything serious, I don't think I would recommend it or join one again."

Schlitt tells the story of a patient suffering a pinched nerve in his neck, who had to wait a month before getting surgery scheduled through his managed care plan, during which time the patient had to stay home from work.

A study of California HMOs by the Medicare Advocacy Project, turned up several similar anecdotes.

Two-Year Wait

One story involved a California resident told by his HMO doctor in 1989 that he needed cataract surgery.

For two years, the HMO failed to schedule the operation, although it kept promising to do so.

During that time, the elderly man lost his ability to drive or read.

In desperation, he paid out-of-pocket for the surgery, which restored his vision.

Another elderly California patient, stricken with a severe headache, blurred vision and numbness, was sent to the patient's HMO's Urgent Care Clinic.

The doctor prescribed an aspirin a day.

After nearly a month of suffering with these symptoms, the patient was finally referred to a neurologist. And that was only after repeated complaints to plan officials — and after an ophthalmologist told the patient there was evidence of an aneurysm.

The neurologist told the patient, "You should have seen me three weeks ago!"

Another form of subtle rationing is to deny patients access to newer tests or more expensive drugs. Many HMOs, for example, do not offer the latest screening tests for prostate or ovarian cancer.

Rationing by restricting access to area physicians also occurs, critics charge.

'Deselected' Physicians

The Washington area Blue Cross and Blue Shield has been sued by doctors dropped from the plan's preferred provider network.

"Physicians who take care of sicker, more complicated patients appear to have been systematically 'deselected,' " said Dr. Mark Whitten, an ophthalmologist and chairman of the Medical Society of the District of Columbia.

The doctors noted that some doctors who practiced both in the suburbs and in the city were approved by the plan only for treatments given in their suburban offices.

The implication drawn by the doctors was that Blue Cross was attempting to exclude patients who live in the city — and who tend to be sicker — from coverage.

"We think that Blue Cross is engaged in rationing by inconvenience and rationing by hassle," said Dr. Paul Rudolf, who practices internal medicine.

Tight restrictions on doctors affiliated with a particular plan can spell trouble for some patients.

When Massachusetts' Bay State HMO faced financial difficulties, it fired hundreds of psychiatrists. The plan's patients were instructed to call an 800 number, describe their symptoms and get assigned to a new doctor.

In addition, patients in managed care plans are increasingly directed away from major medical centers to lower-cost community hospitals that don't offer the latest treatment or staff the top experts, some analysts say.

"I know that the patient load in radiation oncology is down at Memorial Sloan Kettering and other cancer centers," said Richard Levy, executive vice president of Varian Associates, a Palo Alto company that manufactures medical equipment.

"Many of the major medical centers are concerned, either because its already happening, or because they are afraid it's going to happen," he said.

Levy and others see the continued expansion of managed care as threatening to slow down medical advances as manufacturers struggle to recoup their costs.

Cutting back approved hospital stays, or denying them altogether, is another tactic.

Blue Cross of Rhode Island recently proposed "optimal recovery guidelines" — which would be used to determine coverage for hospital stays for various procedures.

In some cases, the proposed cutbacks were dramatic. While the national average hospital stay for amputating a leg above the knee is more than two weeks, the guidelines would set the "optimal" stay at two days.

Cutbacks In Coverage

While the average coronary bypass patient stays about 13 days in the hospital, the proposal suggested four days is adequate.

Managed care plans already have cut back substantially coverage for hospital stays.

Stays in hospitals were cut some 20% between 1982 and 1990, according to Schwartz, who argues that much of the cost advantage for managed care came by cutting hospital stays.

Most new mothers, for example, get only a one-night stay in the hospital if they are in a managed care plan. They are discharged by noon even if the baby was born as late as 9 p.m. the previous night.

The most obvious example of rationing is outright denial of payment for an expensive treatment.

Managed care plan administrators say they aren't rationing care, they are simply weeding out inappropriate treatment. The only problem is, nobody knows what appropriate care is in many circumstances — given the complexity of illnesses and wide variations in patient characteristics and responses to treatments.

"Uncertainty is inherent in medical practice because patients present individual and complex medical circumstances," wrote Sandra Tanenbaum, a professor at Ohio State University's College of Medicine, in the New England Journal of Medicine.

'Arbitrary And Capricious'

A study in the same journal found that approvals for payment of bone marrow transplants — the procedure denied Nelene Fox — varied from plan to plan.

