— THURSDAY April 1st —

AACP - Thurs

- Friendly? - malp / yes / • seen as more progressive, accept reform
- • member working w/ us
- overlap - not much overlap
- paragraph re: Monday mtg
  - Gore doing this

testimony from today's hearing

Summit speech / Fri

- should outline what BC will do for kids
- urw Bill Galston

Tipper > kids - ?

Carol > same as HRC > Top part of speech

- CTR on bud & pol priorities
  (Evelyn
- CDF response to BC proposals

Suite 250, 700 Thirteenth Street, NW, Washington, DC 20005, Telephone 202 393 1650 or 800 633 9400

American College of Physicians

February 8, 1993

Ms. Marcia Hale
Assistant to the President and
Director, Scheduling and Advance
The White House
Washington, DC 20500

Dear Ms. Hale:

I would like to bring to your attention the enclosed invitation for the President to address the Annual Session of the American College of Physicians (ACP), in Washington on April 1.

I hope you will agree this is an exceptional opportunity for the President to address issues of health care reform:

- **The audience is approximately five thousand physicians** practicing, in whole or in part, primary care internal medicine and gathered in Washington for a major scientific meeting.

- **The presidents of most major physicians' organizations** in this country will be on the stage, as well as a number of physician leaders from other nations.

- When ACP announced our health care reform plan in September, then-Governor Clinton greeted it as consistent with his own approach, and cited it repeatedly during the campaign. He also mentioned the College in his recent announcement of the health care reform task force.

Given the complexities of an event of this size, but also understanding that you must be swamped with invitations, we hope that you will be able to respond as soon as possible. Please contact me if I can provide additional information.

Sincerely,

Howard B. Shapiro

Howard B. Shapiro, PhD

Independence Mall West, Sixth Street at Race, Philadelphia, PA 19106-1572, Telephone 215 351 2400 or 800 523 1546

American College of Physicians

Willis C. Maddrey, MD, FACP
President

January 21, 1993

The President
The White House
Washington, DC 20500

Dear Mr. President:

The American College of Physicians would be greatly honored if you would accept our invitation to give the keynote address at our 74th Annual Session on April 1 in Washington, DC. This address opens one of the most respected scientific and medical meetings held in the United States. The American College of Physicians, with almost 80,000 members, is the largest medical specialty society in the country. We expect 6,000 to 8,000 of our members will attend the Annual Session.

As many have noted, and you stated in the campaign, there are many similarities between your health care reform recommendations and those supported by the American College of Physicians. We believe, as you do, that there are increasing numbers of physicians who recognize the need for comprehensive reform of the health care system and are willing to challenge the status quo in order to improve the system for everyone.

The timing of our meeting may provide an ideal forum for a major Administration address on health care reform. Even if your comprehensive legislative proposals are not completed by April 1, our meeting would afford an opportunity to further discuss the issues that must be resolved in achieving meaningful reform. In a sense, our meeting may be an opportunity to present a progress report on the development of your proposals. We hope this event will convey to the American people that physicians are committed to working with you to achieve much needed reforms.

Our opening ceremony is scheduled for 9:00 a.m. on April 1 in the Washington, D.C. Convention Center. We would be pleased to work with your staff to structure an event that could be an important step in building consensus for health care reform.

Sincerely,

Willis Maddrey

Willis C. Maddrey, MD, FACP

Vice-President of the United States
Address to the the American Medical Association
March 24, 1993

I'm delighted to be with you today.

The First Lady regrets very much that her father's illness prohibits her from being here with you today. I know you join me in wishing her well.

In the last several weeks no one has worked harder than she to improve health care in America. She has reached out to so many with her caring heart and sharp mind to help us shape new and better policies, and we are in her debt.

In our campaign and in the first weeks of our Administration we have focused most intensely on the two issues that the American people are most concerned about: restoring our economy to long term health and restoring our health care system to well being.

During my entire career but especially in the last year I've talked to thousands of people about health care, and now have sat in our Cabinet meetings and visited at length with the President, as we collectively try to come to grips with the enormous health care problems.

But I believe we can do it.

In fact, I believe we are on the brink of an historic moment - that we are about to deliver on the change the American people voted for in November, and fundamentally reform the health care system in America.

On January twenty-first the President asked the First Lady to Chair the Task Force On National Health Care Reform. And the President challenged them to work extremely hard to seek out the very best advice, to reach out, and to hear all sides, and to prepare comprehensive legislation that the President can submit to Congress this Spring.

All told 500 people serving on 30 working groups, and including more than 60 physicians, have had hundreds of meetings, and listened carefully to literally thousands of experts and concerned men and women across the nation.

We are still in the fact-finding stage, and trying to build on the good work of so many others. Nobody knows better than you how difficult this is but the Task Force is deadly serious about meeting its deadline and delivering to the President the full set of options he needs to write and pass health care reform this year. It hasn't been a perfect process but it is a very good one given the size of the task, the shortness of the time, and the

absolute importance of achieving cost containment and other basic reforms now.

But my purpose today is not to describe our process. Most of you read the papers so you probably know what it is we are doing - although I can tell you as someone who has been in the room that a lot of what you've read belongs in the fiction section.

I want you to know where we are and what we've learned, because it is so vitally important that we reform the health care system this year. And I wanted to come here and speak with you directly because as our primary care-givers you must be part of any solution to this problem.

One of the things that I don't like about the health care debate is that we throw around slogans and jargon, and I'm afraid we sometimes leave the impression that health care reform is some abstract notion. Just the opposite is true. This crisis hits at the heart of every American family.

We have learned this, and a great deal more, much of it very painful, some of it hopeful, all of it critically useful.

We've learned what it is like for a hard working family to sit around the dinner table and decide to declare bankruptcy because a parent has Alzheimer's.

We've learned how frightening and frustrating it is to lose your coverage. It is every bit as devastating as getting laid off, and it's happening to more than 100,000 of us every month.

We've learned what it is like to build a small business and have to deny your employees health care because you can't afford to provide it.

And I've learned from physicians what it is like to be trapped in a nightmare of paperwork and regulation that you had no role in designing, but that basically forces you to practice with the government looking over your shoulder. It's not right -- and it's wrecking the system.

Loud applause

You became doctors to give care and find cures, to be among those who serve a higher purpose and feel better for it. I know you are the backbone of our system, and that many of you are anguished when talented young people choose to avoid medicine because the rewards no longer exceed the demands.

Part of our goal is to honor your original motives -- great motives -- by re-creating a system that allows you to practice medicine the way you thought you would when you chose your career.

That's why I'm delighted at the flexibility and leadership and reform-mindedness shown by the AMA and Doctor Todd.

This Administration knows that we cannot, and do not want to, build a better health care system without the cooperation and leadership of the AMA. But the days when one association -- no matter how prestigious -- can dominate the health reform debate are over, and they should be. We must all join in and pull in the same direction.

