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First Lady's Office
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FOLDER TITLE:

[Media] [loose] [2]

2013-0359-S

ry1429

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

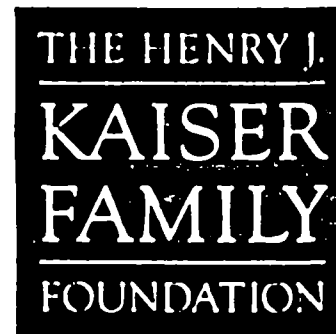
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION

(AS OF DECEMBER 22, 1993)



PREPARED FOR THE KAISER HEALTH REFORM PROJECT

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OVERVIEW

Issue	American Health Security Act of 1993 HR 1200/S 491 McDermott/Wellstone	Health Security Act HR 3600/S 1757 President Clinton/Gephardt/Mitchell	Health Equity and Access Reform Today Act of 1993 -- HR 3704/S 1770 Thomas/Chafee	Managed Competition Act of 1993 HR 3222/S 1579 Cooper/Breaux	Affordable Health Care Now Act of 1993 HR 3080 Michel	Consumer Choice Health Security Act of 1993 -- S 1743 Nickles
Coverage/ Approach	Universal, mandatory coverage of all citizens and legal residents by 1995 through a "Canadian-style" single payer system of federal government-sponsored health insurance administered by states.	Universal, mandatory coverage by 1998 of all citizens and legal residents who do not receive Medicare, through a system of subsidized private group health insurance administered by states and purchasing alliances. Financed through a combination of individual, employer, federal payments, and state contributions for low-income persons and small employers.	Universal, mandatory coverage by 2005 of all citizens and legal residents who do not receive Medicare through use of a system of subsidized private group health insurance administered by states and purchasing alliances. Financed through a combination of individual premiums, voluntary employer premiums, and federal and state contributions for low-income persons and small employers.	Universal, voluntary coverage through group purchased private insurance for persons not covered by Medicare through a system administered by states and regional purchasing pools. Financed through individual and voluntary employer contributions, state and federal subsidies available for low-income persons and small employers.	Improved access to private health insurance for persons not covered by Medicare through insurance practice and coverage reforms and through new program of insurance subsidies for Medicaid beneficiaries and other low-income persons.	Mandate to individuals not eligible for Medicare to purchase private health insurance, through system administered by federal government and financed through individuals premiums and subsidies for low-income persons.
Benefits/ Cost-Sharing	Comprehensive, explicitly defined benefit package coverage primary, acute, and long-term care benefits, with no cost-sharing.	Explicitly defined benefit package consisting of primary and acute benefits, with specific permissible cost-sharing levels. Health insurance benefits supplemented with services for persons with developmental, chronic and long-term care illnesses and conditions through continuation of Medicaid and a new long-term care block grant.	Broadly described benefit package; legislation indicates several categories of items and service coverage, with an emphasis on primary and acute care benefits. Cost-sharing permitted.	Coverage rules left to a national commission, which is given broad direction to develop within certain guidelines that assure coverage of preventive and diagnostic services. Cost-sharing permitted.	Broadly defined minimum requirements for standard and catastrophic benefit packages to be offered by employers and to individuals, with authority delegated to NAIC to develop actuarial coverage standards. Benefits not stated in terms of defined content but rather in terms of actuarial value. Cost-sharing permitted.	Broadly defined categories of benefits that must be offered by participating health insurance plans, with authority in HHS and state insurance commissions to develop and enforce coverage standards. Cost-sharing permitted.
Financing	Both insurance coverage and other reforms financed through a combination of new taxes, consolidation of Medicare and federal Medicaid expenditures, state contributions and premiums for long-term care.	Insurance coverage financed through mandatory employer contribution, individual premiums, state and federal contributions, reductions in Medicare and Medicaid spending, taxes on large corporations, and sin taxes. Other provisions financed through special taxes on insurers and general revenues.	Insurance and other reforms financed through individual contributions, voluntary employer contributions and Medicare and Medicaid spending reductions. Other reforms financed through general revenues.	Insurance financed through individuals and voluntary employer contributions and Medicare and Medicaid spending reductions. Other reforms financed through general revenues.	Insurance financed through individual and voluntary employer contribution and through Medicare and Medicaid spending reductions. Other reforms financed through general revenues.	Insurance financed through individual contributions and through Medicare and Medicaid spending reductions. Other reforms financed through general revenues.
Cost Containment	Enforceable federal budget accompanied by the elimination of private insurance and government spending controls over pricing.	Enforceable federal budget for insurance premiums paid by employers, individuals and the federal and state government, supplemented with reforms designed to increase price competition among private insurers. Limitations on the deductibility of private insurance premiums to spur competition, accompanied by Medicaid and Medicare spending reductions.	Increased price competition among insurers through market reforms, limits on the deductibility of health insurance to spur competition, caps on Medicaid spending, Medicare cuts and Medicaid spending reductions.	Increased emphasis on price competition through insurance market reform, accompanied by limits on the deductibility of private insurance costs. In addition, Medicaid is repealed and replaced with low-income assistance capped program. Medicare spending is reduced, and all federal contributions for state long-term care Medicaid programs are ended.	Increased emphasis on price competition through market reform. Reductions in Medicaid spending through caps on the cost of acute care and the creation of a new capped health allowance program. Medicare spending reductions also proposed.	Termination of employer insurance expense deductions and employer exclusion, limitations on the deductibility and favorable tax treatment of individual tax expenditures. Caps on federal payments for Medicaid acute care coverage expenses, other Medicaid spending reductions, and Medicare savings.
Administration	Federal and state administration.	Federal and state administration, with use of mandatory regional and employer purchasing cooperatives.	Federal and state administration, with use of small employer and individual purchasing cooperatives.	Federal and state administration, with use of mandatory purchasing cooperatives for individuals and small firms.	Federal and state administration.	Federal and state administration.
Medicare	Consolidated with new insurance plan.	Retained, but with state option to consolidate with new insurance plan.	Retained.	Retained.	Retained.	Retained.
Medicaid	Consolidated with new insurance plan.	Partially consolidated into new system with respect to those Medicaid benefits now covered by the health benefit plans. Medicaid benefits not covered by health plans generally still available to Medicaid eligible persons.	Consolidated with health plans at state option. Medicaid benefits not covered by health plans still available to Medicaid eligible persons.	Repealed and replaced by low-income assistance program. Responsibility for Medicaid services not covered by health plans relegated entirely to states without federal financial participation.	Revised to give states authority to purchase private insurance for Medicaid beneficiaries and other low-income people. Medicaid spending capped.	Medicaid revised to permit states to buy insurance for beneficiaries and low-income persons. Medicaid spending capped.
Access to Care	A defined portion of health budget allocated to resource development for underserved.	Requests funding for resource development for underserved.	Requests funding for new resource development for underserved.	A defined portion of health budget allocated to resource development for underserved.	Requests funding for new resource development for underserved.	Requests funding for new resource development.

**SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION
A PRODUCT OF KAISER HEALTH REFORM PROJECT
DECEMBER 22, 1993**

LEGISLATION:

American Health Security Act of 1993 (Rep. McDermott/Sen. Wellstone)
Health Security Act (President Clinton; Rep. Gephardt/Sen. Mitchell)
Health Equity and Access Reform Today Act of 1993 (Rep. Thomas/Sen. Chafee)
Managed Competition Act of 1993 (Rep. Cooper/Sen. Breaux)
Affordable Health Care Now Act of 1993 (Representative Michel)
Consumer Choice Health Security Act of 1993 (Senator Nickles)

CRITERIA:

1. General Approach
2. Coverage
3. Scope of Coverage Pools
4. Benefits
5. Federal Costs
6. Effect on Overall National Health Costs
7. Federal Financing
8. Premiums, Cost-Sharing, and Out-of-Pocket Payments
9. Tax Treatment of Health Insurance
10. Cost Containment
11. Federal Administration
12. Provider Reimbursement
13. Phase-In of Coverage
14. Coverage of Older Persons
15. Coverage of Low-Income Persons
16. Coverage of Persons with Disabilities
17. Treatment of Medicare
18. Treatment of Medicaid
19. Reforms in Health Insurance
20. Reforms in Health Care Access
21. Reforms in Health Professions Education
22. Managed Care
23. Quality
24. Protections for Individuals
25. Malpractice Reform

SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION DECEMBER 1993

	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 401	HEALTH SECURITY ACT HR 3600/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
	SPONSOR AND # OF COSPONSORS		McDermott (D-WA)/ Wellstone (D-MN) 93 In House/4 In Senate	(President Clinton) Gephardt (D-MO)/ Mitchell (D-ME) 100 In House/30 In Senate	Thomas (R-CA)/Chafee (R-RI) 4 In House/23 In Senate	Cooper (D-TN)/Breaux (D-LA) 52 In House/4 In Senate	Michel (R-IL) 130 In House	Nickles (R-OK) 25 In Senate
1	GENERAL APPROACH	- Public/Private mixture - Voluntary system - Administered by insurance companies, States, Federal government, and large and small businesses	Individual entitlement to government-sponsored health insurance secured through mandatory enrollment in State-administered programs and financed through various taxes	Individual entitlement to health coverage secured through mandatory enrollment in private health plans offered by health alliances and financed through a combination of individual and employer premiums and government assistance	- Individual entitlement through mandatory enrollment in qualified health plans offered through purchasing cooperatives, large employer plans or a government program - Financed through individual and employer premiums, changes in tax deductibility and government assistance	Voluntary program that establishes cooperative arrangements to improve access to affordable health coverage, conditions tax exemptions for coverage on enrollment through purchasing cooperatives, provides subsidies for low income individuals and reforms insurance practices	Voluntary program that reforms and standardizes group health insurance sales practices and provides expansion of Medicaid coverage for low-income individuals	Voluntary program imposing financial penalties for individuals who fail to enroll in a private health insurance plan, with restructuring of tax deductibility of health care coverage, and redistribution of Medicaid funds to expand access for low-income individuals
2	COVERAGE	- Voluntary coverage 84% under 65 had insurance coverage in 1991¹ --62% employer-related insurance¹ --8% individual coverage¹ --11% received Medicaid¹ --16% uninsured¹ - One in four Americans lost health insurance in two year period between 1987 and 1989² 98% of elderly receive Medicare 3.2 million undocumented persons in the U.S., heavily concentrated in five States³	- Universal and mandatory coverage of all US citizens and legal residents by 1995 - Covers undocumented persons if National Board or States expand eligibility - Employers are assessed a payroll tax to pay for program - Other revenues used to cover costs of coverage	- Universal and mandatory coverage of all US citizens and permanent legal residents by 1998 - Excludes undocumented persons - Employer mandate to help pay for coverage by paying 80% of the average family premium (divided by the average number of workers per family and adjusted by family type) - Individual mandate to purchase coverage with subsidies for low-income individuals through regional alliances - Imposes penalty for non-compliance equal to double cost of average premium	- Promise of universal and mandatory coverage of all lawful permanent residents by 2005 - Excludes undocumented persons - Individual mandate to purchase coverage in long-term, with federal subsidies for low-income individuals - Requires employers to offer, but not pay for, coverage - Imposes penalty for individuals failing to obtain coverage equal to 120% of the average yearly premium in a local area (low-income protected from penalties)	- No coverage mandate - Expands access to health insurance coverage through insurance marketing reforms - Undocumented persons who do not work are excluded - Requires employers to offer, but not pay for, coverage - Government subsidies available for low-income individuals - Allows individuals tax deductions for their share of plan premiums	- No coverage mandate - Expands access to health insurance coverage through insurance marketing reforms - Silent on coverage of undocumented persons - Requires employers to offer, but not pay for, coverage	- No coverage mandate, but strong financial penalty (elimination of personal tax exemption) for failing to purchase catastrophic insurance by 1997 - Silent on coverage of undocumented persons - Employers currently offering coverage must maintain until 1997 and pay difference in wages if they cash-out their plan after that date - Individuals responsible for paying for coverage and health care - Provides personal income tax credits to offset health care costs

SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION DECEMBER 1993

	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 491	HEALTH SECURITY ACT HR 3600/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
3	SCOPE OF COVERAGE POOL	• Private insurance sold by more than 1,500 insurance companies • Insurance pools range from single persons to large corporations (5,000+ employees) • Private insurance regulated by States • Medicaid is a separately administered Federal/State coverage pool • Medicare is federally administered insurance	• Single pool administered by each State • Establishes National Health Board to interpret standards for benefits and to assist States in developing budgets • States must meet Federal standards	• Requires States to establish one or more regional alliances that are non-profit corporations or State agencies which oversee insurance companies and providers --A Metropolitan Statistical Area may not have more than one alliance --Alliances must be big enough to negotiate effectively --Alliances cannot cross State lines • Requires employers and individuals to purchase insurance exclusively through their regional alliances which negotiate rates, pay premiums to plans, and provide consumer information on price and quality • Allows States to establish statewide or alliance-wide single payer systems • Allows large corporations (5,000 employees), Taft Hartley Trusts, rural electric and telephone cooperatives to create corporate alliances • State and Federal employees are included in regional alliances • Allows States to include Medicare beneficiaries in regional alliances through Federal waiver	• Requires States to establish health care coverage areas for small employers, less than 100 employees --Allows more than one purchasing group to operate in a geographical area --Limits the type of State agencies that may act in an alliance role • Individuals and small employers may join on voluntary basis • Requires larger employers, more than 100 employees, to offer the standard or catastrophic benefits package • States may opt out of national plan to implement alternative reforms if they meet certain financial requirements	• Requires that States establish Health Plan Purchasing Cooperatives (HPPCs), State-chartered non-profit cooperatives, for individuals and businesses with no more than 100 covered employees --Limits the type of State agencies that may act as a purchasing cooperative --Requires cooperatives to have exclusive service territories • Requires individuals and employers with fewer than 100 employees to purchase through the cooperative to maintain tax deductibility • Allows employers with more than 100 employees to directly purchase an Accountable Health Plan (AHP) • Allows large employers to form their own group purchasing arrangements * States may increase above 100 as long as no more than half of employees in the State would purchase through HPPCs as a result	• Allows States the option to establish voluntary insurance purchasing cooperatives for small employers • Allows existing employer and group plans to continue • Allows individual consumers to act as their own purchasing agents	• Individual consumers will act as their own purchasing agents • Allows existing employer and group plans to continue without tax deductions • Changes in tax treatment allow individuals to choose among insurance plans • Employers currently offering coverage are required to add the value of insurance to their workers' wages if they decide to cash-out benefits

SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION DECEMBER 1993

	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 481	HEALTH SECURITY ACT HR 3600/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
4	BENEFITS	• No standard benefits package	• Uses medically necessary and appropriate as general standard • Mandates comprehensive benefits package, specified in the statute • Includes inpatient and outpatient services, professional services of state-authorized practitioners, community-based primary health services, outpatient therapy, home dialysis, emergency ambulance services, prosthetic devices, DME, prescription drugs and biologicals, and prenatal and well child care • Family planning services are included in benefits • Preventive services included without cost-sharing • Mental health services and chemical dependency treatment are included • Long-term care benefits include home and community-based long-term care, nursing facility services, home health services, and hospice care • No exclusions of abortion • Additional benefits and clarification provided by National Health Board • Allows States and employers to provide additional benefits at their own expense	• Uses medically necessary and appropriate as general standard • Mandates comprehensive standard benefits package, specified in statute • Includes inpatient and outpatient hospital services, emergency and ambulatory medical services, services of physicians and other health professionals, ambulance services, laboratory/diagnostic services, DME, prosthetics and orthotics, extended care services, outpatient rehabilitation services following an acute illness, eyeglasses for children under age 18, prescription drugs, preventive and emergency dental care coverage, and health education classes • Clinical preventive services without cost-sharing • Family planning services included in benefits • Initially includes limits on mental health and substance abuse services; by 2001, expands these services • Creates new long-term care program (non-entitlement) for home- and community-based care through grants to States • No exclusions of abortion • National Health Board to interpret benefits package and modify preventive benefits • Allows individuals to purchase supplementary insurance • Preempts State mandated benefit laws for group health plans	• Uses effective and appropriate as general standard • Requires qualified health plans to offer standard benefits package or combination of catastrophic benefits package and medical savings accounts to small businesses • Specific benefit levels to be clarified by National Benefits Commission, after enactment • Standard package to include services under the following broad categories: medical and surgical services and equipment, prescription drugs and biologicals, rehabilitation and home health services related to an acute care episode, hospice, and transportation • Preventive health services included, not established whether cost-sharing required • Severe mental health and substance abuse services are covered • Long-term care services are not included in standard package • No exclusions of abortion • Additional services and lower cost-sharing may be offered separate from standard package • Preempts State mandated benefit laws for group health plans	• Uses medically necessary and appropriate as general standard • Requires all plans to offer standard benefits package • Includes broad outline of covered services, benefits to be established, after enactment, by Health Care Standards Commission • Requires standard benefits package to include full range of preventive services with no cost-sharing • Silent on issue of family planning • Mental health and substance abuse benefits are not specified in the bill • Long-term care benefits are not included in benefits package • No exclusions of abortion • Allows plans to offer supplemental benefits as long as they are non-duplicative and offered separately • Preempts State mandated benefit laws for group health plans	• No standard benefits package • Insurers are required to offer small employers a choice of three plans: standard coverage, catastrophic coverage, and a medical savings account • Establishes broad definitions of the three types of plans and requests National Association of Insurance Commissioners to determine actuarial value of coverage • Allows insurers to create any benefits package for small employers that fits within 5 percent of actuarial value • Silent on issues of preventive care, substance abuse and mental health and long-term care • No exclusions of abortion • Preempts State mandated benefit laws for group health plans	• Imposes penalty for not obtaining at least a catastrophic benefits package • Establishes broad categories that benefits package is required to meet • Catastrophic benefits package must include at least medically necessary acute care services: physician services, inpatient, outpatient and emergency hospital services, and inpatient and outpatient prescription drugs • Benefit package not required to include preventive services, mental health and substance abuse, or long-term care services • Explicitly states that benefits package does not have to include abortion services • Preempts State mandated benefit laws

SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION DECEMBER 1993

	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 491	HEALTH SECURITY ACT HR 3800/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
5	FEDERAL COSTS ¹	• Federal spending on Medicaid \$65 billion dollars in 1992 • Federal spending on Medicare \$130 billion in 1992	• Rechannels approximately \$370 billion per year in current private spending to the Federal government through tax system, replacing most private spending • States pay providers, hospitals and nursing homes	• Treasury Department estimates \$390 billion in Federal funds over 5 years to pay for plan • Estimates \$57.7 billion reduction in the budget deficit over five years	• \$213 billion cost of low-income subsidies, 1997-2005; only implemented after savings realized in Medicaid and Medicare and tax revenue increases • Budget neutral to the Federal deficit	• \$25 billion in Federal funding per year or \$125 billion over 5 years to implement • Budget neutral to the Federal deficit	• \$17 billion in additional Federal costs to implement reforms over 5 years • Budget neutral to Federal deficit	• \$133 billion in additional Federal costs to finance tax changes between 1997-1999 • Budget neutral to Federal deficit
6	EFFECT ON OVERALL NATIONAL HEALTH COSTS	• Total health care spending 13.6% of GDP in 1991 • Lewin/VHI estimates total spending without health reform at \$1.63 trillion in 2000	• Bill sponsors estimate total spending at \$1.47 trillion in 2000	• Lewin/VHI estimates total health care spending to be \$1.57 trillion in 2000	• Not specified	• Not specified	• Not specified	• Not specified
7	FEDERAL FINANCING	• General tax revenues finance Medicaid, Medicare, CHAMPUS, Veteran's Administration and the Public Health Service	• Federal financing through employer payroll tax and sin taxes • Details of financing are still under revision • Eliminates employer and individual premiums for health insurance which covers services in the comprehensive benefit package	• Estimates 5 year revenues of \$89 billion from cigarette and corporate alliance taxes • Estimates 5 year revenues of \$124 billion from spending reductions in Medicare; \$65 billion from Medicaid • Estimates 5 year revenues of \$40 billion from other Federal programs • Estimates 5 year revenues of \$71 billion as a result of limits on tax exempt health spending, and other changes • Caps Federal spending: \$10.3 billion in 1996; \$28.3 billion in 1997; \$75.6 billion in 1998; \$78.9 billion in 1999; and \$81.0 billion in 2000	• Estimates 5 year revenues of \$213 billion from reductions in growth of Medicare and Medicare spending	• Slows the rate of growth in Medicare by \$40 billion over 5 years • Phased-in elimination of disproportionate share hospital payments • Increases premiums for Medicare Part B for high-income Americans • Caps employer tax deductions to lowest cost qualifying accountable health plan, raising \$16 billion per year • Imposes 1% premium tax on Accountable Health Plans to fund new GME program • Repeals Medicaid program, generating unspecified Federal savings	• Estimates 5 year revenues of \$13 billion by increasing Federal retirement age from 55 to 62 and prefunding retirement health insurance costs • Estimates 5 year revenues of \$4 billion by phasing out Medicare subsidies for seniors with incomes over \$100,000	• Estimates revenues of \$72 billion between 1995-1999 from reductions in the growth of Medicaid spending • Estimates revenues of \$67 billion between 1995-1999 from changes in the Medicare program

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8	PREMIUMS, COST-SHARING, AND OUT-OF-POCKET PAYMENTS	• Average 1991 premium for private insurance⁶: --Individual, \$1,700 --Family, \$4,200 • Employers contributions to insurance premiums are voluntary --Employers contribute for 75% of full-time employees and 8% of part-time employees --Average contribution levels are: 88% for individual and 70% for families • Cost-sharing levels: --HMO and Point of Service range from \$4 to \$8 copayments per visit --Typical coinsurance amounts in fee-for-service plans are 20% • Out-of-pocket limits range from less than \$500 up to \$5,000 and higher • In a recent Kaiser/Commonwealth/Harris survey, 33% of Americans reported paying more than \$500 out-of-pocket last year for health care	• No premium payments required for acute care • Premiums required for long-term care • No deductibles, copayments, or coinsurance is required of individuals for acute or preventive care • Requires copayments for long-term care • Providers must accept reimbursement as payment in full and cannot bill individuals for additional amounts	• Premium payments required and limited by premium caps • Mandates employers in regional alliance to pay 80% of average family premium for full-time employees and their families (> 30 hours/week), with pro-rated contributions for part-time workers and families (> 10 hours/week) • Individuals (other than AFDC and SSI beneficiaries and certain retirees) and families contribute 20% of cost for the average weighted premium plus excess, if they choose above-average plan • Non-workers, other than AFDC and SSI recipients, responsible for 100% of premiums w/ discounts • Cash assistance welfare recipients pay nothing; Federal/State governments subsidize full payment • Premium discounts available for: --Non-working individuals with unearned income under 250% poverty (80% share) --Low-income families under 150% poverty (20% share) --Low-wage workers in corporate alliances • Family premiums capped at 3.9% for families with incomes under \$40,000 • Establishes three cost-sharing schedules: low cost-sharing (HMO-type plans), high cost-sharing (fee-for-service plans), and combination cost-sharing (preferred provider organizations) • Cost-sharing assistance offered to welfare recipients only in HMO-type plans • Providers must accept reimbursement as payment in full	• Premium payments required • Places no limit on premiums • Requires employers to offer, but not pay for, coverage • Phases-in Federal premium assistance vouchers to individuals with incomes of below 90% of the Federal poverty level by 1997; to 110% by 1998; to 130% by 1999; to 150% by 2000; to 170% by 2001; to 190% by 2002; to 210% by 2003; to 230% by 2004; and to 240% by 2005 • Cost-sharing levels to be determined by Benefits Commission • Does not specify out-of-pocket limits • Cost-sharing assistance provided for Medicaid beneficiaries	• Premium payments required • Places no limit on premiums • Requires employers to offer, but not pay for, coverage • Full premium assistance available for low-income populations under 100% of poverty level with sliding scale up to 200% • Benefits Commission will specify copayment, deductible and out-of-pocket limits after enactment • Requires cost-sharing, except for preventive services • Nominal cost-sharing for low-income individuals • Providers must accept reimbursement from insurers as payment in full for services	• Premium payments required • Places limits on insurance premium rate variations charged to small businesses • Requires employers to offer, but not pay for, coverage • Provides subsidies for low-income individuals to buy into Medicaid • Individual cost-sharing levels are not specified	• Premium payments required • Places no limit on premiums • Establishes maximum limit on individual and family deductibles of \$1,000 and \$2,000, respectively, indexed to inflation in future years • Establishes \$5,000 limit on annual family out-of-pocket costs, indexed to inflation • Does not specify cost-sharing amounts under the aggregate limits • Assistance for health care costs provided through individual income tax credits

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	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 491	HEALTH SECURITY ACT HR 3600/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
9	TAX TREATMENT OF HEALTH INSURANCE	• Employer health contributions are 100% tax deductible • Employee contributions have 100% tax exclusion • Self-employed purchasers can deduct 25% of insurance costs • Long-term care insurance not tax deductible • Individuals can deduct unreimbursed medical expenses which exceed 7.5% of adjusted gross income	• Not applicable, private health insurance will be virtually eliminated • Program is financed through new employer payroll taxes and sin taxes • Imposes long-term care premium/tax on persons over 65 of \$65 per month (exemptions for low-income elderly)	• Raises deduction for self-employed to 100% • Effective January 1, 2004, eliminates exclusion from employee income of employer-paid health benefits beyond those required under the Act • Terminates tax exclusion for employee flexible spending accounts • Medical savings accounts are not available • Provides the same tax benefit for long-term care insurance as other health insurance	• Allows all individuals to deduct 100% of the cost of their health insurance premiums, up to a specified tax cap • Tax cap on individual exclusion is equal to lowest one-half of certified plans in an area • Medical savings accounts are available and tax deductible • DHHS determines tax treatment of multiple employer trusts • Provides the same tax benefit for long-term care insurance as other health insurance	• Allows all individuals to deduct 100% of the cost of their health insurance premiums, up to the tax cap • Self-employed insurance tax deductible up to the cap • Caps deductibility at the lowest cost plan in a region which offers standard benefits package and meets minimum quality and enrollment criteria • Silent on tax treatment of long-term care	• Raises deduction for self-employed to 100%; provides deductions for employees who purchase own insurance • Phases in deduction for previously uninsured who are not offered employer coverage • Medical savings accounts and catastrophic coverage fully tax deductible • Provides the same tax benefit for long-term care insurance as acute insurance; gives option to use IRAs, 401(k) plans or life insurance to purchase long-term care coverage	• Eliminates tax deductibility of health insurance • Replaces with refundable income tax credits for health care expenditures on sliding scale: --25% credit for health spending under 10% adjusted gross income (AGI) --50% between 10%-20% of gross income --75% over 20% of AGI • Allows 25% credit for medical savings account up to \$3,000 per individual • Long-term care would receive preferred tax treatment • Personal income tax exemption is disallowed as a penalty for being uninsured
10	COST CONTAINMENT	• Utilization review and other managed care arrangements in the private sector • Prospective payment system, utilization review, RBRVS-based fee schedule under Medicare • Low provider reimbursement and movement to managed care in Medicaid	• Establishes annual global budgets for health care, limiting growth in expenditures to GDP • State sets physician fees, hospital and nursing home budgets • National Health Board negotiates prescription drug prices with drug companies • Sets separate budgets for capital projects, such as new equipment • Administrative savings	• Sets limits on insurance premiums paid by individuals, employers, State and Federal governments • Promotes price cuts through managed competition • Imposes limits on Medicare and Medicaid spending and Federal subsidy payments • Changes in tax provisions to limit tax deductibility • Medical malpractice reform • Administrative savings	• No global budgets or premium limits • Managed competition among health plans in insurance purchasing cooperatives for individuals and small businesses • Reductions in Medicare and Medicaid spending growth • Changes in tax provisions to limit tax deductibility • Reforms medical malpractice • Administrative savings	• No global budgets or premium limits • Managed competition among accountable health plans • Reductions in Medicare spending growth • Repeal of Medicaid • Changes in tax provisions to limit tax deductibility • Medical malpractice reform • Administrative savings	• No global budgets or premium limits • Voluntary managed competition • Encourages price competition among insurers • Reductions in Medicare spending growth • Medical malpractice reform • Administrative savings	• No global budgets or premium limits • No managed competition • Price competition among insurers for consumers • Reductions in Medicare and Medicaid spending • Changes in tax provisions to limit tax deductibility • Medical malpractice reform • Administrative savings
11	FEDERAL ADMINISTRATION	• Medicare is federally administered by DHHS • Medicaid is a joint Federal/State administered program • Limited Federal oversight of private health insurance market beyond assuring solvency	• Establishes National Health Board to set standards for benefits and to assist States in developing budgets • States must meet Federal standards	• Creates a National Health Board within Administration to determine benefits, set national and regional budgets and determine compliance • Oversight by the National Health Board and Departments of Health and Human Services, Labor and Treasury • Federal administration of regional alliances, for 15% fee, if States fail to establish • Permits regional alliances to borrow Federal money to cover cash-flow shortfalls	• Creates a Health Standards Commission to recommend specific benefits and cost-sharing levels to Congress • Federal government monitors multi-State plans • Federal government will set up purchasing cooperatives if States fail to establish	• Creates independent Health Care Standards Commission to determine the specific benefits covered in standard benefit package, risk adjustment factors and outcomes reporting requirements • Creates private sector advisory board to advise Commission	• Creates Office of Private Health Care Coverage within Department of Health and Human Services • Establishes an Office of Emergency Medical Services to coordinate rural access to emergency care • Combines administration of Medicare Part A and Part B	• No new Federal administration • Secretary of DHHS, with the National Association of Insurance Commissioners, develops guidelines for Federally qualified health plan, proposes health insurance market reforms, and suggests non-binding rating standards

SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION DECEMBER 1993

	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 481	HEALTH SECURITY ACT HR 3600/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
12	PROVIDER REIMBURSEMENT	• Fee-for-service paid at some percentage of usual and customary rate charged by providers in an area • Medicare RBRVS fee schedule established by Federal government • Medicaid fee schedule established by States • Capitated plans negotiate rates with individual providers • Medicare and Medicaid disproportionate share payments are made to hospitals that care for the uninsured	• Pays hospitals and nursing homes based on global budgets established annually • Reimburses other facility-based services, including outpatient services, home-, school- and community-based services, through annual operating budgets, fee schedules, capitation payments or an alternative prospective payment method • Reimburses independent health care professionals based on fee schedules negotiated at the State level • Can pay community health service organizations (HMOs) an annual capitated rate • Prohibits balance billing by providers	• Capitated health plans negotiate rates with individual providers similar to current situation (anti-trust reforms permit provider negotiations) • Alliance or State develops fee schedules for fee-for-services plans • Allows for reimbursement for specified services which would be furnished by a physician but could be performed by a health professional who is licensed to perform such services in the State • Designated essential providers have minimum reimbursement protection • Reimbursement for emergency and urgent care provided outside alliance service area according to FFS schedule in alliance where services provided • Replaces Medicaid disproportionate share (DSH) payments with smaller vulnerable population adjustment and reduces Medicare DSH payments • Prohibits balance billing (both under comprehensive benefit package and Medicare)	• Provider payment methodology is not specified • DSH payments to providers for uncompensated care are phased out by 2000	• Payment methods to providers are not specified • Medicaid DSH payments are eliminated with the repeal of the program on January 1, 1995 • Prohibits balance billing by providers in qualified health plans	• Payment methods to providers are not specified • Medicaid DSH payments to providers can be used by States to expand insurance coverage	• Payment methods to providers are not specified • Medicaid DSH payments to providers are converted into grants to States to expand coverage
13	PHASE-IN OF COVERAGE	• In 1992, according to March Current Population Survey, 39 million Americans were uninsured	• Begins 1/1/95	• Allows participating States to start in 1996 • Requires States to have an approved plan by 1/1/98 • Corporate alliances may not start until 1/1/98	• Requires individuals to have insurance by 2005 • Phases-in Federal premium assistance to individuals with incomes of below 90% of the Federal poverty level by 1997; to 110% by 1998; to 130% by 1999; to 150% by 2000; to 170% by 2001; to 190% by 2002; to 210% by 2003; to 230% by 2004; and to 240% by 2005	• Enrollment in HPPCs, low-income assistance and tax reforms begin on January 1, 1995	• Insurance reforms begin on January 1, 1997 • Implements malpractice reforms three years after enactment of legislation	• Tax changes take effect on December 31, 1996 • Grants to States for low-income uninsured issued between 1997-2000 as DSH payments are phased out • Medicaid and Medicare reductions begin in FY 1995

