Fiscal Summary

	1995-1999	2000-2004
Outlays		
Subsidies		
Medicaid		
Medicare		
Other Federal Health		
Revenues		
Tobacco tax		
High Cost Plan Assessment		
Net Deficit Effect		

direct
Small
cost

- Individual deduction
- Firms (same except)

Tax exclusion & current deduction

Year by Year Analysis of Low Income Voucher Program

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Subsidy Liability										
Medicaid										
Medicare										
Tax expenditures										
Net Expected Surplus or Shortfall										

MAINSTREAM COALITION PROPOSAL: ISSUES AND PROBLEMS

1. **Coverage:**

   Sizeable population of uninsured remains.

   Uncompensated care problem continues, including cost shift to private payors.

   Premiums will be high in the community rated pool due to adverse selection.

   Some moderately sized firms (100 to 500 workers) will continue to be subject to bad experience rating.

2. **Subsidies:**

   Schedule specified creates high marginal tax rates.

   Subsidies tied to the average premium in an area implies that low income individuals may have difficulty affording coverage in the community rated pool.

3. **Benefit Package:**

   Adverse selection problem: individuals will tend to sort into standard and basic plans according to health status.

   Uncompensated care problem continues among those insured with the basic plan.

4. **High Cost Plan Assessment**

   The assessment is likely to be imposed on plans with a sicker than average population, due to lack of community rating outside of the small firm/individual market, and due to adverse selection in the small firm market.

   Little revenue will be raised due to the fixed rate specified and the split of the premiums into two separate groups.

5. **Medicaid:**

   Limitation of Federal payments while leaving Medicaid program and obligations largely as in the current system, places states at substantial risk.

6. **Medicare:**

7. **Tax Incentives:**

Tax deductibility for individuals tied to the average priced plan in a geographic area penalizes those in plans with adverse selection.

8. **Financing:**

Financing is unlikely to be sufficient to allow for expansion of subsidy eligibility.

Tobacco tax -- can it be used to offset costs of subsidy shortfall? If not, what is it used for?

WEDNESDAY, JUNE 22

8:15 AM - 8:45 AM	COMMUNICATIONS MEETING ROOM 100
8:45 AM - 9:30 AM	INTERNAL POLICY MEETING ROOM 216
10:30 AM - 11:30 AM	U.S. PUBLIC HEALTH SERVICE INDIAN TREATY ROOM
4:00 PM - 5:00 PM	SENATOR BRADLEY'S STAFF HART 731
5:00 PM - 6:00 PM	LEGISLATIVE MEETING

June 1, 1994

MEMORANDUM

To: John Drabek

From: Lisa Alecxih

Subject: Annual Premiums for Proposed Long Term Care Benefits

---

This memo presents estimates of the annual per capita premiums for persons age 18 and over required to fund a fairly comprehensive long term care benefit package.[1] We have also developed crude premium levels consistent with designations of insurance unit type as defined under the current Kennedy proposal.

Per Capita Premium for Persons Age 18 and Older

The assumed program would cover both nursing home and home and community-based care. Nursing home care would be subject to a 25 percent copayment, with those unable to pay the 25 percent receiving supplemental payments from the program on a basis similar to Medicaid eligibility rules. Home and community-based services coverage and eligibility would be based on a program that covers all persons with disabilities (any ADL or IADL) who cannot care for themselves. We assumed that the proportion of persons served under the program would be double the current proportion receiving paid services by disability level (100 percent induced demand). The level of service estimated under the program was based on increasing current use for paid services by 20 percent by disability level. Persons with disabilities would receive home and community-based services with a sliding scale copayment requirement similar to the one outlined under the Health Security Act (HSA).

The annual per capita premium levels for persons age 18 and over in 1996 for program funded expenditures are shown below. These estimates reflect the total public costs of these benefits, not the public costs. They include Medicare payments and exclude copayments by participants.

	Institutional Care	Home and Community-Based Care	Total
All Persons	$480	$355	$835
Non-Elderly	$135	$150	$285
Elderly	$2,115	$1,340	$3,455

[1] That is, total expenditures are in the numerator and only persons age 18 and over are in the denominator.

In developing these estimates we did not model some of the specific features of the program. We did not model the deductible and out-of-pocket limits because these apply to all health care expenditures (not just long term care) and these amounts vary depending upon whether an individual chooses a low cost-sharing or high cost-sharing plan. In order to model total health care expenditures, we would need to estimate acute care expenditures as well as long term care expenditures. Also to better model the plan, we would have to develop criteria for deciding whether an individual will chose the low cost-sharing plan, the high cost-sharing plan or the combination plan.

The estimates above also do not take into account current law public expenditures for these services. If such a financing scheme were implemented, public expenditures for long term care services would end. The annual per capita 1996 current law public expenditure levels for persons age 18 and over eligible for the program described above are shown below. These estimates include Medicare expenditures.

	Institutional Care	Home and Community-Based Care	Total
All Persons	$255	$220	$475
Non-Elderly	$105	$90	$195
Elderly	$950	$835	$1,785

Net premium required can be calculated by subtracting the program premiums levels from the current law premium levels.

Finally, under the proposal, the sponsors may wish to exclude Medicare payments from being funded by premiums. Medicare expenditures for long term care services account for the following annual per capita expenditures for persons age 18 and over.

	Institutional Care	Home and Community-Based Care	Total
All Persons	$40	$100	$140
Non-Elderly	$2	$8	$10
Elderly	$225	$520	$745

Insurance Unit Premium Levels

Developing premium estimates on an insurance unit basis (i.e., single individuals, married couples, single parent families, and two parent families) is difficult because it requires knowledge of the long term care expenditures for each of the insurance units separately. It also may not be good policy to develop long term care insurance premiums strictly based on the expected expenditures for a given type of unit because some units will have very high premium levels. For example, developing separate premiums based on expenditures for elderly single and married individuals would result in high premium estimates for single persons relative to the married couple premium due to the fact that the vast majority of long term care expenditures are for single individuals. Therefore, we have developed premium estimates by insurance unit type based on modifications of the per capita premiums calculations presented above.

For the elderly, we used per capita premium rates for persons age 65 and over, with single individuals assigned one times the per capita rate and married couples assigned two times the per capita rate. For the non-elderly, we estimated per capita expenditures for persons under age 18 separately. Estimates of the per capita expenditures for persons age 18 to 64 were then used to calculate the working age adult premiums for the singles (one times this level) and married couples (two times this level). Finally, the family premiums were based on the single and couple premiums calculated for persons age 18 to 64, plus an average number of children of 2.5 per family times the per capita expenditures for persons under age 18. These calculations result in the following premium levels:

	Non-elderly	Elderly
Single	$270	$3,455
Married Couple	$540	$6,910
One Parent	$340	
Two Parent	$610	

Please give me a call if you have any questions.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

NOTE TO BOB PELLICCI

We are trying to obtain clearance to provide Senator Kennedy's staff with the attached premium estimates. These estimates pertain to an amendment to the Kennedy bill sponsored by Sen. Kassebaum. She proposes to replace the long term care benefit in the Kennedy with a directive to the Commission to estimate the premium necessary to provide long-term home and community-based or nursing home care to individuals with physical or cognitive impairments which render them unable to care for themselves.

Although the proposed amendment is quite vaguely worded, the attached estimates clearly show that such a benefit would be very expensive. To fully fund her proposal in FY1996 would cost nearly $96 billion. This is much more than it would cost to fully fund the administration's home and community-based services proposal in FY1996 ($25 billion), and even the administration's proposal would not be fully phased in until FY2003. The premiums required to generate such a large amount of revenue would be prohibitive. Moreover, these premiums would have to increase in future years as the population ages, because the premiums just cover current expenses. Clearly, the proposed amendment is not a viable alternative to the administration's proposal.

We urge you to clear the document today. The proposed amendment is the first order of business when the markup resumes next week. If the amendment is adopted it would eliminate the administration's proposed long term care benefit from the Kennedy bill.