I believe that no Americans have more to gain from a complete overhaul of the medical system than doctors. You're the ones who see the scared faces of the mothers who delay seeking care for a feverish child. You're the ones who spend hours working the phones in search of permission to admit your patients or to prescribe a certain treatment. You're the ones who wonder what to do when a neighbor or friend comes for treatment and has no insurance. You're the ones for whom the status quo is unacceptable.

And so here is what we offer you: we are going to ask you to help us control skyrocketing health care costs. In return, we are going to work very hard to reform the malpractice laws and cut the bureaucracy and the paperwork which make it difficult for you to be caregivers.

Fixing this system, as you well know, will not be easy. But the American people have demanded that we fundamentally reform a system that costs too much and wastes too much and serves too few; and, that we make the system work better for real people with real problems.

We will never succeed if our reforms fail at the crucial moment when someone is sick and needs help. That is the test.

Our goals are simple. First, we must control costs that are rising four times the rate of inflation. If we do not it will cost our nation an average of $14,000 per family by the end of the decade. We must cut waste and increase competition and stop those in the insurance and pharmaceutical industries who are profiteering excessively.

Second, we want people to be secure and to be guaranteed a benefits package that is truly comprehensive.

Third, we want the system to be simple. The President has already made a serious commitment to reform the way government does business. He has made historic cuts in the budget, starting with his own staff and federal workers. We must make the same commitment to better management and greater savings in the health

care system, including implementing tough new anti-fraud and abuse measures.

If we do not, we will waste another 80 billion dollars next year and every year on paperwork and bureaucracy, when those resources are needed to improve the system and care for people. And you will keep spending the equivalent of ten working days each month just to keep up with the paperwork.

Fourth, our health care plan will provide continuity in two senses: we will preserve your patients' right to pick the doctor they want, and we will continue to offer them the highest quality care in the world. In addition, we will provide them with a new right: to choose the coverage they want, not simply what their employer or insurance company will allow.

Finally, health care reform should also be comprehensive, in the sense that all Americans should be covered.

In reaching these goals, rest assured that we will translate what you have told us into reality. That means malpractice reform.

Today, malpractice too often lives up to its name - it has made the practice of medicine worse at the juncture it matters most - that critical point of communication and trust between doctor and patient. It is an ancillary industry whose practitioners often only do well if you are accused of doing wrong, and that is wrong -- ~~and we should do something about it~~.

It also means relieving pressure on you.

We've heard and we believe that practicing medicine has become too big a hassle. The bureaucracy has gotten too big and the time for treatment too small. The traditional autonomy between you and your patients has given way to the new triad of medicine - a doctor, a patient, and an accountant.

We want to write a plan that allows you to return full time to medicine.

Like you the American people are frustrated with the cost and the waste and the frustration and the fear. They want change now. Most of you have your own deep disappointments in the system. You want change now.

As a doctor told Mrs. Clinton and my wife when they visited St. Agnes hospital in Philadelphia: "You know the saying, 'If it ain't broke don't fix it.' Well Mrs. Clinton, the system is broke and it's time to fix it."

The American people desperately need a system that works for them again, and the time has come to balance your needs with theirs. Under a good plan no one will get everything that they want, but everyone will get a better deal all around.

Last year, the American people proved that they have the courage to change. Now it is time for us to prove ours, by enacting real health care reform.

Our system can be improved, dramatically improved. We know we can do better because many in our nation are doing better already. But this is the year to act.

The President understands this.

He has said he will take the heat when things go wrong and doesn't care who gets the credit when things go right.

And the American people have rallied to his side.

After years of political gridlock we are beginning to move quickly to solve our most serious problems. Most importantly, we have begun the glorious act of uniting again as Americans determined to leave our children the American dream.

Thank you very much.

AMERICAN COLLEGE OF PHYSICIANS

MEMBERS:	77,000 members
REPRESENTS:	Largest medical specialty society and rin the U.S. with 77,000 members practicing internal medicine, both general internists (pc phys) and internal medicine subspecialists (cardiologists, gastriology,..). One of the two large medical specialty organizations to come forward with a reform plan that endorses a global budget as part of cost containment.
TODAY'S SPEAKER:	?? (See attached biography)
SCOPE OF INFLUENCE:	One of two organizations representing general medicine (other is the more conservative is the ASIM). Not known as big lobbying organization, more academically and professionally oriented.
POSITION ON PLAN:	Nervous about managed competition, more supportive of national regulatory mechanisms.
APPROACH TO REFORM:	Pay-or-play universal coverage within a global budget
SUMMARY OF POSITION:	The ACP supports a global budget, pay-or-play universal coverage, ban on preexisting condition exclusions, community rating, outcomes research and practice guidelines, and the control of technology. Must change patient expectations for health care. Support changing incentives to increase number of primary care providers. Very strong on cost containment, particularly through the control of technology.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Meetings during transition, with Secretary Shalala, Ira Magaziner; Mrs. Clinton speaking to their Annual Meeting on April 1

Health Care Reform: An American Imperative

The little boy stood weeping on the cabin's front porch, one leg horribly charred. "Why didn't you take him to the doctor?" the equally young passerby asked. "Because we got no money," the little boy's mother replied. Later the passerby learned the boy had died.

No one should go without medical care for lack of money. As physicians, we struggle daily against the chaos of illness and injury, whether in the context of clinical, laboratory, or administrative practice. We try our utmost to restore or to preserve health, yet the lack of access to care for many Americans increasingly frustrates our best efforts. In this issue of *Annals* (1), the American College of Physicians proposes a plan to ensure high-quality care for everyone.

The young teacher had battled brittle diabetes for years. After one job was abolished, she could find no work because employers were reluctant to add her to their health plans. She finally found work that provided minimal benefits exclusive of claims related to her diabetes.

No one should have to mold his or her life around predetermined benefits packages. Patients tell us insurance premiums are becoming unaffordable; our patients who own businesses speak of unmanageable costs for the health care of their employees. The College plan calls for a health care system that provides all medically necessary care to everyone, regardless of the payer.

A 55-year-old man with long-standing hypertension and high blood cholesterol was admitted to the hospital with severe chest pain, which was relieved by nitroglycerin drip. Evaluation showed no acute myocardial infarction, and a stress thallium test was normal. The private insurance company denied payment for the hospitalization.

A 70-year-old woman had carpal tunnel syndrome. The total bill for surgery and outpatient treatment was $5200. The patient protested that the charges were excessive but was reassured that Medicare would cover the expenses.

No one in America can afford to tolerate a system that wastes billions on unnecessary care. The nation's health care bill is the highest in the world, yet necessary services are denied payment while excessive charges for questionable procedures are tolerated. Bureaucratic intrusions by government review organizations and private insurers into the practice milieu drain precious resources of time and money while community health services wither from lack of funding. The College proposes a global health care budget and other measures to promote effective care, discourage unnecessary procedures, and reduce administrative waste.

