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Health
MAC
[April 1976]

April - . .

Dear Mr. Simmons:

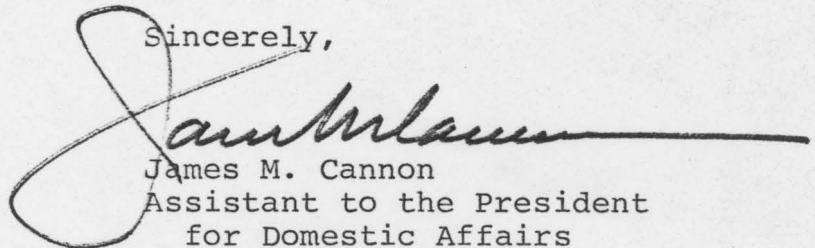
Thank you for your telegram to the President of April 5 and your letter to me of April 8. The decision to delay implementation of the Maximum Allowable Cost (MAC) drug regulations from April 26 to August 26, 1976, was made solely by Secretary Mathews of the Department of Health, Education, and Welfare on the recommendation of the Pharmaceutical Reimbursement Board, which oversees the drug cost control program and which is chaired by Dr. Theodore Cooper, HEW Assistant Secretary for Health.



Pursuant to its normal coordinating function, the Domestic Council has been kept informed by the Department of its efforts to implement the MAC program, but neither the President nor the Domestic Council has participated in the decision made in regard to the MAC regulations. The purpose of the four-month delay by HEW is to allow additional time for State Medicaid programs to become familiar with updated cost guidelines being prepared by HEW and to conduct studies of pharmacy operating costs. This delay should also give the National Association of Retail Druggists additional time to present further data to the Department.

If I may be of further assistance, please do not hesitate to contact me.

Sincerely,



James M. Cannon
Assistant to the President
for Domestic Affairs

Mr. Willard Simmons
Executive Secretary
National Association of Retail
Druggists
1 East Wacker Drive
Chicago, Illinois 60601

THE WHITE HOUSE

ACTION

WASHINGTON

April 7, 1976

MEMORANDUM FOR: THE PRESIDENT
FROM: JIM CANNON *J. Cannon*
SUBJECT: LETTER TO DR. MARK VASU

Attached for your signature is a letter to Dr. Mark Vasu about the inclusion of Emergency Medical Services in your health block grant proposal.

The text has been approved by Paul O'Neill and Robert T. Hartmann (Smith).

I recommend that you sign the attached letter.



THE WHITE HOUSE

WASHINGTON

Dear Mark:

Thank you for your letter expressing concern about the inclusion of the Emergency Medical Services (EMS) program in my Health Block Grant Proposal.

I fully agree with you that the EMS program is important. I was aware when I made the proposal to consolidate 16 separate categorical health programs into a single Federal block grant to the States that State and local health authorities would have to exercise difficult choices in setting priorities. I have received expressions of support such as yours from State and local officials. Thus, I am hopeful that EMS activities would compete successfully with other necessary health programs for a fair share of the available resources. Since the overall goals of the block grant proposal are to strengthen responsibility, accountability and resources at the State and local levels, I feel it would not be appropriate to mandate such a Federal priority for the EMS program.

You also expressed concern about national standards for all paramedics. As you probably know, a committee within the Department of Health, Education and Welfare has for the past year been studying the need for standardized credentials for those in the health science fields, including paramedics. These recommendations are being reviewed within HEW. The Department will continue to cooperate with the States, professional organizations, and educational institutions to improve health manpower licensure and certification.



I hope this has been responsive to your concerns.
It is always a pleasure to hear from you.

Sincerely,

C. Mark Vasu, M.D.
Grand Valley State Colleges
Allendale, Michigan 49401 ,

THE WHITE HOUSE
WASHINGTON

SIGNATURE

April 8, 1976

MEMORANDUM FOR: JIM CANNON
FROM: SARAH MASSENGALE *SM*
SUBJECT: PRESIDENTIAL MEMO ON
MAC REGULATIONS

Attached for your signature is a memorandum
to the President on the MAC regulations.

I recommend that you sign.



Attachment

THE WHITE HOUSE

WASHINGTON

INFORMATION

April 8, 1976

MEMORANDUM FOR: THE PRESIDENT
FROM: JIM CANNON
SUBJECT: MAXIMUM ALLOWABLE COST REGULATIONS

The Department of Health, Education and Welfare announced on Tuesday, April 6, that the implementation date for the Maximum Allowable Cost (MAC) regulations has been postponed until August 26. The program was to have gone into effect April 26. As you know, the purpose of the program is to control the costs of prescription drugs under HEW health care programs, particularly Medicaid.

The decision to delay was made by Secretary Mathews on the recommendation of the Pharmaceutical Reimbursement Board, chaired by the Assistant Secretary for Health, which oversees the cost control program. The delay had been requested by several State Medicaid programs and by pharmacist organizations. The four month delay will allow additional time for the programs to become familiar with the updated HEW cost guidelines and to conduct studies of pharmacy operating costs.



THE WHITE HOUSE
WASHINGTON

April 12, 1976

ADMINISTRATIVELY CONFIDENTIAL

MEMORANDUM FOR:

JIM CANNON

FROM:

JIM CONNOR *JEC*

SUBJECT:

Response to Kelly Forehand

The attached newspaper was returned in the President's outbox with the following notation:

"This young man asked me a question and I responded but I think we should write a more detailed answer."

Please follow-up with appropriate action.

cc: Dick Cheney

Attachment:

Copy of SPOTLIGHT ON AMARILLO
Saturday, April 10, 1976



Ford To Face Injury Study Question

By RICHARD HAMM
Globe-News Staff Writer



Saturday, April 10, 1976

Page 25

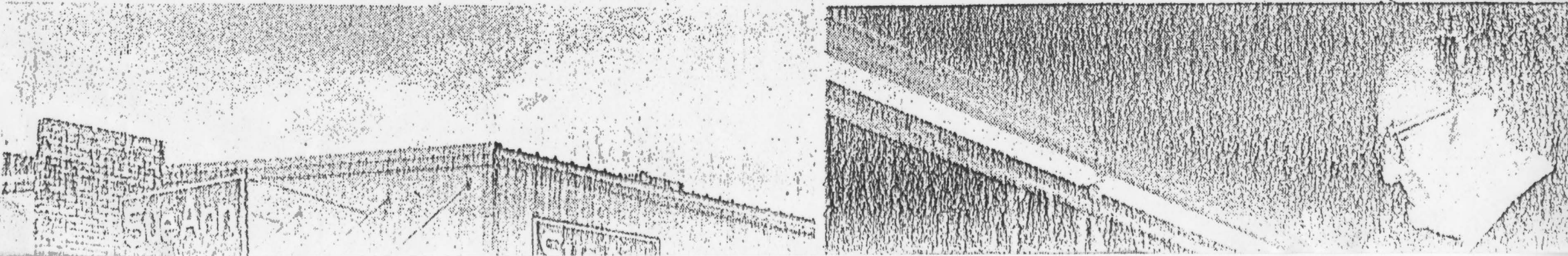
While President Gerald R. Ford is trying to get his message across to voters gathered in the West Texas State University Field House tonight, Kelly Forehand, 18, paralyzed during a 1974 Canyon High School football game, will be on hand attempting to get a message through to the President.

Kelly wants to walk again. He hopes his presence on the front row at the field house will make Ford aware there are thousands of other Americans just

(See FOREHAND on Page 26)

KELLY FOREHAND

Hereford Garment Plant Holds Open Hou.



Health

THE WHITE HOUSE
WASHINGTON

April 14, 1976

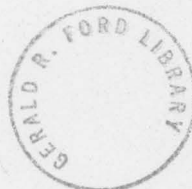
MEMORANDUM FOR: ED SCHMULTS
FROM: JIM CANNON *J. Cannon*
SUBJECT: MAC Regulations

Attached for your information are copies of correspondence between the White House Staff and Mr. Willard Simmons, Executive Secretary of the National Association of Retail Druggists (NARD), plus newsletters from NARD and HEW. This is to supplement the materials we discussed this morning.

BACKGROUND

Mr. Simmons and his wife saw the President briefly in the Oval Office on February 27 on a social call. It is our understanding that Mr. Simmons took the opportunity to express his concern about HEW's Maximum Allowable Cost (MAC) regulations which were to go into effect on April 26. According to Mr. Simmons, the President said he would speak with Secretary Mathews "about the feasibility of postponing implementation of MAC regulations." (See NARD news release at Tab A.) As far as we can determine, no such request was made of HEW by any member of the White House staff.

