

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. biography	Carol Urban (1 page)	n.d.	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3979

FOLDER TITLE:

Pennsylvania Health Care Conference Briefing Book [binder] [1]

2014-0483-S

sb451

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]

BRIEFING BOOK FOR PA HEALTH CARE CONFERENCE

AGENDA

OPENING TALKING POINTS

ACCESS SESSION

- ◆ Format
- ◆ Shoshonna Sofaer
- ◆ Presenters

- ◆ Access - Background
 - Coverage in PA
 - PA Medicaid Program
 - Local Initiatives

- ◆ Access - Issues
 - Managed Competition
 - Benefit Packages
 - Rural Health
 - Long-term Care
 - Service Delivery Reform
 - Other Providers
 - Training Programs
 - Retirees
 - Low-income Beneficiaries

COST SESSION

- ◆ Format
- ◆ Lynn Etheredge
- ◆ Presenters

- ◆ Cost - Background
 - Costs in PA
 - Fiscal Clarity
 - Federal Deficit

- ◆ Cost - Issues
 - Managed Competition
 - National Budget/Rate Regulation
 - Other Cost-containment Strategies
 - Drug Prices
 - Retirees
 - Workers' Compensation
 - Financing Options

ROLES OF GOVERNMENT SESSION

- ◆ Format
- ◆ Presenters

GOVERNOR'S PROPOSAL

DPC DISCUSSION PAPER

DASCHLE/WOFFORD BILL

OTHER PROPOSALS

Pennsylvania Health Care Conference
Thursday, February 11, 1993
9:00 a.m. - 6:00 p.m.
Pennsylvania State University -- Harrisburg
Capitol Union Building / Student Center

AGENDA

9:00-9:30 Welcome and Introductions

Senator Harris Wofford

Governor Robert Casey

Thomas Langfitt
President, The Pew Charitable Trusts

9:30-12:00 Morning Issue Session: Access

Moderator: Senator Harris Wofford

Speaker: Shoshanna Sofaer
Department of Health Care Sciences
George Washington University

Presenters: Bonnie Albrecht
West Chester, PA

Carol Urban
Kingston, PA

David Lockhardt
Statewide President
Pennsylvania State Council of Senior Citizens
Allentown, PA

Marshall Rozzi
Executive V.P.
USHealthcare, Inc.
Blue Bell, PA

Tanya Raggio, M.D.
Director
Healthy Start
Pittsburgh, PA

Bill George
President
Pennsylvania AFL-CIO
Harrisburg, PA

Donna Torrisi
Director
Abbottsford Community Health Center
Philadelphia, PA

Joanne Cochran
CEO
Keystone Rural Health Center
Chambersberg, PA

Open discussion

12:15-1:15 Lunch and Break-out Sessions

Lunch and discussion will take place in eight rooms in a nearby building. Conference participants will be divided up randomly. Room numbers will be indicated on name badges participants will receive at registration.

1:30-3:30 First Afternoon Issue Session: Cost

Moderator: Senator Harris Wofford

Special Guest: Hillary Rodham Clinton

Speaker: Lynn Etheredge
Health Care Consultant
Jackson Hole Group

Presenters: Edrie Cross
Altoona, PA

Robert Laurito
Jermyn, PA

Ralph Pontillo
President
Manufacturers Association of N.W. Pennsylvania
Erie, PA

Michael Dopera
Manager, Employee Benefits
Bethlehem Steel
Bethlehem, PA

Jane Berry, M.S.N., J.D.
Nurse Manager
Hospital of the University of Pennsylvania
Philadelphia, PA

Peter Bouxsein, J.D.
Deputy Director
American College of Physicians
Philadelphia, PA

Sister Joanne Marie Andiorio
President
Mercy Hospital
Pittsburgh, PA

Theo McCracken
Volunteer
American Association of Retired Persons
Harrisburg, PA

Ernest Sessa
Executive Director
Pennsylvania Health Care Cost Containment
Council
Harrisburg, PA

Gerry Karabelas
V.P., Pharmaceutical Division
SmithKline Beecham
Philadelphia, PA

Open Discussion

3:30-3:45 Break

3:45-5:45 Second Afternoon Issue Session: Roles for Government

Moderator: Senator Harris Wofford

Presenters: Jack Tighe
Deputy Chief of Staff for Operations and
Administration
Governor's Office
Harrisburg, PA

Ann Bacharach
Executive Director
Pennsylvania Healthy Mothers/Healthy Babies
Coalition
Bryn Mawr, PA

Deborah Beck
President
Drug and Alcohol Service Providers
Organization of Pennsylvania
Harrisburg, PA

Lee Van Volkenberg
Senior Director, Public Affairs
Capital Blue Cross
Harrisburg, PA

Mary Kay Pera
Executive Director
Pennsylvania Association of Home Health Agencies
Lemoyne, PA

Ronald Heigler
Executive Director
Greater Philadelphia Health Action
Philadelphia, PA

Claire Fagin
President
National League of Nursing
Professor
University of Pennsylvania, School of Nursing
Philadelphia, PA

J. Sanford Schwartz, M.D.
Executive Director
Leonard Davis Institute of Health Economics
Philadelphia, PA

Robert Doe, M.D.
Lancaster County Task Force
Conestoga, PA

Open discussion

5:45-6:00 Wrap-up

Opening Remarks

Welcome. We're lucky enough to have in this room and around this table some 200 Pennsylvanians from all over our state are meeting to discuss one of the most challenging questions facing our nation: How to reform our health care system. There could just as easily be 2,000 people in the room - - or two million -- because if there's one thing that the people of Pennsylvania helped explain to the people in Washington, it's that the skyrocketing cost of health care affects everyone. Families and communities, employers and workers, federal state and local budgets.

But one state's mandate wasn't

enough. We needed last year's presidential election to deliver the national mandate we needed for a strong cure for our health care system. This has to be the year we take action to control costs and turn the right to affordable health care into a reality for every American.

Remember, the infamous sign on the war room wall in Little Rock didn't just say, "The economy, stupid." The unabridged version was "Change versus more of the same. The economy, stupid. **And don't forget about health care.**"

We've been planning today's conference for nearly two months. Luckily, it turns out to be just the kind of event that can make a real

contribution to Hillary Clinton's effort to craft a health care plan that the President can propose and Congress can enact this year.

As Abraham Lincoln said just a few miles down the road from here in Gettysburg, "It is altogether fitting and proper that we should do this." It provides another great opportunity for Pennsylvanians to lead the way on health care reform. The first vital step, as Philadelphia opthamologist and conference participant Robert Reinecke put it to me in the summer of 1991, is declaring the right: it says in the constitution that those accused of a crime have the right to a lawyer, but it's even more fundamental that every American has the right to see a doctor.

It wasn't enough for the founders in Philadelphia 200 years ago to issue the Declaration of Independence stating self-evident truths; they needed come back to craft a Constitution creating a government capable of turning rights into reality. So now we have to craft our own new constitution for this huge part of our national life. Because the need for change grows deeper every day. When I began campaigning for national health care reform, it was estimated that the U.S. spent some \$670 billion on health care in 1990. That total leapt to some \$830 billion in 1992 and it's expected to grow to \$930 billion this year. If we don't act, there's no end in sight to the cost spiral.

Next week, the President will present his economic recovery and deficit reduction plan. But as Bill Clinton himself explained when he pounded his fist on the table at his Little Rock economic summit in December, insisting that "we're kidding ourselves" if we believe that we can tame the federal budget deficit and provide long-term economic growth without putting the breaks on skyrocketing health care costs. Some 85 percent of the current increase in the federal deficit can be traced to out-of-control health care costs.

It's said that taking-on health care reform and putting Mrs. Clinton in charge is a big political risk for the President. If there's one message that we must get

through to the American people today at Penn State and in the months ahead, it is that not acting on health care reform is the riskiest, and most costly, strategy of all. The most expensive health care plan tis the one we have right now, which is no plan at all.

Last year I introduced -- together with South Dakota Senator Tom Daschle -- my own comprehensive reform legislation that would create a truly federal structure for setting a national health budget and a basic package of health care benefits available to everyone, throughout their lives, regardless of where they live or work. But it would leave to states and communities the power and flexibility to shape their own

distinctive approaches for providing this coverage.

Governor Casey has already stepped-up to the plate with a realistic and imaginative state plan that includes many of the best new ideas on how to create a competitive health insurance market, while also guaranteeing coverage for everyone. In communities I've visited across the state business, labor, government and health care providers are joining together to consider their own local responses to the problem. Representatives from such efforts in Erie, Lancaster and Wilkes-Barre will be here with us today.

We'll have doctors, nurses,

business and labor leaders, as well as citizens from across Pennsylvania who are struggling to deal with a system which still provides the best quality of care in the world, but only for the fewer and fewer people who can afford to pay for it.

We'll start this morning focusing on the problem of access to care, not only for some 40 million who are now uninsured, but for nearly everyone else who fear that they're one pink slip or serious illness from becoming uninsured.

During lunchtime we'll go into small breakout sessions across the street during which I'd like each group to discuss and decide on four key points you'd like to see communicated to Mrs. Clinton's

Task Force.

When we come back here our first afternoon session will deal with the problem of skyrocketing costs, and how to get them under control.

Finally, we'll wind-up the day by considering what is the best role for each level of government -- federal, state and local -- in a workable national health reform plan.

We're going to listen and learn. And most importantly, we'll try to move beyond insider's terms like "managed competition" and "pay or play" and figure out how to talk about the choices we face in a way that citizens can really understand

and evaluate.

That's a huge challenge. But the iron is hot. We can't afford to lose this opportunity to hammer out a workable solution to the nation's health care crisis. The outlines of consensus do exist. Even groups which have for years opposed comprehensive reform have seen the train pulling out of the station, and are even offering their own reform plans.

Our conference gives us the opportunity -- as the Little Rock Summit did on the economy -- to put the basic choices on the table, to educate ourselves and begin crafting the kind of health care reform that the American people can support and fight for.

It's not enough to send a wake-up call about health care. You also have to get up and go to work. That's what we're going to do today.

#

**UNITED STATES SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES**

HEARINGS ON:

**ACHIEVING EFFECTIVE COST CONTROL IN COMPREHENSIVE HEALTH CARE
REFORM: MANAGED COMPETITION AND REGULATORY APPROACHES**

WRITTEN TESTIMONY:

**CONSUMER PROTECTION UNDER HEALTH CARE REFORM AND COST CONTROL:
POTENTIAL THREATS; POTENTIAL REMEDIES**

Shoshanna Sofaer, Dr.P.H.

December 17, 1992

Senator Kennedy, Senator Kassebaum and members of the Committee:
Good morning. I am Shoshanna Sofaer, Associate Professor in the
Department of Health Care Sciences at George Washington
University Medical Center. Since 1984, I have been conducting
research to support consumers, especially older consumers, in
making decisions about health care coverage and services. I have
had the opportunity to develop and test an innovative method for
informing older consumers about Medicare, Medigap policies,
Medicare HMOs and long-term care insurance policies. I have
studied how consumers respond when their providers switch from
one HMO to another, how they respond to managed care, and what
support they currently have, and want, when they make health care
decisions. Over the last two years I have also studied the
passage and repeal of the Medicare Catastrophic Coverage Act.

I appreciate greatly this opportunity to contribute my
perspective to these hearings. I truly hope that in pursuing
universal access and cost containment through health care reform,

we can learn the lessons of the "Catastrophic" experience and make sure we keep the American public well and truly informed about our plans and provide them with concrete assurance that their interests are being protected. Unless convinced that they are protected, consumers, as voters, will not provide the public support essential to craft effective policy in a context of competing and entrenched interests.

Given the complexity of health care and the diversity of our nation, it is both likely and appropriate for policy makers to take advantage of a number of tools to support equitable access for all Americans to affordable, high quality services. This morning, therefore, I will review several such tools, including those associated with the strategy of managed competition and others associated with more regulatory approaches. But it is entirely possible that all or most of these tools could be effectively combined in a truly comprehensive strategy for national health care reform. I will identify potential threats inherent in these strategies, potential remedies available to address these threats and opportunities they present for positive consumer participation.

Specifically, I will discuss the following elements of managed competition:

* Health Insurance Purchasing Cooperatives (HIPCs) as aggressive purchasers of health care coverage for a sizable pool of citizens in a state or sub-state region;

* the selection by the HIPC of a number of accountable health plans (AHPs) to be offered to consumers they cover;

* annual enrollment of consumers in the AHP of their choice, with the potential for annual disenrollment if they are dissatisfied;

* risk adjusted capitated payments by the HIPCs to AHPs for each individual they enroll, to cover a standard package of benefits;

* variations in premium price across AHPs, such that some plans require consumers to pay the difference between the base premium paid by the HIPC and the actual premium, using their own after-tax dollars; and

* within some but not necessarily all AHPs, use of managed care techniques such as limitation in choice of provider; primary care providers as gatekeepers for specialty care, hospitalization and other high cost services; formularies for prescription medications, etc.

With respect to regulatory approaches, I will discuss:

* regulation of rates and prices for service providers;

* regulation of the volume of services, especially high-cost services, through various forms of utilization review such as second opinions, prior authorization, concurrent or retrospective review of physician practices, etc.; and

* regulation of the supply and/or distribution of health care facilities, current and emerging technology and health care professionals.

As we explore consumer protection, let's remember that consumers are not a monolith: we must examine policy tools not only in terms of the "average" consumer, but in terms of consumers that may be particularly vulnerable, because of illness or disability, or because of their ethnicity, education, income or other socioeconomic characteristics. The white, healthy, upper middle-class marketing MBA with a working spouse and one child is one kind of consumer; the Latino working for a dry-cleaner in East Los Angeles whose wife is out of work and who has three children, one with serious asthma, is another. Our challenge is not just to ensure that they all have health care coverage; it is to ensure that there is reasonable equity in their experience of the health care delivery system.

THREATS AND REMEDIES UNDER MANAGED COMPETITION

Threats Inherent in Unresponsive or Ineffective HIPCs

The single most important element of the managed competition strategy is the development of state or regional HIPCs with authority to select AHPs and enroll consumers in them. In some models of managed competition, the HIPC would be a virtual single payor at the regional level; in other models, large employers would be permitted to "opt out" of the HIPC.

The potential threats to all consumers in the HIPC are:

1. that it will become a massive bureaucracy unresponsive to the needs and concerns of individual consumers; and
2. that in pursuing cost control aggressively, it will fail to emphasize access, quality, provider choice or other valued aspects of health care.

Remedies to these threats must be built into the very structure of the HIPCs, through:

1. Legislation that clearly makes HIPCs responsible for pursuing the interests of consumers across multiple health care values and that mandates key consumer protection functions and resources within each HIPC (e.g. a carefully articulated complaint and grievance system; ombudspersons)
2. A governance structure that incorporates a substantial plurality if not a majority of consumers (as opposed to public or private payors)
3. Oversight of all HIPCs by a National Health Board that regularly collects, analyzes and disseminates information on HIPC performance, using indicators sensitive to the needs and concerns of consumers. Example of such indicators include: the rate of consumer satisfaction with the HIPC, especially its resolution of complaints and grievances; the overall rate of consumer satisfaction with their AHPs; the overall rate of consumer switching among AHPs; the rate of provider switching across plans; trends in premium rate increases; the rate of purchase of supplemental insurance; and the rate of out-of-plan service use.

If substantial numbers of people get coverage through their work (whether via employer or union) there is a potential threat of a different kind: that the HIPC's coverage will be, or be considered, "second-class." The existence of a substantial alternative source of "lives" or "patients" diminishes the bargaining power of the HIPC. Under these circumstances, HIPC coverage could come to be considered "second-class" in at least three ways:

1. if the benefits are less comprehensive;
2. if the extent of plan or provider choice is substantially lower; or
3. if the providers accessible through HIPC coverage is not of equal quality.

The major potential remedy for this threat is to ensure that the HIPC has responsibility for providing coverage to a substantial cross-section of consumers in its region, including consumers of varying socioeconomic levels and health status. This can be achieved by setting a high minimum number of workers that an employer or union must cover before they are permitted to offer their own coverage. Variations in coverage, plan or provider choice and provider characteristics between HIPC's and other plans should be monitored by the National Health Board, who should make report regularly to Congress on needed changes to address disparities.

An alternative threat is also present: if other sponsors provide less coverage, less choice or lower quality providers. Differences in service benefits can be addressed by requiring other sponsors to offer at least the standard benefit package. Differences in choice can be addressed by requiring that other sponsors offer at least some choice (e.g. at least one managed care plan and at least one fee-for-service plan, if available in the region). Differences in quality will be more difficult to assess, monitor and correct.

Threats Inherent in the Design and Choice of Alternative Health Plans

A second key element of the managed competition strategy is that HIPCs will select and offer a range of AHPs to consumers, who will choose among them during an annual enrollment period. All AHPs will have to offer at least a minimum package of benefits. HIPCs will pay AHPs a risk adjusted capitated payment for each enrollee. AHPs, however, can charge an additional premium to enrollees. The heart of "competition" in managed competition is that AHPs compete for enrollees. If the service benefit package is identical across all plans, it is presumed that consumers would not choose a plan with an additional premium unless they believed that it offered commensurate additional value in terms of quality, convenience or provider choice.

Certain elements of this managed competition strategy are essential to protect consumers. They include the following:

1. At least one, and preferable more than one AHP must be offered at the base premium, with no additional charge. From the perspective of competition, this is essential to provide an example (and an option) of cost control to the other AHPs. From the perspective of low-income consumers, or consumers who need to spend discretionary income elsewhere, it is essential to true access to coverage. A choice of plans with no additional premium will be a protection against the development the perception, or reality of a multi-tiered, class based insurance system.

There is a real threat that some HIPC's will be unable to identify and negotiate successfully with an AHP that can offer reasonable access and quality to a substantial number of people at a base premium rate consistent with HIPC resources. There is also a real threat that the gap between the base premium and the premiums charged by other plans will grow over time. The threat in this scenario is not that cost containment measures jeopardize other values; it is that the tool for cost containment itself fails, leading the HIPC to "cut corners" in terms of the enforcement of performance standards for AHPs.

This scenario may be especially likely in regions where market capacity, and thus competitiveness, is limited. It may be wise for HIPC's to have access to rate regulation as a policy tool to stay within budget without sacrificing service coverage, access or quality. One approach would be legislation permitting HIPC's

to apply to the National Health Board for a "waiver" to use rate regulation.

2. Standardization of benefits is essential to ensure a level playing field in which consumers, and the HIPC, can make meaningful comparisons across plans. It will be difficult enough for consumers to assess the relative value of plans in terms of the quality, convenience and provider choice; if benefit packages also differed, they would also have to compare their financial vulnerability in different plans. Benefit structures are also subject to manipulation to bias selection into plans.

3. The risk adjustment of capitated payments to AHPs is also essential to mitigate the tendency of insurers toward biasing enrollment in their favor. Such biased selection works against the interests of consumers in general, but especially works against the interests of consumers who are in greatest need of health care.

4. HIPCs must control the enrollment process, and either provide or review information provided to consumers about the AHPs. They must set and enforce clear limits or outright bans to any marketing done by AHPs or providers. In particular, it is critical to limit person-to-person marketing by AHPs, and to ban entirely "house-to-house" marketing. The potential for abuse in such "invisible" settings is enormous, and can provide a field

day both for encouraging enrollment through misleading statements and for discouraging enrollment among less "desirable" groups.

Even if these essential protections are legislatively mandated, there are additional potential threats to be addressed in these elements of managed competition.

1. The major threat to consumers is that they will not be able to make genuinely informed comparisons among AHPs. As a consequence, consumers might enroll in a plan that was inappropriate to their needs, preference and circumstances. Faced with inadequate information, some consumers might simply purchase a plan on the basis of premium alone. Some might choose the lowest cost plan to save money and find out too late that their associated providers and facilities were very inconveniently located. Other might choose the highest cost plan on the assumption that high cost equalled high quality.

Managed competition provides both an unparalleled opportunity and an unparalleled challenge to provide clear, concise and salient information to consumers about their health care coverage options. Our major current national health plan, the Medicare program, does a very poor job of providing beneficiaries with information; this is exacerbated by the incredible complexity of both the benefit package and claims procedures. The most difficult challenge will be to provide comparative information about the quality of the health care delivery systems accessible

through different AHPs. Information must be provided that is useful to and usable by different kinds of consumers who want different levels of detail or who want their information provided through different "channels"¹."

HIPCs will need a line item in their budget for developing and disseminating information materials through a variety of media and channels. They will need authority to require AHPs to collect, aggregate and provide data on key structural characteristics and performance indicators, for all enrollees and for special sub-groups of enrollees of particular concern (e.g. children, members of minority groups, the disabled). But above all, HIPCs will need creativity and energy to harness both our growing understanding of predictors of good health outcomes and emerging communication and information technologies to serve the information needs of consumers.

2. Unless the standard benefit package is genuinely comprehensive, a market for supplemental insurance is likely to develop. Our experience with Medicare supplements indicates that such a market has enormous potential for exploiting, confusing and wresting lots of money from consumers, by employing a wide range of unsavory sales and marketing tactics. Alternatively or simultaneously, a less than comprehensive benefit package can

1. A more detailed discussion of information needs and strategies is available from the author in a paper entitled "Consumer Information and Protection Under Managed Competition."

lead to extensive out-of-pocket payments by consumers for services that are not covered, or not covered well.

Threats Inherent in Managed Care

Managed competition and managed care are not the same. However, managed care is an important cost containment strategy within managed competition. The fundamental threat of managed care is that, given a capitated payment, AHPs will have the incentive to ration care to enrollees to contain costs. Once again, the consumers who are most vulnerable are those facing serious acute or chronic conditions. However, even the occasional user of service can be inconvenienced or potentially endangered by a managed care system that does not respond promptly and fully to patients' needs.

Rationing of care can be reflected in delays and difficulties in making appointments; inability to get care from preferred providers; delays or difficulties in getting referrals from primary care "gatekeepers" to specialized services; and conflict over the medical necessity and appropriateness of diagnostic or treatment procedures, particular medications, or other services such as mental health, chemical dependency, rehabilitation, skilled nursing or home health.

There are multiple potential remedies to the problem of rationing in managed care:

1. HIPCs should require AHPs to provide standardized information, during open enrollment seasons, on their managed care "ground rules." Consumers need to have this information **before** they make their choices.
2. HIPCs should require AHPs to monitor enrollee satisfaction through regular surveys addressing issues such as waiting times for appointments; access to specialty care; satisfaction with providers; and extent of out-of-plan use in response to access barriers.
3. HIPCs should require AHPs to monitor enrollee dissatisfaction, as reflected in the rate and reasons for disenrollments and the rate and nature of complaints and grievances.
4. Each AHP should be required to have a complaint and grievance system, including ombudspersons assigned to advocate for enrollees and mediate their disputes with providers and the plan.
5. The HIPC should have a parallel complaint and grievance system, to which consumers can appeal if they do not get satisfaction from the AHP. Specifically, if a consumer has been denied medically necessary care, or provided with demonstrably low quality care, the HIPC should have the power to insist it be provided, or to permit the consumer to switch to another health plan, with continuing financial responsibility of the original AHP for any medical care provided by the new plan for that episode of illness.

Rationing of care often reflects inadequate capacity. Thus, the solution to delays and difficulties in getting appointments may be having more staff on the telephone lines or more appointment slots (and therefore more clinicians) available. A remedy for this more fundamental source of rationing is for the HIPC to assess and monitor the capacity of each AHP to serve the needs of its enrollees, given their geographic location, the languages they speak, their age distribution and thus their likely need for services. Contracts between the HIPC and the AHPs might set target enrollment ranges; the HIPC would then examine the providers and facilities available to each AHP to determine if it had sufficient capacity.

A final threat to consumers under managed care is diminished provider continuity. One tool used by managed care plans is to select a limited number of providers to whom they channel their members. Consumers often join particular managed care plans because "their" doctor or the hospital they would want to use is accessible through the plan. However, if providers frequently leave plans, either migrating to other AHPs or to the residual fee-for-service system, this creates serious problems for consumers, especially those under care. They must either change providers, or follow their original provider if they can afford any associated additional premiums. If providers migrate to plans offered by employers but not the HIPC, they become entirely inaccessible.

The problem of provider continuity cannot be entirely avoided. HIPCs, however, should monitor provider switching among plans and publicize the extent and causes of provider switching to consumers during open enrollment seasons. The overall level of provider switching may also be an important performance indicator for the HIPC itself.

THREATS AND REMEDIES UNDER REGULATORY APPROACHES

Threats and Remedies in the Current Insurance Marketplace

The threats faced by consumers under various regulatory approaches will depend on the extent to which the insurance market is simultaneously reformed. Consumers are neither well protected nor well informed in the current insurance marketplace. Access to coverage and care is threatened, for those who are or become seriously ill, by medical underwriting, pre-existing condition limitations and exclusions, and potential policy cancellation. Especially for those in the individual or small group market, financial access to coverage and care is threatened by high premiums relative to actual reimbursements and poor quality coverage. Everyone has faced high and unpredictable levels of premium increases over time.

Under the current insurance marketplace, many consumers have little or no choice of coverage: some can get no coverage at all; for some, only a limited number of choices are available or affordable; many employers are limiting, often to only one, the coverage options for their employees.

Where consumers do have coverage choices, they have little if any objective, useful and usable information available on their options. Plans are not standardized, making comparisons, especially comparisons of potential out-of-pocket cost vulnerability, difficult for well-educated consumers and virtually impossible for those who are less educated. The information that is available typically comes from interested parties such as carriers, health plans or brokers. Group plan sponsors such as employers often try to provide useful information. Some private non-profit organizations have published comparative information for very large groups such as federal employees. But most consumers are on their own in unfamiliar and daunting territory when they try to purchase health insurance coverage.

To address these threats in the current insurance marketplace will require multiple remedies, including:

1. Legislation to limit or ban medical underwriting, pre-existing condition limitations and exclusions, and arbitrary policy cancellations.
2. Legislation to set and enforce standards for minimum loss ratios.
3. Standardization of policies.
4. Stricter regulation of insurance marketing practices, including requirements for provision of standardized information on policies and restrictions on misleading and/or fraudulent

advertising and sales of unnecessary or duplicative products in the individual market.

Many such insurance market reforms have been introduced at the Federal level with respect to Medicare supplements. However, it is likely that state as well as federal action will be essential to comprehensive insurance reform. In addition, no matter what legislation mandates, some "bad apples" will make their way into the bushel, requiring the further remedy of an effective and well-funded complaint and grievance system, probably housed within state insurance departments with some federal oversight.

Threats in Rate and Price Regulation

There are two basic threats inherent in rate and price regulation. The first threat is that some providers and facilities will attempt to balance bill consumers to obtain additional reimbursements for their services. The only remedy here is either to ban balance billing outright or to limit it severely to a percentage above the regulatory rates.

The second, less likely and perhaps less consequential threat, is that a sub-set of providers and facilities will "opt out" of the system by not accepting coverage linked to regulated payments. This is possible under managed competition as well. Consumers could thus get access to these providers only if they paid entirely out-of-pocket. A performance indicator for regulation as a strategy might well be the size and composition of this

group. Unless it exceeds some threshold level set by policy makers, the creation of a small "upper-tier" health care system, does not have to pose a major problem for the public. This threat becomes more serious if rate regulation does not apply to all third party payors, including self-insured companies.

Threats in Utilization Control

The threats inherent in utilization control are similar to the rationing threats inherent in managed care. Utilization review is designed to discourage providers from prescribing or performing unnecessary services. As with managed care, however, utilization review can result in reduced access to medically necessary care for some consumers.

The consumer protection remedy is similar: individuals must have structured procedures, hopefully short of malpractice litigation, for obtaining services they believe are required and appropriate. The appropriate location for such services is less clear without an organizational focal point, such as the HIPC. As with protection against insurance marketing problems, a well-funded public complaint and grievance system will be needed, but health departments or health care licensing and certification agencies may be more appropriate venues than insurance departments.

Under volume regulation, consumers can also get caught in the middle, between providers who have gone ahead and delivered services, and claims or utilization review agencies who have

denied coverage for those services. Legislation may be needed to specify that the provider, rather than the consumer, is liable when coverage is denied.

In addition to public agency consumer protection activities under regulation, support may be needed for private non-profit efforts to inform and advocate for consumers facing problems with insurers, providers, and claims review organizations. The culture of many public bureaucracies makes them less than responsive to the needs of individual consumers, even if they operate under a legislative mandate for consumer protection.

Threats in Regulation of Supply

Excess capacity of specialized facilities, technology and providers has been identified as one of the major "root causes" of health care cost inflation. Regulation in the supply of such resources has been identified as a major element in successful cost containment in other nations. Outcomes and effectiveness research and technology assessment are fast becoming valuable supports to our ability to identify "true" excess capacity.

Although regulation of supply has great potential as a tool for cost containment, it can pose potential threats for consumers. The most basic threat arises if definitions of community need are driven too hard by budgetary constraints rather than empirically validated relationships between resources and health outcomes. The example of Great Britain's National Health Service can be

seen as the "awful warning" of this problem. Potential remedies for this problem are likely to be found in the workings of the democratic political process itself, rather than in specific policies and procedures.

A less generalized threat in the regulation of supply is that given the diversity of our nation, standards for levels of capacity can lead to inequities across communities that face unusually high levels of certain health problems. A related danger is that regulation of supply will make it more difficult to address current inequities in the distribution of providers and facilities that are faced by many inner city and rural residents. The remedies for this threat are more technical: to ensure that supply standards are "adjusted" for community characteristics, and to ensure that distribution as well as overall capacity are addressed.

CONCLUSION

Strategies for universal coverage and cost containment must be assessed not only against each other, but against our current reality. The most fundamental protection consumers need today is protection against current financial and other barriers to health care services. As we have seen, specific threats to consumer protection arise from almost every tool that is used to rationalize our system and improve our capacity to contain costs. So specific remedies will need to be incorporated into

legislation, regulation and system governance no matter what direction is taken in health care reform.

Managed competition offers one significant advantage to consumers over regulatory approaches: the creation of an organizational entity, the HIPC, whose mandate is to arrange coverage for a defined population of people. The existence of such an entity provides a focal point for consumer concern and consumer advocacy. It provides, too, a focal point for creativity and innovation in consumer participation and information, as well as consumer protection. The ultimate form of consumer protection in health care reform using managed competition is uniquely appropriate in our democracy: it is the power of effective consumer involvement in the governance of the HIPC.

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. biography	Carol Urban (1 page)	n.d.	b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3979

FOLDER TITLE:

Pennsylvania Health Care Conference Briefing Book [binder] [1]

2014-0483-S

sb451

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]

DAVID LOCKHARDT
Statewide President
Pennsylvania State Council of Senior Citizens
Allentown, PA

David Lockhardt will make brief remarks on behalf the state chapter of the Council of Senior Citizens. As you recall, the National Council of Senior Citizens is a strong advocate of a single payer health system. Because the state chapter was very helpful to you during your campaign, we have invited them to speak--but have asked them to focus their comments on the need for a social insurance-based long-term care program for persons of all ages. He has a string of horror stories that I have asked him to mention that demonstrate how cruel the current system is in terms of providing--or more accurately, in not providing-- assistance for long-term care needs.

David has a tendency to talk on and on. You might need to interrupt him with a comment in order to get him to conclude his remarks.

Questions

1. Given that most of long-term care is paid for either under Medicaid or out-of-pocket, and that the delivery of these services varies considerably from state to state, do you think that there is merit in expanding coverage for long-term care services through Federal support for state-based programs that meet Federal guidelines?
2. One of the most significant barriers to enacting comprehensive long-term care coverage is the estimated Federal cost of the program. Do you have any recommendations for expanding access to long-term care services under our current tight fiscal conditions?

MARSHALL ROZZI
Executive V.P.
USHealthcare, Inc.

As you know, USHealth is one of the leading managed care plans in the Commonwealth. As you heard Marshall explain at LDI at the conference last weekend, USHealthcare believes that the future of health care lies squarely in the expansion of managed care arrangements.

USHealthcare is definitely one of the more innovative, forward-thinking insurance carriers. Attached is an article about one of the interesting things that USHealthcare is doing with regards to ensuring access to quality care. The basic idea is that they have created mechanisms for linking physician incentives to "good" outcomes measured largely by patient satisfaction surveys.

You might focus your questions or comments to Marshall on some of the most frequent concerns raised by consumer advocates regarding the goal of moving the system more towards managed care.

Questions

1. Persons with disabilities or other chronic health care needs might not be best-served by having a primary care physician as their "gatekeeper." Do your plans take into consideration these kinds of special needs populations?
2. Many experts would envision folding the acute care portion of Medicaid under a system of managed competition. How do you suggest that the interests of low-income populations should be protected under this kind of reform?

WALL STREET JOURNAL

© 1993 Dow Jones & Company, Inc. All Rights Reserved.

EASTERN EDITION

MONDAY, JANUARY 25, 1993

WHITE OAK, MARYLAND

HEALTH

More Managed Health-Care Systems Use Incentive Pay to Reward 'Best' Doctors

By GEORGE ANDERS

Reporter of THE WALL STREET JOURNAL
PORT WASHINGTON, Pa. — Family physician David Badolato wins high marks from patients for being available in emergencies, explaining treatments clearly and listening about their needs.

He also qualified this month for a 19% bonus from U.S. Healthcare Inc., a health-maintenance organization that provides him about half of his 2,300 patients. Each year, U.S. Healthcare surveys members to see how they like their doctors. Dr. Badolato's incentive pay for 1992 was tied in part to his score on patients' questionnaires. His 19% bonus topped the 15% average for doctors in U.S. Healthcare's system.

Incentive-pay systems for doctors are going on, spurred by a belief that they help upgrade the quality of medical care provided by HMOs and other managed-care programs. Other HMOs that begun using them include FHP Inter-medical Corp. in California, the managed-care units of Cigna Corp. and New York Life Insurance Co., and Florida's AvMed-Santa Fe.

Dr. Badolato gets at the question for doctors: How do I excel in managed care? How do I get a chance to do better?" says Dr. Zatz, head of U.S. Healthcare's managed-care program.

Paying bonuses to doctors raises the stakes at a lot of other HMOs. Skeptics question the idea of basing incentives on the issue of "quality," arguing that it puts too much on fringe issues

What It Takes to Be Rated a Good Doctor

Here are some of the more than 20 quality standards used by U.S. Healthcare Inc. to determine what level of incentive payments family practitioners, pediatricians and internists will receive for delivering high-quality medical care.

- How easy is it to make appointments for checkups?
- How long is the waiting time in a doctor's office?
- How much personal concern does a doctor show for patients?
- How readily can patients obtain follow-up test results?
- Would patients recommend their doctor to others?
- Do doctors provide regular immunizations for children? Breast-cancer checks for women? Colon-cancer checks for men?
- What percent of a doctor's patients transfer to another physician's care each year?

NOTE: Answers to first five questions are based on patients' responses to questionnaires. Final two are based on examination of doctors' medical records and U.S. Healthcare's own data.

such as a receptionist's demeanor or a doctor's punctuality.

"Until protocols are developed that clearly assess the quality of care, we're not comfortable with a reward or penalty system" based on patient responses, says Stephen Wiggins, chief executive officer of Oxford Health Plan Inc., a Darien, Conn., health-maintenance organization. He would rather see sophisticated studies of illnesses, treatments and patient out-

comes, which aren't yet readily available.

Another concern, says Gene Lindsay, chairman of the physicians' council at Harvard Community Health Plan, is that merit-pay systems can disrupt doctors' ability to work together in a collegial way. His Massachusetts-based HMO tried — but has since abandoned — a system in which staff doctors got slightly different bonuses depending on whether their section chiefs

Please Turn to Page B4, Column 1

Managed Health-Care Plans Use Incentive Pay to Reward Doctors

Continued From Page B1

judged their work to be "exemplary" or "commendable." Says Dr. Lindsay: "We had doctors almost getting into fist-fights over what amounted to a \$500 bonus."

Still, many health-care professionals are intrigued by the idea of devising a problem-free incentive-pay system for HMO doctors. Some HMO administrators see it as a teaching tool that could nudge doctors to change the way they practice medicine. In addition, quality score cards can help determine which doctors will be allowed to keep practicing under an HMO's umbrella and which ones will be dropped.

The incentive systems are designed for physicians like Dr. Badolato who are in private practice but have a contract to treat patients who subscribe to an HMO. Typically, such doctors are paid a flat rate, such as \$10 a month, for each patient they handle. Some patients need a great deal of care; others need hardly any. On average, though, that flat rate is meant to provide doctors with a competitive income for their overall group of patients.

Flat-rate systems are much easier to administer than conventional billing systems, in which doctors charge each patient separately for services rendered. Administrators like them, too, because doctors can't earn more by providing excessive treatment. Some systems, in fact, withhold part of doctors' payments until year end, and then pay the residuals only to doctors who have held costs below a preset target.

But flat-rate systems aren't always seen as being in patients' best interests. Because doctors don't get paid extra for handling complicated cases, critics contend that HMOs can amount to assembly-line medicine, in which doctors are judged mostly on their ability to process patients quickly and cheaply.

"We want to create an environment where we can empower the physician,"

says Bernard Mansheim, chief of medical services for Avmed-Santa Fe. His company pays doctors a quality-performance bonus of 5% to 15% of their base pay, depending on how they score on patient-satisfaction questionnaires and a review of their office records.

Doctors who take extra steps to serve their patients, such as keeping longer office hours, end up with financial rewards in Avmed's system. Avmed's incentives currently cover only family doctors and other primary-care physicians; the company says it hasn't yet devised a good incentive system for specialists. But it is working on one.

In general, incentive systems work better for HMOs that deal with independent practitioners, as opposed to HMOs that have their own full-time physicians on staff. That's because pay differentials—even tiny ones—are more likely to heat up rivalries among staff doctors, who must work side by side every day.

