PERSONAL
&
~~CONFIDENTIAL~~

American Federation of Labor and Congress of Industrial Organizations

815 Sixteenth Street, N.W.
Washington, D.C. 20006
(202) 637-5000

April 13, 1994

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Wendy has
copy. Liz

Mrs. Hillary Rodham Clinton
The White House
Washington, D.C. 20500

Dear Mrs. Clinton:

The AFL-CIO Executive Council will hold its spring meeting Tuesday, May 10, through Wednesday, May 11, at AFL-CIO headquarters.

It is my pleasure to invite you to address the Council during this meeting at a time that is convenient to you.

As we continue our efforts to win health care reform and passage of the Health Security Act, I know that the members of the Council will be most interested in discussing this vital issue with you.

We are looking forward to having the honor of welcoming you to the Executive Council meeting.

Sincerely,

President

cc: Thomas R. Donahue

THE WHITE HOUSE

August 24, 1994

C. Everett Koop, M.D.
The C. Everett Koop Institute
Hanover, New Hampshire 03755

Dear Dr. Koop:

Thank you for letting me know about Dr. Kenneth Clark. Fraud and abuse rob our health care system of billions of dollars each year, and it is inexcusable that those doctors who make legitimate attempts to report fraud must fear punishment. The bill that Senator Mitchell has introduced protects "whistle-blowers" who provide information about possible violations of the Health Security Act.

It was good to visit with you last week. We are still hopeful that Congress will pass real, workable health care reform this year.

With best wishes, I remain

Sincerely yours,

Hillary

Hillary Rodham Clinton

The C. Everett
Koop Institute
at DARTMOUTH

VIP

C. Everett Koop, M.D.
Senior Scholar

July 22, 1994

First Lady Hillary Rodham Clinton
THE WHITE HOUSE
Old Executive Office Building, Room 100
Washington, D.C. 20500

Dear Hillary:

You remember that I have spoken to you several times about the fact that we have to police the medical profession and hospitals better than we do, and in so doing we have to provide protection for so called whistle-blowers.

The enclosed letter from Dr. Kenneth Clark is a beautiful example of what happens to someone who was not even a whistle-blower but just a public-spirited physician/citizen who testified before a Congressional Committee at my request.

I send this along just as further indication of the gravity of the situation.

Sincerely yours,

C. Everett Koop, M.D.

CEK/fen
Enclosure
cc: Kenneth M. Clark, M.D.

Hanover, New Hampshire 03755-3862
Tel. 603•650•1450 Fax 603•650•1452

The C. Everett
Koop Institute
at DARTMOUTH

C. Everett Koop, M.D.
Senior Scholar

July 22, 1994

Kenneth M. Clark, M.D.
Clark & Clark, LTD.
90 West Grove Street, Suite 100
Reno, Nevada 89509

Dear Dr. Clark:

I am sorry about your experience with the Joint Commission. I have done what I can about this situation, but the problem is, as you know better than most, an enormous one.

I hope you are successful in resolving the matter, as you indicated in your letter that you might be.

Sincerely yours,

C. Everett Koop

C. Everett Koop, M.D.

CEK/fen
Dictated by Dr. Koop but signed in his absence.

Hanover, New Hampshire 03755-3862
Tel. 603•650•1450 Fax 603•650•1452

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KENNETH M. CLARK, M.D. ODETTE M. CLARK, M.D. *

July 5, 1994

C. Everett Koop, M.D.
C. Everett Koop Foundation
Dartmouth Medical School
Hanover, New Hampshire

Re: **Proprietary Chain Psychiatric Hospitals**

Dear Doctor Koop:

I haven't written you since giving testimony, at your recommendation, before Pat Schroeder's Committee on Youth, Children and Families in April, 1992. Illogically and unfortunately, these hearings never led to any reform legislation.

It wasn't my testimony before that Committee, however, that caused me so much grief; rather, it was when I wrote the Joint Commission one of several letters, including one coauthored by my late wife, Odette, who had just completed her tour of duty as Chief of Staff at the local HCA psychiatric hospital, that my problems really began, as the Joint Commission turned that correspondence over to the facility about which we had written, without my permission, which led to the hospital making the determination that I was "disruptive" and not only terminating my staff privileges there, but also reporting me to the National Data Bank.

I am now in my 70th year and am trying to get an attorney who will represent me on a contingency basis, so far to no avail.

If the regulatory agencies are this ineffectual and the hospitals have this kind of power, no health plan will succeed in the United States, as there is so much fraud. The problem isn't just confined to psychiatry; one has only to compare

July 5, 1994

C. Everett Koop, M.D.
C. Everett Koop Foundation

Re: Proprietary Chain Psychiatric Hospitals

the rates of tonsillectomies, hysterectomies, cesarean sections, angioplasties, cardiac catheterizations, laminectomies, etc., etc., with the incidence of such procedures in other industrialized nations, this in comparison to the longevity of the citizens of those nations, to see that the problem is vast, yet no one seems to be talking about it.

As long as this country has a dollar-driven health care system, we will never see an American equivalent of the Medecins du Monde and Médecins sans Frontières, as we don't have enough idealists left in the U.S. health care system to man such humanitarian organizations.

Perhaps you can do something about this.

Sincerely yours,

KENNETH M. CLARK, M.D.

KMC/met

Enclosures

HC - CORR

THE WHITE HOUSE

WASHINGTON

August 18, 1994

Peter J. Kuzmick, D.O.
406 Boston Boulevard
Sea Girt, NJ 08750

Dear Dr. Kuzmick:

Thank you for your letter about health care reform and for your thoughtful suggestions and comments.

The President has an unwavering commitment to guaranteeing private health insurance to all American families. Without universal coverage, the poor will continue to receive health care through government programs and the wealthy will continue to be able to afford to purchase coverage, while the middle class remains at risk. Twenty-four million Americans, most of whom work hard to earn a living, will have no insurance coverage at all, and one million will lose coverage each month. And without universal coverage, cost shifting and the need of individuals without insurance to rely on costly emergency care will persist, causing health care costs to continue to skyrocket.

To reach his goal of health security, the President shares your support for shared responsibility of health care costs between employers and employees. Because nine out of ten Americans with private health insurance get it through their employers, the President believes that reform should build on that tradition by asking employers to help pay for their workers' health insurance premiums.