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14	COVERAGE OF OLDER PERSONS	• Virtually all (98%) elderly have Medicare • Some have supplemental medigap insurance • Some receive supplemental benefits and premium and cost-sharing assistance from Medicaid • Some have only Medicare • Long-term care purchased out of pocket or financed by Medicaid after "spending down"	• Integrates Medicare • Folds Medicare beneficiaries into State systems --Eliminates cost-sharing and deductibles --Expands benefit package to include prescription drugs and other benefits not currently offered • Eliminates need for supplemental private insurance for the elderly • Qualified Medicare Beneficiaries (QMBs) on Medicaid would have no cost-sharing or deductibles • Introduces new long-term care program for persons with 3 or more activities of daily living (ADLs) impairments	• Maintains Medicare as separate program with individual options to integrate: --Requires Medicare-eligible people who work to stay in health alliance --Permits certain Medicare retirees to remain with their regional alliance health plans • Expands benefits to include new outpatient prescription drug benefit • Imposes a co-insurance on laboratory services • Reduces overall Medicare spending growth • Provides 80-100% payment of regional alliance plan premiums in the case of early retirees (ages 55 to 64) • QMBs remain covered under Medicaid • Establishes an expanded long-term care program (mainly home- and community-based services for severely disabled persons) through grants to the States	• Maintains Medicare as a separate program --Individuals have option to enroll in qualified health plans --Requirement to purchase insurance is met by enrolling in Medicare • No new benefits; expands SELECT program to enroll more beneficiaries in HMOs • Imposes a co-insurance on laboratory and home health services • Applies means-tests to Part B premiums • Reduces overall Medicare spending growth • QMBs on Medicaid continue as is • No long-term care program	• Maintains Medicare as a separate program --Allows Medicare beneficiaries to enroll in AHPs --May also remain in current program • Expands Medicare benefits to cover preventive services • Expands SELECT program to enroll beneficiaries in HMOs • Increases Part B premium for high-income individuals • Reduces overall Medicare spending growth • Provides cost-sharing subsidies for low-income elderly similar to current Medicaid • No long-term care program	• Maintains Medicare as separate program • No new benefits; expands SELECT program to enroll more beneficiaries in HMOs • Increases Medicare Part B premiums for high-income elderly • QMBs remain covered by Medicaid • No long-term care program	• Maintains Medicare as separate program • No new benefits are added • Imposes coinsurance for laboratory services, certain home health care services and skilled nursing facilities • Reduces overall Medicare spending growth • QMBs remain covered under Medicaid • No long-term care program • Secretary of HHS to conduct feasibility study of allowing future Medicare beneficiaries to retain private health insurance coverage in lieu of Medicare

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	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 491	HEALTH SECURITY ACT HR 3600/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
15	COVERAGE OF LOW-INCOME PERSONS	• In 1991, Medicaid covered 46% of persons with incomes below poverty level¹ • 20% of poor have private coverage¹ • 33% of poor are uninsured¹ • Uninsured can receive care at community health centers and emergency departments which are reimbursed for uncompensated care	• Integrates Medicaid into State systems • Low-income uninsured receive coverage without premium payments • Comprehensive benefit package equivalent to Medicaid • Provides additional safeguards and outreach efforts to ensure equal access to care • No cost-sharing or deductibles	• Acute care Medicaid replaced with regional alliance plans for all low-income including beneficiaries who are "alliance eligible" (All Medicaid beneficiaries except undocumented persons and Medicare beneficiaries) • Uninsured are also integrated into regional alliances • Provides State and Federal premium assistance for Medicaid beneficiaries and low-income families up to average weighted premium --Assistance for "family share" of premium (20% share) available for families with incomes below 150% poverty --Assistance for the 80% share of premium available to non-working families with incomes <250% poverty --Corporate alliance pays subsidies for low wage employees (under \$15,000) --State and Federal pay 100% premiums for AFDC and SSI • Caps Federal assistance for low-income • Provides cost-sharing discounts to poor people enrolled in HMO-type plans, only if they also receive cash assistance	• Restructures Medicaid • Allows States to purchase private insurance coverage from qualified health plans or retain Medicaid • Provides premium subsidies for low-income uninsured individuals to purchase private insurance (see phase-in coverage under #13 and #8) • Federal subsidies are contingent upon savings in Medicaid and Medicare • Benefits in standard package are less comprehensive than Medicaid • All cost-sharing for current Medicaid beneficiaries enrolled in qualified health plans would be paid by Medicaid • No cost-sharing subsidies for non-Medicaid low-income persons	• Repeals Medicaid and replaces with a program of low-income assistance for health coverage by purchasing into AHPs through HPPCs • Provides full premium subsidies for people with incomes less than 100% of poverty • Provides subsidies on a sliding scale for individuals with incomes between 100% and 200% of poverty • Caps Federal low-income assistance subsidy • Prohibits employers who offer coverage to their employees from dropping coverage for those eligible for subsidy assistance • Provides prescription drugs, eyeglasses, and hearing aids if above basic benefit package for persons with incomes below 100% of poverty • Assures nominal cost-sharing levels for individuals with incomes under 200% of poverty	• Restructures Medicaid to permit States to establish health allowance program for Medicaid and other low-income persons • Caps expansion funding of medical allowance program at expected spending levels without program • Benefits in private plans must at least be actuarially equivalent to per capita medical assistance payments for beneficiaries • Cost-sharing may be required of individuals with incomes over 100% of poverty	• Restructures Medicaid • Medicaid DSH payments replaced by Federal grants to States to establish programs that provide health care for low-income uninsured individuals spending greater than 5% of gross income on health care through: --Financial assistance to purchase health insurance --Direct delivery of medical services --Funding of community and migrant health centers --Improvements in availability of emergency/trauma care • Benefits under DSH grant program may be less comprehensive than Medicaid • Assistance with out of pocket costs applies only to individuals spending more than 5% of gross income

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16	COVERAGE OF PERSONS WITH DISABILITIES	• 15 million persons report disabilities that prevented them from working • In 1992, 3 million low-income persons with disabilities received Medicaid coverage because they qualify for Supplemental Security Income⁶ • An additional 1 million persons with disabilities receive Medicaid through "medically needy" programs⁶ • Medicaid, in many States, covers rehabilitation, PT/OT and other services necessary to treat chronic conditions • Persons with chronic conditions can be excluded from private coverage or charged exorbitant premiums	• No coverage limitations based on the cause of illness or injury for acute care services under national plan • Persons with three or more ADLs are covered under new national long-term care program	• Benefit package does not cover rehabilitation or extended services for persons whose conditions do not result from an injury or illness • Benefits covered by Medicaid but not covered by health plans would be available to low-income persons who qualify for Medicaid • Certain Medicaid beneficiaries (AFDC, SSI, children under 21, and Medicare eligible persons) would get more "wrap-around" benefits than others • Provides new block grants to States for home- and community-based care for disabled persons with 3 or more ADLs • Retains Medicaid coverage of institutional and noninstitutional long-term care • Provides disabled employed individuals who require personal assistance with tax credits covering 50% of their costs up to \$15,000 per year • Prohibits discrimination based on health status or disability	• Standard benefit package does not discriminate in coverage based on type of condition, because benefits are not specified • Low-income persons can continue to be covered under Medicaid program • Medicaid children with special needs remain in fee-for service Medicaid program • Retains institutional and non-institutional long-term care as a Medicaid responsibility for eligible persons • Prohibits discrimination by health insurers on the basis of health status	• Standard benefit package, has no specific limitations or exclusions identified, because benefits are not specified • Current Medicaid beneficiaries with disabilities are folded into HPPCs • Directs Health Care Standards Commission to determine any unmet medical needs of current Medicaid populations as a result of integration • Repeals Medicaid, leaving long-term care as a State responsibility • Limits pre-existing condition clauses	• Benefit packages will be based on actuarial value • No specific limitations or exclusions identified, because benefits are not specified • Retains long-term care portion of Medicaid • Limits pre-existing conditions clauses	• Minimum catastrophic benefit requirements • No specific limitations or exclusions identified, because benefits are not specified • Current Medicaid beneficiaries with disabilities remain as is • Retains long-term care portion of Medicaid • Limits pre-existing conditions clauses

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17	TREATMENT OF MEDICARE	• RBRVS fee schedule for physicians, but they are allowed to balance bill • Medicare does not cover prescription drugs • DRG payment system used to reimburse hospitals • Has significant deductibles and co-insurance which force many elderly to purchase medigap insurance • Limited coverage of long-term care	• Integrates Medicare • Folds Medicare beneficiaries into State systems --Eliminates cost-sharing and deductibles --Expands benefit package to include prescription drugs and other benefits not currently offered • Eliminates need for supplemental private insurance for the elderly • Qualified Medicare Beneficiaries (QMBs) on Medicaid would have no cost-sharing or deductibles	• Maintains Medicare as a separate program --Allows States to get Medicare waivers to bring beneficiaries into alliances --Medicare-eligible workers remain in alliances with Medicare as secondary payer --Allows Medicare beneficiaries to stay with their health insurance plan if it meets Federal standards • Expands benefits to include outpatient prescription drugs • Imposes 20% co-insurance on laboratory services • Reduces Medicare spending by \$124 billion, expecting to decrease rate of growth to 7.4% by the end of the decade • Secretary has new authority to develop new health insurance products for Medicare beneficiaries	• Maintains Medicare as a separate program --Allows Medicare beneficiaries to enroll in qualified health plans • No expansion of benefits • Increases Medicare Part B coinsurance and means tests premium taxes • Imposes 20% copayments on laboratory and home health services • Reduces overall Medicare spending growth • Expands SELECT program to enroll more beneficiaries in HMOs • Directs the Secretary of DHHS to conduct a study on the phase-in of current Medicare beneficiaries into qualified health plans	• Maintains Medicare as a separate program --Allows Medicare beneficiaries to enroll in AHPs --May remain in current program • Expands benefits to include some preventive care • Increases Part B premium for high-income individuals • Reduces overall Medicare spending growth • Expands SELECT program to all States to enroll more beneficiaries in HMOs	• Maintains Medicare as a separate program • No expansion of benefits • Imposes Medicare Part B tax on individuals with over \$100,000 • Expands SELECT program to enroll more beneficiaries in HMOs and eliminates membership limitations on Medicare HMOs • Combines administration of Medicare Parts A and B	• Maintains Medicare as a separate program • No expansion of benefits • Establishes 20% coinsurance for home health care, skilled nursing facilities and laboratory services • Reduces overall Medicare spending growth • Secretary of HHS to conduct feasibility study of allowing future Medicare beneficiaries to retain private health insurance coverage in lieu of Medicare

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18	TREATMENT OF MEDICAID	- Covers low-income welfare recipients, persons with disabilities, and low-income elderly - Currently enrolls only 46% of poor - One-half of spending pays for acute care services^a - Over one-third (36%) pays for long-term care and home health care^a 15% of spending finances hospital disproportionate share payments for uncompensated care and low reimbursement rates^b - Many doctors refuse new Medicaid patients (Highest refusal rates for OB/GYN) - Medicaid reimburses physicians and hospitals at approximately 60% of private fees^c - Many States are moving toward Medicaid managed care to improve access and save money	- Integrates Medicaid into State systems - Comprehensive acute care benefits package is equivalent to Medicaid - Long-term care will be covered under new system for persons with 3 or more ADLs	- Integrates acute care Medicaid for all Medicaid beneficiaries except Medicare-eligible persons and undocumented persons - AFDC and SSI beneficiaries, Medicare beneficiaries and eligible children continue to qualify for Medicaid for benefits not covered under the health plans - Coverage of institutional and non-institutional long-term care remains as is - Coverage rules for Medicare beneficiaries and undocumented persons remain unchanged - Estimates savings of \$65 billion by curbing rate of growth - Repeals Boren amendment - Repeals DSH program and replaces it with smaller Vulnerable Population Adjustment program for hospitals serving large percentage of low-income patients - Mandates medically needy coverage for nursing home benefits - Increases asset limits and living expense allowance for nursing home residents	- Restructures Medicaid - Establishes a per-capita Federal payment based on historical Medicaid costs - Allows States to provide coverage to beneficiaries through a private purchasing cooperative, managed care plan, or other alternative - Allows States to purchase some Medicaid recipients into qualified health plans with protections - Limited to 15% during first 3 years, then phased-in - States will pay copayments and deductibles - Medicaid children with special needs are exempt from enrolling in HMOs and will remain in current program - Institutional and non-institutional long-term care remain unchanged - Caps Medicaid spending growth rate for acute care at national health spending level - Allows States to contract for coordinated care services under Medicaid with managed care organizations (with protections for first 5 years) - Phases out hospital disproportionate share payments by 2000	- Repeals the Medicaid statute - Integrates acute care Medicaid into HPPCs - Provides prescription drugs, eyeglasses, and hearing aids, if above basic benefit package, for persons with incomes below 100% of poverty - Assures nominal cost-sharing levels for individuals with incomes under 200% of poverty - Federal government assumes full responsibility for subsidizing acute care for the poor; States gradually assume responsibility for long-term care portion of Medicaid - Caps Federal subsidies - Establishes phase-down schedule for Federal assistance for States' long-term care programs - Provides cost-sharing subsidies for low-income elderly similar to Medicaid - Directs Health Care Standards Commission to submit a report to Congress concerning any transitional provisions concerning the medical needs of current Medicaid population	- Restructures Medicaid - Allows States to expand Medicaid up to 100% of poverty with an option to expand up to 200% on a sliding scale using DSH payments - Caps expansion funding at expected spending levels without program - Medical Health Allowance Program gives States option to enroll recipients and low-income persons into private health insurance plans as long as they provide a choice of plans and other quality safeguards - Non-institutional and institutional long-term care remain unchanged - Imposes maintenance of effort on States	- Restructures Medicaid program - Federal payments calculated on a per capita basis for children and adults - Allows State Medicaid waivers to pursue cost effective health care - Caps Federal payments to Medicaid on acute care spending to growth in CPI plus 1% beginning in FY95 - Non-institutional and institutional long-term care remains unchanged - Replaces DSH payments with Federal grants to States to establish programs to provide health care for low-income individuals spending greater than 5% of gross income on health care through: - Financial assistance to purchase health insurance - Direct delivery of medical services - Funding of community and migrant health centers - Improvements in availability of emergency/trauma care - Provides States with broad latitude in how they delivery medical care services

SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION DECEMBER 1993

	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 481	HEALTH SECURITY ACT HR 3600/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
18	TREATMENT OF MEDICAID	- Covers low-income welfare recipients, persons with disabilities, and low-income elderly - Currently enrolls only 46% of poor - One-half of spending pays for acute care services⁶ - Over one-third (36%) pays for long-term care and home health care⁶ 15% of spending finances hospital disproportionate share payments for uncompensated care and low reimbursement rates⁶ - Many doctors refuse new Medicaid patients (Highest refusal rates for OB/GYN) - Medicaid reimburses physicians and hospitals at approximately 60% of private fees⁶ - Many States are moving toward Medicaid managed care to improve access and save money	- Integrates Medicaid into State systems - Comprehensive acute care benefits package is equivalent to Medicaid - Long-term care will be covered under new system for persons with 3 or more ADLs	- Integrates acute care Medicaid for all Medicaid beneficiaries except Medicare-eligible persons and undocumented persons - AFDC and SSI beneficiaries, Medicare beneficiaries and eligible children continue to qualify for Medicaid for benefits not covered under the health plans - Coverage of institutional and non-institutional long-term care remains as is - Coverage rules for Medicare beneficiaries and undocumented persons remain unchanged - Estimates savings of \$65 billion by curbing rate of growth - Repeals Boren amendment - Repeals DSH program and replaces it with smaller Vulnerable Population Adjustment program for hospitals serving large percentage of low-income patients - Mandates medically needy coverage for nursing home benefits - Increases asset limits and living expense allowance for nursing home residents	- Restructures Medicaid - Establishes a per-capita Federal payment based on historical Medicaid costs - Allows States to provide coverage to beneficiaries through a private purchasing cooperative, managed care plan, or other alternative - Allows States to purchase some Medicaid recipients into qualified health plans with protections - Limited to 15% during first 3 years, then phased-in - States will pay copayments and deductibles - Medicaid children with special needs are exempt from enrolling in HMOs and will remain in current program - Institutional and non-institutional long-term care remain unchanged - Caps Medicaid spending growth rate for acute care at national health spending level - Allows States to contract for coordinated care services under Medicaid with managed care organizations (with protections for first 5 years) - Phases out hospital disproportionate share payments by 2000	- Repeals the Medicaid statute - Integrates acute care Medicaid into HPPCs - Provides prescription drugs, eyeglasses, and hearing aids, if above basic benefit package, for persons with incomes below 100% of poverty - Assures nominal cost-sharing levels for individuals with incomes under 200% of poverty - Federal government assumes full responsibility for subsidizing acute care for the poor; States gradually assume responsibility for long-term care portion of Medicaid - Caps Federal subsidies - Establishes phase-down schedule for Federal assistance for States' long-term care programs - Provides cost-sharing subsidies for low-income elderly similar to Medicaid - Directs Health Care Standards Commission to submit a report to Congress concerning any transitional provisions concerning the medical needs of current Medicaid population	- Restructures Medicaid - Allows States to expand Medicaid up to 100% of poverty with an option to expand up to 200% on a sliding scale using DSH payments - Caps expansion funding at expected spending levels without program - Medical Health Allowance Program gives States option to enroll recipients and low-income persons into private health insurance plans as long as they provide a choice of plans and other quality safeguards - Non-institutional and institutional long-term care remain unchanged - Imposes maintenance of effort on States	- Restructures Medicaid program - Federal payments calculated on a per capita basis for children and adults - Allows State Medicaid waivers to pursue cost effective health care - Caps Federal payments to Medicaid on acute care spending to growth in CPI plus 1% beginning in FY95 - Non-institutional and institutional long-term care remains unchanged - Replaces DSH payments with Federal grants to States to establish programs to provide health care for low-income individuals spending greater than 5% of gross income on health care through: - Financial assistance to purchase health insurance - Direct delivery of medical services - Funding of community and migrant health centers - Improvements in availability of emergency/trauma care - Provides States with broad latitude in how they delivery medical care services

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	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 401	HEALTH SECURITY ACT HR 3600/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1570	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
19	REFORMS IN HEALTH INSURANCE	- No guarantee that coverage must be offered to all individuals - No guarantee of portability between jobs - Pre-existing clauses can exclude coverage for certain illnesses/conditions (some States regulate these practices) - Large and small companies are rated based on their claims experience - Almost 20% of insurance costs pay for administration - No limit on annual premium increases	- Eliminates the private health insurance industry for benefits in the national package - May be continuing role for private supplemental coverage and HMOs to operate within the new system - Regulates long-term care insurance	- Places caps on premiums in regional alliances based on global budgets - Applies pure community rating within alliances - Guarantees that plans are renewable - Guarantees portability of coverage - Prohibits health plans from denying coverage based on health, employment or financial status	- No premium caps or global budgets - Establishes modified community rating for qualified health plans - Guarantees that plans are renewable - Guarantees portability of coverage - Contains non-discrimination clause based on health status - Limits pre-existing condition clauses	- No premium caps or global budgets - Requires age-adjusted community rating inside HPPCs, and either age-adjusted or pure community rating outside HPPCs - Guarantees renewability - Guarantees portability of coverage - Limits pre-existing condition clauses	- No premium caps or global budgets, but limits maximum annual premium increase for small employers to 15% - Does not establish community rating, but limits premium variation among small employers - Insurers must offer health plans to small employers, including standard, catastrophic and medical savings accounts - Guarantees renewability of coverage - Guarantees portability of coverage - Limits pre-existing condition exclusions	- No premium caps or global budgets - Does not establish community rating - Guarantees renewability of insurance coverage - Guarantees portability of coverage - Prohibits insurers from terminating policy except for non-payment or fraudulent claims - Limits pre-existing conditions clauses - Restricts insurance marketing practices to limit discrimination
20	REFORMS IN HEALTH CARE ACCESS	4,200 areas in US are considered underserved due to provider shortages⁷ 15% of the population is underserved⁷ - Uninsured are more likely to go to emergency rooms for basic care - Significant differentials in utilization and patterns of care exist between poor and non-poor neighborhoods - In Kaiser/Commonwealth/Harris survey, 34% of uninsured reported delaying needed health care compared to only 8% of privately insured individuals and 10% of Medicaid recipients	- Doubles funding for community and migrant health centers - Significantly increases funding through the public health block grants for services such as maternal and child health, preventive health, mental health and substance abuse, and care for people living with AIDS - Authorizes a new program to provide grants to community health centers and other federally qualified health centers to delivery primary care in underserved areas - Allows patients to seek services from any participating doctor or medical facility - Prescribes equal payments to community providers and includes services of community health providers as a specific benefit - Geographic distribution of population calculated into budget and reimbursement determination - Increases funding for NHSC	- Authorizes new health funding for public health and access expansion programs - Authorizes Federal grants and loans to support providers in rural and inner-city communities to form networks and health plans - Provides enabling services for cash-assistance and low-income children - Requires health plans to contract with essential community providers - Prescribes equivalent payment methodologies for community providers - Authorizes the expansion of the NHSC	- Authorizes appropriations for a new program to provide funds to allow federally qualified health centers and others to provide expanded services to medically underserved individuals - Authorizes appropriations for a new community-based primary health care grant program to States to expand access in underserved areas - Authorizes appropriations for rural health grants and demonstrations to improve access to care - Requires qualified health plan to comply with any provisions related to services in underserved areas established by the certifying authority - No payment methodologies specified for community providers - Establishes rural emergency access care hospitals	- Provides grant funding and transitional support for development of accountable health plans in underserved and rural areas - Provides grants to community and migrant health centers to integrate with Accountable Health Plans - Provides transitional support for safety net hospitals - Specifies payment methodology for community providers in chronically underserved areas - Health plans may be required to offer coverage in underserved areas - Establishes rural emergency access care hospitals	- Increases grant funding for community and migrant health centers by \$1.5 billion over five years to improve access for underserved areas - Increases grant funding to coordinate primary health care - Increases funding for rural health services with emphasis on emergency care services - No special designation or payment methodology for community providers - Establishes a Rural Emergency Access Care Hospital (REACHs) program	- States can use Federal "Medicaid DSH" grants to fund community and migrant health centers - No funding increases to promote access to care - No special designation or payment methodology for community providers

SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION DECEMBER 1993

	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 481	HEALTH SECURITY ACT HR 3800/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
21	REFORMS IN HEALTH PROFESSION EDUCATION	• 50% GME paid for by Medicare, which favors tertiary care and specialization • Only 14% of current medical students are choosing primary care less than half the rate (36%) in 1982	• Mandatory reforms • Establishes target of 1:1 primary care providers to specialists five years after enactment of legislation • Establishes Advisory Committee Health Professional Education • Reduces payments to States that fail to meet national goals for graduate medical education • Health Board will establish target number of midlevel primary care practitioners by year 2000 • Increases funding to support health professions education and nursing education, including nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and physician assistants • Increases funding for NHSC	• Mandatory reforms • Provides new entitlement grant funding academic health centers for medical education • Replaces GME and IME payments from Medicare • GME payments to emphasize primary care training • Limits the number of specialty residencies • Increases the authorization for funding for training of nurse-practitioners and physician assistants • Establishes National Council of GME within DHHS • Authorizes expansion of NHSC • Overrides restrictive State practice laws but health plans can still decide which providers it allows to participate in their networks	• Voluntary reforms • Creates GME demonstration projects which allows States to pool GME funds and change specialty mix • Provides tax incentives for primary care providers in underserved areas • Increases the authorization for primary care physicians • Increases the authorization for funding for training of nurse-practitioners and physician assistants • Increases the authorization for funding for PHS and NHSC • Provides tax breaks for NHSC loans	• Mandatory reforms • Establishes National Medical Education Fund • Eliminates separate medical education payments under Medicare • Limits the number of specialty residencies to 110% of applicants • Differential funding for primary care; 25% higher than specialty slots • Increases the authorization for funding for training of mid-level practitioners, NHSC, and Area Health Education Centers • Overrides restrictive State practice laws but health plans can still decide which providers it allows to participate in their networks	• Not specified	• Not specified
22	MANAGED CARE	• 25% of the population with employer coverage was enrolled in managed care⁵ • In many States, Medicaid is enrolling beneficiaries (12%) in managed care	• Managed care is not a major feature of plan, but use of primary group health practices is assumed • Managed care plans continue to compete with fee-for-service	• Growth of managed care is a major feature of plan • Requires at least one fee-for-service option in each alliance • Requires managed care plans to contract with all essential community providers • Preempts State laws that restrict development of managed care	• Growth of managed care is a major feature of plan • Individual mandate to have insurance may be met through catastrophic plan and medical savings account • Requires managed care plans to provide outreach to underserved communities • Encourages and facilitates movement of Medicaid into managed care risk contracts	• Growth of managed care is a major feature of plan • Allows fee-for-service option in HPPCs • Provides grants to community providers to integrate with managed care plans • Lifts State laws to restrict development of managed care	• Managed care is not a major feature of plan • Encourages movement of Medicaid into managed care • Lifts State laws restricting development of managed care	• Managed care is not a major feature of plan • Lifts State laws restricting development of managed care

SUMMARY OF MAJOR HEALTH CARE REFORM LEGISLATION DECEMBER 1993

	ISSUE	CURRENT SITUATION	AMERICAN HEALTH SECURITY ACT OF 1993 HR 1200/S 491	HEALTH SECURITY ACT HR 3600/S 1757	HEALTH EQUITY AND ACCESS REFORM TODAY ACT OF 1993 HR 3704/S 1770	MANAGED COMPETITION ACT OF 1993 HR 3222/S 1579	AFFORDABLE HEALTH CARE NOW ACT OF 1993 HR 3080	CONSUMER CHOICE HEALTH SECURITY ACT OF 1993 S 1743
23	QUALITY	- Individual private insurers and large corporations have quality assurance programs - AHCPR has issued several non-binding guidelines for surgical procedures - Medicare has utilization review program - Outcomes research still in infancy	- Promotes use of practice guidelines and outcomes research - Profiles practice patterns to identify outliers on a systematic basis - Requires States to establish a uniform data base for patient records by 2001 - Establishes centers of excellence	- Creates National Quality Management Council to develop quality, information, and accountability programs - Applies performance measures to all health plans, institutions and practitioners - Disseminates quality reports through regional alliances - Creates uniform licensing standards - Expands AHCPR quality research	- Requires that qualified health plans be certified by the States and meet Federal quality assurance guidelines - Creates a national health data system - Expands federal outcomes research agenda - Creates national medical research fund from overpayments and contributions	- Provides grants to States to develop practice guidelines to be used in malpractice liability cases - Accountable Health Plans required to meet Federal quality and data standards - Applies performance measures to all health plans, institutions and practitioners - Creates Agency for Clinical Research	- Silent on practice guidelines - Grants for development and distribution of State and Federal comparative value information for health care purchasing - Establishment of electronic data standards for providers	- Grants for development and distribution of State and Federal comparative value information programs for consumer information - Establishment of electronic data standards for providers
24	PROTECTIONS FOR INDIVIDUALS	- Individuals and groups can be systematically excluded by insurers (some States regulate these practices) - In case of negligence/discrimination, individual has right to bring suit	- Grievance mechanisms to be developed at State level - State ombudsman provided - Applies existing fraud and abuse controls to system and strengthens them	- Establishes federally-administered external grievance procedures - Alliances develop internal grievance procedures - Includes individual privacy protections - Regional alliances will each have an ombudsman - Strengthens fraud and abuse controls and applies to all payers	- Each qualified health plan required to have internal mediation procedures - Strengthens fraud and abuse controls - Each plan must provide information about person's right to self-determination	- Provides internal grievance mechanism for enrollees - Every HPPC will have an ombudsman to handle disputes between consumers and health plans and consumers and HPPCs - Silent on fraud and abuse controls - Requires notice of advance directive rights for patients entering Medicare	Strengthens fraud and abuse controls	Strengthens fraud and abuse controls
25	MALPRACTICE REFORM	- Individuals have right to go to court - No cap on non-economic damages - No limit on lawyers fees, 1/3 of award is typical - High malpractice insurance costs - Defensive medicine	No changes	- Requires health plans to establish alternative dispute resolution mechanisms - No limits placed on non-economic damages - Requires individual to have a certificate of merit before going to court - Holds lawyers fees to 33 1/3% of award	- Requires mediation and alternative dispute resolution - Limits non-economic damages to \$250,000 - Limits lawyer's fees to 25 percent of award - Loser to pay court and lawyers fees, if appealed	- Requires alternative dispute resolution - Limits non-economic damages to \$250,000 - Limits lawyer's fees to 25% of first \$150,000 and 10% of additional - Loser pays court and lawyer fees, if appealed	- Requires mediation and alternative dispute resolution - Limits non-economic damages to \$250,000 - Limits lawyer's fees to 20 percent of award - Loser would pay court and lawyers fees, if appealed	- Silent on alternative dispute resolution - Limits non-economic damages to \$250,000 - Limits lawyers' fees to 25 percent of first \$150,000 and 15 percent of additional award - Loser to pay court costs for claim if not justified or improperly advanced

1. Based on Kaiser analysis of the 1992 March Current Population Survey.

2. Bureau of the Census, 1992.

3. United States Immigration and Naturalization Service, unpublished report, 1992.

4. Clinton Plan is the only plan that has received cost estimates from the Office of Management and Budget and the Department of Health and Human Services. Figures for other proposals represent estimates by the authors of the bill.

5. Results of the Health Insurance Association of America 1991 Employer Survey.

6. Kaiser Commission on the Future of Medicaid/Urban Institute analysis of HCFA data.

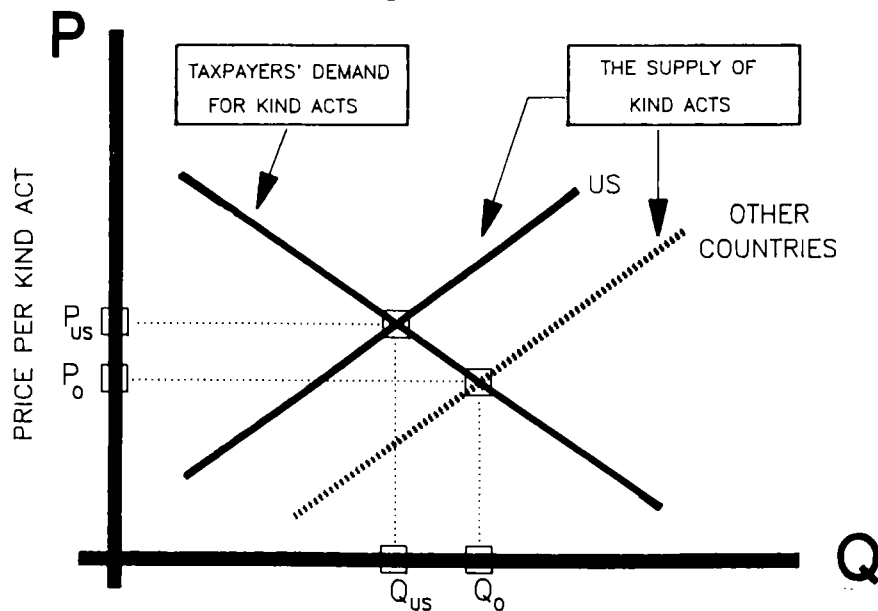
7. Lives in the Balance, 1993.