The nation's biggest staff-model HMO, Kaiser Permanente, based in Oakland, Calif., says it isn't using incentive-pay systems and doesn't expect to. "Incentives may work in the short term," says Sharon Levine, Kaiser's associate executive director for physician support. "But over time, people feel beaten up by them."

Even doctors who score well under current quality gauges have some quibbles about how they are measured. In his recent review, Dr. Badolato, the Pennsylvania family practitioner, got high marks in everything except pediatric record-keeping. His shortcoming: He didn't jot down on children's medical charts whether they were exposed to parents' cigarette smoke at home.

"I always ask about passive smoke," Dr. Badolato says. "But I just didn't put it down on the charts." In the future, he says, he will record smoke-exposure information, but he doesn't think he should have been penalized for the omission last year.

In response, U.S. Healthcare officials say they believe that detailed record-keeping is an important part of medical practice, helping doctors diagnose unexpected changes in patients' health. The company also says it is working hard to include more quality measures related directly to doctors' practices, such as how often doctors administer mammograms to women at risk for breast cancer.

This year, U.S. Healthcare is expanding its incentive-pay system to start covering hospitals and specialists, such as radiologists or obstetricians. It is looking for such things as surgeons with low "complication rates" or obstetricians who don't rely heavily on Caesarean sections to deliver babies.

Because quality score cards for doctors are still a relatively new idea, many of the system's fans say they hope that any current shortcomings can be remedied by more sophisticated measuring systems in the future. "We're still very early in the learning curve in measuring quality in health care," says Avmed's Dr. Mansheim. "You can design various measures. But whether they're truly good measures of quality is an open question."

U. S. Healthcare, Inc.

Presentation

to

Pennsylvania Health Care Conference

Thursday, February 11, 1993

Presented by:
Marshall V. Rozzi
Executive Vice President

Thank you for the opportunity to participate in this important and timely conference.

U.S. Healthcare operates the largest IPA model HMO in the United States. Our 1.5 million commercial, Medicare and Medicaid members have access to physicians at their private practices. With over 20 years of experience, U.S. Healthcare has pioneered the managed care concepts that form the basis of the current proposals for managed competition. We believe HMOs can serve as the model for health care reform because of the comprehensive benefits they provide on a community-rated, cost-effective basis. Our model stresses preventive care and early detection of disease, reduces barriers to care, allows the assessment of quality, and contains medical costs through coordination of care and expert contracting with providers.

The federal Health Maintenance Organization Act of 1973, and the state HMO acts modeled after it, provide the proper direction for national health care reform. Why reinvent the wheel? Regulations for federally qualified HMOs require them to offer a broad array of basic and supplemental services without regard to number of days or amount of dollars spent. These benefits range from well-baby care and immunizations, to adult preventive care, to home care, to organ transplants. We have added a high risk pregnancy program for expectant mothers, early cancer screenings for women and men, and a National Medical Excellence program which seeks the best care for our members anywhere in the country when needed. Our benefits are provided with minimal co-payments and no deductibles to eliminate financial barriers to care. A U.S. Healthcare member simply pays a nominal fee, generally \$2, when visiting the primary care physician they select. There is generally no fee for specialist or hospital care, nor are there any claim forms or bills since all care is prepaid. Members are free to select

their own primary care physicians from a wide range of options and may change to another at any time, as many times as they choose, with just a phone call.

As a federally qualified HMO, U.S. Healthcare uses community rating to determine premium rates over a broad risk pool. This means every group, whether large or small, pays the same premium regardless of the health of its employees. We do not use benefit waiting periods, pre-existing condition exclusions or cancel coverage due to health status or participation level. HMOs compete based on the cost and quality of services and not on risk avoidance or rationing. To increase access to health care for more Americans, we recommend that these and other time-tested methods of improving access to care should be extended to all insurers and should be the basis for reform. People should not have to live with the fear that they may lose coverage or suffer higher premiums if they seek health care.

U.S. Healthcare has created an integrated system of primary care physicians, specialists, hospitals and other providers of care which allows us to offer these comprehensive benefits at an affordable price. While the health care reform debate has only recently centered on access, cost, and quality, HMOs have been successful in these areas for years. In addition to clinical quality measures, a major component of physician and hospital compensation is based upon the individual member's assessment of the quality of care and service. By incorporating such innovative measures to compensate providers, U.S. Healthcare is able to control health care costs while creating appropriate incentives for quality care. Reform must allow such innovation to continue its evolution.

Our network is founded in quality and includes many well-recognized providers. Prior to a physician joining the U.S. Healthcare network, an in-depth credentialing process is

undertaken by our medical directors. This process includes a review of patient charts; the requirement that services be available 24 hours a day; a minimum number of office hours must be available; and the physician must have sufficient capacity. About 25 percent of physician applicants are not admitted. Once a physician is accepted to the network, we conduct periodic reviews to assess the quality of care being delivered to our members. This level of evaluating physicians sets HMOs apart from the fee-for-service world. We believe access to care should not simply be to any physician, but to a physician that meets quality standards and agrees to adhere to accepted guidelines of practice to increase the quality of care.

U.S. Healthcare has developed innovative methods of quality measures and the collection and evaluation of outcomes data. We believe that quality measures are essential when talking about access and cost. U.S. Healthcare determines quality and satisfaction from both members and providers. We annually survey our members to determine their satisfaction with the care they receive. While some claim that consumers might not be happy with managed competition, our results show a 97 percent satisfaction level with our plan.

In summary, the federally qualified health maintenance organization model should serve as the benchmark for reforming the health care system. U.S. Healthcare believes a competitive health care system that competes based on the cost and quality of services will reduce the cost of health care and increase the number of insured Americans.

TANYA RAGGIO, M.D.
Executive Director
Healthy Start, Inc.
Pittsburgh, PA

Attached is a fact sheet describing the Healthy Start Program.

Background

The Healthy Start Program is a Presidential initiative to reduce infant mortality through additional support for comprehensive service delivery in 15 high-risk communities. The program focuses on preventing low birth weight and related infant mortality through early and continuous health care for all pregnant women and their infants.

Pennsylvania has two of the 15 Healthy Start programs nationally. The Philadelphia program provides families with access to employment, housing, education, and mobilization.

The Allegheny/Pittsburgh program, directed by Dr. Raggio, coordinates care and outreach service systems in 6 service areas meeting eligibility requirements.

Both programs are designed to assure that the appropriate comprehensive package of medical, social, educational, and other non-medical services are accessible to pregnant women and children at risk.

Questions

1. We know that education and prevention programs are effective in preventing low birth weight babies. Accepting that there is a finite limit on the services that can be included in a benefit package, in your view, what preventive services must be included?
2. What are the most effective means for ensuring that low-income pregnant women receive necessary pre-natal and well-baby care?

September, 1991

HRSA Fact Sheet

Healthy START

The *Healthy Start* Program is a Presidential initiative to reduce infant mortality through additional support for comprehensive service delivery in 15 high-risk communities. A national public information program will accompany *Healthy Start* to raise awareness of the American public, health providers, and women at risk.

Background

The 1988 United States infant mortality rate is 10 deaths per 1,000 live births, or approximately 40,000 American infant deaths under age one. Although the U.S. infant mortality rate has been cut in half since 1970, the percent of babies who are more likely to die or face a lifetime of serious health problems essentially has remained constant. At least 10,000 infant deaths occurring each year are believed to be preventable with current knowledge. A key factor in preventing low birth weight and related infant mortality is early and continuous health care for all pregnant women and their infants. In addition, cigarettes, alcohol, and drug abuse account for approximately 20% of infant deaths.

- ☐ Underweight babies are 20 times more likely to die than babies weighing over 5.5 lbs. at birth.*
- ☐ For those low birth weight infants who survive, the cost of intensive care is greater than \$1,000 per day.
- ☐ The U.S. ranks 24th in the world for infant mortality rates.

*1988 Data from the National Center for Health Statistics.

The Healthy Start Communities

Through grants administered by the Health Resources and Services Administration, 15 Healthy Start communities with high infant mortality rates (at least 15.7 deaths per 1000 live births) will develop innovative approaches to reducing infant mortality. Local and state government, the private sector, schools, and other community and social organizations will be expected to contribute resources.

Collaborative community efforts will focus on the needs of pregnant women and infants to assure that the appropriate comprehensive package of medical, social, educational, and other non-medical services is accessible. These may include:

- improving participation in Medicaid among eligible pregnant and low-income women
- increasing the number of pregnant women and infants who obtain adequate nutrition and health care referrals through the Women, Infants, and Children (WIC) supplemental nutrition program
- integrating smoking and drug abuse cessation programs into prenatal care and nutrition programs
- use of outreach workers to educate and recruit high-risk clients

The Healthy Start National Public Information Campaign

The Healthy Start National Public Information Campaign will:

- focus national attention on the problem
- create awareness of behaviors to provide all infants with a healthy start
- encourage pregnant women to seek health care for themselves and their babies.

This effort will include a five-year nationwide advertising campaign sponsored by the Ad Council and targeted information efforts in the 15 Healthy Start communities.

The 15 Healthy Start Communities Selected Features

Aberdeen Area Indian Reservation communities
(Nineteen communities in Iowa, Nebraska, North and South Dakota) Rural; IMR*=18.7. Community ownership will be fostered as communities determine the best approaches to solving health problems.

Baltimore, MD. Urban; IMR=20.1. Services will be made user-friendly and residents will be employed as health advocates.

Birmingham, AL. Twelve urban neighborhoods; IMR=18.4. Stop shopping for prenatal and pediatric services will afford pregnant women and their babies easier access to care.

Boston, MA. (Roxbury, North Dorchester, Mattapan, and the South End) Urban; IMR=17.1. Focus on community empowerment with improved services, access, and utilization.

Chicago, IL. Six areas within urban Chicago; IMR=19.6. Community economic development and career growth through business sector involvement.

Cleveland, OH. Sixteen urban neighborhoods; IMR=21.3. Will seek Medicaid approval to provide enhanced services. Strong focus on individuals taking responsibility for their own health status.

Detroit, MI. Urban; IMR=26.3. Mobile service teams will provide outreach and support. Services will be regionalized.

Lake County, IN. (Gary, East Chicago, Hammond, and Lake Station, IN.) Urban; IMR=16.2. One-stop services will be provided and referral networks strengthened.

New Orleans, LA. Urban; IMR=23.3. Local volunteer workers will identify and refer pregnant women to services.

New York, NY. (Central Harlem, Bedford-Stuyvesant in Brooklyn, and Mott Haven in the Bronx) Urban; IMR=19.4. Primary care services will be shifted from hospitals to the community. Strong attention to family violence.

Oakland, CA. Urban; IMR=17.9. Six family resource centers will be created using ethnically targeted education and mobilization.

Philadelphia, PA. Urban; IMR=22.3. Families will be provided with access to employment, housing, education, and social services.

Pittsburgh, PA. Urban; IMR=20.2. Staff placed in each service area. Care coordination and outreach service systems designed by each area.

Pee Dee Region, S.C. (Six counties: Chesterfield, Darlington, Dillon, Marion, Marlboro, and Williamsburg) Rural; IMR=16.1. A gubernatorially led economic development initiative will provide incentives for businesses to locate in the region.

Washington, D.C. (Wards 7 and 8) Urban; IMR=23.2. Services will be provided through non-traditional locations such as churches, schools, and public housing.

*IMR=infant mortality rate—number of deaths per 1,000 live births (average 1984-88)

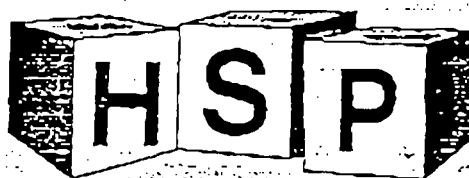
For Additional Information or Referrals

Office of Communications
Health Resources and Services Administration
5600 Fishers Lane, Room 14-43 Parklawn Bldg.
Rockville, Maryland 20857
Telephone: (301) 443-3376 Fax: (301) 443-1989

The Health Resources and Services Administration is an agency of the Public Health Service,
U.S. Department of Health and Human Services.

The Healthy Start Program

The Healthy Start Program of Allegheny County and the City of Pittsburgh is a community collaborative effort to provide unique and comprehensive services that improve birth outcomes and reduce infant mortality by 50%



Allegheny County Health Department
3333 Forbes Avenue
Pittsburgh, PA 15213
(412) 578-8003

Healthy START

Facts At A Glance

Infant Mortality Rates (1988) per 1,000 live births

United States 10.0

HIGHEST STATES

Georgia 12.6
North Carolina 12.5
Mississippi 12.3
South Carolina 12.3
Alabama 12.1
Delaware 11.8
Alaska 11.6
Maryland 11.3
Illinois 11.3
Michigan 11.1

LOWEST STATES

Vermont 6.8
Hawaii 7.2
Minnesota 7.8
Maine 7.9
Massachusetts 7.9
Kansas 8.0
Utah 8.0
Rhode Island 8.2
New Hampshire 8.3

Infant Mortality Rates By Race (1988)

per 1,000 live births

White 8.5
Black 17.6
Hispanic 8.1
Amer. Indian/Alaskan 9.0
Chinese 4.2
Japanese 3.8
Hawaiian 6.9
Filipino 4.1
Other Asians/Pacific Isl. 5.6

Prenatal Care (1988)

1st Trimester:

United States 75.1%
White 82.0
Black 60.8
Hispanic 61.3

3rd Trimester or None:

United States 6.5%
White 4.0
Black 10.9
Hispanic 12.1

Live Births (1988) Total No.

United States 3,909,510
White 3,046,162
Black 671,976
Hispanic 266,699
Amer. Indian/Alaskan 45,861

Low Birth Weight (1988) under 2,500 grams (5.5 lbs)

United States 6.9%
White 5.6
Black 13.0
Amer. Indian/Alaskan 6.1
Chinese 4.7
Japanese 6.2
Hawaiian 6.8
Filipino 7.1
Other Asian/Pacific Isl. 6.4

Mother Under Age 20 (1988)

United States 12.5%
White 10.5
Black 22.7
Hispanic 6.2
Amer. Indian/Alaskan 18.4
Chinese 1.0
Japanese 2.8
Hawaiian 15.4
Filipino 6.2
Other Asian/Pacific Isl. 6.3

Sources:

1988 (Most Recent Data Available): National Center for Health Statistics, Vital Statistics of the United States, [Vol. II, Mortality, Parts A and B and Vol. I, Natality, Part A]

HEALTHY START

Eligibility:

Definition of Project Area:

Total geographic area that has an average of at least 50 but no more than 200 infant deaths per year for 5 year period ending in 1988. The infant mortality rate for that 5 year period must average at least 15.7.

Allegheny County/Pittsburgh Project Area:

Average 81 infant deaths for that period and the average infant mortality rate was 20.2 during 1984-1988. The sum of the six service areas comprise the project area.

Definition of Service Area:

Specific geographic area or neighborhood for which improved personal services are to be planned and implemented under Healthy Start. Areas that contribute significantly to high infant mortality and amenable to the rational planning and organization of maternal and infant health services. Population viewed as collective entity, community, political jurisdiction or service catchment area of Health Department, hospitals, etc.

Allegheny County/Pittsburgh Service Areas:

- Six neighborhoods clustered in order to meet eligibility criteria
- Entire City of Pittsburgh did not qualify
- Community representation outside Pittsburgh city limits includes Allegheny County municipalities - Wilkesburg, Braddock, Duquesne, McKees Rocks. These are within the Community Health Center network.

Source: ACHD, 6-19-91

FIVE YEAR INFANT MORTALITY RATES BY RACE
SUMMARY DATA FOR PROJECT AREA
YEARS: 1984-88 and 1985-89

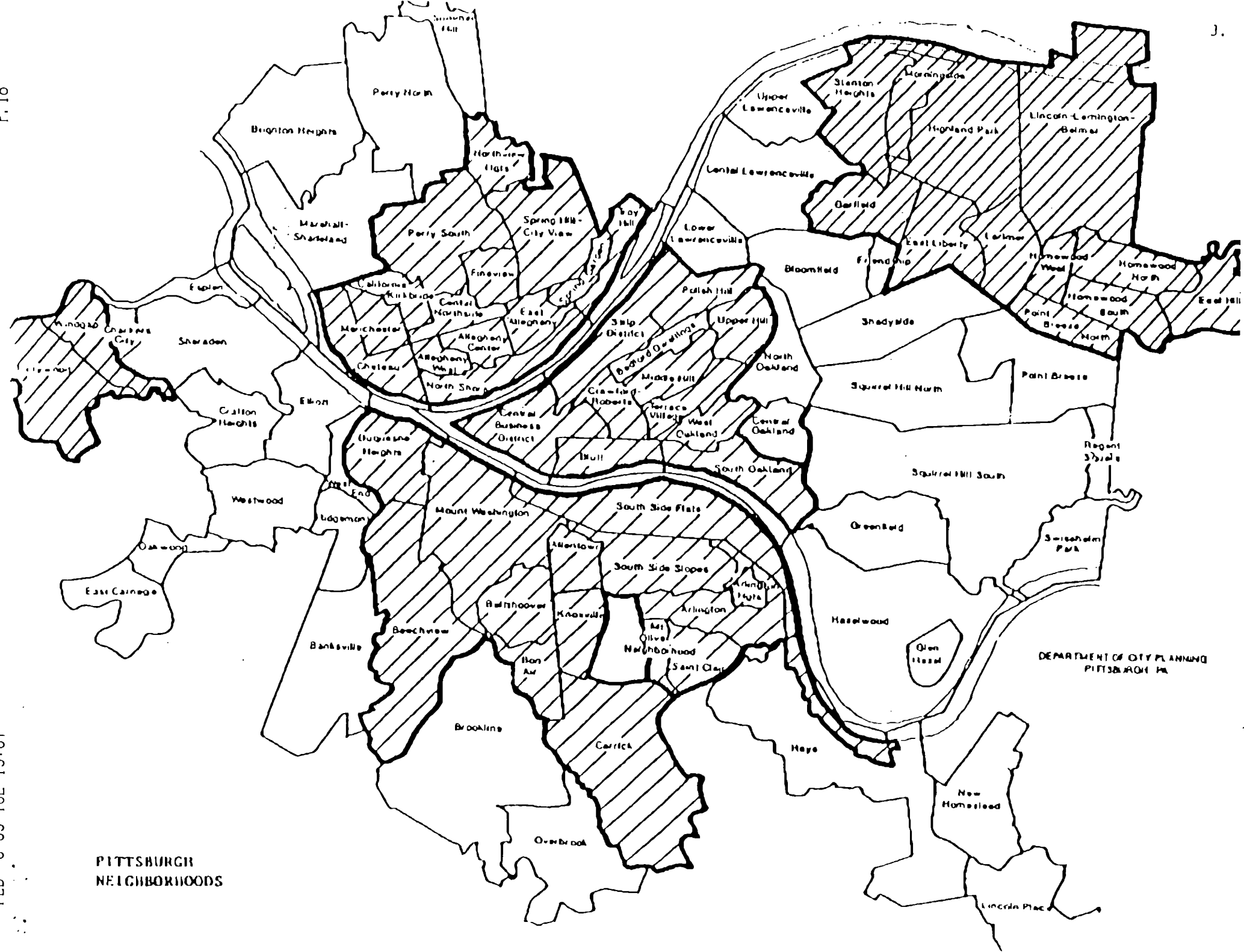
SERVICE AREAS	TOTAL INFANT DEATHS AVERAGE # PER YEAR YEARS: 1984-1988			TOTAL INFANT DEATHS AVERAGE # PER YEAR YEARS: 1985-1989		
	INFANT DEATHS	BIRTHS	RATE	INFANT DEATHS	BIRTHS	RATE
I. NORTHSIDE	12	597	20.4	14	592	23.3
II. CENTRAL CITY	14	529	26.5	14	540	25.6
III. EAST END	27	1,352	19.7	28	1,371	20.7
IV. SOUTH HILLS	18	1,031	17.3	17	1,001	17.4
V. WEST END	5	251	19.9	6	260	23.9
VI. DUQUESNE & BRADDOCK	5	236	22.0	5	237	20.2
TOTAL PROJECT AREA	81	3,997	20.2	84	4,001	21.1
ALLEGHENY COUNTY	197	17,536	11.2	202	17,594	11.5
PITTSBURGH	82	5,340	15.3	87	5,332	16.3

INFANT MORTALITY RATES BY RACE
SUMMARY DATA FOR PROJECT AREA
YEAR: 1990

SERVICE AREAS	TOTAL INFANT DEATHS			WHITE INFANT DEATHS			NONWHITE INFANT DEATHS		
	YEAR: 1990			YEAR: 1990			YEAR: 1990		
	INFANT DEATHS	BIRTHS	RATE	INFANT DEATHS	BIRTHS	RATE	INFANT DEATHS	BIRTHS	RATE
I. NORTHSIDE	7	*600	11.7	-	233	-	7	366	19.1
II. CENTRAL CITY	11	532	20.7	-	70	-	11	462	23.8
III. EAST END	35	1,467	23.9	2	350	5.7	33	1,116	29.6
IV. SOUTH HILLS	12	965	12.4	6	704	8.5	6	261	23.0
V. WEST END	3	282	10.6	2	109	18.3	1	173	5.8
VI. DUQUESNE & BRADDOCK	4	210	19.0	-	76	-	4	134	29.9
TOTAL PROJECT AREA	72	*4,056	17.8	10	1,542	6.5	62	2,512	24.7
ALLEGHENY COUNTY	168	*18,040	9.3	83	14,352	5.8	85	3,682	23.1
PITTSBURGH	72	*5,440	13.2	16	3,062	5.2	56	2,376	23.6

*Includes births where mother's race is not known.

Biostatistics: 12/9/91



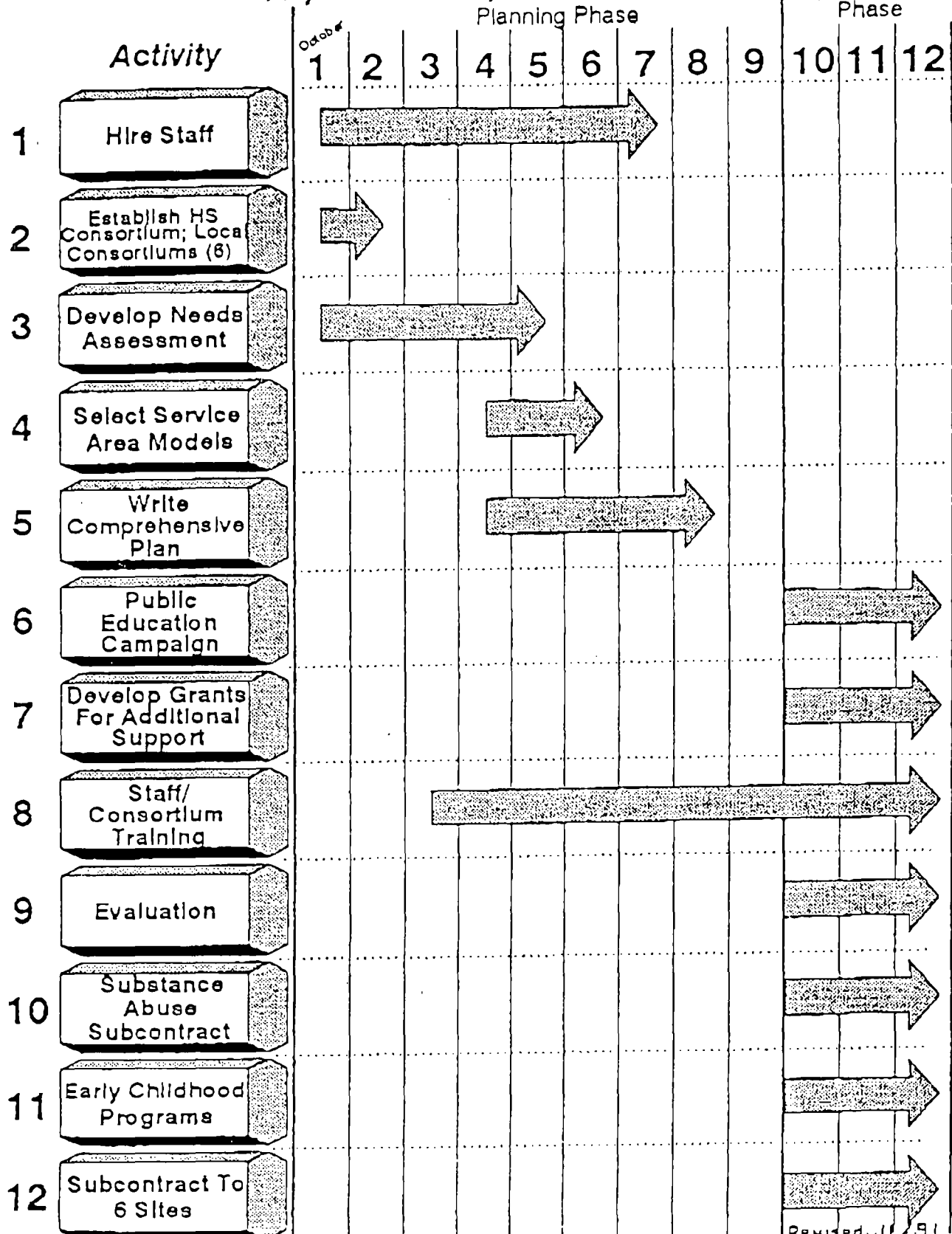
PITTSBURGH
NEIGHBORHOODS

DEPARTMENT OF CITY PLANNING
PITTSBURGH, PA.

THE HEALTHY START PROGRAM

Project Timetable By Month - Year 1

Implementation Phase



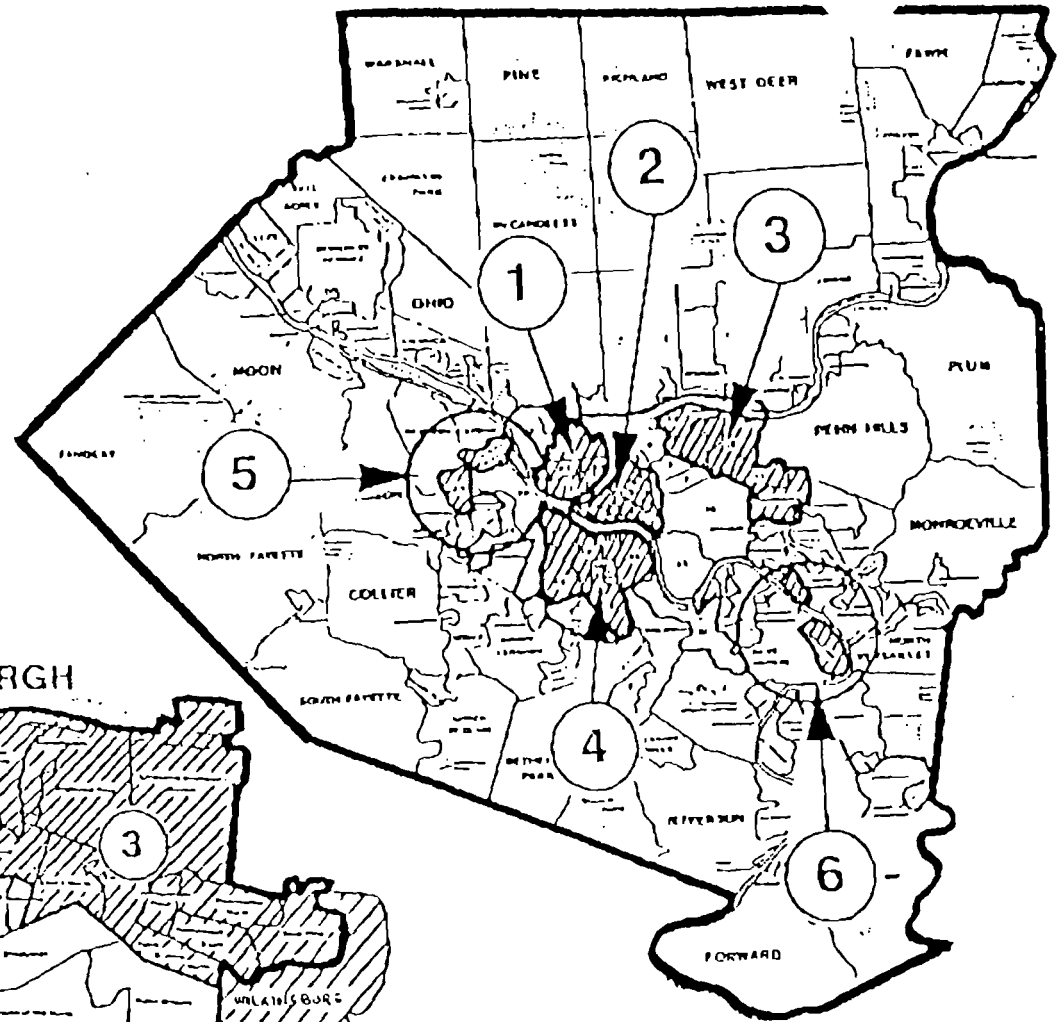
Revised 11/91

APPENDIX E (a)

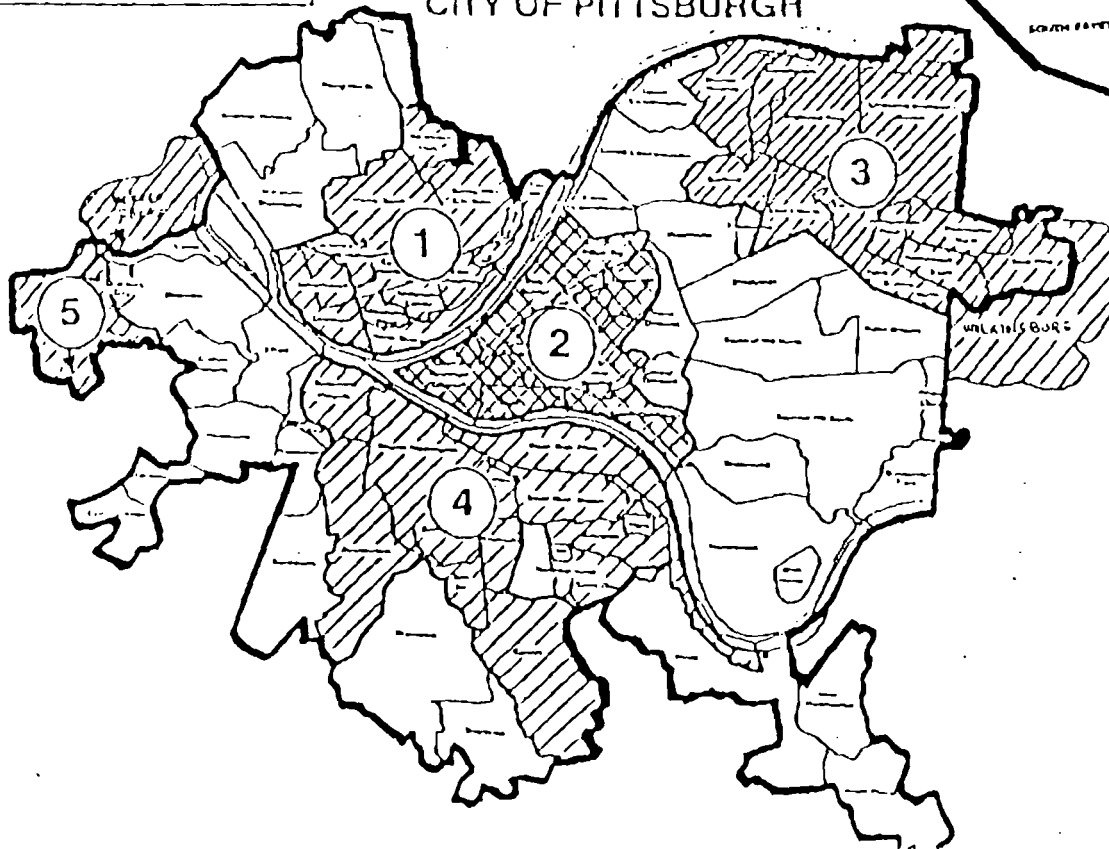
Project/Service Area Map

Consortium Service Area Key

- ① North Side
- ② Central City
- ③ East End
- ④ South Hills
- ⑤ West End
- ⑥ Duquesne/Braddock



CITY OF PITTSBURGH



BILL GEORGE
President
Pennsylvania AFL-CIO

Attached is a letter that Bill George wrote to you recently. As you know, Bill is the co-chair of the Committee on Health Care established through the Pennsylvania Economic Development Partnership. (Jay Tolson from Fischer and Porter is the other co-chair. Jay will not be at the conference.)

Although the PEDP plan is based firmly on the concept of managed competition, you should know, as you will see in the attached letter, that Bill George is not entirely sold on the idea. Labor, in general, has not been thrilled by managed competition. However, since Bill Clinton embraced this as part of the framework for health reform, they have been working with state and Federal leadership to improve aspects of this kind of reform in order to ensure that under this system of reform the goals of universal coverage and cost containment would be met.

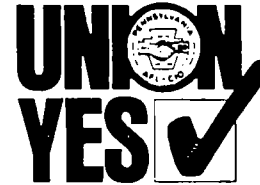
Questions

1. What specific steps do you think should be taken in the short-term and in the long-term to ensure that all Americans have access to health coverage?
2. One of the criticisms of managed competition is that participation is not usually mandatory for all players in the system. What do you think about health reform under which **all** Americans would ultimately be required to obtain health coverage through a state or regional purchasing cooperative?
3. One of the tenets of managed competition is the development of a standardized benefit package. What does Labor think about this? Would you be more supportive of allowing purchasing cooperatives to certify a limited number of plans that differ somewhat either in breadth of benefits or in cost-sharing requirements?

PENNSYLVANIA AFL-CIO

230 State Street, Harrisburg, PA 17101-1138
Telephone: 717-238-9351, FAX: 717-238-8541

AMERICA WORKS BEST
WHEN WE SAY . . . 



WILLIAM M. GEORGE
President

JUDITH HEH
Executive Vice President

JOHN VENTO
Secretary-Treasurer

January 15, 1993

Honorable Harris Wofford
United States Senate
227 Russell Senate Office Building
Washington, D.C. 20510-3801

Dear Senator Wofford:

Universal Health Care will be receiving much attention in the coming legislative session.

Organized Labor's position to the many different viewpoints before the President and Congress must have the four following ingredients:

1. Universal Access (with public pool)

Labor advocates national health care reform that: (1) guarantees access for all Americans, (2) requires all employers to contribute fairly to the cost of care, (3) establishes a federal program for those not in the workforce, including the unemployed and workers on strike.

As a nation, we can no longer afford to spend hundreds of billions of dollars yearly on a system that is inaccessible to about 37 million Americans with no coverage and too costly for another 50 million with inadequate coverage. "Managed competition" doesn't guarantee universal access. "Managed competition" comes in all shapes and sizes. In fact, it's hard to actually define "managed competition." One form of it only requires small business to offer insurance to their employees without requiring employers to contribute to the cost of care. The proposal offers no relief from the escalating cost of care for individuals or businesses, the #1 reason given by both groups as the principal barrier to access.

2. Global Budgets (with real cost containment)

Labor advocates: (1) a cap on the annual rate of increase in health care spending and (2) establishing a capital budgeting system to encourage the efficient distribution of capital.

Health care professionals are themselves, like other working people, trapped in a haphazard, unplanned,

takes place. There are incentives in the system to maximize duplication of expensive technologies and no way to control unnecessary procedures. This fragmented system provides few incentives for preventive care and health care delivery innovations are at risk of being overwhelmed by the rising cost of nearly all health care services from administrative paperwork to malpractice insurance.

3. Retiree Health Care Benefits

Labor advocates no takeaways in retiree health care benefits. A Health Care Reform Plan worthy of the name must preserve the health care benefits of retirees.

The New York Times reported December 24, 1992 that "At least 23 large companies have abandoned the health benefits that they were providing to thousands of retired employees. Dozens more have announced that they will not provide coverage for future retirees, and most employers who still offer the benefits are reducing their share of the costs, which have been climbing steeply. The companies are rushing to shrink these obligations before Jan. 1 when a new accounting rule goes into effect. The rule (Financial Accounting Standard 106) forces employers to subtract from their profits the future costs of providing benefits to retirees."

4. Opposition to Taxation of Health Care Benefits

Advocates of managed competition -- a health care reform strategy that Bill Clinton endorsed late in the campaign -- argue that taxing employee benefits would help control costs by forcing employers and employees to shop for the most economical benefits packages. They argue not for taxing the full value of employee benefits, but for a tax cap which would allow employees to continue deducting the value of a basic benefits package (say \$300 a month for family coverage), but would tax benefits above that level.

But studies have shown that taxing health care benefits won't yield anywhere near enough new money to pay for extension of coverage to all, as its proponents claim.

It is false that workers are getting a tax-free subsidy by leaving health care benefits untaxed. The reality is that for years, workers and their unions have been bargaining for health care benefits instead of wages. Workers are giving up needed wage increases just to keep health care benefits near an adequate level. In the 1980s, inflation-adjusted health care costs rose by 63%, while the real hourly wage fell from \$10.56 to \$10.03.

There is little evidence a tax cap would control health care costs. It is not employee over-utilization that is driving health care inflation, it is other forces including hospital, doctor and carrier profiteering. Moreover, consumers cannot and should not choose coverage solely on the basis of price. The cheapest coverage is not the best. The tax cap could produce the same voter revolt that the 1988 Medicare Catastrophic Coverage Act did. Politicians beware.

Should you have any questions or require additional information, do not hesitate to contact us or Claudie B. Bradbury at 202-637-5155.

We would appreciate your consideration of this request.