I appreciated learning that you support the President's fundamental goal of guaranteeing private health insurance coverage for all Americans. I was also pleased that you are interested in a range of issues that are also important to the President -- including ensuring access to preventive care, prescription drug coverage, elimination of insurance company discrimination and malpractice reform.

As you mentioned in your letter, the need for health care reform is clear. The President and I will continue to work with Congress to pass legislation that guarantees every American the health security they deserve.

Sincerely yours,

Hillary Rodham Clinton

Hillary Rodham Clinton

10 February 1993

Peter J. Kuzmick, D.O.
406 Boston Blvd.
Sea Girt, N.J. 08750
908-974-8148

Task Force of National Health Care Reform
The White House
Washington, D.C. 20510

Dear Mrs. Clinton, et al.:

As a provider and consumer of health care I watch with keen interest at your efforts to reform a system that has come to be one of the most costly in our country. I feel compelled to write to provide a perspective that may be different than any you have heard to date. In setting the theme for my letter I would like to present my conceptual look at our current system.

I see our current system much as a perpetual motion machine. A machine that is energized each time a patient seeks care. It is this activation of the system that sets in motion a number of components which all stand to benefit from the system and whose primary purpose is to perpetuate the initial motion. There are far fewer components poised to or powerful enough to bring the machine to a halt. So, let us look first at what I see as the forward forces:

1. Patients (insured, uninsured) presenting for care, expecting the best care, best medications and perfect outcomes.

2. Physicians, interested in earning a living yet faced with diminishing reimbursement, increasing overhead and regulations as well as the never ending threat of litigation.

3. Medical technology and pharmaceutical companies who stand to benefit by utilization of their products which is controlled by the physicians in number 2.

4. Attorneys, encouraging patients to demand and expect perfect outcomes in diagnostic/therapeutic accuracy in a system which which is far from perfect by the continual threat of malpractice litigation. This litigation being at little to no cost to the plaintiffs in exchange for a percentage of any award.

Now, for the negative forces:

1. Insurers attempting to minimize expenditures by limiting services lowering reimbursements and attempting to micromanage medical care without assuming any of the inherent liabilities of doing so.

2. Insurers refusing to insure less than the healthiest and shifting responsibility for high risk insureds to mandated insurers or government run programs which are frequently not the most efficient.

3. Government, as insurer of last resort, insurer to the poor and elderly as it attempts to stem the growth of medical technology and its' applications to the millions for whom it is responsible.

With this concept in mind I now turn to my major premise which is that health insurance is meant to do the following:

1. Prevent disease through preventive care and the promotion of healthy lifestyles.

2. Protect insureds against the potential financial catastrophe incurred in the event of a medical/surgical illness as a partner to the patient but not necessarily as the sole provider. The insured must have some shared responsibility for prudent utilization of the system yet be protected against costs over which he has no control once the system is activated on his behalf.

3. Protect the insured against unnecessary costs by controlling conflict of interest and encouraging prudent utilization of the available resources on the insureds behalf.

Assuming that you conceptually agree with my premise I would now like to proceed to outline several areas where I see potential for change, remembering that these changes are meant to create a system where all people are insured, all people assume a shared responsibility for their own health and the pressure on costs may be brought down rather than up.

First, I would like to look at the current population and how I see them stratified according to their level of insuredness and their relative shared responsibility. We currently have a population divided into four groups as follows:

1. A segment insured for everything from runny noses to the most complex diagnoses/treatments paid for with pre-tax dollars and with relatively low levels of shared responsibility on the part of these insureds to restrain utilization. This group includes many of our Medicare recipients who have investment or other income and/or accumulated wealth with their $100 deductible/20% co-pay plan.

2. The second segment includes those insured against catastrophic loss only by virtue of extremely high deductibles because the high costs of coverage as in #1. is too much of an expense. This group frequently includes the self-employed who cannot qualify for group rates. In addition, current tax law unfairly penalizes self-employeds by only permitting a 25% health insurance premium write-off yet permitting employees the full benefit pre-tax.

3. The working poor, unable to afford any coverage at all or to qualify for assistance because of incomes above the poverty level or some other arbitrary level.

4. Unemployed and welfare segment provided with extensive coverage through Medicaid but with no financial or personal responsibility to utilize the system prudently, no deterrent to not abuse and no incentive to maintain health.

It is my contention that all people must have some responsibility for their own health and utilization of the health care system. And as a corollary to that I would ask, "Should the fair share costs be the same for a welfare family, a middle class family and an upper class family?" To answer my own quation I would say, "No. But there must be some proportionate fair share." A recent commentary in "Forbes (see enclosed specimen #1.) suggests that a percentage of income as a deductible would seem to be a fairer approach and I agree with them.

My next area of interest derives from the first, specifically, the concept of deductibles and what its' role should be in promoting prudent utilization and shared responsibility. The current deductible system generally serves to establish a finacial threshold after which the patient is at risk for only a percentage of further expenditures on his behalf. In addition, many of these expenditures are ones over which the patient has no control, i.e. inpatient costs, testing whether it be simple or complex, recommended procedures necessary or unnecessary and a variety of other items. A recent example regarding the Medicare system serves as a case in point. On New Year's Eve day the majority of our patients were Medicare recipients coming in to get their year end laboratory studies, medications, MD visits before they slipped into 1993 with its' $100 deductible again. I don't see this as the intention of deductibles. One would be appalled at the number of minor complaints patients present with once their deductibles are met. Small co-payments are no deterrent to imprudent utilization. I see deductibles as follows:

1. A payment meant to deter unnecessary utilization yet enable necessary utilization.

2. A payment meant to provide a mechanism for an insured to share in the financial responsibility of maintaining health without grave financial risk.

3. A payment meant to encourage responsible spending on behalf of an insured within the sytem and not a level that once exceeded serves as the initiation of a "carte blanche" approach with complete surrender of any further responsiblility on the part of the insured.