And, the denials were often rescinded once the patient hired a lawyer. Approval, the study authors found, "appeared to bear little relation to available medical or scientific information, and often seemed arbitrary and capricious."

Why do managed care plans ration? The answer, according to economists, rests on the age-old maxim: "He who pays the piper calls the tune."

Managed care plans typically ask for little, if any, out-of-pocket spending from their enrollees.

"Managed care creates an artificial market for medical care in which the price system is almost completely suppressed," noted John Goodman, president of the Dallas-based National Center for Policy Analysis.

"Since these patients perceive medical care as 'free,' they have incentives to overconsume it. The HMO bureaucracy must institute barriers to keep that from happening," he added.

As a result, managed care often ends up looking like government-run health programs, complete with heavy reliance on rigid rules and procedures to determine available care.

"In the United States, managed care organizations currently perform regulatory functions that governments do elsewhere and that Medicare does here on behalf of its beneficiaries," noted Robert Berenson, who practices internal medicine, in an article in the journal Health Affairs.

ABRIDGE

A SELECTED SUMMARY OF RECENTLY PUBLISHED RESEARCH BY GRANTEES

How People With Chronic Illnesses Fare In Prepaid Systems

As managed care continues to sweep the country, a major concern is how patients with chronic illnesses will fare in this new environment. In systems where there are financial incentives to provide fewer services, many worry that patients with chronic illnesses will receive sub-optimal care.

How does care in a fee-for-service system compare with HMO care for these patients? How do they assess the quality of the care they receive in managed care organizations?

In this study, investigators analyzed data from the Medical Outcomes Study, conducted in Boston, Chicago and Los Angeles from 1986-1990, to determine differences among HMOs, fee-for-service systems and independent practice associations (IPAs) with respect to access, continuity of care, coordination of care and other measures of quality. They obtained quarterly assessments from 1,208 patients with at least one chronic illness. They assessed seven measures of primary care. Based on the patients' responses, each measure was scored on a 100-point scale.

Patients rated fee-for-service and IPA systems higher than HMOs for most of the measures; HMOs were rated higher for coordination of care and financial access to care. These results indicate how difficult it is to develop delivery systems that can perform well on all measures of primary care.

Among the major findings:

- *Access.* Patients with prepaid care (HMO or IPA) had better financial access to care than those with fee-for-service coverage. However, gaining access to care (reaching a physician with a medical question, obtaining care on short notice and obtaining emergency treatment without a long wait) was more difficult in two of the three cities studied. Such problems can make patients dissatisfied with their provider and disrupt the patient-provider relationship.
- *Continuity.* Continuity of care was best among fee-for-service patients. The advantages of patient-clinician continuity are magnified for patients with chronic conditions. Clinical care may be better and costs of care lower. Savings come from fewer physician visits, improved patient communication, better compliance and fewer emergency hospital admissions.
- *Comprehensiveness.* HMO patients scored lowest on comprehensiveness of care, compared to IPA and fee-for-service patients. Less than 5% of HMO patients received primary care from a medical specialist, compared to 36% of fee-for-service patients and 18% of IPA patients. HMOs' lower score for comprehensiveness of care reflects the paradigm of generalist care with specialty referrals as needed.
- *Coordination of care.* Coordination of care — a hallmark of HMO care and an important feature for patients was chronic illness — was highest among HMO patients. A limitation of this study's measurement of coordination is that it relies on patients' perceptions rather than physicians' actual efforts to coordinate care.
- *Accountability.* Prepaid patients were more dissatisfied with the amount of time providers spent with them and with the personal concern they showed. The difference, however, was statistically significant in only one city, indicating wide variations in prepaid systems. Dissatisfied patients switch physicians and don't comply with treatment, making this an important measure of primary care effectiveness.

"Our analyses point to the difficulties of successfully incorporating each of seven elements of primary care into one payment system," the authors write. "Each of the three payment systems has deficiencies that demand attention in the current health care delivery reform climate." ∎

Safran DG, Tarlov AR and Rogers WH. Primary Care Performance in Fee-for-Service and Prepaid Health Care Systems. *Journal of the American Medical Association* 271 (May 25): 1579-1586, 1994.

In Canada, Poor Women Lag In Preventive Care

The Canadian experience provides evidence in two recent studies that universal coverage will go only so far in improving women's and child health. The findings should remind US policymakers that poverty, education and other factors will continue to be barriers to access. They influence health outcomes even when coverage is assured, the authors warn.