Confucius (maybe)

*Teach a Parrot to say
"SUPPLY AND DEMAND"
and you've trained
another economist.*

THE ECONOMICS OF BEING KINDER AND GENTLER:

A Hypothesis



ANNUAL NUMBER OF KIND ACTS TOWARD THE POOR DEMANDED
OR SUPPLIED, AT ALTERNATIVE PRICES, PER TAXPAYER

ON THE ECONOMICS OF BEING KINDER AND GENTLER

1. The kindness and gentleness of taxpayers toward the poor is best measured by what taxpayers would do at alternative prices of being nice--by the taxpayers' demand for kind acts--and not by what taxpayers actually do for the poor. For all we know, Americans, Canadians and Europeans all have the same demand for kind acts toward the poor although, of course, we cannot be sure of that.
2. Alas, the price of kindness in America is high by international standards, because kind acts must be purchased from relatively "pricey" delivery systems. That may be one of many reasons why, by international standards, Americans seem rather unkind toward the poor. Kindness can be priced out of the market.
3. Policy Option I: Reduce the price of mainstream American health care, i.e. shift the supply of kind acts downward to the right through "cost-containment". (Good luck!)
4. Policy Option II: If the supply curve cannot be moved, let our politicians lead us in a concerted effort to shift up our demand-curve for kind acts. (Good luck as well!)
5. Policy Option III, the most viable strategy at this time: Let us abandon the myth that, as an "egalitarian" nation, we just cannot contemplate a two-tier health system. The poor might be better served by a lean delivery system that offers them at least some kindness at a price American taxpayers judge affordable, even if that implies two-tier health care.

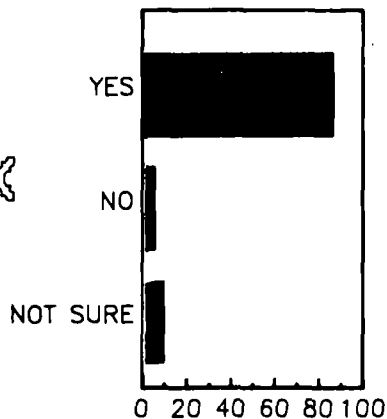
*Season's Greetings
and a
Healthy, Prosperous
New Year*

*Uwe E. Reinhardt
December, 1989*

MAY THE SPIRIT OF THIS MELLOW SEASON DESCEND UPON AMERICAN HEALTH POLICY!

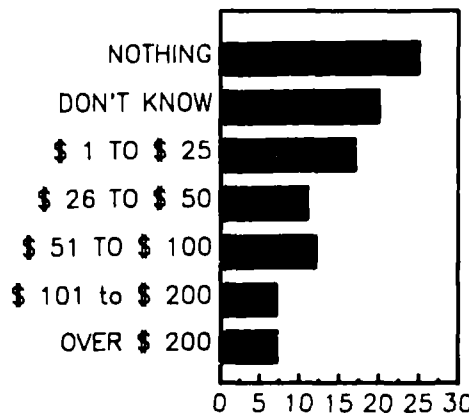


SHOULD ALL AMERICANS HAVE ACCESS
TO THE SAME QUALITY HEALTH CARE
REGARDLESS OF ABILITY TO PAY FOR IT?



PERCENT OF RESPONDENTS

HOW MUCH PER YEAR WOULD YOU BE WILLING
TO PAY TO COVER THE COST OF HEALTH CARE
FOR THOSE WHO CANNOT AFFORD IT?



PERCENT OF RESPONDENTS WITH
INCOME OF \$ 20,000 OR MORE



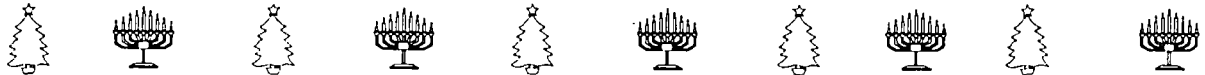
SOURCE: THE BAXTER FOUNDATION, HEALTH MANAGEMENT QUARTERLY, 4TH QTR '86 AND 1ST QTR. '88

*Season's Greetings
and a
Healthy, Prosperous
New Year*

*Uwe E. Reinhardt
December, 1988*

1. Because kidneys differ so visibly from hearts and prostrates, Congress has federalized financial responsibility for the treatment of kidney failure, even for kidneys that are less than 65 years old.
2. Formerly, "patient," or "sick human being."
3. To simplify the highly complex rules that actually determine Medicaid eligibility--rules that vary from state to state--one may define a Medicaid-eligible American as someone who is not a single, adult, non-pregnant, non-disabled or non-AIDS-afflicted person, and who does not belong to a household whose income exceeds the Medicaid threshold of the state in which that household is located. In some states, that threshold is less than half of the official Federal poverty line.
4. There is, of course, no guarantee of such coverage. It is entirely a local matter.
5. America has 1,000 points of light that radiate private charity. Of these, 995 are located in the emergency rooms of America's hospitals.

FOOTNOTES



FOR THE HOLIDAYS THIS YEAR, A VERY SPECIAL GIFT:

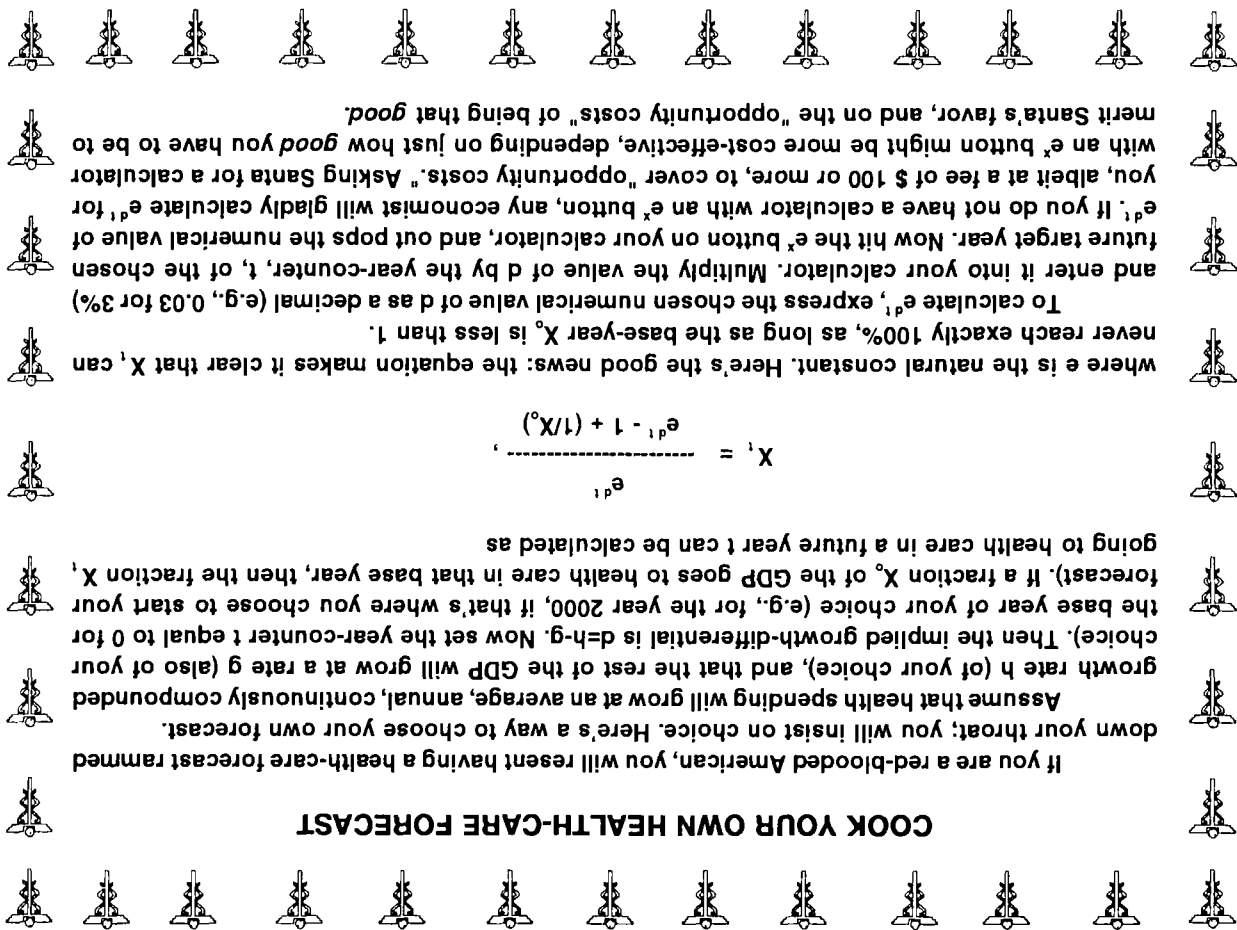


THE ALL-AMERICAN
HEALTH-POLICY KIT

Capable of answering questions such as:

" WHOSE RESPONSIBILITY IS THE COST OF TREATING
A SICK AMERICAN ORGAN? "

(For the answer, just follow our EEZY FLOW-CHART™ on the inside of this card.)



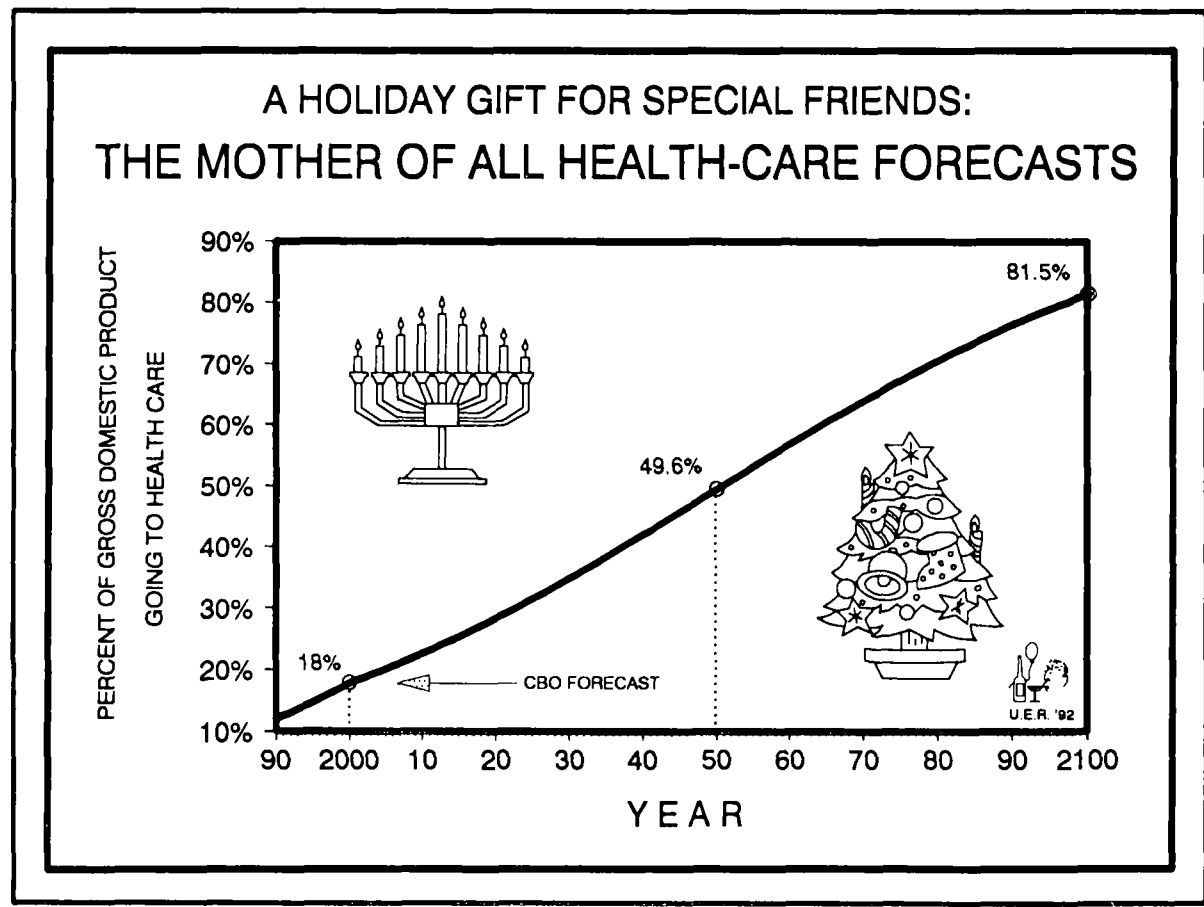
where e is the natural constant. Here's the good news: the equation makes it clear that X_t can never reach exactly 100%, as long as the base-year X_0 is less than 1.

To calculate e^t , express the chosen numerical value of d as a decimal (e.g., 0.03 for 3%) and enter it into your calculator. Multiply the value of d by the year-counter, t , of the chosen future target year. Now hit the e^x button on your calculator, and out pops the numerical value of e^t . If you do not have a calculator with an e^x button, any economist will gladly calculate e^t for you, albeit at a fee of \$100 or more, to cover "opportunity costs." Asking Santa for a calculator with an e^x button might be more cost-effective, depending on just how good you have to be to merit Santa's favor, and on the "opportunity costs" of being that good.

$$X_t = \frac{e^{dt} - 1 + (1/X_0)}{e^d}$$

If you are a red-blooded American, you will resent having a health-care forecast rammed down your throat; you will insist on choice. Here's a way to choose your own forecast. Assume that health spending will grow at an average, annual, continuously compounded growth rate h (of your choice), and that the rest of the GDP will grow at a rate g (also of your choice). Then the implied growth-differential is $d=h-g$. Now set the year-counter t equal to 0 for the base year of your choice (e.g., for the year 2000, if that's where you choose to start your forecast). If a fraction X_0 of the GDP goes to health care in that base year, then the fraction X_t going to health care in a future year t can be calculated as

COOK YOUR OWN HEALTH-CARE FORECAST



OMNISCIENT EXPERT: During the 1980s, the average annual growth of health spending out-galopped the rest of Gross Domestic Product (GDP) by about 3 percentage points. During the preceding period 1965-80, that growth-differential was pretty much the same. American health-policy wonks therefore view that differential as an American tradition--as a natural constant, so to speak, like *e* or *pi*. Alas, the Congressional Budget Office (CBO) now predicts that, during the 1990s, the differential will widen to about 4.7 percentage points, mainly because GDP is limping along so slowly. The CBO projects that, by the year 2000, fully 18% of the GDP will go to health care.

INCREDULOUS LAY PERSON: Good heavens! Soon we'll spend 100% of the GDP on health care!

OMNISCIENT EXPERT: Relax! That can't happen. Even at a differential of 4.7 percentage points, only about 96% of the GDP would go to health care in the year 2100. But let's not be alarmist. Suppose that, after the year 2000, the growth-differential dropped once again to the more staid, traditional 3 percentage points. Then only about 50% of the GDP would go to health care by the year 2050, leaving fully half of the GDP for the other good things in life. And even by the year 2100, only 81.5% of the GDP would go to health care; there would still be some room for other things.

INCREDULOUS LAY PERSON: Health care eating over 80% of the GDP by the year 2100?! Is such a thing even conceivable?

OMNISCIENT EXPERT: In principle, yes. America would be covered, from coast to coast, with king-sized beds, made by Mercedes Benz. Each bed, fully loaded with a myriad of imaging devices made by Sony, would be occupied by two Americans, each equipped with an M.D. degree and with multiple artificial body parts made by Aero Spatiale, Mitsubishi, Rolls Royce and Siemens. Through giant transoceanic pipelines these fully medicalized Americans would be fed intravenously with scrumptious nutrients prepared by the finest chefs in France and China. The M.D.'s would give each other hourly check-ups, continuous body scans and ever more stunning transplants. The bills they would send to one another would add up to 81.5% of the GDP. Voila!

INCREDULOUS LAY PERSON: And who would produce the rest of the GDP?

OMNISCIENT EXPERT: It would be produced by non-medicalized, uninsured, low-wage American workers and their families who, of course, would not be entitled to a bed. These workers would assemble some of the body parts Stateside under foreign license because, to be classified as an "American" in the year 2100, at least 20% of a person's body parts will have to have been "manufactured" in the USA.

INCREDULOUS LAY PERSON: Could America at that time actually pay for the imported beds, body parts and scrumptious intravenous fluids?

OMNISCIENT EXPERT: In principle, yes. America financed its joyous consumption boom during the 1980s partly by running huge trade deficits, which were paid off in part by surrendering to foreigners most of Hawaii, huge chunks of California and most of 5th Avenue in New York, along with numerous American corporations. But, wisely, America kept a good many companies in reserve, along with Arkansas, Nebraska and many other fine states. This vast reserve could be used to finance future trade deficits. In a pinch, the foreign suppliers might even take New Jersey and General Motors.

INCREDULOUS LAY PERSON: But would any nation be dumb enough literally to give itself away for health care?

OMNISCIENT EXPERT: In principle, no. No nation would be that silly. In practice, yes, because to do otherwise might force Americans to *ration* health care. The uninsured aside, *rationing* health care is just not an American thing. Canadians and Europeans do that, which is precisely what makes these aliens so un-American.

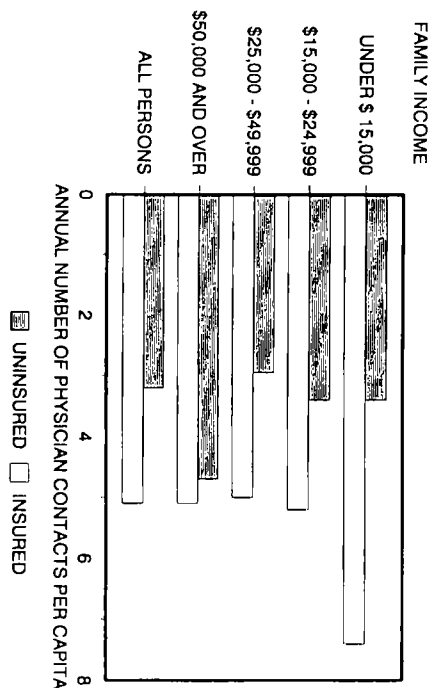
INCREDULOUS LAY PERSON: I'm totally flabbergasted. How do I prepare for this wild scenario?

OMNISCIENT EXPERT: Second, get an M.D. degree. Third, book a hi-tech bed. But, first and foremost, do enjoy fully the holiday season of 1992 and have a healthy, successful 1993!

UWE E. REINHARDT AND FAMILY

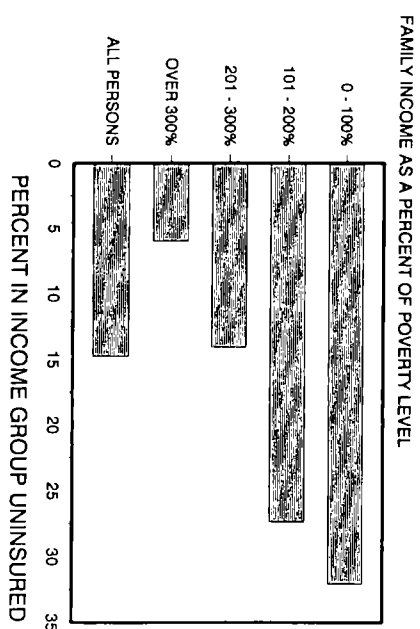
AVERAGE REPORTED PHYSICIAN CONTACTS, 1986

IN DOCTORS' OFFICES, CLINICS, HOSPITAL EMERGENCY ROOMS OR OUTPATIENT DEPARTMENTS



NON-ELDERLY POPULATION WITHOUT HEALTH INSURANCE

BY FAMILY INCOME, 1987



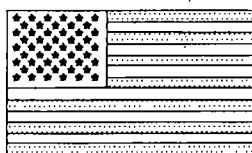
SOURCE: Pepper Commission, Final Report, Table 1-2 and Figure 1-9

THE UNITED(?) STATES OF AMERICA

TWO DISTINCT STATES SHARING THE SAME GEOGRAPHY

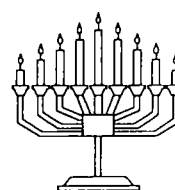
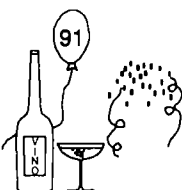
STATE NO. 1

A EUROPEAN-STYLE, MIDDLE-CLASS COUNTRY



STATE NO. 2

A THIRD-WORLD, LESS-DEVELOPED COUNTRY



U. E. R. 1990

I am pleased to share with you this year's letter to Santa:

Dear Santa:

For Christmas this year, please give me an answer to a question that has confounded me for twenty years: When Americans claim that "rationing" health care would be un-American, and when they disparage Canada and Europe for doing so, what do these Americans mean by "America" – the entire United States (State 1 and State 2) or merely State 1? Or do these Americans follow Webster's classical definition according to which "to ration" means "to distribute equitably"?

If you help me solve this riddle, I promise to be a good boy all next year and to be a better health-policy analyst forever.

Respectfully yours,



***Season's Greetings
and a
Healthy, Prosperous
New Year***

***Uwe E. Reinhardt
December, 1990***

UWE E. REINHARDT

Woodrow Wilson School
Princeton University
Robertson Hall
Princeton, NJ 08544-1013



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

NOV 17 1993

PAM NOV 17 1993

MEMORANDUM FOR THE FIRST LADY

We have encountered a problem with the draft of the Health Security Act that, for some reason, we have not been able to get fixed. Let me say at the top that this is not a matter of money. It is instead a matter of fairness and equity, and a matter that could be politically damaging and embarrassing for us if it is not addressed in the Act before introduction.

The problem has to do with the treatment of Native Americans in the Act as it was presented to Congress in October. The Act offers Native Americans a choice of either enrolling with an Indian Health Service (IHS) plan or with a private health plan through an alliance. Low-income Indians electing to enroll in a private health plan are eligible for premium discounts available to other Americans. However, Indians enrolling in the IHS plan (estimated to be 80-90 percent of the total) are not eligible for those premium discounts.

In the Act as presented to Congress, Indians electing to enroll with the IHS plan are promised comprehensive benefit package coverage through the IHS, but the funds to provide coverage for low-income, non-employed Indians must come from annual appropriations made under the discretionary spending caps. This means that while coverage for other low-income Americans is guaranteed through a capped entitlement, this most vulnerable population must rely on an annual appropriation by the Congress in competition with the other health care spending programs under discretionary budget caps.

Let me reiterate, this is not a matter of scoring: the deficit should not increase if this were done. We have been assured that the dollars to pay the premiums for the non-employed, low-income Indians are in the estimates of Federal premium discounts, because Indians were included in the population base counts. The change that we are proposing will allow Indians enrolling in the IHS plan to have the same guarantee of premium financing as non-Indians.

The Department has developed and shared language that will fix this problem.

Donna E. Shalala

Memorandum

DRAFT

To: Ira M. Magaziner
From: Jay Rockefeller and Henry Waxman
Subject: Suggested Strengthening Amendments to the Legislative
Language on Workforce Policy Priorities
Date: November 3, 1993

Health care workforce reform which emphasizes the critical importance of primary care providers is essential to the success of our ultimate reform goals. So much so that it is the sole issue that we, as subcommittee chairs with jurisdiction over these matters, drafted comprehensive legislation of our own. We introduced that legislation in the hopes of giving clear direction on how we believe the federal government should handle these important issues.

Throughout the Task Force process, we thought that our views and policy concerns were being considered and taken into account. Every public and private indication, from the First Lady, to the members of the Task Force and officials in the Department of Health and Human Services, including our personal conversations, led us to believe that we were very much on parallel tracks in our thinking. The leaked September 7, 1993 draft confirmed that we were in agreement on the fundamentals of the workforce provisions. So, we were especially disappointed that the President's legislative language omits some basic provisions and, therefore, in our view, does not adequately reflect some of most important considerations that our legislation addresses.

We hope that you will consider addressing some of these deficiencies as you make final revisions to the President's legislative proposal.

Unless we change the incentives in our current system and set up a process that makes sure the federal government will only pay the training costs of the right kind of providers that we need, and takes the right steps to make sure that primary care providers are available in underserved areas, all our other efforts in reform will have a limited impact on actually getting health care services to people.

Here, I would like to underscore the point that underserved areas are urban areas and rural areas and they can be found all over this country. Every member of the committees of jurisdiction, and the Congress for that matter, should care deeply about whether their constituents have access to primary care providers. Without more primary care providers, we will not be able to provide real access to care once universal coverage is in place, nor will we be able meet our cost containment goals. Timely and substantive workforce reform is vital if the rest of reform is to succeed.

The following is a list of suggestions that, we believe, would significantly strengthen the workforce title in the President's bill. We stand ready to assist you in any way possible and that we very much hope you will use us as a resource. Our staffs are available to work with you on these issues so that we can significantly improve this aspect of the bill.

A Few Major Recommendations:

1. A cap should be placed on the total number of residencies that is equal to the total number of U.S. medical graduates plus 10%.

As endorsed by PPRC, COGME, ACP, ASIM, AAFP, and the Association of Professors of Medicine.

An overall cap is critical because the aggregate supply of physicians and their specialty distribution have very important consequences for health expenditures and the delivery of appropriate care. Only addressing the specialty mix ignores the impact that each additional physician will have on the nation's total health bill.

While data indicate that we are heading toward an oversupply of physicians in the United States, a new health care system that rapidly moves people into managed care would face a shortage of as many as 40,000 primary care providers. Only one-third of all physicians are now in primary care practice, and the proportion of students graduating from medical school expressing interest in primary care has been declining precipitously. In addition, it has been estimated that specialists will be in oversupply to the tune of 80-100,000 by the year 2000. The incentives in the current system serve to encourage the continued mass production of specialists in our major teaching hospitals -- it's just too lucrative to train specialists at the expense of primary care.

Alternative Option:

1. a. Cap the total number of specialists trained at 45% (under your formula) of all U.S. medical graduates.

Capping the number of specialists will not control the volume of services as effectively as an overall cap, but it will at least insure that if we continue to produce physicians in oversupply, at least we will be producing more of the kinds of physicians we need most -- primary care practitioners.

2. Require that the number of entry positions in all approved medical residency programs for residents who begin their initial residency period on or after June 1, 1998, who are not primary care residents, may not exceed 50% of the total number of entry positions in all such programs for all residents who are United States medical graduates.

The timeline in your legislation will not begin to show an improved production of primary care physicians until at the earliest 2006, and more likely, 2010 -- that is too long to wait. Considering that you envision the National Council convening in 1994, their recommendations about allocations of residency slots should be available in late 1994, 1995 at the latest. This proposed revision would give residency programs time to adjust their programs and comfortably meet the new requirements.

Making this timeline more responsive to our primary care needs is critical. We should take steps in the next few years that make change inevitable. Postponing the guts of this process until years hence means we could face repeal efforts before we see real change. You know that even if interest in primary care practice changed so that starting this year fifty percent of graduating medical students chose this path, the "pipeline" of medical training is so long that we would not achieve the more desired 50:50 ratio of generalists to specialists until the year 2040, as Dr. Koop has repeatedly pointed out.

3. Fully fund the scholarship and loan repayment programs of the National Health Service Corps by the year 2000 and pay for with the new 1.5% surcharge on premiums that is allotted to graduate medical education.

Our legislation establishes a regular schedule that will increase funding for the National Health Service Corps that insures that there will be providers in all the health professional shortage areas by the year 2000. Payments are increased \$226 million in FY94, \$294 million in FY95, \$381 million in FY96, \$496 million in FY97, \$644 million in FY98, \$837 million in FY99, and 1,089 million by the year 2000.

A chronic shortage of physicians persists in both rural America and in our inner cities. Despite the hope that the training of more doctors would solve the problem of geographic maldistribution of physician services, primary care physician-to-population ratios in rural counties are still only about one-third those in urban areas. These areas are underserved because of they are geographically undesirable. There is no evidence that we will be able to

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attract sufficient numbers of providers to these areas even with the other payment and practice reforms that accompany national reform. This should be one of our priority areas.

4. Establish criteria that the National Council on Graduate Medical Education will use to allocate residencies that will include:

a) the need to assure that the distribution of positions in approved programs is not inequitable in relation to geographic distribution and that training institutions are qualified to offer such programs;

b) the need to assure the provision of primary care and other health care services to medically underserved communities; and

c) the retention rate of residents who train in an area which is generally underserved.

The lack of criteria which the National Council must consider is a serious deficiency in the President's proposal -- it is an invitation to maintain the status quo. Without these considerations, there are no assurances to either programs or Congress that the allocation process will be conducted fairly, and in a manner that is sensitive to the geographic differences. For example, without special criteria small, quality programs could be at risk of losing out in the allocation process to the larger training centers. We do not want to create regional training centers that will further frustrate our ability to provide quality, trained residents in specialties and primary care alike, in every state of the union. For example, West Virginia has an excellent retention rate for the specialists that it trains. If it were to lose its ability to operate small, quality programs its access problems would be exacerbated.

We are equally concerned that allocations not reduce access to comprehensive services to underserved communities in general.

5. Establish a more equitable formula for your transition payments to programs in compliance which will lose residents available to provide care when their IME adjustments are revised as a reduction is allowable residency slots.

We suggest you seriously consider our transition mechanism which provides that during the transition period, a hospital's IME payment will be reduced to no less than 90%

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of the prior year's fiscal amount; for disproportionate share hospitals the payment should be reduced to no less than 95% of the prior year's amount.

Your transition payment may not adequately buffer the losses of services provided by residents today.

6. Insure that approved, non-hospital training sites will be directly reimbursed for the training that they provide.

The shift of health delivery to settings outside the hospital has created the need for ambulatory training to be an integral part of graduate medical education training. As more services are provided on an ambulatory basis, hospital stays shorten and only the most acutely ill patients are admitted in the inpatient environment offering an increasingly restricted range of educational experiences. Training in nonhospital settings gives residents the chance to acquire skills that span the continuum of care and train in the settings in which they will actually practice most. Moreover, it increases the probability that residents will select primary care as their field. Direct payment will help overcome the transitional barriers to providing training in these offsite settings, as will the transitional adjustment that we recommend. It will also encourage training of other health care professionals in more appropriate settings, such as advance practice nurses and physician assistants.

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INTRODUCTION

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

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

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

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

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

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

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

STRUCTURAL REFORMS

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

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

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

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

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

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

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

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

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

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

COVERING THE UNINSURED

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

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

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

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

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

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

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

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

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SECTION I: BASIC AND STRUCTURAL REFORMS

PART A: BASIC REFORMS

1. Insurance Market Reform

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

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

A. Qualified Health Insurance Plans will:

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

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2. Administrative Simplification

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

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

- A. The Secretaries of Health and Human Services (HHS), Department of Defense (DoD), and Veterans Affairs (VA), and others appointed by the President, will make up a Federal Administrative Standards Panel. A Commission composed of private sector experts will advise the panel.
- B. Duties of the Panel
 - 1. Adopt data standards, within two years, for the electronic reporting and exchange of health care information. Such standards should be:
 - a. based on existing, widely-used criteria.
 - b. designed to include data related to enrollment, eligibility, quality measurement, utilization management, risk assessment, patient satisfaction, outcomes, appropriate data to monitor access to health care services, and other data sets as deemed appropriate by the panel.
 - c. contain strict measures to ensure confidentiality of data.
 - 2. Establish business practices for operation of a nationally-linked health care information database system.
 - 3. Develop appropriate civil and criminal penalties for non-compliance.
- C. Oversight and implementation of standards
HHS is responsible for oversight, enforcement, and implementation of data standards; and for establishment of a certification procedure for database, computer and network vendors.

3. Medical Liability Reform

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

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

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

- A. Mandatory, non-binding Alternative Dispute Resolution (ADR)
 - 1. Parties must participate in an alternative dispute resolution system established by the state.
 - 2. Plans are required to explain this process in their descriptive materials to beneficiaries.
- B. Litigation
 - 1. If one of the parties in the dispute wishes to challenge the result of ADR, he/she may do so
 - 2. If the decision rendered in court is less favorable to him/her than in ADR, he/she shall pay all legal fees subsequent to ADR.
- C. Damages
 - 1. Non-economic damages are capped at \$250,000.
 - 2. Malpractice awards shall be reduced for any collateral source payments to which the claimant is entitled.
 - 3. Periodic Payments
Claimant will be required to accept periodic payment as opposed to lump sum on awards exceeding \$100,000.
 - 4. Punitive damages
50% of a punitive damage award shall be paid to the State for activities approved by the Secretary of HHS to improve monitoring, education, and disciplining of health care providers in that State.
- D. Reform of Procedures
 - 1. Statute of Limitations
 - a. except for minors, no health malpractice action may be initiated more than two years after the date on which the alleged injury should have been discovered, and in no event later than four years after the date of the occurrence.
 - b. with respect to injuries alleged to have occurred to minors (under 6 years of age), no health malpractice action may be brought after reaching 12 years of age.