I suggest to you that deductibles should conceptually be changed to what I term, "deterductibles". To deter those things that that patient has some control over such as, how sick he/she is before they go to the doctor, where they would be willing to go for a test/xray etc., which medication they will accept such as a $100 vs $20 antibiotic. In addition I suggest to you that deductibles should be based on income all the way to the welfare level and as such be used as follows:

1. To pay fully or as a co-payment for all office visits and in doing so serving to restrain utilization rather than promote it. Non-primary care office visits could be subject to higher co-pays unless referred by a primary care provider to deter overuse of specialists.

2. As a co-payment for testing initiated on an insured's behalf as a result of an office visit. This will be discussed in more detail.

3. As a co-payment for medications prescribed as a result of an office visit. This will be discussed in more detail.

4. Not applied to in-patient care since the patient has no control over this aspect of his care and furthermore has far too little knowledge to make decisions regarding medical judgement.

Using the deductible as the first point in attempting to lower costs I will now suggest a method for reducing premiums, at least tax free ones. But I will use my own case to demonstrate where I see a potential for savings.

A number of years ago, as an independent contractor, I opted for extremely high deductibles to keep my premiums low, which they were at $300/qtr for a $2500 deductible/family of four. This was on an income of $80 - 100k and provided a tax deduction of only 25% of $1200 or $300/yr.

I later became an employee and opted for the $250 deductible program which my higher paid partners had and this raised my prem- $4200/yr which is now up to $5200. Therefore I receive $5200 tax free dolars which translates into approximately $8380 pre-tax(31%Fed & 7%NJ) if I had to earn the money and pay the premiums out-of-pocket.

Using the above as an example I see a potential mechanism for lowering costs and making insurance more affordable to all as follows:

1. Raise deductibles to a proportionate share of income. These deductibles would be applied as outlined earlier. In addition, habits known to be anti-health (especially smoking) could result in an additional deductible surcharge.

2. Each person would be entitled to receive tax free an amount equal to the premium for a policy with his approved deductible based on income.

3. Any premiums covering policies with deductibles lower than the the insured's allowed would be taxed to the insured preferably at the pre-tax rate. These taxes would go to subsidize insureds who by virtue of income required policies with lower deductibles.

4. Self employeds would be allowed tax credits equivalent to their employee counterparts of equivalent incomes.

5. Unemployeds and welfare families premiums would be paid through the current tax system, income taxes, excess premiums taxes, etc.

I think that by raising deductibles and using them as outlined on the previous page would have the following effects:

1. Tend to deter utilization.

2. Make people more responsible for more of their everyday minor illnesses.

3. Possibly reduce health insurer's outlays.

4. Reduce the activation of the health care machine which in turn would tend to lower costs of insurers.

5. Possibly reduce premiums further making insurance even more affordable.

6. Possibly foster utilization of the health care system for the serious illnesses and preventive care which is what it is meant to to provide.

Another potential use of the "deterductible" as it pertains to co-pays is in determining indirectly whether a test is medically necessary or financially beneficial to the provider. A system of differential co-pays dependent upon where a test is performed can be used to discourage unnecessary testing or determine where and how monies are spent by the insurer on behalf of the insured especially where a conflict of interest may exist. To paraphrase an old adage, "Profitability is the mother of availability." assuming the acquisition cost is affordable and "Availability is the mother of overutilization." especially if someone else is paying the bill. The problem is that as MD's incomes have slid they have layered on services, some necessary, some not-so-necessary, to bolster sagging incomes. So, for example:

> A patient presents with a cough. Healthy, non-smoking, not severly ill. Physician orders x-ray because he has it in office and it generates revenue, necessary or not. Cost to patient and his insurer is $40 - 70. Effect on treatment is probably negligible.

By differential co-payment structures patients can be deterred from having tests done in offices where a conflict can exist and encouraged to have it if necessary in a location where no conflict can exist. So, for example:

> If MD performs the x-ray in his office the patient co-pay is 80% vs 5% if done out-of-office. So on a $50 x-ray patient stands to lose out-of-pocket $40 vs 2.50. I would drive over to the local radiology office for that.

By virtually eliminating any conflict of interest in ordering tests I suspect that it would reduce the total number of tests ordered (reduced costs to the system overall) and might encourage doctors to lower their costs for tests done in-office so that patients would be amenable to permitting them to be performed in the office but by lowering costs it might eliminate whole segments of testing (lab, x-ray, etc.) in offices and in so doing reduce overhead which would reduce costs further. In so doing, it might encourage doctors so see more of the 30 million (currently uninsured who would be insured) and would result in MD's being paid for what they do best, think. I think that this could serve as a negative force on the runaway health care machine.

The marriage of business and medicine is a bad one doomed for failure . I enclose a recent article from a Colorado newspaper demonstrating just how the influence of business on the practice of health care can be detrimental to that practice. (see specimen #2.)

Many physicians justify overutilization as "covering their ..." against malpractice suits and I will speak to this later. But, as the system corrects for all the unnecessary overutilization it will become apparent that good medical skills, history taking, examination and appropriate testing are the cornerstones of good medicine and defense against litigation.

PHARMACEUTICALS

The pharmaceutical industry has taken a bashing in the recent past. It has been accused of profiteering at the expense of the ill, accused of spending more on promotion than research and has been asked to withhold price increases and to sacrifice as an industry for the benefit of society as a whole. Unfortunately the pharmaceutical industry doesn't have a mass media forum through which to peddle its' wares. It must sell them through physicians to patients. The only way to bring new products to awareness is to promote them to those who control their utilization. Look, for example, at the nicotine patch phenomenon. Patches are advertised in many magazines to the general public. Patients then come in requesting the patch and driving the prescribing of the various patches through their own demand for the product.

I think that drugs cost a lot of money to develop and bring to market. Many are started but never make it to market. This all costs money. When a drug makes it to market current patent law allows the company a set number of years from discovery until it can be copied by the generic companies. Many of those years are spent getting drugs through the approval process leaving only several years in some cases for a company to recoup its' expenses. I would think that if the pharmaceutical industry is going to be expected to sacrifice for the benefit of society then there might be some sacrifice via patent law to enable the industry to recoup legitimate research costs over a longer period of time perhaps by extending the patent from the time the product gets to market not from when it is invented.