MAC is a proposal to control drug reimbursement costs under Medicaid and Medicare, developed in response to the 1972 Social Security amendments which mandated cost saving controls be pursued. This proposal is controversial primarily because not everyone agrees that it will result in cost savings with no loss of safety. Drug manufacturers, pharmacists, the AMA and others have objected to the MAC proposal on these grounds.



The MAC regulations, developed while Casper Weinberger was Secretary, were promulgated by him in his last month of office, July, 1975. They were issued more quickly than had been generally anticipated to avoid a court injunction which could have resulted in extremely long delays.

Secretary Mathews, thus, "inherited" the regulations and the numerous pleas to rescind or suspend them. Shortly after assuming office he decided to delay imposition of the MAC cost controls until April 26, 1976, to allow time for further departmental study.

The White House (Domestic Council and Counsel's office) has also received many objections to the MAC proposal. We have asked HEW to keep us informed as they examine these regulations and their related questions. Beyond requests for information on the decisions and findings at HEW, this matter has been left entirely to the Secretary.

In response to Mr. Simmon's letter of February 12 and telegrams of March 23 urging delay (Tab B), I wrote to him on March 26, explaining that the Secretary had concluded that he should proceed with implementation of the regulations as scheduled. (Tab C) I also sent similar letters to Congressman Archer and Crane in response to their letters urging delay. (Tab D)

CURRENT SITUATION

On April 6, HEW announced that the implementation date was postponed until August 26, because "several State medicaid programs requested a delay" and "pharmacist organizations have questioned the timeliness of ... data provided ... by the Department." (Tab E)

On April 5, Mr. Simmons wrote to the President (Tab F) and on April 8 to me (Tab G) urging the President to take credit for any delay in implementation. No response has been sent.

If you would like any further background information, please let me know.



TAB A

NEWS

FROM THE **N.A.R.D.** THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

One East Wacker Drive
Chicago, Illinois 60601
Phone 312-321-1146



WILLARD B. SIMMONS,
EXECUTIVE SECRETARY

CONTACT: Keith Kellum (312) 321-1146
or
Bill Arrott (312) 565-1200

PRESIDENT FORD TO WEIGH HEW PRESCRIPTION PRICE PLAN



CHICAGO, Mar. 3--President Ford has agreed to investigate a plan recently proposed by the U.S. Department of Health Education and Welfare that would reduce government payments to pharmacists for Medicaid prescriptions, according to Willard B. Simmons, executive secretary of The National Association of Retail Druggists.

The President's decision stems from a recent meeting with Simmons, who informed the President that the delivery of pharmaceutical health care to needy Americans could be jeopardized if HEW implements its new prescription price reimbursement schedule as planned on April 26.

That schedule, called Estimated Acquisition Costs of Prescription Drug Products (EAC), is a wholesale price list of 300 widely prescribed drugs that HEW wants the states to use as a guide for reimbursing pharmacists for Medicaid prescriptions under the Maximum Allowable Cost (MAC) program.

A NARD study has shown that under EAC, community pharmacists all over the country would be reimbursed for Medicaid prescriptions in a number of instances for less than the actual cost of the drugs dispensed.

Simmons said that the President expressed concern about possible inequities to community pharmacists and the resulting curtailment of services to Medicaid patients that might result from implementation of EAC.

"Mr. Ford indicated to me personally that he would talk to HEW Secretary Mathews about the feasibility of postponing implementation of EAC and MAC regulations," Simmons said.

NEWS

FROM THE **N.A.R.D.** THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

One East Wacker Drive
Chicago, Illinois 60601
Phone 312-321-1146



WILLARD B. SIMMONS,
EXECUTIVE SECRETARY

CONTACT: Keith Kellum (312) 321-1146
or
Bill Arrott (312) 565-1200

PHARMACISTS ACT AGAINST HEW RULES

THEY SAY WILL CRIPPLE MEDICAID

CHICAGO, Mar 3--The National Association of Retail Druggists (NARD) revealed here today plans for legal action against the U.S. Department of Health Education and Welfare to postpone adoption of regulations the group says will cripple Medicaid. The Boston law firm of Paul T. Smith has been retained to represent the association.

Willard B. Simmons, NARD's executive secretary explained that HEW has just issued an Estimated Acquisition Cost (EAC) reimbursement schedule for its Maximum Allowable Cost program (MAC) that will force pharmacists to lose money on many Medicaid prescriptions.

"At present, a pharmacist who dispenses a Medicaid prescription is reimbursed for the wholesale cost of the drugs and receives a dispensing fee to cover professional services and business overhead. Each state determines its own schedule for reimbursing pharmacists, based upon the average wholesale price of prescription drugs and a dispensing fee.

"Now HEW intends to reduce prescription drug reimbursement to the point where it will be impossible for thousands of independent pharmacists to fill Medicaid prescriptions. As a result, many aged and infirm patients will no longer be able to have their Medicaid prescriptions dispensed at a nearby community pharmacy where their health care requirements are a matter of ongoing concern to the pharmacists," Simmons said.

NARD's legal action is aimed at blocking HEW from forcing the states to accept its new EAC schedule by the target date of April 26.

Pharmacists Act Against HEW Rules--2
They Say Will Cripple Medicaid

"The best way to judge the potential impact of EAC is to compare EAC prices with what pharmacists actually have to pay for prescription drug products. For example, in the State of Texas, the average wholesale price paid by pharmacies for a frequently prescribed drug for arthritis (Indocin 25 mg, 100's) is \$9.88. The EAC price is \$8.10. EAC actually calls upon the pharmacy to sell the product for \$1.78 less than it costs. The average wholesale price of Valium, one of the nation's most widely prescribed drugs (Valium 5 mg, 100's) is \$8.89. The EAC reimbursement price is \$7, or \$1.89 less than the average wholesale price. Since the dispensing fees nationally average \$1.85, EAC effectively deprives pharmacists of reimbursement for their services and cost of doing business.

"We've checked average wholesale prices in many states, and the pattern is consistent. The loss imposed by EAC prices will, in many cases, completely cancel out the pharmacists professional dispensing fee," Simmons said.

"EAC was developed hastily and arbitrarily without a study of actual prescription drug costs throughout the country. Our legal action is aimed at postponing implementation of EAC until realistic reimbursement levels can be established to assure every Medicaid patient and the American taxpayer that quality pharmaceutical health care will be delivered to everyone who needs it on an economical and equitable basis in the community in which he lives."



TAB B



20
WILLIAM D. WICKWIRE, PRESIDENT
2310 HOMESTEAD ROAD, LOS ALTOS, CA 94022
SALVATORE J. D'ANGELO, PRESIDENT-ELECT
2400 CANAL ST., NEW ORLEANS, LA 70119
JAMES H. VINCENT, FIRST VICE-PRESIDENT
315 E. 8TH AVE., YUMA, CO 80759
NELSON E. TAYLOR, SECOND VICE-PRESIDENT
112 HOLLY, NAMPA, ID 83651
H. JOSEPH SCHUTTE, THIRD VICE-PRESIDENT
9907 TAYLORSVILLE ROAD, JEFFERSONTOWN, KY 40299
DAVID P. ROSENFELD, FOURTH VICE-PRESIDENT
1253 WASHINGTON AVE., CARNEGIE, PA 15106
LONNIE F. HOLLINGSWORTH, FIFTH VICE-PRESIDENT
4816 34TH ST., LUBBOCK, TX 79410
WILLARD B. SIMMONS, SECRETARY
ONE EAST WACKER DRIVE, CHICAGO, IL 60601
JOHN W. WHITE, TREASURER
1736 THOMASVILLE ROAD, TALLAHASSEE, FL 32303



SAM A. MCCONNELL JR., CHAIRMAN
7777 EAST HEATHERBRAE, SCOTTSDALE, AZ 85251
KENNETH G. MEHRLE
937 BROADWAY, CAPE GIRARDEAU, MO 63701
PAUL J. DUMOUCHEL
2 KENILWORTH RD., WELLESLEY, MA 02181
JESSE M. PIKE
853 CHURCH ST., NO., CONCORD, NC 28025
NEIL L. PRUITT
105 W. DOYLE ST., TOCCOA, GA 30577
JOHN A. JOHNSON
101 EAST MISSION ST., BELLEVUE, NE 68005

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

Spencer Johnson
OFFICE OF THE SECRETARY • ONE EAST WACKER DRIVE • CHICAGO 60601

AC 312 321-1146

February 12, 1976

The Honorable Gerald R. Ford
President of the United States
The White House
Washington, D.C. 20500

Dear Mr. President:

I talked with your secretary, Ms. Mildred Leonard, hoping, of course, I might have the opportunity for a visit with you and get some consideration for the postponement of the MAC Regulation which is to become effective approximately April 26th. If you could request the Secretary of HEW to postpone the proposed effective date, whereby further study of several months could be done on this regulation, it would be beneficial to the consumer, the pharmacist, the physician, the drug manufacturer, the wholesale druggist and, Mr. President, I can say if this regulation becomes effective as it is now proposed, it will cost the independent retail pharmacist more than \$40,000,000 and, of course, this would eliminate many of our pharmacists who provide a real service to hundreds of our communities throughout this country.