The College's plan, "Universal Insurance for American Health Care," described in this issue (1) is a bold new initiative to replace America's failing system of health care. The plan is the product of intensive efforts by a broad coalition of College members working on the issue for the past three years (2, 3). In much the same way as internists approach a sick patient, the College has gathered and sifted data and has elicited opinions from leaders of business, other medical organizations, the retiree community, and government. Most importantly, the College has listened to our own members who are on the front line of medicine.

The plan calls for identical health benefits for all Americans based on medical necessity and appropriateness, not on predetermined insurance packages or the source of payment. Both the public and private sector would sponsor and pay for health care. Global budgeting would contain costs effectively while assuring secure and rational funding and curtailing waste. Sweeping reform of administrative practices, partly through consolidating public and private insurance plans, would free physicians to practice efficiently and free funds for patient care. All of these elements would improve the quality of care and preserve the integrity of the doctor-patient encounter.

One of the most important aspects of our commitment to change is the understanding that the health care system must learn to live within limits. Voices from all sectors of society are shouting that growth in health care costs must be slowed. Physicians should participate fully in the debate on cost containment. Indeed, our professional knowledge, experience, and central role in the public's health obligate us not only to join the discussion but to lead it.

The College's plan should serve as the basis for future discussion on implementing universal health care. Within the College, that process will lead to a new phase of work that will require more detailed analyses of the budgeting and rate setting processes, the role of private insurance companies, and the cost of reform.

In discussing budgeting, we will need to look to the experience of communities in the United States and other nations. We will have to consider how to accommodate both fee-for-service and capitated arrangements, coordinate the public and private sides of the system, designate negotiators for payers and providers who would work within the global budget, and balance the interests of general and specialty physicians.

Insurance companies have an important role in working with providers to create efficient and effective practice arrangements. Price and quality of service would become the new basis of competition, rather than underwriting,

which avoids risk and shifts cost. Insurance organizations might also serve in the role of claims processors for states and localities and data repositories for evaluating medical practice and developing practice profiles.

In projecting the cost of the reforms, important considerations will include the time necessary for them to produce actual savings. Like the "peace dividend," savings will not be immediate.

The College offers a blueprint for a better health care system, a system in which care is a right and not a matter of economic privilege. We recognize reform will require careful implementation and will take years. But if we as a nation begin now, we will soon reach the day in which all Americans have access to high-quality care and physicians have the revitalized practice environments in which to deliver it.

Let us get on with the work.

For the American College of Physicians
Willis C. Maddrey, MD, President
Rolf M. Gunnar, MD, Chair, Board of Regents
Paul F. Griner, MD, President-elect
James J. Bergin, MD, Chair, Board of Governors
Clifton R. Cleaveland, MD, Chair, Health and Public Policy Committee
John R. Ball, MD, JD, Executive Vice President

Annals of Internal Medicine. 1992;**117**:528-529.

References

1. **American College of Physicians.** Universal insurance for American health care: a proposal of the American College of Physicians. Ann Intern Med. 1992;117:511-9.
2. **American College of Physicians.** Access to health care. Ann Intern Med. 1990;112:641-61.
3. **Greenberger NJ, Davies NE, Maynard EP, Wallerstein RO, Hildreth EA, Clever LH.** Universal access to health care in America: a moral and medical imperative. Ann Intern Med. 1990;112:637-9.

700 E[illegible] Street, NW, Suite [illegible], Washington, DC 20005, Telephone 202 [illegible]

American College of Physicians

Howard B. Shapiro, PhD
Director
Public [illegible]

MEMORANDUM

TO: Molly Brostrom

FROM: Elizabeth Prewitt EP

DATE: March 22, 1993

SUBJ: April 1 Forum on Health Care Reform

As we discussed this morning, the College has asked Judy Feder to participate in a forum at the ACP Annual Session on April 1 from 1:30 to 3:00 pm, entitled "Health Care Reform: A Progress Report from the Administration, Congress, the States." We have not yet received a response to our invitation.

Dr. Paul Griner is moderating the session and Governor Dean of Vermont and Senator Wofford are on the panel, giving the state and congressional views on health care reform respectively. Dr. Feder has been asked to give a progress report on the development of the Administration's proposal. The meeting is at the DC Convention Center. We will make every effort to schedule the panels' remarks at their convenience during the 1:30-3:00 pm session.

This forum would provide an outstanding opportunity to follow-up on Mrs. Clinton's keynote address that morning. We would greatly appreciate whatever Mr. Magaziner could do to provide an appropriate spokesperson, such Judy Feder, Ken Thorpe, or himself.

Thank you in advance for your help.

MARCH 22, 1993

TO: IRA
FROM: MOLLY
RE: MEETING WITH AMERICAN COLLEGE OF PHYSICIANS--8:30, 3/23

John Ball (President), Scott Denny, Elizabeth Prewitt, Kathleen Haddad, and Paul Griner will be attending the meeting. Dr. Griner is expected to be the next president of the College; he is currently involved with the Rochester plan.

The College and the American Adademy of Family Physicians are the only two large medical specialty organizations to come forward with a reform plan that endorses a global budget as part of cost containment.

The ACP's plan was printed in the Annals of Internal Medicine in September 1992. The College supports a global budget, pay-or-play universal coverage, a ban on preexisting condition exclusions, community rating, outcomes research and practice guidelines, and control of technology. A copy of their plan is attached.

POSITION PAPER

Reprinted from ANNALS OF INTERNAL MEDICINE Vol 117; No. 6, 15 September 1992
Printed in U.S.A.

Universal Insurance for American Health Care

A Proposal of the American College of Physicians*

America urgently needs comprehensive health care reform. The American College of Physicians (ACP) believes that universal access to care can be achieved only through system-wide reform in the organization and financing of health care (1). This paper outlines our proposal for a national policy to achieve that reform.

Overview

As a professional society of physicians whose goal is excellence in medicine, we see a system failing all who are a part of it—patients, physicians and other health professionals, purchasers, and insurers. Most of the problems have been well documented: over 35 million Americans without health coverage, excessive utilization of high technology coexisting with substandard care, astonishing increases in spending without commensurate gains in health status, acute care promoted at the expense of preventive services and technology-based care at the expense of primary care. As practitioners, we feel the fear of uninsured and underinsured patients at the prospect of severe illness, and appreciate the dilemma of those locked into jobs just to keep health coverage. We confront every day the crushing bureaucracy of a system that diverts time, energy, and resources from patient care, frustrating the ability of physicians and patients to deal with illness.