In a more practical light I would like to address the medication phenomenon and how it might be incorporated into the "Universal Plan". The way it works now is:

> Drug company develops new medication. After it passes FDA approval they begin promoting it to physicians. This is frequently reinforced with perks (lunches, pens, etc. and sometimes less than ethical ones such as vacations, etc.) There's the old conflict of interest again. Anything to encourage a MD to prescribe a product.

The real question that must be asked is, "Is it really better? And if so, at what price?" Should the system as a whole have to pay the price of patients receiving $100 antibiotics when $20 antiobiotics may do? I say, "No." Cost effectiveness is an important issue in determining appropriateness of a medication (or anything for that matter) especially when you are asking someone else to pay for it. Of course this means that some may not be able to benefit from a product unless they pay for it themselves but all would be entitled to receive at little or no cost products known to be effective and cost-effective. By paying for cost effective medications more people will be in a position to utilize products that they currently cannot afford. A recent article which I am enclosing (see specimen #3.) demonstrates this quite nicely I think regard-

ing the Hepatitis B vaccine. Currently the Academy of Pediatrics is recommending vaccination of all infants at birth. Yet the article suggests through what appears to be sound statistical analysis that a change from the current recommendation to one where only high risk infants are immunized and all children are then immunized at ten and twenty years of age would reduce the cost-per-year-of-life-saved from $3300 to $330. After showing the article to a pediatrician in our group she said, "I'll keep recommending immunizing all infants." Can our system afford the $3300 option when and $330 option will do quite nicely? I say, "No." It is exactly this type of analysis that needs to be applied to all of medicine from drugs to tests to the most costly procedures. So how can the system provide guidance to its' constituents in the case of medication use?

Again we turn to differential reimbursement similar to what exists in many prescription plans already where generics are provided at a lower co-pay than name brands. But, I would make the differential much more severe in order to discourage patients from wanting or physicians from prescribing medications not cost-effective. A recent "NY Times" article noted that one company spent thousands getting its' drug "Duricef" approved for strep throats. But at what price? It costs 4 to 5 times what penicillin costs. Is it worth it? Probably not. It is easier, once a day vs four times a day and there is probably better compliance but is compliance something the system should have to pay for? Patients need to be responsible for taking the medications as prescribed. If they can't be then we ought to just give them the one time penicillin injection which precludes the need for any further pills. If the statisticians can factor in compliance, treatment failures, etc. and determine that once a day vs four times a day is cost effective then maybe the system should pay for it but if not then if shouldn't.

All patients would be provided with prescription plans which would cover necessary medications determined to be cost effective for a given disorder. In order for medications to be acceptable they would have to be on a "National Formulary". It would be the role of government in cooperation with the health insurance and medical communities to develop this formulary through consensus and analysis of pharmaceutical data. This could be through funded research, conferences, academia and some of the government's current institutions, i.e. CDC, NIH, FDA, etc. Medications determined to be cost effective would be provided with a small co-payment. Non cost-effective medications would be eligible for reimbursement at the lower co-payment level only if there were extenuating circumstances that justified its' use otherwise the patient would have to pay the differential out-of-pocket. If a patient wanted a more expensive product their out-of-pocket expense would be higher (a lot higher in a lot of cases) and the cost to the insurer would remain the same. Monies paid out-of-pocket for optional medications would not be applicable against any deductibles. Every patient would be guaranteed access to appropriate cost-effective medications and protected against the catastrophic costs of super drugs in the event they were truly required. There would be obvious downward pressure on physicians to avoid prescribing uncovered medications and the same pressure on patients to not request them when they could receive a much less expensive alternative at a much lower out-of-pocket cost. I would expect that this would bring pressure on pharmaceutical companies to keep their prices as low as possible so there products could be deemed "cost-effective" and included on the "formulary" otherwise they would be something of an orphan drug, invented, effective but too expensive to be used. In this age of computerized pharmacies the written prescription could include the diagnostic code which would serve as a cross reference between diagnosis and medication being prescribed to insure acceptability. Exceptions would require additional coding to be authorized for low co-pay reimbursement.

PREVENTION

As I mentioned earlier, prevention is an important part of a "Universal Plan". In fact, I think it is so important that it should be free just as immunizations should be. Not only free but mandatory. If preventive care were offered at no charge then all responsibility for prevention would fall to the system and all the patient would have to do is show up. It is amazing the number of patients that refuse to participate in recommended screening, saying, "I don't believe in it. Nobody in my family ever had cancer.", etc. But I say that if society is willing to assume the responsibility for preventive screening than all patients must be motivated to participate. In fact I propose this question to you, "If a person refuses free mammography for whatever reason should it then fall on the rest of society to foot the bill? To this I say, "No." If, as a consenting adult, you refuse to participate in the recommended (and preferably mandatory) screening and you develop the disease then you should be liable for a greater percentage of the cost of treatment in the event you develop the disease that you did not undergo screening for. You must be accountable for your actions especially when your irresponsiblity costs others money. This could be tracked through variations in diagnostic coding which would reflect whether the disease, i.e. breast cancer, had been screened for or not screened. Patients would have to be advised of this up front so there would be no, "I didn't know that" excuses.

As patients also became more responsible for their own minor illnesses they would need more information on what they could do for themselves. I have proposed on a number of occasions that an insurance company might do an experiment as follows. Pick a diagnostic code, something simple that patients frequently seek care for, such as URI (upper respiratory infection). Target a segment of their constituents and send out information in a non-threatening format and observe to see if there is a lower incidence of claims under that ICD code. The information should be such that it would not be construed by the constituents as "Don't go to the doctor" but rather "Try these things first unless you are really sick." Currently, if a patient has insurance (especially a low co-pay program) there is little to deter him from seeking care for his minor illnesses. If he wll be financially responsible for his minor illnesses then he should be interested in how he can treat it himself. This type of information dissemination could be provided in all areas of illness so that patients would become better self-care proponents and better utilizers of the health care system.

As preventive health care would be reimbursed fully it would seem that physicians would become interested in participating in it due to the potential for increased earnings. This should serve to shift emphasis toward prevention. The American College of Physicians puts out just the type of guidelines necessary to orchestrate such a system.(see specimen #4). Granted, there are some areas of disagreement between the agencies that analyze the data. This is where the government would again, through consensus, determine what would be appropriate and mandated to the insurers to reimburse for and to the patients and health care providers to participate in.