I believe postponement of this effective date of the MAC regulation would bring about very favorable comments from all of the associations and their members.

I am anxious that you will be the leader in the Republican primary in New Hampshire.

I hope you and your family are enjoying good health and look forward to the time when I can have a visit with you.

Sincerely,

Mildred Simmons
Executive Secretary

WBSimmons:sum

DOMESTIC SERVICE	
Check the class of service desired; otherwise this message will be sent as a fast telegram	
TELEGRAM	☒
DAY LETTER	☐
NIGHT LETTER	☐

\$
S
E

WESTERN UNION

TELEGRAM

W. P. MARSHALL
CHAIRMAN OF THE BOARD

R. W. MCFALL
PRESIDENT

INTERNATIONAL SERVICE	
Check the class of service desired; otherwise the message will be sent at the full rate	
FULL RATE	☐
LETTER TELEGRAM	☐
SHORE-SHIP	☐

NO. WDS.-CL. OF SVC.	PD. OR COLL.	CASH NO.	CHARGE TO THE ACCOUNT OF	TIME FILED
			NARD - CCH 082148	March 23, 1976

Send the following message, subject to the terms on back hereof, which are hereby agreed to

HON. GERALD R. FORD, PRESIDENT OF THE UNITED STATES
THE WHITE HOUSE, WASHINGTON, D.C.

REACTION OF THE RETAIL PHARMACISTS OF THIS COUNTRY TO HEW'S INTENTION TO IMPOSE THE MAXIMUM ALLOWABLE COST AND ESTIMATED ACQUISITION COST REGULATIONS UNDER MEDICAID ON APRIL 26, ABOUT WHICH YOU AND I HAVE TALKED, IS FAST BECOMING ONE OF OUTRAGE.

I DO BELIEVE IT WOULD BE IN THE BEST INTEREST OF ALL CONCERNED IF SECRETARY MATHEWS WOULD POSTPONE THE IMPLEMENTATION OF THESE REGULATIONS UNTIL THEY COULD BE THOROUGHLY STUDIED AND MADE EQUITABLE TO ALL CONCERNED.

IF ARRANGEMENTS WERE MADE TO POSTPONE THESE REGULATIONS WITHOUT FURTHER DELAY, I WOULD THEN DO ALL IN MY POWER TO COMMUNICATE YOUR HELP, CONCERN AND INTEREST TO ALL THE RETAIL PHARMACISTS OF THIS COUNTRY.

WILLARD B. SIMMONS, EXECUTIVE SECRETARY
NATIONAL ASSOCIATION OF RETAIL DRUGGISTS



17
Spencer Johnson

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PMS HONORABLE GERALD R FORD

PRESIDENT OF THE UNITED STATES

WHITE HOUSE

WASHINGTON DC

REACTION OF THE RETAIL PHARMACISTS OF THIS COUNTRY TO HEW'S
INTENTION TO IMPOSE THE MAXIMUM ALLOWABLE COSTS AND ESTIMATED
ACQUISITION COSTS REGULATIONS UNDER MEDICAID ON APRIL 26, ABOUT
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HELP, CONCERN AND INTEREST TO ALL THE RETAIL PHARMACISTS OF THIS
COUNTRY.

WILLARD B SIMMONS, EXECUTIVE SECRETARY NATIONAL ASSN OF RETAIL
DRUGGISTS
NNNN

1976 MAR 24 AM 9 08

MAIL ROOM

TAB C

Summary: Here is copy of

THE WHITE HOUSE

WASHINGTON

March 26, 1976

Dear Mr. Simmons:

The President has asked me to thank you for your letter and your telegrams expressing the concern of The National Association of Retail Druggists about implementation by the Department of Health, Education, and Welfare of the Maximum Allowable Cost (MAC) regulations.

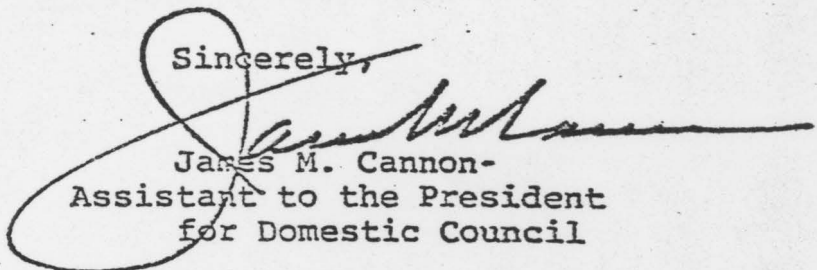
The suggestion has been made to HEW by a number of associations, legislators and others that the MAC regulations be set aside until further studies can be carried out. Secretary Mathews has given careful consideration to these suggestions and has concluded that the regulations should be implemented and studied for their economic effects at the same time.

As you know, under the Social Security Amendment of 1972, HEW is obliged to achieve economies in the Medicare and Medicaid programs. The intent of the regulations certainly is not to place pharmacists in financial jeopardy. The regulations require the States to conduct periodic surveys of pharmacy operating costs, overhead, and profits to assure that dispensing fees are reasonable, equitable, and current.

With the help of a non-governmental advisory committee (on which practicing pharmacists will have substantial representation), Secretary Mathews plans to monitor the MAC program very carefully, particularly its effects on pharmacy participation.

If I may be of any assistance, please do not hesitate to contact me.

Sincerely,



James M. Cannon-
Assistant to the President
for Domestic Council

Mr. Willard B. Simmons
Executive Secretary
The National Association of
Retail Druggists
One East Wacker Drive
Chicago, Illinois 60601

TAB D

THE WHITE HOUSE
WASHINGTON

March 26, 1976

MEMORANDUM FOR: JIM CANNON
FROM: SARAH MASSENGALE

Attached for your signature are three letters concerning HEW's Maximum Allowable Cost (MAC) proposal. The letters are to Congressmen Archer and Crane (Tabs A and B) and to Willard Simmons, President of the National Association of Retail Druggists (Tab C).

As you will recall, MAC is a controversial proposal to control drug reimbursement costs under Medicaid and Medicare. This proposal is strongly opposed by the drug manufacturers, pharmacists, AMA and others.

The regulations were published for comment last summer and elicited over 2600 comments, a very large response. The final MAC regulations are due to be implemented on April 26.

The issue now is that the President has been asked to request that Secretary Mathews postpone final implementation of the cost limits under the regulations. Archer and Crane requested that by letter. Simmons raised the question a few weeks ago when he visited the Oval Office as a personal friend. According to Simmons, the President expressed concern and agreed to talk with Secretary Mathews (see press release at Tab D).

This issue was one of the first ones to confront Secretary Mathews after his confirmation. At that time he agreed to study the MAC program carefully before proceeding with implementation. (Weinberger had been a strong proponent and signed the regulations on July 25, 1975.) Mathews has now decided to proceed with final implementation and to monitor and study the effect of the regulations after implementation.

May I suggest that you may wish to discuss this at a Senior Staff Meeting. Simmons is putting the pressure on through his press release, telegrams and letters from pharmacists pleased with the President's "intervention."



- 2 -

I feel that the only appropriate course of action for us is to agree with Mathews. Therefore, I recommend that you sign the attached letters notifying Archer, Crane and Simmons of the Secretary's decision.



THE WHITE HOUSE

WASHINGTON

March 26, 1976

Dear Congressman Crane:

The President has asked me to thank you for your letter about the Department of Health, Education, and Welfare's Maximum Allowable Cost (MAC) drug regulations.

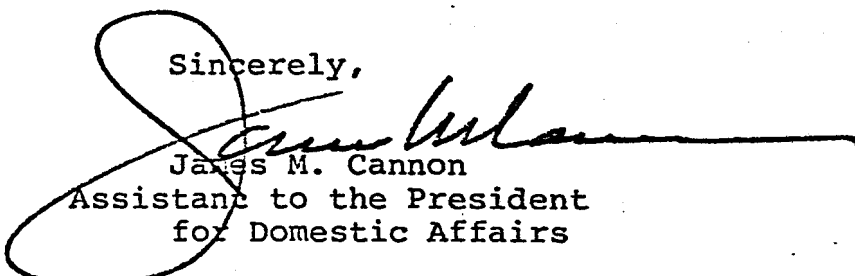
Your letter raises two important questions: (1) whether the program costs will be greater than the savings; and (2) whether the promulgation of the regulations should be postponed, pending further study.