Three aspects of the health care system appear particularly troubling. First, it promotes inequity and conflict between its private and public components. Costs are shifted from one component to the other, public programs lacking a powerful constituency are underfunded, and the total system suffers from unwieldy administrative complexity and cost. Second, benefit packages consist of circumscribed lists of covered services that reflect more the needs of payers than those of the patients. Third, cost-control efforts have failed to make the system affordable and have imposed an intrusive regulatory burden on both patients and physicians.

The College would correct these problems through a universal health insurance system covering everyone living in this country. Our design for a reformed system addresses the major problems through four elements:

- *Assuring Access to Care:* We propose a universal insurance system that relies on employer and publicly sponsored insurance plans. All public programs for health care would be consolidated, and everyone would be guaranteed coverage, funded through a combination of private premiums and public revenues.
- *Assuring High-Quality and Comprehensive Health Care:* We propose that all medically effective services be covered when they are appropriate for a particular patient.
- *Promoting Innovation and Excellence:* We propose measures to enhance the crucial institutional underpinnings that sustain excellence in medical care—research, education, and medical information management.
- *Controlling Costs:* We propose a national health care budget with a mixture of centralized and decentralized mechanisms to influence the price, volume, supply, and demand for health care services.

The ACP plan envisions substantial change, including insurance reform, limitations on spending, fee negotiations, and new structures such as a national health care commission representing all sectors of society. At the same time, the College's plan would incorporate elements of our current system that are valued by patients and providers—for example, a pluralistic approach that would accommodate fee-for-service and managed-care options, but a role for government that is circumscribed.

The College has developed this plan after extensive consultation, including input from a network of 4500 ACP members and from many organizations, review of other proposals, and examination of health care systems of other nations. Careful transition will be essential, but the nation must move forward quickly to adopt and implement a comprehensive plan.

Assuring Access to Care

The College proposes a plan for universal insurance, through a mixture of private and public financing, in which everyone living in the United States would be insured. Covered benefits would be the same for everyone: all medically effective and appropriate care. Public plans serving specific segments of the population would be eliminated.

We envision an integrated system in which employer-sponsored and publicly sponsored insurance plans would offer practice arrangements ranging from traditional fee-for-service to various organized delivery systems. Patients and providers would perceive no difference between health care in employer-sponsored and publicly sponsored plans; only the source of financing would be different.

Other proposals have suggested separate systems of care: private insurance through employers, public coverage for the unemployed, and continuing entitlement

* This paper, authored by H. Denman Scott, MD, MPH, and Howard B. Shapiro, PhD, was developed for the Health and Public Policy Committee: Clifton R. Cleaveland, MD, *Chair*; Cecil O. Samuelson, Jr., MD, *Vice-Chair*; Christine K. Cassel, MD; David J. Cullen, MD; Harold C. Sox, Jr., MD; Quentin D. Young, MD; Robert A. Berenson, MD; John M. Eisenberg, MD; Woodrow A. Myers, Jr., MD; Steven A. Schroeder, MD; and Gerald E. Thomson, MD. Approved by the Board of Regents on 10 July 1992.

programs for others (Medicare, Veterans Affairs, and other programs). Separate public and private systems perpetuate inequitable access to care, both because people in some public plans have only "minimum" benefits, in contrast to full benefits in most private plans, and because public programs are likely to be underfunded. Separate systems also perpetuate complex, overlapping, and costly administrative bureaucracies.

Some proposals rely on single-payer or centralized government approaches—basically a Medicare program for all. Government may be efficient at some functions, like collecting taxes and writing checks, but it is not well suited to administer and oversee the complicated set of interactions in the health care system. Nor would centralized control promote the variety of approaches to health care delivery that a private, insurance-based system fosters.

Employer-Sponsored Insurance

In the ACP plan, employers would have an option: They may sponsor insurance for employees up to 60 years of age and their dependents (including part-time employees) or pay a tax so that those employees can enroll in a publicly sponsored insurance plan. To encourage employers to sponsor plans, we propose three steps to make coverage more affordable and premiums more predictable:

- phase out employer responsibility for retirees and shift them into publicly sponsored plans;
- switch employees into publicly sponsored plans at 60 years of age; and
- provide payment for all catastrophic costs (over $50 000 per year per person) through publicly financed coverage.

These measures would remove the most expensive patients from employer-sponsored plans. The intent is to make premiums equal to or less than the payroll tax that would otherwise be required, encouraging employers to continue or initiate coverage. This addresses a criticism of those "play or pay" plans in which the premium cost to "play" is so much higher than the tax to "pay" that employers would terminate coverage and transfer employees to the public program—eventually leading to a single public system.

Employers who sponsor insurance would choose among private plans that meet national guidelines. The minimum employer contribution to the premium would be 50%, with the employee paying the rest, although the employer may choose to fund a larger proportion of the premium.

Publicly Sponsored Insurance

Everyone not covered by employer-sponsored insurance would enroll in a publicly sponsored plan. This group would include: employees whose employers choose not to offer plans, employees over 60 years of age, retirees, and the unemployed and those outside the labor market. The current array of federal and state entitlement programs created for specific groups would be replaced by the publicly sponsored insurance plans, which would provide benefits identical to those in employer-sponsored plans.

Funding for publicly sponsored plans would come from:

- payroll taxes from employers and employees in companies not sponsoring insurance;
- income-related premiums, collected through the tax system, for retirees and people not working but with incomes greater than the poverty level and for employees over 60 years of age in firms sponsoring insurance;
- increased alcohol and cigarette taxes; and
- general tax revenues.

The general revenues will be necessary to support premiums for low-income and unemployed people who pay no or reduced premiums, to pay for catastrophic coverage, and to cover costs for the elderly beyond premium revenues. We believe these expenditures are properly the responsibility of the public.

Our catastrophic costs program would be not only a public payment mechanism for costs in excess of $50 000 per year but would also be a stimulus to development of high-cost case management techniques, reliance on centers of excellence, and cost-efficient care. Our goal is to encourage smart decision making to govern allocation of resources.

The ACP approach to publicly sponsored insurance would strengthen the constituency of public programs. By including employees and dependents from companies not sponsoring insurance, retirees, and anyone facing catastrophic costs, the publicly sponsored plans would have strong backing under this proposal. Every person would have a stake in the system.

Insurance Plans and Insurance Reform

We believe an insurance-based system offers the best means of fostering a wide range of practice arrangements to suit the needs and preferences of patients and providers. This does not mean we approve of how private insurers have handled coverage in the past. We propose substantial reforms to alter their practices. We also believe system administration is best handled at the decentralized level, under national criteria.

Insurance plans would not compete on the basis of benefits offered, because all plans would cover all effective and appropriate care. They would not compete by underpricing reimbursement to providers, because there would be uniform rates for all payers. And they would not compete by excluding sick people.