TORT REFORM

The tort reform issue is one of great interest to all involved in providing medical care. It is a thorn in our sides. Attorneys wait in the wings for any less than perfect outcome. Once identified they attempt to capitalize on it (30% recovery) by offering "no recovery, no fee" incentives to ecourage a patient to file a malpractice suit basically at no risk to the patient in the event of a loss but a real cost to the system in the way it must operate. What they fail to realize, attorneys and some patients alike, is that

medicine is far from a perfect science and that all less than perfect outcomes are not the result of malpractice. Some are simply statistical results.

The fact of the matter is that the current system does not answer the needs of all injured. Many patients truly injured by negligence go unnoticed and without just reward. Attorneys will not take cases where the judgement may be financially unacceptable to them in relationship to their time invested and overhead, etc. But does this mean that the patient doesn't deserve something for an injury caused by bad practice? I'm sure there are many physicians who have escaped the jaws of a malpractice case by virtue of good bedside manner, a devoted patient or the fact that no attorney happened to hear about the case. But, under a "Universal Plan", certain risks would become inherent (as they really are even in today's system) in the statistics of providing less than the "ultimate" care to few in exchange for providing "cost-effective" care to the many. Some patients will suffer at the expense of others. Some children who aren't immunized against Hepatitis B at birth will develop Hepatitis B before they are immunized at age ten, albeit a small number. This is risk spreading. In exchange for "universal Care" we must all accept a slightly increased risk of various outcomes expecially where "ultimate" care does not equal "cost-effective" care.

In keeping with the concept of "risk spreading" across the population in exchange for "Universal Care" how could the current system be modified?

1. All patients injured would be entitled to arbitration at minimal cost to themselves. There has to be some deterrent to nuisance and unfounded suits being brought to arbitration.

2. Attorneys' fees would be regulated for arbitration. No percentage recovery.

3. Limits would be placed on pain and suffering due to the subjective nature of these complaints.

If a patients refused arbitration and opted to pursue a claim through the court system for an injury then:

1. Patients would be liable for defendant's legal fees in the event the defendant prevailed. This would serve as a deterrent to nuisance suits and suits weakly grounded in fact. Even a suit "dismissed with prejudice" would incur some cost to the filer.

2. Attorneys' fees could be raised, but again perhaps less that than the 30 to 33% currently received. Where is it written that attorneys are entitled to 30 or 33%. Is this not price fixing? If I ask the MD next door to me how much he charges for an EKG I'm charged with price fixing.

To date there has been no societal concern over attorneys' fees. Basically, it was whatever the traffic would bear because legal fees had no true societal impact like medical costs and are not construed as a right or necessity except in defense against criminal charges and for that we have public defenders. We are now starting to see where legal fees and attorneys' behaviour are impacting on the cost of what is being perceived as a basic "right", the cost of health care. As society prepares to sacrifice across the board so that "Universal Care" will be realized the legal fee structure/award structure may become the subject of new regulation in an effort to provide an equitable avenue of recourse for patients and providers.

I think that such changes might result in:

1. More cases of negligence being arbitrated and more of the patients truly injured receiving appropriate awards.

2. Redistribution of awards to patients with attorneys receiving reasonable remuneration for their time.

3. Increased recognition of physicians truly negligent with potential for increased corrective action by licensing and credentialling boards.

4. Patients and attorneys alike thinking twice before initiating court suits due to the potential financial responsibility in the event of a defeat when there is a much less risky avenue available.

5. Reduction in frivolous suits via arbitration or the courts.

6. A possibly negative force on the momentum of the health care system compared with the positive force it now serves.

GOVERNMENT ROLE

1. Determine the "Minimum Standard Coverage" to which all Americans would be entitled. This coverage would vary only in the amount of the deductible and its' attendant premium to which each insured would be entitled tax-free.

2. Define "Minimum Standard Coverage". Through consensus determine acceptable and "cost-effective" tests, procedures and treatments. (Take the Oregon experience as an example.) All items determined to be acceptable and cost-effective would then be mandated to be provided by all insurers. Some insureds would be denied some items based on "cost-benefit" analysis. All procedures, medications, etc. would be evaluated. Items determined to be "non-efficacious" would be reevaluated to determine if they fall into consideration as "experimental". Items determined to be "experimental" would be subject to further study. This study would be in a limited number of centers and for a limited amount of time. Funding would be through pooled funds so that no insurer would individually have to pay for experimental procedures, all insureds could obtain experimental procedures until such time that final status was determined and no insurer would have to determine whether it would pay or not. If a procedure ultimately was determined to be acceptable and cost-effective it would be mandated otherwise it would not be covered.

3. Collect taxes on premium overages and redistribute as necessary to establish parity among employers, insurance companies and insureds.

4. Establish the "National Formulary". Guide consensus in prioritizing medications according to cost and cost-benefit. Assist the industry in establishing insurers' and insureds' percentage of payment distribution.

5. In the interest of national health review the pharmaceutical industry, its' research and marketing costs/tactics and current patent law as it impacts the development and marketing of new products beneficial to society as a whole and how changes might change pricing, availability and cost-benefit.

6. Review the tort system looking for changes to make attorneys and patients more responsible for their actions and less likely to utilize courts for no-risk potential windfall cases which only serve to drive health care costs higher and deprive the truly injured of their fair share.

7. Actively review through appropriate agencies changing trends in diagnostic and therapeutic interventions and revise mandatory coverage to reflect this.

8. Actively review through appropriate agencies RBRVS and mandate appropriate reimbursement and reduce over-reimbursement where appropriate.

9. Review alternative forms of health care, i.e. chiropractice, acupuncture, etc., and determine whether or not they are "efficacious" and "cost-effective" and as such should be mandated or not and if so, at what level society should be asked to pay for these. If accupuncture cannot be proven to be efficacious and cost-beneficial then it should not be mandated, and, as such, payments for it should not be applicable against deductibles for other mandated services.

10. Establish a statistical data bank of information regarding diagnoses and treatment outcomes which would serve as a standard against which all outcomes could be weighed. This would allow bad outcomes to be determined to be "matters of fact" and not "matters of law" in consideration of liability determinations. Should every adverse reaction to pertussis be a liability to the vaccine maker or just a "matter of fact" statistical occurence inherent in science, a science which the system is currently promoting?