Judy Feder

Chris
J.
See Greg
ASAP

United States Senate

COMMITTEE ON FINANCE
WASHINGTON, DC 20510-6200

May 26, 1994

Dear Ms. Genn:

I am truly sorry that we have been unable to meet personally to discuss health care reform. I do understand your frustration. We will try to schedule a meeting in the near future.

Until such time, I want you to be assured that I am very much aware of your positions on the issues central to comprehensive health care reform. I am concerned that my history and current position on these issues is unclear to your member organizations. I was the only cosponsor in 1992 of Senator Bob Kerrey's single payer health system proposal and continue to strive to achieve the goals set out in that ambitious legislation. Further, I introduced President Clinton's Health Security Act in the Senate this year and endorse its provisions whole-heartedly. I support -- indeed, I insist -- that we must have universal coverage. I support an employer mandate and will oppose the taxation of benefits. I absolutely support long-term care. And I believe that States must have the single-payer option.

I hope that I have clarified for you where I stand on these important issues. We share the same goals, and I do look forward to working with you to achieve them.

Sincerely,

Daniel Patrick Moynihan

Ms. Shirley Genn
Brooklyn-wide Interagency Council of the Aging, Inc.
4520 4th Avenue
Brooklyn, N.Y. 11220

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

TO: Chris Jennings

FAX: 456-7431

FROM: David Nexon

DATE AND TIME: _____

NUMBER OF PAGES: COVER + 3

RETURN FAX NUMBER: (202) 224-3533

IF THERE IS TROUBLE RECEIVING THIS FAX, PLEASE CALL (202)224-7675

Per our discussion -- These are possible scenarios for a trigger approach to controlling costs.

To Ken

TRIGGER SCENARIOS

CLINTON

Premium increases gradually lowered to CPI by 1999

In 2001, increase is GDP growth + an amount to cover benefit improvements (GDP = 4.4%, benefit improvements = 3.6%)

After 2001, increases equal GDP growth (4.4%)

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	4.5	4.0	3.5	3.0	3.0	8.0	4.4	4.4	4.4
1.00	1.05	1.09	1.12	1.16	1.19	1.29	1.35	1.40	1.47

SCENARIO 1

Increases in 1996 and 1997 equal CBO estimates of premium increases under Cooper (slightly below baseline)

Trigger would limit increases in to CPI beginning in 1998 until costs equal Clinton, except that the increase in 2001 equals CPI (3.0%) + cost of new benefits (3.6%)

Costs equal Clinton by about 2004

Subsequent increases equal growth in GDP (same as Clinton)

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	3.0	3.0	3.0	6.6	3.0	3.0	3.0
1.00	1.08	1.16	1.20	1.23	1.27	1.35	1.39	1.43	1.48

SCENARIO 2

Assumes Cooper increases in 1996 and 1997

Increases are limited to CPI minus 1 (2%) per year from 1996-2000

Increase in 2001 is CPI - 1 (2%) plus the cost of benefit improvements (3.6%)

In 2002, increase is slightly below Clinton growth rate (GDP) to bring costs in line with Clinton beginning in that year. After 2002, increases equal GDP growth.

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	2.0	2.0	2.0	5.6	4.0	4.4	4.4
1.00	1.08	1.16	1.18	1.21	1.23	1.30	1.35	1.41	1.47

SCENARIO 3

Increases equal Cooper in 1996 and 1997

Trigger brings costs back to Clinton level by 1999 by allowing zero nominal growth in 1998 and 1999. Subsequent increases equal Clinton.

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	0.0	0.0	3.0	8.0	4.4	4.4	4.4
1.00	1.08	1.16	1.16	1.16	1.19	1.29	1.35	1.40	1.47

SCENARIO 4

Increases equal Cooper in 1996 and 1997

Trigger would reduce the rate of growth or premiums to bring costs down to the Clinton level as quickly as possible. However, the growth rate could not be reduced below negative one percent per year.

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	-1.0	1.0	3.0	8.0	4.4	4.4	4.4
1.00	1.08	1.16	1.15	1.16	1.19	1.29	1.35	1.40	1.47

SCENARIO 5

Increases equal Cooper in 1996 and 1997

Trigger would reduce premiums in 1998 to the level they would have been under Clinton.

Subsequent increases equal Clinton

Annual and Cumulative Premium Increases

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
--	8.1	7.4	-3.2	3.0	3.0	8.0	4.4	4.4	4.4
1.00	1.08	1.16	1.12	1.16	1.19	1.29	1.35	1.40	1.47

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503

URGENT

June 2, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-2872

TO: Legislative Liaison Officer -

EOP - Review Only, See Distribution Below - ( ) - -

FROM: JANET R. FORSGREN (for) B Pellicci
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI (395-4871)
Secretary's line (for simple responses): 395-7362

SUBJECT: HHS Qs and As RE: S 1757, Health Security Act

DEADLINE: NOON June 3, 1994

COMMENTS: SEN. KENNEDY REQUEST FOR INFORMATION -- The attached responds to a request for information about funding a long term care benefit package (possible Kassebaum amendment).

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

CC:
Nancy-Ann Min
Ira Magaziner
Chris Jennings
Jack Lew
Lynn Margherio
Judy Feder
Judy Whang
Greg Lawler
Meeghan Prunty
Jason Solomon
Barry Clendenin (2)
Len Nichols
Linda Blumberg
Shannah Koss
Janet Forsgren

LRM #I-2872

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is **simple** (e.g., concur/no comment) we prefer that you respond by **faxing** us this response sheet. If the response is **simple** and you prefer to call, please **call the branch-wide line** shown below (NOT the analyst's line) to leave a message with a secretary.

You may **also respond** by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please **include** the LRM number shown above, and the **subject** shown below.

TO: Robert PELLICCI
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-4871
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Qs and As RE: S 1757, Health Security Act

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet

June 2 1994

MEMORANDUM

To: John Drabek

From: Lisa Alecxih

Subject: Annual Premiums for Proposed Long Term Care Benefits

---

This memo presents estimates of the annual per capita premiums for persons age 18 and over required to fund a fairly comprehensive long term care benefit package.[1] We have also developed crude premium levels consistent with designations of insurance unit type as defined under the current Kennedy proposal.

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The assumed program would cover both nursing home and home and community-based care. Nursing home care would be subject to a 25 percent copayment, with those unable to pay the 25 percent receiving supplemental payments from the program on a basis similar to Medicaid eligibility rules. Home and community-based services coverage and eligibility would be based on a program that covers all persons with disabilities (any ADL or IADL) who cannot care for themselves. We assumed that the proportion of persons served under the program would be double the current proportion receiving paid services by disability level (100 percent induced demand). The level of service estimated under the program was based on increasing current use for paid services by 20 percent by disability level. Persons with disabilities would receive home and community-based services with a sliding scale copayment requirement similar to the one outlined under the Health Security Act (HSA).

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The estimates above also do not take into account current law public expenditures for these services. If such a financing scheme were implemented, public expenditures for long term care services would end. The annual per capita 1996 current law public expenditure levels for persons age 18 and over eligible for the program described above are shown below. These estimates include Medicare expenditures.

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Finally, under the proposal, the sponsors may wish to exclude Medicare payments from being funded by premiums. Medicare expenditures for long term care services account for the following annual per capita expenditures for persons age 18 and over.

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	Non-elderly	Elderly
Single	$270	$3,455
Married Couple	$540	$6,910
One Parent	$340	
Two Parent	$610	

The net premium amounts (program premiums less a calculated premium for current law public expenditures) are as follows:

	Non-elderly	Elderly
Single	$95	$1,675
Married Couple	$170	$3,345
One Parent	$105	
Two Parent	$190	

Please give me a call if you have any questions.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503

SPECIAL

June 2, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #I-2871

TO: Legislative Liaison Officer -

EOP - Review Only, See Distribution Below - ( ) - -

FROM: JANET R. FORSGREN (for) B Pellicci
Assistant Director for Legislative Reference

OMB CONTACT: Robert PELLICCI (395-4871)
Secretary's line (for simple responses): 395-7362

SUBJECT: SBA Qs and As RE: HR 3600, Health Security Act

DEADLINE: NOON June 6, 1994

COMMENTS: HOUSE SMALL BUSINESS QUESTIONS AND ANSWERS -- The attached responds to a number of questions raised by the Small Business Committee.