The studies compared use of prenatal care and gynecological cancer screening by women in different socioeconomic groups in the US and Canada. In one study, the authors found that low-income Canadian women did not use breast and cervical cancer screening services as much as more affluent women did, even though health care coverage is uniform and universal in Canada.

The authors compared results of large population-based surveys that included information on education and family income. Data were analyzed for 23,932 women 18 and older in the 1990 US National Health Interview Survey and 23,521 women in the 1990 Ontario Health Survey.

Compared with women who have less than a high school degree, college graduates in both the US and Canada were more likely to receive gynecological screening. They were over twice as likely to receive a clinical breast exam 1.7 (Canada) to 1.9 (US) times as likely to receive a Pap smear.

Mammography rates were two to three times higher in the US than in Canada, but the pattern of mammography use was similar in both countries. In Canada, higher-income women were 1.8 times more likely to use preventive services, and in the US 2.7 times more likely.

"Physicians face special challenges in facilitating the provision of preventive medical care to the poor," state the authors of the cancer screening study. "Unfortunately, even under an optimal universal health insurance scenario this challenge will not disappear."

In another study of single births in the US and Canada, researchers concluded that poor Canadian women are less likely to have inadequate prenatal care than poor US women. Still their risk for having a low-birthweight infant is greater than it is for more affluent Canadian women. The authors analyzed birth certificates, hospital discharge abstracts and Medicaid data for 95,401 births in Washington State in 1988-1989 and 72,831 births in Canada in 1987-1988.

In the US, inadequate prenatal care was linked with delayed enrollment in Medicaid. Women who enrolled in Medicaid before they became pregnant were only slightly more likely to have inadequate care compared to women in British Columbia.

The researchers in both studies expected to find a less of a difference between Canadians of different incomes with regard to screening and low birthweight. However, socioeconomic gaps persisted. ∎

Katz SJ and Hofer TP. Socioeconomic Disparities in Preventive Care Persist Despite Universal Coverage. *Journal of the American Medical Association* 272 (August 17):530-534, 1994.

Katz SJ, Armstrong RW and LoGerfo JP. The Adequacy of Prenatal Care and Incidence of Low Birthweight among the Poor in Washington State and British Columbia. *American Journal of Public Health* 84 (June):986-991, 1994.

Dr. Katz is a former Robert Wood Johnson Clinical Scholar.

3/13/95

Lex,

Thought this might be of interest to you.

Ky

New York Program to Finance Long-Term Care Wins Innovation Award

Long-term care is costly — whether its simple help with daily activities at home or highly skilled care in a nursing home. In New York state, for example, the typical cost for care is $65,000 a year in a nursing home with the average length of stay two years. One in two residents who lives 65 years will require some form of long-term care.

Faced with a possible bill of $150,000 at the end of life, many elderly in New York and elsewhere choose "spending down" to poverty in order to qualify for Medicaid and the "privilege" of spending their final days or years as a ward of the state. Originally conceived as a safety net for the indigent, Medicaid has become, in large measure, the payment program for all but the wealthiest elderly. In New York, Medicaid picked up the bill for more than $7 billion of long-term care in 1993. Though only 14% of the state's Medicaid population requires nursing home or home care, these people's health care bills consume half of the total Medicaid dollar.

When the Robert Wood Johnson Foundation challenged the states to create programs to make long-term care insurance more affordable by forming partnerships with private insurers, New York was one of four states to step forward.

"New York saw a disaster coming, and I'm sure we were not alone," says Gail Holubinka, project director of the New York State Partnership for Long-Term Care. "A study showed that unless something dramatic was done, New York's Medicaid funding for long-term care would be $23 billion by the year 2010. That was enough incentive for the policy makers in this state.

"It became very clear that we had to act to enable middle-class people to support their own long-term care and to enjoy some of the savings that they had accumulated over the years. The public-private solution was far more feasible than if we had waited for a purely governmental approach."

Last September, the New York State Partnership for Long-Term Care was cited as one of 1994's ten "innovations in state and local government" by the Ford Foundation at a ceremony in Washington, D.C. The Innovations Award program is administered by the John F. Kennedy School of Government at Harvard University.

In addition to New York, Connecticut, Indiana and California have implemented Partnership programs. Those three states offer "dollar-for-dollar" tradeoffs, in which a consumer purchases one dollar of asset protection for every dollar of insurance that he or she buys. For example, a 65-year-old Indianan can purchase long-term care insurance worth $60,000 for an annual premium of $600 to $1,000 and thereby become eligible for Medicaid while retaining $60,000 in personal assets.