Sincerely,

WILLIAM M. GEORGE, President
JUDITH HEH, Executive Vice President
JOHN VENTO, Secretary-Treasurer

bg/UFCW-72

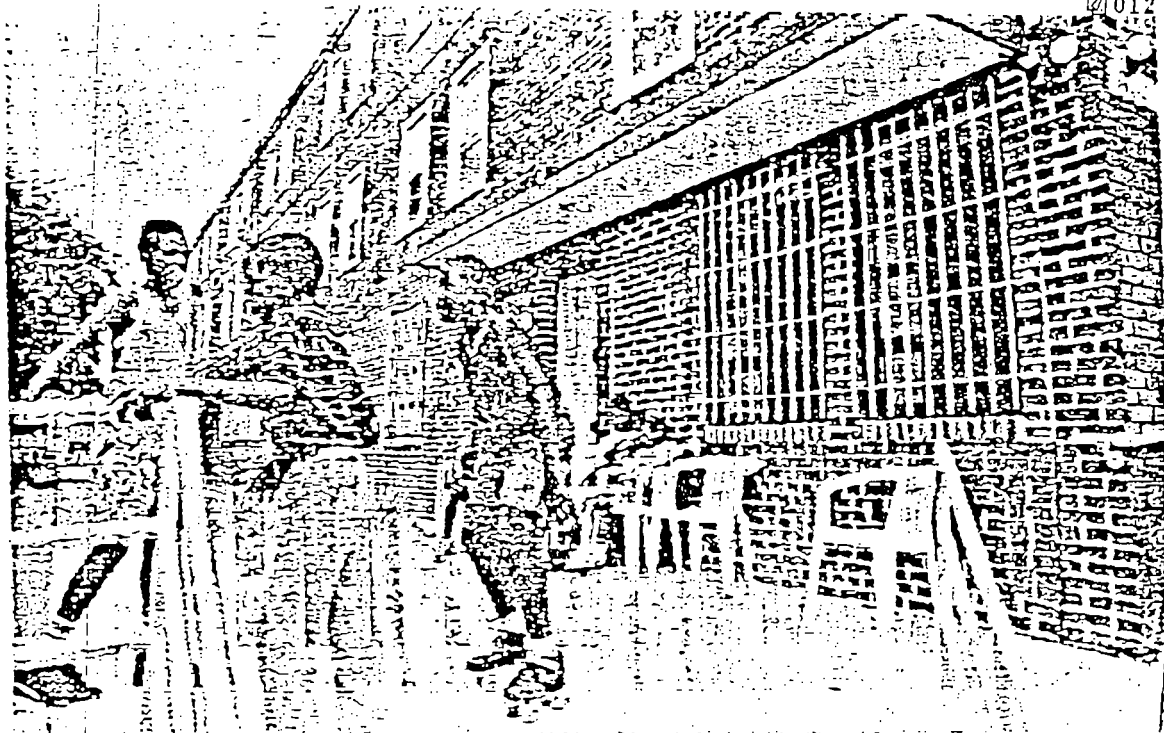
DONNA TORRISI
Director
Abbottsford Community Health Center
Philadelphia, PA

Attached are several articles that have been written about the work of Donna Torrissi, the Director of the Abbottsford Community Health Center. What makes this center so unusual is that it is based in a public housing development. Having the center located in the middle of this community has meant access to primary care services for a population who in the past would more typically have relied on hospital emergency rooms for primary care. The center represents an interesting model for bringing a range of services to people to address a broader definition of health care. In this case, one that encompasses one's environment and personal sense of self.

Even under a reformed health care system where all Americans have access to health coverage, there will still be a need to ensure access to health services, which means that the kind of program represented by Abbottsford will continue to play an important role in serving the underserved.

Questions

1. What are some of the most important lessons that you have learned in developing your center that those of us at the national level should be mindful of in developing health reform legislation?
2. One of the interesting characteristics of your center is the attention you pay to the broad "health" concerns of your patients, with health defined as more than just physical well-being. What are the applications of this approach for other communities--rural, middle income, etc.?



Neighborhood children play in front of Abbottsford Homes' newest addition: a health clinic. It is scheduled to open next week.

Not 'the projects' anymore

Once, residents were ashamed of Abbottsford Homes. Not now.

By Roxanne Patel
DEPT. OF CITY PLANNING & DEVELOPMENT

Vera Miller remembers the years when her small East Falls neighborhood was called Piper's Row because of all the drug use.

She remembers how Defense Terrace, the short street she lives on in the Abbottsford Homes, was a source of shame to residents and an eyesore that contributed to its reputation as a "project."

And she remembers her daily fear that her two children would someday become mixed up in the crack culture that surrounded them.

But today, Miller speaks proudly

of her neighborhood, which is free of drugs and quickly is becoming the center of the Philadelphia public housing development. She turns and looks at the new health clinic that now occupies one row of former crack houses, and her past shame disappears.

"With this, we're probably going to get some respect," said Miller, a 12-year resident of the development. "They'll treat us like human beings. Maybe they won't label this 'the projects' anymore."

"I was here when it was bad... I was here when it was rotten. Now, I'm here for the good."

The health clinic, scheduled to open next

week, is the most recent innovation for Abbottsford Homes, which became in May 1991 the only tenant-run public housing development in the state. The clinic will provide the 1,500 residents with private health care advice and education, which officials say is tailor-made for the complex.

Danna Torrist, director of the health center, said the clinic would encourage patients to take care of themselves rather than neglect their health and then rely on doctors.

With a clinic on site, Abbottsford residents will be able to get treatment relatively quickly and be greeted by a staff that will

See ABBOTTSFORD on B4

Knocking the stigma of living in 'projects'

ABBOTTSFORD born 91 accord them respect, Torrist said.

"Our mission is to serve the underserved," she said. "What we attempt to do here is empower people to take better care of their lives. Besides the medical treatment of their bodies, we are also addressing the psycho-social aspects of their lives."

Toward that end, Torrist said the clinic would train some tenants to act as outreach workers in the community for various health issues such as nutrition, prenatal care and child care. Residents also will be hired to work as the clinic's receptionist, driver, security and maintenance staff.

Three years ago, things turned around for Defense Terrace and other drug-plagued parts of the 700-unit Abbottsford Homes. A group of about 75 residents took to the streets with bullhorns and candles to force drug wars out. Long-time resident Dorothy Harrell, a community

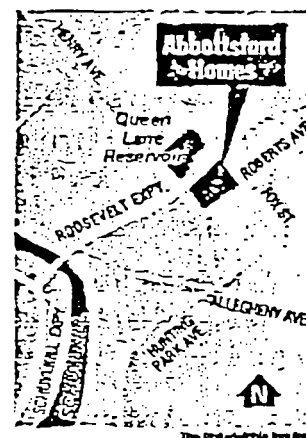
leader, said the 14-day protest, which attracted the police, drew attention to the drug use and shut down business for dealers around the complex.

Since then, residents have established the clinic, and they plan to open a day-care center across the yard, where boarded-up houses still stand.

After living with the drugs for so long, Harrell said residents were now ready to live with hope.

"This signifies to the community and the people who live here that we're taking the negative and turning it into positive," Harrell said. "How better to show that than a health center and day care?"

Harrell is president of the Tenants Management Corp., the group of Abbottsford residents who oversee all operations of the development. She said the tenants took over in May 1991 after six years of being trained on how to run a housing development.



Today, the residents run all aspects of the complex independent of the Philadelphia Housing Authority and the U.S. Department of Housing and Urban Development, the landlord for Abbottsford. The residents handle all security, maintenance and leasing difficulties, and they oversee operation of the health center, including hiring and firing of the director.

Taken from the
Phila Inquirer
7/10/92

Health Strategy Network WINNER ANNOUNCED

Abbottsford Health Center Selected as Winner

The Abbottsford Community Health Center, located in the East Falls section of Philadelphia, celebrated its grand opening on July 9, 1992 with the help of dignitaries, friends and several hundred of the 3,000 residents of Abbottsford Homes, the public housing development in which the Center has been created. Full-time direct service to the residents began July 20, 1992.

The Health Center, one of only seven of its kind funded in a new initiative by the U.S. Department of Health and Human Services, will be a model for resident-driven primary care facilities within public housing. Primary health care, health promotion and education, and disease prevention are the emphases of the Health Center.

In effect, this Center functions as a "family doctor" to residents who have been traditionally blocked from access to health care by lack of money, transportation and user-friendly facilities. For Abbottsford Homes — which in May, 1991 became the only tenant-managed public housing development in Pennsylvania — the

Health Center is a positive presence that demonstrates the growing spirit of hope among its residents.

The Abbottsford program has two basic components. First, Certified Nurse Practitioners provide the administration as well as direct care services. These services include basic primary care, home visits for the home-bound, complete perinatal care, laboratory testing, pick-up and delivery of prescriptions, and after-hours access to emergency information and referral. Second, a clinical psychologist and a team of outreach workers provide home visits and group education workshops in health promotion/health education, mental health and substance abuse issues. The staff is community and patient oriented and determined to make the Center's services responsive to community and individual need. Such decisions as hours of operation and hiring of indigenous staff were conscious decisions to create a healthcare environment which meets the needs of

(Continued on page 21)

Abbottsford Health Care Center Selected as Winner

(Continued from page 15)

those it serves. A long-term goal of the Center is to be continuously open to ideas for programs and services which respond to the changing needs of the community.

Abbottsford residents are clearly excited and motivated by the presence of the Health Center. At the grand opening event, the crowd joined hands in prayer and combined voices in a song entitled, "Victory." Children quickly volunteered to push brooms

reception room in the community building. And, of course, residents of all ages were on hand to smile at the cameras of the local television station covering the grand opening event of their Health Center.

The Health Strategy Network is very pleased to confer its annual award to the Abbottsford Health Care Center. A formal presentation will be made at the HSN Program on Tues., Dec. 4 at the Four Seasons Hotel in Philadelphia.

Call Chris Mucci at (215) 946-2773

QUARTERLY NEWSLETTER
FALL 1992
ANNUAL AWARD

place, according to the AHA.

See "DRUG," page 22

See "TPP," page 23

See "TPP," page 23



While nurse practitioner Katie Fleming, RN, left, examines a young patient at the Abbottsford Community Health Center, nurse practitioner Donna Tomisi, MSN, RN, far right, speaks with the child's mother. Since opening its doors July 20, the Abbottsford center has averaged 65 patients a week, most of them children.

New NP-run healthcare center in Abbottsford serves as model

By Mary Alice Cookson

How to bring accessible, user-friendly and cost-effective health care to the medically underserved is a question that challenges communities across the country. Federally funded primary care centers located within public housing communities, such as the Abbottsford Community Health Center in Philadelphia's Germantown, are being tested as a possible answer.

The center, which opened this summer and is the only such center run by nurse practitioners, is Pennsylvania's first resident-driven health facility within the state's first tenant-managed public housing community. Located within three renovated ground-floor apartments, the Abbottsford center offers a full range of primary care and health education services.

See "NPs," page 24

effort

AKIRA SUWA, LAUREL STROGGS

1992

SEE PAGE 16 FOR OPTIONS

NPs provide 'hands on' care

Continued from "NEW," page 1

According to the Abbottsford program director, nurse practitioner Donna Torrisi, MSN, RN, a primary concern of the center is to treat people with dignity and respect.

"The poor have been alienated, neglected and discounted most of their lives," she says. "By treating people with respect and by educating them, we empower them to take charge of their lives."

Another of Torrisi's goals is to minimize the red tape associated with health care. "We are accessible. We are touchable. We pick up the phone quickly. We greet people when they walk in the door," she says. "We take time with people and focus not just on the problems (at hand) but on potential problems. Health care means not just what's going on with your body, but also with your life."

Recognizing the need for such accessibility, the Bureau of Health Care Delivery and Assistance (BHCDA) of the U.S. Department of Health and Human Services



Torrisi examines a teen-age patient at the center. In addition to primary care, the center's NPs provide home visits, lab testing, and 24-hour access to emergency information and referrals.

(DHHS) in its 1991 fiscal year awarded about \$3.38 million to fund seven public housing primary care centers in six states.

These centers provide comprehensive services to public housing residents regardless of their ability to pay and involve residents in the planning, organization and implementation of services and programs. Because centers are located where these medically underserved people live, the plan is that regular medical care will become a routine part of their lives.

The Abbottsford center is one of the model centers. The others are Roxbury Comprehensive Health Center in Roxbury, Mass.; Great Brook Valley Health Center in Worcester, Mass.; West End Medical Center Inc. in Atlanta; The Clinic in Aligeld in Chicago; the Federated for Community Planning in Cleveland; and Grace Hill Neighborhood Health Center in St. Louis.

Like other public housing communities, Abbottsford's 3,000 residents are believed to be at high risk for chronic diseases related to poverty and for high incidences of substance abuse, teen-age pregnancy, low birth weight babies, violence, family neglect and abuse, STDs and AIDS.

"Living in poverty is a full-time job, so medical care hasn't been a high priority for these people," says nurse practitioner Kate Fleming, RN, who works at the Abbottsford center.

"There's such a great need here for health maintenance care and for the management of common illnesses and chronic diseases, which nurse practitioners are very adept at handling," says Fleming, who has 10 years' experience in family practice.

Of the seven centers, only the Abbottsford site officially is run by nurse practitioners. But even in the others, "you won't find a cadre of physicians in charge; these are nurse-managed models," says James Gray, chief of the Health Care for the Homeless Branch of the BHCDA, which is based in Rockville, Md.

"The concept of the nurse practitioner model was important for us to test," says Susan Lynn Heckroate, development director for Resources for Human Development Inc. (RHD), a large nonprofit organization that provides social service programs in the Philadelphia area and initiated the idea for the Abbottsford center.

"Yes, it is cheaper to staff with nurse practitioners, but that's not why we did it. We did it because of our perception that patients get better care from nurse practitioners. They get the kind of hands-on care, health education and health promotion that physicians are less likely to do. And this population, of all populations, needs those desperately."

The Abbottsford center staff includes two full-time and two part-time nurse practitioners, another RN, a counselor/case manager, and a paid lay outreach and support staffer from the Abbottsford community. Two nurse practitioners have joint appointments on the University of Pennsylvania School of Nursing faculty; nursing students are allowed to train at the center.

The Abbottsford center also retains the services of a podiatrist and an internist. These staff physicians/consultants review complicated medical problems and collaborate on protocol issues. Plans are being made to contract services from a nurse midwife.

Nurse practitioners are eligible for Medicaid and other third-party reimbursement for their services. Aside from providing primary care, they offer home visits for the home-bound, laboratory testing, pick-up and delivery of prescriptions and 24-hour access to emergency information and referrals.

The staff counselor and team of trained outreach workers, who link the center and the community, also make home visits and do basic assessments of healthcare needs. The staff conducts educational workshops on topics such as nutrition, substance abuse and AIDS prevention.

"It's easy to round up the children," says Colleen McCauley, RN, full-time nurse educator for the center. "But with adults, we need to build a track record." McCauley, who is a first-year nurse, says confidentiality is an issue because the support staff who work at the center also live in the community.

"We need to earn our patients' trust one-on-one," says McCauley. "When the people learn that they can go to the center and what they say (or hear) remains confidential, trust will build in the community."

Considering the trust factor, the "slow time" of manner, and the fact that the center's outreach program only recently got under way, the number of patients is good, according to RHD's Heckroate.

RHD, which has a 22-year history of providing diverse social service programming throughout the Philadelphia area, was the grant recipient for the center and has been involved in all phases of its development. RHD formed a relationship with Abbottsford residents six years ago when it was awarded a DHHS contract to begin:

Head Start program in the community. RHD's crime prevention experts also helped residents rid their neighborhood of drugs. Thus, when a DHHS request for grant proposals was rumored to be coming out for a public housing primary care program, RHD was in a key position to see the center through to fruition.

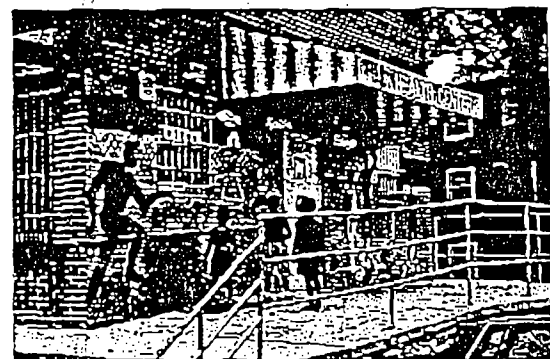
At the start of the brainstorming process, RHD retained two nurse consultants: Torrisi, who later became the center's program director, and Margaret Grey, DrPH, RN, FAAN.

"It's very exciting bringing healthcare to people where they are," says Grey, who is associate professor and director of the primary care graduate program at the University of Pennsylvania School of Nursing. "This project has so much potential because of the tenants' intimate involvement. It was developed in a collaborative manner."

Torrisi, a family nurse practitioner with 12 years' experience, primarily within a large HMO, co-authored the grant proposal with RHD's Heckroate. Torrisi, who has been an adjunct clinical faculty member at the University of Pennsylvania School of Nursing for several years, continued to serve as a consultant after the grant was awarded in September 1991.

The Abbottsford community is directly involved in the organization and implementation of the center's services and educational programs. Residents have the majority of seats on the center's advisory board, which has hire-fire power over the director.

Torrisi says she is convinced that the federal money used to operate the center "is



The two-story brick building that houses the Abbottsford center is adorned with colorful murals depicting children at play. It was painted by Abbottsford teen-agers under the direction of the Philadelphia Anti-Graffiti Network.

money well spent," and that preventive health care costs less than "waiting for accidents to happen."

The burden will be on the center to prove its cost-effectiveness, she says, and the center will conduct computerized program evaluations.

In the future, says Torrisi, the center may offer its services to another public housing community located nearby. "My dream is for this model to have siblings, so we can increase the access to other low-income and underserved communities."

While it is too soon to gauge the success of these centers, optimism prevails among health officials. According to the BHCDA's Gray, the organization expects to fund from five to nine more centers in the 1992 fiscal year, and a decision regarding who receives funding is expected to be made this month. □

For more information

Contact nurse practitioner Donna Torrisi, MSN, RN, or Colleen McCauley, RN, Abbottsford Community Health Center, 3205 Defense Terrace, Philadelphia, PA 19129; (215) 843-9720.

Health Center

have been forced to do without those vital aids.

A Child and Elderly Safety Education Program is in the works as one of the Center's efforts to help prevent injuries and illness—injuries like falls and burns. It hopes to include the provision of smoke detectors and night lights, important safety tools taken for granted by people with higher incomes but missing in much public housing.

Donna says, "Our outreach workers are seen as angels by this community. Many people here are living in depressed circumstances, and feel very down and out. Some are so discouraged and so used to not



Photo by Marc Burag

Director Donna Torrisi consults with a community member outside of the Center.



Photo by Marc Burag

Nurse Practitioners deliver many services at the Center, where maternal and child health are high priorities.

getting help that they don't take advantage of our service but the word is getting out that we are here to help, and we are accessible. People are starting to come in and say, 'Can you fix up like you fixed Joe?'

"It's amazing that many people have been denied the most basic health care," Donna says. "This Center, which is managed by the people it serves, has been a Godsend. It's made a tremendous difference in a few short months."

For information on the Abbottsford Community Health Center model, contact Donna Torrisi at 843-9720 or Susan Lum Heckrotte at 951-0300.



JOANNE COCHRAN
CEO
Keystone Rural Health Center
Chambersberg, PA

Attached is a brief description of the Keystone Rural Health Center founded by Joanne Cochran in 1986 to provide health care to migrant and seasonal farmworkers and their families.

Background

Keystone Rural Health Center originally served migrant workers and has expanded to serve indigent and minority populations.

On July 22, 1992, Keystone was officially declared a Rural Health Center by the Health Resources and Services Administration in the U.S. Public Health Service. Many of the patients are elderly, minorities, or indigent.

In 1992, the Center was selected by the Health Resources and Services Administration as one of five migrant health centers nationwide demonstrating the success of integrated interagency delivery systems for farm workers.

Questions

1. As a provider of health care services to a rural population, what kind of changes in health system would help you better serve your patients?
2. How do the services you offer differ from the typical health care center?
3. How might your center become part of an "organized care network"?

KEYSTONE HEALTH CENTER 1992 ACITIVITIES REPORT

REPORT FROM THE CEO

This year has been a landmark year for the Keystone Rural Health Center, a 501 (c) (3) not for profit corporation. Many anticipated plans have come to fruition. Keystone Migrant Health was founded in 1986 by Joanne Cochran, a masters prepared nurse, to provide healthcare to migrant and seasonal farmworkers and their families. This program was a seasonal program with months of operation correlating with the picking season for apples and peaches in Franklin County. After the second year of Keystone Migrant Health Center's operation, it became difficult to close the health center in November after the migrants had gone because the indigents and minorities in the community began to use the health center. By 1990, a sizable non-migrant population was receiving healthcare at Keystone. At this time, a task force was formed of all health care providers in the community. At this first meeting, all members of the task force agreed that while health care was available in Franklin County, it was not accessible to everyone. There were many barriers to accessing healthcare identified: language, finances, transportation, culture, etc. It was decided that there was a great need for a community health center. It was at this time that we began converting the Keystone Migrant Health Center into a Rural Health Center. On July 22, 1992, Keystone Migrant Health Center was officially declared a Rural Health Center. Keystone continues to provide health care to migrant and seasonal farmworkers and their families during the months of July through November; however, the center also provides health care to everyone in the area year round. This includes migrant and seasonal farmworkers, medical assistance clients, Medicare clients, self-pay clients, third party clients and clients with limited funds. Charges are based on income and family size for those with limited financial resources.

Keystone has been operating as a Rural Health Center for six months and are seeing 70-80 patients daily with an average of 20-30 new patients each week. Many of the patients are elderly, minorities or indigents. There is a tremendous need for programs such as this. Everyone is welcome regardless of ability to pay. Keystone has employed one full-time physician, one part-time physician, two physician assistants, one nurse practitioner, and an ancillary staff comprised of nurses, receptionists, medical records clerks, business office employees and secretaries. Presently Keystone employs 19 individuals.

Keystone works closely with many other organizations at the local, state and federal levels, constantly striving to provide a comprehensive, integrated, accessible and cost-effective delivery system. In 1992-1992, Keystone was selected by the U.S. Health Research Services Administration as one of the five migrant health centers nationwide as a successful model of integrated interagency delivery systems for farmworkers.

SERVICE STATISTICS

Keystone Health Center has provided healthcare services to 6,912 patients from July 7, 1992.

2,140 Self-pay/Reduced fees
1,545 Blue Shield
1,719 Medicare
1,508 Medical Assistant

Keystone has provided healthcare to Piney Mountain Nursing Home since July 1992. Both a physician and physician assistant visit the home twice a week with approximately 15 to 20 patients seen each week.

Keystone provides healthcare to approximately 200 boys from ages 13-20 at two VisionQuest camps located in the South Mountain area. Approximately 15-20 kids are seen per week.

Keystone also provided physicals to students in the Chambersburg Area School District.

The migrant health program at Keystone had 1,026 visits by farmworkers. There were 177 patients seen at the migrant dental clinics. Keystone provided physicals to 33 migrant Headstart children.

Keystone also provides HIV and AIDS health care follow-up for the Pennsylvania Department of Health. In fact, Keystone Health Center is one of the few centers in the county providing health care to this population.

PLANS FOR THE FUTURE

The nature of health care has changed drastically over the last forty years. Reasons for seeking health care are not primarily motivated by disease causing organisms or pathology. More recently individuals present themselves for health care because of a symptom related to behavior. To cite some examples, the incidence and prevalence of sexually transmitted disease, AIDS, hypertension, gastritis, diarrhea, depression, anxiety, colds, dental disorders, obesity and malnutrition and all the other nutritional disorders are all related to behavior. It is almost impossible to operate a health care center without addressing related human services. In addition to expanding the medical health care delivery system, it is the intention of the Keystone Health center to provide either directly or contractual, human services. For the purposes of this paper, human services are those services intended to improve the social functioning and well-being of people, i.e., Drug and Alcohol, Mental Health and Social Service.

ACCESS - Background

- ◆ Coverage in PA
- ◆ PA Medicaid Program
- ◆ Local Initiatives

COVERAGE IN PENNSYLVANIA

The Uninsured

Approximately 10 percent (1.3 million) Pennsylvanians are uninsured compared to 16.5 percent or 37 million nationally. Of the uninsured in the commonwealth:

- 66 percent are workers or their dependents
- 38 percent (over 400,000) are children
- Blacks are twice as likely to be uninsured as whites
- many of the uninsured work for small employers
- the rate of uninsured varies by region
 - * the Pittsburgh area has a high level of uninsured
 - * the Philadelphia area has one-quarter of the uninsured.

The Insured

Insurance coverage is provided in the following proportions:

43.6 percent Blue Cross/Blue Shield
15.9 percent Medicare
11.7 percent Medicaid
9.4 percent uninsured
19.4 percent other

Major carriers in Pennsylvania are:

- * The Blues: 4 regional; 1 statewide BS (5.5 million)
- * Major private insurers: Prudential, Cigna, Metropolitan, Aetna, Travelers, Continental
- * For profit HMOs: U.S. Health Care, Keystone
- * Non-profit HMOs: Geisinger

Overall, there are approximately ____ insurance carriers in Pennsylvania. There are 20 HMOs covering 1.8 million or 11.5 percent of the insured.

Pennsylvania has not enacted legislation regarding the small group market as many other states have. Small group market

legislation usually allows insurance carriers to market plans that are "bare bones" policies, that is, they do not cover all otherwise state mandated benefits and they typically impose restriction even on coverage for hospitalization and physician visits.

State mandated benefits are as follows:

	Group Policies	Individual Policies
Alcohol drug coverage	X	
New born children	X	X
Physically handicapped/ mentally retarded	X	X
Chemotherapy	X	X
Mammography screening	X	
Conversion requirement	X	

The following coverage is provided on a non-discriminatory basis:

Nurse midwives
Nurse practitioners
Birthing screening
Nurse anesthetist
Nurse practitioner
Certified Enterostomal therapy nurse
Certified community health nurse
Certified psychiatric mental health nurse
Certified clinical nurse specialist
Chiropractor
Physical therapist
Osteopath
Podiatrist
Dentist
Psychologist
Optometrist

Pennsylvania has programmed almost \$3 billion, or about one-fifth of the state's total budget, for health care in the current fiscal year."

The single largest expenditure is for Medical Assistance, which includes both the federal/state-funded health care program for low-income adults and children known as Medicaid and the entirely state-funded health care program for General Assistance recipients. In 1992-93, the Commonwealth has appropriated \$2.09 billion, or about 15 percent of the state's budget, for the provision of health care for the approximately 1.6 million Medical Assistance recipients in the state.

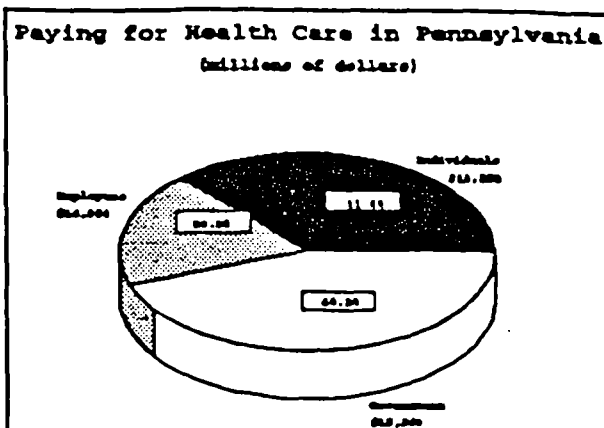


Figure 1

In Pennsylvania, as in the nation at large, access to adequate care has diminished even as overall cost has increased. Lack of health insurance, limited insurance coverage and limited access to providers are leading factors in this condition.

The result: more than a million Pennsylvanians are uninsured or underinsured. The number who are medically underserved, while more difficult to calculate, is certainly even higher. Almost one-quarter of the population in Philadelphia has been identified as being medically underserved. Two other counties, Franklin and Sullivan, report that more than 20 percent of their population is underserved. Thirty three other counties in the Commonwealth estimate that between 10 percent and 20 percent of their population that is medically underserved.²

Many who are underserved live in areas with an inadequate number of providers. Ten percent of Pennsylvanians -- 600,000 in rural areas and 600,000 in inner city areas -- live in areas with severe shortages of primary care providers.

Many of the underserved are children. A recent study found that 402,000, or about one out of every five children in Pennsylvania under the age of 15 lack health insurance. Four out of 10 of the uninsured children live in households where the head is employed full-time and another four live in households where the head is employed on a part-time basis.³

And, many of the employed who are uninsured work for smaller businesses. In fact, 19 percent of the businesses in Pennsylvania with fewer than 50 employees currently

" For additional details on the programs included in this total see Appendix E.

provide no health insurance for their employees. These businesses employ 331,440 full-time workers.⁴ About one-quarter of these smaller firms once provided health insurance but have discontinued the benefits -- more than half due to the high cost of premiums.

What about the nearly 90 percent of the state population that is insured? Most have a traditional fee-for-service indemnity plan provided through an individual's or family member's place of employment. Copayment and deductible features have become increasingly common features in response to the escalation of health care costs.

Managed care arrangements have become increasingly popular in response to these cost pressures. Under managed care arrangements, hospitals, physicians and other health care providers combine in one of several different types of organizational structures to provide health services to those who enroll with the organization.

Nationally, the number of Health Maintenance Organizations (HMOs) peaked in 1987 at 647. However, enrollment has continued to climb steadily to 34,004 today. In Pennsylvania, there are currently 20 HMOs providing services to 1.38 million enrollees, or 11.5% of the insured. Additionally, there are 37 Preferred Provider Organizations (PPOs) operating in the state, up from 28 in 1987.

The Medical Assistance program is also moving in the direction of managed care. There are currently three types of managed care programs available to Medical Assistance recipients: Health Maintenance Organizations, a Health Insuring Organization and a capitation contract with a Community Health Center. In total, these programs serve over 200,000 MA recipients.

HealthPASS is a managed care program for Medical Assistance recipients in which the state Department of Public Welfare has contracted with a Health Insuring Organization to serve 82,000 people in South and West Philadelphia. An independent evaluation of the HealthPASS program has concluded that this venture has been successful in increasing access, fostering continuity and improving the quality of care. And, HealthPASS has been a cost-effective investment for the state Department of Public Welfare and the federal government.

Health outcomes in Pennsylvania mirror the national experience. The infant mortality rate in Pennsylvania is 10.5 infant deaths per 1,000 live births. The U.S. rate is 10.4 percent. Low-birthweight babies account for 6.9 percent of all births in both Pennsylvania and the nation. The current life expectancy for a Pennsylvanian is 73.5 years while for Americans it is 73.7 years.

Of course, in urban and rural pockets of the state beset by poverty and other problems that make the availability of quality health care less likely, health outcomes are significantly worse.

APPENDIX C

PROFILE OF HEALTH CARE DELIVERY IN PENNSYLVANIA

	State	U.S.
<i>DEMOGRAPHICS</i>		
Total population, 1990 (000s)	11,881	248,709
Percent age 65+, 1990	15.4	12.5
Percent nonwhite, 1990	11.4	19.7
Percent in rural areas, 1990	15.2	24.8
Percent receiving Social Security, 1990	18.8	15.6
Percent below poverty, 1990	11.1	13.1
Personal income per capita, 1991	\$19,306	\$19,092

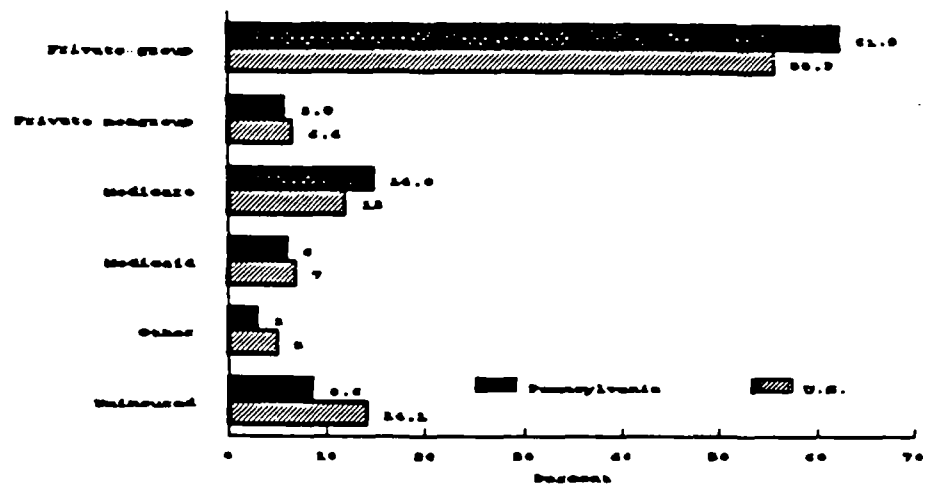
	State	U.S.
<i>HEALTH STATUS</i>		
No. of infant deaths per 1,000 live births annually, 1991	9.1	8.6
Percent of births of low birth weight, 1989	7.1	7.0
No. of deaths per 100,000 population, 1991	1,016.5	853.9
Cumulative no. of AIDS cases reported, Oct. Sept. 1992	6,668	230,179
No. of substance abuse treatment admissions per 100,000, 1991	520.5	810.8

UTILIZATION OF SERVICES

	State	U.S.
Hospital admissions per 1000 population, 1989	155.1	135.9
Occupancy rate of hospitals, 1989	74.7	69.9
Emergency room visits per 1000, 1989	403.4	361.5
Outpatient hospital visits per 1000, 1989	1,280.6	1057.5
Occupancy rate of certified nursing homes, 1987	92.5	N/A

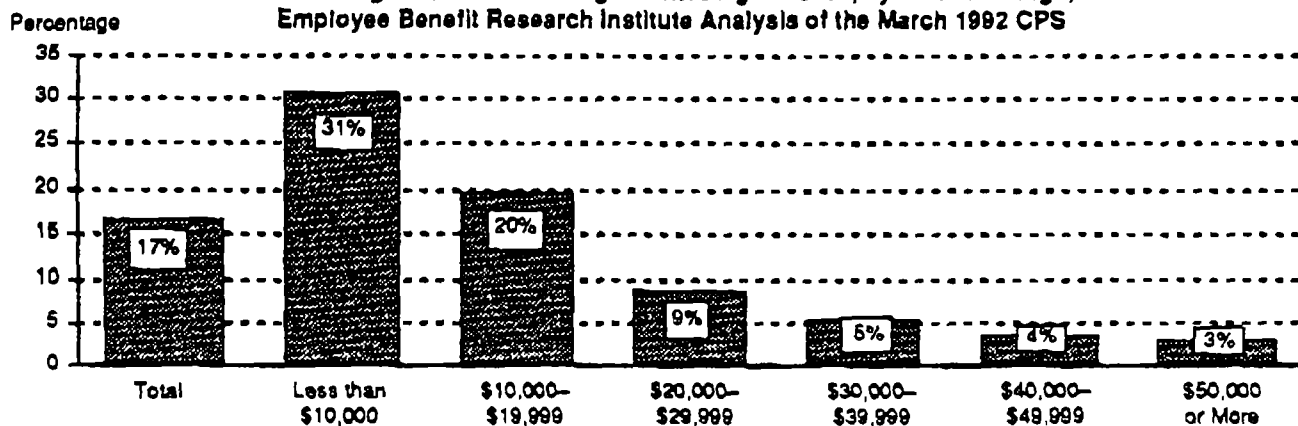
COVERAGE

Insurance Status



	State	U.S.
Maximum income for Medicaid eligibility: AFDC, 1990 (as % of poverty)	47.8	47.4
Medically needy, 1990 (as % of poverty)	53.1	59.2
SSI, 1988 (as % of poverty)	178.23	N/A
Ratio of nonelderly Medicaid eligibles to the poor, 1989	0.55	0.44
No. of elderly with buy-in coverage, 1989	56,319	1,696,621

Chart 7
Percentage Uninsured among Workers Aged 18-64, by Total Earnings,
Employee Benefit Research Institute Analysis of the March 1992 CPS



Note: See table 32.

covers 49 percent of the poor and 24 percent of those just above the poverty line. The increase in private health insurance among individuals in families with income just above the poverty line does not offset the sharp decline in the proportion receiving publicly financed coverage.

Eighty-nine percent of the uninsured were in families with an estimated adjusted gross income (AGI) of less than \$20,000 (see table 12).⁸ Twenty percent of individuals in that income class did not have health insurance in 1991, compared with 3 percent of individuals in families with AGI of \$75,000 or more.

Workers with low earnings are more likely to be uninsured than workers with high earnings. Thirty-one percent of workers with earnings below \$10,000 were uninsured, compared with only 3 percent of workers with earnings of \$50,000 or more (chart 7) (see also table 32). Low-income workers may be employed in industries less likely to offer health insurance or may have a weaker (or temporary) attachment to the work force. In addition, these workers may be employed only part time or unemployed at times.

Location

The proportion of the nonelderly population with and without health insurance varies by location as a result of differences in employment-based coverage and Medicaid eligibility. In 11 states and the District of Columbia, more than 20 percent of the population was uninsured in 1991 (table 3).⁹ In many of these states a smaller

proportion of the population was eligible for private insurance and/or a larger proportion was eligible for publicly financed health programs than the national average (see table 16). Although some states exhibited substantial changes in the percentage of their population without health insurance between 1988 and 1991, states with a low percentage of uninsured in 1988 generally also had a low percentage of uninsured in 1991. The same trend was experienced in states with a high percentage of their population without health insurance. However, in states with small populations, it is unclear whether increases and/or decreases in the proportion of the nonelderly population without health insurance are the result of sampling error or shifts in the well-being of population groups. Nearly all of the states with the highest percentage uninsured were in the south or southwest regions. Lower average income, lower Medicaid eligibility rates, and higher unemployment rates may all be factors contributing to this difference. In addition, many of these states have a higher concentration of racial and ethnic groups that were less likely to be covered by health insurance (see table 15).