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

CC:
Nancy-Ann Min
Ira Magaziner
Jack Lew
Chris Jennings
Lynn Margherio
Judy Feder
Judy Whang
Greg Lawler
Meeghan Prunty
Jason Solomon
Barry Clendenin
Janet Forsgren

LRM #I-2871

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is **simple** (e.g., concur/no comment) we prefer that you respond by **faxing** us this response sheet. If the response is **simple** and you prefer to call, please **call the branch-wide line** shown below (NOT the analyst's line) to leave a message with a secretary.

You may **also respond** by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please **include** the LRM number shown above, and the **subject** shown below.

TO: Robert PELLICCI
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-4871
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ (Date)

_____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: SBA Qs and As RE: HR 3600, Health Security Act

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____

_____ FAX RETURN of _____ pages, attached to this response sheet

June 1, 1994 Small Business Administration
Questions & Answers

1) **As the plan now stands, won't most of the costs for total coverage be shifted to small and medium sized businesses especially those that don't offer or cover their employees?**

The President has fought very hard to ensure that he could offer small businesses what they needed in order to afford comprehensive health care coverage. Discounts are included in the plan to assist low-wage businesses who were less able to afford health insurance. Discounts ranging from 3.5% to 7.9% of payroll (depending upon the size and average wages) will substantially lessen the impact of participation on these businesses. The President's plan will also lower overall health care costs, including the health portion of worker's compensation costs, which will benefit small businesses in general.

Answers go from cleared Q+A

What is the employer portion of the coverage and how is it determined?

March 1994 House Ways & Means Committee

Employers are required to contribute 80% of the weighted average premium for qualifying employees. A qualifying employee includes anyone who works at least 40 hours to 120 hours a month for part-time employees or a minimum of 120 hours a month for a full-time employee. Employers will be required to pay a pro-rated share of the health insurance premium for part-time employees and 80% of the weighted average premium for full-time employee.

2) **A typical SBNA member company profile -- Business category - - manufacturing: Number of employees 200; gross sales $750,000. A typical SBNA NOW2 reader company-- Business category -- retail/service: Number of employees 5 to 10; annual gross sales $120,000. What will the health plan do financially, both in terms of costs and tax benefits to these types of companies?**

CBO report

Estimates prepared by Henry Aaron and Barry Bosworth at the Brookings Institution estimate that community rating and requiring firms to contribute would cause a decrease in health insurance premium costs in the manufacturing sector by almost $1,050 per worker. In the case of the manufacturing business with 200 employees, and an annual gross sales of $750,000, the firm would be capped at 7.9 percent of payroll and not eligible for any discounts under the President's plan. The second business scenario, with 5 to 10 employees, dependent upon the average wage, be eligible for discounts between 3.5 to 7.9 percent of total payroll.

3) **Who will actually pay for coverage or part-time workers? The part-timers obviously cannot afford to foot the bill themselves, and according to the proposal, employers only have to pay a portion of the coverage. So, the question remains, who picks up the cost of the tab?**

Employers will be required to pay a pro-rated share of the health insurance premium for part-time employees depending if the part-time employee works at least 40 hours a month. The part-time employee will be responsible for the 20 percent portion of the premium and the remaining cost of the premium that is not picked up by the employer will be paid for with federally-funded discounts.

4) **How will the plan affect those small and medium sized businesses that have a presence in more than one state? Won't they have to deal with more than one alliance? And won't this create an extra burden of paperwork?**

gotten over phone from Labor →

The presence of an employer in more than one state will have to deal with more than one alliance, although it is no different than the current payments employers must make to multiple jurisdictions for their tax payments.

5) **On the proposal of issuing ID cards, how are you going to control counterfeit card issues? Why do we need cards if everyone is guaranteed coverage? Is the purpose behind the cards to help prevent illegal aliens from abusing the system? If yes, what will they do for coverage?**

→ taken from Cleared by A's from Hoiby's Committee

An eligible individual is any person who resides in the U.S. and who is a citizen or a national of the U.S., an alien lawfully admitted for permanent residence in the U.S. or a long-term nonimmigrant. Aliens lawfully admitted for permanent residence in the U.S. are defined as an alien who is admitted as a refugee, granted asylum, admitted for residence under the amnesty programs under the INA, one whose deportation is withhold, an alien who has been paroled indefinitely into the U.S. or who has been granted an extended voluntary departure, an alien who is the spouse or unmarried child under the age of 21 of a citizen or the parent of a citizen over age 21 and has applied for permanent residence, and any other classes of permanent resident aliens as the HHS recognizes. Long-term nonimmigrants include: aliens entering under a treaty of commerce or trade and their families and certain temporary workers and trainees.

Emergency care for anyone in need will be available through emergency rooms and community and migrant health centers paid for through the existing Medicaid and Public Health Service programs. Primary and preventive care services will continue to be provided through the Public Health Service programs. These services will be available since it is necessary to protect the public's health. For example, it

is important that all children are vaccinated and that all persons with active TB receive medical treatment.

6) **Bottom line: Where is the money to pay for all this going to come from? The "Sin Tax" alone won't pay for all of it. Who will suffer the most financially?**

The primary source of financing for the Health Security Act is the same source that is primary now: private employers and households paying for their own health insurance. These funds will comprise about 3/4 of all premium spending. Additional funding will come from several sources: a Federal excise tax on tobacco products, slower growth in tax exempt health spending, excluding health insurance from cafeteria plans, tax changes and corporate retiree assessments, and a moderation of growth in entitlements such as Medicare and Medicaid.

taken from Cleared Q+A

House SB Committee March 1994

FOR ALL WHO RECEIVE THIS HEALTH CARE REFORM PACKET

HOW TO USE THIS DAY/TIMER Time Saver LETTER TO SAVE TIME.

Type or write your reply in the space below. Then mail the white copy to us and keep the pink copy for your files. You'll save time and effort, and we'll have your answer much faster! Thank you.

MESSAGE

FOLD

Ladies/Gentlemen: DATE May 20, 1994

The health care reforms put forth in the enclosed packet are not Republican Plan or Democratic Plan or Independent Plan—these reforms will provide an AMERICAN REFORM PLAN.

In the attached proposal, you will find parts of each of the plans under discussion in Congress--PLUS new ideas that are NOT in any of the previous plans.

There is one significant difference between what I propose here and what the Congress is now considering. The ideas herein come from over 50 years "hands-on" experience PLUS graduate study in Hospital Administration.

Feel free to distribute copies of these materials to all members of the various committees. I am sending copies to 2 House and 2 Senate committees, Ira Magaziner and to my own Senator. Can't afford $50(!)worth of postage to send copies to everyone on every committee!

Lots of work involved here. PLEASE read it, OK? CMF

SIGNED

REPLY

DATE

FOLD

THOMAS PAINE IV

P6/b(6)

SIGNED

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MEMORANDUM OF CALL

TO: Jack Lew / Chris Jennings

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☐ WILL CALL AGAIN ☐ IS WAITING TO SEE YOU

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INTRODUCTION

From the original Common Sense by Thomas Paine, 1776:

The sentiments(positions on issues) contained in the following pages (may) not yet be sufficiently fashionable(popular) to procure them general favor(acceptance); a long habit of not thinking a thing wrong gives it a superficial appearance of being right, and raises at first a formidable outcry in defence of custom (conventional wisdom). But the tumult soon subsides. Time makes more converts than reason(common sense).

The author has studiously avoided everything which is personal among ourselves. Compliments as well as censure to individuals make no part thereof. The wise and worthy need not the triumph ...those whose sentiments are injudicious...will cease of themselves, unless too much (effort) is made to convert (them).

The cause(s) of America are in a great measure the cause(s) of all mankind.