"We had to act to enable middle-class people to support their own long-term care."

In New York, where nursing home and home care costs are double the national average, the state offers coverage that is different than in the other three states with Partnership programs. New York coverage is based on time. By purchasing a Partnership policy, a person can protect all remainging asssets and receive either three years of nursing home care or six years of home health care — or a combination of the two. In 1993, the average cost of total asset protection premiums in New York was a little more than $1,400 annually for healthy people aged 65 and approximately $2,000 for healthy people aged 70.

Regardless of premium costs, linking private insurance companies with state Medicaid programs is an experiment worth watching, according to Partnership national program director Mark Meiners, based at the Center on Aging at the University of Maryland.

"It's inconceivable that new federal or state health reforms will finance comprehensive long-term care in a time of bulging deficits," says Meiners. "But the capacity is lacking in the private sector alone to finance long-term care for the millions of Americans who need it. The blending of state monies and the quality assurance that accompanies state certification with the experience and marketing skills of private insurance make for a very reasonable, high quality option for millions of middle-class Americans.

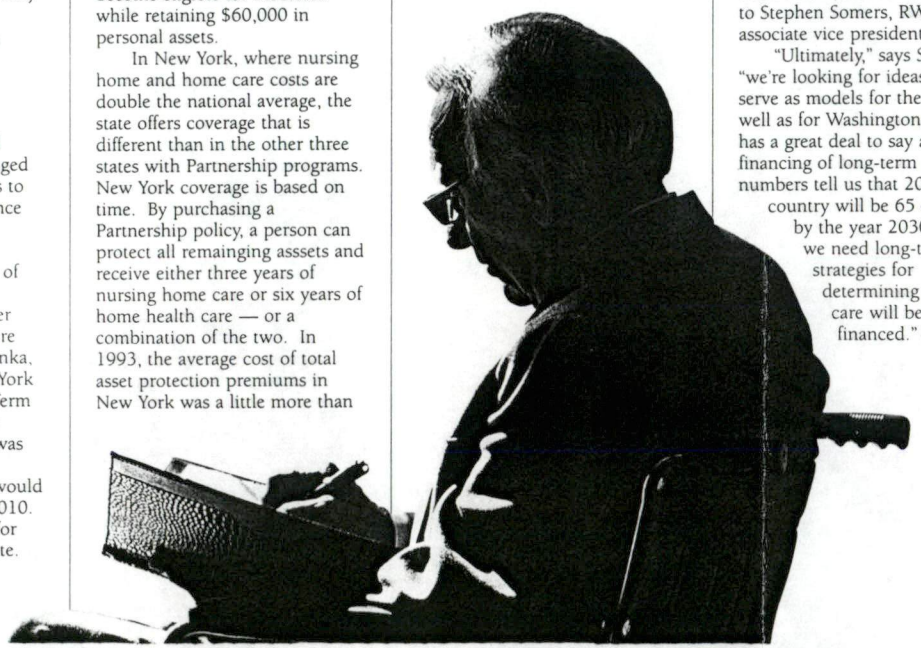
"It's inconceivable that new federal or state health reforms will finance comprehensive long-term care in a time of bulging deficits."

"We still have to educate the public that long-term care is not somebody else's problem, but a reality that is likely to cost in the hundreds of thousands of dollars for many American families," adds Meiners. "It simply makes sense for people to purchase protection in the healthy years before long-term care devours a family's accumulated savings. It can provide peace of mind if and when the need arises."

One by-product of the Partnership program is a heightened awareness in the states about long-term care insurance. According to a survey in New York, the long-term care insurance business in that state has increased more than 60% since the onset of the Partnership in 1993.

The national Partnership for Long-Term Care has spawned creative thinking about other state financing options. In January, five states will receive funds from RWJF's $3.6 million Program for State Initiatives in Long-Term Care. This new program will enable states to experiment with models that emphasize public and private sectors respectively, as well as those that blend both, according to Stephen Somers, RWJF associate vice president.

"Ultimately," says Somers, "we're looking for ideas that can serve as models for the states as well as for Washington, which has a great deal to say about the financing of long-term care. The numbers tell us that 20% of the country will be 65 or older by the year 2030. Clearly we need long-term strategies for determining how their care will be financed." ▮



A Season For Giving Thanks

TEXAS MEDICAL CENTER

NEWS

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Lex Frieden: "Champion for People with Disabilities"

by ROGER WIDMEYER
Texas Medical Center News

Lex Frieden is on a conference call. He is all business. Assembled via the telephone lines, the group is discussing a draft of a report. Add a sentence here, Frieden says. Strengthen the introduction. He adds some sentences to the conclusion.