11. Evaluate the differential reimbursement concept as it may apply to the underserved areas. By altering the ratios of co-payments for in-office vs out-of-office testing/procedures this might encourage physicians to locate to underserved areas where increased revenues might be possible. This might be under the auspices of the Public Health Service and could be on a certificate of need basis. Of course this would necessitate utilization review to insure no overutilization.

12. Evaluate training programs and the percentages of the various types of specialists being trained vs primary care physicians. Consider altering financial incentives (i.e. forgiving or delaying payments of loans) for physicians entering the types of programs the system desires or willing to locate to areas where need exists and not where financial reward looks to be the greatest.

13. Evaluate alternate forms of payment which might encourage providers to participate and in so doing reduce paperwork which reduces costs further to the system. With the proliferation of credit cards why couldn't the insurance industry go to a plastic card system which would electronically accept diagnostic code and charge, weigh this against deductible account data (much as a back card does) and transfer funds almost spontaneously with minimal paper shuffling. All data would be internal at the insurers' computer banks. Prescription cards could function the same way.

I realize that this became quite lengthy but the whole system is in need of an overhaul. I don't think the government has to be the final insurer. I think it can serve as an advisor and overseer through its' many conections. But to create a whole additional bureaucracy to run a system that already exists, albeit somewhat fractionated, seems costly and unnecessary.

Sincerely,

Peter J. Kuzmick, D.O.

"With all thy getting get understanding"

Fact and Comment

By Malcolm S. Forbes Jr., *Editor-in-Chief*

HOW FORBES CURBED SPIRALING HEALTH CARE COSTS

A YEAR AGO, like numerous other companies, we were hit with major hikes in our health insurance premiums. We responded with traditional cost-cutting measures such as boosting deductibles, but we knew that these measures alone weren't enough. They had no incentives for individuals to fundamentally change their health care habits.

Our solution was to reward those who stay healthy and who avoid filing claims for routine medical expenses. Starting last January, FORBES each year offers people an opportunity to earn up to $1,000 of extra, *aftertax* income.

Here is how it works: If someone's claims for the calendar year are under $500, we not only pay him or her the difference between that total and the $500 but we also double it; moreover, individuals will pay no payroll or income taxes. Should an employee submit medical expenses of $200, his reward would be $600 ($500 – $200 = $300; $300 x 2 = $600).

People here quickly recognized that each dollar of claims costs them $2 and that they win if total submissions are under $1,000 (if your expenses are $800 and you don't submit them to the insurer, you will receive that $1,000 and come out ahead by $200).

Our goal was to cut down on routine, time-consuming claims and mountainous paperwork.

Result: At a time when health insurance premium rates are rising an average of 20% to 25%, ours are going down almost 10%. Those savings will cover most of the payouts to our now price-conscious colleagues here. Our overall health expense increases will be a minuscule fraction of the national average.

Our program has national implications in that we rely on individuals to do the job. All other approaches are top-down. They depend on bureaucrats, insurers and employers to control costs.

What is so remarkable about this whole debate is the uniform assumption that individuals can't operate in this market the way they do in every other market. But you don't have to be an engineer to buy an automobile, a carpenter to buy a house or a programmer to purchase a computer. So, too, you don't need to be a physician to make health care choices, to seek, say, the best price for prescriptions.

"No, no! We attach the IV to the patient's wrist, nurse. We only *bill* them through the nose."

The U.S. doesn't have genuine free markets in health care because of the tax code. Insurance premiums are deductible for employers but not for employees. As far as individuals are concerned, health plans are almost all stick, no carrot. People should get the deductions and, if unemployed, tax credits to buy insurance. That way individuals and families could purchase insurance tailored to their own needs, not what some politico or pressure group or employer thinks they should have. Their coverage would be portable and thus not dependent on a particular job.

Most individuals would opt for a big deductible, which is, in effect, what we have done here at FORBES.

With free-market-oriented tax changes, tens of millions of Americans would police this market.

TALKING ABOUT DEDUCTIBLES...

Most corporate plans have a fixed amount for individuals and a fixed amount for families. At FORBES, the deductible is fixed at 1% of your salary. The more you earn, the more you pay. Isn't that a fairer approach?

MALPRACTICE

THE HEALTH INSURANCE ASSOCIATION OF AMERICA, representing 270 insurers, is calling for a major expansion of Washington's role in health care. They want a law requiring that all Americans have health coverage. The government would mandate "essential" benefits, but employees would be hit with taxes if their company plans were too "generous." Washington would have a larger role in controlling fees charged by doctors and hospitals.

Opinion

Low-cost doctor treated in sick way

Mike Royko

Getting sued for being a really nice guy must be a legal rarity. But that's what appears to have happened to Dr. William Klipfel, 36, a pediatrician.

Klipfel used to work at a clinic in Frankfort, Ill., in the far south suburbs of Chicago.

His clinic was a small satellite of the big Suburban Heights Medical Center in Chicago Heights, which is run by a board of directors made up of doctors.

Last November, Klipfel was fired. But not because he was incompetent, lazy, disliked by his patients, or dropped kids on the floor. To the contrary, his patients thought highly of him.

He got the boot because he wasn't charging enough and didn't order tests he thought unnecessary.

"Where I work," he says, "a lot of families are in trouble. With the economy, many of my families didn't have the money to cover the expensive tests and immunizations.

"So I ordered fewer tests than the other doctors, and if a patient came in for a recheck, for example, I wouldn't charge them anything.

"Look, some of these people had a large deductible or a large copayment. If they couldn't pay it, they'd wait to come in or sometimes not come in at all. I'm a doctor, you know."

Klipfel says the clinic officials warned him that he wasn't charging enough. "They raised their rates a year ago. The quality didn't go up. They just wanted us to jack up the fees. The average office fee went from $33 to $45. That's a lot of money during a recession, when people are losing their medical coverage."

The main clinic has its own lab and X-ray facilities. "Because I ordered fewer tests, I brought in less money. The more tests, the more money you make. They said what I was doing was wrong. But how much I should charge was not in my contract. I came up with what I thought was reasonable for the patients, and they threw me out on my ear."