Insurance plans would compete on the basis of *premium price* and *value* offered to employer and public purchasers. By better administration and other efficiencies, a plan could offer a lower premium. Another plan might market itself as providing better value at the same or even a higher price—for example, by organizing a group of providers it believes provides higher quality care. Traditional indemnity plans reimbursing fee-for-service providers could continue under this approach and might compete by offering greater value—for example, unrestricted choice of providers. Insurers might also compete by offering benefits beyond those covered,

although under the benefits process outlined below, we do not see much of a market for that option.

Our plan should reinforce the movement of physicians and hospitals, as well as purchasers and payers, to organize more effective and efficient delivery systems to enhance their competitiveness. There would be strong incentives to develop criteria for quality of care, measure outcomes, and help practitioners provide effective and efficient care.

Competition among insurers would be channeled in this positive direction through reforms to eliminate the current risk-avoidance practice of insurers. Insurers would be required to accept all applicants. There would be no exclusions of coverage due to health problems ("preexisting" conditions). Experience rating (premiums calculated on the health status of the group), which has made rates unaffordable for many small groups, would be eliminated in favor of adjusted community rating (premiums that reflect the health status of the entire community) for all employers.

Finally, with insurance for all medically effective and appropriate services, individual state health benefit mandates would be eliminated.

Underserved People

Even with extension of health insurance to all, there would likely remain underserved people, including the poor, minorities, and rural populations. Providing insurance coverage is insufficient if the barrier to care is lack of nearby physicians and health care facilities. People in inner cities and remote rural areas as well as migrant workers will need more than an insurance plan. We therefore support an expansion of the public health system, including community health centers, local health departments, and the National Health Service Corps, and other ways to deal with geographic maldistribution of health care workers and facilities. Education reforms and related incentives are essential for producing providers to meet the needs of the underserved.

Fiscal, professional, and lifestyle incentives will be necessary to attract and retain health professionals in underserved areas. Capital will be necessary to develop or upgrade facilities and equipment. More effective integration of health services will be required, including efficient transportation and communication. Telephone and computer-based links and mobile clinics may help to deliver care to patients in sparsely populated areas. Strategies must consider cultural differences that influence how care can be delivered effectively.

Assuring High-Quality and Comprehensive Health Care

The College proposes a patient-oriented benefits determination process. Under our plan, a national health care commission would be responsible for determining covered benefits—with the requirement that all medically effective services be covered—and setting and allocating budgets. The commission would have representation from patients, physicians and other health professionals, employers, insurers, government, and other key sectors of society.

All effective and appropriate health services would be covered under all publicly sponsored and employer-sponsored plans. The scope of benefits covered would be based on medical effectiveness research and expert consensus. We would further ensure high-quality care by promoting practice guidelines, creating a scientifically reasoned system of quality assurance, and redefining malpractice protection.

Benefits Determination

For determining benefits, we propose a cascading process structured around three questions of increasing specificity to the patient.

1. Is a service medically effective?

2. Is the service medically appropriate for a particular group of patients or set of clinical circumstances?

3. Is the service appropriate and of value to a particular patient?

Effectiveness

The question of whether a service is medically effective is answered by research or expert consensus. Effectiveness extends along a continuum from clearly ineffective, to unknown/unproven but promising, to somewhat/sometimes effective, to clearly effective care. Decisions at the extreme are clear, but decisions become complex for interventions in the middle range. Greatly expanded efforts in medical effectiveness research will be essential to ensure that clinical decisions would be based increasingly on scientific data and less on individual opinion. Meanwhile, we recognize that there are procedures and therapies that clinical consensus would deem effective but that have not been scientifically evaluated. Such interventions should not be excluded from coverage while their effectiveness is being measured, but measurement should be expedited.

Services that would be assessed for effectiveness would represent all aspects of health care: preventive care; primary care; medical, surgical, and psychiatric care both in-hospital and in outpatient facilities; ambulatory mental health and substance abuse care; oral health; rehabilitative services; and prescription drugs. The *medical care* needs of patients in home care programs and nursing homes will also be included.

The national health care commission would be responsible for determining covered benefits and for establishing the global budget. Should rationing of care become necessary, this mechanism would allow decisions to be explicit and apply to everyone, in contrast to the rationing now done tacitly through the allocation of resources, and largely affecting the poor. These decisions will confront the commission clearly with the trade-offs between expanding medical technologies and limited resources.

The commission's proposals on what services would be covered would not be subject to selective change by Congress. Congress could reject the entire package, but not add, delete, or modify individual items.

Appropriateness According to Guidelines

For services deemed effective, the next step would be to determine the appropriateness of the service under

practice guidelines developed by the clinical community. Guidelines may indicate that a particular procedure is effective for some patients but ineffective for others. As an example, annual screening mammography is effective and indicated routinely for women in their 50s but not in their 30s.

Practice guidelines should be professionally developed and viewed primarily as a means for assisting physicians and patients in making appropriate clinical decisions. They will also help correct over- and underutilization. It is important they not be viewed as a cost-control mechanism.

Guideline development is a science in its infancy. The College has committed our resources to developing guidelines, and we call for increased public and private funding. For the present, guidelines should be applied judiciously, with reliance more on those for which there is strong scientific evidence and less on those for which there is controversy or insufficient evidence.

When practice guidelines are available, they would be tied to the profiling of practice patterns to determine if a physician is generally following the criteria for clinically appropriate use of services. "Generally following" is the key phrase: Oversight would look at patterns, not at individual case decisions. If a practice pattern consistently deviated from guidelines, there would be reason to challenge payment for services. If guidelines are not available, practice profiles would allow comparison with community norms.

Appropriateness for an Individual Patient

Clinical guidelines may not always apply to a specific patient, because guidelines are usually more general and apply to patient groupings. Individual patients may have unique characteristics not covered by the guidelines. A physician may decide, in consultation with the patient, that it is reasonable not to follow the guidelines. This decision will reflect individual clinical circumstances and the personal values of the patient. After the physician provides a service that is medically effective and appropriate for the patient, reimbursement would be made. There would be no questioning of decision making or denial of reimbursement. Payment could be challenged only retrospectively, and only if the physician's practice pattern, indicated through profiling, consistently departed from guidelines.

Other Considerations

To promote innovation, the benefits determination process must accommodate experimental procedures, tests, and therapies. We propose that experimental diagnostic and therapeutic services be evaluated for clinical effectiveness. Insurance plans would cover experimental services if both the physician and patient agree to participate in a formal, scientific evaluation sanctioned by the national health care commission.

We believe the process we have described would provide reimbursement for all appropriate services. Some patients, however, will want services beyond those covered. Others will want amenities such as a hospital suite. Under our proposal, people can pay for these services out-of-pocket or through supplemental insurance, but those expenditures would not be tax-deductible or included in the national health care budget.