Who the author of this (book) is, is wholly unnecessary to the public, as the object for attention is the doctrine itself, not the man. Yet it may not be unnecessary to say that he is unconnected with any (political) party, and under no sort of influence, public or private, but the influence of reason(common sense) and principle.

On the Origin and Design of Government in General

Some writers have so confounded(confused) society with government as to leave little or no distinction between them; whereas they are not only different, but have different origins. Society is produced by our wants; government by our wickedness. The former promotes our happiness positively by uniting our affections; the latter negatively by restraining our wickedness.

Society in every state is a blessing, but government, even in its best state, is but a necessary evil; in its worst state an intolerable (evil). For when we (are exposed to and suffer from) the same miseries (with) a government which we might expect in a country without a government, our calamity(misery) is heightened(made worse) by reflecting that we (are) furnishing the means by which we suffer.

Government, like dress, is the badge of lost innocence; the palaces of kings are built upon the ruins of the bowers of paradise.

--Thomas Paine, Common Sense, 1776

THOMAS PAINE IV
P6/b(6)

May 11, 1994

Director, President's Health Care Task Force
Chairmen, Various Senate Committees
Chairmen, Various House Committees
Senators Sponsoring Specific Health Care Plans
Representatives Sponsoring Health Care Plans

Gentlemen:

The members of my immediate family and I have a total of over 50 years experience in the health care industry. At present, no family members work in health care, have any financial interest in any health care facility or any financial interest in any of the many companies supplying products and services to health care facilities.

These two facts--extensive hands-on experience and no conflicts of interest--add weight to what I have to say about health care reform in the attached essays, some of which have been published in the local newspaper, the others to be printed soon.

Unlike most witnesses appearing before the various committees--who have jobs to protect, financial interests to protect, PAC contributions to protect, profits to protect, other personal interests to protect--there is nothing to prevent me from being frank, honest, unbiased, objective. In short, nothing to prevent me from "telling it like it is"!

In addition to hands-on experience, my educational background and intellectual qualifications privide me with unique insight into the real problems in the health care industry--and what must be done to solve them.

I studied Economics at UK, Hospital Administration in graduate school. I am a member of Mensa with an IQ somewhere above the 99th percentile. I was purchasing agent for 6 years in a 220 bed hospital; purchasing director for 6 years in a large medical center($35,000,000 annual budget). Active in a buying coop in a large metropolitan area(we purchased for over 30 health care facilities), I chaired the policy and procedures committee and many other coop committees over a period of 10 years. Later, as VP of a consulting firm, I prepared a national purchasing program for use by hospitals throughout the country. After leaving the health care field, I worked as a financial consultant, which involved checking out health care companies as potential investments for my clients. In one instance, I spent two weeks with the CEO and Chief Financial Officer of a home health care company which billed over three million dollars per month to Medicare and Medicaid.

This company operated one of the slickest "scams" I have ever seen anywhere! As much as 25% of the $3 million per month was excess profits. And, the company and its many subsidiaries were structured so that, on the surface, all appeared to be within the normal Medicare/Medicaid rules and regulations! We declined to invest in the project.

My wife retired recently after having worked for over 25 years as a Registered Nurse and Nursing Supervisor. From her, I learned many of the various "scams" of the medical staff as well as the internal workings of the medical care facilities of health care facilities. Incompetent doctors who cannot be removed from the medical staff, who continue year after year, to inflict pain, injury, even death upon their unsuspecting patients. Doctors protect their own! The expensive bureaucracies, unnecessary paperwork, red tape, inefficiencies, lack of cost controls, etc. that are rampant throughout both the medical/nursing areas and in hospital administration--a fact that I can attest to from my experience in administration and my studies in school.

It is my firm conviction, based on all of the above, that <u>there is no need whatsoever to worry about extra funding for total health care reform, including universal care for everyone</u> and adding on the various services not now paid for by most insurance policies. If complete reform--NOT a watered-down version of partial reform--is passed by the Congress, the savings that result will be more than sufficient to pay any extra costs involved. <u>No additional funds will be needed.</u>

Why? We already pay for health care for those without insurance coverage. The cost of their care--and its usually very expensive care since they wait until almost dead before going into emergency rooms for care--is already paid--as increases in premiums for those who DO have insurance. The hospitals simply increase the cost of everything done for paying customers by enough to cover un-paid-for care.

We're paying 56% more than the highest amount paid by any other industrialized nation for partial coverage for 85% of the people. Their much-lower-cost insurance provides full coverage for 100% of the people! This $560 billion dollars (56% of over 1 trillion dollars!)is more than enough to pay for full coverage for everyone--if the "fat and fraud" is removed from the health care system.

Why a sequel to Thomas Paine's original Common Sense pamphlet? The scarcity of common sense in the discussions of health care is a prime example of the need for common sense. Not only in this area, but in virtually every area, every national problem. As Mark Twain observed, "Common Sense is Very Uncommon"!

Thomas Paine IV

Thomas Paine IV(aka Mike Farmer)

P6/b(6)

OVERVIEW: HEALTH CARE REFORM

Health care reform, if done right, will generate more than enough savings from elimination of fat, fraud and over-pricing to pay for good universal health care for everyone.

This conclusion is based on over 50 years of health care experience in my immediate family plus over 20 years of experience in managing other businesses.

The health care industry has been totally out of control for the past 20-30 years! Largely unregulated and uncontrolled, health care costs have skyrocketed, insurance premiums have increased dramatically while benefits decreased.

We have the best "sick care" in the world. But, it is so expensive that almost half the people cannot afford it! We have the world's worst preventive care/well care system.

The goal that the Congress should be striving for should be universal health care for everyone at the same or less cost.

This goal CAN be achieved if Congress can overcome the long-standing "mind-set" in Washington that the solution to every problem is to throw more money at it! Money is no substitute for common sense! A good example is our 3½ trillion dollar national debt accumulated in the 1980s--most of it wasted.

To achieve our health care reform goal...

a) Congress must receive, and act upon, good solid factual data from reliable, unbiased sources. (Congress is NOT now getting this from most of the people testifying before congressional committees, each interested only in "protecting his own turf")
b) Congress evaluates this objective, unbiased data, reaches common sense conclusions, sets realistic national goals.
c) Congress structures the new health care system so that it is industry-operated, government-regulated. But NOT government-operated. (Based on past performance, the government should not operate any business. Examples abound!)
d) Congress adds incentives for good performance, disincentives for sub-standard performance.
e) Congress mandates professional management/management practices within all health care facilities. Training programs.
f) Congress mandates professional purchasing personnel and practices, including large buying coops and mandatory participation. Coops staffed/operated by professionals.
g) Congress mandates regional planning commissions, staffed by CEOs of participating facilities. Planning activities reviewed by government regulatory body
h) Individual Congressmen have the courage to resist PAC pressures(and money), tackle problems head-on, enact meaningful conprehensive reforms this year that are effective in 1995.

LETTERS

Inefficiency, fraud biggest problems in health-care system

Our health-care industry is riddled with examples of inefficient bureaucratic management and provider frauds.

1. The operation of our Veterans Affairs hospitals is the most stunning and glaring example of waste and mismanagement. If we could close all VA hospitals we could supply every veteran with Blue Cross/Blue Shield's best policy and still have an annual surplus of $37 billion which would take care of the 37 million people now without health insurance.