But firing him wasn't enough for his former employers.

When he left, he received two months' severance pay. His contract included a non-competition agreement that said he wouldn't practice within 10 miles of the Chicago Heights clinic.

So he opened his own office in Frankfort. He says he thought it was more than 10 miles away because he had seen a highway sign that indicated it was.

However, his new office was about 8 miles from the Chicago Heights clinic.

And his former associates were upset because hundreds of his loyal and devoted patients followed him. But for some, finding him wasn't easy.

"When they phoned the clinic, it was as if I had dropped off the face of the Earth. I had left forwarding phone numbers, but the clinic employees were told by the board not to say where I was. So it was implied that I'd abandoned my patients, which is terrible."

But many of the patients had his home phone number or found it through directory assistance and were able to reach him when the clinic wasn't helpful.

(A reporter called the clinic and asked for him. A woman said: "We don't have a forwarding address or number. Try directory assistance. We don't have anything." Fortunately, the reporter wasn't someone with a sick kid.)

You would think that with all the hundreds of thousands of people in that part of the Chicago suburbs, there would be enough patients to go around.

But the Suburban Heights Medical Center, which filed the lawsuit, doesn't appear to think so. "Now they're claiming I'm doing irreparable harm to their corporation, but I never made up even 1 percent of their revenue," which he said amounted to about $30 million a year.

"They claim I'm violating my 'restrictive covenant.' But there are about 20 other similar doctors between my practice and the center. Also, I was fired, so the covenant isn't valid. You can't fire someone illegally, then deny them the right to make a living. And I also know of several doctors who left the clinic voluntarily and practice in the area. The corporation is mad because my patients came to me. But I didn't advertise. I did not solicit at all. But I'm their doctor.

"The corporation claims it owns these patients, that I should be barred from seeing them. They're trying to take away my ability to make a living, and they want an injunction slapped on the whole community from seeing me."

The lawyers for the clinic didn't return phone calls asking them for their side of the dispute. Which is understandable. When you go into court and complain that a doctor wasn't squeezing enough money out of his patients, what more is there to say: That it takes a lot of blood tests to buy a Mercedes Benz?

A judge is pondering the issues. I wouldn't be so presumptuous as to advise a judge. But I hope he noted that quite a few of Dr. Klipfel's patients came to court to talk about what a fine, dedicated physician he is.

On the other hand, there have been no reports of patients coming to court, waving their checkbooks, and saying: "Hooray for the corporation — I want to pay more, more!"

A Reappraisal of Hepatitis B Virus Vaccination Strategies Using Cost-Effectiveness Analysis

Bernard S. Bloom, PhD; Alan L. Hillman, MD, MBA; A. Mark Fendrick, MD; and J. Sanford Schwartz, MD

■ *Objective*: To determine clinical and economic consequences of alternative vaccination strategies for preventing hepatitis B virus infection (HBV).

■ *Methods*: Decision analysis was used to evaluate costs, outcomes, and cost-effectiveness of three HBV management strategies ("no vaccination," "universal vaccination," and "screen and vaccinate") in four populations (newborns, 10-year-old adolescents, a high-risk adult population, and the general adult U.S. population). Information on HBV incidence and prevalence, clinical course, and management of acute illness and chronic sequelae was obtained from the literature and a panel of experts. Actual payments (costs) were obtained from Blue Cross/Blue Shield and local pharmacies. Incremental cost-effectiveness was calculated from the perspective of the payer of medical care and subjected to sensitivity analysis.

■ *Results*: Vaccination (with or without screening) prevents more disease at somewhat increased cost than no vaccination for the neonatal, adolescent, and adult populations. Vaccination (with or without screening) is a dominant strategy in adult high-risk populations (lower cost and greater benefit than no vaccination). Optimal cost-effectiveness, with nonmonetary benefits not discounted, results if all pregnant women are screened for active HBV infection, and HBV vaccine and hepatitis B immune globulin are administered to babies born to mothers with positive screening tests. Then HBV vaccine is administered to all children at age 10 and again 10 years later (incremental cost-per-year-of-life-saved relative to the "no vaccination" strategy is $375). A strategy of universal newborn vaccination alone leads to an incremental cost-per-year-of-life saved of $3332. If adolescents are vaccinated at age 10, incremental cost-per-year-of-life saved is $13 938; for the general adult population, the incremental cost-per-year-of-life saved of universal vaccination is $54 524. Discounting benefits will increase cost-per-year-of-life saved 7 to 12 times for all strategies.

■ *Conclusions*: HBV vaccine is most cost-effective when a strategy of screening newborns is combined with routine administration to 10-year-old children. The means to achieve substantial improvements in the health of the public in a cost-effective fashion are now available and should be pursued aggressively.

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Hepatitis B virus (HBV) is the world's most common blood-borne viral infection, chronically infecting more than 200 million people worldwide (1). It is responsible for substantial morbidity and mortality and is a leading cause of hepatocellular carcinoma. Approximately 300 000 Americans are infected with HBV each year, an annual incidence rate of 11.5/10 000 population (2-3). Serologic evidence of previous infection is found in 4.8% of the U.S. population (4). Each year approximately 4000 persons in the United States die of HBV-related cirrhosis and about 800 people die of HBV-related hepatocellular carcinoma (3, 5, 6).

The goal of our study was to determine the clinical and economic impact of alternative HBV vaccination strategies for selected U.S. populations. This analysis updates the earlier work of Mulley and colleagues (7) by incorporating more recent data on incidence of HBV infection, cost of acute disease and chronic sequelae, and safety and effectiveness of HBV vaccine, by focusing on a broader range of populations, and by modeling a longer period.