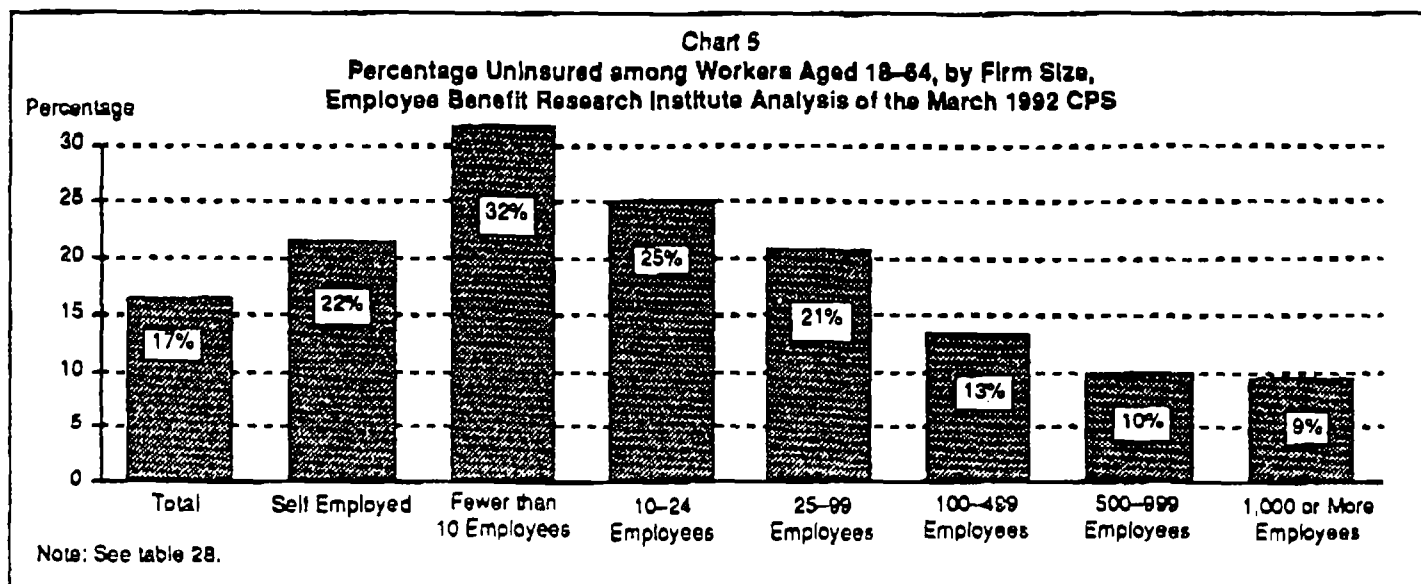
Individuals living in metropolitan areas located in the southern or western regions were more likely to be uninsured than individuals living in other metropolitan areas (see table 17). The metropolitan areas with the highest percentage uninsured were San Antonio (31.0), Miami/Ft. Lauderdale (29.3), and Los Angeles/Anaheim/Riverside (26.5). Individuals living in the Pittsburgh/Deaver Valley metropolitan area were least likely to be uninsured (7.2 percent).

Individuals living in rural areas were slightly more likely to be uninsured (17.2 percent) than those living in urban areas (16.5 percent) (see table 18). In both areas, low-income families were more likely to be uninsured than high-income families. In addition, members of rural families with a head of household

⁸ Adjusted gross income was estimated by the Census Bureau from reported income.

⁹ These states and their uninsured rates were Alabama (20.6 percent), Arizona (21.1 percent), California (21.7 percent), the District of Columbia (30.3 percent), Florida (23.5 percent), Idaho (20.8 percent), Louisiana (23.8 percent), Mississippi (22.1 percent), Nevada (21.8 percent), New Mexico (24.5 percent), Oklahoma (22.1 percent), and Texas (25.3 percent).

From: Nora Super Jones, EBRI



President Bush. There is considerable congressional support for increasing the deduction to 100 percent and making it permanent even in the absence of more comprehensive reform.

Workers covered by an employer health plan were most likely to receive an employer contribution to that plan if they were working for large firms. Estimated average annual employer contributions to employee or family plans ranged from \$2,002 in firms with 10-24 employees to \$2,213 in firms with 1,000 or more employees (see table 35).⁶

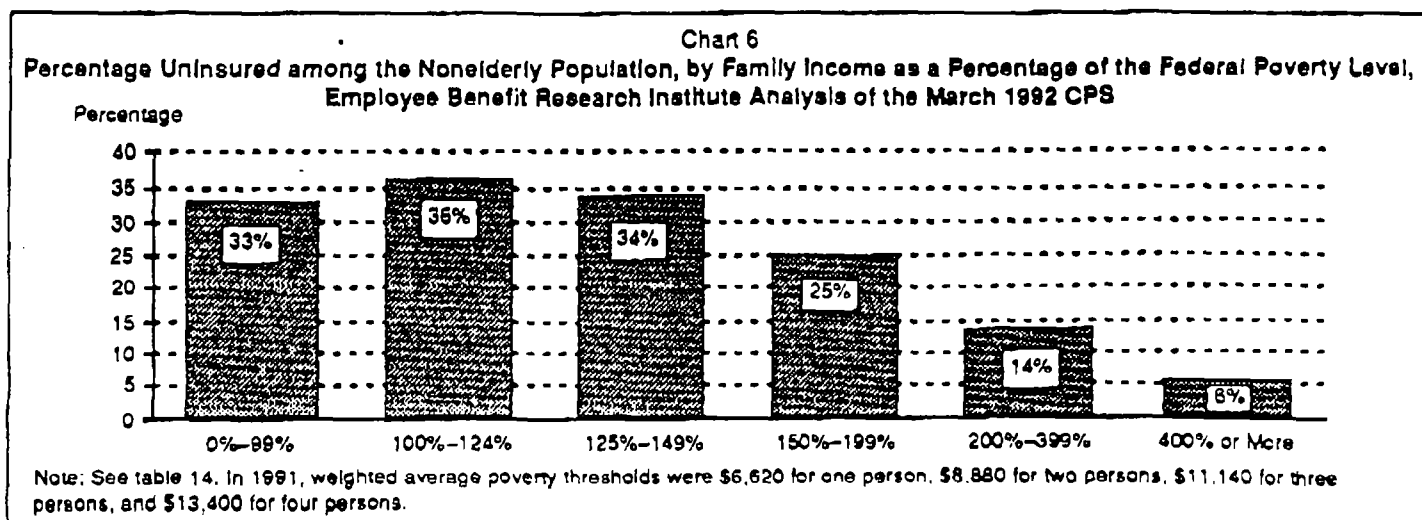
Income

The uninsured are concentrated disproportionately in low-income families. In 1991, 54 percent of the uninsured were in families with income under \$20,000 annually (see table 11). Thirty-four percent of individuals in families with income less than \$5,000 were uninsured, compared

with only 6 percent of those in families with income above \$50,000. Generally, as income increases, the percentage of the population without health insurance decreases, the percentage covered by private health insurance increases, and the percentage covered by publicly financed health insurance programs decreases. However, because of the impact of the Medicaid program, the percentage uninsured among individuals with income slightly higher than the poverty line was greater than the percentage uninsured among those below poverty (chart 6) (see also table 14).⁷ Medicaid currently

⁶ Ibid.

⁷ Medicaid eligibility levels are set by individual states and vary from 19 percent of the federal poverty rate in Alabama to 77 percent of the federal poverty rate in Alaska. About two-thirds of the states have higher income eligibility thresholds for "medically needy" persons. All states are required to provide Medicaid coverage to pregnant women and children up to age 6 if their income is less than 133 percent of the federal poverty level. In addition, states must cover children born after September 30, 1983, in families with income below the poverty level.



PENNSYLVANIA MEDICAID PROGRAM

The Medicaid, or Medical Assistance Program, as its known in Pennsylvania, purchases health care for low-income individuals who have no means to pay for it.

Eligibility

In fiscal years 1990-1991, there were over 1.35 million persons eligible for benefits through the Medical Assistance Program. This was an 8.9 percent increase over the 1.25 million eligible in fiscal 1989-1990. Fifty-seven percent were members in the Aid to Families with Dependent Children (AFDC), 21 percent were General Assistance (GA) and State Blind recipients, 19 percent were disabled persons eligible through Supplemental Security Income (SSI), and 3 percent were Healthy Horizons (HH) recipients.

Benefits

Pennsylvania's medical assistance program mandatory services are listed in an attached chart.

Programs of the Medical Assistance Program

The Pennsylvania Medical Assistance Program offers prepaid capitation programs which provide comprehensive medical services to eligible recipients. This includes the HealthPASS program, a Health Insuring Organization located in Philadelphia, five health maintenance organizations and one community health center.

Because the capacity for Medical Assistance recipients in HMOs is limited, the Department expanded recipient participation in prepaid capitated programs by establishing Health Insuring Organizations (HIOs). The HIO program replaced fee-for-service for approximately 81,000 recipients in south and west Philadelphia. There are Medicaid managed care organizations in Pittsburgh, Harrisburg, and Philadelphia.

The basic principles and incentives of prepaid capitation programs apply equally to both Health Maintenance Organizations and Health Insurance Organizations. The programs differ in that HIOs are fiscal agents that administer the delivery of services to Medical Assistance recipients, while a HMOs both administer and provide services to all income groups.

Federal waivers were required to establish the Health Insuring Organization. In 1985, such waivers were granted so that the Health Insuring Organization demonstration project could be implemented.

HealthPASS in Philadelphia was established through this process and attained full enrollment in 1986. The program serves a 100 percent Medicaid population. Ostensibly, all services covered under the fee-for-service program continue to be available to these recipients.

Healthcare Management Alternatives, Inc.(HMA) replaced the Penn Health Corporation as the contractor responsible for operating the HealthPASS program on July 1, 1989.

Statewide, 227,000 or 15 percent of Medicaid recipients are in managed care; the majority are in the Philadelphia area.

Capitated rates are 90-95 percent of fee-for-service costs. Estimated savings to the state in 1991 were \$36 million.

The Philadelphia Inquirer

Monday, January 18, 1993

Mercy's millions

HMOs for the poor need some fine tuning

Pennsylvania Welfare Secretary Karen Snider says one of her "highest agendas" is to channel hundreds of thousands more welfare recipients into managed-care health plans. The rationale? Quality care at cheaper prices — a claim proven by experience and the inadequacies of alternatives like Medicaid mills and emergency rooms.

The question today is no longer whether HMOs should be pursued: They can clearly help stretch the public health-care dollar in a state that's projecting a \$40 million deficit in its Medicaid program this year — and provide adequate care.

The question is whether Harrisburg — always quick to throw rocks at the city's management of state welfare funds — can meet the challenge that the move to HMOs imposes on its own torpid bureaucracy.

That question came up loud and clear in a recent article by Inquirer staff writers Gilbert M. Gaul and Walter F. Roche Jr. regarding the Philadelphia area's Mercy Health Plan, a welfare HMO serving about 70,000 people. For nearly a decade, the state poured money into the non-profit HMO, never asking for an audit — never apparently wondering whether it was getting good value or subsidizing someone else's agenda.

When that audit finally came in this spring, it was an eye-popper. Part of the news was terrific: Pennsylvania paid the plan 10 percent less than the going Medicaid rate, and its patrons got more care — non-mandated eyeglasses and dental work, for example. The theory behind HMOs proved out. But there was this unsettling reality as well: Mercy's HMO piled up about a \$40 million profit in the last five years, using a big chunk of the surplus to expand a hospital in suburban Haverford.

The most egregious detail: Mercy was able to take the state's payment of \$20 a month per member for mental-health services and find a subcontractor to provide the services for \$6.75 a member, reaping a \$10 million-a-year windfall.

At a time when growing numbers of Pennsylvanians desperately need Medicaid to help them through the recession, we need the biggest bang from every health-care buck.

Merely creating HMOs and walking away from them, obviously, doesn't accomplish that goal.

As the Welfare Department does a mid-course correction — it is currently negotiating tighter terms — Ms. Snider ought to take a page from Mercy's book: Shop smart for the best health deals at the best price.

Friday, January 8, 1993

50 cents outside the region

Temporary pact will ease impact of Medicaid cuts

DPW agreed to liberalize the cap on prescriptions, loosen dental restrictions and reinstate certain drugs.

By Amy S. Rosenberg
INQUIRER STAFF WRITER

A temporary agreement was reached yesterday that will ease some of the harshest consequences of newly enacted cuts and restrictions in the state's Medicaid program.

Under the agreement, the state Department of Public Welfare agreed to liberalize the cap on prescriptions, loosen restrictions in dental coverage and reinstate certain classes of drugs that had been excluded from Medicaid coverage.

The settlement grew out of a class-action lawsuit filed by Community Legal Services. The suit seeks to

restore cuts that went into effect on Jan. 1 in the state medical program, which serves more than 730,000 people.

The lawsuit challenges the Casey administration's plan to restrict a range of services, including doctor visits and prescriptions, on the grounds that the restrictions violate federal protections under the Americans With Disabilities Act and the due-process guarantees of the 14th Amendment.

Under the cuts implemented by Gov. Casey, projected to save \$12 million by June 30, about 150,000 recipients covered by the state-funded gen-

eral assistance plan are allowed no more than 18 visits to physicians per year and three prescriptions per month.

The state also stopped Medicaid coverage for certain drugs, and limited home-health care visits and in-patient treatment for drug addiction and alcoholism. It also placed limits on emergency room care.

The settlement, read yesterday before U.S. District Court Judge John R. Padova by John A. Kane, chief counsel for the state Department of Public Welfare, includes these five points:

- Four types of drugs which had been cut from coverage were reinstated: immunosuppressors, gastrointestinal drugs, hormones and steroids.
- The department has agreed that

dental emergencies will include root canal and other urgent work, not just fillings and extractions. All denture work that began before the cuts took place Jan. 1 will be completed and paid for.

- The cap on prescriptions to three per month was eased somewhat. The state agreed to send six months' worth of prescription vouchers in the next two to three weeks, instead of nine now and nine in March.

- Additional notices will be sent out to patients and providers to clarify the cuts, who is affected by them and the most recent adjustments covered by the settlement.

- Because some state residents have been mistakenly subjected to the new restrictions and given new identification cards that erroneously limited their coverage, the state has

agreed to refund the additional co-payments those people have been assessed. Under the cuts, co-payments doubled from \$1 to \$2 for doctor visits and prescriptions, and from \$7 to \$14 a day for hospital stays. Under yesterday's agreement, the state pledged that anyone miscategorized will receive a new identification card within 24 hours of notifying the state of the error.

The agreement is effective for 120 days. A trial date was set for April 26, but both sides said they hoped a permanent settlement could be worked out before that time.

"It's not all of what we wanted," said Richard P. Weishaupt, a lawyer with Community Legal Services. "But it will address many of the most dire emergencies that could have arisen."

STATEWIDE AND LOCAL INITIATIVES

Wyoming Valley Health Care Systems, Inc.

This non-profit health delivery system with multiple subsidiaries provides a full range of quality healthcare services to meet family's need from caring for the newborn to the elderly. It also promotes and sponsors health education.

Partnership for Community Health in the Lehigh Valley

The partnership for Community Health in the Lehigh Valley is an effort to collaboratively plan how the health status of the region's population can be enhanced while decreasing the costs of delivery of health services and simultaneously improving access to care for those with the greatest need.

The members of the partnership are the seven hospitals serving the region, the Lehigh and Northampton county medical societies, and the Trustees of the Dorothy Rider Pool Health Care Trust.

Their goals for the year include: a regional health status assessment, improving the health of children, using Medicaid funds to enhance access to care for low-income families and individuals.

Lancaster County Task Force on Health Care

This group has put together a coordinated care system for Medical Assistance recipients in Lancaster County. It has the support of the community, the Dept. of Public Welfare and the Health Care Financing Administration. Three local hospitals have each donated \$50,000 to develop a database for the program. Savings to the Commonwealth are projected at 10-20 percent.

The coordinated program contains several initiatives: (1) a computerized network (consisting of patient health information) to link all major providers of Medicaid services, (2) primary care physicians will act as case managers and will receive a set case management fee per patient per month in addition to fee-for-service reimbursements, (3) the installation of a telephone advice service for patients, (4) incentives for Medical Assistance recipients not to use emergency services if unnecessary.

Children's Health Insurance Act

This bill was signed into law on December 2, 1992. The act establishes a public-private insurance program that will provide health care to 300,000 uninsured children.

The fund, totalling approximately \$21.5 million is supported through a two cent increase in the cigarette tax.

Elements of the bill include the following:

- * The program will be administered by Blue Cross/Blue Shield under the direction of the state insurance and health departments.
- * The program will offer free or low-cost health insurance for children from families with annual incomes up to \$32,782 for a family of four (235 percent of the federal poverty level (FPL)). Specific levels of coverage and payment requirements are:
 - 100 percent of the FPL. The program will extend health coverage at no charge to children up to the age of 12 in families earning up to 100 percent of the FPL (\$13,950 per year for families of four).
 - 185 percent of the FPL. Coverage will be provided at no charge to children up to age six living in families earning up to 185 percent of FPL (\$25,807 per year for a family of four).
 - 185 percent to 235 percent of the FPL. Coverage will be provided at 50 percent of cost to children up to age six living in families earning between \$25,807 and \$32,782 per year. Such families would receive a 50 percent subsidy and would pay annual premiums of approximately \$450 per year per child.

This bill also contains the following provisions to improve that availability of primary care in medically underserved areas:

- * The bill appropriates \$1.25 million to recruit, train, and retrain primary care physicians in underserved areas.
- * The bill creates a loan forgiveness program for primary car physicians, dentists, physician assistants, nurse practitioners, and nurse midwives who agree to practice in medically

underserved areas in Pennsylvania for three years.

- * The bill authorizes the Department of Health to provide challenge grants to medical schools and communities to help place primary care professionals and develop clinics.

Child Medical Support Law

On December 4, 1992, Governor Casey signed a child medical support law. The legislation grants the courts the authority to order separated and divorced parents, whether or not they are charged with custody, to provide health insurance for their children.

Insurance Carrier Initiatives for Low Income and Small Group Markets.

Blue Cross/Blue Shield offers subsidized plans to low income individuals, notably working uninsured, that provides comprehensive preventive care and standard acute care for children.

The Blues have applied to administer the new Child Care Health Bill.

Blue Cross/Blue Shield provides insurance to small groups. For all plans, the premiums are not age-adjusted and are available to all Pennsylvanians without regard to health status. For new enrollees, most plans do include a one-year pre-existing condition exclusion waiting period. Eric Brenner from the Pennsylvania Insurance Department thought that Governor Casey would propose legislation this year that would mandate a core benefit package and be community-rated.

Uniform Billing Form Law

This law, enacted last year, provides a uniform billing form for all carriers based on the HCFA designed form. Medicaid is not required to use the form; it would do so with various modifications.

Childhood Immunization Act

In 1991, there were 1,448 cases of measles and eight deaths in Pennsylvania. In 1992, Pennsylvania passed the Childhood Immunization Act. The new legislation required health insurance policies to pay for the cost of immunizations against childhood diseases as measles, mumps, whooping cough, rubella, polio and diphtheria. No deductibles or dollar limits will apply, although

it could be subject to co-payments and co-insurance requirements.

Coverage for Mammograms and Consumer Protection for Long-term
Care Insurance

A new law enacted in 1992 requires health insurance policies to cover the cost of screening mammograms for women age 40 and over. The law also stipulates that insurance companies must pay for mammograms for women under age 40, if a physician recommends it.

Another aspect of the legislation protects older people from unfair and deceptive enrollment practices of providers of long-term care insurance.

Health Care Cost Summit

3537 West 12th Street • Erie, Pennsylvania • 165
814/833-3200 • FAX 814/833-4844

HEALTH CARE COST SUMMIT FAST FACTS

- ESCALATING HEALTH CARE COST IS THE MOST PRESSING ISSUE FOR THE '90S. THERE IS GENERAL AGREEMENT THAT SOMETHING MUST BE DONE, HOWEVER; NO ONE PERSON OR GROUP KNOWS EXACTLY WHAT THAT "SOMETHING" IS. THE GENERAL CONSENSUS IS THAT HEALTH CARE COST IS A NATIONAL ISSUE AND SHOULD BE RESOLVED AT THE NATIONAL LEVEL. IN THE ERIE COMMUNITY, THERE IS A GROWING BELIEF THAT THIS IS, IN FACT, A COMMUNITY ISSUE AND MUST BE ADDRESSED AND RESOLVED ON A COMMUNITY LEVEL.
- ON JANUARY 16, 1992, THE ERIE COMMUNITY SPONSORED A HEALTH CARE COST SUMMIT. FOR THE FIRST TIME, ALL THE MAJOR STAKEHOLDERS OF THIS ISSUE-HEALTH CARE PROVIDERS, INSURANCE COMPANIES, EMPLOYERS, UNION LEADERS AND POLITICIANS- MET TO FORMULATE A COMPREHENSIVE STRATEGY TO ADDRESS HEALTH CARE COSTS IN ERIE. THESE STAKEHOLDERS CAME TOGETHER NOT TO PHILOSOPHICALLY DISCUSS HEALTH CARE COSTS OR TO ASSESS BLAME. THEY CAME TOGETHER TO ATTACK A COMMON ECONOMIC THREAT TO ERIE- SPIRALING HEALTH CARE COSTS.
- AS A RESULT OF SUMMIT I, FOUR COMMITTEES WERE FORMED TO ADDRESS THE FOLLOWING TOPICS:
 - 1- DETERMINE WHAT WE- THE ERIE COMMUNITY- REALLY WANT FROM OUR REGION'S HEALTH CARE SYSTEM.
 - 2- DETERMINE THE LEGAL/LEGISLATIVE PROBLEMS THAT MIGHT PREVENT OR BECOME AN OBSTACLE TO COLLABORATIVE EFFORTS.
 - 3- DETERMINE THE LESSONS TO BE LEARNED FROM PREVIOUSLY SUCCESSFUL AND UNSUCCESSFUL COLLABORATIVE EFFORTS.
 - 4- DEVELOP A MENU OF WHAT COLLABORATIVE EFFORTS MIGHT OCCUR.
- THE INFORMATION GATHERED BY THESE FOUR COMMITTEES BECAME THE SUBSTANCE OF HEALTH CARE COST SUMMIT II HELD ON JUNE 30, 1992. SUMMIT II ALSO ALLOWED FOR A GROWING REPRESENTATION AT THE SUMMIT OF COMMUNITY LEADERSHIP. THE EVER GROWING INTEREST IN AND COMMITMENT TO A PROCESS, SUCH AS THE SUMMIT, DEMONSTRATES THE SIGNIFICANCE OF THE HEALTH CARE COST ISSUE TO ERIE. THE SECOND SUMMIT PARTICIPANTS AGREED TO:
 - 1- FORM A COMMUNITY HEALTH CARE NEEDS TASK FORCE
 - 2- FORM AN ANTI-TRUST/TORTE REFORM TASK FORCE
 - 3- FORM AN ADVISORY COMMITTEE COMPRISED OF SUMMIT PARTICIPANTS

Health Care Cost Summit

3537 West 12th Street • Erie, Pennsylvania • 16505
814/833-3200 • FAX 814/833-4844

- 4- HIRE A SUMMIT ADMINISTRATOR
- 5- SCHEDULE A THIRD SUMMIT NO LATER THAN SIX MONTHS FROM THE SECOND SUMMIT DATE.

- ON JANUARY 12, 1993, HEALTH CARE COST SUMMIT III WILL CONVENE. ONCE AGAIN, INTEREST GENERATED BY THE SUMMIT CONCEPT HAS BROADENED THE PARTICIPANTS LIST. SUMMIT III WILL BRING TOGETHER DECISION MAKERS FROM HEALTH CARE, EDUCATION, INDUSTRY, LABOR, INSURANCE AND POLITICS.

- PLEASE REFER TO THE ATTACHED AGENDA FOR A LIST OF THE TOPICS TO BE PRESENTED AT HEALTH CARE COST SUMMIT III.

List of
Invited
Participants

Gerald Alonge
Anthony Andrezski
John Ayrnong
Gene Barone
F. Brad Biggar
Karl Boyes
Joseph Borgia
Harry Brown
Pat Bruno
Atty. Donald Buseck
Italo Coppabianca
Robert Casey
Robert Cisler
Allan Concohy
Donald DiPlacido
Dr. David Doupe
Dr. Richard Dreyfus
Mary Eckert
Martin P. Eisert
Thomas Foley
Dr. John Fleischauer
William Fox
James Freeman
J. B. Frith
Dr. Teresa Fryer
Dr. Yen Jen Fuh
Frank Gerlach
Chester Giermak
Thomas Hagen
Corrine Halperin
Sister Margaret Ann Hardner
Robert Harrison
Dr. David D. Howell
Dr. William Garvey
Thomas Hoffman

Dr. David A. Klees
Deanna Klein
Linda Bebko Jones
Fiore Leone
Dr. John Lauenberger

Horizon Joint Venture
State Senator (49th District)
American Sterilizer Co.
Blue Cross of Western Pennsylvania
International Paper
State Representative (3rd District)
Erie City Council
EBC Industries, Erie Ball Division
AFL-CIO
Erie County Bar Association
State Representative (2nd District)
Governor
VA Hospital
Erie Forge & Steel
Erie Chamber of Commerce
Hamot Health Foundation
Saint Vincent Health Center
Millcreek Community Hospital
Erie Insurance Group
Department of Labor and Industry
Edinboro University
Great Lakes Rehabilitation Hospital
Lorit Corporation
Metro Health Center
Metabolic Disease Associates, Inc.
VA Hospital
Saint Vincent Health Center
Eriez Magnetics
Erie Insurance Group
NW PA Area Labor Mgt. Council
Saint Vincent Health Systems
JFK Minority Development Enterprises
Erie County Medical Society
Mercyhurst College
Erie Conference on Community
Development
Metro Health Center
Fairview Manufacturing Corporation
State Representative (1st District)
Erie County Council
Intermediate Unit #5

John O'Brien
Judy Lynch
Cynthia Maleski
Ronald Mangine
Dr. William Makarowski
Joseph Marchini
Raymond McGarvey
Cameron McGinnis
Michael Mead
James Merry
Ronald Mong
Robert Molsinger
Louis Musante

Robert Nardelli
James Nelson

John Peterson
Louis Pollock
Ralph Ramlila

Bruce Raimy

Thomas Ridge
Denise Robison
M. Shawn Rooney
Msgr. David Rubino
Joyce Savocchio
George Schafeld

Thomas Scrimenti
Sydney Smith
Arlen Specter
Dr. John Tedesco
John Tramontano
Philip Tredway
Atty. Michael Visnosky
Fred Williams
Benjamin Wiley
Thomas Wedzik
Harris Wofford
William Wollgemuth

Hamot Health Foundation
Erie County Executive
State Insurance Commissioner
General Electric Company
Great Lakes Rehabilitation Hospital
Metro Health Center
Saint Vincent Health Systems
Erie County Department of Health
Times Publishing Company
State Representative (5th District)
Mong Dairy Company
General Electric Company
Westminster Manufacturing
Corporation
General Electric Company
United Electrical, Radio and
Machine Workers of America
State Senator (25th District)
Morris Coupling Company
Manufacturer's Association of
Northwest Pennsylvania
Erie Conference on Community
Development
U.S. Congressman (21st District)
Erie City Council
Niagara Plastics Company
Gannon University
Mayor, City of Erie
Coalition for Health Cost
Containment
State Representative (4th District)
Union City Chair Company
U.S. Senator
Millcreek Community Hospital
Teledyne Penn-Union
Erie Molded Plastics, Inc.
Millcreek Community Hospital
Martin Luther King Center
GECAC
Banking Clearinghouse
U.S. Senator
The Travelers



THE HOSPITAL ASSOCIATION OF PENNSYLVANIA

John A. Russell
President

1750 Lindle Road, P.O. Box 8600
Harrisburg, PA 17105 8600
(717) 564 9200
FAX (717) 561-5333

February 9, 1993

The Honorable Harris Wofford
283 Russell Senate Office Building
Washington, DC 20510

Dear Senator Wofford:

As a follow up to the information your staff requested when we met with you in Washington last week, I am listing examples of demonstration projects that our association's Pennsylvania Health Care Vision 2000 project has recognized for leadership in health care reform and improving the health status of Pennsylvania citizens that are consistent with the vision, values, and goals of our statewide effort.

I would be happy to highlight three or four of these demonstration projects at the Pennsylvania Health Conference you are conducting on Thursday, February 11, if you consider it appropriate for your agenda.

1. A county-wide rural health care delivery model--Laurel Health System, Tioga County - Contact person: Robert H. Morris, President and Chief Executive Officer, (717) 724-1631
2. The Lehigh Valley Community Health Partnership--Project Director: Michael Felix, (215) 366-0736. This project was initially sponsored by the Pool Trust and has emerged as a community-wide health care reform initiative whose priorities include improved services to children in the Lehigh Valley and creating a demonstration site for Medicaid reform.
3. The Capital Region Health Futures Project--Contact person: Donald A. Mazzlotti (717) 731-0701. This project was launched January 1, 1993, under the sponsorship of the Capital Region United Way. The project is based in part on the model established by health futures for Rochester, New York--a private sector initiative undertaken to achieve community consensus and actions which will assure accessible, appropriate, and affordable care in the greater Harrisburg area.
4. Crozer-Keystone Health System Status Assessment Project--Contact person: John C. McMeekin, President (215) 892-8003. This in-depth study of the Delaware County health care status and needs is serving as the baseline for developing a health care delivery system designed to improve the

The Honorable Harris Wofford
 February 9, 1993
 Page 2

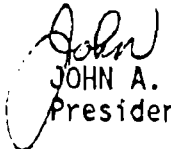
health status of the community and reposition the hospital to become part of the fabric of the community by offering cost-effective programs and services to meet community need.

5. The Latino Project, Philadelphia--Contact person: John E. Flood, President, Delaware Valley Hospital Council (215) 735-9423.
6. The Healthy Communities Project, Western Pennsylvania--Contact person: Jack C. Robinette, President, Hospital Council of Western Pennsylvania, (412) 776-6400.
7. The Magee Women's Community Outreach Network--Contact person: Irma Goertzen, President, Magee Women's Hospital (412) 647-1000.
8. Western Pennsylvania School-Based Clinics Projects--Contact person: Jack C. Robinette, President, Hospital Council of Western Pennsylvania, (412) 776-6400.
9. Coordinated Care Programs for Worker's Compensation--A variety of projects have been initiated throughout Pennsylvania to improve service and lower the cost for worker's compensation activities. Health care institutions that have assumed leadership in this effort include:
 - Geisinger Medical Center, F. Kenneth Ackorman - President (717) 271-6211;
 - Capital Health System, John S. Cramer - President and Chief Executive Officer (717) 231-8200;
 - Polyclinic Health System, Stephen H. Franklin - President (717) 782-2606;
 - Main Line Health, Douglas S. Peters - President and Chief Executive Officer (215) 254-8840; and
 - Harmorville Rehabilitation Center, Inc., David R. Hirsh - President and Chief Executive Officer (412) 828-1300.
10. Medicaid demonstration projects:
 - Lancaster area primary care case management project
 - Philadelphia area health insuring project
 - Health partners HMO project

The Honorable Harris Wofford
February 9, 1993
Page 3

11. Allegheny and Philadelphia County Immunization Projects--County-wide efforts to insure that children receive appropriate immunizations. Contact persons: Jack C. Robinette, President, Hospital Council of Western Pennsylvania, and John E. Flood, President, Delaware Valley Hospital Council. (See No. 5 and No. 8 above for telephone numbers.)

Sincerely,


JOHN A. RUSSELL
President

/pt

Briefing on Saidman Lecture

FACT SHEET

Paul, Dr.

EVENT: The First Annual Nathan and Sarah Saidman Lecture

PLACE: Thomas P. Saxton Medical Pavilion
Edwardsville, PA

DATE: November 17, 1992

TIME: Tuesday evening, 6:00 p.m. Cocktails
7:15 p.m. Presentation
with general reception thereafter

TOPIC: "The Future of the Healthcare System"

PRESENTER: The Honorable Harris Wofford
United States Senator for Pennsylvania

AUDIENCE: Cross section of professionals within our community: Business, Education, Government, Law, and Health, approximately 600 individuals invited to attend.

HISTORY: The Wyoming Valley Health Care System, Inc. is a non-profit health delivery system with multiple subsidiaries that provide a full range of quality healthcare services to meet a family's evolutionary needs from the nurturing of the newborn to the care of the elderly.

An additional role of this inclusive healthcare system is to promote and sponsor health education. An Endowment Fund was recently established by a prestigious member of Wilkes-Barre General Hospital's medical staff to assist this important function.

Dr. Lester Saidman, an outstanding physician and citizen of this community, created the series of annual educational lectures as a vehicle to inform the medical community and other community leaders regarding future developments that may impact the delivery of healthcare.

This progressive educational resource will appeal to physicians and the public alike, support our role to ensure the availability of continuing medical education programs, and notably serve as an ongoing vehicle to bring current medical developments to our Wyoming Valley.

Dr. Saidman designated this lecture series in memory of his father, Nathan, and in honor of his mother, Sarah, who is now 100 years old and quite pleased with his thoughtful gesture.

Dr. Saidman, as a respected member of the Wilkes-Barre General Hospital Medical Staff for nearly 44 years, has admirably served his colleagues, his patients, the Wilkes-Barre General Hospital, and our community. The Nathan and Sarah Saidman Lecture Series admirably demonstrates that continued commitment.

RESERVED SEATING - FIRST ROW

(Left to Right)

Steven C. Bjelich, Executive Director, Wilkes-Barre General Hospital

Ron Stern, President and C.E.O., Wyoming Valley Health Care System, Inc.

John D. McCarthy, Chairman, Board of Directors, Wyoming Valley Health Care
System, Inc.

The Honorable Harris Wofford, United State Senator for Pennsylvania

Lester M. Saidman, M.D.

Mrs. Carol Saidman Greenwald

David Greenwald, M.D.

Bruce Saidman, M.D.

Mrs. Melissa Saidman

Sheila Saidman, Esquire

Mr. Philip Krauss

Mr. Allan Saidman

SAIDMAN LECTURE SERIES
PROGRAM FORMAT

WELCOME..... Carol Saidman Greenwald

REMARKS..... Ron Stern
President and C.E.O.
Wyoming Valley Health Care
System, Inc.

INTRODUCTION..... Sheila Saidman, Esquire

PRESENTATION. "The Future of the Healthcare System".. The Honorable Harris Wofford
United States Senator
for Pennsylvania

CLOSING REMARKS..... John D. McCarthy
Chairman
Board of Directors
Wyoming Valley Health Care
System, Inc.

RECEPTION

FLOW FOR PROGRAM

CAROL SAIDMAN GREENWALD - Welcome, Introduces Mr. Stern.

MR. STERN - Remarks.

- Calls Sheila Saidman forward

SHEILA SAIDMAN - Introduces Senator Wofford and his topic.

SENATOR WOFFORD - "The Future of the Healthcare System"

(20 min. presentation)

(20 min. question & answer)

MR. MCCARTHY - Presents plaque to Senator Wofford.

- Calls Dr. Bruce Saidman and Dr. David Greenwald forward;
they present a surprise plaque to Dr. Lester Saidman on
behalf of the Medical Staff recognizing nearly 44 years of
service.

MR. MCCARTHY - Comes forward to close, to say thank you, and to invite
everyone to enjoy the reception which follows.

as of 11-12-92

The First Annual

NATHAN AND SARAH SAIDMAN
LECTURE

*In Honor of Sarah Saidman
In Memory of Nathan Saidman*

Tuesday, November 17, 1992
Thomas P. Saxton Medical Pavilion

A REMEMBRANCE

In Loving Memory
of

Mrs. Bertha Bishop Saidman

who passed away
August 3, 1992

THE
NATHAN AND SARAH SAIDMAN LECTURE
TUESDAY, NOVEMBER 17, 1992

PROGRAM

Welcome

Carol Saidman Greenwald

Remarks

Ron Stern

*President and Chief Executive Officer
Wyoming Valley Health Care System, Inc.*

Introduction

Sheila Saidman, Esquire

Presentation

*The Honorable Harris Wofford
United States Senator for Pennsylvania
"The Future of the Healthcare System"*

Closing Remarks

John D. McCarthy

*Chairman, Board of Directors
Wyoming Valley Health Care System, Inc.*

Reception

THE NATHAN AND SARAH SAIDMAN
LECTURE SERIES

The Wyoming Valley Health Care System, Inc. is a non-profit healthcare delivery system with multiple subsidiaries that provide a full range of quality healthcare services to meet a family's evolutionary needs from the nurturing of the newborn to the care of the elderly.

An additional role of this inclusive healthcare system is to promote and sponsor health education. An Endowment Fund was recently established by a prestigious member of Wilkes-Barre General Hospital's medical staff to assist this important function.

Dr. Lester Saidman, an outstanding physician and citizen of this community, created the series of annual educational lectures as a vehicle to inform the medical community and other community leaders regarding future developments that may impact the delivery of healthcare.

This progressive educational resource will appeal to physicians and the public alike, support our role to ensure the availability of continuing medical education programs and notably serve as an ongoing vehicle to bring current medical developments to our Wyoming Valley.

Dr. Saidman also designated this lecture series in memory of his father, Nathan, and in honor of his mother, Sarah, who is now 100 years old and pleased with his thoughtful gesture.