ENGLEHART/HARTFORD COURANT

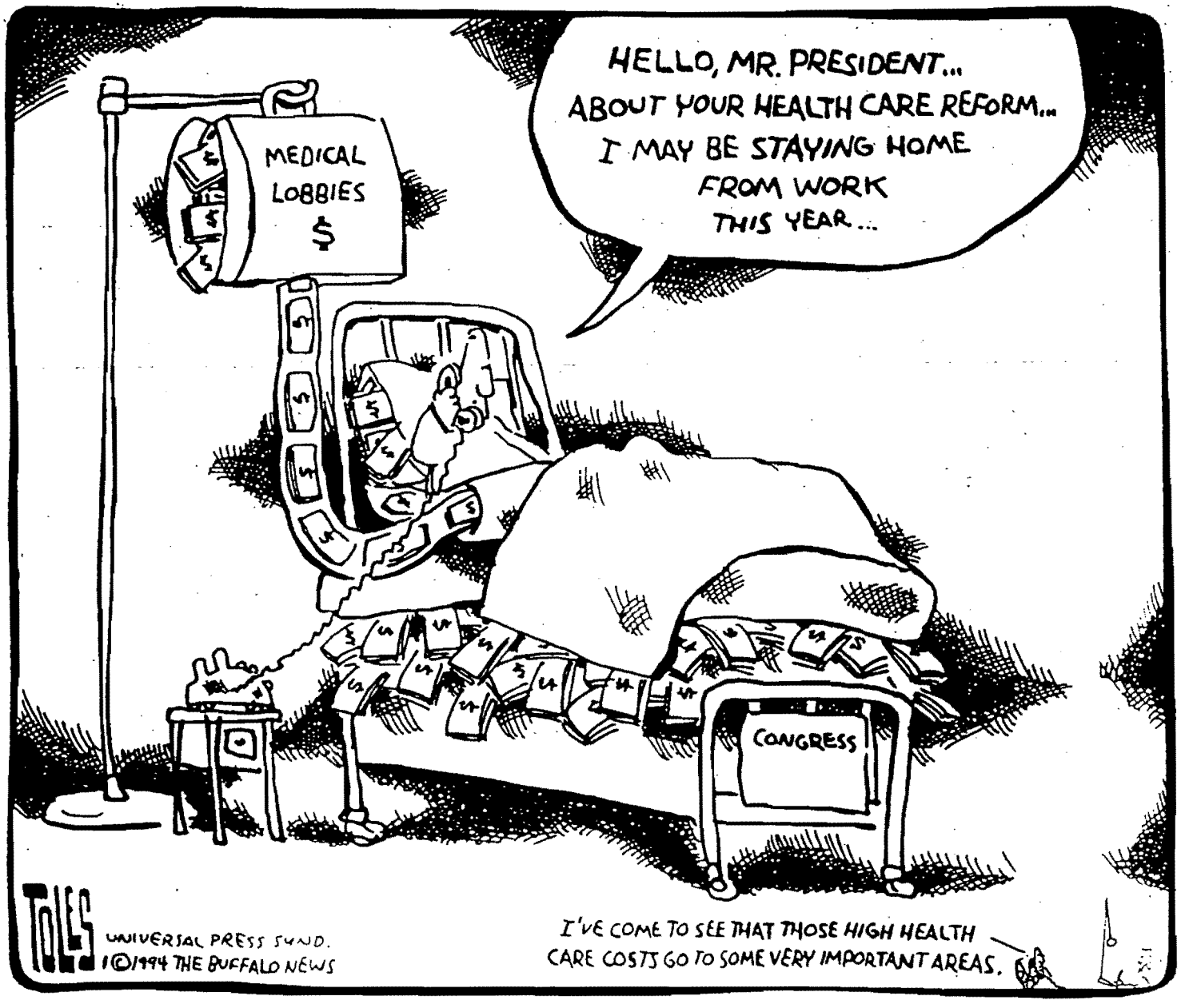
2. Fraud is widespread in the health-care industry. Many hospitals, physicians, pharmacists, nursing homes, and home health organizations are ripping off the people. The federal government recently settled a fraud case with National Laboratories for $100 million plus a sizable fine.

3. The overhead cost for operating Medicare and Medicaid is about 25 percent. The system is also very cumbersome, time consuming and expensive for the providers of health care.

4. Currently 47,000 sleazy special interest health-care lobbyists are in Washington waiting to greet the members of our congress.

5. There are 1,500 health insurance companies in our country who will be striving to maintain a strong position in the administration of the health-care program. I am leaning more and more toward a one-payer system as the lesser of two evils.

ORIS AARON, M.D.
COLUMBIA


HELLO, MR. PRESIDENT...
ABOUT YOUR HEALTH CARE REFORM...
I MAY BE STAYING HOME
FROM WORK
THIS YEAR...
MEDICAL
LOBBIES
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I'VE COME TO SEE THAT THOSE HIGH HEALTH
CARE COSTS GO TO SOME VERY IMPORTANT AREAS.

THE IMPORTANCE OF INCENTIVES/DIS-INCENTIVES

The incentive/dis-incentive, carrot/stick, reward/punishment method of behaviorial control has been a universally-accepted psychological principle for many years.

First discovered by Pavlov, he proved his hypothesis in experiments with dogs. Later, many other psychologists replicated the results of Pavlov's experiments using everything from mice to humans.

Pavlov's theory is quite simple--and it works, every time it is used. Reward someone for desirable behavior and they will do it again--to receive additional rewards. Punish them for undesirable behavior and they will not do it again--to avoid additional punishment.

In everyday life--at home, at school, at work, at play--this simple psychological theory is in use and successful. Yet, in the health care industry, the use of this fundamental principle of behaviorial control is virtually non-existent! When it does appear, it is reversed. We reward people/companies for undesirable behavior; we punish them for desirable behavior.

The results are predictable--and obvious. People and companies who work in and do business with, health care facilities engage in more and more undesirable behavior, receive more and more rewards for doing so. And, after a few decades of this, a health care crisis results.

Incorporate incentives for desired behavior, dis-incentives for what we do not want into the new health care reform act and the results will be outstanding--far better health care at much lower cost.

Fail to do this and the new health care system will be no better than the old one. Fail to reward people/companies for correcting the problems of the present system and the problems will not be corrected. Continue to reward those who have created present problems--and we will have even more problems.

This same principle works equally well (or equally badly) in government. Reward an elected official who isn't doing the job with re-election and he will return to office and do a bad job for another term (hoping to be rewarded again by being re-elected again). Reverse the procedure and the official who is re-elected (rewarded) for doing a good job will come back and do an even better job in his next term (anticipating re-election again (another reward). Unfortunately, in recent years, voters have done the former more often than the latter.

On the next page(s), I have briefly described some of the incentives and disincentives that should be incorporated into the new national health care reform act. And the reasons why.

This list may not be all inclusive. But, those who work on this legislation should ask themselves this question as they review each section: Are we rewarding the people/companies involved for doing the things that we want them to do and punishing them for doing the things that we do not want them to do? If the answer is YES, proceed. If NO, revise!

PROPOSED INCENTIVES AND DISINCENTIVES

PARTICIPANTS (Suppliers/professions)	WHAT WE WANT (Desirable Behavior)	INCENTIVE(S) (Rewards)	DISINCENTIVE(S) (punishments)
US Congressmen	Health Care Reform, effective 1995	Re-election in November	Retirement in November
Health Care Facilities	Reasonable patient charges	Bonus for below-average patient charges--substantial amounts.	Reimbursement of average patient charges ONLY. Excessive cost paid by the health care facility.
	Charges correlate to needs	Low cost/no cost loans for the construction of low cost facilities for low-care-need patients.	Payments based on what customer needs--not what he is given. Excess paid by the facility--a loss to it.
	Reasonable overhead/admin costs	Average costs paid PLUS bonus paid for below average costs	ONLY average costs paid. If above average, NOT paid. Report prepared.
	Experienced professional mgt.	Increased pay scales for all mgt personnel. On-going training programs provided/paid for.	National Health Care Board sets up standards for mgt personnel. Those hired must meet/exceed standards.
	Generally-accepted mgt/accounting practices used in all facilities	CFOs paid more--equal to pay in industry. On-going training.	CFOs/CEOs must meet/exceed standards set up by National H/C Board. CFO must be CPA, for example.
	Cost accounting/cost control	Pay personnel salaries equal to those paid in industry.	National Board requires personnel that meet/exceed requirements.
The Medical Staff	No unnecessary operations, tests	Malpractice/tort reform. Caps on awards. Recognition for exceptional performance/conformance	National Board requires second opinion, all major surgery. Review board checks on work of doctors
	No conflict of interest	No hassle from National Board	Divestiture of all interests in any company providing services or products to H/C facilities. Stiff penalties/fines for violators.
	Medicare/Medicaid "scams" stopped	Bonuses/recognition for doctors who control costs, who accept all M/C, M/A patients, do good work.	Tough auditing/control of M/C, M/A billings. Violators penalized severely--high fines/prison terms.
	No "freebies" from suppliers		Tough penalties for violators.
	Practice more preventive medicine	Recognition/encouragement for the doctors who do so. On-going training in how to do it.	Standards for preventive care set up by National H/C Board. Patient cases reviewed by Review Board.
	Cost controls--products, services and salaries.	Encouragement/training/recognition and cash bonuses for implementing cost controls, all three areas.	Review of costs/salaries by the National Review Board. If out of line, doctors must explain why.
	Improvements in all areas	Encouragement/training/recognition and cash bonuses/awards, etc.	Censure, privileges revoked, lic- to practice revoked, fines/prison.
The Patient/Customer	No mis-use, over-use of system	Lower insurance premiums. less paid in deductibles. No hassles.	Reasonable deductibles required for all medical care. Employees pay 50% of health care premiums.