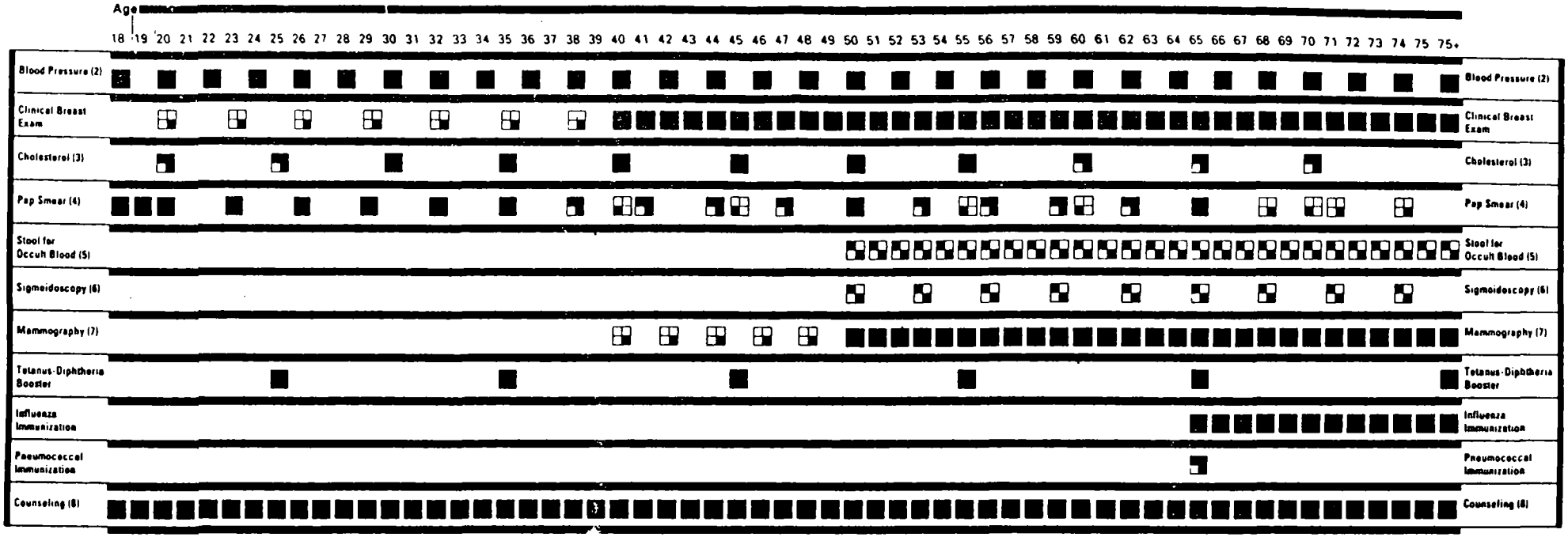
A safe and effective vaccine to prevent HBV infection was introduced in the United States in 1981. Nonetheless, the overall incidence of HBV infection increased 14.5% between 1981 and 1987 (2, 3), especially in selected high-risk groups (8) (77% increase between 1981 and 1988 among injection drug abusers). The clear relationship between HBV infection and primary hepatocellular carcinoma indicates that HBV vaccine is the first effective anti-cancer vaccine (6). However, the vaccine is not administered to most high-risk people (fewer than 50% of high-risk health care workers have received a complete HBV vaccination series) (3, 9, 10).

Acute HBV infection manifests itself clinically along a spectrum from asymptomatic, subclinical infection through fatal fulminant hepatitis (1, 5, 11). More than 50% of HBV infections in adolescents and adults in the United States are asymptomatic (2, 9, 12, 13). Others exhibit a variety of nonspecific viral symptoms; one quarter become ill with jaundice (3). More than 10 000 people with acute HBV infection are hospitalized annually (3). About 250 die each year of fulminant infection (3). Both asymptomatic and nonfulminant symptomatic HBV infection are similarly associated with chronic forms of infection, which, in turn, may lead to cirrhosis and hepatocellular carcinoma (1, 5, 6, 11, 14-16).

The epidemiology of HBV infection varies greatly by geography and sociodemographic factors (1-4, 17). Populations at greatest risk include those with multiple sex partners, sexually active male homosexuals, injection drug abusers, family members of HBV carriers, newborn children of actively infected mothers, medical personnel who are exposed to blood and blood products,

SPECIMEN # 4.

Figure 1. Preventive Care Guidelines for Asymptomatic, Low-Risk Adults: Recommendations from Various North American Health Organizations (1)



A blackened square indicates that the service is recommended. An empty square indicates that either a recommendation has been made to not provide the service or that no recommendation has been made for or against the service by the particular authority. The placement and spacing of squares indicate a suggested age range and frequency for testing rather than actual ages at which services should be provided.

ACP	USPSTF
CTF	OTHER

ACP American College of Physicians
USPSTF US Preventive Services Task Force
CTF Canadian Task Force on the Periodic Health Examination
Other Immunization Recommendations - CDC Immunization Practices Advisory Committee.
Cholesterol Recommendations - National Cholesterol Education Program Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults.
Hypertension Recommendations - Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure.
Cancer Screening Recommendations - American Cancer Society.

Harward Steinberg, Ford Rozen Roach

1. This list shows selected, age-specific preventive care services recommended by at least one of the ACP, CTF, or USPSTF, which should be offered to persons who do not have a family history, symptoms, signs, or other diseases that place them at increased risk for preventable target conditions. All authorities stress the importance of determining each person's unique risks for preventable disease in order to individualize preventive care. Strategies for the selective provision of a wider range of services to persons at low and increased risk for particular target conditions are found in Tables 2 through 5.

2. The CTF recommends screening at least every 5 years and at every clinical encounter. Others agree or suggest screening every 2 years.

3. The CTF recommends periodic serum cholesterol testing in men between the ages of 30 and 59 years. The USPSTF recommends determinations in middle-aged men and suggests that testing of young men, women, and the elderly may be clinically prudent.

4. ACP and USPSTF recommend a Papanicolaou smear for women over 65 years of age who have had consistently normal smears in the previous decade. CTF suggests Papanicolaou smears every 3 years before 35 years of age and every 5 years to 74 years of age, after two normal annual smears following the onset of sexual activity.

5. CTF and USPSTF concluded that there is insufficient evidence to recommend for or against fecal occult blood testing.

6. ACP recommends sigmoidoscopy every 3 to 5 years or air contrast barium enema every 5 years. Neither the CTF nor the USPSTF recommends for or against screening sigmoidoscopy.

7. American Cancer Society recommends annual or biennial mammography for women from 40 to 49 years of age.

8. ACP, USPSTF, and CTF emphasize that all adults should be routinely counseled about tobacco use, nutrition, exercise, sexual behavior, substance abuse, injury prevention, and dental care.