Frieden and his colleagues are drafting a report to be delivered to President Clinton on Nov.15 regarding a national policy of employment for disabled people.

Lex Frieden, 49, has been active in legislation affecting disabled people for more than 20 years. He has been almost completely paralyzed for 31 years.

ROGER WIDMEYER

Mac Brodie and Lex Frieden – a mutually beneficial partnership.

Frieden has just returned from Washington D.C., where he received the 1998 Henry B. Betts Award, an honor given to one person each year who has made contributions toward improving the quality of life for people with disabilities. The award carries a $50,000 non-restricted cash award with it. In nominating Lex Frieden for the award, former President George Bush wrote, "Throughout his life, Lex has been a champion for people with disabilities."

As the major architect of the Americans With Disabilities Act – passed in 1990 – Frieden may know more about the difficulties a person with disabilities faces than anyone else in America.

"There have been several important laws," says Frieden. "The Rehabilitation Act of 1973 was very important, and it's been amended and improved since then. The 1975 Education for Handicapped

(Continued on page 18)

Holiday Precautions Force Bacteria to Go 'Cold Turkey'

by JOAN CARTER, R.D.
Children's Nutrition Research Center

An ounce of prevention can keep food-borne bacteria from becoming an uninvited guest at your holiday table.

"Think sink, stove, and refrigerator," says Becky Gorham, a registered dietitian and research nutritionist with the USDA/ARS Children's Nutrition Research Center at Baylor College of Medicine. "These kitchen staples are effective tools in preventing the growth of illness-causing bacteria," she says.

At the sink:

• Wash hands before and after handling any food. Keep utensils, dishes, counters, cutting boards, sinks, sponges, and towels clean. Use two cutting boards, one for meat and one for other foods, to prevent cross-contamination.

Students, Community Helping Fund New $60 Million Building

by PAMELA LEWIS
The University of Texas-Houston

raising in the Houston community."

Bush Library Photocopy Preservation

Frieden...

(Continued from page 1)

Children Act was critical because it meant that kids with disabilities would receive their education in 'normal' schools, integrated with the rest of their peers."

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In 1967, Lex Frieden was an honor student looking forward to his first year of college at Oklahoma State University. But his dreams of college were shattered, just as his neck was, in an auto accident; he was a passenger in the car.

His father visited rehabilitation facilities in New York, Chicago, Los Angeles and Houston. "He said there was no choice, really: TIRR was the place for me," says Frieden. "Dr. Ed Carter was my doctor. He's still here." Following rehabilitation, Lex applied to a university in Oklahoma, an architecturally modern group of buildings. He was denied admission because of his wheelchair.

"I couldn't believe it," he recalls. "I had a 4.0 grade point, excellent test scores and recommendations. I spent several weeks in shock.

"It darn sure had an impact on the way I looked at life."

At another school, the University of Tulsa, the dean had a simple solution. "He said they would simply hold the classes I wanted to take in a new building which was accessible. No big deal. But it gave me the idea of 'reasonable accommodation,' a concept which we have incorporated into the Americans With Disabilities Act."

Back in Houston in 1972 to pursue a master's degree in social psychology at the University of Houston, Lex met Mac Brodie, a Vietnam veteran who had suffered a severe brain injury. "He was living in a halfway house but he was also volunteering at the assisted living dormitory in which I was living," says Frieden. "This was a dorm actually begun by a bunch of former TIRR patients who were now going to school, and Dr. Spencer encouraged us to hire assistants and arrange our own transportation.

"Anyway, Mac and I started a partnership – and friendship – that has benefited us both."

Mac lives with the Friedens – Lex, his wife, Joyce, and their grandson Trey. Joyce is paraplegic because of disease which struck her brain and spinal cord.
Mac helps Lex with physical tasks, and Lex helps Mac compensate for deficits in his memory and ability to reason.

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"We have 20 years of data that indicates 99 percent of people with disabilities would greatly prefer community living to institutional care," says Frieden. "No surprise there. What is surprising is that we continue to pour millions of dollars into nursing homes and institutions – when community living is cheaper and certainly provides a more independent feeling to that person."