PARTICIPANTS	WHAT WE WANT	INCENTIVES	DISINCENTIVES
The Medical Staff	Greater incentive for doctors to practice good medicine. Doctors available for all areas	More competition. Doctors must compete for more lucrative business/areas/facilities	Enlarge medical schools and build more of them. Increase supply of doctors/competition.
The Insurance Companies	Reduce cost of premiums Non-cancellable policies. Cover pre-existing conditions. Same price for everyone. Stop "cherry-picking". No lifetime limits. Pay reasonable/average costs. Reduce overhead/admin. costs. "No Hassle" claims processing. Standard claim form for everyone. Full coverage--all health care. Drugs and long term care included. Immediate payment of claims.	Competition for business. If companies compete, they get the business. Incentive is greed and profit(reasonable)from the business they get by being competitive and providing the services specified on the bids. Large purchasing coops with 500,000 or more customers and staffed by professional buyers—NOT bureaucrats/political hacks—are the ONLY way to have enough purchasing power to get good prices.	If they are not competitive in both prices and services, they will lose the bsuiness. Loss of business is the best incentive there is--period! COST CONTROLS DO NOT WORK! The only annual increase controls that work are those based on the annual increases in the Cost of Living or Wholesale Price Indexes
The Drug Companies	Reasonable prices for drugs No exorbitant pricing of proprietary drugs. No free drugs to doctors/pharmacists--bribes for using company's products. Stop selling drugs overseas for less than same drugs sold here. No more price-fixing. Prices based on production cost plus reasonable profit.	Competition for the business. Those who have best prices and services receive the business and profits therefrom. R&D that results in successful, useful drugs paid for at 3-5 times cost. No R&D paid for in advance for speculative purposes. Additional payments for successful R&D will pay for non-productive speculative R&D. No R&D costs may be added to the sale prices of drugs. New drugs become "community property" and can be produced by everyone. Competition is the key to lower prices. Also supply & demand.	Prices must be based on total production costs plus reasonable profit. No R&D costs added. All drugs available from more than one company. Creates competition/reduces prices. Strong enforcement of the excess profit laws, price-fixing, other anti-competitive practices. Huge fines/long prison terms for those who violate drug laws and the National Baord rules. No "freebies"/bribes to anyone in the health care industry. Severe penalties/fines/prison.
The Legal Profession	Fewer malpractice lawsuits. No frivolous lawsuits. Lower malpractice premiums	Reduce the potential reward for ambulance-chasing lawyers looking to sue someone. Prepare Awards Guidelines--similar to Sentencing Guidelines used in criminal cases. Anything above guideline amount goes to the victim or to the national health care fund--NOT to the lawyer. The only way to reduce malpractice lawsuits is to make the awards less lucrative for lawyers.	Lawyers' fees may not exceed 25% of the award made for ONLY actual medical expenses plus lost wages of the victim. Any punitive damages go to the national health care fund--not to lawyers or to victims. Pain and suffering portion goes to the victim ONLY.

PROPOSED INCENTIVES AND DISINCENTIVES - PAGE 3

PARTICIPANTS	WHAT WE WANT	INCENTIVES	DISINCENTIVES
Medical Equipment/Supplies	Competitive prices Quality products Good service Reputable business practices	Competitive bidding. The low bidder receives the business, the profits. Large purchasing coops, staffed by professional buyers, are the best assurance of getting the best prices from suppliers. Only the large coop can successfully negotiate low prices with large suppliers. Coops are essential. Mandatory participation essential.	Suppliers lose the business and the profits therefrom. Those who engage in shady practices risk removal from the bidders list--and criminal prosecution.
Other Suppliers	Ditto above.	Ditto above.	Ditto above.
Purchasing Coops	Competitive bids/prices on: Drugs Insurance, health care liability malpractice property Other Medical supplies/equip. Other supplies/equipment Outside services, all kinds	The large purchasing coop, staffed by professionals, is the best way to obtain low prices. Using competitive bidding, followed by negotiation, will ensure the lowest possible prices. The individual health care facility does NOT have the purchasing power to get good prices from large multi-million dollar companies—or even smaller companies. Coops are the best!	Loss of the business by those who price their products and services too high. Loss of sales and profits are the best disincentive to suppliers! But, the loss must be substantia which is why purchasing coops ar essential to getting the very best prices from suppliers.
Planning/oversight Committees NOTE: Planning Committees should be staffed by H/C CEOs, CFOs	Area-wide planning of health care facilities, extra beds, extra equipment, expansion of facilities. Better utilization of existing facilities.	Lack of adequate planning by health care CEOs and by local planning Committees, if any, are some of the reasons why under-utilization of very expensive equipment and facilities is so prevalent in health care today.	Planning prevents over-expansion purchase of unnecessary equipment, adding more un-needed beds spending money that need not be spent. adding more costs to the health care provided, increasing overall health care costs and insurance premium costs.
National Health Care Board	To oversee/regulate BUT NOT MANAGE, health care facilities.	Basic functions should be to ensure operation of all health care facilities in a uniformly efficient manner. Secondly, to provide statistical data, patient records info, other info to everyone.	

PARTICIPANTS	WHAT WE WANT	INCENTIVES	DISINCENTIVES
The Employer	Most employers IN the system so as NOT to lose the benefits of their purchasing power for the entire group.	All, except the very largest employers will pay less for better plans. Employers with more than 100,000 employees--provided that their employee receive equal(or better) health care at equal(or lower)cost.	75% or more of the people will receive comprehensive health care at lower costs than they presently pay. Employers pay 50% of the premiums, if in coop.
The Employee	Most employees IN the system to keep their purchasing power in the coops, thus reducing the insurance premiums for all.	Ditto above. For all employees, except possibly those in very large groups, the premium costs would be lower. If employee's spouse has family plan elsewhere, employee receives cash payment equal to 50% of the cost of individual plan(the employer's share which he pays to the individual instead of to insurance co)	Ditto above. Employees pay 50% of the cost of individual coverage--all of family coverage(the extra cost If spouse is working, she will receive 50% of individual plan cost as cash payment, from her employer--offsetting the extra cost for the family plan paid for by her husband.

This is somwwhat complicated to explain. But, once you understand it, you will see that there are some really good incentives here for both the employee and the employer. The employer pays no more than 50% of the cost of an individual plan. The employee pays 50% of the individual plan's cost plus the additional cost of the family plan. His spouse receives a refund of 50% of the individual plan's cost. This refund will be more than the extra cost her husband pays for the family plan. The savings on the cost of both individual and family plans, due to being in the coop, will save everyone from 35 to 50% of what they now pay.