Dr. Saidman, as a respected member of the Wilkes-Barre General Hospital Medical Staff for nearly 44 years, has served his colleagues, his patients, the Wilkes-Barre General Hospital and our community. The Nathan and Sarah Saidman Lecture Series admirably demonstrates that continued commitment.

THANK YOU TO

The Honorable Harris Wofford and Staff

*The Nathan and Sarah Saidman Lecture Series
Planning Committee*

*Co-Chairpersons
Carol Saidman Greenwald
Sheila Saidman, Esquire*

*Robert Brown, M.D.
Alfred D'Anca, M.D.
Patricia Finan
David Greenwald, M.D.
Philip Krauss
John D. McCarthy
Bruce Saidman, M.D.
Lester M. Saidman, M.D.
Melissa Saidman
Albert Schiowitz, M.D.*

Lynn R. Keiser, Supreme Cuisine

Our Honored Guests

LESTER M. SAIDMAN, M.D.

An innovative leader, willing teacher, trusted physician and friend. These attributes best describe the many talents of Lester M. Saidman, M.D., whose academic appointments and subsequent accomplishments pay tribute to his 50 years of outstanding service to countless patients, aspiring medical students, and fellow physicians.

Dr. Saidman received his Medical Degree from Temple University Medical School in 1942 and completed an internship at Wilkes-Barre General Hospital in 1943. He served as a medical officer from 1943 to 1946 in World War II including overseas service in Hollandia, the Phillipines and Japan.

Appointed to Wilkes-Barre General Hospital's Department of Medicine in 1949, Dr. Saidman was named an Associate in Medicine in 1951 and in 1954, he formed a partnership group and reorganized the Lake Noxen Clinic to provide comprehensive healthcare for families in that area.

In 1969, he was named Chief of Service and Director of Medical Education at Wilkes-Barre General Hospital, where he was responsible for externship and internship programs for medical students, as well as planning programs for seminars. He established the fifth and sixth pathway groups for the American graduates of foreign medical schools. Dr. Saidman conducted teaching rounds for over 20 years.

Dr. Saidman serves as the Associate Medical Director of the Northeastern Division of the International Ladies Garment Worker's Union.

He held the position of Medical Director of Rural Health Corporation for Luzerne County from October 1970 through 1975.

Dr. Saidman was appointed Director of the first Physician Assistant Training Program in Pennsylvania in February 1971, and has been a speaker and adviser at various seminars and programs concerning the course. He is a member of the Pennsylvania Medical Society and the American Medical Association, and has served in all offices including President of the Wyoming County Medical Society.

Dr. Saidman was active in the original planning of the Hahnemann-Wilkes program and was appointed to a teaching position in 1973 as an Associate Professor in the Department of Medicine at Hahnemann. He was named a Diplomat of the American Academy of Family Practice, and Director of the Physician's Assistant Program at King's College. Dr. Saidman served as Medical Staff President at Wilkes-Barre General Hospital from 1977 to 1979.

Today, Dr. Saidman cares for his patients as a family practitioner with the Linden Medical Group while continuing his efforts to enhance medical education.

SENATOR HARRIS WOFFORD

Harris Wofford brings a lifetime of public service to his role as Pennsylvania's United States Senator. He has served as a special assistant to President John F. Kennedy, an adviser to Dr. Martin Luther King, as one of the founders of the Peace Corps and as president of both a public and a private college. He has also been a leader for more than two decades in the movement to make citizen service the common experience of America's young people.

Wofford was sworn in to the United States Senate on May 9, 1991 after he was appointed by Governor Robert P. Casey to the seat formerly held by the late Senator John Heinz.

In a special election held on November 5, 1991 Senator Wofford won a landslide 340,000-vote victory over former Pennsylvania Governor and U.S. Attorney General Dick Thornburgh. In winning the right to complete a three-year unexpired term, Senator Wofford became the first Democrat to be elected Pennsylvania Senator since Joe Clark in 1962.

Senator Wofford's upset victory became a national and international news event and helped bring a new attention to key issues facing American families: the skyrocketing cost of healthcare, the decade of stagnant incomes of the middle class, the need for fair trade laws and for federal action to help all Americans prepare themselves to be productive workers and good citizens.

Until his appointment, Senator Wofford served for over four years as Pennsylvania's 29th Secretary of Labor and Industry. His central focus as a member of the Governor's cabinet was on creating new jobs and new opportunity in Pennsylvania's economy, primarily by building on the historic strengths of the state's workforce: its skill, productivity and dedication.

After leaving the Peace Corps in 1966, Senator Wofford became founding president of the State University of New York's College at Old Westbury. From 1970 to 1978 he was president of Bryn Mawr College in Montgomery County, Pennsylvania.

He later joined the Philadelphia law firm of Schnader, Harrison, Segal & Lewis where he divided his time between private clients and public interest work. Prior to becoming state Secretary of Labor & Industry, Wofford was Democratic State Chairman during Robert P. Casey's winning gubernatorial campaign of 1986.

He resides in Bryn Mawr with his wife Clare, who was managing director for the University of Pennsylvania's 250th Anniversary Celebration. They have three children: Susanne, Daniel, and David, and three grandchildren, Gabriel and Nathaniel Leira, and Ben Wofford.

NATHAN & SARAH SAIDMAN

In Russia during the early 1900's, education was truly considered a luxury because it was virtually non-existent or unavailable to minority groups.

Nathan Saidman was just 20 years old when he emigrated from Russia to America to begin a new life. He began working as a carpenter prior to establishing a successful grocery business.

It was here that he met his future wife, Sarah, who journeyed from Russia at age 16 to also pursue opportunities in a new land. While working in the Ladies' Garment Industry, Sarah earned 10 cents an hour, which was considered a reasonable rate because one could purchase breakfast for a mere 5 cents, at typically 1 cent per item.

After they married, the Saidmans settled on a small farm in the west section of Ashley, known as Carey's Patch, and eventually relocated their family to Kingston.

They realized the value of education and struggled to save their money to provide a higher education for all of their children at a time when simply graduating from high school was considered an achievement.

The Lecture Series is dedicated by the Saidman family to both Nathan and Sarah to recognize their commitment to higher education.

Indeed, Nathan Saidman would have been pleased that this lecture series was established to honor his memory and provide a wide-range of educational topics for both medical professionals and the public alike.

Sarah Saidman, who is now approaching her 101st birthday, is pleased and honored by the establishment of this lecture series.

WILL ATTEND SAIDMAN LECTURE

Dr. Richard P. Abramowitz
Mr. and Mrs. Charles T. Adams
Mr. and Mrs. Stephen Alinikoff
Dr. Richard Alley
Dr. Joseph A. Anistranski
Mr. George Balla
Mr. and Mrs. Sandy Baltimore
Dr. and Mrs. David Barras
Mr. Stephen M. Barrouk
Mr. Raymond Bartosh
Mr. Justin Bergman, Jr.
Dr. and Mrs. Benjamin Berley
Mr. Richard J. Biscontini
Attorney and Mrs. Richard Bishop
Mr. Steven C. Bjelich
Dr. Richard Blum
Mr. John J. Bonchonsky
Dr. Christopher N. Breiseth
Mr. Edward P. Brennan
Attorney Cody Brooks
Dr. Frederic Brown
Mrs. Jane Brown and Spouse
Dr. Robert Brown
Dr. Robert Budin
Dr. William E. Burak
Dr. Michael Callahan
Dr. Thomas M. Campbell
Judge and Mrs. Gifford Cappellini
Dr. Thomas Castellano
Mrs. Denise Cesare
Dr. Demetrius Christoforatos
Dr. John Citti
Dr. Bill Clearfield
Mr. and Mrs. William H. Conyngham
Dr. Karen Cooper and Guy Bloch
Dr. and Mrs. George Cimochofski
Dr. and Mrs. Richard Coslett
Mr. William J. Crossin
Attorney Albert Danoff
Mr. and Mrs. Jeffery Davidowitz
Mr. and Mrs. David Davies
Dr. Gary R. Decker
Dr. Patrick DeGennaro
Dr. Thomas J. Delehanty
Dr. S. C. DePasquale
Attorney Michael J. Donohue
Mr. Thomas J. Dougherty
Dr. and Mrs. John H. Ellis, IV
Dr. Dorothy Farrell
Dr. and Mrs. Peter Feinstein
Dr. Herbert Fellerman
Dr. Michael Ferraro
Mr. and Mrs. Daniel J. Fierman

Ms. Patricia Finan
 Dr. Robert L. Fiorelli
 Mr. James Fitzgerald
 Dr. Martin L. Freifeld
 Dr. Jeff Fremont
 Dr. Martin Fried
 Dr. John Frye
 Mr. John F. Fulgoney
 Dr. Michael J. Gallagher
 Dr. Nestor T. Garcia
 Mrs. Lori Gerich
 Dr. Gerald Gibbons
 Mr. Robert P. Goodwin
 Mrs. Ruth Greenwald
 Dr. Loren Grossman
 Dr. and Mrs. Gerald Gunster
 Mr. Joseph C. Guyaux
 Attorney Andrew Hailstone
 Mrs. Elaine Halesey
 Dr. Thomas W. Hanlon & Spouse
 Dr. Ronald Harris
 Ms. Karen Hoban and Wayne Pontieri
 Mr. Paul Holdren
 Attorney Alan and Debbie Hollander
 Dr. William Hottenstein
 Mr. Edward P. Hourigan
 Dr. and Mrs. Irvin Jacobs
 Dr. Albert Janerich
 Mr. Henry Janoski
 Dr. Mark R. Katlic
 Mr. and Mrs. Robert A. Kaufer
 Dr. Eugene Kaczorowski
 Mrs. Mary Ann Keirans
 Mr. and Mrs. Larry S. Keiser
 Dr. Edward Kelly
 Mr. Jay Kelly
 Mr. and Mrs. Keith Kleinman
 Ms. Mary Beth Komnath
 Dr. Dan Kopen
 Attorney and Mrs. Joseph C. Kreder
 Dr. Charles A. Krivenko
 Dr. Victor Labbate
 Rev. James Lackenmier
 Mr. Richard F. Laux
 Mr. Robert Leonardi
 Dr. Joseph Litchman
 Dr. Diane Lowe
 Dr. Samuel J. Mackall
 Mr. and Mrs. Morris Malett
 Dr. Stephen Marcella
 Mr. John D. McCarthy
 Mr. William J. McCarthy, III
 Mr. Joseph McDonald

Mr. Edward McLaughlin
 Drs. William and Donna McLaughlin
 Mr. Michael Messersmith
 Mr. Edward P. Michael
 Dr. Richard Michelstein
 Dr. Kenneth Miller
 Mr. Michael Morgan
 Attorney John E. Morris, III
 Dr. Robert Morris
 Mr. Louis Myers
 Attorney and Mrs. Morey Myers
 Judge Peter Paul Olszewski
 Dr. Glenn Panzer
 Dr. Dwaraki Bai Penugonda
 Dr. Harry Penugonda
 Mr. David J. Plaviak
 Father Clement J. Podskoch, C.S.C. and Father Marc Fallow, C.S.C.
 Dr. David Potash
 Dr. Robert D. J. Potorski
 Dr. M. N. Prakash
 Dr. Lisa Rainey
 Mr. James E. Rakshys
 Dr. Sylvia Reich
 Dr. Michael Rittenberg
 Dr. Samuel V. Rizzo
 Dr. John Rogers
 Dr. and Mrs. John Rothschild
 Ms. Lisa Rowley
 Dr. William A. Rusin
 Mr. Allan Saidman
 Dr. Lester M. Saidman
 Ms. Marilyn Saidman
 Dr. Bruce and Mrs. Melissa Saidman
 Attorney Sheila Saidman and Mr. Philip Krauss
 Dr. Susan L. Salak
 Mr. and Mrs. Jack Savitz
 Mr. Thomas P. Saxton
 Mr. William H. Sayre, Jr.
 Mr. Conrad Schintz
 Dr. Albert Schiowitz
 Dr. Mark Schiowitz
 Dr. Norman Schulman and Rozanne Weinberger
 Dr. Joseph R. Sgarlat
 Attorney Robert P. Sheila, Jr.
 Mr. and Mrs. Judd Shoval
 Mr. and Mrs. Arthur Silverblatt
 Mr. Ed Sivelly
 Dr. and Mrs. William P. Smedley
 Dr. Richard M. Somma
 Mrs. Margaret R. Spencer and Spouse
 Mr. and Mrs. Ron Stern
 Mr. and Mrs. Wallace F. Stettler
 Mayor Joseph J. Stochla

Dr. Joseph J. Szustak
Mr. Brian Thomas
Dr. George C. Tsoutsoplides
Mrs. Rose Tucker
Attorney and Mrs. Murray Ufberg
Mr. William Wallick
Mr. Peter Warrington
Dr. Daniel F. Weisberger
Mr. Stanford L. Weiss
Mr. Brian Yeager - 211

ACCESS - Issues

- ◆ Managed Competition
- ◆ Benefit Packages
- ◆ Rural Health
- ◆ Long-term Care
- ◆ Service Delivery Reform
- ◆ Other Providers
- ◆ Training Programs
- ◆ Retirees
- ◆ Low-income Retirees

MANAGED COMPETITION AND UNIVERSAL ACCESS

Attached are materials discussing managed competition, purchasing cooperatives, the benefit package, and rural health care in relationship to access. Paul Starr's testimony before the Labor Committee addresses the role of purchasing cooperatives and universal access. Shoshanna Sofaer's Labor Committee testimony and Linda Bergthold (Princeton conference paper) focus on benefit package and universal access. The Kronick et al. New England Journal of Medicine article discusses managed care in rural areas.

Background

Universal access is an achievable goal. Countries like Germany, France, and Canada provide high-quality health care to all their citizens, yet spend a considerably smaller share of their nation's resources on health.

Universal access will not be free. Universal access will require major changes in the role of government, the structure of the health financing system, and the financial responsibilities of individuals and employers.

Managed competition would achieve universal coverage by mandating that all individuals buy health insurance, and share with their employers the cost of health insurance premiums.

Purchasing Cooperatives

The degree to which all individuals obtain insurance from the purchasing cooperative will have important consequences for access.

Paul Starr notes that substituting the purchasing cooperatives for individual employers as the means of access to health insurance will break the link between health insurance and work status (Paul Starr, Labor Committee testimony).

The more inclusive the purchasing cooperative the easier it will be for people to move from job to job or out of the work force without any loss or disruption of health coverage. This accomplishes the goal of national health insurance advocates while at the same time enhancing competition among private health plans.

By combining individual employers into large purchasing cooperatives, managed competition achieves several objectives: economies of scale, countervailing powers, expansion of choice, capacity to manage competition, implementation of global budgets.

Issues/Options

- How large do HIPC have to be in order to be effective? The following points were made by Larry Levitt at the Princeton Conference last fall.
 - o The HIPC needs to be large enough to represent a broad spectrum of health risk and income levels, so that it is the predominant source of health coverage in the community, to control enough of the market so that it cannot be ignored.
 - o A rough analysis indicates that a cutoff equivalent to half the working population might be considered minimally acceptable for effective purchasing cooperative in most regions, while a cutoff equivalent to 75 percent of employees would be preferred.
 - o Based on the breakdown of employment in the U.S. by size of firm, these decision rules would translate into a minimum cutoff of 100 employees (covering half the workforce) and a preferred cutoff of at least 500 (covering at least 75 percent of employees).

Statement of PAUL STARR
Princeton University
Hearings Before the
Senate Committee on Labor and Public Welfare
December 17, 1992

Mr. Chairman, I appreciate the chance to discuss with you this morning the prospects for a new compromise on health care reform, bridging long-standing differences between conservatives and liberals and aimed at achieving universal insurance and cost containment. The emerging name for this approach is "managed competition under a cap"; I attach an article of mine describing the approach that will appear in January in *The American Prospect*.

The article further develops the approach I take in my recent book, *The Logic of Health-Care Reform*. It also reflects a more recent collaborative project I organized, with financing from the Robert Wood Johnson Foundation, on the policy choices and implementation problems in a managed-competition strategy for universal health insurance and cost containment. I expect the full results of that project to be published early next year in a special issue of the journal *Health Affairs*. The preliminary drafts of the papers have already been made available to committee staff.

Everywhere I speak on this topic, Mr. Chairman, I run into much confusion about managed competition. For understandable reasons, nearly everyone confuses managed competition with managed care--the two phrases sound alike. A lot of people mistake managed competition for a pure free-market proposal. Some advocates of managed competition identify the idea of managed competition with limits on tax benefits for health insurance--in my view, a desirable but nonessential and easily distorted aspect of the proposal. Many observers contrast managed competition with national health insurance, when managed competition is better seen as a strategy for making health insurance available as a right of citizenship--which, to me, is the essence of national health insurance. Often analysts counterpose managed competition to global budgeting; in fact, not only are the two compatible--managed competition provides a mechanism to do global budgeting that should minimize federal microregulation of health care.

But to dispel all these preconceptions takes some time, and it requires an open and undogmatic frame of mind. The debate over health care reform has been plagued by an excessive and misleading polarization between "competition" and "regulation." Managed competition, we are told, is an example of a competitive strategy; price controls, an example of a regulatory strategy. This is deeply misleading. Managed competition does not "release" the forces of the market; it reconstructs the market. And even without the global budgeting system I advocate, managed

uniform benefit package will enable consumers to make clear-cut choices based on the price and quality of plans; it will also strengthen the hand of the HIPC in its negotiations with plans (since plans will no longer have the excuse of complex benefit variations for higher prices). This standard package must not be minimal, barebones, or "basic," but rather a mainstream package broadly acceptable to the public.

(3) **Routine quality measurement:** Federal legislation should specify uniform standards for the plans to report data on quality of care, including outcomes of treatment. The purchasing cooperatives would publish such data to help consumers in their choice of plans, and it would regularly survey consumers for satisfaction and complaints, oversampling vulnerable groups, such as people with disabilities and those living in low-income areas, to monitor whether they are receiving the services that the plans are contractually responsible for providing to them.

(4) **Contribution pegged to the low-cost plan:** For any given enrollee, the purchasing cooperative would pay no plan more than it pays the low-cost plan--that is, the plan providing the uniform benefit package at the lowest price. If consumers choose other plans, they would pay the marginal difference in cost.

(5) **Community-rated premiums charged to the enrollees; risk-adjusted premiums paid to the plans:** The same premium rates would apply to all consumers--premiums would not be higher for those who are older or for people with disabilities or pre-existing conditions. However, the purchasing cooperatives would risk-adjust the overall payments to plans--that is, they would estimate differences in average risk among the plans' enrolled populations, adjusting upward payments to plans attracting higher-risk subscribers and adjusting downward payments to plans enrolling lower-risk subscribers. The techniques for risk adjustment would be prescribed by the National Health Board.

insurance have always wanted. But many people have wrongly assumed that if we moved away from employer-provided insurance, we would necessarily move into a single, governmental insurance system. Managed competition through purchasing cooperatives makes it possible to break the link between health insurance and jobs while preserving--indeed, enhancing--competition among private health plans. *

The purchasing cooperatives are the single most important innovation in this approach. Small and medium-sized employers cannot readily offer their employees choice of a health plan. Indeed, they cannot purchase health insurance efficiently; a large percentage of every premium dollar paid by small employers goes into insurance administration. And even large employers have had little success in controlling health care costs. By combining individual employers into large purchasing cooperatives, managed competition simultaneously achieves several objectives:

- 1) **Economies of scale:** The individual firm can spread the costs of managing health benefits only over its employees; the purchasing cooperative, negotiating for health benefits on behalf of that employee group and many other people, will spread the costs over a large population. As a result, it will be able to deploy a more sophisticated staff at a lower cost.
- 2) **Countervailing power:** Bargaining on behalf of large blocks of subscribers, the purchasing cooperative will have far greater leverage with health plans than individual employers or consumers have had. The HIPC should be conceived not simply as a passive "price taker," but as an active, imaginative agent of the purchasers--that is, consumers and employers--getting the best possible price and performance from the plans under contract to provide services.
- 3) **Expansion of choice:** When employers separately opt for managed care, they often restrict their employees' choice of physician. There is a world of difference between that kind of employer-based managed care and an array of choices provided by a purchasing cooperative--diverse HMOs, preferred provider plans, and a conventional free-choice-of-provider option. While many consumers are now losing choice in their company-sponsored health plans, they will gain options through the purchasing

people and low-wage employers--a much smaller burden than paying ** for its entire cost. The system would tie both governmental and employer obligations to the low-cost plan in any region. Finally, it would make regions accountable for their costs and create strong incentives for employers and others in an area to take a * strong interest in the regional HIPC's (whose boards should consist of employer and consumer representatives).

Under the Robert Wood Johnson project, we have had the budgetary costs of this approach to reform estimated by the consulting firm, Lewin-VHI. The results, I believe, show this approach to be practical and affordable, even with a relatively comprehensive benefit package. I discuss some of the findings in my accompanying article, and I am making the Lewin VHI report available to the committee with this testimony.

The Lewin report, I should emphasize, makes extremely conservative assumptions about savings--indeed, it does not consider the effects of the profound structural change in health care that would follow from the managed-competition system I am describing. Most advocates of managed competition have presented it as increasing cost-conscious choice among individual consumers. I have argued that, in addition, it creates a powerful countervailing force on the demand side of the market place and that it provides a mechanism for population-based budgeting in health care. This is not just a matter of managed care versus conventional fee-for-service; managed competition is a device for fiscal clarification--for clarifying the true economic * consequences of the alternatives facing individual consumers, health plans, and regions.

The current term for this is "benchmarking"--that is, giving consumers, plans, and regions a benchmark for their decisions. For the consumers, the benchmark is the low-cost plan. Are the others worth the extra cost? For the health plans, the benchmark is how well the best-performing plan is doing in controlling some element of cost or improving some aspect of quality. The role of the purchasing cooperative is not only to bargain but to teach--that is, to make clear to plans with poorer performance what other plans have done to solve the same kinds of problems. Is the cost of heart surgery in one plan three times that in another but with no better results? At the annual negotiations, the purchasing cooperative can stipulate that the plan with higher costs bring them into line.

The same benchmarking process can work for regions. Regions with higher costs will have an incentive to learn from regions with lower costs. That does not happen under public programs today. For example, under Medicare, a region with low costs does not get lower Medicare taxes. Indeed, regions have no incentive to control Medicare costs since they are passed on to taxpayers across the country. But the purchasing cooperatives will not be

through our nation's pockets, and we manage to spend more on health care than any other Western country, yet have more people uninsured and higher levels of public dissatisfaction. We cannot simply import a solution from abroad as many would like; we must work with what we have and face up to the distinctive political and economic requirements of our situation. Managed competition under a cap is an effort to do that to break through the obstacles that have so long obstructed reform.

No one in public life, Mr. Chairman, has done more than you to sustain national concern about the inadequacies of our health insurance system. I have been struck over the years by your devotion to the cause of universal coverage and by your flexibility as you have come up with a series of different approaches to achieve that aim. The model I outline is, I believe, consistent with the underlying principles to which you have been devoted. I am sure that these ideas will receive your careful attention, and I hope they win your support.

**UNITED STATES SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES**

HEARINGS ON:

**ACHIEVING EFFECTIVE COST CONTROL IN COMPREHENSIVE HEALTH CARE
REFORM: MANAGED COMPETITION AND REGULATORY APPROACHES**

WRITTEN TESTIMONY:

**CONSUMER PROTECTION UNDER HEALTH CARE REFORM AND COST CONTROL:
POTENTIAL THREATS; POTENTIAL REMEDIES**

Shoshanna Sofaer, Dr.P.H.

December 17, 1992

Senator Kennedy, Senator Kassebaum and members of the Committee:
Good morning. I am Shoshanna Sofaer, Associate Professor in the
Department of Health Care Sciences at George Washington
University Medical Center. Since 1984, I have been conducting
research to support consumers, especially older consumers, in
making decisions about health care coverage and services. I have
had the opportunity to develop and test an innovative method for
informing older consumers about Medicare, Medigap policies,
Medicare HMOs and long-term care insurance policies. I have
studied how consumers respond when their providers switch from
one HMO to another, how they respond to managed care, and what
support they currently have, and want, when they make health care
decisions. Over the last two years I have also studied the
passage and repeal of the Medicare Catastrophic Coverage Act.

I appreciate greatly this opportunity to contribute my
perspective to these hearings. I truly hope that in pursuing
universal access and cost containment through health care reform,

we can learn the lessons of the "Catastrophic" experience and make sure we keep the American public well and truly informed about our plans and provide them with concrete assurance that their interests are being protected. Unless convinced that they are protected, consumers, as voters, will not provide the public support essential to craft effective policy in a context of competing and entrenched interests.

Given the complexity of health care and the diversity of our nation, it is both likely and appropriate for policy makers to take advantage of a number of tools to support equitable access for all Americans to affordable, high quality services. This morning, therefore, I will review several such tools, including those associated with the strategy of managed competition and others associated with more regulatory approaches. But it is entirely possible that all or most of these tools could be effectively combined in a truly comprehensive strategy for national health care reform. I will identify potential threats inherent in these strategies, potential remedies available to address these threats and opportunities they present for positive consumer participation.

Specifically, I will discuss the following elements of managed competition:

* Health Insurance Purchasing Cooperatives (HIPCs) as aggressive purchasers of health care coverage for a sizable pool of citizens in a state or sub-state region;

* the selection by the HIPC of a number of accountable health plans (AHPs) to be offered to consumers they cover;

* annual enrollment of consumers in the AHP of their choice, with the potential for annual disenrollment if they are dissatisfied;

* risk adjusted capitated payments by the HIPCs to AHPs for each individual they enroll, to cover a standard package of benefits;

* variations in premium price across AHPs, such that some plans require consumers to pay the difference between the base premium paid by the HIPC and the actual premium, using their own after-tax dollars; and

* within some but not necessarily all AHPs, use of managed care techniques such as limitation in choice of provider; primary care providers as gatekeepers for specialty care, hospitalization and other high cost services; formularies for prescription medications, etc.

With respect to regulatory approaches, I will discuss:

* regulation of rates and prices for service providers;

* regulation of the volume of services, especially high-cost services, through various forms of utilization review such as second opinions, prior authorization, concurrent or retrospective review of physician practices, etc.; and

* regulation of the supply and/or distribution of health care facilities, current and emerging technology and health care professionals.

As we explore consumer protection, let's remember that consumers are not a monolith: we must examine policy tools not only in terms of the "average" consumer, but in terms of consumers that may be particularly vulnerable, because of illness or disability, or because of their ethnicity, education, income or other socioeconomic characteristics. The white, healthy, upper middle-class marketing MBA with a working spouse and one child is one kind of consumer; the Latino working for a dry-cleaner in East Los Angeles whose wife is out of work and who has three children, one with serious asthma, is another. Our challenge is not just to ensure that they all have health care coverage; it is to ensure that there is reasonable equity in their experience of the health care delivery system.

THREATS AND REMEDIES UNDER MANAGED COMPETITION

Threats Inherent in Unresponsive or Ineffective HIPCs

The single most important element of the managed competition strategy is the development of state or regional HIPCs with authority to select AHPs and enroll consumers in them. In some models of managed competition, the HIPC would be a virtual single payor at the regional level; in other models, large employers would be permitted to "opt out" of the HIPC.

The potential threats to all consumers in the HIPC are:

1. that it will become a massive bureaucracy unresponsive to the needs and concerns of individual consumers; and
2. that in pursuing cost control aggressively, it will fail to emphasize access, quality, provider choice or other valued aspects of health care.

Remedies to these threats must be built into the very structure of the HIPCs, through:

1. Legislation that clearly makes HIPCs responsible for pursuing the interests of consumers across multiple health care values and that mandates key consumer protection functions and resources within each HIPC (e.g. a carefully articulated complaint and grievance system; ombudspersons)
2. A governance structure that incorporates a substantial plurality if not a majority of consumers (as opposed to public or private payors)
3. Oversight of all HIPCs by a National Health Board that regularly collects, analyzes and disseminates information on HIPC performance, using indicators sensitive to the needs and concerns of consumers. Example of such indicators include: the rate of consumer satisfaction with the HIPC, especially its resolution of complaints and grievances; the overall rate of consumer satisfaction with their AHPs; the overall rate of consumer switching among AHPs; the rate of provider switching across plans; trends in premium rate increases; the rate of purchase of supplemental insurance; and the rate of out-of-plan service use.

If substantial numbers of people get coverage through their work (whether via employer or union) there is a potential threat of a different kind: that the HIPC's coverage will be, or be considered, "second-class." The existence of a substantial alternative source of "lives" or "patients" diminishes the bargaining power of the HIPC. Under these circumstances, HIPC coverage could come to be considered "second-class" in at least three ways:

1. if the benefits are less comprehensive;
2. if the extent of plan or provider choice is substantially lower; or
3. if the providers accessible through HIPC coverage is not of equal quality.

The major potential remedy for this threat is to ensure that the HIPC has responsibility for providing coverage to a substantial cross-section of consumers in its region, including consumers of varying socioeconomic levels and health status. This can be achieved by setting a high minimum number of workers that an employer or union must cover before they are permitted to offer their own coverage. Variations in coverage, plan or provider choice and provider characteristics between HIPC's and other plans should be monitored by the National Health Board, who should make report regularly to Congress on needed changes to address disparities.

An alternative threat is also present: if other sponsors provide less coverage, less choice or lower quality providers. Differences in service benefits can be addressed by requiring other sponsors to offer at least the standard benefit package. Differences in choice can be addressed by requiring that other sponsors offer at least some choice (e.g. at least one managed care plan and at least one fee-for-service plan, if available in the region). Differences in quality will be more difficult to assess, monitor and correct.

Threats Inherent in the Design and Choice of Alternative Health Plans

A second key element of the managed competition strategy is that HIPCs will select and offer a range of AHPs to consumers, who will choose among them during an annual enrollment period. All AHPs will have to offer at least a minimum package of benefits. HIPCs will pay AHPs a risk adjusted capitated payment for each enrollee. AHPs, however, can charge an additional premium to enrollees. The heart of "competition" in managed competition is that AHPs compete for enrollees. If the service benefit package is identical across all plans, it is presumed that consumers would not choose a plan with an additional premium unless they believed that it offered commensurate additional value in terms of quality, convenience or provider choice.

Certain elements of this managed competition strategy are essential to protect consumers. They include the following:

1. At least one, and preferable more than one AHP must be offered at the base premium, with no additional charge. From the perspective of competition, this is essential to provide an example (and an option) of cost control to the other AHPs. From the perspective of low-income consumers, or consumers who need to spend discretionary income elsewhere, it is essential to true access to coverage. A choice of plans with no additional premium will be a protection against the development the perception, or reality of a multi-tiered, class based insurance system.

There is a real threat that some HIPC's will be unable to identify and negotiate successfully with an AHP that can offer reasonable access and quality to a substantial number of people at a base premium rate consistent with HIPC resources. There is also a real threat that the gap between the base premium and the premiums charged by other plans will grow over time. The threat in this scenario is not that cost containment measures jeopardize other values; it is that the tool for cost containment itself fails, leading the HIPC to "cut corners" in terms of the enforcement of performance standards for AHPs.

This scenario may be especially likely in regions where market capacity, and thus competitiveness, is limited. It may be wise for HIPC's to have access to rate regulation as a policy tool to stay within budget without sacrificing service coverage, access or quality. One approach would be legislation permitting HIPC's

to apply to the National Health Board for a "waiver" to use rate regulation.

2. Standardization of benefits is essential to ensure a level playing field in which consumers, and the HIPC, can make meaningful comparisons across plans. It will be difficult enough for consumers to assess the relative value of plans in terms of the quality, convenience and provider choice; if benefit packages also differed, they would also have to compare their financial vulnerability in different plans. Benefit structures are also subject to manipulation to bias selection into plans.

3. The risk adjustment of capitated payments to AHPs is also essential to mitigate the tendency of insurers toward biasing enrollment in their favor. Such biased selection works against the interests of consumers in general, but especially works against the interests of consumers who are in greatest need of health care.

4. HIPCs must control the enrollment process, and either provide or review information provided to consumers about the AHPs. They must set and enforce clear limits or outright bans to any marketing done by AHPs or providers. In particular, it is critical to limit person-to-person marketing by AHPs, and to ban entirely "house-to-house" marketing. The potential for abuse in such "invisible" settings is enormous, and can provide a field

day both for encouraging enrollment through misleading statements and for discouraging enrollment among less "desirable" groups.

Even if these essential protections are legislatively mandated, there are additional potential threats to be addressed in these elements of managed competition.

1. The major threat to consumers is that they will not be able to make genuinely informed comparisons among AHPs. As a consequence, consumers might enroll in a plan that was inappropriate to their needs, preference and circumstances. Faced with inadequate information, some consumers might simply purchase a plan on the basis of premium alone. Some might choose the lowest cost plan to save money and find out too late that their associated providers and facilities were very inconveniently located. Other might choose the highest cost plan on the assumption that high cost equalled high quality.

Managed competition provides both an unparalleled opportunity and an unparalleled challenge to provide clear, concise and salient information to consumers about their health care coverage options. Our major current national health plan, the Medicare program, does a very poor job of providing beneficiaries with information; this is exacerbated by the incredible complexity of both the benefit package and claims procedures. The most difficult challenge will be to provide comparative information about the quality of the health care delivery systems accessible

through different AHPs. Information must be provided that is useful to and usable by different kinds of consumers who want different levels of detail or who want their information provided through different "channels¹."

HIPCs will need a line item in their budget for developing and disseminating information materials through a variety of media and channels. They will need authority to require AHPs to collect, aggregate and provide data on key structural characteristics and performance indicators, for all enrollees and for special sub-groups of enrollees of particular concern (e.g. children, members of minority groups, the disabled). But above all, HIPCs will need creativity and energy to harness both our growing understanding of predictors of good health outcomes and emerging communication and information technologies to serve the information needs of consumers.

2. Unless the standard benefit package is genuinely comprehensive, a market for supplemental insurance is likely to develop. Our experience with Medicare supplements indicates that such a market has enormous potential for exploiting, confusing and wresting lots of money from consumers, by employing a wide range of unsavory sales and marketing tactics. Alternatively or simultaneously, a less than comprehensive benefit package can

1. A more detailed discussion of information needs and strategies is available from the author in a paper entitled "Consumer Information and Protection Under Managed Competition."

lead to extensive out-of-pocket payments by consumers for services that are not covered, or not covered well.

Threats Inherent in Managed Care

Managed competition and managed care are not the same. However, managed care is an important cost containment strategy within managed competition. The fundamental threat of managed care is that, given a capitated payment, AHPs will have the incentive to ration care to enrollees to contain costs. Once again, the consumers who are most vulnerable are those facing serious acute or chronic conditions. However, even the occasional user of service can be inconvenienced or potentially endangered by a managed care system that does not respond promptly and fully to patients' needs.

Rationing of care can be reflected in delays and difficulties in making appointments; inability to get care from preferred providers; delays or difficulties in getting referrals from primary care "gatekeepers" to specialized services; and conflict over the medical necessity and appropriateness of diagnostic or treatment procedures, particular medications, or other services such as mental health, chemical dependency, rehabilitation, skilled nursing or home health.

There are multiple potential remedies to the problem of rationing in managed care:

1. HIPCs should require AHPs to provide standardized information, during open enrollment seasons, on their managed care "ground rules." Consumers need to have this information before they make their choices.
2. HIPCs should require AHPs to monitor enrollee satisfaction through regular surveys addressing issues such as waiting times for appointments; access to specialty care; satisfaction with providers; and extent of out-of-plan use in response to access barriers.
3. HIPCs should require AHPs to monitor enrollee dissatisfaction, as reflected in the rate and reasons for disenrollments and the rate and nature of complaints and grievances.
4. Each AHP should be required to have a complaint and grievance system, including ombudspersons assigned to advocate for enrollees and mediate their disputes with providers and the plan.
5. The HIPC should have a parallel complaint and grievance system, to which consumers can appeal if they do not get satisfaction from the AHP. Specifically, if a consumer has been denied medically necessary care, or provided with demonstrably low quality care, the HIPC should have the power to insist it be provided, or to permit the consumer to switch to another health plan, with continuing financial responsibility of the original AHP for any medical care provided by the new plan for that episode of illness.

Rationing of care often reflects inadequate capacity. Thus, the solution to delays and difficulties in getting appointments may be having more staff on the telephone lines or more appointment slots (and therefore more clinicians) available. A remedy for this more fundamental source of rationing is for the HIPC to assess and monitor the capacity of each AHP to serve the needs of its enrollees, given their geographic location, the languages they speak, their age distribution and thus their likely need for services. Contracts between the HIPC and the AHPs might set target enrollment ranges; the HIPC would then examine the providers and facilities available to each AHP to determine if it had sufficient capacity.

A final threat to consumers under managed care is diminished provider continuity. One tool used by managed care plans is to select a limited number of providers to whom they channel their members. Consumers often join particular managed care plans because "their" doctor or the hospital they would want to use is accessible through the plan. However, if providers frequently leave plans, either migrating to other AHPs or to the residual fee-for-service system, this creates serious problems for consumers, especially those under care. They must either change providers, or follow their original provider if they can afford any associated additional premiums. If providers migrate to plans offered by employers but not the HIPC, they become entirely inaccessible.

The problem of provider continuity cannot be entirely avoided. HIPCs, however, should monitor provider switching among plans and publicize the extent and causes of provider switching to consumers during open enrollment seasons. The overall level of provider switching may also be an important performance indicator for the HIPC itself.