As you point out, HEW's estimates of potential savings differ from the estimates by the drug industry. The Department believes that the regulations will save between \$60 and \$75 million annually. After the program is in full effect the administrative costs at the State and Federal level are estimated to be \$4.9 million in the first year, and \$1.7 million annually thereafter. I am enclosing for your information, a copy of the Department's inflation impact statement which discusses the savings and cost estimates in more detail.

After careful consideration, Secretary Mathews has decided not to withdraw the regulations. He will, however, monitor very closely the economic effect of the regulations after implementation. He will be assisted in this monitoring effort by the Pharmaceutical Reimbursement Advisory Committee, a non-governmental advisory group of experts whose purpose is to assist in the implementation of the program.

I hope this letter is responsive to your concerns. I would be pleased to answer any other questions you may have about the regulations.

Sincerely,



James M. Cannon
Assistant to the President
for Domestic Affairs

The Honorable Phillip M. Crane
House of Representatives
Washington, D.C. 20515

Enclosure

THE WHITE HOUSE

WASHINGTON

March 26, 1976

Dear Congressman Archer:

The President has asked me to thank you for your letter about the Department of Health, Education, and Welfare's Maximum Allowable Cost (MAC) drug regulations.

Your letter raises three important questions: (1) whether the program costs will be greater than the savings; (2) whether implementation of the regulations is consistent with the President's views on regulatory practices; and (3) whether the promulgation of the regulations should be postponed, pending further study.

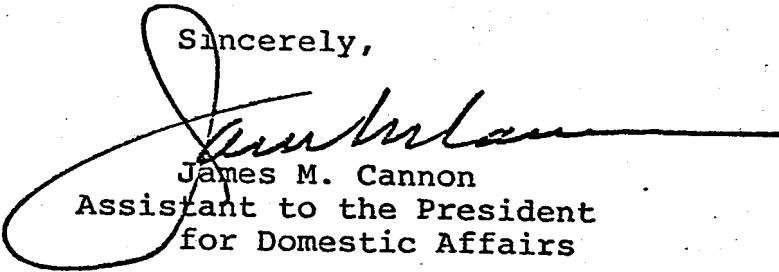
As you point out, HEW's estimates of potential savings differ from the estimates by the drug industry. The Department believes that the regulations will save between \$60 and \$75 million annually. After the program is in full effect, the administrative costs at the State and Federal level are estimated to be \$4.9 million in the first year, and \$1.7 million annually thereafter. I am enclosing for your information, a copy of the Department's inflation impact statement which discusses the savings and cost estimates in more detail.

With regard to your second point, as you know, under the Social Security Amendment of 1972, HEW is obliged to achieve economies in the Medicare and Medicaid programs. The MAC program, as you are aware, does not regulate drug prices. Rather it limits Federal reimbursement for any drug to the lowest cost at which a quality product is consistently and widely available. Drug prices will continue to be set by the usual market forces.

After careful consideration, Secretary Mathews has decided not to withdraw the regulations. He will, however, monitor very closely the economic effect of the regulations after implementation. He will be assisted in this monitoring effort by the Pharmaceutical Reimbursement Advisory Committee, a non-governmental advisory group of experts whose purpose is to assist in the implementation of the program.

I hope this letter is responsive to your concerns. I would be pleased to answer any other questions you may have about the regulations.

Sincerely,

A large, stylized handwritten signature in dark ink, appearing to read "James M. Cannon", is written over the typed name and title.

James M. Cannon
Assistant to the President
for Domestic Affairs

The Honorable Bill Archer
House of Representatives
Washington, D.C. 20515

Enclosure

TAB E

HEW



NEWS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

FOR IMMEDIATE RELEASE
Tuesday, April 6, 1976

Shirley Barth 301/443-2155 (office)
202/337-6935 (home)

The Department of Health, Education, and Welfare announced today that the implementation date for its new drug cost control effort has been postponed until August 26. The program was to have gone into effect April 26.

The purpose of the program is to control the costs of prescription drugs under HEW health care programs, particularly Medicaid. In fiscal year 1975, Medicaid spent \$1.6 billion on prescription drugs. There are two parts to the program. The first is to limit government reimbursements to pharmacists for drugs they dispense to Medicaid patients. The limit is to be based on an estimated acquisition cost to the pharmacist, plus a dispensing fee.

In the second part of the program, the government will set a Maximum Allowable Cost for drugs which are produced by different manufacturers and sold at varying prices. The Department will pay no more than the lowest cost version which is generally available across the country. But first the Food and Drug Administration would have to assure that there were no problems of quality and therapeutic activity among the different brands.

HEW has been gearing up to implement the program since final regulations were published in the Federal Register last July. But

(more)

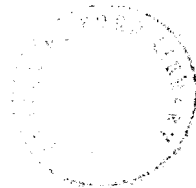
recently, several State Medicaid programs requested a delay in the implementation date.

Also, pharmacist organizations have questioned the timeliness of cost acquisition data provided to States by the Department.

The four month delay will allow additional time for the programs to become familiar with updated cost guidelines being prepared by HEW and to conduct studies of pharmacy operating costs. States prepared to implement the regulations in advance of the August date will be encouraged to do so.

The decision to delay was made by Secretary David Mathews upon the recommendation of the Pharmaceutical Reimbursement Board which oversees the cost control program. The Board is chaired by Dr. Theodore Cooper, HEW Assistant Secretary for Health.

#



TAB F



TELEGRAM

APRIL 5, 1976

PRESIDENT FORD
WHITE HOUSE
WASHINGTON, D. C.

JAMES CANNON'S LETTER TO ME OF MARCH 26 INDICATES THAT IN RESPONSE TO YOUR INQUIRY SECRETARY MATHEWS DOES NOT INTEND TO POSTPONE THE MAXIMUM ALLOWABLE COST (MAC) AND ESTIMATED ACQUISITION COST (EAC) REGULATIONS ABOUT WHICH YOU AND I TALKED ON FEBRUARY 26. YET SUBSEQUENT INFORMATION IN THE DRUG TRADE PRESS INDICATES THAT HE MAY WELL DO SO AFTER ALL. IT WOULD CERTAINLY HELP WIN SUPPORT FOR YOU AMONG THE RETAIL PHARMACISTS OF THIS COUNTRY IF YOU WOULD TAKE POSITIVE ACTION NOW TO ASSURE THAT THIS HAPPENS AS SOON AS POSSIBLE, OTHERWISE OTHER PEOPLE MAY WELL TAKE THE CREDIT.

WILLARD B. SIMMONS
NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

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THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

OFFICE OF THE SECRETARY • ONE EAST WACKER DRIVE • CHICAGO 60601

AC 312 321-1146

April 8, 1976

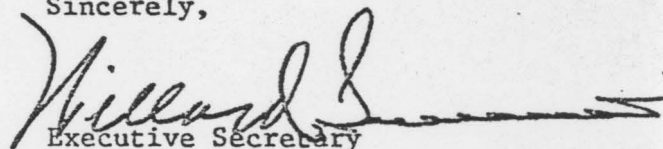
Mr. James M. Cannon
Assistant to The President
The White House
Washington, D.C.

Dear Mr. Cannon:

Enclosed is a copy of a letter marked "confidential." We have had about 150 copies of letters from individual pharmacists, State pharmaceutical associations and metropolitan pharmaceutical organizations. This gives you some idea of the pharmacists' views around the country with regard to the MAC and EAC regulations. Also please note the release made by HEW.

I was hoping, in view of my friendship with President Ford, that he would have made some comment to me regarding this postponement whereby he could have received proper and due credit for his efforts, but I am not sure there is adequate time to really restudy the regulations and have some input that will not take anything away from the patient or consumer and not increase prices to them but will give pharmacists an opportunity to have available opportunity for input whereby pharmacists may continue to operate their pharmacies on a sound business basis inasmuch as retail pharmacists provide this service to recipients of this program in all of our communities for prescription drugs.

Sincerely,


Executive Secretary

WBSimmons:ldh
encls.

President Ford Committee

1828 L STREET, N.W., SUITE 250, WASHINGTON, D.C. 20036 (202) 457-6400

April 8, 1976

Mr. Jim Cannon
Assistant to the
President for
Domestic Affairs

Dear Jim:

Attached please find the material as promised.