Quality Assurance and Utilization Management

An essential element of systemic reform is restructuring the external oversight of quality of care. We believe physicians will accept the constraints necessary in a reformed system, particularly to control costs, if there is an end to the overwhelming regulatory intrusion that dominates practice today.

The goal of assuring quality has been displaced by the imperative of utilization management—a set of techniques designed primarily to drive down costs. Part of this trend has been the transfer of many of these review activities from the traditional setting of quality assessment (the clinical service, the hospital, the organized group practice) to the purview of insurance carriers, Professional Review Organizations, and a rapidly growing number of proprietary groups. These reviewers have relied mainly on time-consuming and intrusive case-by-case reviews. Review criteria are often unspecified and left to the judgment of the reviewer. The techniques are labor intensive, costly, and have not been shown to improve quality of care. Rather, they have intruded excessively into the daily clinical decisions of most physicians, and contributed to mounting frustration and dissatisfaction within the profession and among patients.

The College believes the primary locus of quality assurance must be returned to the medical profession and to health institutions. Clinicians should be responsible for providing high-quality, cost-effective care, and be held accountable for efficient use of resources. Concepts of continuous improvement should underlie this responsibility.

Under the proposed national health care budget, medical organizations would have the responsibility and incentive to monitor practice patterns because those would affect the resources available to the organization and the community. We envision a process tied to the second stage of the benefit determination process described earlier. Practice guidelines are used at this stage to determine the appropriateness of providing services in particular clinical circumstances. Profiling would indicate whether the overall pattern of a physician's decisions falls within the guidelines. Profiles would be relayed from the insurance plans to hospitals, organized delivery systems, and professional organizations so that they can identify outliers, determine reasons for the deviation, and help the practitioner make appropriate changes.

Malpractice Reform

The nation must restore the medical liability system to its proper role: compensation for patients injured by substandard care. We propose substantial reforms of liability determination, as well as stronger efforts by the profession and licensing authorities to monitor physicians and correct problems.

The College has been committed to improving the competence of practitioners, through writing practice

guidelines (2) and developing criteria to establish skill levels for procedures (3). Professional standards help identify good care. Continuing education keeps practitioners current in basic and clinical science and will help physicians meet the important new requirement of periodic specialty board recertification.

The profession must take greater responsibility for monitoring itself. Physicians must identify colleagues who are impaired or show evidence of deficiencies, correct problems, or, if necessary, limit the practice of those impaired physicians. Licensing boards must have the resources and the authority to enforce standards. Data on quality of care will be essential to these efforts. Federal and state governments, insurers, accrediting agencies, institutions, and the profession must agree on indicators for monitoring quality of care.

Significant tort reforms are necessary to defuse the malpractice crisis and begin the retreat from the defensive medicine so ingrained in physicians' patterns of thinking. Tort reforms may not have a dramatic impact, but they are a necessary beginning to restructuring the entire process of liability determination. For various constitutional and political reasons, most states have been unable to enact meaningful tort reform. The malpractice crisis is a national problem that demands a national solution. Congress can and must take steps immediately to pass legislation that preempts state tort law for malpractice, with the following reforms:

- a cap on awards for non-economic damages (so-called "pain and suffering" awards);
- the elimination of suits seeking full damages from all parties (joint and several liability);
- an offset of awards if there are collateral sources of recovery (insurance, workers' compensation, and so forth);
- a penalty for frivolous lawsuits;
- modifications to the statute of limitations; and
- limits on attorney contingency fees.

Also, it should be noted that universal coverage would eliminate costly awards for future medical care.

We reaffirm that the profession must set and enforce standards for physicians who serve as expert witnesses (4). The testimony of these physicians should be subject to ongoing peer review.

Although the jury trial is an ingrained part of dispute resolution in the United States, we question whether it is the best method to achieve the goals of the malpractice system: identifying substandard care and compensating injured patients. The College has been a founding member of the AMA/Specialty Society Medical Liability Project, which formulated an innovative administrative process for liability determination (5). There would be administrative review and appeal, with final determination by a state board. This model deserves serious testing, supported by adequate federal funding. We also support testing alternatives, such as pre-trial screening panels, to eliminate claims not likely to have merit in court, and mandatory arbitration, in which parties to a dispute are bound by the decision of an arbitrator.

Promoting Innovation and Excellence

The American health care system must foster innovation and excellence in medical education, research, and data-based decision making. The College proposes adequate and dedicated financial support for each of these components of the "infrastructure" necessary for the delivery of high-quality medical care.

Medical Education

Reform of medical education is necessary to encourage and enable more students to become generalist physicians, to provide specialty care efficiently, and to prepare physicians to manage patients under the constraints of a health care budget.

A critical element of education reform is that all payers, both public and private, be required to contribute a fixed percentage of health expenditures to graduate education. In addition, appropriate mechanisms to finance training in ambulatory care settings must be developed.

Financial incentives could be used to achieve a balance of generalists and specialists. Financing of graduate medical education might be limited to the number of years required for residency training in general internal medicine, family practice, and general pediatrics. Payments per resident could be weighted for the training of generalists. Reduced or interest-free loans could be granted, or loan repayments deferred, only for residents training to be generalists. Loans might be partially or entirely forgiven for generalists practicing in underserved areas. Increased federal and state grants could be provided to support residency programs for generalists. Other, nonfinancial methods may be required, including capping the number of slots for nongeneralist training, and limiting the accreditation of new programs.

The nation must broaden opportunities for medical education. The government should supplement funding of undergraduate medical education to allow minorities and lower income students greater access. Funding is an increasingly urgent problem; three fourths of graduating medical students have debts, with an average of over $50 000 (6).

Optimal health care requires that physicians educate themselves actively throughout their careers. A new and more effective health care system will require even higher standards of physician competence. Thus, a design for greatly improved continuing medical education, including more meaningful curricula, more effective learning methods, better integration with guidelines, and other quality improvement techniques, as well as expanded, stable funding, should be included in planning for a new health care system.

Biomedical and Health Services Research

A major virtue of the U.S. health care system is its capacity to be innovative—in diagnosis and treatment and in delivering and evaluating care. Sustained investment in basic and applied research is essential to improve the health of the American people. To assure continued vigor in biomedical, clinical, and health services research, the College supports 1) regular increases

in appropriations for the National Institutes of Health and 2) a percentage set-aside from total health care expenditures (for example, one quarter of one percent) to secure predictable funding for clinical and health services research.

Medical Information Management

The College is committed to informed, data-based decision making. This philosophy underlies health care reform. Informed decision making requires data systems to support excellence, not only in medical practice, but also in planning, policy development, and system administration.

To understand the dynamics of medical care and variations in use of hospitals and technologies, a reformed system must adopt common diagnostic and procedural codes, common indicators of quality of care, and a common data set. Unique identifiers for hospitals, physicians, and health plans would need to be standardized for statistical profiling to be meaningful and for evaluations of care. In addition, population-based data are essential to promote the effective distribution of health resources (manpower, technology, and facilities).