Frieden describes a model of assisted living that is a kind of hybrid nursing home. The assisted living quarters are outfitted with adaptive devices, and a caregiver comes in two or three times a day for meals and to help with dressing. "We don't need physicians and nurses to help us pull up our pants," he says.

Frieden, now a senior vice president at TIRR and mastermind of TIRR's grants program, is also the founder and director of TIRR's Independent Living Research Utilization Program, a national center of research and training about independent living. "It is one of my missions to spread the word about independent living," he says.

Frieden was asked to come to Washington in 1984 to serve as executive director of the National Council on Disability, a 16-member board appointed by the President. "The council had been given an ultimatum by Congress: produce a report with meaningful recommendations, or pack your bags," says Frieden. Under his leadership, the council produced "Toward Independence," a landmark document which for the first time clearly articulated the needs of disabled people. "It was really hard work, partly due to the political environment in Washington, but we did produce some reports that were respected." The reports that came out of Frieden's four-year term as director of the National Council on Disability have influenced international standards on civil right for people with disabilities and helped generate new policies at the Centers for Disease Control and Prevention (CDC) and the U.S. Department of Education.

Most importantly, Frieden's work produced the original draft of the Americans With Disabilities Act, the most important piece of legislation affecting people with disabilities. Essentially, the ADA is a civil rights law, guaranteeing people with disabilities rights to access, employment, and all the opportunities every American has.

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"Look, a whole lot of people come out of rehabilitation programs," says Frieden, "but they are lost once they finish because the community they are going to lacks a support system for them. That's why I work so hard to focus public policy on two fronts: ensuring an opportunity to work and an opportunity to live independently. There are still too many employers who look at a disabled person and simply fail to see the qualifications of that person. In 1990, when the ADA was passed, 68 percent of people with disabilities were unemployed. Today, 68 percent are still unemployed. And there are still too many people who spend a lot of time and energy convincing the government that they are indeed disabled so they can collect benefits – and they come to see themselves as dependent.

"We – our community and our society – have to do better." ■

Building...

(Continued from page 1)

"The building will serve a dual role for students," says Carol Walker, 1997-98 president of the UT-Houston Student InterCouncil. "Not only will it serve an educational purpose, but it will also become the centralized location for most, if not all, student services – a distinct advantage for the busy student."

The design, construction and interiors of the building are part of a new era of sustainability on the campus, says Brian Yeoman, assistant vice president for support services at UT-Houston. "We are making sure that it will meet the needs of the current generation of students without having a negative impact on future generations."

For years, the School of Nursing [illegible] 600 [illegible] to advance health professionals for the 21st [illegible] front of state and national efforts in academic and research excellence, and is currently growing at a phenomenal rate," says Dr. Low.

* It has been named to the 1998 Top Graduate Nursing Schools and its nurse anesthesia program was cited as eighth in top graduate nursing programs by *U.S. News and World Report*.

* It has the only clinical doctorate in nursing (D.S.N.) in Texas, the only master's nursing programs in oncology, the only dual degree with nursing and public health in Texas, and the only emergency nurse practitioner program in the country.

* The school is ranked Number 2 in the U.S. for faculty practice revenues and its nurse practitioner managed clinic is a national model.

"We see this building not only as a place [illegible] of Nursing.

"Nurses represent the single largest group of health professionals," says Dr. Starck, "and are also, in my judgment, the health care professionals closest to human suffering, being in hospitals 24-hours-a-day, seven-days-a-week, often in the wee hours when patients express their deepest needs. Caring for patients' human spirit is as important as physical care. The new building will be a joyous place to work and learn and will help students develop the caring aspect of their professional practice."

"Also experiencing substantial growth is the department of health informatics in the School of Allied Health Sciences, which also will be housed in the building," says Dr. Low. Health informatics is a blending of health care knowledge and computer science skills, which will be a critical need in the [illegible] doing now, but also will have an infrastructure flexible enough to adapt to future needs. The faculty, staff, and students anticipate working and studying in a building which will support new ways of doing education, especially our department of health informatics with its trans-disciplinary programs of electronically exchanged data and ideas.

"This cutting-edge master of science program is the first in Texas and the first in the nation that is truly interdisciplinary," she adds. "We will always push the boundaries of doing education and research in collaboration with other entities in the Medical Center and beyond."

"Together these two schools are poised for leadership roles in the education of health professionals, as well as in developing vital collaborative health care research efforts both internally and with other institu-