Best regards,



Bill Low
Director
National Advisory Board



Attachment

On February 27, 1976, President Ford met with NARD's Executive Secretary, Willard B. Simmons, to discuss a number of federal government actions that may decisively effect the future of pharmaceutical health care delivery in the United States. In this interview, Mr. Simmons reports on that meeting and considers some of its implications for community pharmacists.

Editor: Considering the pressures of the President's schedule during this election year, how were you able to convince him of the need for a personal meeting to discuss government-pharmacy relations? After all, the President could have referred your request for a conference to one of his high-level aides, with the proviso that the report on such a meeting be passed on to him.

Simmons: Probably one of the most important reasons is my long-standing personal acquaintance with Pres. Ford. Also the President recognizes that the independent pharmacists in this country are a very important political force, out of proportion in their numbers because they meet with about 15 million patrons a day. But probably the decisive reason for his being willing to hear me present NARD's point of view is his often expressed determination to eliminate unfair government regulation of business and the professions.

Editor: Was there any particular problem that convinced you that an immediate meeting with the President was critical?

Simmons: Actually, I had been planning for some time to talk with President Ford about several major issues where government and the pharmacist interact. When I wrote him to request a meeting, I was specifically planning to concentrate my presentation on four basic issues. I wanted to enlist his support for resolutions introduced in Congress by Senator Carl T. Curtis and Representative W. S. Stuckey that would permanently block FTC efforts to pre-empt state and local laws permitting prescription drug price advertising.

I also planned to propose to President Ford that he veto legislation calling for repeal of the Robinson-Patman Amendment to the Clayton Anti-trust Act and instead demand strict enforcement of Robinson-Patman. It was planning to discuss at length his supporting Senate Bill S. 2110, which makes it a federal offense to commit a crime against a pharmacy to obtain controlled substances.

Then after the President invited me to see him, a new development made this meeting even more critical. As a result, our actual conversation focused on the problem that has upset just about every pharmacist in the country, HEW's Estimated Acquisition Cost (EAC) maximum drug product price reimbursement list.

Editor: Before we talk more about EAC, I think it's worth mentioning that one of the issues you had originally planned to discuss with the president—better enforcement of the Robinson-Patman Act—is working out a way that will benefit community pharmacists. Don't you think that the recent Robinson-Patman action against the Thrifty Drug Store chain on the west coast, which prohibits that chain from seeking or receiving preferential treatment from its suppliers, may indicate a basic shift in the administration's policy?

Simmons: To the extent that personnel changes at FTC reflect the administration's position, I would say that is a reasonable assumption. The major opponents of the Robinson-Patman Act at FTC—chairman Louis Engman and commissioner Mayer Thompson—have resigned, and acting commissioner Paul Rand Dixon is a strong supporter of Robinson-Patman. Certainly it seems to me that the new FTC policy is more in accord with President Ford's political philosophy, which opposes collusive agreements that interfere with fair competition. How much more remains to be seen.

Editor: You have indicated that your original intention to discuss a number of issues with President Ford was suddenly pre-empted by MAC and EAC. Was there any advance warning of this new HEW price policy?

Simmons: I detect a note of amazement in your question, and that's exactly what I felt when I was suddenly confronted in the third week of February with a document from HEW announcing EAC. Included in this document is a listing of suggested maximum drug product price reimbursements to pharmacists for dispensing Medicaid and other prescriptions dispensed under federal funding programs. NARD had not been informed that such a list was in preparation; nor, to the best of my knowledge, were pharmaceutical

manufacturers and wholesalers invited to contribute to or review the list.

Even more incredible was EAC suggesting maximum price reimbursement for certain drug products that are lower than many wholesale drug prices.

Editor: Are you saying that EAC prices are lower than average wholesale prices in certain localities, or that they are just excessively low across the board?

Simmons: I started my analysis of EAC by checking with our members in various states, and received extensive documentation that EAC prices were lower than AWP prices for a number of products. At that point, there seemed to be good reason for assuming that the adoption of EAC would make it economically prohibitive for thousands of independent community pharmacies to dispense Medicaid prescriptions.

There seemed to be a clear and present danger that a huge percentage of Medicaid patients—particularly the chronically ill and disabled—who depend upon the easy accessibility of a nearby independent pharmacy—would be deprived of a vital health service.

As a result, it seemed best to skip over the other problems confronting pharmacy with the President and instead make an urgent appeal to him to delay the application of EAC and MAC regulations pending further study.

Editor: HEW spokesmen have said that EAC figures are *advisory*. They claim that the states are free to change EAC figures provided they are able to prove that EAC figures are too low.

Simmons: Judging by the number of states cutting dispensing fees, there doesn't seem much reason to believe that state Medicaid officials would go out of their way to reject EAC prices—even in the face of a clear hardship worked on Medicaid patients and pharmacists. I asked the President to consider delaying the regulations pending further study in order to give HEW an opportunity to develop more equitable programs based upon the realities of the marketplace.

Editor: I understand that Mrs. Simmons participated in your meeting with the President.

Simmons: Yes, it was a chance for her to renew acquaintances with President Ford. But more importantly, she was able to express to the President her awareness that women in pharmacy and in pharmacy organizations such as WONARD are very much concerned with this proposed regulation. As you know, both the President and Mrs. Ford have been quite responsive to women's interests. The President thanked Mrs. Simmons for adding what he seemed to consider a very important perspective to our discussion.

Editor: What was President Ford's reaction to your meeting?

Simmons: The President indicated that he would discuss with HEW's Secretary Mathews the possibility of delaying the implementation of this regulation.

Editor: But, nevertheless, NARD is taking legal action against HEW to prevent implementation of MAC and EAC.

Simmons: Yes, we are. We are doing everything possible to cope with the serious danger that this regulation presents to the delivery of pharmaceutical health care to the people who need it most.

Editor: What about the likelihood of there being a delay in the application of EAC?

Simmons: There is a very strong likelihood that there will be a delay. President Ford seemed concerned about the problems this regulation could create. NARD, and many state pharmaceutical associations, many drug manufacturers, and wholesale druggists are, for the most part, all united in voicing strong protest against this unworkable regulation. Of course, we have to expect that the zealots at HEW who were responsible for MAC and EAC will continue to push their position.

Once a federal agency proposes a regulation, it does not voluntarily reverse its stand. But the forces for change that I have already mentioned are extremely powerful. Moreover, I am much impressed with Secretary Mathews' open mindedness, and I believe that President Ford's interest and concern in the problem will lead to Secretary Mathews taking a closer look at the issues. He is bound to recognize the essential impracticability and unworkability of this regulation.

Editor: NARD is advocating that immediate action be taken to delay implementation of the regulation, pending further study.

Simmons: Yes. In that way, there will be less possibility of public confusion arising from Medicaid prescription drug reimbursement policies.

Editor: What about dispensing fees?

Simmons: HEW does not establish the professional dispensing fees for which pharmacists may be reimbursed under Medicaid; the individual states do that. But HEW is in a position to insist that fee reimbursements be adequate to cover the actual operating costs of providing professional services. This is HEW's responsibility and we are calling on them to do it. This is essential.

TELEGRAM

APRIL 5, 1976

PRESIDENT FORD
WHITE HOUSE
WASHINGTON, D. C.

JAMES CANNON'S LETTER TO ME OF MARCH 26 INDICATES THAT IN RESPONSE TO YOUR INQUIRY SECRETARY MATHEWS DOES NOT INTEND TO POSTPONE THE MAXIMUM ALLOWABLE COST (MAC) AND ESTIMATED ACQUISITION COST (EAC) REGULATIONS ABOUT WHICH YOU AND I TALKED ON FEBRUARY 26. YET SUBSEQUENT INFORMATION IN THE DRUG TRADE PRESS INDICATES THAT HE MAY WELL DO SO AFTER ALL. IT WOULD CERTAINLY HELP WIN SUPPORT FOR YOU AMONG THE RETAIL PHARMACISTS OF THIS COUNTRY IF YOU WOULD TAKE POSITIVE ACTION NOW TO ASSURE THAT THIS HAPPENS AS SOON AS POSSIBLE, OTHERWISE OTHER PEOPLE MAY WELL TAKE THE CREDIT.

WILLARD B. SIMMONS
NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

NEWS

FROM THE **N.A.R.D.** THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

One East Wacker Drive
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WILLARD B. SIMMONS,
EXECUTIVE SECRETARY

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Bill Arrott (312) 565-1200

PRESIDENT FORD TO WEIGH HEW PRESCRIPTION PRICE PLAN

CHICAGO, Mar. 3--President Ford has agreed to investigate a plan recently proposed by the U.S. Department of Health Education and Welfare that would reduce government payments to pharmacists for Medicaid prescriptions, according to Willard B. Simmons, executive secretary of The National Association of Retail Druggists.