THREATS AND REMEDIES UNDER REGULATORY APPROACHES

Threats and Remedies in the Current Insurance Marketplace

The threats faced by consumers under various regulatory approaches will depend on the extent to which the insurance market is simultaneously reformed. Consumers are neither well protected nor well informed in the current insurance marketplace. Access to coverage and care is threatened, for those who are or become seriously ill, by medical underwriting, pre-existing condition limitations and exclusions, and potential policy cancellation. Especially for those in the individual or small group market, financial access to coverage and care is threatened by high premiums relative to actual reimbursements and poor quality coverage. Everyone has faced high and unpredictable levels of premium increases over time.

Under the current insurance marketplace, many consumers have little or no choice of coverage: some can get no coverage at all; for some, only a limited number of choices are available or affordable; many employers are limiting, often to only one, the coverage options for their employees.

Where consumers do have coverage choices, they have little if any objective, useful and usable information available on their options. Plans are not standardized, making comparisons, especially comparisons of potential out-of-pocket cost vulnerability, difficult for well-educated consumers and virtually impossible for those who are less educated. The information that is available typically comes from interested parties such as carriers, health plans or brokers. Group plan sponsors such as employers often try to provide useful information. Some private non-profit organizations have published comparative information for very large groups such as federal employees. But most consumers are on their own in unfamiliar and daunting territory when they try to purchase health insurance coverage.

To address these threats in the current insurance marketplace will require multiple remedies, including:

1. Legislation to limit or ban medical underwriting, pre-existing condition limitations and exclusions, and arbitrary policy cancellations.
2. Legislation to set and enforce standards for minimum loss ratios.
3. Standardization of policies.
4. Stricter regulation of insurance marketing practices, including requirements for provision of standardized information on policies and restrictions on misleading and/or fraudulent

advertising and sales of unnecessary or duplicative products in the individual market.

Many such insurance market reforms have been introduced at the Federal level with respect to Medicare supplements. However, it is likely that state as well as federal action will be essential to comprehensive insurance reform. In addition, no matter what legislation mandates, some "bad apples" will make their way into the bushel, requiring the further remedy of an effective and well-funded complaint and grievance system, probably housed within state insurance departments with some federal oversight.

Threats in Rate and Price Regulation

There are two basic threats inherent in rate and price regulation. The first threat is that some providers and facilities will attempt to balance bill consumers to obtain additional reimbursements for their services. The only remedy here is either to ban balance billing outright or to limit it severely to a percentage above the regulatory rates.

The second, less likely and perhaps less consequential threat, is that a sub-set of providers and facilities will "opt out" of the system by not accepting coverage linked to regulated payments. This is possible under managed competition as well. Consumers could thus get access to these providers only if they paid entirely out-of-pocket. A performance indicator for regulation as a strategy might well be the size and composition of this

group. Unless it exceeds some threshold level set by policy makers, the creation of a small "upper-tier" health care system, does not have to pose a major problem for the public. This threat becomes more serious if rate regulation does not apply to all third party payors, including self-insured companies.

Threats in Utilization Control

The threats inherent in utilization control are similar to the rationing threats inherent in managed care. Utilization review is designed to discourage providers from prescribing or performing unnecessary services. As with managed care, however, utilization review can result in reduced access to medically necessary care for some consumers.

The consumer protection remedy is similar: individuals must have structured procedures, hopefully short of malpractice litigation, for obtaining services they believe are required and appropriate. The appropriate location for such services is less clear without an organizational focal point, such as the HIPC. As with protection against insurance marketing problems, a well-funded public complaint and grievance system will be needed, but health departments or health care licensing and certification agencies may be more appropriate venues than insurance departments.

Under volume regulation, consumers can also get caught in the middle, between providers who have gone ahead and delivered services, and claims or utilization review agencies who have

denied coverage for those services. Legislation may be needed to specify that the provider, rather than the consumer, is liable when coverage is denied.

In addition to public agency consumer protection activities under regulation, support may be needed for private non-profit efforts to inform and advocate for consumers facing problems with insurers, providers, and claims review organizations. The culture of many public bureaucracies makes them less than responsive to the needs of individual consumers, even if they operate under a legislative mandate for consumer protection.

Threats in Regulation of Supply

Excess capacity of specialized facilities, technology and providers has been identified as one of the major "root causes" of health care cost inflation. Regulation in the supply of such resources has been identified as a major element in successful cost containment in other nations. Outcomes and effectiveness research and technology assessment are fast becoming valuable supports to our ability to identify "true" excess capacity.

Although regulation of supply has great potential as a tool for cost containment, it can pose potential threats for consumers. The most basic threat arises if definitions of community need are driven too hard by budgetary constraints rather than empirically validated relationships between resources and health outcomes. The example of Great Britain's National Health Service can be

seen as the "awful warning" of this problem. Potential remedies for this problem are likely to be found in the workings of the democratic political process itself, rather than in specific policies and procedures.

A less generalized threat in the regulation of supply is that given the diversity of our nation, standards for levels of capacity can lead to inequities across communities that face unusually high levels of certain health problems. A related danger is that regulation of supply will make it more difficult to address current inequities in the distribution of providers and facilities that are faced by many inner city and rural residents. The remedies for this threat are more technical: to ensure that supply standards are "adjusted" for community characteristics, and to ensure that distribution as well as overall capacity are addressed.

CONCLUSION

Strategies for universal coverage and cost containment must be assessed not only against each other, but against our current reality. The most fundamental protection consumers need today is protection against current financial and other barriers to health care services. As we have seen, specific threats to consumer protection arise from almost every tool that is used to rationalize our system and improve our capacity to contain costs. So specific remedies will need to be incorporated into

legislation, regulation and system governance no matter what direction is taken in health care reform.

Managed competition offers one significant advantage to consumers over regulatory approaches: the creation of an organizational entity, the HIPC, whose mandate is to arrange coverage for a defined population of people. The existence of such an entity provides a focal point for consumer concern and consumer advocacy. It provides, too, a focal point for creativity and innovation in consumer participation and information, as well as consumer protection. The ultimate form of consumer protection in health care reform using managed competition is uniquely appropriate in our democracy: it is the power of effective consumer involvement in the governance of the HIPC.

DRUG INFORMATION ASSOCIATION

The following will be held: "Good Clinical Practice — Obligations of Sponsors, Monitors and Clinical Investigators" (Washington, D.C., Jan. 23-27); "Practical GCP Compliance Auditing Training Course" (Bruges, Belgium, Feb. 1-3); "Self-Medication Medicines: The Impact of Emerging International Regulations on the Future of the Self-Medication Sector" (Brussels, Belgium, Feb. 15 and 16); "Quality of Life Assessment" (Nice, France, Feb. 22-24); "Toxicokinetics — The Way Forward: Discussions on the Harmonization of International Guidelines" (Nice, France, Feb. 24-26); "GCP for the Novice: An Educational Forum on Implementation and Practical Applications" (Bern, Switzerland, April 19-21); and "FDA Pre-Approval Inspections" (London, April 28-30).

Contact in U.S.: DIA, P.O. Box 3113, Maple Glen, PA 19002-8113; or call (610) 625-2288. Contact in Europe: DIA European Office, Postfach, 4012 Basel, Switzerland; or call (41) 61 44-90-19.

PALM SPRINGS DERMATOPATHOLOGY

The symposium will be held in Palm Springs, Calif., Feb. 13-21. Contact: Horace Nygaard, 300 E. 40th St., Suite 26H, New York, NY 10016; or call (212) 263-7268.

ARMED FORCES INSTITUTE OF PATHOLOGY

The "8th Annual Neuroimaging Review Course" will be offered in Bethesda, Md., Feb. 27 and 28. Contact: American Registry of Pathology, AFIP, Washington, DC 20306-6000; or call (301) 427-5231.

CORRECTIONS

Case Records of the Massachusetts General Hospital (Case 36-1992) (September 10, 1992;327:790-9). On page 790, in Table 1, the serum uric acid concentration should have been 12.6 mg/100 ml (750 μ mol/liter), not 12.6 μ g/100 ml (0.7 μ mol/liter) as printed.

Warfarin in the Prevention of Stroke Associated with Nonrheumatic Atrial Fibrillation (November 12, 1992;327:1406-12). On page 1409, in Figure 1, the solid line should have referred to the patients in the warfarin group and the broken line to those in the placebo group. We regret the error.

SPECIAL REPORT

THE MARKETPLACE IN HEALTH CARE REFORM

The Demographic Limitations of Managed Competition

Abstract Background. The theory of managed competition holds that the quality and economy of health care delivery will improve if independent provider groups compete for consumers. In sparsely populated areas where relatively few providers are required, however, it is not feasible to divide the provider community into competing groups. We examined the demographic features of health markets in the United States to see what proportion of the population lives in areas that might successfully support managed competition.

Methods. The ratios of physicians to enrollees in large staff-model health maintenance organizations were determined as an indicator of the staffing needs of an efficient health plan. These ratios were used to estimate the populations necessary to support health organizations with various ranges of specialty services. Metropolitan areas with populations large enough to support managed competition were identified.

Results. We estimated that a health care services

market with a population of 1.2 million could support three fully independent plans. A population of 360,000 could support three plans that independently provided most acute care hospital services, but the plans would need to share hospital facilities and contract for tertiary services. A population of 180,000 could support three plans that provided primary care and many basic specialty services but that shared inpatient cardiology and urology services. Health markets with populations greater than 180,000 would include 71 percent of the U.S. population; those with populations greater than 360,000, 63 percent; and those with populations greater than 1.2 million, 42 percent.

Conclusions. Reform of the U.S. health care system through expansion of managed competition is feasible in medium-sized or large metropolitan areas. Smaller metropolitan areas and rural areas would require alternative forms of organization and regulation of health care providers to improve quality and economy. (N Engl J Med 1993; 328:148-52.)

MANAGED competition has received widespread support from members of Congress, President-elect Bill Clinton, large insurance companies, and editorialists writing in influential publications.¹⁻⁴ A central tenet of the managed-competition theory is that providers are divided into competing economic units. As discussed by Enthoven and Kronick,^{5,6} the most effective competition occurs when all the doctors in a community are grouped into several prepaid practices with each doctor fully committed to one organization. Health care services, however, are largely purchased locally, and there are sparsely populated areas of the United States where providers have a natural monopoly. In a geographically isolated area with a population base large enough to support only one hospital and one group of physicians, it is difficult to envision how competition would work. If the hospital decides to increase its scope of services or its prices substantially, threatening to build a competing hos-

pital is a poor option, and transporting patients to another city may be unacceptable. Similarly, if most physicians are members of a single multispecialty group practice, purchasers have little recourse if the physicians use more, rather than fewer, resources.

We estimated the minimal population size for a health services market area that could support managed competition and the proportion of the population of each state and of the nation as a whole that is in such areas.

METHODS

An estimate of the minimal population required to support managed competition is based on three assumptions: the national average physician-to-enrollee ratio; the minimal number of health care organizations needed to support healthy competition; the ratios of physicians to enrollees and of hospital beds to enrollees in efficiently managed health plans; and the geographic boundaries of health services markets. This section

presents the assumptions and methods we used to make our estimates.

To What Extent Must Competing Organizations Be Independent?

The "classic" health maintenance organization (HMO) — the large, staff-model prepaid group practice epitomized by Kaiser-Permanente or Group Health Cooperative of Puget Sound — is the prototype of the efficient competitor. Unlike many other forms of managed care, classic HMOs are capable of health planning: they regulate the supply of hospital beds, physicians, and other providers in relation to the size of the population they serve. Physicians employed by classic HMOs, because they are salaried, are not subject to the tendencies toward supplier-induced demand inherent in fee-for-service medicine; they are able to allocate their workloads efficiently among various tasks, such as evaluating and counseling patients, performing operations or diagnostic tests, and performing the duties required for continuous improvement in the quality of care. This flexibility makes it possible for classic HMOs to adapt easily to the changes in demand that occur when patients are informed about medical options and make decisions according to their preferences.⁷

The efficiency of the classic HMO model contrasts sharply with that of the independent practice association (IPA) model, particularly when individual physicians are affiliated with many health plans. Enthoven describes the inefficiencies of an IPA market in which each physician belongs to 10 plans:

Each doctor would have to deal with the utilization controls and fee schedules of ten health plans, none of which would command his loyalty. If one health plan persuaded a doctor to adopt a more efficient health practice, the benefit would be likely to be spread immediately over all ten plans, reducing the incentive of any plan to make the effort to pursue innovation at the provider level. None of the health plans would be matching numbers of doctors to the needs of the population.⁸

Between the contrasting extremes of the mature classic HMO and the multiple-IPA model is a large, ambiguous middle ground. Each of a set of health plans might have its own primary care physicians and contract with the same specialists. Or, in addition to primary care, a plan might provide some specialty services (such as cardiology, urology, and gastroenterology), using its own physicians during regular business hours, but it might contract with overlapping sets of providers for after-hours specialty care and for inpatient services. When considering competition among health plans that are less comprehensive than classic HMOs, a key factor is the configuration of inpatient hospital services in a community. If health plans are not large enough to own their own hospitals and hire the full complement of specialists but, instead, contract separately with overlapping sets of hospitals, then no organization will be responsible and accountable for population-based health planning for hospital services.

In areas in which the population is too small to allow competing health plans to exert effective control over specialists' services and hospital resources, some alternative or adjunct to managed competition will be required in order to achieve effective health planning. Conceivably, this might be accomplished by cooperative planning efforts by the major health plans operating in a community. Alternatively, some form of government regulation of hospital capacity and budgets may be necessary.

How Many Competitors Are Needed?

Ideally, a large number of qualified health care plans would be available in each geographic area. No single plan would be able to have much influence on the demand for care, thus making collusion among plans difficult. However, the minimal number of plans needed to avoid a market with strong oligopolistic tendencies is not clear. One competitor is obviously not enough. If there are only two competitors, the temptation of implicit collusion will be hard to resist. Why should the competitors work hard to restrain the growth of costs or profits when both competitors will be better off if they

engage in cozy behavior? There is no theoretical basis on which to infer the minimal number of firms that can successfully sustain competition, but the fewer there are, the greater the tendency toward oligopoly. Somewhat arbitrarily, we assumed that at least three health plans are needed in order to create a situation in which providers and plans will continually strive to improve quality and economy.

What Is the Critical Population Size Needed to Sustain an Efficient Firm?

The size of the population required for a managed-care firm to organize efficient primary care and specialty units varies according to specialty and according to assumptions about the minimal number of physicians needed to sustain the service. We grouped physician specialties into four categories. The first, primary care, included general internal medicine, podiatry, and family medicine. For these specialties we assumed that at least five physicians are needed to provide full night coverage and to sustain the collegial relations required for high-quality care in the group-practice environment.

The second category included hospital-based specialties that involve frequent night and weekend consultation for emergencies or postoperative care and that are required in a full-service acute care community hospital — specifically, emergency medicine, obstetrics and gynecology, general surgery, orthopedics, anesthesiology, radiology, psychiatry, cardiology, and urology. For these specialties, we assumed that three full-time physicians are needed to staff a minimal service in order to meet coverage obligations and provide high-quality care. We used these specialties to estimate the lower limit of the zones where competition based on the classic HMO model might succeed if there were some sharing of hospital facilities, with staffs independent.

The third category included neurosurgery and cardiothoracic surgery, the additional three-physician specialty services required for a tertiary hospital. This sets the minimum for a classic HMO that is fully independent for all clinical specialties. The fourth category consisted of other specialties involving secondary and tertiary care that is usually not of an emergency nature — ophthalmology, otolaryngology, dermatology, pathology, hematology and oncology, neurology, gastroenterology, allergy and immunology, pulmonary medicine, nephrology, rheumatology, endocrinology, infectious diseases, and plastic and reconstructive surgery. On the basis of our estimate that 24-hour coverage is not essential for these specialties, we assumed that the services of only one specialist are required to achieve independence.

To estimate the population required for independence and efficiency, we examined the staffing patterns of the Group Health Cooperative of Puget Sound and four other large, nonprofit staff-model HMOs. For each classic HMO, data were provided by the organization's medical staff office. For most specialties the number of enrollees per specialist was averaged across plans to derive an estimate for the HMOs as a whole. To estimate the need for primary care practitioners we used the Group Health Cooperative's staffing ratio for family practitioners (1 to 2000). For emergency medicine, psychiatry, pathology, and thoracic surgery, we used data from other sources.⁹ (Supplemental material on our procedures is available elsewhere.¹⁰)

The age structure of the enrollees was obtained for the age groups <14, 15 through 44, 45 through 64, and ≥65 years. The proportion of enrollees in each age group approximated the national age distribution except for the population 65 years of age or older. The elderly make up 12.5 percent of the national population, whereas the percentages for the five HMOs were 11.7, 9.4, 8.0, 11.4, and 8.2 percent.

HMOs typically use fewer than 2 beds per 1000 enrollees. The estimate of 2 beds per 1000 is compatible with the assumption that the population under 65 years of age uses 360 hospital days per year.

©1993 MATE Publishing, Inc. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or by any information storage and retrieval system, without permission in writing from MATE Publishing, Inc., 1000 10th Ave., Suite 1010, New York, NY 10018-1010. Return to address (in U.S. funds only) \$7.75 for photocopies or \$4 for microfiche. Outside the U.S. and Canada add postage of \$4.50 (\$1.50 for microfiche postage). There is a \$15 invoicing charge on all orders filled before payment.

Only ^{(F) 41%}
^{(I) none} % of
^{(M) 47%}

(1) Florida's
(2) Iowa's
(3) Michigan's
population lives in market
areas of over 1.2
million people - the
number projected by
one group of experts to be
necessary to support
three HMOs ^(the minimum for competition) capable of
providing nearly all
necessary services for
area enrollees. Below
that level, "substantial
public sector under managed
competition"

NEJM 1/14/93

per 1000 enrollees and the population 65 or older uses 2430 days per 1000; that 13 percent of the enrollees are 65 or older, and that hospital occupancy is 85 percent.

What Are the Location and Size of Health Care Markets?

We assumed that metropolitan areas, as defined by the Office of Management and Budget,¹⁰ are the relevant market areas for health services in nonrural parts of the United States. Metropolitan areas are defined as a "place" with a population of at least 50,000 or an "urbanized area," as defined by the U.S. Bureau of the Census, with a population of 50,000 and a metropolitan area with a total population of at least 100,000. Surrounding counties are included if they have a minimal commuting rate to the central county. This definition of metropolitan areas results in high-density geographic units with economic and travel ties that are consistent with a regional economic market.^{11,12} The size and location of health services markets for people living outside metropolitan areas are usually determined on the basis of small-area analysis. Although we were not able to perform such an analysis for the entire nation, previous studies in northern New England have resulted in the division of this territory into 72 distinct hospital market areas.¹³ We used these areas to illustrate the constraints of demographic forces on managed care in nonmetropolitan areas.

RESULTS

Population Requirements for Managed-Care Organizations

The minimal population necessary to support a classic HMO offering referral hospital services and using its own staff physicians is approximately 450,000 enrollees. A health plan with 300,000 enrollees would be able to offer virtually all ambulatory and hospital services with its own panel of providers and own a 600-bed hospital, but it would need to contract for some coverage of cardiothoracic surgery and neurosurgery. A plan with 120,000 enrollees could provide the full complement of acute care hospital services associated with a community hospital, using its own staff physicians, although the cardiology and urology services would be close to the minimal three-person service. This plan would need approximately 240 hospital beds; it would be able to exert substantial control over one or two hospitals, but it would have to share some inpatient facilities with other plans. A plan with 60,000 enrollees could support 71 full-time-equivalent physicians (Table 1) and a 3-physician service in most of the specialties required for general hospital services, but it would need to share cardiology and urology services and engage in substantial sharing of inpatient facilities with other plans. A plan with 10,000 members could support an independent primary care service but would be required to share both physicians and inpatient hospital services in all specialties.

Population Required for Managed Competition

Assuming that three health plans are the minimum required for competition, then at least 360,000 persons are needed to support three HMOs that can plan for and deliver most general hospital services, although sharing of acute care hospital facilities would be necessary. A smaller community of 180,000 could support three health plans capable of providing a large portion of physicians' services in hospitals, using physicians

Table 1. Estimated Number of Full-Time-Equivalent Physicians and Hospital Beds Needed, According to the Size of the Health Plan.

SPECIALTY OR TYPE OF SERVICE	No. of ENROLLEES				
	20,000	60,000	120,000	300,000	450,000
number					
Physicians					
Primary care (family medicine)*	10.0	30.0	60.0	150.0	225.0
General hospital services					
Obstetrics-gynecology	2.2	6.5	13.0	32.6	48.9
General surgery	1.1	3.2	6.3	15.8	23.7
Orthopedics	0.9	3.0	5.9	14.9	22.3
Emergency medicine	0.9	2.9	5.9	14.7	22.1
Anesthesiology	1.0	3.0	6.0	15.0	22.5
Radiology	1.2	3.6	7.3	18.2	27.3
Psychiatry	0.8	2.3	4.6	11.4	17.1
Cardiology	0.6	1.7	3.4	8.5	12.8
Urology	0.5	1.5	3.1	7.7	11.5
Subtotal	9.2	27.7	55.5	138.8	208.2
Tertiary hospital services					
Thoracic surgery	0.2	0.5	1.0	2.5	3.8
Neurosurgery	0.1	0.4	0.8	2.0	3.0
Subtotal	0.3	0.9	1.8	4.5	6.8
Other specialties†	4.1	12.2	24.3	60.8	91.2
Total	23.6	70.8	141.6	354.1	531.2
Hospital beds	40	120	240	600	900

*Staffing will vary depending on the mix of family practitioners, internists, and pediatricians.

†The other specialties are ophthalmology, otolaryngology, dermatology, pathology, hematology and oncology, neurology, gastroenterology, allergy and immunology, pulmonary medicine, nephrology, rheumatology, endocrinology, infectious diseases, and plastic and reconstructive surgery.

who are employed as staff by the health plan, but they would require shared inpatient services. A community of 30,000 might support three independent primary care networks, but all hospital services would need to be shared if the residents were to receive inpatient care locally. At the other extreme, a much larger community of at least 1.2 million persons would be required to support three HMOs capable of providing almost all services with their own resources.

Proportion of the U.S. Population Living in Competitive Zones

Twenty-nine percent of the U.S. population lives in markets with populations below 180,000 and thus in areas where substantial sharing of hospital services would be required for use to be efficient (Table 2). Eight percent live in markets with populations between 180,000 and 360,000, where managed competition has some potential to organize acute hospital care at least semi-independently, but where plans would need to be supplemented with substantial public-sector involvement in health planning. Twenty-one percent are in markets with populations between 360,000 and 1.2 million, where the demographic requirements for HMO-based managed competition are largely met but where some public-sector efforts are likely to be required in the planning of tertiary hospital services. Forty-two percent reside in markets with populations of more than 1.2 million.

The location of these markets in the United States is shown in Figure 1. Twenty-three states and the District of Columbia have at least one metropolitan area

with a population of 1.2 million or more, sufficient to support three classic HMOs, each owning a referral hospital; in 10 (Arizona, California, the District of Columbia, Illinois, Maryland, Minnesota, Missouri, New Jersey, New York, and Texas) the majority of the people live in such areas. However, large land areas in the United States are outside the competitive zone for HMOs, and no state is entirely within it. Most states will require mixed strategies. Some part of their populations live in areas where managed competition could be effective in promoting HMOs, but many live in more sparsely settled areas where other strategies are

needed. In 19 states the majority of the population lives in areas of less than 180,000 population, where hospital services must be extensively shared. In 42 states, 20 percent or more of the population lives in such areas.

The health markets in northern New England illustrate the complexities of structuring competition in states with no large metropolitan areas. Maine, New Hampshire, and Vermont together contain 83 acute care general hospitals and 2.5 million people; 64 of the hospitals are the sole hospitals in their local areas. The vast majority of primary care services in these areas are delivered by local physicians who use the local hospital for their patients. None of these areas have a big enough population to support three independent cardiology services. Only two market areas — Portland, Maine, and Manchester, New Hampshire (containing 13 percent of the population) — are sufficiently large to support three independent general-surgery, emergency, and orthopedic services. Twenty-seven percent of the population of northern New England lives in hospital market areas that cannot support three independent primary care competitors, assuming that each plan would need to have at least five physicians.

DISCUSSION

We recognize several limitations to our study that cause uncertainty about our estimates. We estimated the minimal population required to support three efficient organizations in a steady state; population estimates may be unrealistic, however, since the motivation of competition includes growth and in small markets this cannot occur without driving a competitor out of business. Our assumption that three competitors are sufficient to avoid collusion cannot be supported by empirical evidence, since managed competition is an experiment that has yet to run its course. Three may not be enough. Each of these factors would tend to cause us to underestimate the market size required to promote efficient competition. We have also not considered other potential limits to reform, such as barriers to enrollment of providers and bureaucratic inefficiencies in the case of public-sector health planning. On the other hand, since the enrollees of HMOs tend to be younger than the general population, smaller health markets could support managed competition with a higher proportion of elderly persons. The conclusion, however, is the same: demographic factors will limit the full implementation of managed competition as the vehicle for reforming the U.S. health care economy.

We hope our study will help to move the policy debate beyond polarization, either for or against competition and regulation. The complexities and the highly localized nature of the health care economies in the various states indicate the need for care on the part of state governments in setting the rules for structured competition, or the need for alternative models of reform (based on planning and the promotion of cooper-

Table 2. Percentage of State (or District) Populations in Different Sized Health Market Areas.*

STATE OR DISTRICT	POPULATION	POPULATION OF MARKET AREA		
		>180,000	>360,000	>1.2 MILLION
		percentage of state population		
Alabama	4,041,000	49	34	0
Alaska	550,000	41	0	0
Arizona	3,665,000	76	76	58
Arkansas	2,351,000	24	24	0
California	29,760,000	94	91	77
Colorado	3,294,000	74	61	49
Connecticut	3,287,000	79	53	0
Delaware	666,000	66	66	0
District of Columbia	607,000	100	100	100
Florida	12,938,000	88	72	41
Georgia	6,478,000	61	50	44
Hawaii	1,108,000	75	75	0
Idaho	1,007,000	20	0	0
Illinois	11,431,000	78	66	58
Indiana	5,544,000	53	44	23
Iowa	2,777,000	23	17	0
Kansas	2,478,000	44	44	24
Kentucky	3,685,000	42	29	8
Louisiana	4,220,000	59	42	29
Maine	1,228,000	22	0	0
Maryland	4,781,000	89	89	87
Massachusetts	6,016,000	79	68	48
Michigan	9,295,000	74	68	47
Minnesota	4,375,000	64	55	55
Mississippi	2,572,000	26	18	0
Missouri	5,117,000	60	55	55
Montana	799,000	0	0	0
Nebraska	1,578,000	47	34	0
Nevada	1,202,000	83	62	0
New Hampshire	1,109,000	39	10	0
New Jersey	7,730,000	98	90	55
New Mexico	1,515,000	32	32	0
New York	17,990,000	89	81	62
North Carolina	6,629,000	45	41	0
North Dakota	639,000	0	0	0
Ohio	10,847,000	74	69	40
Oklahoma	3,146,000	53	53	0
Oregon	2,842,000	63	44	44
Pennsylvania	11,832,000	81	72	49
Rhode Island	1,003,000	89	65	0
South Carolina	3,487,000	53	53	0
South Dakota	696,000	0	0	0
Tennessee	4,877,000	64	64	0
Texas	16,987,000	73	62	50
Utah	1,723,000	78	62	0
Vermont	563,000	0	0	0
Virginia	6,187,000	66	63	47
Washington	4,867,000	73	60	41
West Virginia	1,793,000	34	0	0
Wisconsin	4,892,000	49	38	30
Wyoming	454,000	0	0	0
Total	248,709,000	71	63	42

*In health markets that cross state boundaries, people have been allocated to their state of residence.

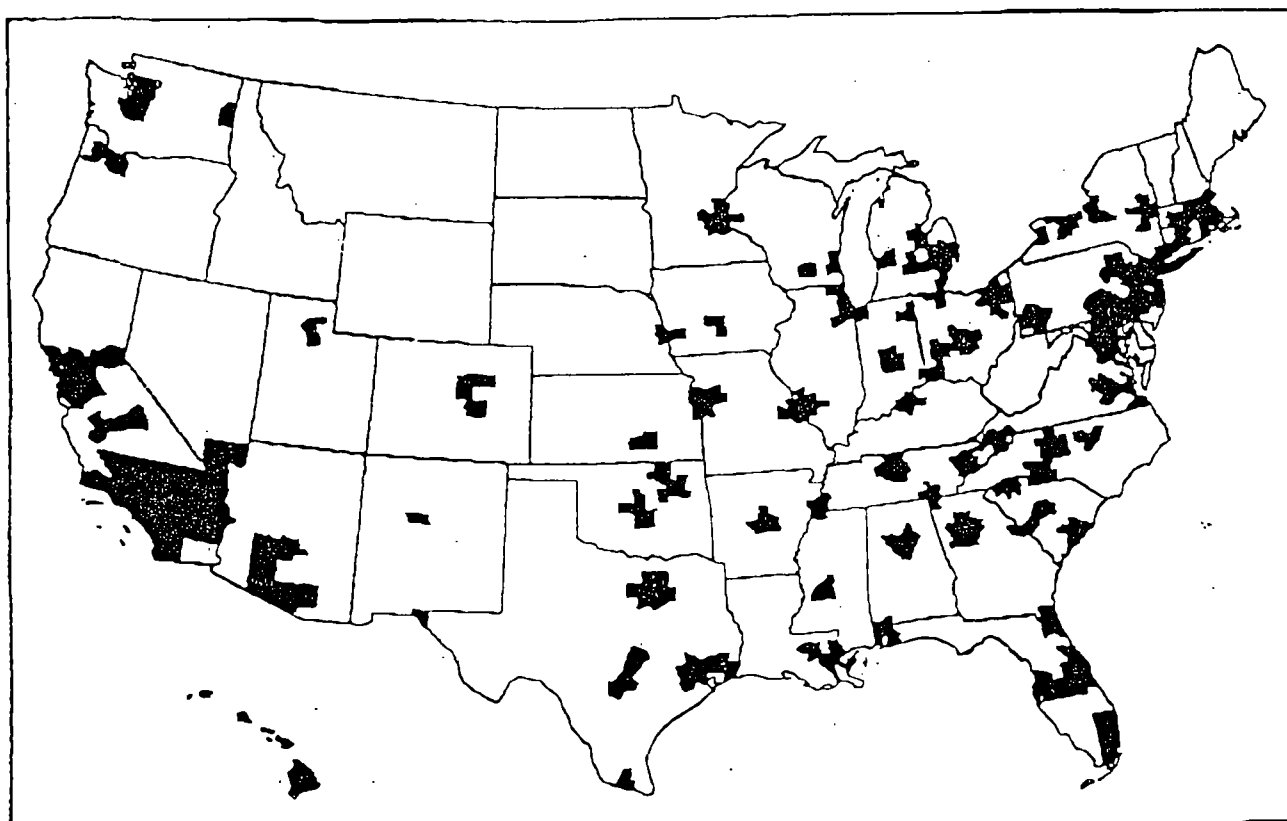


Figure 1. Health Markets with Populations $\geq 360,000$ in the United States.
Metropolitan areas (health markets) with populations $\geq 360,000$ are shown in black.

ation as the basis for achieving the efficiencies that the population-based perspective of the classic HMO brings to the health care economy). Monitoring by the states should be based on a sophisticated understanding of their health care systems, including detailed information about the location and level of use of resources in local and regional markets. Each state will need to recognize the limitations as well as the advantages of managed competition, particularly the need for support within an overall regulatory framework that can deal effectively with all the territory within its jurisdiction.

We recommend that the states be given wide latitude to undertake experiments in setting the rules for managing health care reform within their territory. We expect a provocative series of experiments that promote a variety of approaches to the complex problem of building population-based systems of care. Some will result in as yet unanticipated hybrid solutions that reflect demographic factors, the history of the state's health care industry, and regional traditions and preferences.

University of California—
San Diego
La Jolla, CA 92093

Dartmouth Medical School
Hanover, NH 03755

Group Health Cooperative
of Puget
Seattle, W

RICHARD KRONICK, Ph.D.
DAVID C. GOODMAN, M.D.
JOHN WENBERG, M.D.

EDWARD WAGNER, M.D., M.P.H.

We are indebted to Chiang-Hua Chang, M.S., and Thomas Bubolz, Ph.D., for their analytic support.

Address reprint requests to Dr. Kronick at the Department of Community and Family Medicine, University of California-San Diego, La Jolla, CA 92093.

Supported by a grant (HS 05745-05) from the Agency for Health Care Policy and Research.

REFERENCES

1. The guts to reform health care. *New York Times*. August 2, 1992:16.
2. Fallermayer E. Let's really cure the health system. *Fortune*. March 23, 1992:46-58.
3. Garland SB. A prescription for reform. *Business Week*. October 7, 1991:55-66.
4. Talking points on health care. Little Rock, Ark.: Clinton/Care Campaign Committee, 1992.
5. Enthoven AC, Kronick R. Universal health insurance through incentives reform. *JAMA* 1991;265:2532-6.
6. Enthoven AC. Theory and practice of managed competition in health care financing. Amsterdam: Elsevier North-Holland, 1988.
7. Kasper JF, Malley AG Jr, Wernberg JE. Developing shared decision-making programs to improve the quality of health care. *QRB Qual Rev Bull* 1992;18:183-90.
8. Mulhausen R, McGee J. Physician work: an alternative projection from a study of large, prepaid group practices. *JAMA* 1989;261:1930-4.
9. Hicks LL, Clemens JK. Too many physicians in the wrong places and specialties? Populations and physicians from a market perspective. *J Health Care Marketing* 1989;9(4):18-26.
10. Codes, titles, and components of metropolitan areas (MSAs, CMSAs, and PMSAs). Washington, D.C.: Bureau of the Census, 1990. (Department of Commerce report 2-52.)
11. 1990 Census of population and housing: summary population and housing characteristics — New Hampshire. Washington, D.C.: Government Printing Office, 1991. (Bureau of Census report CPH-1-31-A-8.)
12. Half the nation's population lives in large metropolitan areas. Press release of the Department of Commerce, Washington, D.C., February 21, 1991.
13. Freeman JL. The evaluation and refinement of New England Hospital Service Area definitions. Hanover, N.H.: Dartmouth Medical School, 1991.

2. Samaan NA, Vieto R, Schultz PN, et al. Hypothalamic, pituitary and thyroid dysfunction after radiotherapy to the head and neck. *Int J Radiat Oncol Biol Phys* 1982;8:1857-67.
3. Lintley MD, Shalet SM, Beardwell CG, Ahmed SR, Applegate O, Surtee ML. Hypopituitarism following external radiotherapy for pituitary tumours in adults. *Q J Med* 1989;70:145-60.
4. Lintley MD, Shalet SM, Beardwell CG, Robinson EL, Surtee ML. Radiation-induced hypopituitarism is dose-dependent. *Clin Endocrinol (Oxf)* 1989;31:363-73.
5. Harrop JS, Davies TJ, Capra LG, Marks V. Hypothalamic-pituitary function following successful treatment of intracranial tumours. *Clin Endocrinol (Oxf)* 1976;5:313-21.
6. Richards GE, Wern WM, Grumbach MM, Kaplan SL, Sheline GE, Conte FA. Delayed onset of hypopituitarism: sequelae of therapeutic irradiation of central nervous system, eye, and middle ear tumors. *J Pediatr* 1976;89:553-9.
7. Cozzine LS, Wolff PD, Cass D, et al. Hypothalamic-pituitary dysfunction after radiation for brain tumors. *N Engl J Med* 1993;328:87-94.
8. Jodanis A, Jimenez LE, Joplin GP. Long-term effect of ⁹⁰Y pituitary implantation in acromegaly. *Acta Endocrinol (Copenh)* 1987;115:301-6.
9. Lintley MD, Shalet SM, Morgenstern GR, Deskin DP. Endocrine and reproductive dysfunction following fractionated total body irradiation in adults. *Q J Med* 1991;78:265-74.

CONTROLLING COSTS BY "MANAGED COMPETITION" — WOULD IT WORK?

In an editorial four years ago I suggested that universal health insurance was an idea whose time had come.¹ That prediction may have been a little premature — but now, with the election of a president strongly committed to health care coverage for all, early legislative action seems very likely. However, Mr. Clinton clearly understands there can be no universal insurance without effective cost controls. Virtually all experts now agree that cost control is the key. The central task is to slow or stop the relentless inflation of costs, while making necessary services available to all and preserving or improving the quality of care. Many possible approaches to this daunting problem have been suggested, but they all rely to some degree on expanding and improving the management of care. "Managed care" refers to the kind of care provided by health maintenance organizations (HMOs) of various types and by preferred-provider organizations (PPOs), both of which limit the patient's choice of physician to doctors in an organized system of care. It also refers to the care provided by indemnification insurance plans that offer a free choice of physician but manage care by monitoring claims and denying or reducing payment for those deemed unjustified. The great majority of managed-care plans are of this type. A recent Health Policy Report by Iglehart² provides a useful description of the various forms of managed care.

All forms of managed care attempt to control costs by modifying the behavior of doctors, although they do so in different ways. In group-model and staff-model HMOs, care is provided almost entirely by multi-specialty groups of salaried physicians who practice in common facilities provided by the owners of the HMO, and in a general style established by the group. In independent practice association (IPA)-type HMOs, physicians practice in their own offices and devote only a part of their time to the care of the IPA's subscribers. IPAs vary in their organization and the extent to which they control their participating physicians, but all attempt to encourage cost-conscious patterns of practice. Some IPAs pay primary care physicians on a capitation basis and make them

responsible for referring patients to selected specialists, who are paid on a fee-for-service basis.