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2. Joint and Several Liability
For non-economic and punitive damages, liability for payment of damages shall be based on the degree of contribution to the negligent act.
- E. Practice Guidelines Rebuttable Presumption
Providers following practice guidelines approved by the Agency for Health Care Policy and Research (AHCPR) shall have a presumptive defense against malpractice claims.
- F. Products: drugs and devices
 1. All medical liability reforms listed above apply.
 2. If approved by the Food and Drug Administration (FDA) and used properly, no punitive damages will be allowed.
 3. If FDA approval was based upon misleading or false information, the prohibition on punitive damages will not apply.

4. Quality Assurance

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

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

- A. Health insurance plans must have a recognized quality assurance program as defined by the Secretary of HHS. In developing such standards, HHS must consult with recognized private sector entities engaged in quality assurance, such as the Joint Commission on Accreditation of Healthcare Organizations, the National Committee for Quality Assurance, or other recognized organizations.
- B. Plans must provide quality data including information on outcomes and effectiveness in the format developed by the Secretary of HHS in conjunction with the Federal Administrative Standards Panel.
- C. AHCPR is directed to expand its present research agenda to include the following:
 1. A fund investigator to initiate research on the relationship between treatments and outcomes.
 2. Priorities for the research community to strengthen

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- the research base.
- 3. Effectiveness trials in collaboration with medical specialty societies and qualified health plans.
- 4. A clearinghouse and other registries on clinical trials research data.
- 5. Continued and expanded development of practice guidelines to provide information to health care practitioners and plans.
- D. Establishes a Medical Research Trust fund to guarantee funding for medical research.

5. Anti-Fraud and Abuse

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

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

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

6. Antitrust Reform

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

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

- A. The Attorney General, in consultation with the Federal Trade Commission (FTC) and the Secretary of HHS, shall establish competition guidelines and safe harbors for state-licensed health care providers and for qualified health plans and buying cooperatives, including guidelines for areas where competition cannot function effectively, e.g., certain rural areas.
- B. The Attorney General, in consultation with the FTC and the Secretary of HHS, shall promulgate standards and procedures to issue on an expedited basis waivers, which shall exempt persons and organizations in the health care market from all penalties (civil and criminal) under the anti trust laws. The Departments of Justice and HHS, and the FTC, shall establish procedures for expedited waiver review.
- C. Cooperative ventures in the health care industry, when not deemed approved by certificate or other public license, shall be subject to the rule of reason analysis.
- D. Buying cooperatives may be organized to represent consumers.
 - 1. Such cooperatives shall be deemed single entities under the antitrust laws and shall not be found to be illegal combinations in restraint of trade under the antitrust laws.
 - 2. Such cooperatives shall be subject to the antitrust laws for any anticompetitive use of buying power, unless subject to safe harbor or approved certificate.

7. Rural and Inner City Special Assistance

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

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

- A. Grants to States for Coordination of Health Care Services

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1. A block grant to states will be established to assist in the delivery of health care to populations residing in rural and inner city urban areas.
 2. States will develop a plan for expanding and /or coordinating existing state and federal health programs, or could use funds to provide services for which federal funds are not currently available.
- B. Additional Requirements for Health Plans serving Special Needs Populations
1. Health plans will be required to provide additional benefits to populations in defined geographic areas.
 2. Health plans will be compensated for these services either through a method of enhanced reimbursement or through a grant program.

8. Primary Care Provider Education

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

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

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

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9. Long-Term Care

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

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

A. Tax Clarification/Insurance Reform

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

PART B: ESSENTIAL STRUCTURAL REFORMS

1. Establishment of Small Business and Individual Purchasing Cooperatives

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

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

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- A. States will establish geographic areas in which individuals and small businesses may form purchasing cooperatives.
 - 1. The State may authorize one or more purchasing cooperatives in a geographic area.
 - 2. Interstate agreements for geographic regions encompassing more than one state can be established.
 - 3. States will be responsible for making risk adjustments between all health plans operating in a given geographic region, in accordance with federal guidelines.
- B. The membership of these purchasing cooperatives will be limited to employers and employees in businesses of 100 employees or fewer, and to all other individuals not enrolled in an employer health benefit plan who live or work in the geographic area.
 - 1. Purchasing cooperatives must allow all eligible businesses or individuals to join.
 - 2. Purchasing cooperatives may be governed only by the members.
 - 3. Purchasing cooperatives will collect premiums from members and forward them to the appropriate plan.
 - 4. Purchasing cooperatives must offer eligible individuals the opportunity to enroll in a health benefit plan within thirty days for new enrollees, or after first becoming eligible to enroll in the purchasing cooperative. Each fall an open-season date will be set by the Secretary of Health and Human Services. During that time, purchasing cooperatives will allow eligible individuals to enroll in a benefit plan or to change the plan in which they are enrolled. In addition, they will maintain a special enrollment process for individuals who experience a change in family status during the year.
 - 5. Purchasing cooperatives can charge members a limited fee to pay for operating expenses.
 - 6. Purchasing cooperatives will distribute to their members information regarding prices, outcomes, enrollee satisfaction, and other information pertaining to the quality of the plans offered within the purchasing cooperative.
- C. Small business associations that currently offer health insurance to their members, and that exist for reasons other than to offer health insurance, will be allowed to

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

2. Responsibility for Coverage

A. Individual Responsibility

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

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

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

B. Small Employer Responsibility

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

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

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

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

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

C. Large Employer Responsibility

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

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

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

3. Tax Treatment of Health Care Costs

Purpose: to create equity in the tax code.

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

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

A. Tax-free fringe benefits

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

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- B. Deductibility
 - 1. the cost - up to the tax cap - of a plan will be fully deductible to individuals and the self-employed, regardless of employment status.
 - 2. the deductibility of health insurance premiums paid by individuals for certified health insurance plans will not be limited by the 7.5% medical expense deductibility floor; all cost-sharing, co-payments, co-insurance, deductibles, and other out-of-pocket costs will continue to be deductible only to the extent they exceed 7.5% of Adjusted Gross Income.
- C. Employer deduction
 - 1. the cost - up to the tax cap - of providing a certified health insurance plan can be deducted by the employer.
- D. Tax Cap
 - 1. the tax cap applies both to the excludibility of health insurance provided to an employee by an employer and to the deductibility of health insurance premiums paid by an individual.
 - 2. the cap is calculated as the average cost of the lowest priced one-third of the certified health insurance plans offered in the purchasing cooperative area in which an individual lives or works.
- E. Medical Savings Accounts (MSAs)
 - 1. an MSA will be available for those individuals electing the catastrophic benefit plan option.
 - 2. contributions to an MSA will be tax-favored up to the amount of the tax cap, i.e., they will be fully deductible if made by the individual and excludible from taxable income if made by the employer.
 - 3. the cost of the catastrophic benefit plan premiums must be subtracted from the tax cap in determining the amount of contributions to an MSA that will receive tax-favored treatment.
 - 4. funds remaining in an MSA at the end of the year can be carried forward to the subsequent year. Amounts carried over from a previous year will be subtracted in computing the applicable tax cap for the individual in the subsequent year.

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4. State and Federal Certification of Health Insurance Plans

Purpose: to ensure plans are of high quality.

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

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

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

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

5. Benefit Package

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

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

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

- A. Standard Benefit Package Guidelines:
 - 1. Medical and surgical services and equipment.
 - 2. Prescription drugs and biologicals.
 - 3. Preventive health services.
 - 4. Rehabilitation and home health services related to an acute care episode.
 - 5. Severe mental health services (narrowly defined).
 - 6. Substance abuse services.
 - 7. Co-payments and deductibles for all but certain preventive health services.
 - 8. Plans are required to cover the cost of a service only if it is medically necessary. The benefit plan does not create an entitlement to each benefit. Other benefits may be purchased, but will not receive favorable tax treatment.
- B. Alternative catastrophic benefit plan with an integrated cash value medical expense account or income-related deductible.
 - 1. Same benefit parameters as above.
 - 2. High cost sharing, including deductibles (Amount rolled over from year to year)
- C. Benefit disputes
 - 1. Plans and enrollees are required to resolve such disputes through a timely, mandatory, binding-arbitration process.
 - 2. Enrollees must show by a preponderance of the evidence standard that the plan's decision to decline the service is inappropriate based upon available scientific evidence.

6. Benefits Commission

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

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

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

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

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7. Ability of States to establish an alternative system

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

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

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

PART C: TREATMENT OF EXISTING FEDERAL PROGRAMS

1. Medicaid

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

2. Medicare

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

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

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

3. Federal Employees

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

4. Public Health Service

No change in existing program.

5. Veterans Administration health benefits

No change in existing program.

6. Department of Defense and CHAMPUS

No change in existing program.

7. Indian Health Service

No change in existing program.

SECTION II

COVERAGE AND FINANCING FOR POOR AND WORKING POOR AMERICANS

PART A: GUARANTEED COVERAGE PHASE-IN

1. By 1995

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

2. By 1996

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

3. Vouchers

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

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

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

PART B: ACCELERATED PHASE-IN

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

"A Force of Nature or a Clod of Ailments?"

Presentation to Hillary Rodham Clinton

September 17, 1993

**James L. Reinertsen, M.D.
President and Chief Quality Officer
HealthSystem Minnesota**

This nation's leaders are contemplating dramatic change in our system of purchasing and delivering health care--The American Health Security Act--a change so dramatic that even the staid New York Times described it as "breathtaking in its sweep, its complexity, and its ambition." (NY Times, September 11, 1993, p.1)

If this change is to succeed, it will require active, enthusiastic participation by our nation's physicians. As we contemplate our response to the changes proposed, we face the choice described by George Bernard Shaw: "This is the true joy in life, the being used for a purpose you consider a mighty one, the being a force of nature rather than a feverish, selfish clod of ailments and grievances complaining that the world will not devote itself to making you happy." Simply stated, if the proposed change results in physicians choosing to become a "feverish, selfish clod of ailments," it will fail.

The experience of Minnesota's integrated care systems such as the Mayo Foundation, Group Health and HealthSystem Minnesota provide real encouragement, and some useful advice, both to the architects of the American Health Security Act, and to this country's doctors. The encouragement and advice can be summarized as follows:

1. Integrated care systems such as multispecialty group practices can not only control costs, but can also improve quality. These models give no reason to fear that promotion of these types of integrated care systems, as contemplated by the American Health Security Act, will compromise the health of Americans.
2. To the extent that health reform perpetuates compartmentalized, piece-work, payment systems, such archaic systems will inhibit the innovation and collaboration vital to successful reform. We need to focus on **how** doctors are paid, rather than on **how much** they are paid.

3. While measurement of quality is vital to improvement, there is a dark side to data. If data on health quality are used in a fear-based system of inspection, reward and punishment, rather than for improvement and learning, reform will fail.

These three points can be supported by data and examples from Minnesota's major integrated care systems, and particularly from those systems which have multispecialty group practices as their core. These organizations are systems of professionals in health care, led by physicians who are focused on a common aim, and organized in such a way as to achieve that aim. For example, the aim of Park Nicollet Medical Center is "to provide all and only the care that is in the best interests of our community of patients." A critical aspect of how we are organized to achieve that aim is that our physicians are salaried: They have absolutely no personal incentive to either over-treat or under-treat their patients. Characteristically, these types of practices also feature two other important elements: a common medical record, and an active commitment to research and education.

The quality record of Minnesota's integrated care systems is impressive. For example, HealthSystem Minnesota detects 96 percent of the breast cancers in our patients while the cancer is still in a curable stage. Group Health has extraordinarily low premature birth rates. Mayo Clinic sets benchmarks for hospital mortality, despite hospital costs which are far below national norms.

And these results are obtained without the use of externally imposed standards, regulation by plan managers, or "Captain, may I?" inspection systems. These results are obtained by physicians working together "for a purpose they consider a mighty one"—better care for their patients. If the American Health Security Act promotes the nationwide development of systems such as these, it need not fear that quality of care will suffer.

The second point—that compartmentalized piecework pay (as exemplified by Medicare) is a profound inhibitor of innovation—can best be illustrated by an example. Two years ago, Park Nicollet's doctors implemented an inexpensive new technology called Mammotest, in the workup of women with possible breast cancer. Compared with traditional methods, this device is able to biopsy breast abnormalities with greater accuracy, at 30 percent lower cost, and far less patient pain and suffering. Most important, through use of this device the doctors were able to shorten the "sleepless nights factor"—the time between a woman learning of a possible problem to receiving a definitive answer—down to as little as two hours.

So what's the problem? Why hasn't this technology been implemented all over the country? The problem is the piecework reimbursement system by which American, Canadian, and most of the world's doctors are paid. Breast biopsies are traditionally done

"A Force of Nature or a Clod of Ailments?"

James L. Reinertsen, M.D.

September 17, 1993

by surgeons—about \$40,000 per year per surgeon in fees. The new Mammotest procedure is done by a radiologist, not a surgeon. So, in order to implement this real quality improvement—better technical accuracy, less pain and suffering, lower cost, and fewer sleepless nights—each surgeon in a piecework reimbursement system would have to transfer up to \$40,000 to a radiologist. Is it any wonder that this technology has not been widely implemented?

Integrated practice systems with salaried physicians can implement such innovations as Mammotest, because they don't have to fight these piecework barriers. Park Nicollet and Mayo patients and purchasers are already experiencing this quality and cost improvement.

And this is but one example. In conversations with over a hundred practicing doctors I've repeatedly heard that they would innovate on a massive scale, were it not that the piecework reimbursement system forces them to choose between better care and economic disaster. These are not bad doctors. This is a bad system.

If we are to add 37 million uninsured to the system, while accommodating the twin juggernauts of new technology and an aging population, all the while restraining the growth of costs, our nation's doctors must be unleashed to innovate as never before. If the Medicare experience has taught us nothing else, it has taught us that we cannot deal with this problem by paying a little bit less for each piece of work. If this is how reform plays out, either through the Medicare payment system, or through the payment methods chosen by the regional and corporate health alliances, it is highly likely that, instead of innovators, our doctors will become a "feverish clod of ailments," fighting over fees.

The third message from Minnesota's integrated care systems deals with data. Our experience in the Institute for Clinical Systems Integration—a collaborative effort of 21 large employer purchasers (the Business Health Care Action Group), HealthPartners, Park Nicollet, Mayo Clinic and dozens of smaller primary care practices—has taught us that W. Edwards Deming was right: We must drive fear out of the system if we are to succeed.

The Institute's mission is to make our various practices into a living laboratory for the continuous improvement of health. On a huge scale, we are designing, implementing, measuring and redesigning guidelines in a never-ending cycle of improvement. The measurements we generate—conformance to guidelines, outcomes, total costs, etc.—are generated for one purpose: improvement. These measurements are not used for inspection, regulation, reward or punishment. For example, we will not rank physicians' performance and then publish the rankings. We already know that 50 percent of our physicians performance will be below the median for any performance measure we

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choose—that's a relentless fact of statistics. But how would the doctors who are below the median feel? How would any of us feel?

Were we to use measurements for these "dark side" purposes, we would guarantee that the majority of physicians', clinics', and hospitals' efforts would go into attacking the measurements rather than into improving processes. We would caution the architects of health reform not to misuse data in this way. To do so would be to ensure that our nation's physicians would become a "feverish, selfish clod of ailments."

In summary, Minnesota's integrated care systems give encouragement to health reform designs based on competition among truly integrated systems, provided that these systems are allowed to use physician payment systems which encourage innovation, and are also free to use data for improvement, rather than for fear. Under these circumstances, our nation's physicians will be a powerful force of nature working on a purpose they consider a mighty one.

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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

BIOGRAPHICAL SKETCH**James L. Reinertsen, M.D., F.A.C.P.****ADDRESS**

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BIRTHDATE/PLACE

(b)(6)

[0661]

CITIZENSHIP

U.S.A.

SOCIAL SECURITY NUMBER

(b)(6)

EDUCATION

B.A. 1969

St. Olaf College
Northfield, Minnesota

Summa Cum Laude
(Phi Beta Kappa)

M.D. 1973

Harvard Medical School
Boston, Massachusetts

Alpha Omega Alpha

PROFESSIONAL EXPERIENCE

1973 TO 1974

Internship in Internal Medicine
San Francisco General Hospital
San Francisco, California

1974 TO 1976

Residency in Internal Medicine
University of California Hospitals
San Francisco, California

1976 TO 1978

Clinical Associate, Arthritis and Rheumatism Branch,
National Institute of Arthritis; Metabolism and Digestive
Diseases, National Institutes of Health
Bethesda, Maryland

1978 TO PRESENT

Department of Rheumatology
Park Nicollet Medical Center
Minneapolis, Minnesota

CERTIFICATION/LICENSURE

Certified, American Board of Internal Medicine, 1976
Certified, American Board of Internal Medicine — Rheumatology, 1978

Licensure, California (G27678)
Licensure, District of Columbia (9636)
Licensure, Minnesota (24020)

POSITIONS/APPOINTMENTS

1993 TO PRESENT	President and Chief Quality Officer HealthSystem Minnesota Minneapolis, Minnesota
1992 TO PRESENT	Chairman Institute for Clinical Systems Integration Bloomington, Minnesota
1986 TO 1992	President and Chief Executive Officer Park Nicollet Medical Center Minneapolis, Minnesota
1984 TO 1986	President Park Nicollet Medical Foundation Minneapolis, Minnesota
1981 TO 1983	President and Medical Director SHAPE, Inc.

MEMBERSHIPS/COMMITTEES

Fellow, American College of Physicians
American Rheumatism Association, 1978
Board of Trustees, American Group Practice Association
Board of Directors, Minnesota Business Partnership

PROFESSIONAL INTERESTS

Quality improvement of medical care and service, health promotion and wellness, health care cost containment, epidemiology and genetics of rheumatologic disease.

PERSONAL	Married (Cheryl Grangaard), two children
SPECIAL INTERESTS	Music, fly fishing, golf

JOHN CLENN, OHIO
BILL BRADLEY, NEW JERSEY
J. BENNETT JOHNSTON, LOUISIANA
JOHN B. BURLAUX, LOUISIANA
RICHARD SHELLEY, ALABAMA
HARRY REID, NEVADA
BOB GRAHAM, FLORIDA
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United States Senate

SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

~~PERSONAL AND CONFIDENTIAL~~

September 2, 1993

Mrs. Hillary Rodham Clinton
Chairperson
President's Task Force on Health
Care Reform
The White House
Washington, D.C. 20500

Dear Hillary:

I am writing to let you know that, shortly after returning from the August recess, I would like to challenge pharmaceutical manufacturers to sign a short-term, "voluntary" price restraint commitment with the Secretary of Health and Human Services (HHS).

Under this commitment, drug manufacturers would limit the average annual increase in their weighted average manufacturer's price to the projected increase in the inflation rate. It would also require manufacturers to limit price increases to the inflation rate on individual product package sizes of drugs normally distributed to the retail class of trade.

I feel strongly about proposing such a commitment at this time for the following reasons. To date, only 17 pharmaceutical manufacturers have publicly stated that they would "voluntarily" limit the price increases on their products to the rate of inflation. Other manufacturers have developed "model" contracts and commitments that they would propose to sign with the Secretary of HHS to achieve the same objective. I commend those manufacturers that took the time to craft their own model "voluntary" restraint commitments because these have served as the basis for the commitment that I am proposing here.

Federal anti-trust laws, however, prohibit the entire industry from developing a uniform pricing restraint proposal of its own. Therefore, I have crafted a commitment which I believe meets the industry's public declaration to "voluntarily" restrain its price increases. This commitment would also standardize a pharmaceutical price restraint approach for all manufacturers in the industry, and provide a mechanism to assure the President, the Congress, and the American public that the manufacturer has met its commitment.

DETERMINED TO BE AN
ADMINISTRATIVE MARKING

INITIALS: RU DATE: 8/26/2013

2013-0359-5

Mrs. Hillary Rodham Clinton
September 2, 1993
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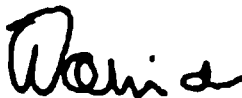
In addition, by signing this commitment, a drug manufacturer would be publicly demonstrating its desire and intent to voluntarily restrain pharmaceutical price increases. This is a goal which has been stated frequently by representatives of the drug manufacturing industry and its member companies.

An important part of this commitment would require that manufacturers limit price increases to the rate of inflation on individual retail pharmaceutical package sizes. This is very important. Data from the first half of 1993 indicate that many individual prescription medications are still increasing in price much faster than the rate of inflation. A table of price increases for over 90 prescription medications for the first half of the year is enclosed. This approach would assure that pricing restraints are meaningful for all Americans, especially the millions of our nation's older Americans, who rely on prescription medicines to maintain life and health.

As you know, for the past four years, the Senate Aging Committee has been carefully following the pricing practices of drug manufacturers. The bottom line is that meaningful restraint on pharmaceutical price increases in the United States is long overdue. Between 1980 and 1992, prescription drug prices increased six times the rate of inflation. As a result, millions of Americans -- especially older Americans -- have had to make the unfortunate choices between buying food or medication. Therefore, to provide relief to older Americans as quickly as possible, I would encourage each brand-name drug manufacturer to sign and return this commitment to the Secretary of HHS by October 15th, 1993.

Your support, and that of the President, for this initiative would be very much appreciated. Because I would like to go public with this commitment next Thursday, September 9, I would appreciate if you would let me know as soon as possible if you have any questions, concerns, or just want to talk about this proposal. Thank you very much.

Sincerely,



David Pryor
Chairman

Enclosures

cc: Ira Magaziner
The Honorable Donna Shalala, Ph.D.

Witness

LEVEL 1 - 1 OF 1 STORY

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Los Angeles Times

September 12, 1993, Sunday, Home Edition

SECTION: Part A; Page 1; Column 1; National Desk

LENGTH: 5305 words

HEADLINE: COLUMN ONE;
FAITH LOST, A DOCTOR TURNS BITTER;
A DRUG USED AS AN ANIMAL DEWORMER IS ALSO FOUND TO HELP TREAT CANCER. ITS PRICE
JUMPS -- FOR CANCER PATIENTS. A KEY RESEARCHER FEELS BETRAYED. BUT THE MAKER
SAYS IT'S ONLY RECOVERING ITS COSTS.

BYLINE: By BARRY SIEGEL, TIMES STAFF WRITER

DATELINE: ROCHESTER, Minn.

BODY:
In more ways than one, it was an act of faith for Dr. Charles Moertel to rise, late in the morning on Sept. 28, 1989, before a dozen people seated around a National Cancer Institute conference table in Rockville, Md.

The cautious Mayo Clinic cancer researcher, a former president of the American Society of Clinical Oncology, had come to the NCI to describe a set of extraordinary test results. In a federally funded \$11-million study of nearly 1,300 patients who'd undergone surgery to remove cancerous colon tissue, Moertel's team had reduced recurrence of the disease by 41%, and the overall death rate by 33%, among those with advanced Stage C cancer. They'd done this, incredibly, with a therapy that combined levamisole, which has been used for 30 years to rid farm animals of worms, and fluorouracil, a widely used but not terribly effective chemotherapy drug.

By instinct a skeptical physician, reluctant to endorse new drugs not clearly proven safe and effective, Moertel for once felt convinced enough to go along with what others were urging. This therapy, he agreed, should be provided at once to certain colon cancer patients, even before the Food and Drug Administration granted formal approval.

Moertel's faith in his science was matched by a trust in his audience. He was at the NCI, after all, to hand over his test results to officials from Johnson & Johnson, the giant \$12-billion-a-year health care company that markets -- and holds the patent on -- levamisole. He was also there to offer Johnson & Johnson his considerable influence in winning FDA approval for this new combination therapy.

"I will do everything I can to help get this treatment to patients," Moertel told the NCI, FDA and Johnson & Johnson people sitting before him. "I will appear before the FDA myself to speed up the approval process. In return, I ask only one thing. All I want is a promise from Johnson & Johnson that you will market this at a reasonable price."

Looking back, there are those, of course, who would call Moertel's stance a bit naive. After all, over the last decade prices for prescription drugs have

Los Angeles Times, September 12, 1993

risen nearly three times as quickly as other consumer prices. Drug companies' average profit margin of 15.5% is more than triple the average of all Fortune 500 companies. Pharmaceuticals didn't lead all United States industries in profitability in 1990 by letting Mayo Clinic professors decide what is a "reasonable" price for their drugs.

Nonetheless, Moertel left the NCI meeting that morning four years ago with his faith in science and drug companies intact. He believed he'd secured Johnson & Johnson's promise.

"They definitely, unequivocally promised levamisole would be reasonably priced," he recalled later. "I believed their assurances. I assumed they were honest and honorable people."

Not until nine months later did Moertel learn that Johnson & Johnson -- its new FDA approval in hand -- had increased the price of levamisole a hundredfold. Marketed as an animal dewormer, levamisole costs 6 cents a pill; marketed as a cancer drug, it costs \$6. Where a year's supply costs \$15 for a sheep, the same amount -- 150 milligrams a day -- costs \$1,200 for a human.

As Johnson & Johnson executives explained it, they were finally recovering their 25 years of research costs; as Moertel saw it, they were taking advantage of a captive market.

"I was amazed when I heard," Moertel said recently. "I couldn't believe it. This fell a little short of my definition of reasonable."

So began the transformation of a trusting Mayo Clinic researcher into an outraged, outspoken industry critic.

Johnson & Johnson sees matters differently. "We disagree with Dr. Moertel. . . We firmly believe that this price is fair and reasonable and that we are acting in the public interest," said F. Robert Kniffin, the company's vice president for external communications.

But for Charles Moertel, the story of levamisole, as richly revealing a portrait of the drug industry as any, has become an unceasing battle cry.

The Wonder Drug

The Belgian physician and researcher Paul A. J. Janssen had lofty goals when he set out, in the early 1960s, to find a superior treatment for parasite infestation in animals. He wanted a drug that was potent, safe, economical, injectable and active against a wide variety of larvae and worms.

In levamisole, he found just what he was after. Here was a fast-acting and quickly metabolized drug, effective in all sorts of animals, wild and domestic. By 1965, it was being marketed in Belgium. A year later, it was in Brazil. Soon, it was everywhere.

Levamisole gradually revolutionized agriculture, becoming the most widely used worm remedy in the world for cattle, pigs, sheep and poultry. It also became a popular dewormer for people; Johnson & Johnson, which had acquired Janssen Pharmaceutica in 1961, vigorously marketed levamisole for human use in Third World countries.

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"For a while, it was the gold standard," said Moertel. "It was a huge income source."

As time went by, Paul Janssen began to hear intriguing reports about unexpected side effects. It looked as if levamisole was doing more than killing worms.

Pre-weaning mortality of beagle pups in Belgium fell from 25% to 5% when the bitches were given levamisole before whelping. Resistance of cattle in Chad to contagious bovine pleuropneumonia increased noticeably. Sheep in South Africa experienced a striking decrease of chlamydial infections. The weight of "poor-doing" calves and pigs in Australia suddenly normalized.

Most veterinarians tended to attribute these effects to levamisole's impact on the larval stages of worms. The larvae were thought to decrease resistance, so their elimination would naturally restore it.

But Janssen couldn't avoid speculating: Might levamisole be a wonder drug? Might levamisole somehow be boosting immune systems? Might levamisole even be an effective anti-cancer drug?

In 1971, clinical studies began to test levamisole's effect on myriad diseases -- rheumatoid arthritis, multiple sclerosis, chronic hepatitis, herpes, Crohn's disease. In 1972, Janssen and Johnson & Johnson filed their first application with the U.S. Patent Office, seeking a sweeping patent on levamisole as an aid in the "regression and palliation" of virtually all tumors -- "neoplastic disease" -- whatever their nature and location.

"Drug research is like an orchestra . . . " Janssen wrote soon after in a journal article about levamisole's development. "Creative thinking cannot but suffocate in a world of bureaucratic materialism where ideals cannot be realized and beautiful dreams can no longer come true. . . . Superior drugs, designed to meet essential health needs, will not be found or even recognized by the complacent, unimaginative and lazy-minded. . . . "

Be they unimaginative and lazy-minded, or merely dubious of unproven claims, Patent Office examiners weren't buying what Janssen's group had to offer. The patent file for levamisole as a cancer drug involves a half-foot-high, 13-year-long pile of petitions, rejections, appeals, refilings and more rejections. Between 1972 and 1985, eight separate or amended applications were turned down.

"Neoplastic disease" was "too broad and indefinite" a definition of what the drug treats, the examiner ruled repeatedly. What's more, "there is insufficient evidence" that the drug is "safe and effective."

By the early 1980s, the patent applications were specifying types of cancers -- breast, lung, colon -- and offering a summary of 26 levamisole studies worldwide. Still, the Patent Office was not impressed. In 1983, an examiner remained of the opinion that "there is insufficient evidence . . . demonstrating (that) the applicants' compound is effective for treating cancer in humans."

One problem, according to Moertel, was that "the studies of levamisole were pretty junky. Some would come along and say, 'Whoopee.' Others would say, 'No, it doesn't help, it even hurts.' There were funny results. . . . Evidence for

Los Angeles Times, September 12, 1993

therapeutic benefit has almost invariably failed the test of confirmation."

Moertel heard about one such study in early 1978, while attending a conference in Bethesda, Md. In a test involving 60 patients with advanced Stage C colon cancer (the type that has spread to nearby lymph nodes), a Belgian researcher named Herman Verhaegen was reporting a distinct survival advantage for the 30 who'd received levamisole after surgery.

Moertel wasn't overly impressed, for Verhaegen's work involved quite a small group. What's more, although Verhaegen had made it sound like a truly randomized test -- a "placebo-controlled" trial, he'd called it -- the patients in fact had not been randomly assigned to the levamisole or placebo groups. Verhaegen had decided which patients would get the levamisole. By doing so, he could easily have skewed the results.

Still, Moertel was interested. Three years before, he'd gathered a number of upper Midwest community clinics together and formed the North Central Cancer Treatment Group, with him and the Mayo Clinic as consultants. Colon cancer was precisely what this group was seeing over and over, in places like St. Cloud and Fargo and Duluth. Nationwide, colon cancer was second only to lung cancer as the leading cause of cancer-related deaths. Colon cancer afflicted more than 100,000 Americans a year, and caused 54,000 deaths. In the advanced Stage C type, cancer recurred in about half of the 21,000 patients who underwent surgery each year.

It would be a good idea for our group to test levamisole, Moertel reasoned. Even if it didn't work, it would establish our testing procedures and quality control.

Because levamisole's credentials as a stand-alone cancer drug weren't impressive, Moertel decided to combine it with the chemotherapy drug fluorouracil, commonly known as 5-FU. In use for 25 years, 5-FU's impact had been limited -- some tumors shrank, some relapses were delayed, that was all -- but Moertel thought the drugs just might work in tandem.

He began with a small pilot group of Mayo Clinic patients with incurable colon cancer to reduce chances of unusual side effects. When none were apparent, he launched a first-phase study of 401 colon cancer patients throughout the upper Midwest. One randomly selected group received levamisole after surgery, one group no treatment, and one group levamisole combined with 5-FU.

Three years into the study, it became apparent that the levamisole alone was having virtually no effect. But it also became apparent that the combination of levamisole and 5-FU was significantly delaying or stopping the return of cancer in advanced Stage C patients.

"By 1984, we were saying, 'Hey, this is something we haven't seen before'" Moertel recalled. "The study wasn't over, but it looked very interesting."

In January, 1985, with full NCI funding, a larger, nationwide, 1,300-patient second-phase trial began under Moertel's supervision. Johnson & Johnson supplied the levamisole for free, but otherwise played no role in the test. "We had no contact with them," said Moertel. "There was no communication."

Johnson & Johnson, all the same, was in motion. The pharmaceutical concern had never given up trying to get a patent on levamisole as a cancer drug.

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After providing the Patent Office only with an article summarizing 26 levamisole studies, the company finally delivered the actual studies.

All had been conducted before 1980, and none had been followed up with more contemporary experiments. In 1992, a scientific review of levamisole in the "Biologic Therapy of Cancer" would describe pre-1980 levamisole studies as "inconclusive or negative" and "relatively unsophisticated."