The President's decision stems from a recent meeting with Simmons, who informed the President that the delivery of pharmaceutical health care to needy Americans could be jeopardized if HEW implements its new prescription price reimbursement schedule as planned on April 26.

That schedule, called Estimated Acquisition Costs of Prescription Drug Products (EAC), is a wholesale price list of 300 widely prescribed drugs that HEW wants the states to use as a guide for reimbursing pharmacists for Medicaid prescriptions under the Maximum Allowable Cost (MAC) program.

A NARD study has shown that under EAC, community pharmacists all over the country would be reimbursed for Medicaid prescriptions in a number of instances for less than the actual cost of the drugs dispensed.

Simmons said that the President expressed concern about possible inequities to community pharmacists and the resulting curtailment of services to Medicaid patients that might result from implementation of EAC.

"Mr. Ford indicated to me personally that he would talk to HEW Secretary Mathews about the feasibility of postponing implementation of EAC and MAC regulations," Simmons said.

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NEWS

FROM THE **N.A.R.D.** THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

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PHARMACISTS ACT AGAINST HEW RULES

THEY SAY WILL CRIPPLE MEDICAID

CHICAGO, Mar 3--The National Association of Retail Druggists (NARD) revealed here today plans for legal action against the U.S. Department of Health Education and Welfare to postpone adoption of regulations the group says will cripple Medicaid. The Boston law firm of Paul T. Smith has been retained to represent the association.

Willard B. Simmons, NARD's executive secretary explained that HEW has just issued an Estimated Acquisition Cost (EAC) reimbursement schedule for its Maximum Allowable Cost program (MAC) that will force pharmacists to lose money on many Medicaid prescriptions.

"At present, a pharmacist who dispenses a Medicaid prescription is reimbursed for the wholesale cost of the drugs and receives a dispensing fee to cover professional services and business overhead. Each state determines its own schedule for reimbursing pharmacists, based upon the average wholesale price of prescription drugs and a dispensing fee.

"Now HEW intends to reduce prescription drug reimbursement to the point where it will be impossible for thousands of independent pharmacists to fill Medicaid prescriptions. As a result, many aged and infirm patients will no longer be able to have their Medicaid prescriptions dispensed at a nearby community pharmacy where their health care requirements are a matter of ongoing concern to the pharmacists," Simmons said.

NARD's legal action is aimed at blocking HEW from forcing the states to accept its new EAC schedule by the target date of April 26.

Pharmacists Act Against HEW Rules--2
They Say Will Cripple Medicaid

"The best way to judge the potential impact of EAC is to compare EAC prices with what pharmacists actually have to pay for prescription drug products. For example, in the State of Texas, the average wholesale price paid by pharmacies for a frequently prescribed drug for arthritis (Indocin 25 mg, 100's) is \$9.88. The EAC price is \$8.10. EAC actually calls upon the pharmacy to sell the product for \$1.78 less than it costs. The average wholesale price of Valium, one of the nation's most widely prescribed drugs (Valium 5 mg, 100's) is \$8.89. The EAC reimbursement price is \$7, or \$1.89 less than the average wholesale price. Since the dispensing fees nationally average \$1.85, EAC effectively deprives pharmacists of reimbursement for their services and cost of doing business.

"We've checked average wholesale prices in many states, and the pattern is consistent. The loss imposed by EAC prices will, in many cases, completely cancel out the pharmacists professional dispensing fee," Simmons said.

"EAC was developed hastily and arbitrarily without a study of actual prescription drug costs throughout the country. Our legal action is aimed at postponing implementation of EAC until realistic reimbursement levels can be established to assure every Medicaid patient and the American taxpayer that quality pharmaceutical health care will be delivered to everyone who needs it on an economical and equitable basis in the community in which he lives."

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V.P.
File

Office of the Vice President

PROPOSALS FOR A NATIONAL HEALTH POLICY
ADDRESS OF VICE PRESIDENT NELSON A. ROCKEFELLER BEFORE THE
NATIONAL LEADERSHIP CONFERENCE ON AMERICA'S HEALTH POLICY
WASHINGTON, D. C.
THURSDAY, APRIL 29, 1976

(Ninth of a Series)

SUMMARY



"I recommend adoption of a comprehensive, two-phased National Health Policy: First, to control health care costs and broaden the health care delivery system; and Secondly, to extend the availability of health insurance to those who are not now covered...

"Let me emphasize that without the first phase of getting quality health care costs under better control, the second phase of expanding coverage would be of little value... (for) our health care system will just keep sopping up every dollar that it receives, without significantly improving the quality or delivery of health care..."

SPECIFIC RECOMMENDATIONS -- PHASE ONE

1. Enact amendments (now before the Senate) to improve competitive position of Health Maintenance Organizations.
2. Provide fast tax write-offs of start-up costs for Health Maintenance Organizations and Medical Care foundations.
3. Undertake Federal experimental program of institutional licensing of health personnel to encourage use of paraprofessionals (medical corpsmen, vocational nurses, physicians' assistants).
4. End cost-plus reimbursement of hospitals under federal programs, setting Federal maximums by area.
5. Restrain demands for unnecessary care by requiring that consumers pay a portion of their health costs and health insurance premiums.
6. Enforce Health Planning Act to stop construction of unnecessary facilities and duplication of costly equipment.
7. Extend Professional Standard Review to care outside hospitals.
8. Establish Federal reinsurance pool to backstop malpractice insurers under State programs which set-up arbitration of claims and limit attorneys' fees.

PHASE II

1. Replace Medicaid with a nationwide, Federally-financed health insurance program for low-income families and individuals.
2. Provide option of Federally-reinsured health insurance policies at group rates to individuals.
3. Enact President Ford's proposal for insurance coverage against catastrophic illness for Medicare recipients.

FULL TEXT FOLLOWS

FOLLOWING IS FULL TEXT OF SPEECH:

I want to compliment Congressman Rogers, Congressman Rostenkowski, and the National Journal for sponsoring this invaluable conference on "America's Health Policy." And I personally appreciate this opportunity to participate. No subject is more vital to every man, woman and child in this Nation.

In our free society, two things are essential for every American to reach his or her fullest human potential, the opportunity for good education, and the opportunity for good health care. Given access to both these opportunities our people can go just as far as their God-given talents will take them.

My concern with the health problems of the American people is the result of growing up in a family dedicated to the advancement of medical science, research and good health for all. Among the first of the family's major philanthropies was the Rockefeller Institute for Medical Research, which my grandfather founded in 1901. This Institute focused its efforts on the cause and cure of major illnesses.

In 1913, the Rockefeller Foundation was founded and its International Health Division worked with governments at home and abroad in applying this research on a massive scale, which led to the virtual eradication of such widespread diseases as hook worm, Yellow Fever, and Malaria. This was the beginning of private foundation support of medical research and international health programs.

My first opportunity for public service came in the health field. In 1933, I was asked to serve on the Westchester County New York Board of Health, where I remained a member for over 20 years.

Then when President Roosevelt asked me to serve as Coordinator of Inter-American Affairs in the 1940's, we organized the Institute of Inter-American Affairs which undertook cooperative health programs in some 20 countries in the Western Hemisphere.

Later, President Eisenhower asked me to head a task force on government organization which led to the creation of the Department of Health, Education and Welfare. I was privileged to serve as the first Under Secretary of HEW, under Secretary Oveta Culp Hobby. Mrs. Hobby and I were appalled to learn at that time, that catastrophic medical expenses were bankrupting about 3 per cent of all American families each year. To protect against this kind of tragedy, we agreed to establish a Federal pool to reinsure private insurance companies if they would write health coverage for catastrophic illness. That was back in 1954 -- and, unfortunately, they failed to respond.

When I became Governor of New York in 1959, I immediately initiated a study on the feasibility of adopting a comprehensive State health care plan. We had to abandon the idea, for the study revealed that a State-financed health program was not feasible because of its high cost to employers, employees, and taxpayers in the State. Unless all other States took similar action, the additional cost to New Yorkers would have jeopardized the State's competitive position as a place to live, work and do business. Therefore in 1964, I recommended that a form of Universal Health Insurance be considered on a national basis.

(MORE)

The private sector and voluntary, philanthropic initiatives have made America the undisputed leader in training those who provide health care, in building the facilities where that care is provided, in developing health insurance to help cover the costs of that care, and in carrying out medical research.