Despite these differences in organization and style of practice, all HMOs — group model, staff model, and IPA — are alike in combining the insurance and delivery aspects of medical care. HMOs accept a fixed prepayment for which they agree to provide all necessary care within a defined range of coverage. Their owners are motivated thereby to encourage a cost-conscious style of practice by their physician members. In contrast, most managed-care plans run by indemnity insurance companies have no formal relation with physicians other than to pay their bills. Consequently, their ability to monitor and modify practice is much more limited and reactive. In PPO indemnification plans, however, insurers select a particular group of fee-for-service physicians who are judged to be competent and cost-efficient and who agree to accept a negotiated fee that is usually lower than customary.

In group-model HMOs, and sometimes in staff-model HMOs, physicians are largely responsible for the management of care within a fixed budget. In IPAs and in indemnification plans, management is done by the insurance company, which, naturally enough, focuses on costs. With a few exceptions, the management of these plans is concerned more with costs than with the quality of care. However, since they are based largely on fees for service, indemnification plans and most IPAs have been less successful at controlling costs than have group- and staff-model HMOs.

Some particularly successful staff- or group-model HMOs have been able to provide care for considerably less than the costs of traditional indemnification insurance, largely through the reduced use of hospital services. However, the cost reduction achieved by most managed-care plans has so far been modest at best and highly variable. In any case, no managed-care plans have been able to slow the current rate of inflation in costs, whatever their effect on the base-line level of expenditures.

Approximately 95 percent of the 153 million Americans insured through their employers are covered by some type of managed-care plan, but managed care is used by less than 10 percent of the 60 million people

insured through Medicare or Medicaid.² Some planners believe that the cost-control problem can be solved simply by expanding managed-care plans to include people not now covered by such arrangements and by intensifying present management efforts, but there is little support for that optimistic view. Not only have most managed-care plans failed to slow cost inflation, but their intrusive surveillance and control methods have also increased discontent among physicians and patients.

In 1978 Enthoven first proposed that costs could best be controlled by combining market competition with managed care — a plan subsequently known as "managed competition."³ According to his basic idea, managed-care organizations would be encouraged to compete on the basis of price and quality for insurance contracts with employers, Medicare and Medicaid, and any other payers interested in low-cost insurance. The competition would be regulated by public agencies that would certify approved managed-care plans, define standard benefits, ensure open enrollment, and monitor quality. Only the costs of the lowest-priced approved plan or plans would be tax deductible. Employers or individuals who chose more expensive plans would have to pay the difference in costs with taxable dollars. The public agencies would also require approved plans to participate in quality control and outcome evaluation. Although PPOs and other managed indemnification plans might be permitted to compete, they almost certainly would not be successful. Most physicians would therefore become affiliated with HMOs of some type, most of them probably owned by insurance companies.

In his 1978 Shattuck Lecture,³ Enthoven described the extensive changes in the practice of medicine that would be needed to support his plan. In 1989 he and Kronick extended and refined the proposal for managed competition, but the basic concept remained the same.⁶ The idea has recently gained much support, and now, with the election of Mr. Clinton, it may well become the key element of the new administration's efforts to control costs and reform the health care system.

Would managed competition really work? A study by Kronick et al. in this issue of the *Journal*⁷ suggests that populations large enough to support three or more competing managed-care plans exist only in middle-sized and large metropolitan areas. Smaller metropolitan and rural areas, containing roughly one third of the U.S. population, would therefore require alternative forms of organization and regulation. This analysis should give pause to those now touting managed competition as a comprehensive solution to our national health care problems. The same point was recently mentioned by Simmons et al.⁸

But there is reason to be concerned about how managed competition would work even where population is dense enough to support competing HMOs. Setting aside the formidable expense and administrative prob-

lems involved in establishing the necessary regulatory agencies and creating the many new managed-care groups that would be required, would price competition really control costs and would it do so without compromising quality?

In the absence of some limit on total expenditures, how can we be sure it would save money in a system so driven by expansive entrepreneurial forces? In our present profit-oriented medical insurance market, wouldn't all insurers try to keep their prices as high as possible while still staying competitive? And as a result might not the prices of all competitors still continue to rise, even though none would be far out of line with the others? Furthermore, as Kronick et al. point out,⁷ "There is no theoretical basis on which to infer the minimal number of firms that can successfully sustain competition." The authors chose to assume that a minimum of three competing HMOs would be necessary for the system to work well, but there is no assurance that this number, or any other number of competing HMOs, would ensure genuine competition instead of covert collusion to maintain prices.

A second concern about managed competition is the effect it might have on the quality of care. If the rise in prices were constrained by competition, one way of maintaining profits would be to limit services. Although competition would theoretically be based on quality as well as price, no practical system of monitoring by public agencies could be expected to ferret out all the subtle ways in which managed-care organizations, controlled by third parties determined to show a profit, might stint on services. The Enthoven plan allows — even encourages — management by insurance companies. However, good cost-effective care is best defined as the care provided by a competent and compassionate physician who has no incentive to do more or less than is judged appropriate in each case. It is most likely to be achieved when properly motivated physicians working with patients are given the authority to manage medical care without the intrusion of third parties but within clearly defined cost limits.⁹ To be cost effective, care must certainly be managed, but the responsibility for management is best placed directly in the hands of doctors and their patients.

There is much about the Enthoven plan that makes good sense. I particularly applaud its recognition that insurance subsidized by employers or government must inevitably be capitated and delivered by organized groups of physicians. As it should, the plan allows fee-for-service options, with the added costs borne by individuals. It quite properly emphasizes the need for technology assessment, outcome evaluation, and quality assurance. It is right on target in stressing the need for more primary care physicians and the importance of requiring referrals to specialists.

Medical care in the future will have to be more effectively managed. But the important question is,

Who should do the managing and with what incentives and constraints? I doubt whether management by third parties in an open-ended price-competitive market would control health care costs while protecting quality. In my view, the best method of containing costs is to set a fixed budget, based on capitated prepayment, within which autonomous, not-for-profit groups of doctors and patients would agree to operate. These doctors should be paid in ways that avoid incentives for underservice. The best way to ensure quality is to require internal evaluation and accountability by these groups and to allow them to compete for members on the basis of quality, not price.

Since most management of care is now accomplished indirectly by insurance companies through the management of costs, encouraging price competition among insurers would simply increase the pressures on third parties to intrude into health care decisions that ought to be made professionally within the doctor-patient relationship. Before the new administration proposes health-reform legislation, I hope it will consider alternative versions of the "managed compe-

tion" idea that would put the responsibility for cost and quality control where it belongs — on physicians and their patients.

ARNOLD S. REILMAN, M.D.

REFERENCES

1. Reilman AS. Universal health insurance: is time has come. *N Engl J Med* 1989;320:117-8.
2. Iglehart JK. The American health care system — managed care. *N Engl J Med* 1992;327:742-7.
3. Enthoven AC. Consumer-choice health plan: inflation and inequity in health care today: alternatives for cost control and an analysis of proposals for national health insurance. *N Engl J Med* 1978;298:650-8.
4. *Idem*. Consumer-choice health plan: a national health insurance proposal based on regulated competition in the private sector. *N Engl J Med* 1978;298:709-20.
5. *Idem*. Cutting cost without cutting the quality of care. *N Engl J Med* 1978;298:1229-38.
6. Enthoven A, Kronick R. A consumer-choice health plan for the 1990s: universal health insurance in a system designed to promote quality and economy. *N Engl J Med* 1989;320:29-37, 94-101.
7. Kronick R, Goodman DC, Wennberg J, Wagner E. The marketplace in health care reform: the demographic limitations of managed competition. *N Engl J Med* 1993;328:148-52.
8. Simmons HE, Rhodes MM, Goldberg MA. Comprehensive health care reform and managed competition. *N Engl J Med* 1992;327:1525-8.
9. Reilman AS. Reforming the health care system. *N Engl J Med* 1990;323:991-2.

U. S. SENATE LABOR AND HUMAN RESOURCES COMMITTEE

**"ACHIEVING EFFECTIVE COST CONTROL IN COMPREHENSIVE HEALTH CARE
MANAGED COMPETITION AND REGULATORY APPROACHES"**

DECEMBER 16, 1992

"MANAGED COMPETITION IN PRACTICE"

TOM J. ELKIN

TESTIMONY

INTRODUCTION

As the search for solutions to America's health care crisis intensifies, a model has emerged which may dampen the rising cost of care and expand coverage to those who are currently uninsured. This model is called "Managed Competition". A key part of this model is the Health Insurance Purchasing Cooperative (HIPC). Many of the primary elements of the HIPC, i.e., uniform benefits, multiple employer purchasing, consumer protection, quality monitoring, comprehensive data collection and aggressive contract negotiating have been successfully implemented by the California Public Employees' Retirement System (CalPERS) Health Benefits Program. By taking advantage of market competition among health maintenance organizations, CalPERS has slowed the escalating cost of care while improving access and quality.

BACKGROUND

The California Public Employees' Retirement System was established in 1935 to administer the retirement program for state employees. The System is administered by a 13-member board which acts as the fiduciary for all benefit and investment programs including health care. Its primary mission is the efficient and accurate administration of member benefits.

Over the years, the System has grown to include not only state employees but employees from hundreds of public agencies in California. Currently, CalPERS administers retirement benefits for over 900,000 public employees throughout California.

The value of the pension investment portfolio is in excess of \$70 billion, the largest public pension fund in the nation. The size of the Investment Program provides CalPERS with significant presence as a stockholder in many major corporations. The CalPERS Board has been very active in the corporate governance arena, holding CEOs more accountable for the performance of their corporations.

The Health Benefits Program was established in the mid-1960s to purchase health care initially for state employees only. Legislation was passed in the early 1980s to allow other public agencies, in addition to the State of California, to join the CalPERS Health Benefits Program.

Initially, growth was slow; and only a few agencies joined the program in the early years. However, as the cost of health care began to accelerate and the complexity of managing and administering multi-carrier programs increased, more agencies recognized the value of joining the CalPERS program. The cost of administering small risk pools of employees, and the inability of smaller agencies to negotiate favorable premiums were the primary reasons for joining CalPERS.

Currently, there are 757 public employers participating in the CalPERS Health Benefits Program. These range from the State of California with 626,000 covered lives to the Antelope Valley Mosquito Abatement District with two members. There are over 875,000 covered lives in the program today, 75 percent of which are enrolled in an HMO. Eighty two percent of the members are active employees and 18 percent retired.

CalPERS contracts with 22 HMOs to provide care to its members, and administers a self-funded preferred provider organization (PPO), plan for those members who reside in rural areas with no HMO option or for those who want to remain in a PPO plan. The annual expenditure for health premiums is \$1.3 billion.

Last year, 75 public agencies joined the program primarily because the CalPERS premium structure was more favorable and the administrative tasks related to health benefits could be transferred. It is estimated that over 100 additional public employers will join the program in 1993. Currently, the public agency sector of the program makes up 28 percent of the total enrollment, with the remainder being state members. However, given the recent growth rate of smaller public employers, it is estimated that over 50 percent of the membership will be public agency employees by the year 2000.

GOVERNING BOARD OF CALPERS

The success of the CalPERS Health Benefits Program in providing quality, affordable health care to the many hundreds of employers enrolled in their system is, to a great extent, due to the composition and leadership of the Board of Administration. The CalPERS Board governs the Retirement System, the investment portfolio and the Health Benefits Program. It is a 13-member Board; six elected by the membership of the System (consumers), five represent employers and two are appointed by the Governor and the California Legislature.

The Board has the exclusive authority for the administration of the program and operates with a great degree of independence. The Board employs staff to administer the various programs and provides policy direction which is implemented by staff. The Board has established a Health Benefits Advisory Council to provide medical, technical and health policy advice on various issues related to the Health Benefits Program. This Council consists of doctors, economists, health plan executives, consultants and other members knowledgeable in health care.

SERVICES CALPERS OFFERS EMPLOYERS

CalPERS provides a full range of services to employers, which relieves them of an administrative burden many are not equipped to adequately perform. Employers are charged .5 percent of their health care premiums as a fee for these services, which is significantly less than it costs the employer to perform the same tasks.

The following are services provided to employers:

1. Enrollment processing, adjustments and deletions.
2. Premium collection, deposits, distribution, and retroactive adjustments.
3. Edits and audits to prevent double coverage, and ineligibility.
4. Annual open period for plan selection.
5. Production and distribution of health plan benefit information booklets to all members.
6. Member complaint resolution and appeal processing.
7. Premium negotiations.
8. Consumer surveys and quality assurance monitoring.
9. Contract compliance and monitoring.
10. Provider access review and assurance.
11. Employer assistance and training.
12. Cost and quality outcome data collection.

As a condition of participation, agencies cannot restrict enrollment due to pre-existing conditions, age or sex. There is no waiting period; coverage begins the month following enrollment for all employees and retirees of the agency. Employers must

provide coverage for their retirees and all employers participate in the statewide premiums regardless of their size, location or age of their members.

One of the strengths of the program is that the administration and risks are spread over a large risk pool which enables CalPERS to provide services for a low administrative cost. This has enabled the PERS Board to provide access to comprehensive services at affordable rates for all members of the program.

RATE NEGOTIATION PROCESS

In response to severe state and local budget reductions and limitations on employer contributions for health care last year, the CalPERS Board established a negotiating strategy of zero percent for HMO premium increases. The Board believed that it could dampen the cost of care by taking advantage of the \$1.3 billion purchasing power to more aggressively negotiate premiums. In a letter sent to all 22 carriers, the Board set out its philosophy, describing the serious condition of the California State Budget and emphasizing the fact that this was not "business as usual." In response to this message, five plans responded with either zero increases or modest reductions to their current premiums.

In preparation for negotiations, CalPERS required its carriers to submit cost data to support their rate request. This data allowed CalPERS to develop comparative analyses which displayed how well various plans were managing specific benefits. The data, presented on a per-member-per-month basis, illustrated wide variation between the costs of each of 20 separate benefits. For example, the data for prescription drugs across 22 plans revealed a wide range of difference in the average cost of drugs. CalPERS brought these differences to the attention of those plans with high drug costs, questioning their ability to effectively manage that component of their benefit design.

This process was used throughout the negotiating cycle to encourage carriers to examine high cost centers and implement managed care techniques to lower costs and reduce premiums. In essence, this process became an HMO evaluation as well as a price negotiation and has resulted in changes within the management of some HMOs, making them more efficient in the delivery of care.

The result of this process was a 6.2 percent average premium increase for all HMOs for the 1992 contract year. The average increase for 20 of the 22 carriers was 3.1 percent. However, CalPERS was unable to encourage Kaiser to reduce its 10.5 percent increase, so the overall weighted average was 6.2 percent. Due to the impasse between CalPERS and Kaiser, CalPERS imposed an enrollment freeze on the plan as a sanction for not participating in the cost containment effort. At a time when the industry

average increase was 13.4 percent, it is estimated that the 6.2 percent rate increase negotiated by CalPERS saved and/or cost avoided \$90 million.

STANDARD BENEFIT DESIGN "LEVELING THE PLAYING FIELD"

As the program grew, during the past decade, health plans were added to provide additional choice and coverage throughout the state. As these new HMOs joined the program, they were required to provide a basic scope of benefits comparable to those offered in the private sector. They were allowed, however, the flexibility to customize copay charges, benefit limitations, definitions and exclusions to meet the individual market demand and their unique plan design. Over the years, plans continued to modify their benefit design in response to competition, customer demand, marketing strategy, risk selection and general evolution of the delivery of health care. This process resulted in an excessive range of benefit variations between plans. The proliferation of variations reached a level of confusion that began to adversely affect two areas, member plan selection and premium negotiations.

To assist in selecting a plan, CalPERS sends a booklet every year during open enrollment to each member describing the benefits of the 22 HMOs, explaining the numerous variations. In order to simplify the comparisons, CalPERS developed a large chart containing a graphic display of the various limitations, copays, exclusions and prices of each plan. This chart had 1,110 cells of information related to the differences in benefits and limitations among the health plans. The visual display of the myriad of benefit variations available illustrated the overly complex nature of the options. This complexity made it impossible to determine which plan offered the most value for the premium charged. More importantly, the volume of data proved overwhelming to members in the plan selection process. The proliferation of variations had reached an absurd level which was no longer useful to the members and confused the premium negotiation process.

For example, 15 separate benefits covered by the plans had copay variations accounting for hundreds of possible combinations of charges, benefits and plans. There were four different copay charges for physician office visits, nine different copay charges for mental health outpatient visits, and nine separate charges for prescription drugs with three different volume limitations. To make an informed choice, a member had to perform a complex analysis of projected utilization of various services by each member of his or her family and compare those to the premiums of each plan. This analysis would have to take into account the limitations and exclusions that control the benefits in each plan.

The impact of these variations on the management of the program was made apparent when CalPERS staff attempted to analyze the benefit designs in order to determine the value of each plan preliminary to rate negotiations. The benefit variations were extremely confusing and difficult to measure. During negotiations, many plans claimed that their premium increases were justified because their benefit design was "richer" than their competitors'. Some claimed they had lower copay charges and/or fewer restrictions and, therefore, deserved higher premiums than other plans. For CalPERS to effectively determine the value of each plan, staff would have had to perform a lengthy and complex analysis. This was not possible given the time and resources available during the negotiating cycle.

In response to this complexity, a benefit freeze was imposed for the 1992 rate renewal negotiations which prevented plans from changing their benefit configurations to adjust to premium concessions. Using this strategy and aggressively negotiating price, CalPERS achieved an average premium increase of 6.2 percent for all HMOs for the 1992 contract year. In the process, however, staff recognized that some form of benefit standardization was necessary if they were going to effectively evaluate and compare the efficiency and cost effectiveness of health plans and simplify the plan selection process for members. This was the beginning of the standard benefits design project.

The basis of a standard benefit design was focused on making the benefit design more uniform without reducing the scope of benefits currently available. The concept of standardizing benefits has been implemented by some employers to reduce benefits in order to contain costs. This was clearly not the goal of the CalPERS Board; rather it was to provide affordable, comprehensive, quality health care to all members of the System. Standardizing the benefit design appeared to be an effective method to achieve that goal.

A draft proposal was prepared by CalPERS staff and shared with many constituent groups. Staff worked closely with these groups to develop a standard benefit design which represented a consensus of all concerned. After five months of discussion, analysis and revision, a consensus was reached and the proposal was presented to the CalPERS Board in July 1992 for their review and approval. The Board approved the proposal for the contract year beginning August 1, 1993.

An important part of the project entailed the development of uniform benefit definitions to insure that the level and scope of benefits provided to CalPERS' members would be the same regardless of which plan they joined. Because of the variation between benefit definitions, it was essential that all plans use the same definition for each benefit. Staff reviewed the existing definitions and identified the best, most comprehensive

for this purpose. The health plans were helpful in assisting in this process and provided valuable consultation.

By standardizing the benefit design, unnecessary complexity and confusion have been removed from the plan selection process members face each year. They will be able to make more informed decisions based on price, quality, access, and service rather than be overwhelmed by a complex array of benefits. There will no longer be "air pockets" where a benefit is not covered under certain circumstances nor will there be benefit limitations which encourage high risk patients to select other plans. Members in the CalPERS health program will now be assured that a comprehensive scope of health benefits will be available regardless of the plan they choose.

The standardization has resulted in broader, more comprehensive benefits than previously existed. Eight plans reduced their copay charges for drugs and physician visits, four plans expanded coverage for substance abuse services, nine plans expanded coverage for skilled nursing facility care, and nine plans broadened hospice care.

The premium negotiation process has been simplified and competition between carriers has been enhanced. There are no longer plans with "richer" benefits that must be calculated when negotiating rates. CalPERS has significantly "leveled the playing field" and increased competition between health carriers by removing the variation from the benefit design. This will translate into lower premium increases which will benefit members and employers. An illustration of how this will enhance competition is described below.

An urban area in California has ten HMOs providing care to CalPERS members. The difference between the lowest and highest family monthly premium is 14.5 percent. The majority of these plans contract with the same provider networks and hospitals and provide care to virtually the same demographic mix of members. In the past, this range of premiums would have been justified due to the variations of benefit designs among the plans. Now that benefits have been standardized, a 14.5 percent variation in premiums will be extremely difficult to support. Price competition will be enhanced and plans will have to become more efficient in order to compete for CalPERS' business.

ENHANCED DATA COLLECTION

This past year, CalPERS enhanced its health plan data collection system for the purpose of quality monitoring as well as rate negotiations. As a major purchaser of health care, CalPERS believes that performance data is critical to making informed choices about premiums, quality and access. The data includes more detailed information on a per-member-per-month basis as well

as encounter, quality, and outcome data. This information, as well as proving invaluable at the negotiating table, provides critical information that will enable CalPERS to more aggressively monitor quality and performance.

For example, during a negotiating meeting this year, an abnormally high rate of cesarean sections was brought to the attention of one of the health plans. CalPERS staff pointed out that if the rate of cesarean sections was reduced to a more appropriate level, the plan could reduce inpatient days, reduce surgical costs, improve the quality of care provided to patients and lower their premium. The HMO committed to a plan of correction and reduced their premium to reflect the anticipated savings. Effective management of health services and cost containment initiatives will not only reduce the cost of care but improve the quality and outcome of services provided.

SELF FUNDED PPO PLANS

CalPERS manages a self-funded PPO plan called "PERSCare." It provides a PPO network model for members who live out of state, in rural areas not yet covered by an HMO, or for those who want the freedom of a fee-for-service system. Although it is an adversely selected population, with an average age of 51, CalPERS held premiums to a 4.9 percent increase last year by aggressively managing the plan, out performing industry trends by at least 10 percent. The administrative cost of the plan is 6.5 percent, which is significantly below the average of 12 to 15 percent charged by most commercial plans. There is every expectation that premium increases for the PPO this year will continue to be a single digit percent.

CalPERS uses the paid claim data from their self-funded plan in pre-negotiation analysis of the HMO data, which provides valuable benefit cost data for comparison purposes. The ability to compare specific benefit trends from this plan with trends submitted by HMOs is critical in validating proposed premium increases.

ENROLLMENT SERVICES ELECTRONIC DATA TRANSFER

CalPERS has begun implementation of a multi-year project to consolidate and automate its health enrollment information system. The rapid growth and increased complexity of the program requires that the enrollment system used by over 750 separate employers be upgraded to meet the demands of all users. When completed, all enrollment information for health and dental services will be electronically transmitted to employers, carriers, and CalPERS staff. This system will reduce errors, improve service, reduce carrier administrative costs and avoid significant costs in ineligible coverage.

CalPERS expects to have the initial phase of this system operational by July, 1994 and plans to have the complete system in place by 1997.

FUTURE DIRECTION

By taking advantage of market competition, more effectively negotiating premiums, and continuing to collect cost and outcome data, the CalPERS Board will continue to control cost increases of care. Enhanced data collection will provide information on both cost and quality of care delivered which will allow CalPERS to evaluate the performance of its carriers and more accurately measure their effectiveness.

The strategies and techniques that CalPERS has implemented are of great interest to private employers who are struggling with similar pressures to dampen the cost of health care. CalPERS has recently joined the Bay Area Business Group on Health, a coalition of 14 large corporations based in California who have organized to collectively explore various methods to better purchase and manage health benefits. By combining the purchasing power of CalPERS and major corporations, this organization will be able to jointly collect common performance data, perform quality monitoring and negotiate premiums.

The transferability of cooperative purchasing, standard benefit design, enhanced performance data collection, and quality and outcome measurement from CalPERS to private employers is very high. Many elements of the HIPC model can be put into place quickly, enabling employers and consumers to purchase health care in a more informed and cost effective manner.

CONCLUSION

The primary responsibility of the Board is to the members of the program, both active and retired employees, and to the employers who contract with them to provide health care. The Board's independence, consumer and employer orientation and commitment to providing quality, affordable health care are basic elements of CalPERS' philosophy.

It is the mission of the CalPERS Board to continue to seek innovative ways to provide health care to its members. It is their belief that there are many efficiencies, improvements and changes that can and should be made to the health delivery system which will allow this mission to be fulfilled. Cost containment should not be achieved by eliminating dependent coverage, eliminating retiree coverage or cutting benefits. Other measures to reduce cost, improve quality and organize more efficiently must be considered before the number of uninsured are increased. CalPERS is committed to this philosophy.

Prinuniv.spe

BENEFIT PACKAGE

Under most versions of managed competition, consumers would choose from among "privately administered" health plans offered by the state/regional insurance purchasing cooperatives. We would argue that purchasing cooperatives must offer at least one fee-for-service plan.

Paul Starr and Shoshanna Sofaer maintain that standardizing benefits is essential to ensure a level playing field in which consumers, and the purchasing cooperative, can make meaningful comparisons across plans.

Shoshanna Sofaer believes that it will be difficult enough for consumers to assess the relative value of plans in terms of the quality, convenience and provider choice; if benefit packages also differ, they would have to compare their financial vulnerability in different plans.

Issues/Options

- Should states/regional purchasing cooperatives have any degree of flexibility to develop the benefit plans to reflect local needs, or the needs of special populations, e.g., children?
 - o Children represent a different underwriting case from an insurance perspective since they require preventive services, health education, and routine treatment of ordinary illness rather than protection against unusual risk.
- Should the core packages be defined at the national level while allowing the HIPCs some flexibility to modify the implementation of the benefits packages within the constraints of local delivery systems?
- Unless the benefit package is genuinely comprehensive, a market for supplemental insurance is likely to develop. Experience with Medicare supplements indicate that such a market has enormous potential for exploiting, confusing and wresting lots of money from consumers, by employing a wide range of unsavory sales and marketing tactics.
 - o The center of the continuum of plans and proposals would provide coverage similar to a Kaiser-HMO. Such coverage is comprehensive enough to satisfy American demands for high quality medical care, yet not so rich to break the bank.
 - o Such plans, however, skimp or exclude mental

health and home health care services, and even coverage of relatively cost-effective services such as home care has not been aggressively promoted through HMOs.

- A less than comprehensive benefit package could lead to extensive out-of-pocket payments by consumers for services that are not covered, or inadequately covered. This could also lead to a sub-set of facilities and providers "opting out" of the system, creating an "upper tier" health care system financed entirely out-of-pocket.
- From the consumer viewpoint, Paul Starr (Labor Committee testimony) suggests that managed competition should be seen as a framework of consumer choice among an array of competing health plans, not all of which would necessarily be managed care.
- Choice has been a Republican hobby-horse in the health care debate. There are two important answers to the choice argument.
 - o First, it is something of a myth that individuals have any significant choice in their plans. For most people the option is the coverage that their employer provides; often this coverage places either restrictions or financial disincentives for using providers outside of the plan's network.
 - o We anticipate that local purchasing cooperatives would contract with a number of providers representing the range of delivery system options. For instance, in California where the California Public Employees Retirement System is the closet to this system, there are 26 different plans available. Although there might not be as many as 26 options offered by each local cooperative, we expect that there will be many alternatives -- more in fact than are typically available to most Americans.

RURAL HEALTH ISSUES

In sparsely populated areas where relatively few providers are required, it is not feasible to divide the provider community into competing groups. Attached is a report from the Rural Wisconsin Hospital Cooperative "Rural Health Meets Managed Competition: The Issues?" that lists specific issues related to implementing managed competition in rural areas.

John Wennberg asserts that managed competition will not work for 40 percent of Americans living in areas too sparsely populated to support managed competition based on fully independent groups; many states have no territories where this form of competition could exit. He suggests that if managed care is to work in less populated areas, it will depend on Independent Practice Associations (IPAs) and related models which do not own their hospitals or hire physicians on a per capita basis to cover the full breadth of benefits.

Richard Kronick et al. in a recent N. Eng. J. Med. article has examined the demographic features of the health care market in the U.S. to see what portion of the population live in areas that might successfully support managed competition based on fully independent, staff model, HMOs. Population estimates to support fully independent staff model HMOs are as follows:

- * a health care services market with a population of 1.2 million could support three fully independent plans;
- * a population of 360,000 could support three plans that independently provided most acute care hospital services, but the plans would need to share hospital facilities and contract for tertiary services;
- * a population of 180,000 could support three plans that provide primary care and many basic specialty services, but that shared impatient cardiology and urology services.

Kronick concludes: Larger and medium size metropolitan area can support reform based on the expansion of managed competition. Smaller metropolitan areas and rural areas would require alternative forms of organization and regulation.

Issues/Options

- States should be given authority to make a finding that all or regions of their territory should be exempt from managed competition requirements and prescribe the alternative system that will assure coverage and meet budget

requirements.

- If purchasing cooperatives are established for every territory, in situations where managed competition is not viable, the local purchasing cooperatives could serve as the vehicle for receiving technical grants for helping regions develop community care networks.
- States should be allowed to develop interstate agreements to allow for coverage of residents of adjoining border areas. Regional HIPCs encompassing a number of states should also be allowed.
- Anti-trust and restriction-of-trade laws will require change or reinterpretation to allow mergers and the building of health care networks that serve rural populations.

LONG-TERM CARE

Attached is an article by Mark Schlesinger and David Mechanic on chronic illness challenges and managed competition from the Princeton conference.

Background

- Forty-three percent of all Americans who turn 65 this year will eventually enter a nursing home. Twenty-five percent of that group will stay at least one year, at a cost of \$30,000 to \$40,000. *
- According to the Long-Term Care Campaign, 40 percent of all Americans who need long-term care services are under age 65. Nearly 3.5 million non-elderly Americans have disabilities, and the number of children with disabilities is growing significantly. *
- Equity and increasing prevalence of chronic disability as the baby boom generation ages require attention to long-term care in comprehensive health care reform.
- Some people pay their own bill with their own savings, then turn to Medicaid when their money runs out; others will rely on Medicaid from the beginning. A few will use the proceeds from an insurance policy.

Issues/Options

- Long-term care coverage should be addressed as part of comprehensive health care reform. This might include such incremental steps as expanded coverage for respite and personal assistance as a first step and nursing home services over time.
- Commercial long-term care insurance policies are increasing in popularity; more than 1.5 million policies were sold in 1991, up from 815,000 in 1987. However, behind the sales statistics are serious problems of confusing language, tricky provisions in the way policies are written, the potential for large rate increases, and uncertainty about whether claims will be paid. Many insurance regulators are calling for increased regulation of these products.
- Some experts such as Mark Schlesinger and David Mechanic support the development of:
 - * a special subsidy program to encourage the development of plans that specialize in the treatment of chronic illness;

- * the development of sophisticated case-management models;
 - * elimination of experience rating to reduce discrimination in hiring employees with chronic conditions.
-
- Integrating people with chronic illness into managed competition will be difficult, but Schlesinger and Mechanic believe that there are strong moral, legal, and political imperatives to extend this system to the chronically ill.
 - We need to address issues concerning the "residual" Medicaid program if the acute care system moves toward managed competition.

OTHER PROVIDERS

School-Based Health Clinics

School-based clinics provide free or very low-cost medical, counseling, and family planning services to elementary and high school students. The number of school based clinics has grown steadily - from a handful in the late 1960s to over 300 today. They are supported through state, local, and private foundation funds. Nearly all of these clinics are located in areas with large uninsured populations unable to obtain health care elsewhere. Center directors say they are successful in getting health care to young people because they are located on or near school property. From a policy perspective, school health clinics are appealing because they cut down on high cost emergency department use.

The U.S. Public Health Service, the Office of Technology Assessment, numerous medical societies, philanthropies such as the Robert Wood Johnson Foundation, and the Children's Defense Fund have endorsed school-based clinics.

(Add brief mention of what they have done in Arkansas.)

Issues/Options

- The biggest controversy surrounding school-based clinics is over teenage sexual activity and family planning. Fierce opposition to family planning has come from anti-abortion groups, who equate clinics with abortion. Since most of this opposition come from outside the community, clinic directors say that a key ingredient to forming a clinic is community support.
- Most clinic directors say that national health care reform can only be positive, since any expansion in coverage would increase their financial viability. Most clinics were established with the aid of private foundations; when the money runs out, most clinics have difficulty in making up the loss of funding.
- Two-thirds of all uninsured children live in families with incomes above the federal poverty level, thus falling outside the income limits of the Medicaid expansions. As a result of failures in employer-based insurance, children are increasingly being severed from coverage and left without affordable alternatives.
- There are several successful state projects that have begun experimenting with various strategies for insuring "gap" children. About six states have enacted projects with

approaches ranging from simple Medicaid expansions to contracting with private indemnity plans and health maintenance organizations. The Health Care Financing Administration is also funding demonstration programs to get at this population.

- Health reform should take care to preserve state experimentation and initiatives in school-based health care.

COMMUNITY HEALTH CENTERS

NATIONAL HEALTH SERVICE CORPS

SUMMARY

The National Health Service Corps (NHSC) program, originally enacted in 1970, encompasses two major activities, which are authorized under title III of the Public Health Service (PHS) Act. As amended by P.L. 101-597, NHSC activities include: a field program that places an array of qualified health professionals in areas that have shortages of health personnel, and scholarship and loan repayment programs that provide educational assistance to students of allopathic and osteopathic medicine, dentistry, nursing, and other health professions in return for an obligated service period. In FY 1991, the NHSC received total appropriations of \$91.7 million.

Since program activities began in 1972, the NHSC field program has placed over 16,000 health care providers in health professional shortage areas (HPSAs). Changes in the perception of national health manpower needs provided the basis for two distinct funding phases for the NHSC. During the 1970s, when the perception was that health manpower was insufficient to meet the need for health care services, program funding was rapidly expanded to respond to the shortage of health professionals in certain areas of the country. This was followed by significant funding cuts during the 1980s, because the supply of health professionals, particularly the supply of physicians, was thought to exceed the need for their services. Funding for the Corps peaked in 1980, when total program operations received \$153.6 million in appropriations, of which \$79.5 million was appropriated for NHSC scholarship awards. By FY 1987, total program appropriations had dropped to \$42.3 million, of which only \$2.2 million was appropriated for scholarship awards. By FY 1991, total appropriations for the NHSC had once again increased to \$91.7 million with \$48.8 million appropriated for new scholarship and loan repayment agreements.

Today, as efforts to improve access to health care continue to be at the forefront of policy development, Congress has focused its attention on the NHSC. Currently, there are over 2,000 federally designated primary care HPSAs across the country that would require the placement of over 4,400 primary health care providers to eliminate these shortage designations. As of December 31, 1990, there were 1,106 NHSC providers serving in the field. The Department of Health and Human Services (DHHS) estimates that the number of NHSC providers in 1991 will drop further to 1,009 and then increase slightly to 1,030 in 1992. Most experts agree that health professions shortages may be intractable in certain areas, and these areas will continue to have problems attracting health care providers, despite government efforts through programs like the NHSC.

Congress, recognizing the continuing need for the services of health professions provided by the Corps, enacted the National Health Service Corps Revitalization Amendments of 1990 (P.L. 101-597). The Act was signed into law on November 16, 1990, reauthorizing the NHSC program through the year 2000. Various program reforms were included that are designed to strengthen the Corps' ability to recruit and retain health professionals for service in HPSAs. These provisions include increased program funding authority, greater flexibility in the placement of NHSC obligors, funding set-asides for nurses and mid-level practitioners, and improvements in rural health care delivery through grants to State Offices of Rural Health.

Wanted: GPs

Too many physicians are being trained as specialists and not enough as generalists.

As a result, the nation's health care system emphasizes high-cost, high-technology medicine at the expense of basic and preventive care.

BY JULIE KOSTERLITZ

"As everyone knows, our [health care] system has an oversupply of specialists and not enough primary care physicians," Atul Gawande, a campaign aide to Democratic presidential nominee Bill Clinton, told reporters recently.

But ask Gawande, a 26-year-old student on leave from Harvard Medical School, what branch of medicine he plans to enter, and he replies a bit uneasily, "I don't know."

In his role as a presidential campaign adviser, it's clear to Gawande that one of the key problems to be fixed is the U.S. health system's heavy emphasis on high-cost, high-technology medicine, at the expense of basic and preventive care.

As a medical student, however, he may be a symbol of how hard it will be to reorient the country's health system. "There's no question that Harvard Medical School does not train you for primary care. There's no structure for primary care [education] there. Your role models are all super-specialists [and all the prestige is] with research and the hot-shot specialists."

But it's not just within the medical school culture that the status of the specialist has allure. Gawande, from Athens, Ohio, confesses that the folks back home "keep asking me if I'm going to become a pediatric neurosurgeon."

Overhauling the way the nation delivers health care may be the biggest sleeper issue in the increasingly raucous debate over health care reform. Most of the attention is being focused on how to finance health care for uninsured Americans and how to restrain runaway costs.

Although both presidential candidates and practically every serious congressional reform proposal pay lip service to reemphasizing primary and preventive health care, little is said about training a cadre of medical manpower appropriate to those tasks. "It is a hidden issue," said Sen. John D. (Jay) Rockefeller IV, D-W.Va., at recent hearing.

The nation's supply of doctors grew nearly 3.5 times as fast as the general population during the past decade. Yet

the percentage of physicians trained in primary care—already well below the 50 per cent or more found in many other industrialized counties—has been falling steadily, and now stands at 32 per cent. The share of medical school graduates picking primary care residencies has also fallen dramatically over time.

The situation threatens the achievement of the key goals of health care reform: A shortage of primary care doctors could stymie the expansion of access to health care—particularly in rural and inner-city areas; while an oversupply of high-cost specialists could make it hard to keep a lid on health care spending.

Reordering the priorities within the health care sector to low-cost and, arguably more-appropriate care, according to most experts, will require addressing more than the specialty mix of physicians. It will also require:

- better coordination of the care patients receive from myriad health professionals;
- more and better use of nonphysicians, such as physician assistants, nurse practitioners, pharmacists and social workers;
- more emphasis on community-wide public health and prevention measures outside the doctor's office.

But changing the kind and number of physicians in the system is an important place to start, many experts believe. Although physicians' fees account for only 22 per cent of health care spending, doctors' decisions—whether to hospitalize, what test to order, what drugs to prescribe—can influence a much larger share of spending.