Controlling Costs

The United States cannot afford, and will not achieve, universal access to care without controlling costs, and costs cannot be controlled without system-wide reform. We must limit total health care spending, through a national health care budget and a matrix of national and local controls on the price, supply, and demand for health services. An effective strategy must incorporate both expenditure control and cost control. For expenditure control to be meaningful, participants must have tools to reduce costs; for example, if a community or a hospital is to achieve an expenditure target, it will have to identify and eliminate redundant capacity such as competing MRI units. Our proposals would influence forces that determine the cost and utilization of services.

We recognize that these proposals raise politically and procedurally difficult issues. It will take time and care to work out the details. But no plan for reform can succeed without substantial efforts to control spending.

National Health Care Budget

At the heart of the College's proposals to control costs is the recognition that the health care system must operate within financial limits. We must adopt a national health care budget—a ceiling on total health expenditures, sometimes referred to as a "global" budget. A national budget would take into account changing health needs of the population (including aging), new technology, and general inflation. What the budget should be is uncertain now, but we start with the assumption that the current level of spending, projected to be more than $800 billion in 1992, is enough to provide health care for everyone (7). This level reflects all the waste of the current system: administrative costs estimated by some in excess of 20% of spending, unnecessary utilization, duplicative facilities and equipment, overpriced care, and so on.

The national health care commission would recommend to Congress a health care budget for the nation, covering public and private spending and capital outlays. The commission, in consultation with state authorities, would develop a budget for each state based on its population and disease burden. The overall budget and state allocations would be updated periodically, based on changes in the variables that determine the need for health care and its true costs. In turn, states may choose to allocate funds to regional authorities within the state.

Providing good care within the constraint of fixed income is the underlying principle of the managed care industry (8). Other countries have shown that fee-for-service arrangements can operate within a budget, through negotiations over fees (9-12). Implementation of a national health care budget would be a forceful incentive for all providers, patients, and payers to begin to make decisions reflecting the need to operate within limits. The budget would give the authority to the planning process necessary to allocate resources.

Managing Price: Insurer-Provider Negotiations

States would be required to establish mechanisms for the employer-sponsored and publicly sponsored insurance plans to negotiate fees with physicians, hospitals, and other providers. Using systematic, research-based methods of valuing services, such as the resource-based relative value scale (RBRVS) for physicians and diagnosis-related groups (DRGs) for hospitals, insurers and providers would negotiate and agree on conversion factors to set yearly fee schedules. Uniform rates would apply under all plans within states or sub-state regions, all payers would pay the same price for the same service. Qualified managed care organizations, such as prepaid group practices, would negotiate an overall budget with all insurers based on enrollment, age distribution of enrollees, and expected morbidity; they could develop their own compensation packages for health care professionals. Organized delivery systems would negotiate budgets for institutions and practitioners within the system, to be allocated to providers under their financial arrangements. To permit these negotiations, antitrust restrictions must be revised.

The health care budget would encourage trends such as regionalized services integrated vertically and horizontally, primary care networks, multilocation group practices, and new organizational and financial relationships between hospitals and their medical staffs, all of which should improve quality and reduce costs. Because operating under a budget is normally part of these arrangements, the transition to a national budget should be eased.

Payments under the various fee schedules, when multiplied by expected utilization of services, could not exceed the state's allocation under the national health care budget. A state health care agency would monitor utilization patterns by service category and study variations from predicted use. To stay within the state's allocation, the state (or regional agencies within the

state) would have the authority to change the conversion factor for all providers and suppliers of medical services.

If a state's health care expenditures exceed its budget allocation, even after corrections to the conversion factor, health care spending would not come to a halt. Expenditures that cannot be attributed to unanticipated illnesses would trigger reductions in fee schedules or other remedial action for the following year. The budget is a device to introduce fiscal discipline and evaluate whether expenditures reflect expectations and goals; it is not a mechanism to cut necessary care.

Implementing the global health care budget will require extraordinary cooperation among providers. Physicians, hospitals, and other provider groups would have to work out who would represent them in negotiations and how they would relate to each other. They would also have to create a climate of clinical decision making in which the profession does not tolerate unnecessary care. The important impact of the global budget would be its incentive to eliminate unnecessary expense at all levels of the health system. It would promote cooperation among providers and others to figure out how best to meet the community's needs—an element largely missing in an open-ended system that encourages excessive care and generation of unlimited revenue.

The fee schedules negotiated between insurers and providers would be the total payment for services. Making reimbursement fair in a reformed system would eliminate the need for any additional charge to the patient, or "balance bill" (the amount above what the fee schedule allows).

Managing Supply: Regulatory Approaches

Market forces have not led to appropriate distribution of health resources—manpower, technology, and facilities. Hospitals a short distance apart establish duplicative high-technology services. Running competing, partially utilized services is inefficient and leads to pressure to use the service regardless of clinical need. Freestanding outpatient facilities generate business to try to maximize revenue, and weaken hospitals by skimming away many of the patients having lucrative procedures, while hospitals must maintain their facilities. Many elements of health care have become a business and have adopted a business mentality, and traditional goals of community service have become endangered. The problem is not limited to hospitals or freestanding facilities. Physicians are attracted to specialties where they are not needed, in areas already oversupplied. There is a growing critical shortage of primary care and generalist physicians and providers and facilities in rural and inner city areas.

We conceptualize two levels of regulation: a "macro" level having to do with the capacity, supply or inputs to the system—basically the limits within which care is delivered; and a "micro" level—the physician-patient encounter. The College believes there is an appropriate role for regulation at the macro level, governing the supply of health resources. Government can have substantial impact on costs, in a nonintrusive way, by regulating these "inputs" to the health care system: physician supply and specialization, technology, and capital investment. Micro-level regulation of the physician-patient encounter has failed and would be eliminated under our plan.

We propose that, under federal guidelines, states and communities establish targets for the supply of health resources, expressed, for example, in terms of the distribution and concentration of physicians and other health professionals, beds, and major technologies. Setting these targets would require careful planning and attention to national resources such as teaching hospitals and specialized centers. Enforcing them would require that the targets be linked to the payment system.

The nation must develop a national health manpower policy. Of special urgency is the need to increase the number of primary care and generalist physicians. This shift will be necessary to provide for the millions of people who will gain access to care, as well as to ensure that care is cost efficient. The output of training programs must change from the current distribution of 35% generalists and 65% specialists to a balance in the profession as a whole. To achieve this goal would require major changes in how the country educates medical students and residents and how they would be paid once they move into practice. Fees must be substantially augmented for the evaluation and management services that form the core of practice for generalists, and for physicians practicing in underserved areas.