In the past decade, Federal, State and local governments have accelerated their expenditures and are now investing over \$50 billion annually in the health of Americans, with over 11 per cent of the total Federal budget currently going to health. Yet, the inescapable fact is that for all the progress, for all the concern, for all the expenditures, we find this Nation faced with serious and deepening problems in relation to the cost, delivery and financing of health care.

And even with all this expenditure, our medical care system does not assure adequate health protection for the 19 million Americans with no health insurance. We do not have comprehensive, total health care at all, nor do we have an overall, conceptual policy in this area of fundamental human necessity. What has been built up, through the best of intentions and efforts, is a piling of one program upon another on a piecemeal basis, by a multitude of private efforts and independent initiatives of all three levels of government -- Federal, State and local.

Today, I would like to trace the roots of some of our health care problems and prescribe some hopefully effective medicine for their cure. Medical care began simply enough in this country as a one-to-one relationship between the doctor and the patient.

Government's involvement in the beginning was limited to public health programs and only later followed by institutional care for the indigent and aged.

Individuals, in order to protect themselves against the cost, and with the desire to extend health benefits, expanded this simple doctor-patient relationship to a relationship with a third party, the health insurer, which involved individual insurance plans, group plans, company plans, and union plans, with vastly differing coverage, premiums and forms of payment. Another change in the individual doctor-patient relationship took shape as doctors formed into professional groups.

And then in the early 1960's, the Federal government began to get into the act in a major way. After 20 years of controversy, Congress passed Medicare as a contributory medical program for older Americans, and also enacted Medicaid for the medically indigent, but not in a coordinated or carefully thought way, witness the following example from our experience in New York State.

Since 1929, during Al Smith's time as Governor, New York State had provided marginal health care to its needy citizens. Just before the enactment of Medicaid in 1965, there were 1.4 million persons eligible for the State medical assistance programs. When Medicaid was passed by the Federal Government, New York State expanded its program of eligibility to add an additional 4.6 million newly-qualified persons.



When the members of Congress realized that as a result of the new eligibility standards New York State would thus be entitled to virtually all of the money the Federal government had budgeted for Medicaid that year for the whole country, they were shocked. As a result, Congress changed Federal eligibility standards and New York State was forced to change its law and drop some 1.2 million newly-eligible persons from its rolls. Obviously, this action created a deep feeling of disillusionment, bitterness and cynicism towards the government.

This example is a perfect illustration of what happens when the Federal government passes piecemeal legislation without considering its far-reaching implications. When it came to financing the cost of health care, the Federal government largely addressed itself to the paying of medical bills for welfare families, the disabled, and the elderly.

A great number of needy American families failed to qualify for this help. The tragic hardships these families faced when medical bills exceed their capacity to pay, or when life savings are wiped out by catastrophic illness, are still not being met by the Federal government.

In addition, it should be pointed out that preventive efforts, which could reduce the incidence of acute illness and lower the cost of medical care, have not been effectively addressed. In the absence of a coordinated national health policy, total expenditures keep rising at an intolerable rate, without a comparable increase in the quality or coverage of health care.

Health care costs are the most inflationary item in the Consumer Price Index, outpacing even the sharp increases in the cost of imported fuel due to price increases by the Organization of Petroleum Exporting Countries. Between 1965 and 1975, the cost of health care in America increased over 200 per cent. In just one year, between 1974 and 1975, total public and private spending for health care increased nearly 14 per cent.

With hospital rooms costing an average of \$150 per day, the average stay in a hospital now costs almost \$1,000, an increase of 16.6 per cent in the past year compared to a 6.8 per cent increase of the Consumer Price Index, exclusive of medical costs.

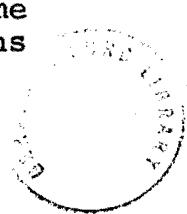
In addition, this Nation's health manpower is not evenly distributed. New York and California, for example, have over 140 physicians per 100,000 of population, while Mississippi and Idaho have less than 90.

Most important, we have scarcely tapped the area of greatest potential -- disease prevention. The leading causes of death in this country, such as heart disease, cancer, and automobile accidents, can be significantly reduced through changes in our life style.

Consider how much medical and hospital care would not have been necessary had we been able to alter and control such living habits as: smoking, alcohol, fast and reckless driving, violent crime, drug abuse, pollution, overeating, poor nutrition, and lack of exercise. All these have been shown in study after study to be related to our national death rate and the high level of expenditures for medical and hospital care.

The establishment of the 55 miles per hour speed limit is a dramatic example of how a change in habits can affect health costs. In 1973, before the new speed limit was imposed, there were 55,000 traffic fatalities. In 1975, although there were more cars on the road, this figure dropped to 46,000. Over the same period, injuries declined by 200,000. This reduction in deaths and injuries saved \$15 billion in accident-related expenses.

(MORE)



Changing all these living habits requires education, self-discipline, and legal sanctions. What then should we be doing as a Nation to lift our sights and perspectives on the complex problems we face, and to achieve an effective health care system at reasonable cost?

A NATIONAL HEALTH POLICY

I recommend, as a first step, adoption of a comprehensive, two-phased National Health Policy: First, to control health care costs and broaden the health care delivery system; and Secondly, to extend the availability of health insurance to those who are not now covered.

PHASE I -- Initially, we must structure the delivery of health care in a way that will bring health costs under control, while assuring high quality medical care. Let me emphasize that without the first phase of getting quality health care costs under better control, the second phase of expanding coverage would be of little value. In the present absence of an effective cost control system, our health care system will just keep sopping up every dollar that it receives, without significantly improving the quality or delivery of health care.

Delivery Systems -- The necessity to have something better than the current hodge-podge of private and government health care efforts does not mean that we have to move to a rigid, narrow, single system. Both in terms of improved quality and greater cost efficiency, the Nation will benefit from a healthy competition among medical care systems. This has traditionally been the pluralistic American way. And it can serve us in improving health care just as it has made America the leader in virtually every other field of human endeavor.

Pre-Paid Medical Care Plans -- The recent development of pre-paid "Health Maintenance Organizations" has proven to be a promising method of stimulating competition. The number of these pre-paid plans has increased over the past five years from 30 to 180. Because of the pre-paid approach, they have an economic incentive to prevent illness instead of just focusing on treatment. In our brief experience with these pre-paid plans, the results in controlling costs are impressive.

For example, the cost to Federal employees covered by two conventional health insurance plans increased this year by 56 per cent. While employees covered by pre-paid plans experienced an 18 per cent increase in their payments. In other words, pre-paid plans cut the cost increase by two-thirds. At the same time, pre-paid plans usually provide more benefits, hence greater health protection.

Unfortunately, the 1974 Health Maintenance Organization Development Act mandated benefits which are more extensive than those normally offered under previous health insurance plans. This law has created a situation where certain Health Maintenance Organizations cannot be competitive in price, since they are required to include extraneous extra services.

(MORE)

I recommend that the Senate move rapidly to adopt amendments now under consideration which will correct this situation and improve the competitive position of Health Maintenance Organizations. In order to expand and develop Health Maintenance Organizations, a massive influx of private investment capital will be required.

I therefore recommend special tax provisions for investments in the Health Maintenance Organizations which would allow a fast write-off of start-up costs. With proper fiscal control, Health Maintenance Organizations provide one of the best approaches for injecting competition into our delivery system. Their development should be encouraged by those who have the greatest stake in controlling health costs, business, labor and middle income families.

Medical Care Foundations -- Another form of pre-paid health plan is the Medical Care Foundation. These Foundations are private, non-profit organizations of physicians and are usually sanctioned by the local medical society. Persons enrolled have pre-paid coverage, while the providers are reimbursed on the conventional fee-for-service basis.

These non-profit foundations are run by physicians. Since the compensation of the managing physicians depends upon their efficiency and expertise, these foundations meet the goals of high quality and lower costs through physicians' review of the care provided.

A recent study indicated that Medical Care Foundations had an average length of stay in the hospital of about eight days for surgically-related cases, while health care provided for on a cost-reimbursement basis ranged up to 14 days. Foundations have found that as much as 15 per cent of the insurance premium rates can be saved through careful monitoring and cost controls. The expansion of Medical Care Foundations will provide one more element of competition in the delivery system. I recommend, therefore, that non-profit Medical Care Foundations be granted tax incentives to stimulate capital investment, similar to the proposal I recommend for Health Maintenance Organizations.