In early 1984, however, the Patent Office examiner who'd been denying the levamisole applications for a dozen years apparently found the 26 articles' cumulative weight persuasive. Relenting, he finally granted most of Janssen's claims. In June, 1985, an appeals board allowed the others.

The patent on levamisole itself had expired months before and couldn't be renewed. But on April 22, 1986, Janssen Pharmaceutica was granted what's called a "use patent," which gave it the exclusive right to market levamisole as a "process of aiding regression and palliation of neoplastic disease in animal and human hosts."

Johnson & Johnson still didn't have the type of convincing proof required for Food and Drug Administration approval to market a new drug; the FDA was a much higher hurdle than the Patent Office. So three years passed without Johnson & Johnson filing an application to use levamisole as a cancer drug.

Then, one day in the summer of 1989, the drug company received a felicitous phone call from someone inside the National Cancer Institute. The NCI official had good news. A team of Mayo Clinic cancer researchers, it seemed, had just come up with precisely what Johnson & Johnson so urgently needed.

Result So Clear

When drafting the protocol for his large second-phase study, Moertel had written a provision saying they'd report their results early if they looked extremely good or bad during interim analyses. To reach that threshold, however, would take quite a lot, for Moertel was notoriously conservative.

Time and again over the years, his colleagues saw breakthroughs where he saw only a dreadful price being paid in side effects, expense and dashed hopes. Sometimes, he took public positions. He organized the government-sponsored study that discredited Laetrile as a cancer cure. He challenged Nobel Prize-winning chemist Linus Pauling's claim of large doses of Vitamin C as a cancer cure. He wrote a scathing medical journal editorial questioning the worth of the immune system booster interleukin-2. He warned about the overhyping of the cancer drug interferon.

All the same, by the spring of 1989 it was clear even to Moertel: Levamisole and 5-FU in combination were substantially reducing recurrence of colon cancer.

In June, 1989, he called the FDA. Preparations soon began to arrange for doctors to get levamisole from the NCI, under certain rules, before the FDA approved it for marketing.

The next step was to secure FDA approval. This was the responsibility not of the Mayo Clinic or the NCI, but of the levamisole patent-holder -- Johnson & Johnson. (5-FU already had FDA approval; no longer under patent, it is sold by

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several companies.)

"Who else could have filed an application?" Moertel asked recently. "I guess I could have. It's not my business to make money on drugs, though. I don't care if the drug company makes money off my work. I get paid a nice salary. And I'm doing something good for folks. I have a nice home, and I'm going fishing this weekend. What more do I need?"

Contacted by the NCI, representatives from Johnson & Johnson met Moertel, FDA and NCI officials in Rockville in September, 1989. It was here that Moertel sought -- and thought he'd secured -- Johnson & Johnson's promise to market levamisole at "a reasonable cost."

On Oct. 2, at an NCI press conference and in a Journal of Clinical Oncology article, Moertel's team announced the results of their Phase I study. Until the FDA cleared levamisole for commercial sale as a cancer treatment, the NCI advised, it would be provided to doctors on a free, experimental basis. When it is cleared for sale, said a spokeswoman for Janssen Pharmaceutica, the drug would be "reasonably priced."

Two weeks later, the NCI gave the company the data tapes from Moertel's study. On Oct. 31, Janssen Research Foundation filed a new drug application with the FDA. On Feb. 1, 1990, Moertel -- having paid for his hotel and airfare to avoid any accusations of conflict -- made a presentation on Johnson & Johnson's behalf before the FDA's oncologic drug advisory committee, a group he'd previously sat on for 13 years. On Feb. 8, Moertel's report of his large Phase II study appeared in the New England Journal of Medicine. On June 18, the FDA gave Janssen approval to market levamisole as a cancer treatment in combination with 5-FU.

A process that on average takes drug companies 2 1/2 years had, with Moertel's endorsement, taken six months.

"It's hard to say what I would have done if I hadn't been assured about the pricing," Moertel said later. "They could have gotten the approval on their own; it just wouldn't have been as easy or quick or cheap. And my main interest was to get this on the market quickly. My main interest was to save lives."

Doctor Storms Around

One morning in late September, 1990, a 77-year-old farm woman named Annie Rhymes stopped by her drugstore in Rockport, Ill., to fill a prescription for her post-operative colon cancer treatment. She gasped when she learned a bottle of levamisole would cost \$200.

After all, down the road from the pharmacy, at the local Farm & Fleet store, a comparable bottle of levamisole intended for sheep was priced at \$6.39.

When Rhymes raised the matter with her physician, he too was taken aback. Dr. Merickston Nicholson knew Rhymes couldn't afford \$200. He also believed the pills over at the Farm & Fleet were the same drug, only a larger dose; according to Moertel at the Mayo Clinic, they had different inert fillers, but were manufactured to federal standards as rigid as the FDA's. If Rhymes were of a mind to, she could buy her pills at the Farm & Fleet, break them up, and take half a pill three times a day.

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Nicholson thought this situation was ridiculous. He also thought it merited public attention, so he called the local newspaper. A day later, a reporter for the Rockford Register called the Mayo Clinic. Moertel erupted when the reporter told him the news.

He began to "storm around," as he later put it. He provided the reporter with a string of angry quotes. He protested to Johnson & Johnson sales representatives. He spoke out during appearances before professional groups.

In time, Johnson & Johnson apparently grew concerned over such a public demonstration by a highly respected cancer researcher. One day, a company representative called Moertel from Johnson & Johnson headquarters in New Brunswick, N. J. Could they fly out to the Mayo Clinic to discuss this matter? Soon, two Johnson & Johnson vice presidents were in Moertel's office, spreading out their graphics.

"They talked about all the money they'd put into basic research," Moertel recalled. "Then they showed me charts with three price-structuring options. The first, \$400 for a year's supply of levamisole, covered profit, marketing and research, even though the taxpayers actually paid for (our) research. The second and third options, \$800 and \$1,200 for a year's supply, covered no additional research or profit; it was all for more promotion."

Moertel understood perfectly why the vice presidents assumed these charts would please and mollify him. Many of those extra promotional dollars attached to the \$1,200 annual price tag, after all, would go to doctors and hospitals.

Most marketing by drug companies is aimed not at the consumer, but at the medical community that writes the prescriptions. This marketing often comes camouflaged as educational and research grants. Increasingly, health economists say, drug companies are hiring doctors as "consultants," and sponsoring conferences, and offering "contributions" to clinics and nonprofit hospitals.

Those who study such matters believe drug makers spend about \$12 billion annually on marketing and promotion -- about \$1 billion more than they do on research and development. Educated estimates vary, since the industry will not reveal precise figures, but Stephen W. Schondelmeyer, a professor of pharmaceutical management at the University of Minnesota, says a typical drug company spends 16% of its budget on research and development and 20% on promotion.

Watching this trend build in recent years, Moertel has grown ever more dismayed. Doctors have always been offered a box of golf balls or doughnuts, but now there are enormous amounts of money on the table. Now every medical group Moertel knows is taking drug company money.

More than once, Moertel himself has received overtures. One drug firm wanted to give the North Central Cancer Treatment Group \$80,000 with no strings attached and no tie-in to the company's products. To Moertel, this was not research and development money, this was drug company "marketing." He turned it down.

The promotion chunk of Johnson & Johnson's levamisole pricing chart looked to Moertel to be nothing more than giving money to doctors and clinics.

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"They didn't have to promote levamisole," he said. "They had extraordinary publicity, and taxpayer-paid research. In essence, they were promoting Johnson & Johnson, not the drug. They were cultivating goodwill by putting money into doctors' pockets. I was not pleased. The patients have to pay in the end. We doctors can pay for our own continuing education."

For a while, Moertel still hung back, reluctant to push the matter further. When the CBS show "60 Minutes" came calling, he declined. Moertel hoped the matter could be resolved privately.

There was no resolution, however. Instead, Moertel watched Johnson & Johnson continue to spend promotional money.

The company, according to Moertel, asked a Mayo Clinic colleague to be a consultant on an "educational program" for doctors, and ended up paying him \$4,000 for editing four sentences that were already written. Other Mayo colleagues, Moertel reported, were provided free airline tickets, hotel rooms and honorariums to "edit" an already prepared slide show.

"Johnson & Johnson also followed me around," Moertel said. "They'd show up at conferences where I was talking. For a while, they were chasing me around with money. I couldn't get away from it. I was scheduled to speak at a Scripps conference in San Diego. Johnson & Johnson went to the Scripps people and said they wanted to make a donation, they wanted to pay for the cost of Moertel's participation. When I learned of this, I refused to go if they were paying."

Moertel's brushes with Johnson & Johnson, in time, set him to stewing more generally about the pharmaceutical industry.

He'd frequently heard drug companies argue that their high profitability was justified because theirs is a high-risk business. We spend an average of \$231 million and 12 years to bring each new drug to market, they'd always point out, and only one of 5,000 compounds tested results in an FDA-approved drug. Without high returns, there'd be no incentive for innovative, risky research. Without high returns, there'd be fewer drugs that save lives and reduce the ruinous cost of surgery.

Although these arguments undeniably carried some weight in the medical community and on Capitol Hill, Moertel by now had little patience with such talk. It would be easier to accept the drug companies' arguments, Moertel felt, if they didn't spend more on promotion than research, and didn't pour an average 58% of their research money into "me too drugs" that duplicate what's already on the market, and didn't benefit so greatly from the taxpayer-financed work of academic and federal researchers. NCI-funded scientists alone, Moertel knew, had played key roles in developing 70 cancer drugs being marketed by private companies.

The last straw for the Mayo Clinic professor came when he learned that a year's supply of levamisole in Europe -- marketed as a cancer treatment, not a dewormer -- was going to average \$150, one-eighth of the cost in America. "American consumers are supporting research and development for the world," he fumed. "They're tough over there in Europe and we're pussycats. We're the only Western nation that doesn't regulate drug prices. This is out of hand. This is nonsense."

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In the spring of 1992 -- after his levamisole study was formally completed, after he was convinced they had a treatment that truly worked -- Moertel decided to go public with his grievances.

He looked at his calender. The annual meeting of the American Society of Clinical Oncology was coming up in San Diego in May. He was scheduled to speak at the plenary session, where he'd submit his final study results. That would be the best forum, he decided. That's where he'd make a public fuss.

On May 19 at the San Diego Convention Center, before an audience of 5,000 doctors and a couple of national news cameras, Moertel devoted most of his talk to his study's final results. Then, near the end, he added two or three lines about levamisole's cost.

The pricing was "unconscionable," he said. "We were specifically promised that it would be marketed at a reasonable price. . . . I'd think after 25 years of profitable marketing, they'd more than made up their costs. The National Cancer Institute, funded by the American taxpayer, sponsored this study. . . . The company got a present dumped in its lap. We gave it to them on a silver platter."

At least implicitly, Moertel was pointing a finger not just at Johnson & Johnson, but also at those of his colleagues who help keep drug prices high by accepting the pharmaceutical industry's "promotional" dollars. So he wasn't sure what kind of response he'd get.

What he got was a loud, huge, sustained ovation. Afterward, many from the audience approached Moertel to congratulate him. You're right, I agree, what can we do? they kept asking.

"Make the Johnson & Johnson-Janssen booth here the loneliest place in town," Moertel suggested.

Company Holds Firm

A flurry of newspaper articles followed Moertel's speech. So did an appearance on the ABC-TV program "PrimeTime Live."

As a result, several colon cancer patients came forward to say they decided to take the sheep version of levamisole, even though Johnson & Johnson -- differing with Moertel -- warned that it is "totally unsuitable for human consumption."

Soon, levamisole was regularly being invoked in the continuing national debate over drug company pricing and health care reform. In Chicago, after watching Moertel on TV in the summer of 1992, Frank Glickman, a 47-year-old real estate business consultant who'd recently undergone colon cancer surgery and levamisole/5-FU treatment, filed a class-action lawsuit challenging Johnson & Johnson's patent on levamisole and seeking damages for the drug company's "unconscionable and outrageously excessive price."

In the face of such aggressive responses, Johnson & Johnson so far has held firm.

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The annual \$1,250 cost of levamisole "is less than the average cost of one day's confinement in a hospital in the United States . . . " observed Johnson & Johnson spokesman Kniffin in a written statement. "Among available cancer drugs, Ergamisol (the company's brand name for levamisole) is very modestly priced. . . . For patients deemed financially unable to pay, we have maintained an indigent patient program that provides Ergamisol free of charge. . . . Over a period of some 25 years, more than 1,400 costly studies involving over 40,000 patients were completed. . . . It was this work, including tens of millions of dollars of research investment made by our company, that led to a study funded by the National Cancer Institute that showed the effectiveness of levamisole. . . . Profits from the sale of Ergamisol . . . will probably never cover the cost of our total investment in research and development for this compound for human use."

Although equally resolute, Johnson & Johnson's reply to Frank Glickman's lawsuit -- which is still in the preliminary-motion stage -- sounded a somewhat different theme. Rather than mention "research costs" or "indigent programs," the drug company's legal brief focused mainly on the monopoly rights of a patent holder.

"Whatever (its) merits, (Glickman) cannot bring this lawsuit . . . " the drug company's memorandum of law argued. "Patentees are given the right to charge whatever price the market will bear for their patented products. . . . (This) freedom . . . is a right deliberately given by the federal government to patent owners in order to reward them for their useful inventions that improve our society. . . . Glickman's complaint is . . . a complaint about federal patent policy itself. As such, it may be remedied -- if at all -- only in the Congress, not in this court."

Johnson & Johnson probably is right. The courts generally have not supported attacks on what is, finally, a monopoly granted under federal patent law. In late July, two generic drug firms that were challenging the Burroughs Wellcome Co.'s patent on the anti-AIDS drug AZT -- because federal money and researchers played a key role in its development -- lost their battle when a federal judge decided he could "no longer find a legal basis for the case."

If changes are to come, they probably must be fashioned -- as Johnson & Johnson suggests -- in Congress. Whether that will happen is unclear.

Over the years, Congress has made frequent but usually fruitless efforts to regulate the drug industry. In 1990, a Senate committee held hearings on the industry's promotional activities, and in 1991 the FDA tried to limit some "continuing education" promotional efforts, but these efforts faltered in the face of negative pressure from the American Medical Assn. So did reform bills introduced in November, 1991, by Sen. David Pryor (D-Ark.) and Rep. Pete Stark (D-Oakland).

Talk still mounts about regulating the pharmaceutical industry as governments do utility monopolies, or letting any company market a drug if it pays a royalty to the patent holder. But Moertel's by-now thoroughly impassioned battle cry -- "We need a price control system, and this business about levamisole shows why" -- will face tough challenges when a health care reform package goes to Capitol Hill.

A Mystery Lingers

Los Angeles Times, September 12, 1993

The particular resolution to the levamisole story, at any rate, may very well come from the laboratories of the Mayo Clinic rather than from the halls of Congress. After all, there's still a lingering mystery about levamisole waiting to be solved. There's still an unanswered question about the true medical value of Johnson & Johnson's drug.

Leading scientists now agree that levamisole -- by itself -- has utterly no effect on cancer. Earlier studies that suggested otherwise -- the earlier studies that helped Johnson & Johnson win a patent in 1986 -- have been soundly refuted in more recent trials.

"Treatment with levamisole alone had no detectable effect," Moertel reported in his February, 1990, New England Journal of Medicine article. "Our study and (another) recently reported trial . . . provide convincing evidence that levamisole alone is of little or no value in patients with colon cancer."

Scientists simply aren't sure why the combination of levamisole and 5-FU works. Some think levamisole enhances 5-FU's effect by boosting the patient's immune system. Some think levamisole and 5-FU may undergo a biochemical reaction when combined. And some think levamisole doesn't do anything at all.

In an editorial published alongside Moertel's study in the New England Journal of Medicine, Dr. Robert J. Mayer of the Dana-Farber Cancer Institute in Boston wrote: "It is possible . . . that the observed effect of (5-FU) combined with levamisole may be attributable to (5-FU) alone, perhaps administered with better compliance among patients than (in) previous trials." Studies show 5-FU "may also be enhanced" by folinic acid. This combination "might prove to be far more effective" than 5-FU and levamisole. Which combination is best "remains to be determined."

The laws of nature, in other words, might yet prove a greater influence on levamisole's price than the laws of Congress or the U.S. Patent Office. Levamisole's greatest value might yet turn out to be as a wondrous -- and inexpensive -- dewormer for humans and farm animals all over the world.

GRAPHIC: Photo, Dr. Charles Moertel holds a pill of levamisole, a common animal dewormer, which he discovered could aid colon cancer patients. Associated Press

TYPE: Non Dup

SUBJECT: MEDICAL RESEARCH; CANCER RESEARCH; MEDICAL TREATMENTS; PRESCRIPTION; DOCTORS; PRICES; JOHNSON & JOHNSON; PHARMACEUTICAL INDUSTRY -- UNITED STATES; BUSINESS ETHICS; LEVAMISOLE (DRUG); FLUOROURACIL (DRUG)

RESEARCH: Doctor Feels Betrayed by Drug's Price

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Associated Pro

Dr. Charles Moertel holds a pill of levamisole, a common animal dewormer, which he discovered could aid colon cancer patients.

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"Drug research is like an orchestra," Janssen wrote soon after

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Because levamisole's credentials as a stand-alone cancer drug

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team announced the results of their Phase I study. Until the FDA cleared levamisole for commercial sale as a cancer treatment, the NCI advised it would be provided to

their graph

"They told us they'd pay for the Moertel study," he showed the price structure. First, \$400,000 for levamisole, then for the testing and research. Taxpayers pay for the research. Options, \$80,000 for supply, cost of research or promotion.

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Those who believe drug R&D costs \$12 billion and promise more than a decade of development may vary, since the data reveal precisely the opposite. W. Schomburg, a pharmaceutical economist at the University of California, San Francisco, says that the typical drug takes only 12 months of its budget to develop.

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NWESA:

From Peggy Gishman
 NPR
 822-2784

Weekend Edition (Sat.) (NPR) September 25, 1993

Transcript #1038 Segment #6

Why are Prescription Drugs so Expensive?

NEAL CONAN, Host: One important concern in the health care reform debate is the price of prescription drugs, which has risen at nearly three times the rate of inflation over the past decade. One widely respected cancer researcher has become an outspoken critic of drug pricing and the practices of many drug manufacturers. Dr. Charles Moertel of the Mayo Clinic in Minnesota discovered that Levamisole, a drug long used to de-worm farm animals, apparently reduces the recurrence of colon cancer in post-operative patients, and rather dramatically. He helped the drug's manufacturer, Johnson & Johnson, get speedy approval of the drug for human use. What he did not expect, indeed what he said he was specifically promised would not happen, is that the price of the drug would leap 100-fold. Johnson & Johnson says that given the difficulties and failures drug companies face with many drugs, the increase was completely justified. Dr. Charles Moertel joins us from the studios of Minnesota Public Radio in Rochester, Minnesota. And welcome-

Dr. CHARLES MOERTEL, Cancer Researcher and Consumer Advocate: I'm pleased to be with you.

CONAN: Tell us how Johnson & Johnson came to make that promise to you- that this would be priced reasonably.

Dr. MOERTEL: Well, when it became apparent to us that this drug, when used in combination with a chemotherapy drug, was really of substantive value to colon cancer patients, we worked together with the Food and Drug Administration and with Johnson & Johnson, trying to bring this to the public in the most expeditious manner. We donated our services to try to assist Johnson & Johnson in getting this drug to the market quickly. As a part of this working together agreement, I'd asked them about the pricing, and they assured me that this drug would be marketed at a reasonable price.

CONAN: But when it actually went on the market, the price went from six cents a pill when it's used as an animal de-wormer, to six dollars a pill as a human cancer drug. Are there any possible explanations that you know of for a price increase when it goes to human use? I mean, I guess- I

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would think a company has to test the drug to make sure it's safe.

Dr. MOERTEL: Well, first of all, the company, for most drugs, incurs some research costs. For this particular use of this drug, however, the company paid nothing. This was all supported by tax dollars from the American public. Eleven million dollars was spent by the American public in developing this drug for this use for Johnson & Johnson. So research expense is rather hard to defend. Certainly, uh, manufacture of the drug- it's no more expensive to manufacture this drug for people than it is for

sheep. The primary increase in cost was due to promotional efforts, where the company takes this money and goes out to doctors to promote the company's name and the company's product.

CONAN: I want to get to the promotional aspects in just a moment, but Johnson & Johnson did tell us that, yes, this particular study was funded by the government, but they had done many other, earlier studies and what they're doing now is just recovering their costs.

Dr. MOERTEL: Well, they can recover those costs very, very quickly, and indeed this drug had been one of the most profitable drugs for animal de-worming and for people de-worming for a long, long time. So the profits in prior research were easily paid for by what had been done with this drug in [the] past. They did not stimulate this research. This was just given to them by the American public.

CONAN: I wanted to clarify one thing- is the drug that Johnson & Johnson is now marketing at six dollars a pill in this country for use in colon cancer treatment, exactly the same drug that you can walk down the street and buy from the veterinary store at six cents-

Dr. MOERTEL: You bet it is. It is exactly the same drug. The only difference is the filler, and in order to get a sheep to swallow the pill you have to give them a bigger pill than to get a people [sic] to swallow the pill. But the active ingredient is precisely the same compound.

CONAN: Now, going on to the promotional aspects of it- I think we have to understand that the drug companies are marketing not to people at large, at least not for prescription drugs, but to doctors, and I think that most of us think of promotional marketing and think of what, you know, a set of golf balls or something that a doctor gets in the mail with a- or a prescription pad with the name of a drug on it.

Dr. MOERTEL: Right, now that used to be the case in years past, but this has changed considerably, and promotion of drugs has taken on new clothes. It's now known as education. The pharmaceutical companies will donate many thousands of dollars to support educational conferences at hospitals and at clinics and at national meetings. I suppose this is all well and good, but I would put to you that we doctors are not underpaid. There are few of us at the poverty level. I think we can darn well afford to pay for our own education and we should not be putting this on the backs of our patients.

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CONAN: Now when you're talking about this- I guess it's a relationship between the drug companies and the doctors, I would think that you would have to find fault with the doctors as well.

Dr. MOERTEL: Yes, I do. I think that a lot of this occurs because we allow it to happen. And some of these promotional efforts are really, in my judgment, unconscionable. One of my colleagues, for example, was offered four thousand dollars just to review four sentences in promotional brochures for Levamisol. Now that's nothing more than a gift. It, you know, it takes no more than five minutes to look at these four sentences. We should not be taking this type of money. For us to take gifts directly

or indirectly through educational vehicles or other- and allow this to be put on the backs of our patients, I think is quite unfair of us. I think the responsibility has to lie on the shoulders of us both.

CONAN: I know you feel- must feel terribly ripped off in all of this and used, but isn't it possible that the drug companies- I mean they do test an awful lot of drugs, most of which I guess don't make it to the market, or even if they do, don't make a lot of money- isn't a price increase for a winner- something that is going to make the money- doesn't that cover the costs of all these other tests that don't go anywhere.

Dr. MOERTEL: Well, I have no objection to a drug company making a fair profit, and I have no objection to drug companies covering research charges, but they are really a mile ahead of the rest of the industries. Their profit margin, with all their risks and drugs that don't make it, has been three times that of the Fortune 500. So, no, I have no problem with them making a fair profit, but their profits and their charges, their inflationary rate, has been just grossly excessive.

CONAN: How did this fundamentally change, or has it fundamentally changed, your view of this entire relationship?

Dr. MOERTEL: Certainly the pricing has changed in a remarkable way. The cost of drugs didn't used to be a dominant factor in health care delivery. Every new drug over the last decade has come out with just extraordinary price tags on them- not only for treating cancer- and we have no idea exactly what the price structure is that goes into these new drugs that are brought on market, because this is all a carefully kept secret. I would suggest that all this become public knowledge because the public is paying the bills for this. And certainly defend all the rights of the pharmaceutical industry to fair profit and to research costs, but also let's defend the interests of the public before we allow these extraordinary prices to come out on the market.

CONAN: Thank you very much. Dr. Charles Moertel of the Mayo Clinic, speaking with us from the studios of Minnesota Public Radio in Rochester, Minnesota. It's now 29 minutes before the hour.

[The preceding text has been professionally transcribed. However, in order to meet rigid distribution and transmission deadlines, it has not been proofread against audio tape and for that reason cannot be guaranteed

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Page #3

as to the accuracy of spelling or speakers' words.)

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SECRET

WILLIAMS & ANDERSON

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111 CENTER STREET
LITTLE ROCK, ARKANSAS 72201

W. JACKSON WILLIAMS

August 23, 1993

Mr. Thomas F. McLarty
Chief of Staff
West Wing, White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Attn: Ms. Janine Stanzione

Re: Federation of American Health Systems

Dear Mack:

Following our telephone conversation the other day I wish to request the rescheduling of an appointment for Mr. Michael D. Bromberg, Executive Director of the Federation of American Health Systems with you. Our meeting originally scheduled for August 17 was postponed at your request as several White House aides who have dealt with health care could not be available for that meeting.

Mr. Bromberg is most desirous of a meeting with you. He would like to discuss nonsubstantive matters dealing with healthcare issues, that is, the practicalities of how several of the Administration's healthcare initiatives might more readily be accomplished. You have met Mr. Bromberg informally on one of your neighborhood walks. He is the owner of Winston, a rather sizable mastiff.

Janine advised me that it will be at least the week of August 30 before you could consult with the President concerning healthcare and that you would prefer to delay scheduling any meetings until such time. I will be back in touch with you after August 30, but in the meantime I wanted you to have this request before you. Our suggested dates are either Wednesday, September 8 or Thursday, September 9, with September 9 being our preference.

Mack, your assistance and cooperation in this matter is appreciated.

Cordially,

WILLIAMS & ANDERSON


W. Jackson Williams

WJW:js
cc: Mr. Michael D. Bromberg

① Huc - Loo
② Your advice
or this?
muf
cc: Skunk
③
VIA TELECOPY
No. 202-456-1121
(501) 372-0800
TELECOPIER
(501) 372-0800
Des

"A Guide to Health Reform", *U.S. News & World Report*, September 27, 1993
Policy Fact Check

Q1: CAN YOU GIVE IT TO ME IN A NUTSHELL?

Description of overall approach is both positive and accurate.

Q2: TELL ME MORE ABOUT "HEALTH ALLIANCES"

Accurate description

Q3: HOW WOULD ALLIANCES WORK?

Overall, this too is a fair and accurate description.

Two slight mischaracterisations:

"This core health plan would be available in up to 15 different ways packaged by various insurers - for example, Prudential, Travelers, Aetna, Cigna, or any of dozens of smaller firms."(p.29)

Health plans could be organized by insurers, like those mentioned, but will also be organized by groups of doctors and other community-based practitioners who choose to put together their own plan. There will be special help available to these groups wishing to organize their own plans, including a loan program within HHS to assist in the development of community-based health plans.

"You could choose traditional "indemnity" insurance that gives you complete freedom to select your own health providers One caveat: this type of coverage would probably cost you substantially more."(p. 29)

While people who pick indemnity plans will definitely have higher out-of-pocket costs than people who choose more managed plans, there really isn't evidence that premiums will be "substantially" higher. Some assume premiums will be higher, but others, like Phil Nudelman, the CEO of Group Health Cooperative of Puget Sound, don't think that's necessarily true.

Q4: HOW MUCH CONTACT WOULD I HAVE WITH THE HEALTH ALLIANCE?

Accurate, except that the article says the health security card "would be encoded with much of your medical and insurance information".(p29) Our plan says "the card itself contains a minimal amount of information."

Q5: HOW GOOD IS THE STANDARD BENEFITS PACKAGE?

Our benefits package is much better than this answer implies. Here's where they're wrong:

"The package is about as generous as 60% of private health policies in the amount of money patients must spend out of pocket for obtaining covered services."(p.30)

In fact, our plan offers better overall protection than most plans for the following reasons:

- Our plan has no lifetime limit. More than 2/3 of people privately insured today have policies with lifetime caps-- dollar limits on what your insurer will pay out for you over the lifetime of your policy. People with chronic or catastrophic illnesses often exhaust their insurance coverage.
- Our plan has free coverage of primary and preventive care services. (see below)
- Our plan has good prescription drug coverage, and spending on prescription drugs goes toward the annual out-of-pocket limit. Many plans out there today won't count spending on prescriptions toward the out-of-pocket limit.

"Many women now have health policies that pay for good preventive care, including regular mammograms and Pap smears."(p. 30)

In fact good coverage of preventive care is a rarity in today's system-- only 30% of people currently insured have regular physicals covered. Ours is a much stronger preventive and primary care package than virtually any policy on the market currently.

"Clinton's package covers mammograms only for women over the age of 50 and generally pays for Pap smears just every three years."(p. 30)

Our 236-page plan includes what's called a "periodicity table" -- a table that lays out the optimal timing for preventive services like immunizations, mammograms, Pap smears and cholesterol screenings. This table represents what the U.S. Preventive Services Task Force determined were the best time periods for these services, as published in their "The Guide to Clinical Preventive Services". *All these services, when delivered at these intervals, are provided free of charge, no matter what plan a person is enrolled in.*

In addition, if for whatever reason a woman and her doctor that it is medically appropriate to perform a mammogram at a younger age, or to have Pap smears every year even if they are always normal, then *these are still covered services*, they are just subject to the same cost-sharing provisions as are all the other covered benefits.

"Similarly, mental health coverage in Clinton's plan falls short of what's in today's state-of-the-art insurance plans...the trend is to offer broader coverage for mental health but to manage it closely, to make certain that patients get really cost-effective care."(p. 30)

Ours is a strong package of mental health and substance abuse benefits, and it gets better over time. The successful innovative models used by private employers were one of the factors that influenced the design of our mental health and substance abuse benefits. It is this private sector experience that led to the decision to phase-in a more comprehensive mental health benefit for the year 2001.

And states have the flexibility to implement a more integrated mental health package sooner, and to conduct demonstrations on the cost-effectiveness of managed mental health benefits.

"States could also enrich the standard package if they chose to - an element of the plan that has the employers, who'd pay the lion's share of the bill, absolutely panicked."(p. 30)

The plan specifically says that any state choosing to offer more comprehensive benefits would have to raise the money through some mechanism other than a tax on employers-- a provision built in to protect employers.

Q6: CAN I BUY ADDITIONAL COVERAGE IF I WANT TO?

Accurate. There will be two standard supplemental policies, one to cover cost sharing, one that provides additional benefits. There is no subsidy for supplemental policies, nor are they tax-deductible. Any other non-covered services people want (i.e. cosmetic surgery) they will have to pay for themselves unless, like the article says, their employer chooses to cover the costs.

Q7: FIRMS ABOVE 5,000?

Accurate. One clarification: if a company decides to create a "corporate alliance", they will need to offer not only an indemnity plan, but at least two other plans as well, so that their employees have a choice.

Q8: WHAT HAPPENS TO COUPLES WHO WORK IN TWO DIFFERENT COMPANIES?

Accurate.

Q9: WHAT IF I LOST MY JOB?

Accurate

Q10: WHAT IF I WORK PART TIME?

Only if a person works more than 10 hours a week would that employer contribute to that workers' coverage. (The article says one hour a week-- not true)

Q11: COVERAGE THROUGH CHAMPUS?

Accurate

Q12: EARLY RETIREES?

Accurate

Q13: 67-YEAR-OLD MEDICARE PERSON-- WHAT HAPPENS?

Accurate, and very favorably described.

Q14: WHAT DOES AVERAGE JOE OR JANE PAY?

Depends on final decisions about premium levels, but employer contribution is definitely not accurate: the employer would pay about \$2,240, not \$3,360.

Q15: WHAT IF I LIKE MY COVERAGE NOW?

I don't think we need to cede that these people will be "out of luck". Bob Boorstin has prepared an answer for this question, which I have attached.

Health Security Plan

"If you like your insurance today..."

Summary

People who like their health insurance today have a lot to gain from the health security plan. First -- and most important -- they'll get something that no amount of money can buy in today's insurance market: security. Lose your job? You're covered. Want to change jobs? You're covered. Your child gets sick? You're covered. You just can't guarantee that today.