The Unemployed and the Under-employed Workers	We want the plan to be self-supporting with no new taxes needed to pay for it. The savings from reduced premiums, from curbing fraud, abuse, etc. should pay for these people.	Employers and employees would pay an additional 10%(of premium cost) as overhead and for providing insurance for the unemployed and the under-employed. By insuring everyone, cost-shifting is eliminated. This reduces insurance premiums.	This 10% surcharge should be sufficient to pay for this care since most of the people in these two groups already receive health care, the cost of it added to the premiums of those who do have insurance.
Independent Contractors and Part Time Workers	Employers are using these two classifications to avoid any insurance payments and payment for other fringe benefits. We want to stop these abuses.	Employers provide the same benefits for these two groups as for regular employees. PT workers receive proportional payments, based on avg. hours worked per week.	There is no savings by putting people on payroll as independer contractors or by hiring more PT workers to avoid fringe benefit

Why should employers and employees share premium costs equally? So both will be equally interested in reducing premium costs!
Why should there be small deductibles for all medical care? When it is entirely FREE, employees likely to over-use, increased cos

THE LAST THING WE WANT IS A HUGE GOVERNMENT BUREAUCRACY ATTEMPTING TO MANDATE COSTS. THIS SIMPLY WILL NOT WORK! BUILD IN THE PROPER INCENTIVES AND DISINCENTIVES AND MARKET FORCES WILL KEEP COSTS IN LINE.

RE: THE HEALTH CARE REFORM ESSAYS WHICH FOLLOW

The attached series of health care reform essays were published, one each week, in the local newspaper--or are to be published during the next few weeks.

Since only one per week is published, it is often necessary to repeat basic facts/data to refresh the readers' memory. Whereever practical, I have removed the duplicated passages, resulting in blank spaces here and there in the essays.

The headings were added by the newspaper. They are sometimes more titillating than accurate.

Most of the essays include, near the end, a "call to arms" urging the readers/voters to call/write their Congressmen stressing the need for action on health care reform this year.

Please do not take my adverse comments concerning "do-nothing" Congresses personally. It is an irrefutable fact that previous Congresses should have solved our health care problems long ago--and long before they reached the present crisis proportions.

An equally irrefutable fact is that the general public has a low opinion of the US Congress. Poll after poll indicates confidence ratings of around 20%--the lowest within memory. If health care reform and other equally important domestic problems are not addressed--and solved--this year, the voters may "clean out the barn" in the November elections--continuing a job began in the 1992 elections.

A good comprehensive national health care reform act, effective in 1995, would do much to "calm the natives", restore confidence in Congress, perhaps prevent wholesale replacement of Congressmen--both good and bad(unfortunately!)by irate voters in the November elections.

The voters are definitely in an ugly mood! They want results--not rhetoric. They want substantive measures--not watered-down versions. They want positive action--not posturing. They want Congressmen who are statesmen, concerned about the next generation--not politicians, concerned only about the next election!

But, most of all, they want Congressmen who have the common sense to know what should be done, the courage to resist PAC pressures and money--and do it!

Health-care crisis: Real or imaginary?

Guest Column

by Thomas Paine IV*

Do we have a health care crisis?

Many members of Congress would have you believe that we do not. Those who say we have no health care crisis are, in many instances, the same congressmen who say that a $5 trillion national debt and $300 billion annual deficits do not represent a financial crisis.

To admit that we have a crisis is to admit that they have not been doing their jobs — solving the nation's problems before they reach crisis proportions.

The facts speak for themselves. We spend 56 percent more for partial health care coverage for only 85 percent of our people than other industrialized nations pay for full coverage for 100 percent of their people (14 percent of GDP vs. 9 percent of GDP).

Thirty-eight million people have no insurance and another 20 million have no insurance at some time during the year.

Eighty-one million people with pre-existing conditions cannot get insurance or pay higher premiums.

Millions risk loss of insurance due to pre-existing conditions worsening, getting sick, changing jobs, losing their jobs, becoming high risk and thus uninsurable.

Seventy-five percent of all policies contain lifetime limit provisions in the fine print. In 1993, we paid $940 billion for partial coverage for 85 percent of the people. Costs of health care are increasing by 12 percent per year. In 1994, health care costs will exceed $1 trillion, more than 15 percent of GDP (Gross Domestic Production).

Reform our health-care system? We don't have a health-care system. What we have is a "sick care" system.

Less than 1 percent of the $940 billion is spent on well-care and preventive care. Less than 40 percent of our 2-year-olds have been immunized (more than 90 percent in other countries!) more than 20 other nations have lower infant mortality rates; 50 percent of all premature deaths are due to preventable or curable medical problems.

Teen-age pregnancies cost us $28 billion per year; drug and alcohol problems, $110 billion; gunshot wounds, other violence, $80 billion per year.

Contagious, deadly diseases (TB, AIDS, others) are spreading rapidly due to failure to follow routine isolation and treatment procedures, education, preventive care.

Why are we paying 56 percent more than other nations for partial coverage for 85 percent of our people? The major reasons are, 1)sick care instead of preventive care, 2)failure to consolidate our buying power to reduce insurance premiums, 3)incompetent management of health-care facilities, 4)no control over malpractice abuses by ambulance-chasing lawyers, 5)exorbitant charges for drugs, for medical equipment, for supplies and, 6)various and sundry "scams" engaged in by virtually everyone involved in providing health care.

Despite the exorbitant cost of health care, we do not have complete health care. Prescription drugs, long-term care, nursing home care, mental health care and virtually all preventive care are not covered.

The problems with our health-care non-system did not happen overnight. They began to develop 30 years ago and were ignored by Congress until the problems increased to crisis proportions.

And, unless we insist upon it, the present Congress will fail to act or, if they do act, pass a watered-down version of health care reform that will "calm the natives" but do nothing to provide complete and permanent solutions to the health care crisis in America today.

Billions of dollars from thousands of PAC groups are already flowing into Washington to members of Congress, many of whom are for sale to the highest bidder.

The only weapon we, as citizens, have to combat these PAC billions is the ballot box.

And, if substantive health care reform is not enacted this year, we should use it in November!

Thomas Paine IV is the pen name of C.M. Farmer, a local resident, who is writing a book-length sequel to Thomas Paine's 1776 pamphlet, Common Sense.

Can we afford universal coverage?

by Thomas Paine IV*

In 1992, Americans spent $940 billion, 14 percent of our Gross Domestic Product, for health care coverage for 85 percent of the people. Fifteen percent (15 percent) of the total population, 38 million people, had no insurance, and millions more were under-insured.

Every other industrialized nation provides basic health care coverage to every citizen — 100 percent of the total population. And, the highest percentage of GDP paid by any of them is 9 percent — 56 percent less than we are paying to insure only 85 percent of our total population.

Converted to dollars, this 56 percent over-charge represents $526 billion per year in excess charges! Add to this the cost to fully insure the 37 million uninsured and the millions who are under-insured and the total "rip-off" of the American people is almost $750 billion — 3/4th trillion dollars — per year!

What are the underlying root causes?

The "Hogs have been feeding at the health-care trough" for decades while "do-nothing" presidents and congresses have looked the other way, lacking the courage to take on the many PACs, special interest groups and professions who are involved in this colossal rip-off of the American people.

Who is responsible for this colossal scam?

Virtually everyone, every company involved in providing health care and in supplying health-care facilities with equipment, drugs and other supplies. Plus, federal and state governments for allowing them to get away with gross overcharges and huge excess profits.

Guest Column

Another contributing factor is bad management of health-care facilities, which is the second worst-managed major industry in the country. Second only to government-run enterprises/businesses.

Who are the major players? Federal and state governments, 1,500-plus insurance companies, the legal profession, the medical profession, administrative management people, the drug companies, medical equipment and supply manufacturers and distributors, service companies and the dozens of PACs representing these groups (AMA, ABA, NAM, etc.) contributing millions in campaign contributions (bribes) to maintain the status quo.

Each of these major players is getting his fair share (or more) of the huge health-care pie. Modern "gold-diggers," they get the gold; everyone else gets the shaft!

Can we afford universal health-car coverage? Yes. If substantive health ca reforms are implemented, we can pr vide coverage for everyone at less co than we now pay for coverage for 85 pe cent of the people.

In fact, if we stop the hogs from fee ing, cut out all or most of the "fat," elim nate pork barrel projects of the polit cians, implement professional manag ment and procurement practices, w should be able to provide full health-car coverage for everyone for no more than percent of GDP — the most paid by an other industrialized nation for universa health care.