Health Manpower -- To make the competitive health care delivery system effective, we must remove many present obstacles to the more efficient use of health manpower. All too often, licensure laws have protected the professionals rather than the patient. Overly restrictive regulation in licensing has been a serious deterrent to the use of para-professionals, such as medical corpsmen, vocational nurses, or physicians' assistants.

Hospitals, clinics, and physician groups need more flexibility in the hiring and use of their personnel. Institutions themselves should be allowed to determine the most productive use of the various types of health personnel.

(MORE)



One approach would be to license an institution and permit it to establish the qualifications of their employees under general guidelines. Understandably, this approach may be unpopular with many doctors, registered nurses, and certain other licensed professionals. But it is essential if we are serious about trying to hold down costs. The armed services have proven, particularly during wartime, that paraprofessionals can relieve highly-trained specialists of many routine duties.

I recommend that the Federal government undertake an experimental program in this respect. If successful on a national basis, the law should be changed to permit licensing of individual health care institutions, instead of the present detailed establishment of credentials for individuals.

Cost Control -- Ever since third-party insurers, private and public, began to pay medical bills, there has been little incentive for doctors, hospitals or patients to hold the line on rising health costs.

In fact, the incentives are in the opposite direction: The more often the patient sees a doctor, the more money the doctor receives; the longer the patient stays in the hospital, the more money the hospital receives. Under our cost-plus reimbursing system, there is no effective restraining force against unnecessary or excessive hospital stays, laboratory tests, the purchase of expensive equipment, and unneeded hospital construction.

There are two alternative primary approaches to controlling medical costs: (1) Government control, which could range from total Federalization of the health care system to the imposition of wage and price controls. However, total government control through a National Health Insurance Plan, under which government would pay all the health bills, would add at least \$60 billion to \$90 billion to the Federal budget, which already faces a \$75 billion deficit.

And our recent experience with cost controls has demonstrated that while they may temporarily stabilize the average costs for services, they do not get at the root causes of medical cost inflation over the long run, for inefficient use of medical services and duplication of facilities continued to drive the overall cost of health care up during the period of price controls. (2) Therefore, we must find an alternative to total Federalization, or excessive government control, and develop systems which respond to competitive forces and thus provide incentives to control costs.

Reimbursement -- In developing systems that respond to these competitive forces, one of the biggest problems is overcoming cost-plus reimbursement of hospitals.

I recommend, therefore, that the government annually determine the appropriate hospital reimbursement rates in a particular area and use these rates as the maximum which hospitals in the area would be paid for services to Medicare and Medicaid patients. Under this reimbursement system, hospitals would have an incentive to operate below the established rate, in order to share in the savings they generate. Legislation, similar in concept, is now pending before the Congress and it deserves careful consideration.

I further recommend that we move toward a structure where consumers pay a portion of their health costs and health insurance premiums. Under this plan, a sliding payment schedule based upon income should be instituted. Otherwise, when the patient pays nothing out of pocket for medical care, there is little restraint against demanding unnecessary care and excessive hospitalization.

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Planning -- A major contributor to the rising cost of health care has been the construction of unnecessary facilities, and the purchase of expensive equipment which duplicates that already available in a community. During the late 1960's, we were able to get some control over this problem in New York by instituting a prior-approval system over health facility construction or expansion.

There is no need for the government or third party insurer to pay for building and maintaining maternity units in four hospitals in a city when each of them averages only 25 per cent occupancy during the year -- as is the case in some communities. Such wasteful practices hit consumers, business, labor and government alike.

I recommend strict application of the provisions of the Health Planning Act, aimed at reducing the construction of unnecessary health facilities and the duplication of expensive equipment.

Quality Control -- One cannot stress too strongly that cost control must not be achieved at the expense of quality medical care. Under current law, the quality and appropriateness of care provided in hospitals to Medicare and Medicaid patients must be evaluated by a Professional Standard Review Organization in the area.

I recommend that this important review be extended to include care provided outside the hospital as well.

Malpractice Insurance -- Another factor in the cost and quality of medical care is malpractice insurance. The steep rise in the cost of malpractice insurance has had its effect on both health care delivery and rising cost. Physicians in certain specialties in some areas are now paying in excess of \$30,000 a year in malpractice insurance premiums; and many hospitals have seen their rates increase 10 times -- or 1,000 per cent. Traditionally, States have dealt with malpractice matters. In my opinion, the problem has grown to a point where some form of Federal action is needed.

I recommend, therefore, that the Federal government establish a Federal reinsurance pool, to provide a financial backstop to insurers within a State when malpractice claims exceed \$200,000.

Insurers would be eligible for this assistance only after the States: (1) Set up a system for arbitrating claims similar to the Workmen's Compensation Appeals Board, thus reducing the load on the courts; and, (2) Adopt regulations to limit fees which attorneys may collect from malpractice suits.

The Federal law should give the States two years to develop and enact their State plans. But Federal leadership is needed to halt the rising costs and unnecessary services traceable to the malpractice insurance problem.

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These are my views of the things we need to do now to: A) Control health care costs, and B) broaden the delivery system. Once the effects of these measures begin to take hold, then we can better deal with the problems of expanding health insurance coverage.

PHASE II -- EXTENSION OF COVERAGE -- About 19 million Americans have no health insurance coverage. The reasons vary from low income and unemployment, and prior illnesses which are uninsurable, to the difficulty which self-employed persons have in obtaining coverage available to groups. Many low income or unemployed persons are not covered by Medicaid because they do not fit the current description of welfare categories.

The benefits available under Medicaid vary widely between States causing significant inequities and costly administration. These problems must be corrected.

I therefore recommend that: Medicaid be replaced with a nationwide, Federally-financed health insurance program for low income families and individuals. The program would be administered by the States and a national uniform level of benefits and eligibility would be established.

Eligible persons would share in the cost of their health care according to their means. This would assure protection to persons living on a low income and, as their income increases, they would transfer to a regular private insurance plan.

The self-employed and high risk individuals who cannot obtain adequate private coverage also need to have protection available. To assure an available source of health insurance for this group:

I recommend that the insurer who processes Medicare claims within a State be required to offer Federally-reinsured policies to individuals for whom group insurance is not available, and at rates and levels of coverage comparable to group policies. If these two proposals are instituted, I think we will have the most significant coverage problem solved, at a cost that would be manageable both in terms of the Federal budget and the private sector.

A major remaining area of health insurance that has been the subject of concern and discussion during recent years, is protection against catastrophic illness. Currently, several proposals are pending before Congress relating to such insurance.

In response to this debate, private insurance firms now provide catastrophic coverage for most working Americans who desire such insurance. Over 75 per cent of new policies being written provide insurance against medical expenses of \$100,000 or more. Major underwriters are beginning to offer this coverage to individuals as well as groups. There is every reason to assume that this trend will continue, which reduces the need for an extensive Federal program.

Since the elderly are most vulnerable to costly medical care, catastrophic coverage should be included in the Medicare program. I urge the Congress to enact the amendments proposed this year by President Ford, which provide coverage against catastrophic illness for Medicare recipients.

Conclusion -- If we continue to delay in getting started on these essential programs, the major health problems of the American people will become more severe, and short-sighted, government-dominated, policies will become more attractive. Unless we move vigorously to structure the delivery and economics of health care, we can only look forward to deteriorating quality at skyrocketing prices.

The Congress and the Administration must work together in developing a comprehensive health policy for this Nation. The many committees of Congress concerned with these issues should be pulled together into Select Committees on National Health Policy in the House and in the Senate. These Select Committees would develop an overall framework for dealing with this crucial issue.

Within the Executive branch, all health programs should be coordinated by one office at the Department of Health, Education and Welfare -- to allow for the administration of a strong, consistent policy.

I have outlined the direction I think the National Health Policy should take. A two-phased approach which would -- first, broaden the delivery system and get costs under control, and second, move toward comprehensive insurance coverage.

The problem will not go away. It must be confronted, and soon, for the health of our people, for the health of our economy and for the health of our country.

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THE WHITE HOUSE
WASHINGTON

You wanted to call Secretary
Mathews on this.

j

627-4951

Ted Cooper

DW

James Dixon

245-6811



THE WHITE HOUSE
WASHINGTON

April 29, 1976

Call Matthews

MEMORANDUM FOR: JIM CANNON

FROM: JENNIFER

SUBJECT: Marsh's Request for Comments on
New York Times Story (attached)

I asked Spencer Johnson for his comments on this and he checked with HEW.

HEW says that the article is basically correct. However, they say Dr. Saffiotti is a bit eccentric and something of a troublemaker. They also stressed that Dr. Saffiotti is not leaving the agency but rather just changing positions. The agency does not expect to feel any loss or be particularly affected by the shift.