People who like their health insurance today will also get increased choices, the chance to stop trading wage increases for the same health benefits, and preventive care benefits that will keep them healthy. Even those Americans who are satisfied with what they've got now have plenty to gain. And they'll probably pay less for better care.

Today

Millions of Americans have worked hard to get the solid health benefits that they enjoy today. Almost all of us have been forced to trade increases in our wages in order to maintain the same health benefits we had the year before. Or worse. And millions are locked into their jobs; they want to find better jobs but can't leave because they fear losing health insurance and not being able to get a new policy.

Even those with excellent health insurance packages live in constant fear of losing that protection. Insurance companies hold all the cards: they can drop you for almost any reason. If you move, change jobs, or get sick, your insurance can disappear overnight and, if someone gets seriously ill, bankrupt your family.

Health Security

The Health Security plan gives every American -- even those who like their health insurance today -- something no amount of money can buy today: guaranteed security. All Americans will receive a Health Security Card that guarantees a comprehensive package of benefits that can never be taken away. No ifs, ands, buts or fine print. No longer will American families be asked to make significant decisions -- about where to live, work or how to care for a sick relative -- based on discriminatory insurance rules.

The plan also:

- **Protects you if you lose your job.** Let's say your company offers you a Cadillac health plan today. That's great. But what happens if the company has to cut back and you lose your job? You lose that Cadillac plan and end up naked in the middle of the road.

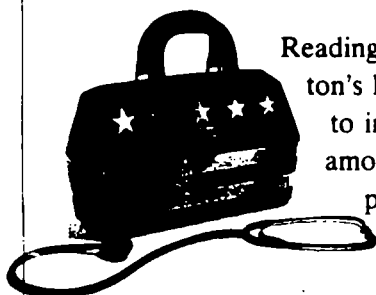
- **Increases your choices.** Today only one of every three companies that employ fewer than 500 people offers employees a choice of plan. And rising health care costs and the bottom line are putting choice out of the reach of more people everyday. The Health Security plan guarantees you a choice of at least three plans in every area: a traditional fee-for-service plan like many people have today, a network of doctors and hospitals, and an HMO-type plan. You -- not your boss or a benefits manager -- choose from whom and how you'll get care.

- **Helps restore lost wage increases.** The Health Security plan will give millions of American workers their first real chance for wage increases in years. For two decades rising health care costs have robbed American workers of wage increases they need and deserve. If we do nothing, health costs for an insured worker will rise from 1 in 5 to 1 in 4 dollars in just seven years. By giving business the bargaining power it needs to get affordable health care and helping provide for retirees -- whose health costs are killing some big manufacturers -- the Health Security plan helps workers.

- **Guarantees preventive care.** By providing a full range of free preventive care benefits, the Health Security plan offers all but a few Americans something new: care to keep them healthy, rather than coverage for after they get sick. Preventive care benefits include such things as physicals, immunizations, mammograms and Pap smears.

A guide to health reform

Answers in plain English to almost everything you ever wanted to know about the Clinton initiative—and how it could affect the medical care you get



Reading reports of President Clinton's health reform plan is bound to induce pain. The proposal is among the most complex social-policy initiatives ever crafted.

Some parts even dumb-founded experts. His team is now revising scores of details in the plan. Many will stay in flux long after it is formally unveiled this week—and will be debated for months by Congress.

Whatever its final shape, the plan would have a profound impact on most Americans' health insurance coverage and the care they receive. Many could gain more generous coverage at lower cost. Others would pay more for fewer benefits than they now receive. And millions of Americans would find themselves dealing with new entities called "health alliances."

Clinton says his proposal would yield less bureaucracy and induce competition to attack health costs. But in truth, the plan could substitute more layers of government regulation for less insurance company bureaucracy. New health plans might well restrain costs—but quite possibly by rationing health care. Here are answers to some of the most frequently asked questions about Clinton's plan.

YOU'RE RIGHT—I'M THOROUGHLY CONFUSED ABOUT CLINTON'S PLAN. CAN YOU GIVE IT TO ME IN A NUTSHELL?

■ The president has diagnosed two major ills with America's health care system. The nation's overall health spending, and health care prices, are growing too fast compared with everything else in the economy—and America already spends one third more per person on health care than the next most expensive country, Canada. Partly because of these pressures, too many Americans are losing their health insurance. About 1 in 4, Clinton says, will be without coverage sometime in the

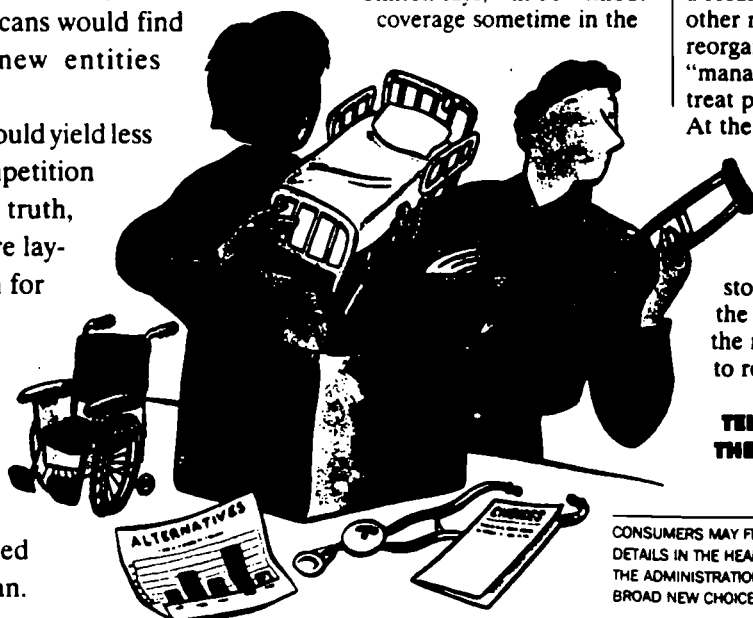
next two years. "The fact that we have permitted this system to persist, because of the difficulty of resolving it, is one of our deepest problems," the president told *U.S. News* in an interview last week.

His remedy is twofold. First, he wants everybody back in the health insurance tent—by requiring employers to help pay for coverage; by subsidizing insurance for small businesses, low-wage workers and the jobless, and by setting up insurance-purchasing pools called "health alliances" to make policies cheaper. He'd require that most people get a prescribed package of benefits almost as good as those offered by most big companies. That would give Americans "health security"—the faith that they would have insurance no matter what fate befell them.

Meanwhile, the president would also try to control health costs. He would cap the two big government health programs, Medicare and Medicaid, so that they grew only about half as fast as they are growing now. Under Clinton's plan, the government would also rewrite the rules for the health-coverage market, so that private insurers would compete by taking care of people in more cost-effective ways, not by tossing sick people overboard as many do now. As a result, doctors, hospitals and other medical providers would reorganize themselves into "managed care" networks to treat people more efficiently.

At the same time, Uncle Sam would impose strict limits on the rate at which private health premiums could rise. These are backstops, Clinton says, in case the competitive forces of the market don't do enough to restrain costs.

TELL ME MORE ABOUT THESE "HEALTH



CONSUMERS MAY FEEL OVERWHELMED BY THE DETAILS IN THE HEALTH REFORM PACKAGE, BUT THE ADMINISTRATION BELIEVES THEY WILL LIKE THE BROAD NEW CHOICES FOR HEALTH COVERAGE.

ALLIANCES." WOULD I GET MY MEDICAL CARE AT A HEALTH ALLIANCE?

■ No. A "health alliance" isn't a bunch of doctors and hospitals, its awkward name notwithstanding. The White House picked that moniker over an alternative, "health-insurance-purchasing cooperatives," an inelegant phrase that more aptly describes the function of these organizations. In effect, they are like giant consumer cooperatives you might join to get a discount on bulk purchases of food. But instead of food, they market health insurance. By selling it in bulk, they can give the same price breaks to small businesses and individuals that are normally available only to large companies. Insurance premiums can be lower than the ones usually offered to small firms because the risks of people getting sick and running up big medical bills are spread across a broad population.

SO HOW WOULD THE ALLIANCES WORK?

■ Imagine a giant restaurant chain with just one item on the menu: steak. However, at any restaurant of this chain, you can get a steak cooked several different ways, and the price varies depending on the cut you order. The so-called regional health alliances would function the same way. The "steak," however, would be a standard package of health benefits (key elements of which appeared in last week's issue of *U.S. News*). But just like having a choice among a T-bone, a sirloin or a filet mignon, this core health plan would be available in up to 15 different ways packaged by various insurers—for example, Prudential, Travelers, Aetna, Cigna or any of dozens of smaller firms. Incidentally, under Clinton's plan, no insurer could refuse to pay for treatment for a pre-existing medical condition or deny you coverage because you had one. And you wouldn't pay higher premiums just because you happened to get sick.

When sorting through

HOW CLINTON'S PLAN AFFECTS WORKERS

The proposal contains hundreds of provisions that would reshape the insurance coverage of workers and their families. There would be lots of winners—such as small-business workers who now lack insurance but would gain broad coverage at relatively low cost. There would also be

plenty of losers: For instance, well-paid workers with generous insurance coverage could end up paying more for fewer benefits than they now have. U.S. News asked the consulting firm Towers Perrin to examine the effect of Clinton's draft proposals on several prototypical families.

GAINING NEW COVERAGE

A \$30,000-a-year banker supporting her family has good health coverage at present—but it won't pay for her treatments for a pre-existing thyroid condition.

CURRENTLY: As it stands, the banker's family health policy costs \$5,600 a year; she pays \$1,500 of that. Out-of-pocket payments for tests and medication for her thyroid problem require an additional \$600.

UNDER CLINTON'S PLAN: Her total insurance premium would drop to \$4,200 for an average plan; the banker would pay 20 percent, or \$840, of that, and her employer would pay the rest. Her pre-existing condition would automatically be covered.

ESTIMATED SAVINGS: The banker's out-of-pocket costs for health coverage would drop by \$1,260 a year.

your health-coverage menu, you could buy a policy offered by a health maintenance organization—a panel of hospitals and doctors with an insurance license, set up to give you

comprehensive coverage at one prepaid rate. Or, if you were worried about having the freedom to pick your own doctor, you could choose traditional "indemnity" insurance that gave you complete freedom to select your health providers. One caveat: This type of coverage would probably cost you substantially more—but how much more, the administration hasn't said. Finally, you could also pick a hybrid sometimes known as a "point of service" plan. This would give you generous HMO-like coverage when you picked from a special list of "preferred providers." When you visited a doctor or hospital not on the list, you'd pay up to 20 percent of the bill.

Under Clinton's plan, every state would have to set up at least one, and probably more, of these regional health alliances by 1997 (a few states, like California and Ohio, already have prototypes up and running). At least three quarters of Americans would get

their health coverage through the alliances. They would include everybody who worked for a company with fewer than 5,000 workers nationwide; the self-employed, the unemployed, part-timers, workers at employee-leasing firms, workers for the federal government (and probably state and local workers as well), people on Medicaid, and Medicare beneficiaries in states that decided to include them.

WHAT KIND OF CONTACT WOULD I HAVE WITH THE HEALTH ALLIANCE?

■ First, the alliance would send you your "Health Security" card—probably a "smart" card that would be encoded with much of your medical and insurance information. Then, during an annual open-enrollment season, you'd get a mailing from the alliance presenting a "menu" of insurance plans and lots of information about the doctors and hospitals that participated in each. You'd pick the plan you wanted, check it off on a ballot and return that to the alliance. The alliance would calculate your share of the premium and send you or your employer the bill. As with your taxes,

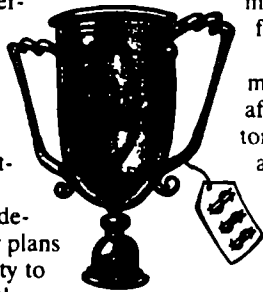


CLINTON SAYS AMERICANS WILL BE GUARANTEED HEALTH SECURITY. A NEW CARD THAT GIVES THEM ACCESS TO IT AND THE ABILITY TO PICK THEIR OWN DOCTORS.

■ COVER STORY

you could elect to have your share of the premium withheld from your wages. If you moved to a new area, or if you became unemployed and lost your coverage, you'd have to let the local alliance know within 30 days. If you didn't pick a plan yourself, the alliance would assign you to the cheapest one in the area.

Some states would run these alliances as government agencies, others as nonprofit corporations. There could be variation in exactly how they operated, but they would all play a major role in regulating health plans—in effect, monitoring everything from the prices the plans charged to the marketing materials they produced. Each alliance would also have an ombudsman to help you if problems arose with your health plan. You'd also get annual "quality performance" reports rating various health plans—for example, telling how long patients had to wait to get an appointment with a doctor. And consumers who decided they hated their plans would "have the ability to walk" by picking another one the next year, says Walter Zelman, a key member of the Clinton task force.



TOP-NOTCH BENEFITS WON'T BE TAXED UNDER CLINTON'S PLAN—BUT WILL THEY SURVIVE?

I'D LIKE TO KNOW A LITTLE MORE ABOUT THAT "STEAK"—THE STANDARD BENEFITS PACKAGE. HOW GOOD IS IT, REALLY?

■ In terms of the services it covers—visits to doctors, hospital stays, prescription drugs—it's identical to most private health plans. Where the package differs from private plans is in the amount of money patients must spend out of pocket when they obtain those services, notes Linda Berghold, a principal at the benefits consulting firm William M. Mercer, who also cochaired the working group on Clinton's health reform task force that drew up the benefits package. In this re-

spect, the package is only about as generous as 60 percent of private health policies. In other words, 40 percent of private plans pick up more of the bill for patients.

In striving to make the package affordable, Clinton's health team also pared it back in other significant ways. For example, many women now have health policies that pay for good preventive care, including regular mammograms and Pap smears.

But Clinton's package covers mammograms only for women over age 50 and generally pays for Pap smears just every three years. His plan doesn't cover adult dental benefits, although the president hopes to phase in coverage for preventive dental care by the year 2000.

Similarly, mental-health coverage in Clinton's plan falls short of what's in today's state-of-the-art insurance plans, notes Frank McArdle, a partner with the benefits consulting firm Hewitt Associates. The package proposed by the administration covers just 30 visits to a psychotherapist and up to 60 days of inpatient care a year. Today's trend among private em-

ployers is to offer broader coverage for mental health but to manage it closely, to make certain that patients get really cost-effective care.

The administration proposes to create a new National Health Board in Washington that would monitor, and periodically update, the standard benefits package as new research on treatments became available. States could also enrich the standard package if they chose to—an element of the plan that has employers, who'd pay the lion's share of the bill, absolutely panicked.

COULD I BUY ADDITIONAL COVERAGE IF I WANTED TO?

■ Yes, but unless your employer helped out, you'd pay

IF HEALTH COSTS FALL, COMPANIES AND THEIR WORKERS MAY WRANGLE OVER THE SAVINGS.



UNINSURED NO MORE

A worker at a big-city chain of hair salons earns \$15,000 a year but has no insurance coverage.

CURRENTLY: The salon can't find an insurer to cover its employees. Individual policies are too costly, so the worker pays \$6,450 in family health care expenses out of pocket.

UNDER CLINTON'S PLAN: The salon would help cover its workers through a regional health alliance. The firm's costs: 80 percent of a \$4,200 family policy. The worker would normally pay 20 percent, or \$840, but because she's a low-wage worker, she would get a subsidy that would limit her contribution for coverage to 1.9 percent of her wages, or only \$288.

ESTIMATED SAVINGS: This worker would save \$6,162 a year and get health insurance to boot.

for any supplemental benefits entirely out of pocket.

LET'S GO BACK TO THOSE ALLIANCES. HOW WOULD I GET MY HEALTH COVERAGE IF I WORKED FOR A COMPANY WITH MORE THAN 5,000 WORKERS?

■ A range of possibilities exists. One, your firm could elect to join a regional health alliance, so that you'd get coverage the same way as described above. Two, states would have the freedom under Clinton's plan to push everybody into a regional alliance, so that even employees of large firms could end up in one. Three, your firm could elect to form its own "corporate alliance." It would offer the standard package of benefits and at least one indemnity plan; what's more, the company couldn't deny you coverage for particular medical conditions. Finally, if you worked for a division of a larger company with fewer than 100 workers in your location, your company could elect to enroll you in the regional health alliance, while putting people back at headquarters into its corporate alliance.

MY HUSBAND AND I WORK FOR DIFFERENT COMPANIES.

WHAT WOULD HAPPEN TO US AND OUR KIDS?

■ If one of you works for a company with a corporate alliance, you can elect to get your family's coverage through it; otherwise, you and your children would all get coverage through a regional alliance. When your children went off to college, they would obtain coverage through the alliance in the area where the institution was located.

WHAT IF I LOST MY JOB?

■ Unless your spouse was still working, and could obtain family coverage through a corporate alliance, you'd get coverage through a regional alliance. Your contributions to the premium would be calculated based on your "unearned," or nonwage, income—for example, the amount of your unemployment-insurance benefits. Subsidies would be provided if your family income was below 150 percent of the federal poverty level, although the administration hasn't spelled out just how big these would be.

WHAT IF I WORKED PART TIME?

■ You'd get coverage through a regional alliance. Any employer you worked for—even for only an hour a week—would have to contribute a prorated share of the costs of your health coverage; you'd pay the rest. That would apply even if you were a domestic worker, like a baby sitter or housekeeper.

By the way, if you were an illegal alien, your firm would have to pay toward your coverage—even though you were not supposed to be working in the first place.

WE'RE A MILITARY FAMILY WITH COVERAGE MAINLY THROUGH CHAMPUS (CIVILIAN HEALTH AND MEDICAL PROGRAM FOR THE UNIFORMED SERVICES). WHAT WOULD HAPPEN TO US?

■ Clinton's plan gives the Pentagon the authority to develop

UNDER THE PLAN, CHANGING JOBS—OR LOSING THEM—WOULD NO LONGER BAR PEOPLE FROM OBTAINING HEALTH COVERAGE.



its own reform proposals. For example, the Defense Department would create special military health insurance plans for about 6 million active-duty troops, military dependents and retirees. The military plans would have to offer at

least the standard benefits package and might also supplement it with extra benefits; military hospitals would play a key role in delivering care, although the plans could also contract with civilian doctors and hospitals. Clinton's plan

envisioned that such plans could also be offered to military families through the regional health alliances.

I RETIRED AT AGE 55 FROM MY COMPANY. HOW WOULD I GET COVERAGE UNDER CLINTON'S PLAN?

■ The administration is still sorting out this question. As the plan now stands, you'd be covered through a regional alliance (unless your spouse had coverage through a corporate alliance and you secured insurance

that way). You'd pay 20 percent of the same average premium that you would normally pay if you were still working. The government, or the alliance, would pay for the rest.

Now, to add just a few more wrinkles: If your former company were already paying for your health coverage, it would switch over to paying your 20 percent share of the premium to the alliance. In that case, you'd pay nothing extra. Alternatively, if your income were below 150 percent of the federal poverty level, you'd get an additional subsidy to help pay your share of the premium.

One final caveat: Clinton hasn't yet said how he would pay for these whopping subsidies for early retirees. So until he does, it's best to consider this whole scheme up in the air.

I'M 67, ON MEDICARE. WHAT WOULD HAPPEN TO ME?

■ Little might change in the way you're currently covered, with a few striking exceptions. First, you'd gain some extra benefits. As of 1996, Medicare would add coverage for prescription drugs; you'd pay a \$250 annual deductible and 20 percent of the cost of each prescription up to an annual maximum of \$1,000. You'd also gain more options to enroll in an HMO or other managed-care program that might pick up an even greater share of drug costs. At some point,

PAYING MORE OUT OF POCKET

Under Clinton's plan, I have to pay an average of \$1,110 more for my health coverage. My company pays \$5,550 a year. The plan also has a \$1,000 deductible. So I pay little when visiting the doctor.

My company also pays for my vision. My firm would have to pay for my vision through a regional health alliance. The cost of the \$4,200 premium is \$840. My company would pay \$1,680 more, for less coverage.

SO LONG, FLEXIBLE BENEFITS

As a graphic designer, I have generous coverage for my children at an advertising firm.

CURRENTLY: Her rich family policy is worth \$6,100. Because her firm has set up a flexible-spending account, she can pay her share of the premium with pretax dollars. Her net cost: \$300.

UNDER CLINTON'S PLAN: Her company would contribute to her coverage through a regional alliance. The policy would cost \$4,200, but she would pay 20 percent of the cost with pretax dollars. Her tab: \$840. Her new policy would also have a \$1,000 deductible; she would pay an additional \$630 out of pocket for preventive care than the Clinton plan would allow.

ESTIMATED COST: She'd pay \$1,110 more, for less coverage.

COVER STORY

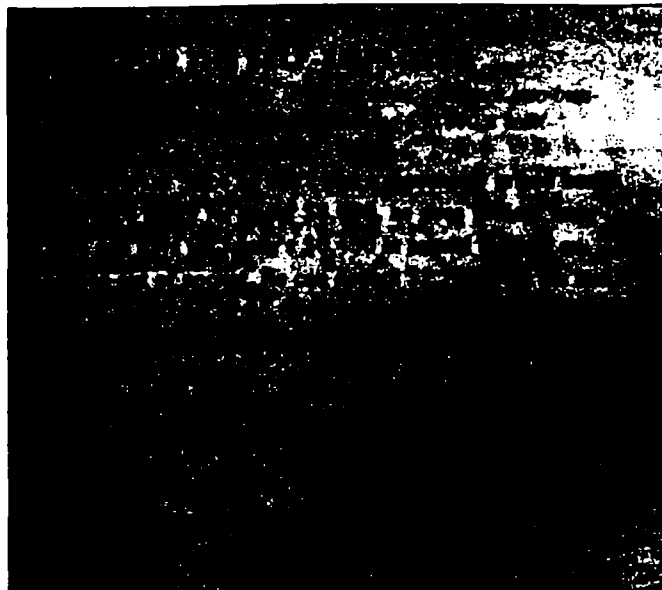
your state might elect to put Medicare beneficiaries into the regional health alliances, so you'd be picking your coverage from a menu of options just like everybody else. You could also benefit from a new, separate long-term-care program Clinton wants to create; for the seriously disabled— young or old— this would help pay for more home care and community care, such as in a day care center for Alzheimer's patients.

If you're a well-off Medicare beneficiary, however, there may not be any free lunch under Clinton's plan. If your income exceeds \$100,000 for individuals or \$125,000 for couples, your premiums for doctors' care would rise— although the administration hasn't spelled out the details of how much.

OK, I'M GETTING THE PICTURE. BUT HOW MUCH WOULD THE AVERAGE JOE OR JANE PAY UNDER CLINTON'S REFORMS? HOW WOULD THAT COMPARE WITH WHAT THEY'RE PAYING NOW?

■ That's the \$64,000 question, to which the only real answer is, "It depends."

Here's the basic formula. Under his plan, Clinton says average health insurance policies would cost about \$1,800 for an individual and \$4,200 for a family. Your employer would have to contribute at least 80 percent of that average premium; that means your firm would pay \$1,440 for an individual policy, \$3,360 for family coverage. You would pay the rest— in other words, \$360 for an individual policy or \$840 for a family policy. However, there are a couple of exceptions. Your employer could choose to pay 100 percent of the premium; in that



case, you'd pay nothing extra. And if you chose a health plan that was cheaper than the average policy, you'd pay even less for health coverage.

Under this scheme, some people would win, some would lose and some would spend about what they're paying now. The profiles of various families that accompany this article, provided by the consulting firm Towers Perrin, offer a glimpse of the possibilities. Generally, families who are now uninsured would do quite well under Clinton's plan, gaining coverage at relatively low cost. Families and individuals with incomes below 150 percent of the

federal poverty level would gain new federal subsidies that would minimize their outlays for health coverage. People who are now covered under employer health plans, but who pay as much as half of the premiums themselves, would also pay less under the reforms. And the self-employed would benefit in several ways: They'd gain access to cheaper policies, could deduct 100 percent of premiums and would

have to spend no more than 7.9 percent of their incomes on health coverage.

BUT WHAT IF I LIKE THE GENEROUS COVERAGE I'M GETTING NOW?

■ You might be out of luck. One group of people hit hard would be those with rich coverage whose employers moved them into regional alliances— for example, well-paid workers in midsize manufacturing firms. Workers with generous coverage could see their benefits reduced to the level of the standard package. Employers could also drop back to paying just 80 percent of the average premium, instead of paying 90

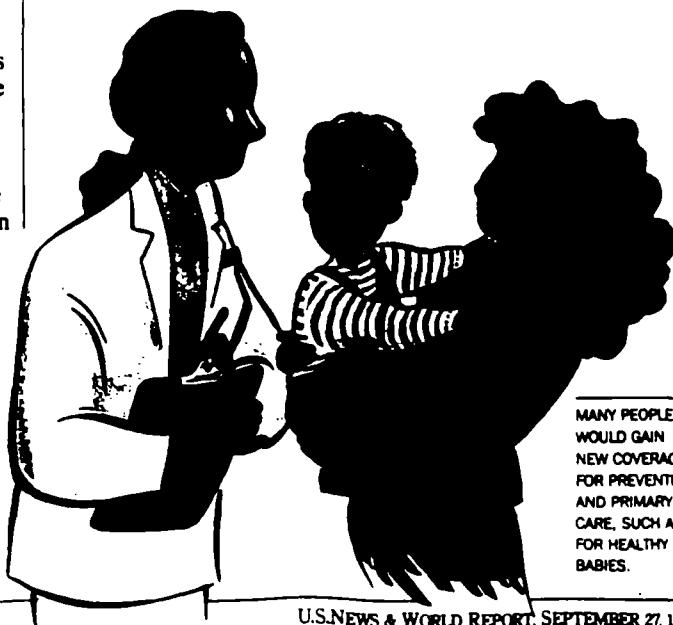
percent to 100 percent as many do now. That would leave their workers holding the bag for the difference.

Another large group of people who could pay more are the estimated 14 million employees with "flexible" or "cafeteria" benefits plans. As things stand now, these people can choose to pay their portion of health premiums with pretax dollars— a provision of the tax code that now costs the Treasury more than \$5 billion a year in forgone revenues. Clinton's plan would bar this, forcing those inside or outside regional alliances to pay their share of health premiums with after-tax dollars. The difference to individual workers and their families could be substantial— even more so if employers offering generous coverage entered the regional alliances, which would cut workers' policies to the level of the standard benefits package. To say the least, "we're going to have some unhappy health care consumers out there," notes Kenneth Feltman, executive director of the Washington, D.C.-based Employers Council on Flexible Compensation.

OUCH. LET'S SAY MY EMPLOYER ENTERS AN ALLIANCE, MY BENEFITS FALL AND MY FIRM SPENDS LESS ON COVERAGE. WOULD THE COMPANY HAVE TO GIVE ME THE MONEY SAVED?



THE SERIOUSLY DISABLED WOULD GAIN COVERAGE FOR HOME AND COMMUNITY CARE UNDER A NEW PROGRAM.



MANY PEOPLE WOULD GAIN NEW COVERAGE FOR PREVENTIVE AND PRIMARY CARE, SUCH AS FOR HEALTHY BABIES.

■ This could be a sleeper issue. The administration assumes that most employers whose health costs fall will make up the difference by boosting employers' wages. But there's no guarantee of that built into the plan. And in today's competitive markets, "it's a leap to assume that the money will be passed along to employees," says McArdle of Hewitt Associates. Instead, firms might take advantage of lower health costs by cutting prices of products or raising payouts to shareholders. Watch for Congress to take a good look at this question—and perhaps even to require firms to share the windfall with employees.

ANYTHING ELSE I SHOULD KNOW ABOUT THE COSTS OF CLINTON'S PLAN?

■ A few points bear making. Clinton may have underestimated the price tag of average health insurance premiums. These premiums would be "community rated," which means that everybody in the health alliance would effectively pay the same rate regardless of health status. For complex reasons, actuaries say the costs could be higher than Clinton projects; if so, that would bump up the amount both firms and their workers would pay. On the other hand, Clinton's plan would also offer broad safeguards limiting how much people had to pay out of pocket for health care beyond their premiums. No individual would pay more than \$1,500 a year on doctor or hospital bills, lab tests or prescription drug coverage, and no family would have to pay more than \$3,000. Those "catastrophic" limits would protect many families.

To get the best possible sense of what Clinton's plan would cost you, you would have to factor in your own contribution to paying for the entire reform package. As yet, the financing is murky—and it could well include tax hikes on cigarettes and alcohol that would hit many people right in the pocketbook. Finally, by attempting to brake the rate of growth in health spending,

MAD OVER MENTAL BENEFITS

Clinton's plan would cap the cost of mental health care at \$2,000 a year for most people. But what if you need more than that? Here's how Clinton's plan would handle it.

UNDER CLINTON'S PLAN: If you're in a regional alliance, and his payments would rise to \$300. He would lose \$74 in tax benefits, since he'd have to pay his share of the premium with after-tax dollars. He'd also lose about \$200 in medical benefits provided by his old plan. But he'd get \$1,000 more out of pocket for his visits to his psychiatrist.

ESTIMATED COST: He would pay a total of \$2,000 if he continued to see the psychiatrist.

Clinton's plan might succeed in containing the price of health care and insurance coverage over time. Thus, even workers who paid more for their coverage in years immediately following health reform could end up paying far less in the long run.

SO MUCH FOR EMPLOYEES. HOW MUCH WOULD CLINTON'S PLAN COST COMPANIES?

■ Here again, there would probably be thousands of different scenarios depending on the company's size, the industry it was in and how much it spent for health benefits for employees and retirees. Clinton says companies wouldn't have to pay more than 7.9 percent of payroll on health care; if so, that would be a huge windfall for some large companies like the Big Three auto makers, which now spend as much as 20 percent of payroll on health coverage for workers and retirees. The problem is that almost no company believes that employer contributions could be held to that low a level for long.

Small businesses with fewer than 50

workers and average wages below \$24,000 would pay even less under Clinton's plan; their contributions to health coverage would be capped as low as 3.5 percent of payroll, with government subsidies making up the difference in the costs of employees' coverage. But Clinton says those subsidies would be discontinued after about a decade, leaving small employers to pay their full share of the costs.



MEDICARE BENEFICIARIES WOULD GAIN COVERAGE FOR DRUGS—BUT THE BETTER OFF WOULD PAY HIGHER PREMIUMS.

WE'VE TALKED A LOT ABOUT COVERAGE AND COST. BUT HOW WOULD MY HEALTH CARE ACTUALLY CHANGE?

■ Of all the questions raised by Clinton's plan, this may be the toughest to answer. For some people, the answer may be very little. They might continue to see the same physicians and hospitals much the way they do now; the only thing that would change is the behind-the-scenes way that these providers are paid. Other patients might move into proliferating "organized systems of care," such as state-of-the-art HMOs, which might do a better job of overseeing and managing their total health (story, Page 38).

But the tight limits Clinton would impose on increases in government health programs and private health insurance premiums raise plenty of concerns. The administration contends that private insurers won't even bump up against these limits, since it will be so easy to squeeze fat out of the bloated health care system. "We think there will be tremendous savings—and they're going to be bigger than anybody thinks," asserts top health reform aide Ira Magaziner. Not everybody agrees—and some health economists

are worried that the limits will force health providers to ration medical care that people really need. Even Magaziner concedes these tight limits might have to be lifted in the next decade, when much of America's population begins aging quickly.

"When people complain about the plan I'm proposing, [the question to ask is] compared to what? Look at where we are," Clinton says. It's a fair point, since the current system is so much in need of repair. But the president knows his plan is in for hundreds of changes in the coming months. And all 257 million of America's health care consumers will be watching.

BY SUSAN DENTZER

HOW MUCH WILL HEALTH CARE REFORM COST?

MUCH of the current apprehension about health care reform stems from the assumption that a universal and comprehensive health care system would necessarily cost more than we are now spending. The assumption is reasonable; after all, we would be expanding coverage, and you can't get something for nothing. But this view presumes that we are now getting our money's worth. I will here argue that this is far from the case — that, on the contrary, we are now spending so much on health care that we could cover all medically indicated care for all Americans without any additional spending.