"If we are to control the skyrocketing cost of health care, we need to get a handle on the partition of generalist versus specialist," former Surgeon General C. Everett Koop, recently told a Senate subcommittee. "Generalists seem able to function adequately as diagnosticians and therapists without resorting to overuse of resources now rather common among specialists," added Koop, who is working on a Dartmouth Medical School project studying ways to reform the medical education system.

The problem, however, is tough to

IN WEST VIRGINIA HEALTH EDUCATION PROGRAM . . .

WYOMING COUNTY, W.VA.—Not many youngsters escape the economically depressed coal-fields in the southwestern corner of this state to pursue a higher education. De Vonna Miller is one of the exceptions.

But this summer, Miller—a fourth-year pharmacy student—was back in her tiny hometown of Oceana for a month of training and says she hopes to practice here when she finishes school. “If I’d done my fellowship in Morgantown,” the state’s second-largest city and site of the University of West Virginia’s main campus, “I would’ve probably stayed there” to go into practice, she said in a recent interview.

As part of a team of nearly a dozen students in medicine, dentistry and relat-

ed fields, Miller is in the vanguard of a program that West Virginia officials hope will transform both medical education and health care delivery in the state. By getting the students out of big-city and big-hospital settings and into rural areas, the state is trying to increase the likelihood that they will practice in those areas and to get the state’s medical schools more involved in delivering care to underserved areas.

The state also hopes to promote greater collaboration among medical, dental, nursing and other health professionals, both during their education and, after graduation, in an integrated approach to practice that will maximize patient care resources.

The idea is not entirely new, but West

Virginia officials say there is more financial and institutional commitment to their project than previous, piecemeal, experiments have enjoyed. The state has matched a \$6 million grant from the Kellogg Foundation with \$6 million of its own money—no small feat for a poor state in the midst of a recession. A smaller federal grant is also involved.

The goal is to create 14 rural health education centers around the state, serving a network of 120 training sites—from rural hospitals and clinics to individual practitioners’ offices. By 1994, all health sciences students in the state’s university system will be required to have some training at rural sites.

The winds of change began to stir two years ago in the West Virginia Legislature. Concern was raised that although the state has four publicly subsidized medical schools, 44 of its 55 counties were designated as “health professions shortage areas.”

“We started looking at what is our percentage of [state medical school graduates] staying in the area,” said Del. Patricia Holmes White, from a rural district outside Charleston, who chairs the House of Delegates’ Health Care Oversight Committee. When it came to obstetricians, a group in particular demand, she said, they discovered “none had stayed in the state.”

As in a growing number of other states, West Virginia lawmakers started taking steps to ensure that their state gets a tangible return on the money it invests in medical education in the schools. When the lawmakers told the dean of West Virginia University’s med-



In a clinic in Pineville, W.Va., Philip Bibb trains to become a physician’s assistant.

Julie Kneiff

tackle. It touches upon everything from physicians’ incomes and retirement of student loans to questions of hospital finance, exposure to malpractice suits and antitrust concerns. Besides physicians, many other players—from medical school department heads to insurers—have vested interests in the outcome.

Although some of the diffuse interests groups are beginning to talk to one another and advance proposals for change, some analysts believe it will take stronger measures than those currently on the table to reverse today’s trends in medical education. (See box, this page.)

More sobering still, given the length of time it takes to train medical students, and the length of time today’s physicians will remain in practice, even radical changes in the educational pipeline won’t

translate into a commensurate change in the population of practicing physicians for at least a decade or two.

MEDICAL EDUCATION

Critics tend to lay much of the blame for the overabundance of specialists at the feet of the medical education system: four year medical schools and the teaching hospitals at which graduates spend typically a minimum of three years as interns and residents.

Thanks in large part to the flow of federal research dollars that began after World War II, medical schools have put more and more emphasis on increasingly esoteric areas of medicine. From being just another branch of a university, relying on practicing community doctors as

part-time instructors, they have developed into major medical complexes with full-time academics oriented toward research and the treatment of unusually complex and severe diseases, rather than everyday ailments.

High-tech medicine has also become a cash cow for the schools. “Medical schools reward and recruit specialty faculty because the schools are highly dependent on specialists for essential revenue,” said William Toby Jr., acting administrator of the Health Care Financing Administration, which oversees the federal medicare program, in recent testimony submitted to the Senate. Today, medical schools get roughly 21 per cent of their revenues from federal research grants, 42 per cent from treating patients and just 4 per cent from tuition and fees.

... COUNTRY ROADS LEAD STUDENTS BACK HOME

ical school that they wanted more emphasis on primary care and rural placements of students, "he was very indignant," said White, who is also a nurse practitioner and runs a free clinic.

A bitter war of words ensued. The university charged that the Legislature's plan threatened academic freedom and would devastate the economy of Morgantown. The lawmakers threatened to cut funds if the state's retention rate for medical school graduates didn't improve. Eventually Gov. Gaston Caperton helped resolve the crisis by proposing the \$6 million matching grant as an incentive to the universities to change their ways.

The university's medical school dean resigned. W. Donald Westin, dean of medicine at Michigan State University, was hired to fill a new vice chancellor's post to coordinate the activities of the state's competing medical schools and to run interference for them with the Legislature.

The schools are charged with seeing that 40 per cent-50 per cent of graduating medical students go into primary care specialties by 1995—up from 35 per cent now. "When you're a public institution, it's not wrong for a state government to say, 'These are the outcomes we want,'" Westin said.

A growing number of states are sending that message. Nearly a dozen have just passed or are considering legislation to boost the percentage of medical students entering primary care specialties. "Academic medicine is waking up to the fact that we have an obligation to train what is needed by society," Kansas Uni-



Medical education guru W. Donald Westin confers with Del. Patricia Holmes White.

Julie Kosterlitz

versity School of Medicine Vice chancellor D. Kay Clawson told the *American Medical News* recently after the defeat of one such bill.

Part of a student's training in the West Virginia program is to look beyond treating individual patients and try to deal with the broader health problems of the local communities, which can be complicated by such barriers as lack of running water and lack of transportation.

A student team in Wyoming and McDowell counties homed in on the dental problems of the local populations, which in turn forced them to confront a host of other social problems, from poor self-image to poor nutrition. "It's a junk-food culture," said Philip

Bibb, a student physician's-assistant doing an externship at a children's clinic housed in a trailer in tiny Pineville.

Students report that becoming involved in the lives of the people they serve has been rewarding and a refreshing change from impersonal, big-city health care practice. Richard Siemans, a fourth-year student at Marshall School of Medicine in Huntington, said his training in the office of a rural solo practitioner in Mingo County made him "more idealistic" and more likely to practice rural medicine.

But it can also be sobering. "It's far more than an educational experience," said Miller. "It's kind of depressing to see all the problems here. I cry inside, because these are my people."

Post-medical-school training—internships and residencies—occurs almost exclusively in large teaching hospitals geared toward the treatment of advanced diseases that require specialized care. In such settings, it seems only natural to develop a specialty. In addition, these hospitals have come to rely on interns and residents as relatively cheap sources of labor for delivering high-technology services that bring in big revenues.

The bias toward specialized hospital-based training is reinforced by public and private insurers, who often tack on special payments to compensate hospitals for their training costs. Medicare, the federal health program for the elderly, is alone paying roughly \$5 billion a year to hospitals for the costs of training residents—regardless of specialty. "The loca-

tion of medical education has to change," said Jordan J. Cohen, dean of the medical school at the State University of New York at Stony Brook. "Most of what we need to teach them [about] basic clinical skills and to illustrate what true general practice is about requires ambulatory settings," such as clinics and doctors' offices.

Medical academia has internalized the bias by adopting its own pecking order, which equates specialization with achievement. "Some of the smartest people in my class have been told, 'You have so much intelligence, why would you want to do family practice?'" said Richard Siemans, a fourth-year medical student at Marshall School of Medicine in Huntington, W. Va.—one of the few U.S. schools that emphasize family practice.

Actually, the creation of the specialty of family medicine in 1969 was itself an early effort to boost both the training requirements and the standing of generalist physicians beyond those of the traditional general practitioner. (Other specialties commonly considered part of the primary care system include pediatrics, obstetrics and gynecology, and internal medicine. Many of those who initially specialize in these fields, however, go on to subspecialize and become experts in narrower areas.)

Today, 99 of the nation's 126 medical schools have departments of family medicine. But that hasn't reversed the continuing trend toward specialization. "Many crucial issues are beyond the control of what medical educators can do," argues Stony Brook's Cohen, who chairs a task



Former Surgeon General C. Everett Koop, proponent of reforms in medical education
He says that the "overuse of resources [is] now rather common among specialists."

Richard A. Hirsch

force on primary care medicine for the Washington-based American Association of Medical Colleges.

For many residents, the strongest incentive to specialize may be the promise of substantially higher income. The median income of a family practitioner (after expenses, but before taxes) is \$93,000; for anesthesiologists and surgeons, the figure is \$200,000.

For young doctors, the lure of higher income may be more practical than venal. Graduating medical students, on average, have racked up \$56,000 in debt, and the amount frequently rises during their low-paid residencies.

Because most of their services are comparatively small-ticket items, primary care doctors tend to see more patients, and that means longer hours and more insurance paperwork. On top of the additional hassle, generalists suffer the insult of lower prestige among their peers. Primary care doctors in rural and some inner-city settings, have to work without the backup of well-equipped hospitals and a network of nearby peers for support, consultation or relief shifts.

Medical students "are bright people who say, '[Why should I] make less money, be more disgruntled by low pay and bureaucracy, have less prestige and have to accommodate to a life-style that is less forgiving in terms of having other interests and a family?'" Cohen said.

THE COST FACTOR

The rising recognition that the nation is both paying too much for health care and not providing many citizens with enough of it has focused interest in medical manpower and the structure of health

care delivery, much as it earlier raised interest in reforming the way the system is financed.

"Americans simply do not have enough health problems to keep all of our specialists appropriately occupied," said Steven A. Schroeder, president of the Robert Wood Johnson Foundation, in prepared Senate testimony. "Low rates of disease and a large capacity to treat it means many instances of too-aggressive care" that produce "only marginal improvements in health."

A study in a March issue of *The Journal of the American Medical Association (JAMA)* found family practitioners substantially less likely to hospitalize patients than specialists treating patients who had similar levels of illness. It also found that doctors in health maintenance organizations (HMOs) are less likely to put patients in hospitals than doctors in a single-specialty fee-for-service practice.

The *JAMA* study amounted to a vote of confidence in primary care physicians, because most HMOs rely heavily on them to serve as a "gatekeeper"—seeing patients first and coordinating referrals to specialists and hospital admissions. Other studies have found that generalists are far likelier to practice in rural and inner city areas faced with chronic shortages of doctors.

Large employers, desperate to cut employee health care costs, are already fans of HMOs and other managed care plans. Many of them are critical of the oversupply of specialists. "Corporations have been increasingly concerned about wellness—prevention and early intervention—things like cholesterol management. You don't need specialists for these things," said Mary Jane England,

president of the Washington Business Group on Health, which plans a special session on the issue at its January meeting.

Federal and state health officials are also starting to focus on the problem. In August, Health and Human Services Secretary Louis W. Sullivan unexpectedly summoned representatives of various medical groups to discuss the overspecialization of health care delivery. His aides hint that corrective proposals may be unveiled this fall.

Action thus far has been confined to studies, commissions and small-scale demonstration programs, sponsored by foundations and obscure federal agencies. But those activities have grown in number and have gradually encompassed individuals and groups in a position to make a difference.

In May, for example, a group of health professionals from 17 major academic health centers, published an article in *JAMA* calling on academic medicine to rededicate itself to meeting the broader health needs of communities.

Of particular significance is the fact that a task force of the Association of Academic Medical Centers, an organization long viewed as an obstacle to change, is scheduled to report in September on ways to redress the generalist-specialist imbalance.

Interest in the problem is also heating up on Capitol Hill. Congress has asked its influential Physician Payment Review Commission to recommend ways of tackling the issue in its annual report next April. "I'm more optimistic now that attention is being focused and that people are saying the right things than at any prior time," said Robert Graham, executive vice president of the American Academy of Family Physicians (AAFP).

Among the changes for which there appears to be broad philosophical support are:

- retooling medical education to put more emphasis on primary care and on training outside the hospital setting;
- reducing medical student debt;
- expanding coverage of preventive and primary care services under private insurance policies and federal health programs;
- narrowing the price gap between primary care and high-technology procedures;
- reducing the paperwork and regulatory hassles that disproportionately affect primary care doctors.

Accomplishing these goals, however, will be tough: Each medical school sets its own curriculum; each department in each teaching hospital decides how many residency positions to offer in the various specialties; each insurer decides how much it will pay for doctors' services. In

fact, an agreement among teaching hospitals on the number of residencies each should provide could run afoul of anti-trust laws.

By contrast, Canada has achieved a more balanced mix of generalists and specialists. That's largely because its Royal College of Physicians and Surgeons was able to decree that all specialists serve as consultants to primary care physicians, and because the government, which pays all health care bills, has set a fee scale that makes general practice more attractive.

In the United States, such reforms have been fiercely resisted by those with a vested interest in the status quo. In the mid-1970s, for example, teaching hospitals, which rely on subspecialist residents to help bring in larger patient revenues, helped defeat legislation to limit subspecialty residency positions.

FEDERAL INTERVENTION?

Proponents of a balanced ratio of generalists and specialists say that bold action is needed on a variety of fronts, with a key player being the federal government.

Past government efforts have consisted mainly of a scattering of small programs aimed at encouraging medical students to become generalists: grants to medical schools to increase such training and loan repayment programs that reward those who go into general practice. The National Health Service Corps, for example, offers financial aid in return for service in underserved rural areas and inner cities.

Many of these programs, small to begin with, have been cut back during the Reagan and Bush Administrations. The budget of the health service corps program was slashed in the early 1980s and is only now seeing modest increases. The Bush Administration's 1993 budget proposed no money for several direct grant programs to medical schools and hospitals for generalist training.

Moreover, the amount of money in those programs is dwarfed by medicare hospital payments that reinforce the current bias toward specialization.

At least one dramatic step is being taken at the federal level, however, that is designed, over time, to decrease the huge gap between payments for the low-tech services provided by primary physicians and those for the sophisticated, technology-intensive procedures performed by surgeons and other specialists.

The medicare program's revolutionary new fee scale for physicians, being phased in starting this year, is designed to replace a haphazard system of charges, largely dictated by doctors themselves, with a system based on the time, skill, risk and



Richard A. Bloom

Administration official William Toby Jr. Rewards go to medical school specialists.

difficulty of decision making involved in a given medical procedure.

But so far the fee schedule, which won't fully be in effect until 1996, hasn't had much impact on the relative incomes of physicians. Some primary care doctors' groups worry that a combination of medicare budget cuts and political interference by specialty groups may dilute the fee scale's ultimate impact. Medicare accounts for roughly 25 per cent of doctors' incomes, a significant but perhaps not decisive share.

Some proposals for change call for speeding up the timetable for the fee schedule's adoption, and finding ways to encourage private insurers to adopt medicare's reimbursement schedules.

Another approach, included in a proposal by the Bush Administration and in a bill recently passed by the House Energy and Commerce Committee, is to pay hospitals more for residency positions in primary care than in other specialties. But critics of the Administration's plan say it is designed less to change policy than to save money. An earlier version of the House bill was killed in the Senate last year, reportedly after stiff lobbying resistance on behalf of key teaching hospitals.

None of these approaches is expected to dramatically alter the makeup of the nation's future supply of physicians, conceded Paul Ginsburg, executive director of the Physician Payment Review Commission. Medicare's new physician fee schedule, which Ginsburg says is "more powerful than any policy we've had in the past to address specialty mix" may arrest the decline in the share of doctors who

are trained in primary care, but it may not be enough to increase that share.

The commission is considering additional hard-nosed policies, such as limiting the number, kind and location of residency positions medicare will pay for. Perhaps the boldest proposal has been outlined by another federal advisory group, the Council on Graduate Medical Education, in a report to be released in October. A current draft calls for 50 per cent of all medical school graduates to be trained as generalists and a commission to set national targets for the number of physicians. State commissions would determine regional needs for doctors and residency programs to meet those needs. Medicare funds for graduate medical education funds would be funneled through regional "consortia" of medical schools and hospitals, rather than going directly to hospitals.

A major overhaul of the nation's health care financing system could have an even greater impact on how health manpower is deployed in the delivery system. Beneath the rhetoric, however, its not clear how much current reform proposals would actually accomplish.

President Bush's health care reform proposal takes an incremental approach that would build on existing government programs to encourage an increase in primary and preventive care.

Clinton—and several key Democrats in Congress—envision a much larger and more activist role for government in the financing of care, which could in turn, give it far greater leverage over the training and payment of physicians. Under most of the leading Democratic plans, for example, a government or quasi-governmental body would set a national budget for all health care spending, and devise a fee schedule to be used by all insurers as well as the government.

But if the nation embraces sweeping health care reforms any time soon, it could face a major mismatch between the demand for primary care services and the supply of doctors trained as generalists.

Bringing the uninsured into the mainstream of the health system, according to the AAFP's Graham, would mean "long lines outside every emergency room and doctor's office [of patients] looking for the care now promised them, but there won't be the doctors to provide it."

In such a situation, specialists would probably be drafted to give primary care, a service that many of them lack the training or experience to provide. Many observers worry that the result would be inappropriate or unduly costly care.

"If you want to create an entitlement to health care in 1995," Graham said, "you should have changed manpower strategy in 1985." ■

The Philadelphia Inquirer

Wednesday, January 13, 1993

Solution to the nurse shortage: Train them in the neighborhood

By CLAUDE LEWIS

Many American hospitals suffer from a critical shortage of nurses despite the fact that salaries and working conditions for those in white have been upgraded.

It's not unusual for registered nurses to earn in excess of \$40,000 a year, and for licensed practical nurses routinely to be receive \$25,000. A program at Presbyterian Medical Center in West Philadelphia is demonstrating that the critical shortage of nurses in America may well be a problem of faulty recruiting rather than a genuine lack of qualified potential nursing students.

Five years ago, after a century of training nurses, Presbyterian closed its nursing school because of difficulty in attracting middle class students to study and work in an inner-city hospital.

Hospital president I. Donald Snook, Jr. made a business decision that had vast social implications as well. If Presbyterian couldn't bring outsiders into the inner city, he reasoned, the hospital would recruit nursing students from the inner city itself.

Snook believes that special efforts at neighborhood recruiting — accompanied by effective support mechanisms ranging from remedial courses in math, English, science and life skills — provides an adequate base upon which to create effective nursing students.

To accomplish this, Presbyterian offers day and evening courses in order to accommodate students who may be working or caring for children. The program contracts with Community College of Philadelphia. Students receive college credits in addition to their nursing degrees. With only an additional 30 credits, they can become registered nurses after just 12 months of study.

During the last four years, Snook's programs have helped to improve the operation of Presbyterian Hospital by beefing up its nursing staff. The program has also improved the lives of many people who often worked at low-paying dead-end jobs. Twenty-two percent of the last graduating class were receiving public assistance.

"We have a commitment to the people because of our mission, and what better way to demonstrate that commitment than with the employees and the community who are our resource and who help us meet our needs," Snook said.

Some Presbyterian staffers donate their expertise to assist students with a variety of legal problems such as obtaining child support. Once such problems are resolved, students perform surprisingly well.

Hospital recruiters often overlook a rich reservoir of potential nurses who live or work in the neighborhood. In an effort to find new nurses, some institutions have recruited overseas, offering students costly incentives, such as free room and board. Instead

of helping local people begin nursing careers, many recruiters routinely allow people with potential talent to languish on welfare or unemployment without help or hope.

One very successful local student in Presbyterian's "Ladder out of Poverty," program is Mary Ann Couch, who worked for six years as a nursing assistant. In August, Couch became a graduate licensed practical nurse and is now on staff at Presbyterian. Her salary went from \$5.25 to \$12 an hour. She is working to become an RN despite her recent separation from her husband and the demands involved in raising three young children.

"It's not easy," Couch, who lives with her mother, said in an interview. "But the effort has changed me and my children. As they see me study, they are more involved in their own school work. Everybody competes for good grades now," she says.

Couch hopes eventually to earn a master's degree in nursing and help nurses achieve greater independence from doctors.

"It makes you feel proud of what you can do," Couch said. "Sometimes, when you're a member of a minority group, you give up all hope. You don't think you have a chance. But this program has taught me that if I work hard, I can make it. I'm proud that I no longer stand on welfare lines for a handout."

Since 1990, more than 200 Presbyterian employees have signed up for career-development programs. People in the neighborhood whose dreams appeared to have died long ago are taking advantage of the opportunity at Presbyterian. Many are exchanging welfare checks for paychecks. Instead of being drains on society, they are now taxpayers.

Many hospital administrators have been reluctant to depend on the locals as a reliable resource for hospital personnel.

Sometimes people in positions of authority make harmful assumptions about those they are not familiar with. Such assumptions often keep others from reaching their potential.

However, Snook's clear-headed solution to Presbyterian's needs may well induce hospital administrators nationwide to reduce recruiting efforts overseas and concentrate their efforts right in their own backyards. It's entirely possible that healthy attitudes about America's poor, on the part of nursing and other recruiters, could end the persistent critical shortage of skilled workers in hospitals and other industries.

Presbyterian's nursing program is proving that sometimes all that is needed to change the lives is new opportunities along with imaginative, creative and innovative recruiting efforts among America's disenfranchised.

WORTH REPEATING . . .

Education costs just grow and grow

The idea that more money, by itself, will lead to improved education is held by too many. The representative of one educational group in the state, commenting a few months ago at a hearing of the state House Education Committee on the Outcome-based Education proposals being put into effect, said they would be difficult to implement "when funding of education is at an all-time low." This caused Chairman Ron Cowell to say that, while the committee was there to receive comments and not to debate with anyone, it is more accurate to say that funding of public education is at an all-time high. And it is.

Figures from the Condition of Education/1992, the latest annual report from the U.S. Department of Education, prove it.

Using constant 1991 dollars, total revenues per pupil were \$623 in 1930. By 1990, they were \$5,399, nearly nine times as great.

They grew from \$623 in 1930 to \$835 in 1940, up 34 percent. By 1960 funding grew 59 percent, to \$1,885, and the 1960s saw a tremendous surge in costs, 67 percent, to \$3,144 in 1970, a decade that also saw a great increase in the number of students, from 35.2 million in 1960 to 45.6 million in 1970, the greatest increase of any single decade.

By contrast, enrollment declined in the 1970s and 1980s, from 45.6 million in 1970 to 41.6 million in 1980 and to 40.5 million in 1990.

Still, per pupil revenues rose, up 33 percent from 1970-1980, reaching \$4,188 in 1980; and 29 percent more in the 1980s, to \$5,399 in 1990.

The 29 percent rate of increase in the 1980s was the lowest of any of the six decades, but note that the base to which that rate applied was much greater. So, while the rate increase was only 29 percent, the dollar per pupil growth was \$1,211, almost twice as great as the total dollar per pupil in 1930.

U.S. Department of Education, *The Road to Educational Achievement*

Study shows nurse practitioner care may rival physician primary care

With the severe shortage of primary care physicians and millions of people in need of basic health services, a new study has found that nurses perform as well as or better than physicians in delivering primary health care.

The study, conducted for the American Nurses Association (ANA), found that nurses provided more health promotion activities than did physicians and scored higher on quality-of-care measures. The study was a meta-analysis to assess the effectiveness of nurse practitioner (NP) care when compared to physician care.

A meta-analysis is a quantitative research method for synthesizing research in a given content area. The analysis included more than 38 studies of nurse practitioners and 15 studies of certified nurse midwives, using physician care as the standard for comparison. All published and unpublished studies that met criteria for relevance and acceptability were included in the analysis. Adjustments in meta-analytic procedures to account for differences in sample size and heterogeneity were incorporated.

Among the study's findings:

- Nurse practitioners provided more health promotion activities than did physicians, such as patient education and exercise prescriptions.

- Nurses ordered slightly more laboratory tests. The NPs ordered laboratory tests for 36 percent of their

patients and the physicians ordered lab tests for 30 percent. However, the cost of the laboratory tests was slightly lower (eight percent) for the nurses.

- The nurses scored higher on the quality-of-care measures than did the physicians. Most of the quality-of-care outcomes involved diagnostic accuracy and/or completeness of the care process, such as taking a comprehensive medical/health history.

- Both the NPs and the physicians were equivalent in rates of prescribing drugs.

With regard to clinical outcomes, nurses achieved equivalent outcomes or scored more favorably than physicians on most variables. The patients of the nurses, compared to physician patients, demonstrated equivalent or greater: (1) satisfaction with their health care provider; (2) compliance with health promotion/treatment recommendations; and (3) knowledge of their health status and treatment recommendations.

Other findings included: nurses spent more time per visit with their patients than did physicians (an average of 24.9 minutes per patient for nurses versus 16.5 minutes per patient for physicians); the number of visits per patient was equivalent for nurses and doctors; and patients of nurses experienced slightly fewer hospitalizations than did patients of physicians.

On average, the study found, the

NPs had two years of experience as compared to 17 years of experience for the physician. The average cost per visit for NP patients was significantly lower (39 percent) than the cost for a physician visit. The patient knowledge was equivalent for the nurse practitioner and the physician groups.

"Between 60 percent and 80 percent of the basic health care performed by doctors can be done by nurses with the same quality outcomes at a much lower cost," said Virginia Trotter Betts, JD, MSN, RN, president of the American Nurses Association. "This latest study only adds to the volumes of other studies that support our assertion. Nurses can provide more affordable care because most preventive and primary care does not require the expensive specialization that characterizes physician education today."

Part of *Nursing's Agenda for Health Care Reform* calls for using

nurse practitioners and other advanced practice nurses to deliver primary health care as an economical alternative to physician-centered health care.

"With the shortage of primary care physicians and their reluctance to work in rural and other underserved areas, it is time to look at registered nurses and advanced practice nurses as part of the solution to America's health care crisis," Betts said.

A Meta-Analysis of Process of Care, Clinical Outcomes, and Cost-effectiveness of Nurses in Primary Care Roles: Nurse Practitioners and Nurse Midwives, was prepared for ANA by Sharon A. Brown, PhD, RN, associate professor of nursing and associate dean for research, University of Texas-Houston Health Science Center School of Nursing, and Deanna E. Grimes, DrPH, RN, associate professor of nursing, the University of Texas-Houston Health Science Center School of Nursing.

Edelman to speak at ANF fund-raising dinner

Marion Wright Edelman, founder and president of the Children's Defense Fund (CDF) will be the keynote speaker at a fund-raising dinner.

Success: A Letter to My Children and Yours, which is based on her family's services to others, and "Twenty-Five Years of the CDF."

ANA advocates APNs for primary care

By Pamela Mittelstadt, MPH, RN

The American Nurses Association (ANA) and the American Association of Nurse Anesthetists presented testimony to the Physician Payment Review Commission (PPRC) that made several recommendations to increase the utilization of advanced practice nurses (APNs) to meet the primary care needs of this nation.

Anne Keane, EdD, RN, FAAN, associate professor, University of Pennsylvania, delivered the testimony that addressed Medicare Graduate Medical Education (GME) and the implications for nurses delivering acute and primary care, "split care" or care received by a beneficiary by more than one provider, and the role of nurses in case management.

The PPRC is considering GME policy changes in response to the oversupply of physicians and the

undersupply of primary care physicians or generalists. GME is the Medicare funding that supports the education and training of residents. This program also supports nursing education but in an extremely limited manner.

Five major recommendations were made:

—That advanced practice nurses be utilized to meet hospital service needs as the GME policy is changed and the number of residencies are reduced. In addition, financing options for the education of these advanced practice nurses needs to be addressed.

—That the PPRC eliminate the unnecessary incentives in the Medicare GME program (to train an oversupply of specialists) that frequently leads to incentives to replace staff, such as certified registered nurse anesthetists, with residents.

—That the PPRC consider the revision of GME policy to emphasize the education of non-physician providers in order to educate more primary care providers and needed providers.

—That the PPRC consider how case management provided by registered nurses and physicians can improve the delivery when care is provided by more than one provider.

The testimony was well received by the commissioners. Their response to this testimony will be included in their annual report to the Congress, which will recommend GME policy changes and other policies effecting Medicaid and the Medicare fee schedule for physician services.

The ANA will continue to lobby on changes to the GME program to support the education on needed APNs to deliver primary care and acute care in the hospital.

Pamela Mittelstadt is an associate director for ANA Governmental Affairs.

Residence: Initial Program

Initial Program will provide nurses with a
use of chemical dependency and its

at the detoxification process, including
of the patient's needs, principles of
experience the functioning of a treatment
as the treatment process.

30, 1993. MNA credits are available.

alden Community Prevention
2-0080.

ALDEN

HEALTH PERSONNEL DISTRIBUTION AND HEALTH PROFESSIONS IN PA

Physician Training

There are nine medical schools in the state (the newest school is in Erie). Post graduate programs in family medicine are at Hershey, Jefferson, and soon to resume at Temple.

Nurses

There are 31 schools offering baccalaureate degrees, 16 offer master's degrees in areas of nurse practitioner, midwifery, clinical nurse specialist. Three schools offer doctoral degrees in nursing. 59 schools offer diploma or associate degrees.

Health Personnel Shortage Areas

Pennsylvania is one of 12 states that has a medically underserved population of one million person or more.

National Health Service Corps

Physicians in Pennsylvania serving in the National Health Service Corps are estimated to be: 76 primary care physicians, 58 dental practitioners, and 52 psychiatric practitioners.

The New York Times

Copyright © 1992 The New York Times

NEW YORK, THURSDAY, DECEMBER 24, 1992

COMPANIES ACTING TO TRIM BENEFITS PROMISED RETIREES

PAID HEALTH CARE HALTED

Primerica Is Latest to Cut Back as It Cites New Regulation Governing Accounting

By MILT FREUDENHEIM

At least 23 large companies have terminated the health benefits that they were providing to thousands of retired employees. Dozens more have announced they will not provide the coverage for future retirees, and most employers who still offer the benefits are reducing their share of the costs, which have been climbing steeply.

The companies are rushing to shrink these obligations before Jan. 1, when a new accounting rule goes into effect. The rule forces employers to subtract from their profits the future costs of providing benefits to retirees.

In the latest such action, the Primerica Corporation, a financial services concern previously known as the American Can Company, set yesterday as the deadline for 7,800 retirees to agree either to pay the full cost of continuing coverage, or go without it. The retirees learned of the deadline only three weeks earlier.

Class-Action Suits

Primerica and others of those companies, including McDonnell Douglas, the aerospace concern, and Unisys, the computer maker, have been charged by retiree groups in class-action lawsuits that the changes violate the terms of the companies' retirement agreements. A ruling in the Primerica case could come by late January.

Under the new accounting rule, Financial Accounting Standard 106, employers must put a value on future retiree health costs and combine them with current medical costs as an expense. Previously, companies were required to recognize only the cost of benefits they had actually paid.

Although the actual expenditure does not increase, the resulting annual expense that must be reported can rise sharply under the new rule, often quadrupling the health-care costs for industrial companies that have many older employees or whose retirees were promised generous benefits.

A Jolt to Retirees

Some retirees were shaken by the turn of events. "They told us, 'Either you take it by Dec. 23 or you drop out and cannot be reinstated,'" said Marie Esposito, a 68-year-old retired American Can executive secretary in Brooklyn. "Was it a scare tactic? If it is, they're doing a good job on me. I'm single. I live alone. I have no one I can turn to."

Ms. Esposito, who worked at American Can for 19 years, until her department was shut down, said medicine to treat her blood pressure and stomach ulcers costs \$177.67 a month, of which

she currently pays \$17.77. Continuing this coverage would now cost \$144 a month, swallowing most of her \$240-a-month pension. "I can't swing the \$144 for medical coverage, which I desperately need," Ms. Esposito said.

The new accounting rule was intended to make a company's health care liabilities clear to investors. It allows companies to take a single charge against earnings before the first quarter of 1993, or to spread the charges over 20 years.

As a result of the rule, the Ford Motor Company recently said it would take a \$7.5 billion charge against its earnings this year. General Motors has estimated that it must account for \$16 billion to \$24 billion of benefits.

'The Weakest Excuse'

Advocates for retirees have accused employers of using the new rule as an excuse to shirk their obligations. "Companies have had several years' notice that they would have to comply with the accounting rule," said Cathy Ventrell-Monsees, a workers' rights manager at the American Association of Retired Persons. "To come out in this last quarter of 1992 and say, 'We are compelled to eliminate benefits because of F.A.S. 106 accounting' is the weakest excuse for hurting people just to save money."

Representative Ron Wyden, an Oregon Democrat who is a member of the House Select Committee on Aging, has asked the General Accounting Office to investigate the cancellation of retiree health benefits. "My sense is that we're going to see more and more scheming to use F.A.S. 106 and other accounting sleight of hand to dump seniors and get out from under paying health benefits."

Alain Enthoven, a health economist and professor of management at Stanford University, said that curtailing retiree benefits was "a very unfortunate consequence of costs being out of control." The cutbacks underline the urgency of fixing the health care system, he said.

Unisys announced in November that it would phase out contributions to the medical plans of its retirees over the next three years, and McDonnell Douglas said in October that it would pay health benefits for sala-

ried retirees with surplus pension funds, but only for the next four years. That will cut in half the approximately \$1.2 billion accounting charge McDonnell Douglas would have had to have taken.

In the Primerica case, retirees were told in October that they had to decide whether to accept any of three benefits packages the company had arranged, to take advantage of a group rate. But even under the most expensive of those plans, retirees' medical coverage will be reduced. Instead of \$10,000 in free life insurance, they can buy a \$2,000 life insurance policy. A Primerica spokeswoman conceded that the new policy would be "expensive."

Less Than Chief Was Paid

Primerica has not said how much it would cost to continue to pay retiree benefits, but that had not been a major expense in the past. In 1991, it spent \$8.7 million for medical benefits for 7,800 retirees, including the American Can group. That is less than the compensation package of Primerica's chief executive, Sanford I. Weill, that Graef S. Crystal, the compensation expert, estimates at about \$10.2 million in stock options and \$2.2 million in salary and bonuses. It is also less than 2 percent of Primerica's profits last year of \$478 million on revenues of \$6.61 billion.

P. 1 of 2

Promises Under the Microscope

Wording that American Can used in a booklet explaining its health plan to retirees:

American Can "expects to continue this Plan indefinitely, but necessarily reserves the right to amend, modify, or discontinue the Plan in the future in conformity with applicable legislation."

"If any changes become effective under the Medicare Program by reason of current or future Governmental legislation or regulation, then full consideration will be given to appropriate modification in this Retired Group Insurance Plan."

Source: Court documents

Large companies spent \$2,345 for each retiree, on average, for health costs in 1991, said Patricia Wilson, a principal with A. Foster Higgins, a benefits consulting firm. That is more than double Primerica's costs, which

averaged \$1,115 a retiree.

Like other companies, Primerica had previously tried to shift part of its medical costs to retirees. It began asking retirees to pay more for benefits shortly after Mr. Weill acquired the company in a 1988 merger with his Commercial Credit Group Inc.

Raised Monthly Premium

Primerica raised the monthly premium paid by the American Can retirees to \$50, from \$5, in January 1989. Trying to block the increase, the retirees and a group of former executives, headed by William F. May, who was American Can's chairman from 1965 to 1980, filed a class-action lawsuit in Federal District Court in Newark charging that they had been assured of receiving the \$5-a-month medical package until they died, when their heirs would then get \$10,000 in life insurance.

But Primerica said the terms of the agreement allowed it to change the benefits, and now to terminate them. A booklet describing the health plan said the company "expects to continue this Plan indefinitely, but necessarily reserves the right to amend, modify or discontinue the Plan in the future in conformity with applicable legislation."

Jack McGoldrick, a retired American Can executive who helped prepare the plan descriptions, said the clause meant only that changes might be made if required by new laws. The next paragraph said that "full consideration will be given to appropriate modification" if the Federal Government changed the Medi-

care program. The company argued that the wording allowed unrestricted changes.

Retirees' Case Dismissed

In July 1991, Judge Alfred J. Lechner Jr. ruled in Primerica's favor in United States District Court in Newark. He dismissed the retirees' case, citing other court decisions that have invalidated retiree health benefits when an employer has clearly reserved the right to do so.

But on June 25, a three-judge panel of the Court of Appeals for the Third Circuit in Philadelphia unanimously reversed the dismissal, ruling that the clause in the booklet was ambiguous. The appeals court sent the case back to Judge Lechner and told him to determine the facts "as to whether the company promised lifetime fixed-cost benefits to its retirees."

In early December, after Primerica announced the Dec. 23 deadline for retirees to choose among the three plans to pay their own benefits, lawyers for the retirees asked Judge Lechner to act in the case.

Asked for More Time

The Primerica lawyers said they needed more time to deal with the 28 affidavits submitted by the retirees' lawyers. Saying the request for a hearing on short notice was "outrageous" because of the lengthy documents and legal arguments involved, Judge Lechner scheduled the hearing for mid-January. "Perhaps Christmas Day, you want me to come in here?" he said.

The retirees appealed to the court in Philadelphia "to order the district judge to take action or to restrain Primerica from making any changes in the plan until the district court acts," said Robert D. Towey, a lawyer with Riker Danzig Schaefer Hyland & Perretti in Morristown, N.J. But the appeals court ruled against the retirees last week, leaving the scheduling of the hearing to Judge Lechner.

Mary McDermott, a spokeswoman for Primerica, said yesterday that 55 percent of the company's retirees had responded by Monday. Primerica sent them a reminder letter this week, she said.

P. 2 of 2