Managing Demand

Demand for services can be dampened by promoting individual responsibility. Patients must view good health as a lifelong endeavor, beginning with early prenatal care and maintained through careful habits and appropriate preventive care. Physicians must educate their patients about their diseases and the public about the benefits of health promotion and disease prevention, and funding must be available for these initiatives. In the long run, full insurance coverage for preventive services will do much to promote health and control spending.

Patients and families must understand that, in some circumstances, a diagnostic or therapeutic intervention is futile. Understanding is best accomplished in the context of a long-standing, doctor-patient relationship in which the patient is fully included in the decision-making process. The profession and public health authorities must teach patients more about reasonable expectations.

Research (13) and the experience of our members support the conclusion that a co-payment (typically, a flat payment or a percentage of the allowed fee) required of the patient discourages unnecessary services. For low-income people, however, co-payment may also discourage necessary care. We accept the need for an appropriate co-payment as a useful restraint on demand, as well as a source of revenue for the system. However, we propose the elimination of co-payments for low-income patients, so that the entire fee would be covered by insurance. For others, co-payment would be limited to a specified percentage of the fee, and subject

to an annual cap. We would hope that as both patients and physicians become more knowledgeable about medically appropriate care, the need for co-payments will diminish and ultimately cease.

Payment reform is an essential element of managing utilization. Reimbursement continues to favor procedures over careful evaluation of the patient, and high cost technology over less expensive procedures. The new Medicare fee schedule was based on the concept of equitable payment, but its implementation has further eroded payment for evaluation and management services. Until the system is restructured so that it values general medical care, incentives to overutilize procedures will continue to drive up spending.

Finally, there should be restraint on patient self-referral to a specialist or subspecialist. We propose that most patients establish a clinical relationship with a primary care or generalist physician who would refer to specialty services as needed. We recognize that some patients need ongoing care from subspecialists.

Managing Administrative Costs

The nation must recapture the billions of dollars wasted in administrative expenditures, and redirect that spending for medical care. We predict substantial savings from administrative simplification under the ACP plan. Eliminating experience rating and fee discounts and forcing companies to compete on premium price and value is likely to result in the consolidation of health insurance companies. Eliminating case-by-case review would also save money. On the public side, replacing the many current programs would save the substantial costs of maintaining separate bureaucracies and developing and enforcing divergent sets of rules.

We propose a highly simplified claims process. Providers would file claims with a single processing agent at the state level (either a state agency or a firm under contract). That agent would make payments to providers and bill the patient's insurance plan. Patients would require only a plastic card encoded with the name of their plan and the source of the financing. We must adopt a uniform claims form, and move as rapidly as is feasible to electronic filing and computerized patient records.

Conclusions

Any proposal for change implies gains and losses for the participants in a system. One criterion of the seriousness of a plan is the degree to which it asks all parties to accept responsibility for achieving its goals. The College plan asks everyone to be responsible for ensuring access to care, improving quality, and controlling costs.

The recommendations in this paper have evolved from our philosophy on the role of a professional society that holds the public's interest primary; from listening to our members who care for and about their patients and the practice of medicine; and from our assessment of what should and, we believe, can be done.

The key change is the acceptance of limits, both philosophically and in the reality of operating within a national health care budget. In contrast to an open-ended system, squandering resources on unnecessary care or on bureaucratic excess in a limited system means that those resources are not available for patients in need and are taken from responsible colleagues and institutions in the community. Combined with a decentralized approach to the allocation of resources, the demands of providing care for all when there are limits on spending will be a powerful force to engender cooperation among all parties in meeting the community's needs.

Learning to live within limits will require sacrifices. For patients, limits imply that they cannot have everything they want; for providers, investments and incomes must know some bounds; for insurers and other administrators, no more micro-managing the system; and for employers not providing health insurance, an end to their free ride.

What are the gains? All patients are guaranteed coverage for all effective and appropriate services. No one is without care, and there is no second-class care. Our plan restores to physicians, hospitals, and other providers their central role in meeting the community's health care needs. They receive appropriate compensation for all care, and are relieved of the regulatory intrusion that characterizes the current system. Government and other payers gain predictability of expenditures and limits on the rate of growth. And employers get control of their costs and a boost in their ability to compete. They also see an end to cost-shifting—the hidden tax for uncompensated care which they have paid through their private insurance premiums.

Finally, the College insists that reform must be comprehensive. We cannot modify one element of the system without affecting others. For example, expanding access to care would be a false promise if we do not produce more generalist physicians. Attempting to control costs becomes doubly difficult if we do not eliminate pressures for defensive medicine through liability reform. Comprehensive reform does not imply that all changes must be implemented at one time. Careful transition and phasing, particularly with regard to the financial impact, will be necessary under an overall strategy that relates the components and presents a clear plan for achieving an integrated system and comprehensive reform.

The American College of Physicians offers its professional and organizational commitment to the task of reforming health care. The proposal we have offered is a conceptual outline. We recognize that important and practical details must be completed. Financial projections must be developed and tested. We are prepared to adjust our thinking as our own analysis proceeds and as the public debate continues. We look forward to participating with all others to achieve universal access to care and comprehensive reform.

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ABOUT THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians is the largest medical specialty society in the United States, with 77,000 members practicing internal medicine.

Doctors specializing in internal medicine provide non-surgical medical care to adults and adolescents. General internists diagnose and treat illness involving any of the body's internal organ systems. Subspecialists in internal medicine have additional expertise in one particular area, such as allergy and immunology, cardiology, endocrinology, gastroenterology, hematology, infectious diseases, medical oncology, pulmonary disease, or rheumatology. Internists, including subspecialists, provide much of the nation's primary care, managing their patients' overall health care and making referrals to other health professionals when necessary.

Founded in 1915, the College's mission is to foster excellence in the practice of medicine through continuing education and the development and advocacy of public policies affecting public health and medical practice. The College publishes *Annals of Internal Medicine*, the most widely cited medical specialty journal in the world.

For more information about the College's health care reform proposal, write:

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American College of Physicians
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Washington, D.C. 20005

MARCH 22, 1993

TO: IRA
FROM: MOLLY
RE: MEETING WITH AMERICAN COLLEGE OF PHYSICIANS--8:30, 3/23

John Ball (President), Scott Denny, Elizabeth Prewitt, Kathleen Haddad, and Paul Griner will be attending the meeting. Dr. Griner is expected to be the next president of the College; he is currently involved with the Rochester plan.

The College and the American Adademy of Family Physicians are the only two large medical specialty organizations to come forward with a reform plan that endorses a global budget as part of cost containment.

The ACP's plan was printed in the Annals of Internal Medicine in September 1992. The College supports a global budget, pay-or-play universal coverage, a ban on preexisting condition exclusions, community rating, outcomes research and practice guidelines, and control of technology. A copy of their plan is attached.