In 1990 (the most recent year for which figures are available) the United States spent nearly \$670 billion on health care, or \$2,566 per American citizen. All other Western countries spent far less; for example, Canada spent \$1,770 per citizen, and the United Kingdom only \$972.¹ This year the United States is expected to spend an astonishing \$3,380 per citizen (a total of over \$900 billion), and the gap in cost between the American health care system and the others is growing.²

Why does health care for Americans cost so much more? It is not that we are sicker or suffer from more expensive illnesses. All the Western countries are afflicted by nearly the same constellation of illnesses at roughly the same rates; for example, heart disease, cancer, and strokes are the major killers in all of them. It is not that we are aging disproportionately; all the Western countries have aging populations. And it is not that we have unique, more expensive technology. The same technology is available in all the Western countries — although, to be sure, it is more widely disseminated in the United States. Nor is our health care better; by all the usual, albeit crude, measures of health outcome — for example, life expectancy, infant mortality, childhood immunization rate — the United States does somewhat worse than most Western countries. The only plausible explanation lies in the system — in the way health care is paid for and delivered in this country. Clearly, our system is peculiarly inefficient and inflationary.

There are three principal reasons for this remarkable predicament. First, unlike most other Western countries, the United States treats health care as a market commodity, not as a social good. It is distributed according to the ability to pay, not according to medical need.³ The more you can pay for, the more you get; if you can pay for a lot, you may get far more than you need. Defensive medicine adds to the list of marginal or unnecessary services. Furthermore, doctors and hospitals are reimbursed largely on a piecework, fee-for-service basis, which preferentially rewards high-technology care delivered by expensive specialists and subspecialists.⁴ Not surprisingly, given the incentives, we consistently produce too many such specialists and subspecialists, and they can to a large extent generate their own business.⁵

Despite our treating health care as a commodity, the market is far from a classic one.⁶ The health care industry is largely protected from the usual consumer constraints by the existence of third-party payers. In addition, people are not inclined to shop for bargains in health care, particularly when they are sick and dependent on their physicians' judgment. Thus, the health care market has few limits on its expansion.

The second reason our health care system is so inefficient and inflationary is that it is not really a system at all. Instead, it is a nonsystem, consisting of a multitude of arrangements that are more or less independent and that often work at cross purposes. Each element in this jumble tries to lower its costs by shifting them to others. In particular, the 1200 or so private insurance companies compete not by lowering premiums or increasing benefits, but by insuring only the best risks, limiting the coverage of those they do insure, dropping those who acquire expensive illnesses, and resisting claims. For its part, Medicare shifts costs to the private sector, and states shift the costs of the poor to the cities. Increasingly, all payers are shifting costs to patients in the form of higher deductibles and copayments. The system, then, resembles a giant shell game, in which costs are passed off among the parts, and savings for one are costs for another.

Primarily because of all this fragmentation and cost shifting, our administrative costs are extraordinarily high and rising faster than the costs of any other component of the system. In 1987 over 20 percent of health care costs went toward administration, including the overhead for our huge insurance industry and the costs of billing and marketing. In contrast, administration accounted for about 10 percent of Canada's health care costs.⁷

And third, unlike most other Western countries, the United States does not attempt to limit the total amount spent on health care by establishing a global cap. Instead, we have an open system, in which health care competes for resources with all other sectors of the economy. Since the health care industry is lucrative and largely insulated from the usual disciplines of the marketplace, it has been able to absorb an ever-growing fraction of the gross domestic product. Indeed, it has become the black hole of our economy.

Over the past decade or so, most efforts to contain costs have involved some form of managed care. Managed care can be defined broadly as any effort by a third party — government, private insurers, or big business — to contain costs by controlling the delivery of care. For example, indemnity insurers may require second opinions or utilization review before agreeing to cover certain expensive procedures. Increasingly, however, the term "managed care" has come to mean care provided in health maintenance organizations (HMOs).

Although there are many forms of HMO, they all have in common payment by capitation rather than through fees for service. A group of providers agrees to supply all necessary care to its enrollees for a set monthly premium — regardless of how much care

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they actually deliver. If the costs to the HMO are lower than the premiums, the HMO profits. Cost containment is supposedly achieved by the greater use of primary care doctors who function as gatekeepers, regulating access to the more expensive components of the system, such as specialist consultation and hospitalization.⁸

The economic incentives of HMOs are the opposite of the incentives in the traditional fee-for-service system. The fewer services the HMO provides, the better it does financially. Not surprisingly, owners of HMOs often tightly regulate the amount of care provided, using a variety of methods, many of which are highly nettlesome to both doctors and patients. Have HMOs been successful in containing costs? It is very difficult to know, since only 15 percent of Americans are enrolled in HMOs, and HMOs are embedded in a larger fee-for-service system, to which they can shift costs in a variety of ways. For example, an HMO may agree to send its patients to a particular hospital in return for a discount, but the hospital will offset the discount by increasing charges to patients with indemnity insurance. What evidence we have, however, suggests that HMOs generally have lower premiums but have not been notably successful in slowing the rate of inflation.^{8,9}

Nevertheless, the Clinton administration seems to be making HMO-like health plans the cornerstone of its efforts to contain costs. It hopes to devise a system, termed "managed competition," that would foster price competition among these plans.¹⁰ In my view it is highly doubtful that managed competition would contain costs while maintaining quality. The plans might well collude to increase prices rather than compete to lower them. Insofar as they did compete, they might do so by stinting on services, which would require still more micromanagement of physicians. And the oversight of the system would require another layer of bureaucracy. Thus, we would see an exacerbation of the present trend in our health care system to divert dollars from the actual delivery of health care to extraneous administrative functions.

It is time to acknowledge that market forces are simply not suited to distributing health care efficiently according to medical need, no matter how successful the market may be in distributing toothpaste or computers. If we regarded health care as a social good rather than as a commodity, as other Western countries do, we could devise a more rational system for delivering it. Both to increase coverage and to contain costs would require the following three fundamental changes:

First, we would need to place a global cap on health spending. This could be set by Congress as a percentage of the gross domestic product, and allocated to regions or states according to relevant demographic variables, such as the age of the population. Such a cap would control costs at the level of overall funding, not through intrusive micromanagement at the level of the individual doctor-patient interaction.

Second, we would need a Canadian-style single-

payer system to fund the delivery of health care. A single-payer system is not only more efficient than multiple payers, but it also eliminates cost shifting.¹¹ Those who doubt the capacity of the government to collect and distribute money efficiently should remember that Medicare's administrative costs are far less than those of the private insurers.^{7,12} Where would the money come from? It is already in the system, and all of us are the ultimate payers. We pay for health care through our paychecks, deductibles, copayments, and the prices of goods and services. Although the notion of funding health care through an earmarked tax on income is politically perilous, such a system might well be less costly (and ultimately more acceptable) to most Americans than the present relatively inefficient and regressive methods of funding, including employer-based methods.

Third, we need to minimize price competition rather than increase it. This seems counterintuitive if the aim is to contain costs, but when prices for health care are determined by the market, costs nearly always rise, and the type of care provided reflects financial incentives rather than human needs. It would be preferable to keep prices constant and compete on the basis of patient satisfaction.

If we had such a system — with a global budget, a single payer, and competition on the basis of quality and not price — then we might for the first time really get our money's worth. And since we are spending far more per citizen than any other country, that would mean Americans would have the very best medical care in the world. There would be no need for the queues or de facto rationing experienced in some countries that spend much less on health care. The assumption that an expanded health care system would necessarily cost more money, then, is simply not true; what it would cost is the political will to redesign the system.

MARCIA ANGELL, M.D.

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WHAT WE LEARN FROM INFANTS WITH BRAIN TUMORS

INFANTS and young children with primary brain tumors pose a unique moral and medical dilemma. For parents and physicians alike, the late neurotoxic effects of radiation therapy in children whose nervous systems are in a critical stage of development are sufficiently formidable to encourage such divergent views as therapeutic nihilism or an enthusiasm for novel treatment alternatives. A major goal for these patients is to develop treatment strategies that minimize the dose of radiation to the central nervous system.

The first step toward reaching this goal would be to demonstrate that an alternative therapy such as parenteral chemotherapy, which is deemed to have fewer long-term detrimental effects on the developing brain than radiotherapy, can be safely employed as the initial treatment (neoadjuvant chemotherapy) in a protocol that would later include radiotherapy. The neoadjuvant chemotherapy should produce tumor regression in a high proportion of patients. The next step would be to show that a protracted course of neoadjuvant chemotherapy (one to two years) can prevent tumor regrowth or progression and thus permit deferral of radiotherapy without compromising survival. Later, it would be desirable to reduce the dose of radiotherapy in children who have substantial tumor regression after neoadjuvant chemotherapy. When these conditions have been met, one must take the ultimate step of eliminating radiotherapy altogether in young patients who remain in continuous and complete remission after a prolonged course of chemotherapy. All these measures must be taken despite the fact that radiotherapy would be curative for some children with tumors such as medulloblastomas and despite the uncertainty about the short-term benefits and long-term risks of chemotherapy. Quite remarkably, all these objectives have been addressed to some extent in the article by Duffner and colleagues in this issue of the *Journal*.¹

This study should serve as a benchmark for the planning of future clinical trials. It explores the usefulness of neoadjuvant chemotherapy in a population of patients most apt to benefit from the deferral of radiotherapy: infants with primary brain tumors. Duffner and colleagues selected a chemotherapy regimen that produced not only a high rate of response (39 percent) in a variety of primary brain tumors, but also sustained responses (12 to 24 months) in 40 percent of the patients with a response to chemotherapy, with an acceptable rate of toxic effects. The outcome in children who had a complete response to chemotherapy was comparable to that in patients who had had a gross total resection before the study began. Nevertheless, the majority of children died of their brain tumors.¹

This study challenges designers of pediatric studies that incorporate neoadjuvant chemotherapy to devise more effective chemotherapy regimens for the common brain tumors of children that are not surgically curable, such as primitive neuroectodermal tumors,

ependymomas, and high-grade astrocytomas. Radiotherapy can be deferred or the dose selectively reduced in patients who respond. The intensity of chemotherapy can now be increased by the use of supportive measures that were not available when the study by Duffner et al. was conducted, including treatment with a cytokine (granulocyte colony-stimulating factor) during periods of neutropenia, the use of more effective and safer antiemetics (such as ondansetron), and the use of peripheral stem cells or autologous bone marrow for hematopoietic reconstitution after myeloablative doses of chemotherapy. There are encouraging reports of long-term survival in small numbers of infants with primary brain tumors who receive moderately intensive chemotherapy, such as a combination of mechlorethamine, vincristine, procarbazine, and prednisone or an eight-drug regimen ("8 in 1"), as the sole treatment.^{2,3}

Recent experiences have taught us to proceed cautiously. The predisposition of several primary childhood brain tumors (e.g., primitive neuroectodermal tumors) to disseminate in the central nervous system is well established. The introduction of craniospinal radiotherapy more than 30 years ago has been the most important contribution to a predictable cure rate, but younger children have paid a price in terms of the resultant cognitive dysfunction, growth retardation, and hormonal deficiencies. A recent European study of neoadjuvant chemotherapy with radiotherapy that spared the supratentorial region led to an unacceptably high rate of failure in the unirradiated region: cancer recurred above the tentorium in 9 of 13 patients.⁴ A recent randomized study comparing conventional (36 Gy) and reduced (24 Gy) doses of craniospinal radiotherapy in standard-risk primitive neuroectodermal tumors was stopped early because of a higher failure rate in both the primary site and the neuraxis in the group that received the reduced dose.⁵

The scientific basis for delaying cerebral radiotherapy has not been established. There are few data to support the contention that delaying cerebral radiotherapy for 12 to 24 months (as in the study by Duffner et al.) will spare an infant substantial neurocognitive complications. Although the injurious effects of cranial radiotherapy appear to be inversely related to the age at administration, there is limited information regarding a "safe age" for such treatment.⁶ It is not entirely clear whether intensive chemotherapy will also have a detrimental effect on the development of the brain. Studies of brain tumors in infants rely heavily on neuropsychometric testing to identify treatment-induced brain injury, but it is difficult to conduct prospective neurocognitive studies in infants. Thus, the results of such efforts must be interpreted with caution.

Can research on infants with brain tumors lead to improvements in the care of older children and adults as well? Young children may tolerate intensive chemotherapy better than adults, and their tumors, although histologically similar to those of adults, may be more sensitive to chemotherapy. But radiotherapy causes cognitive impairment in both adults and children.

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Dear Hillary:

As I promised at the reception last night, I am sending you a copy of the TV spot on health care initiated by the ILGWU and CWA and produced by Greer, Margolis, Mitcheil.

We have put together a budget of \$250,000 with help from additional unions. The ad is currently appearing on Sunday opinion leader programs in more than a dozen cities, including Philadelphia, Detroit, Boston, Miami, Cleveland and St. Louis. When Congress returns, it will appear in Washington for three weeks in September.

We view this as an initial contribution to keeping the pressure on for comprehensive health care reform and look forward to the release of the Clinton health care plan and to working with you in a massive national campaign to make health care a right for everyone in this country.

I'd be interested in your comments or suggestions.

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A handwritten signature in cursive script that reads "Jay".

Jay Mazur
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MICHAEL SCHRAGE

Health Debate's Unmasked Question: What's the Outcome of That Input?

Not even 20 years ago, the few doctors and nutritionists who championed diet as an approach to cancer prevention were viewed as medicine's lunatic fringe. Today, the National Cancer Institute publishes beautiful four-color wall posters festooned with leafy vegetables that remind you to eat your beta carotene.

"We used to call them crackpots," acknowledges Robert Blendon, chairman of health policy and management at Harvard's School of Public Health. "Now we have our best epidemiologists running the numbers on their studies."

The nation spends more than \$12 billion a year on bypass procedures—almost 40 percent more than the



entire budget for the National Institutes of Health. Since 1970, the number of bypasses performed in the United States has risen more than 2,800 percent. In addition, about 300,000 arterially

choked Americans get themselves unclogged through angioplasties costing as much as \$10,000 each. These surgeries are the biggest-ticket surgical items in the nation's \$800 billion-plus annual health care budget.

Yet there are a number of respected and statistically compelling studies demonstrating that—for a large percentage of the patients undergoing these invasive procedures—the health benefits are marginal at best.

For most angioplasty patients, for example, the arteries begin to exhibit "re-stenosis"—choking up with fatty deposits yet again—within months. Within the cardiovascular establishment, there are angry debates not merely about the cost-effectiveness of bypasses and angioplasties but also about their usefulness.

"Science is not applied nearly as uniformly and consistently as people might believe in the evaluation of treatment modalities," says Dean Ornish, president and director of the San Francisco-based Preventive Medicine Research Institute, who has enjoyed excellent results exploring lifestyle—as opposed to surgical—interventions for reversing heart disease. "Whether you're on the leading edge or the fringe is merely a matter of perspective or time—so long as you can successfully demonstrate results."

Consequently, much of today's health care debate about who should pay how much for what kind of coverage misses the essential point. Health care "cost-effectiveness" conversations that spend 90 percent of the time focusing on "cost" and barely 10 percent on the challenge of "effectiveness" obscure rather than clarify the issues deserving intensive care.

To make 37 million people eligible for medical procedures that don't really work can hardly be considered a bold advance in public health.

The simple reality is that medicine remains more of a craft than a science. Perhaps the most important contribution of the proposed Clinton health policy initiative is that it will—gradually—force society and health care providers to come to grips with our ignorance of what medically works and what doesn't.

Ideally, this knowledge would lead us to a consensus about what treatments and therapies are appropriate for what populations. In practice, we may well see a further Balkanization of health care as different pharmaceutical houses, hospital plans and specialists develop dueling databases to argue that their approaches are the best.

"In too many areas, we actually don't know the outcomes of treatments and interventions," says Harvard's Blendon. "There was belief in clinical judgment in how well things worked out or not, but the statistics revolution made people suspicious of the judgments of six or eight doctors who saw 20 patients. It turns out that if you really had extensive epidemiological data, much clinical judgment turns out to be fallacious."

Indeed, Blendon and other health care researchers believe that excellence in medical practice is moving away from the collective judgments of expert practitioners to broad-ranging, extensive database analyses of health "outcomes" based on treatments and populations. So whose studies will "win"? How will outcomes research be linked to the actual practice of medicine? The answer to these questions—not just who gets covered for how much—will really determine the future value of America's health care system.

"Outcomes research is a relatively new type of health care research," says Clifton Gaus, senior adviser to the assistant secretary for health at the Department of Health and Human Services. "We now spend about \$60 million a year on outcomes research and the development of guidelines for practitioners."

Gaus notes that the Clinton plan will require a big increase in both the quality and quantity of outcomes research if it hopes to attain its stated goal of greater cost-effectiveness and efficiencies.

"I'm extraordinarily comfortable with the notion that we must develop immediately mechanisms, rule guidelines and eliminate unnecessary procedures," says Robert H. Brook, who runs Rand Corp.'s Health Sciences Program and has done extensive work on outcomes analysis and guideline development.

But even he acknowledges that Rand surveys reveal that as many as half the nation's physicians are unaware of essential "best practices" in many critical diagnoses and treatments. Clearly, new information isn't enough to change old practices.

Gaus points out that the new National Health Board will be charged with transforming outcomes research into explicit guidelines for how the regional alliances run their health care practices. But he acknowledges that it's still unclear precisely how that sort of transformation will take place.

It's unfortunate that neither the president nor the First Lady has placed the same kind of focus on the quality and value of health care as they have on access and cost. As the policy debate unfolds, politicians will discover that Americans care more about outcomes than they do about expense.

Michael Schrage is a columnist for the Los Angeles Times.

He - He may be giving us a good clue -

THE WASHINGTON POST FRIDAY, OCTOBER 1, 1993

it's in your plan - it is a big part of the security argument - someone should call her -

THE WHITE HOUSE

WASHINGTON

October 1, 1993

MEMORANDUM FOR PRESIDENT CLINTON
HILLARY RODHAM CLINTON

FROM: IRA C. MAGAZINER

SUBJECT: WHERE WE ARE POSITIONED

In my former life as a corporate strategist, it was always important to think backward from the "end game" when setting positions at the outset of negotiations. This often involves putting "in play" proposals which are extreme and are designed to be modified as concessions.

As the dust settles from our introduction, I am increasingly confident that we are positioned correctly for the political discussions ahead.

The overriding political factors necessary for success are:

1. A clear understanding by the public, the Congress and the interest groups that the President is serious about fighting "all out" for health care reform and will not compromise on key principles.
2. A clear sense that we are willing to listen and modify our views on the details as we hear better ideas -- a sense of humility, that we don't know all the answers, we know we are doing something of large scale and that we must therefore be cautious in our approach.

Our challenge has been to span a very broad chasm between single payers and pure managed competition advocates, without falling to oblivion. Had we proposed bare bones benefits for universal coverage or a slow phase-in, liberals would have deserted us. Had we opted for a broad based tax to finance coverage, moderate Republicans and conservative Democrats would be in rebellion. Financing by employer/employee mandate, a sin tax and slowing the rate of growth in costs is both good policy and the best initial political position. I would rather fight a debate with economists about how fast system growth can be slowed than to be accused of "copping out on universal coverage" or being a "tax and spend" Democrat.

This approach led us to a series of additional policy steps to solidify our footing on both sides of the chasm:

- Generous small business discounts to make the mandate affordable.
- A Medicare drug benefit and a good long-term care package to make the Medicare and Medicaid savings possible for the AARP, NCSC, etc. to support.
- The early retiree discounts to solidify large business, labor, senior and state and local government support.
- The 10 year maintenance of tax deductibility as a compromise between managed competition advocates and those with good benefits today.
- The integration of Medicaid into the alliances and the essential provider provisions to assure urban and rural underserved constituencies that capping the rate of growth in Medicaid and Medicare will not hurt them.
- Enforceable private sector caps to go along with Medicare and Medicaid caps -- to avoid cost shift and make entitlements caps acceptable to liberals and private caps acceptable to conservatives.
- Alliances that are large but not too regulatory to bridge the gap between managed competition and single payer advocates.
- Incentives for primary care, administrative simplification and anti-trust relief to hold strong support among many provider groups.
- A malpractice reform which is okay with consumer groups and approaches (if not quite meets) the acceptable range for provider groups.
- A single payer state option to make competition as a national approach tolerable to single payer advocates.

By constructing our package to have "movable parts" and being flexible, we are in a good position to proceed through negotiations on "the Hill," feeling our way to the right mix of "parts" for the majority we need.

The policy we introduce in two weeks should fundamentally not change, though some adjustments are necessary where we have missed the mark.

There are a few hundred detailed suggestions for policy improvements which we should incorporate into the book. I will forward them to you. In addition, we should write the book differently to be clearer and include background and rationale material.

There are only a few major policy changes I would recommend:

- The plan sounds and is too regulatory. We need to remove some of the powers of HHS, the Board and the Alliances. I will forward a list of suggestions.
- We need to smooth out the small business discount schedule.
- We need to spell out the ways patients and doctors will have more choice.
- We should create a consortium of medical schools and academic health centers to be the organizers of the quality system rather than the federal government.

We should announce these and many of the smaller changes so that people know that we are listening and are flexible. The changes should be presented as examples that the Administration listens and responds, not as defeats or retreats.

On financing, we should promote the idea that there are "movable modules" in the plan which we can discuss, as long as our fundamental principles are met.

- Size of Medicaid savings.
- Size of Medicare savings.
- Amount of deficit reduction.
- Rate of growth allowable for private sector caps.
- Phase-in of drug benefit.
- Phase-in and size of long-term care program.
- Phase-in of universal coverage.
- Size of tobacco tax.
- Size of corporate assessment.
- Discount generosity to small business.

- Discount generosity for early retirees.
- Discount generosity for families.

There is plenty of room for us to modify our "going in" proposals as we gain a sense of thoughts in Congress.

At the end of the day, we must get the Republicans and conservative Democrats to agree to real universal coverage in a reasonable period of time which means the employer/employee mandate; we must have some type of budget cap on the private sector; we must eliminate competition based on risk pools; and we must have some Medicare drug and long-term care programs.

To achieve consensus, we may have to agree to make our alliances smaller, to phase-in long-term care and the drug benefit tied to realized savings (but we cannot make universal coverage contingent), to lesson our Medicare savings, to phase-in universal coverage and the drug benefit a little slower; to loosen our private sector budget somewhat both in phase down and enforcement; and to do more on malpractice.

For now, we should argue our current positions but be open and listen. As the "lay of the land" becomes apparent, we should discuss when to make our moves.

We probably should assemble a small group to meet a few times a week to discuss strategy as the situation unfolds.

MACK McLARTY

Sept. 1, 1993

To The First Lady:

I would like to explore Alan's role
in our upcoming debate.

Mack



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July 9, 1993

Mr. Mark Middleton
Office of The Chief of Staff
The White House
Washington, DC 20500

Dear Mark:

I want to thank you for visiting with our Arkansas NFIB group for breakfast on Tuesday. It was unfortunate that we were unable to visit longer, but I had to get back into the hall for my reserved seat for the President.

The President agreeing to speak was a great favor to me. He indicated to Jack Faris and John Motley of NFIB on Thursday that he was unaware that he had declined my urgent request. John advised him that I had a definite decline from Marcia Hale at the White House. The President told John to call Al White and tell him he did not have a decline because I will speak to that group on Tuesday.

As you know, I did receive the decline and I am totally convinced that Mack had a lot to do with Bill changing his mind. Perhaps he had a little help from David Pryor who promised me in Little Rock on June 4th that he would speak to the President. It was the right decision for the President and I do not know how Mack did it, but the fact that it was done was wonderful.

I want to thank you again for all the kind help you have given me, and it was so nice to see you.

Sincerely,

Alan L. White, Sr.
Arkansas Federal Liaison Officer, NFIB

ALW/vld

① HNC - 2
I would
L. H. to explain
Al's role
is our upcoming
debate.
W. J.
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THE WHITE HOUSE

WASHINGTON

November 5, 1993

MEMORANDUM TO HILLARY RODHAM CLINTON

FROM: MARILYN YAGER

I wish to bring to your attention an issue of critical importance to the National Association of Retail Druggists and the National Association of Chain Drug Stores, two associations which have been strongly supportive of the Health Security Act. I have attached their memo citing their concern regarding the final language on wholesale pricing for prescription drugs.

The language that has consistently been presented to these groups stated that the reimbursement rate shall be equal (not less than) to 93% of the average wholesale price plus dispensing fee. The current statutory language is incorrectly drafted on the basis of non-retail prices.

Mike Lux and I raised this issue earlier this week with Ira and Chris Jennings. Chris indicated to me this afternoon that he believed we had agreed to correct this provision, and it was certainly his belief that we should do so.

From the business community, these two groups produced significant support during the past two months, including the support from 17 corporate CEOs of chain drug stores. During the weeks that followed the September 23 event, we received over 200 letters from individual drug stores pledging their support. Both of these associations are generating real grass roots support and they are working closely with the DNC on the larger campaign. However, the need to quickly clarify this issue with their membership will be key to their ability to generate enthusiastic support. We would hate to send the wrong signal so early in the process to two organizations that have been so constructive in their assistance to us.

Any assistance your office could give to resolving this would be greatly appreciated.

cc: Ira Magaziner
Chris Jennings
Mike Lux

NACDS

National Association of Chain Drug Stores

MEMORANDUM

INFORMATION

October 29, 1993

TO: Chris Jennings
FROM: Robert A. Waspe
SUBJECT: Correction to the Health Security Act

DISCUSSION: As we discussed today, the Health Security Act contains a drafting error that, if uncorrected, would have disastrous consequences for providers of outpatient prescription drugs under the Medicare program. In brief, the current language calls for providers to be reimbursed at the lower of the 90th percentile of their actual charge or the administrative fee (\$5.00) and the Estimate Acquisition Cost (EAC) of the product. The EAC, as determined by the Secretary of HHS, can not exceed 93% of the net acquisition cost by a hospital or other institutional purchaser for the product. No community retail pharmacy could afford to accept this level of product reimbursement, with or without equal access to discounts.

You indicated in our conversation that the Administration's intent was to define EAC as an amount determined by the Secretary, but not to exceed 93% of Average Wholesale Price. I indicated this was an acceptable definition from our standpoint. I have also discussed this with John Rector of NARD and he agrees.

Therefore, the following are the corrections that are necessary to meet our mutual objective in the legislative language.

Section 2002. Payment Rules and Related Requirements for Covered Outpatient Drugs.

“(C) Determination of Unit Price. - (page 347)

“(I) In General. - The Secretary shall determine, for the dispensing of a covered outpatient drug product in a payment calculation period, the

estimated acquisition cost for the drug product. with respect to any covered outpatient drug product, such cost may not exceed 93 percent of the average manufacturer non-retail price for the drug (as defined in section 1850(f)(2)) during the period."

Section 2003. Medicare Rebates for Covered Outpatient Drugs.

"(f) Definitions (page 368) - For purposes of this section

"(1) Average Manufacturer Retail Price. - The term 'average manufacturer retail price' means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price ~~(inclusive~~ exclusive of discounts for cash payment, prompt payment, volume purchases, and rebates, ~~(other than rebates under this section), but~~ and exclusive of nominal prices) paid to the manufacturer for the drug in the United States for drugs distributed to the retail pharmacies ~~class of trade.~~"

"(2) Average Manufacturer Non-Retail Price. - The term 'average manufacturer non-retail price' means, with respect to a covered outpatient drug of a manufacturer for a calendar quarter, the average price ~~(inclusive~~ exclusive of discounts for cash payment, prompt payment, volume purchases, and rebates, ~~(other than rebates under this section), but~~ and exclusive of nominal prices) paid to the manufacturer for the drug in the United States by hospitals and other institutional purchasers that purchase drugs for institutional use and not for resale."

As you can see, we have now benchmarked EAC to the average manufacturer retail price before discounts, which I believe is average wholesale price. To keep the ratio consistent for purposes of calculating the manufacturer rebate, I had to modify

the language of both the retail and non-retail price in the definitions section. I also deleted the reference to class of trade since, as you well know, that is an especially abused term in the pricing of drug products whose usage should be discouraged.

Finally, as we discussed, we would support a change in the Equal Access to Discounts section to go back to the language you and I believe is clearer in meeting our intent.

Lastly, as I mentioned, please think about where we put the Equal Access language if Congress won't support an outpatient prescription drug benefit under Medicare. As always, you can reach me at the office, (703) 549-3001 or at home (703) 379-6920.

cc: Ronald L. Ziegler
Charles M. West
John Rector



DATE: November 11, 1993

TO: Hillary Rodham Clinton

FROM: Stan Greenberg

**RE: HEALTH CARE -- MESSAGE UPDATE
(Revised)**

We have successfully drawn the line in the sand on our first principle: universal and comprehensive insurance that you can never lose. This memorandum represents a kind of summary and reminder so that we can continue to communicate effectively about health care.

Explaining the Clinton Plan

We have done an excellent job of setting out the goals of our plan, and we have begun to set out the specifics, but we have not yet mastered the explanation of what it is. To one side, is the single-payer approach; to the other side, is the pure market approach. What is our approach?

The following (untested) proposal is seen, increasingly, as the best description of our approach:

The Clinton plan offers a system of **guaranteed private insurance**. We are proposing to build on the current system of private insurance with two critical changes: first, the guarantee of comprehensive health insurance that you can never lose; and second, greater consumer power (for people and small business) to choose quality health insurance at lower cost.



Best Contrast and Positioning

The following contrast provides us with the best advantage -- against both the status quo (insurance companies) and against the alternative plans. The contrast contains emotion, sets out the opposition, and underscores health care security.

The Clinton plan makes it illegal to refuse someone insurance because of a pre-existing condition or for any other reason.

The other plans still allow insurance companies to pick and choose whom they will cover.

That contrast picks up Perot voters and "shifters" (voters receptive to health care reform), particularly older and non-college women.

Strong Contrasts

There are a number of other contrasts that strongly favor the Clinton plan, though not as strongly as the contrast above.

Specificity contrast:

The Clinton plan sets out specifically what is in the comprehensive benefit package and what people will pay.

The other plans leave the specifics to be determined after the bill becomes law.

Seniors contrast:

The Clinton plan uses savings from new efficiencies in Medicare to expand benefits for seniors, including prescription drugs (or long term care).

The other plans do not expand benefits for seniors.

Comprehensiveness contrast:

The Clinton plan guarantees a comprehensive benefit package with low deductibles.

The other plans provide for a basic package with high deductibles.



Will This Help or Hurt My Family?

For ordinary people, the principal question in evaluating the Clinton health plan is the following: "will this help or hurt my family"? In the regression analysis, that question is 2.5 times as important as any other consideration. People want to know the details which is what our current phase is all about.

To get that answer, our communication should concentrate on a number of simple "facts" that say a lot:

- **Security.** Everyone is insured, no matter what.
- **Choice.** Choice is protected and expanded: everybody has a choice of plans and a choice of doctors.
- **Medicare.** Medicare is maintained and expanded with prescription drug benefits and long-term care.
- **No limits.** Most insurance policies today have life-time limits, so you can lose it when you need it. Our plan has no life-time limits.
- **Deductibles.** Many plans will have no deductibles; for those that do, it is \$200 for an individual and \$400 for a family.
- **Single form.** We create a single form to cut bureaucracy and red tape.
- **Fraud.** The plan includes tough measures against health care fraud -- to keep greed from raising health care costs.
- **Payments.** Premiums are based on family status (single, married, family). Payments will not rise with age, sickness or medical history. It is simple and secure.



Target audiences

The attached memorandum from my office sets out the target audiences: voters who have moved from undecided to opposed but who are still receptive to our health care reform proposals. The primary targets include: older and non-college women, seniors, union members, and moderate Republicans.

DEMOGRAPHIC TRENDS

The following groups have shown larger than average drops in supports:

Bigger drops, but key targets:

Retired and Older Women -- Retired women have held steady since the last survey, but their support has eroded 10 points and opposition has grown by the same amount since the speech. They now support the plan by 49 to 33 percent. Support from older women has dropped 10 points since 9/27 to 50 to 35 percent. Strong support has also dropped 10 points, and opposition to the plan has increased 12 points. Both of these groups, however, respond favorably to the arguments in the survey, and 16 percent of all older women and 20 percent of retired women shift toward favor.

Non-college Women -- Support among non-college women has slipped from 60 to 26 percent on 10/5 to 53 to 35 percent. This remains a good target group with 15 percent shifting toward favor.

Perot Voters -- Perot voters have moved from majority support on 10/5 (51 to 35 percent) to tentative opposition in this survey (46 to 42 percent). Those who identify themselves as Democrat or leaning Democrat support the plan by 51 to 36 percent (N=54), and those who identify themselves as Republican or leaning Republican oppose it by 55 to 35 percent (N=67). Altogether, 21 percent of Perot voters shift toward favoring the plan.

Union Households -- Support among union households has dropped 9 points since our last survey on 10/13 -- although strong support has held steady and opposition has increased just 3 points. With 17 percent who shift toward favor, union households should be an important target.

Independents -- Support among independents has dropped 10 points since late September -- 8 of those in the last two weeks -- and opposition has grown by a comparable amount. Independents now favor the plan by just 9 points (48 to 39 percent). They are no more likely to shift toward favor than the total sample.

Northeast and Central -- Regionally, northeastern remain the strongest supporters of the plan, though support has slipped significantly from 65 to 24 percent on 10/13 to 57 to 33 percent in this survey. Support among central region voters has dropped 11 points since 9/27 and are now almost split with plan support at 47 to 42 percent; however, strong support remains steady. Central voters are the most likely to shift in favor of the plan (16 percent move toward favor).

Moderate Republicans -- Moderate Republicans reversed their support for the plan between 10/5 and 10/13, and they now are opposed to the plan by 51 to 36 percent. However, 22 percent of this group shifts in favor of the plan after hearing the differences between the Clinton and other plans. This group will be an important target if we can get some bipartisan congressional support for the plan.

Big drops, harder to get

Ages 30 to 39 -- Support among this group peaked in early October at 60 percent and has dropped 9 points to 51 to 39 percent. Strong support has also dropped 10 points, and opposition has increased 11 points. Just 10 percent of this group shifts toward favor on the plan, compared to 13 percent of the overall sample.

Ages 50 to 64 -- Support among this group has dropped 11 points since 9/27 (7 points since the last survey), and opposition has increased 13 points (8 points from last survey). This group now favors the plan by 51 to 39 percent. They are no more likely to shift toward favor than the total sample, but a plurality do think that the plan will help the economy (39 to 36 percent) and their coverage will be better (44 to 38 percent), and they are split on whether it will help or hurt their family.

Big drops, now net opposition to plan

College Graduates, Especially College Men -- College graduates, who favored the plan by 2-to-1 in late September, now support the plan by just 49 to 41 percent (-11 from 9/27). As of 10/13, supporters still had a 20-point advantage, but this has slipped to just 8 points. College men also favored the plan by almost 2-to-1 in late September, but now a plurality are opposed to the plan by 47 to 42 percent. Since the most recent survey on 10/13, support has dropped and opposition increased by 8 points each. While strong support and strong opposition are comparable among most demographic groups, the strong opponents have a definite advantage among college (25 percent strongly opposed, 16 percent strongly favor).

Homemakers -- A plurality of homemakers now are opposed to the plan by 47 to 43 percent -- a 16-point drop from last survey. Support is back to pre-speech levels. Strong support has dropped from 23 percent to 10 percent, and strong opposition now outweighs strong support by 2-to-1.

Some other things worth noting:

Working and Younger Women -- Support remains strong from working women and younger women, although undecided appear to be moving to the opposed column.

Under 30 Voters -- Support has increased among under 30 voters, and they are now one of the strongest groups in backing the plan (55 to 34 percent, 22 percent strongly favor). In addition, 16 percent of this group shifts toward favor on the plan. The guaranteed coverage and the fact that no one can lose their insurance arguments hold even strong appeal for this group than for the total sample.

Seniors -- Support among seniors dipped in the 10/13 survey but is back up to majority in favor (52 to 33 percent).

Non-college Men -- Support appears to have increased among non-college men voters from 51 to 39 percent on 10/13 to 55 to 34 percent in the current survey. However, the group in this survey is more Democratic than usual (44 percent, compared to 36-40 percent in the other surveys since the speech).

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Hillary;
FJE



November 1, 1993

Mr. Ira Magaziner
Senior Policy Adviser to the
President for Policy Development
Domestic Policy Council
The White House
Washington, DC 20500

Dear Ira:

Enclosed as promised is a copy of the Wall Street Journal article following your speech in Boston on October 20. It looks as though colloquy attracted some attention.

I thought your presentation and that of your colleagues was well received at the Princeton conference -- your presence was referred to repeatedly and appreciated. Wally Zelman was especially effective on Sunday morning in his comments responding to the "private sector" panel.

I was personally much encouraged by overtures from David Cutler and Marina Weiss to coordinate our forthcoming analysis of the Clinton Plan and trust that the same level of cooperation will prevail with others such as Ken Thorpe. Our early reading is that our own analysis will substantially corroborate your own estimates.

All in all, I believe the net effect of the Princeton conference was a significant step forward for the Clinton Plan in the eyes of those attending. Is it too early to call this a trend?

All the best.

Sincerely,

Lawrence S. Lewin
Chairman and CEO

Stephen Zuckerman and Jack Hadley

Clinton's Cost Controls Can Work

Controlling medical care spending is "Job One" for the Clinton administration's health care reform plan. System savings from successful cost control will help pay for extending insurance to the 37 million Americans who don't have it, for making sure that those who have it can't lose it and for guaranteeing that every insurance plan includes a comprehensive benefit package.

Not surprisingly, critics from both the left and right are concentrating their firepower on the administration's cost-control plan. The criticisms can be roughly divided into two camps. One is that the plan's cost-control features won't work. The other, oddly enough, is that they will work too well and lead to massive disruption in the provider system and the rationing of care.

What is the administration's cost control plan? Although often ridiculed as being of, by and for policy wonks, the basic strategy is quite simple. It has two lines of attack. The first is to promote competition among insurance plans under a cap on the average premium in an area. The second is to limit the amount of new money flowing into the system by capping the rate at which insurance premiums are allowed to increase.

The Clinton proposal requires that all insurance plans offer a comprehensive package of benefits and charge the same premium to all comers, regardless of age, health history or employment situation. According to the theory of managed competition, with the product standardized and insurance companies less able to compete by rejecting or avoiding high risks, competition will have to take the form of price and quality competition. Insurance plans will attract customers and prosper by providing value for money.

In spite of the promise of managed competition, it largely remains a theory. To put teeth into it, the Clinton plan will impose a financial penalty on any insurance plan that tries to increase its premium more than the cap allows. There is little doubt that if faced with constrained revenues, insurance plans will limit their expenses. Each plan will decide the best way to do this, including constraining the overuse of services and limiting what they pay doctors, hospitals and other health care providers. But they will have every incentive to do it in a way that doesn't drive away subscribers. One critic characterized this approach as "getting the insurance plans to do the government's dirty work." However, it seems far preferable that insurance companies that are responsible to their subscribers make these decisions than having the federal government involved in detailed price negotiations and review procedures with individual hospitals and physicians. As another critic put it, "That's like bombing from 30,000 feet. You can't see whom you kill."

In reality, the administration's cost-containment goal is modest. Its original estimate is that annual savings would be \$136 billion in the year 2000. That's a lot of money to anyone. But let's put it into perspective. At the time this estimate was made, the Congressional Budget Office projected that health care would absorb 18.9 percent of GDP by the year 2000. The Clinton plan would bring that down to 17.3 percent. We currently spend 14.3 percent of GDP on health care, while no other industrialized



country spends more than 10 percent. Thus, the Clinton plan's "draconian" cost-containment combination of more competition and caps on premium growth permits about a 3 percent increase in the share of GDP going to health. This plan does not try to shrink health spending relative to where we are now. No health care jobs will be lost, though fewer new jobs may be added in the future.

How will the system respond to these constraints? The specter of sick patients being unable to receive care is completely farfetched. The U.S. health system is fraught with inefficiencies and excesses that have no measurable health benefits. The constraints on spending growth will, for example, force more frugality to reduce the estimated 15-30 percent of diagnostic tests and surgeries that may be unnecessary. Private insurers will no longer be willing to pay providers prices that are 30-40 percent above Medicare, nor should they. Providers will be able to survive with lower prices for private patients, because universal coverage will mean an end to uncompensated care and low prices for Medicaid beneficiaries.

Studies of the present system have shown that hospital costs are 10-15 percent higher than they would be if all facilities produced services more efficiently, and this excludes savings that would accrue from not producing unnecessary services. Imposing financial pressure through caps on premiums means some hospitals will scale back their investments in buildings and equipment—which are often underutilized—and reorganize their staffs.

Our own current research on a nationwide sample of almost 1,450 hospitals suggests that they respond to financial pressure primarily by controlling costs. The 25 percent of hospitals with the lowest profits in 1987 experienced cost increases of 13.3 percent between 1987 and 1989 compared

with an average of 27.6 percent for hospitals with the highest profits. In contrast, for both groups of hospitals, total revenues grew at virtually the same rate, about 21 percent over the three years; 30-day post-admission mortality rates for Medicare patients improved slightly; and the shares of hospitals' patients covered by Medicare and Medicaid increased by about 3 percent.

Patients will also need to change. They may need to accept a less-intensive approach to diagnosis and treatment as currently practiced in the best-quality HMOs. And they may also need to consider whether a high-cost health plan is worth the extra money. If it is not, consumers will be able to choose a less costly health plan. People may not like these changes simply because change can be uncomfortable. However, Americans will no longer fear losing their coverage if they become very sick or lose their jobs.

How fast would spending growth begin to subside? If the speed with which hospitals have responded to Medicare's prospective payment system, other rate-setting systems and lowered-profits is a guide, the answer is almost immediately. When providers are paid less, they move quickly to cut their expenses and organize service delivery more efficiently. When Medicare phased in its prospective payment system between 1982 and 1984, hospitals that faced the greatest potential financial loss held their expense growth to one-third that of hospitals facing prospects of financial gain, 3.2 percent compared with 10.2 percent. Hospitals in California that faced strong competitive pressures as well as prospective losses from PPS actually cut their costs by 4.3 percent between 1983 and 1985. The annual increase in the volume of so-called "overpriced procedures" provided to Medicare beneficiaries by physicians fell from 9.3 percent in 1986-87 to 2.4 percent in 1988-89 in response to a 2.4 percent cut in average fees. Given this evidence and congressional action within the next year, the system should be able to adjust by the year 2000 without major adverse consequences.

The Clinton proposal aims to alter incentives by a combination of regulatory and market forces. Some critics would rather see much greater reliance on changes in the tax treatment of health insurance premiums as the way to change incentives. Despite its intellectual appeal to some, there is little evidence to show that this approach would succeed. On the other hand, even though strict systems of regulated spending and price controls have good track records of controlling costs, they do not have widespread political support. Many people view such systems as administratively burdensome, inflexible and likely to lead to explicit rationing. The Clinton proposal relies on competition among plans, but limits the amount of tax-subsidized dollars that can flow into the system and requires the development of a potentially regulatory framework for limiting total spending. This is a compromise. But, its acceptability and likely success may be greater than either pure alternative.

Stephen Zuckerman is a senior research associate at the Urban Institute. Jack Hadley is co-director of the Center for Health Policy Studies at Georgetown University School of Medicine.

difficult for voter-taxpayers to judge what they will be paying."

Third, even if U.S. firms did use some of the health dividend to invest or lower prices, the effects of those improvements could be quickly offset by adjustments in exchange rates.

The dollar has weakened more than 15 percent against the yen over the past year, for example, more than offsetting even the most dire estimate of health care cost increases for the Big Three U.S. automakers during that period.

To be sure, Clinton's plan would mean huge initial savings for old-line manufacturers, where health benefits account for a much higher percentage of worker compensation.

Under the Clinton plan, the government would reimburse firms for health care spending above 7.9 percent of payroll. It also offers an 80 percent federal subsidy for workers between the ages of 55 and 65 who opt for early retirement.

And if accounting rules allow corporations to avoid carrying health care promised to retirees as a liability, many big manufacturers would be able to reduce borrowing costs dramatically.

These provisions would be giant bonuses for carmakers. General Motors Corp. executives project first-year savings in the billions of dollars if all aspects of the president's proposal were adopted.

The administration says the benefits for traditional manufacturers will help boost the trade balance because those companies tend to be big exporters.

But the relatively high levels of health care spending at most of the nation's traditional manufacturers reflect work force demographics rather than the escalation of health costs in the economy as a whole.

Because auto unions protected the jobs of workers with the most seniority during the layoffs of the 1980s,

the age of the average employee at the 'Big Three' U.S. automakers has climbed to well over 40. Older workers have more health problems and are thus more costly to insure.

Moreover, the short-term windfall to old-line manufacturers would come at the expense of firms in other industries—computer and software manufacturers, for example—that have lower health costs now.

American automakers fork out \$1,100 on health care for every car they manufacture. Reich lamented in his testimony, while "many of our competitors [are] producing cars with a health care component of \$500 or \$600."

But economists warn that oft-cited statistic isn't what it seems.

The estimate, made by researchers at the University of Michigan, does not adjust for age differences among the auto companies, and makes no effort to determine whether the health benefits received by workers at Japanese or German firms are comparable to those received by workers at U.S. companies.

'Job Lock' Impact

Economists also question the administration's assertions that the health plan will enhance U.S. competitiveness by promoting mobility within the labor force.

The administration claims nearly a third of the nation's workers are "locked" into current jobs because they fear a new employer may not offer insurance or because a family member has a condition that would not be covered if they switched jobs.

Experts in labor mobility say it is all but impossible to measure precisely how much eliminating "job lock" would improve the performance of the economy as a whole. "There's no quantifiable evidence on that," says Brigitte Madrian, a Harvard University economist whose research documents the connection between health security and labor mobility.

This nation already boasts the most mobile work force in the world. Indeed, some economists worry that the ease with which Americans hop from job to job prevents firms from investing adequately in worker training.

"I don't think getting rid of job lock is the cure-all for America's poor economic performance," Madrian said. "I think the issue has gotten too much hype."

Don't paint us as the villains, insurance industry says

Attacks on Clinton plan are working, conference is told

By Andy Miller
STAFF WRITER

With weapons from T-shirts to pledges of more TV ads, the health insurance industry resumed its attack Monday on pieces of the Clinton administration's health care reform plan.

At an Atlanta conference on health care reform, Ken Evason, a board member of the Health Insurance Association of America, vowed that the group will keep running its "Harry and Louise" TV ads, which he said have been "overwhelmingly effective" in questioning facets of the Clinton plan.

The TV spots, funded by HIAA, feature a couple discussing the Clinton plan over their kitchen table, ending with the remark, "There's got to be a better way."

Last week, Hillary Rodham Clinton condemned the ads and accused insurance companies of deceiving Ameri-



cans to protect industry profits and preserve the ability to exclude people from coverage.

"We were startled by the first lady's reaction," said Evason, who later spoke to the conference, sponsored by the Georgia Association of Health Underwriters. "The insurance industry has been portrayed as the villain — that it's against change. That's wrong."

HIAA represents more than 300 insurance companies, which sell 35 percent of all private insurance. The conference drew about 600 health insurance agents and industry officials.

Addressing the conference, Evason outlined the trade group's chief objections to the Clinton plan, including proposals requiring participation in giant health alliances, caps on insurance premiums, and an insurance rating system requiring the young and old, sick and

healthy to pay the same price for health coverage.

Individual agents and small insurance carriers would have a "minimal role to no role if the Clinton plan gets enacted," Evason added.

Nevertheless, he said, the industry and White House agree on several planks of reform, including universal coverage and elimination of exclusions for pre-existing health conditions.

Earlier, Rep. Newt Gingrich (R-Ga.) told the conference that the Clinton proposal would create "a government-dominated system." He advocated a more market-oriented reform, arguing for Republican alternatives that include medical savings accounts, and malpractice and insurance reforms.

Bill Wetzel of the National Association of Health Underwriters told the conference that the Clinton plan "will never be enacted. ... Your role as agents will be preserved."

For sale at the conference was a T-shirt with a caricature of Mrs. Clinton that read, "Doctor Feelgood: Her Prescription Could Kill You."

Rival proposals fall short, first lady argues

By Steve Sternberg
STAFF WRITER

Washington — Hillary Rodham Clinton took aim at congressional alternatives to the White House health care reform plan Monday, saying the rival plans fall to assure comprehensive coverage for all Americans.

She also said the congressional plans do not detail the health benefits Americans can expect from insurers and fail to set out what those benefits will cost.

"We do not see any way to accomplish the cost savings that have to be achieved through reform in the absence of universal coverage and benefits that are priced out," Clinton said.

The first lady, fresh from a well-publicized scuffle with insurers over the accuracy of ads attacking the White House health plan, appeared to be taking the offensive against rival proposals that have been touted as a likely basis for compromise.

Rep. Jim Cooper (D-Tenn.), who has proposed reforming the insurance market and providing a tax credit to help the

uninsured buy coverage, said he was surprised by her statements.

"We're just as sincere, just as committed to health reform in this Congress as she is," Cooper said.

The administration's strategy aims to cut health costs in two ways. One is to cover every American so each gets timely care in a cost-effective setting. It also would eliminate "cost-shifting," a practice in which hospitals pad the bills of paying patients to cover unpaid bills of the uninsured.

The second involves standardizing the benefits offered by various insurance companies. The goal is to enable consumers — represented by large, regional purchasing co-ops — to compare health plans and choose those that provide the best coverage at the lowest price.

Employers would be required to pay 70 percent of workers' premiums; employees would pay the rest. Small businesses and their employees would get government subsidies to help ease the burden. The government would provide coverage for the poor.

To Lisa & Mark

First Lady vows to press health reform fight

By Tom Hamburger
Washington Bureau Chief

Washington, D.C.

Hillary Rodham Clinton vowed Monday to continue to fight for the administration's health care reform principles until legislation is voted on next year.

She also said that she will speak out about civic violence and the need for more effective control of guns.

Meeting with a group of health reformers yesterday, Clinton said she hoped Congress would ban assault weapons and "control the use of guns among teenagers." She also touted the Brady Bill, which would establish a five-day waiting period for those

She also says she'll speak for gun control measures

wanting to buy handguns.

She said a proposal by Sen. Daniel Moynihan, D-N.Y., to tax handgun ammunition deserved "serious consideration," though the revenue Moynihan's proposal would raise is not necessary to fund health reform.

During the hour-long session, the First Lady provided a critique of alternative health reform proposals and offered views on issues ranging from living wills to mental health coverage.

In reviewing legislative alternatives,

Clinton said only two met the administration's minimum requirements: a Canadian style single-payer proposal (backed by Rep. Jim McDermott D-Wash. and Sen. Paul Wellstone, D-Minn.) and legislation sponsored by Sen. John Chafee, R-R.I., that calls for universal coverage but does not require employers to provide insurance.

The Chafee proposal, also supported by Senate Minority Leader Robert Dole of Kansas, has been described by other top administration officials as a likely compromise vehicle for bipartisan reform efforts.

Clinton was caustic yesterday in reviewing a bipartisan reform proposal backed by Sen. Dave Durenberger, R-Minn., and Rep. Jim Cooper, D-Tenn. While it does not set universal coverage as a goal, its backers have said that it comes close to achieving it.

"I don't know anyone who has studied [the Cooper-Durenberger bill] who really thinks it will achieve universal coverage," Clinton said. "It would leave many millions uninsured and what would we get for our money? Deficits would continue to go up."

The Chafee plan is similar but less ambitious than the administration's. It has no cost control mechanism and wouldn't require employers to provide insurance for workers. Clinton said she was willing to discuss these differences and seek a compromise. But she was worried about Chafee's proposal to reform health care without an employer mandate.

"We have worries that ... the absence of employer responsibility would lead an untold number of employers to drop coverage for workers they currently insure, which would create more costs for the government and leave the system in

Health care continued on page 8A

1 of 2

James J. Wongan

Health Care: Why We Failed the Last Time

I am the doctor who was at the bedside when the last national health proposal, put forth by the Carter administration, died. The time was May 1980 and the place the Senate Finance Committee. I was the White House representative for the Carter administration during the committee's bill-drafting session. The proposal died quietly, with little attention from the media, after a two-year "wasting illness" during which it shrank from a large, relatively robust proposal to a small, anemic shadow of its former self.

The Carter plan began, under principles released in July of 1978, as a proposal for a phase-in of universal coverage. But the administration was never certain of support for the increased taxes of employer mandates necessary to make universal coverage a reality. So the plan began to diminish even before it was released in "draft form" in January of 1979—to a proposal for a phase-in of coverage, with each expansion conditional on certain economic circumstances. This conditional phase-in was then diluted further, during congressional consultations, to one conditioned on further congressional votes for implementation at each phase.

Finally, universality was left behind in March of 1979 when the Carter administration fell back to an attempt to pass a phase-one-only bill that would have achieved some modest expansion of low-income coverage, along with a diluted employer mandate of much less expensive coverage, against only catastrophically high health costs. The proposal finally expired in May 1980 when the Finance Committee failed to reach agreement even on this anemic remnant of the original proposal.

I write now in the hope that we can learn some lessons from an autopsy of this case that might lead to a different outcome for the Clinton proposal.

There are important similarities between the Carter and Clinton plans and their political context. Both proposals, at least at the outset, have been quite broad in scope, calling for a phase-in of universal coverage, and a broad set of benefits, financed in good part through an employer mandate, with appropriate subsidies. There are also some similarities in the political setting with, in both instances, a Democratic president working with a Congress controlled by Democrats.

There are also, of course, important differences. Substantively, the Clinton proposal has a somewhat different administrative structure, relying on state-based health alliances that foster managed competition. There is a relatively large role for state flexibility. The Carter plan had a larger federal role, with employers having a choice of obtaining private coverage, or obtaining coverage through a federally sponsored public backup program modeled after Medicare.

As for the political setting, there are at least two important differences. First, President Clinton has placed health insurance high on his agenda from the earliest months of his administration. In the Carter administration, health insurance took a back seat to energy issues and welfare reform, to

name but two competing issues. Secondly, there appears to be somewhat more cohesion among Democrats than there was in 1979 and 1980, when health insurance became an important battleground in the struggle between President Carter and Sen. Edward M. Kennedy prior to the primary election fights in 1980.

What lessons can be learned, then, from the story of the ill-fated Carter proposal? First we must establish the cause of death. The Carter proposal wasted away a little at a time, gradually growing smaller and smaller. Why? Undoubtedly, division among the Democrats was a major factor; it gave the administration little choice but to attempt to build a more conservative coalition around a much smaller proposal in the Finance Committee. Equally important was the subordination of the goal of universal coverage to other goals—among them avoiding tax increases and employer mandates, which aroused the anger of the small-business community.

The first lesson, then, is to remember the importance of party cohesion. A health insurance bill cannot be passed by Democrats alone. It surely cannot be passed with a badly fractured majority party. Democrats who want health insurance to pass must not allow the best to become the enemy of the good and bog down the debate in repeated tests of ideological purity.

Having said that, the second lesson is that during the pull and tug of congressional action, the moral compass to guide us through the health insurance debate and lead to a successful conclusion must not be lost or set aside. That moral compass is the attainment, by a date certain, of universal coverage. Once this debate begins to slide down the slippery slope away from universal coverage, through contingent universal coverage, on down to incremental expansions of coverage, it will suffer the same death by degrees as the Carter proposal.

Although just about everyone in Congress, of both parties, is ostensibly in favor of the concept of universal coverage, there is still a notable queasiness about the employer mandates and taxes necessary to make universal coverage real.

In the quest to gain the broad bipartisan support that will be necessary to pass legislation, there is the danger that the goals of avoiding taxes and mandates will again take precedence over the goal of achieving universal coverage—and we will again fail to meet the major moral test of this debate.

There is a message here for members of Congress. You can negotiate on the types and mix of taxes and mandates, but a guaranteed date for universal coverage must be nonnegotiable if we are to avoid the mistakes of the past and seize this historic opportunity. The test of history will be simple: Is everybody covered?

The writer was associate director of the White House domestic policy staff in the Carter administration. He is now dean of the medical school at the University of Missouri-Kansas City.

THE WASHINGTON POST — TUESDAY, NOVEMBER 9, 1993

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US Mayor Nov 1, 1993

U.S. Census: More Americans Without Health Insurance as Poverty Deepens

By Jenell Williams

The number of Americans below the poverty line increased in 1992 for the third straight year, according to the Census Bureau's annual report on poverty in the United States, which was released October 4. New data also suggest a significant increase in the number of Americans without health insurance coverage.

The 36.9 million Americans living in poverty in 1992 represent an increase of 1.2 million from 1991. The poverty rate was 14.5 percent in 1992, not significantly different from the 14.2 percent rate in 1991. In 1989, 31.5 million or 12.8 percent of Americans were poor.

The number of persons in poverty in 1992 is the highest since 1962, when 36.1 million persons were poor. The poverty rate that year was 19.0 percent.

Central cities of metropolitan areas had the highest poverty rate, 20.5 percent. In 1992, 42.4 percent of the poor lived in central cities, compared to 30.1 percent of all persons. Poverty rates in metropolitan areas were unchanged between 1991 and 1992 in both central cities and suburban areas. The number of poor and rate of poverty increased significantly in nonmetropolitan areas.

Children had the highest poverty rate of any age group at 21.9 percent. The poverty rate for persons aged 18 to 64 was 11.7 percent; it was 12.9 percent

for those 65 and older.

The poverty rates of African Americans (33.3 percent), whites (11.6 percent), Asians and Pacific Islanders (12.5 percent), and Hispanics (29.3 percent) were not significantly different in 1992 from the previous year.

Daniel Weinberg, chief of the Housing and Household Economic Statistics Division at the Census Bureau, described a corresponding trend in the number of persons without health insurance coverage, which increased from 35.4 million in 1991 to 37.4 million in 1992. Weinberg stated, "The decrease in the proportion of Americans with health insurance between 1991 and 1992 from 85.9 to 85.3 percent included a decrease in the proportion of people with private health insurance and military health insurance. Over the same time period, the proportion of people covered by Medicaid increased from 10.7 to 11.2 percent."

Among the poor, 20.1 percent of children and 3.1 percent of the elderly had no health insurance. Persons with income below the poverty level represented 28.1 percent of the 37.4 million persons who reported having no health insurance during 1992.

Jenell Williams is a student at Bethel College who is currently an intern at the U.S. Conference of Mayors.

November 1, 1993

Clinton Health Plan

As U.S. MAYOR goes to press, President Clinton and First Lady Hillary Clinton are presenting their health care legislation to Congress. Conference staff will continue analyzing the plan over the next few weeks for the purpose of providing mayors a clearer picture of what it means for local governments and citizens of our cities. Fort Worth Mayor Kay Granger is the Chair of our Health Standing Committee. Working with the local health officers and Conference staff, Mayor Granger will present our leadership with information for our members as they develop their health policy recommendations. While our leadership has praised the President and the First Lady for their efforts, city officials at our last Health Committee meeting had a number of questions concerning how the proposed plan will work and what the financial ramifications to our already stressed-out budgets will be.

U.S. Mayor Nov. 1, 1993

Local Health Directors Seek Detailed Information on Their Role in Massive Clinton Health Care Reform Plan

By Byron J. Harris

With the release October 27 of the Administration's 1,345 page Health Care Security Act of 1993, the debate over health care reform escalated in Washington and throughout the country.

Those concerned with the role of state and local public health departments in the reformed system met with Department of Health and Human Services Assistant Secretary for Health, Dr. Philip Lee on October 14. In his overview of the new system, Lee said that "the role of public health in most circumstances must change to one of setting standards and monitoring rather than one of providing direct medical services at the local level; and that to the degree public health can keep their populations well, this will help drive down the cost of premiums."

Regarding local funding, Lee said, "The Administration will set aside funding to support core public health functions, such as data collection and surveillance, lab work, policy development, and other assessment functions." He said funds would be disbursed through a competitive bidding process.

Earlier drafts and discussions of the President's plan stated a formula would be used to disburse these funds. Financing to support core public health functions might be obtained through a tax on tobacco products and an assessment tax

on the premiums of health alliances.

Lee also revealed that many of the categorical grants to states and localities will be continued during the transition phase of the plan, which is to last four or five years.

Dr. Guadalupe Olivas, President of the U.S. Conference of Local Health Officers, an affiliate of The U.S. Conference of Mayors, expressed the need for local health directors to continue as "full partners in the formation" of health care reform. "The undocumented are not in the health plan...we [health directors] are trying to find funds to adequately address this population in the president's plan," she said.

Lee mentioned that approximately 1 billion dollars could be found in the current version of the President's health plan to address the needs of the undocumented but said some states such as New York, Texas, California, Florida and others may need additional funds. At press time, according to a White House source, there is approximately 2 billion dollars set aside in legislation sent to Congress for the poor and emergency medical services for the undocumented.

Other individuals representing the Conference of Local Health Officers were Milwaukee health director, Paul Nannis, and Lincoln-Lancaster County, (NE) health director, M. Jane Ford.

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^First Lady Pledges Relentless Health-Care Fight (Washn)

^By Marilyn Milloy= ^(c) 1993, Newsday=

WASHINGTON Hillary Rodham Clinton Monday promised a relentless fight with those who resist proposals to provide health coverage to every American, and again singled out the insurance industry as a prime target of administration attacks.

"If the forces arrayed against reform want a real battle in which their self-interest is exposed and their real agenda is made public, they'll get it because I think a lot is at stake," the first lady said in an interview with a group of reporters.

She made no apologies for her recent accusation that an insurance industry trade group was spreading lies in its advertising campaign against the administration's health-care plan. And Clinton responded, "Heavens no!" when asked whether she had succeeded in muzzling the trade group, the Health Insurance Association of America.

"If they've got all that money to spend on these misleading ads," she added, "I find it hard to understand how badly they're going to be hurt by changes in the insurance market. ... I just think when someone puts on six-and-a-half-million dollars of advertising and it goes unanswered, that's a mistake."

The trade group's executives have responded that the ads which suggest the administration proposal might bring health-care plans to ruin are accurate and raise important issues.

Clinton, who headed the task force that developed the administration plan, said Monday that her tough words were not meant to suggest the administration had retreated from its promise to work with all sides to come to a solution. "We absolutely intend to work with everybody," she said.

Yet she drew clear battle lines between the administration and other supporters of universal coverage and those, including some influential Democratic lawmakers, who have called for something less.

At one point, she said the "conversation" in Congress should be among a group of moderate Republicans, some liberal Democrats who support a government-sponsored or "single payer" system, and the administration all of whom are urging universal coverage, which President Clinton has called the administration's one non-negotiable principle.

But even among those who share that basic aim, she said, "Our being open doesn't mean we will agree with them. That is not at all the same." She cited a litany of problems the administration sees with the moderate Republican and single-payer approaches to reaching universal coverage.

"It's not enough for somebody to say we have a better idea," she said. We've got to say, 'Great, sounds good. Now, let's run the numbers. Let's see what the best minds think about it, how it would work in practice.'"

The first lady left room for movement, saying the administration would consider stretching the proposed five-year period for capping the rate of growth of insurance premiums.

She dismissed polls that have showed public support for the administration's plan waning, saying once the public understands the plan, the more popular it will be. "It's just a question of slowly and steadily and persistently getting information out to people," Clinton said.

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But she seemed aware of the difficulty of combatting pervasive criticisms she called them "horror stories" about the complexity of the plan.

She argued that it actually involves less government regulation than the current system does.

Opponents "try to make it sound like there's some great big apparatus out there" that would make new kinds of decisions about premiums, she said. But when insurance commissioners set rates in 50 different states, "nobody thinks that's out of the ordinary," she said.

"I have no doubt that the forces of the status quo will dig in their heels and do everything they can while praising the potential of reform trying to undermine it ever being enacted," she said.

But, the first lady said, "I feel like to some extent I have committed myself to all these literally thousands of people I have met and talked to and who have shared their personal stories with me. I have their pictures running through my head all the time, and I don't think I can back out on them. I think they expect the president will be able to change this system and that all of us will be better off when we do, and I agree with that."

^Distributed by the Los Angeles Times-Washington Post News Service=

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