My qualifications for evaluatin health care: More than 30 years o health-care experience in my immediate family including administration, pur chasing, nursing, financial counseling o health care facilities and the study of eco nomics in college, hospital administra tion in graduate school.

In future guest columns, we will dis cuss how each of the major players in th health care industry is operating his own scam and what can be done to stop them.

And, we will compare the pros and cons of the various health-care reform proposals being debated in Congress.

**Thomas Paine IV is the pen name of C.M. Farmer, a local resident, who is writing a book-length sequel to Thomas Paine's 1776 pamphlet, Common Sense.*

Health care and insurance firms

by Thomas Paine IV*

Guest Column

Today we pay 56 percent more for incomplete health coverage than other industrialized nations pay for full coverage for all their people. We're paying more and getting less.

Health care costs are increasing at 12 percent per year, over three times the annual inflation rate. In 1993, total health care costs exceeded $1 trillion. If nothing is done, costs will double to $2 trillion by 1999!

Despite such outrageous costs, almost 40 million people have no insurance coverage whatsoever; and more than 45 million people with insurance will loose it for one reason or another within the next year — either temporarily or permanently.

Those who do have insurance have only partial coverage. They have no prescription drugs, no pre-existing conditions, no preventive care, no portability, no long-term care, or no guarantee that they will always have health care coverage.

Individuals, small and medium-sized businesses, unable to negotiate successfully with the huge multi-billion dollar insurance companies, are paying exorbitant insurance premiums for limited coverage.

Only the very largest companies in the country and the U.S. government have the buying power to negotiate good prices.

Everyone else is making huge contributions to the excess profits of the major insurance companies. If you doubt this, consider the assets of just four of the 1,500 companies in the country: Hartford, $61 billion in assets; Travelers, $101 billion; Prudential, $218 billion; Metrolife, $1,205 billion!

Added together, their total assets are more than $1½ trillion — an amount equal to the entire 1994 budget of the federal government! And, these are the assets of only four of a total of 1,500 insurance companies nationwide.

How did they accumulate trillions of dollars in assets? By overcharging everyone — except the very largest companies and the U.S. government — for insurance and "cherry-picking" (insuring only those with minimal risk), are all manners of disreputable business practices to add even more to their excess profits.

Consumers Union has done numerous reports on the insurance industry. Their conclusion: Either intentionally or otherwise, insurance companies and their representatives grossly misrepresent the actual coverages and exclusions of virtually every policy they sell. CU shoppers contacted companies and agents anonymously — nationwide — and published data to support their conclusions. Insurance companies are "ripping off" virtually everyone. (Consumer Reports August 1993 pg. 525-534, available at the public library.)

Nowhere is this more evident than in the health-care industry. Insurance companies are one of the "hogs feeding at the health-care trough" — a major player in the health care shell game.

How do we bring insurance costs down to the levels they should be? Control or eliminate them from the health-care industry. A single payor system is the one sure way to get them out of the game; once and for all.

It has been estimated by reputable people that the savings from a single payer system of health care would save enough money to pay for complete coverage for everyone; including those who don't have any insurance at all. The savings in administrative costs alone would be $150 billion per year.

Canada, with a single payer system, pays 2 percent while we pay 17 percent for administrative costs — 15 percent less than we pay now.

Incidentally, while discussing health care with friends in a Lexington restaurant, a man at the next table overheard us and broke in to tell us that he was from Canada, that their health care system gives them complete peace of mind and that they receive good service (he had major heart surgery last year), they could use any doctor or any medical facility in the country, and they were satisfied with their single payer universal health-care plan. Quite a contrast from the propaganda of the insurance companies and the media!

Congressman Jim McDermott has submitted a single payer health care proposal — HR 1200. For a copy call 202-225-3106. HR 1200, cosponsored by 91 other congressmen, provides for full coverage for everyone by Jan. 1, 1995, and many other desirable features.

The next best way to control insurance costs is to set up large buying pools (purchasing coops); then to define a specific basic benefits package to any and all insurance companies.

Competition for the business will bring down costs and keep them down. Such purchasing coops will work only if they are administered by professionals; not political appointees of government bureaucrats.

Insurance companies are spending millions on fancy TV commercials and in campaign contributions to bribe U.S. congressmen which is all to prevent health-care reform from reducing their excess profits.

We must eliminate or control them, if we are to ever be able to afford health care for everyone. Call or write your congressman. Let him know you expect to support health-care reform this year.

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METRO-LIFE FINED $20 MILLION BY NAIC
by Thomas Paine IV

Recently, the National Association of Insurance Commissioners fined Metro-Life 20 million dollars for engaging in misleading sales practices.

Metro-Life admitted that its Tampa office mailed sales solicitations nationwide which described its life insurance as a retirement savings plan, without once mentioning the word "insurance". Further, that Metro-Life instructed its sales agents to avoid using the term "insurance", that company sales literature made no reference to insurance, that insurance premiums were referred to as "deposits" and insurance policies referred to as "investments".

The big difference between life insurance and retirement savings plans is that, for the most part, insurance payments go toward the death benefit while savings plan payments go toward a retirement nestegg.

In addition to the $20 million fine, Met-Life agreed to refund up to 76 million dollars to over 60,000 people in 44 states who were "duped" by Metro-Life's misleading sales practices.

According to John Calagna, spokesman for New York insurance regulators, "Met-Life isn't the only company misrepresenting its insurance products to the public." Consumers Union discovered widespread abuses when it sent out scores of anonymous shoppers for insurance. (See August, 1993 issue of Consumer Reports, in the library)

The single incident described above is only the "tip of the iceberg"! The 1500 insurance companies selling health insurance are "ripping off" the American people and American businesses for billions each year--perhaps as much as 25% of the one trillion dollars per year now spent on inadequate, incomplete health care coverage.

There is only one way to curb or eliminate these widespread abuses of power--managed competition. With managed competition, market forces (supply and demand, direct competition), NOT government, control prices. (Another frequently-mentioned option is a single payer (government-controlled/managed) system. But, based on how badly the government manages other businesses, it would probably manage health so badly that it would cost even more!)

Managed competition, an element of the Clinton plan, provides for huge mandatory buying cooperatives, staffed by purchasing professionals (contrary to the Clinton plan), specific, comprehensive benefits packages, competitively bid and negotiated to/with many insurance companies. This is the only way to force insurance companies to provide adequate coverages at reasonable prices. The individual, the small group, the small/medium-sized business does not have any chance whatsoever pitted against the billion dollar insurance companies. Small businesses now pay 35% too much; individuals pay even more in excess charges.

A working example of managed competition is the California Public Employees Retirement System (CALPERS) which purchases

health insurance for over a million public employees, retirees and their dependents.

In the past three years, CALPERS has saved its members over 500 million dollars in reduced health care premiums. And, in 1994, CALPERS already-low premiums were reduced by 1.1% while others faced an 8% increase in premiums!

CALPERS' Tom Elkins says, "If you want to pay low prices for food, you join a food coop and buy food by the case. Why not do the same thing when buying health insurance? For years, insurance companies would tell us how much of an increase they wanted and we would say, "Do you want cash or will you accept a check?" Now, we tell them what we're prepared to pay, what services we expect in return.

What makes this possible? The combined purchasing power of a million CALPERS members, professional buying practices, standard benefits packages (CALPERS has 24!) and competitive bidding/negotiating from a position of strength.

The bottom line, says Elkins, is that we provide low-cost affordable health care for everyone. "Its amazing what you can get--if you ask for it!" I agree. As purchasing director for a major medical center, working closely with an area-wide purchasing coop, I saved 29% on annual purchases of $20 million dollars. Insurance purchasing coops, if large enough and professionally-managed, should be able to reduce insurance costs by 25 to 40 percent. Anything you hear to the contrary is probably insurance PAC propaganda! Or from politicians interested only in keeping the millions of PAC dollars flowing into Washington by maintaining the status quo! Call/write your Congressman--today!

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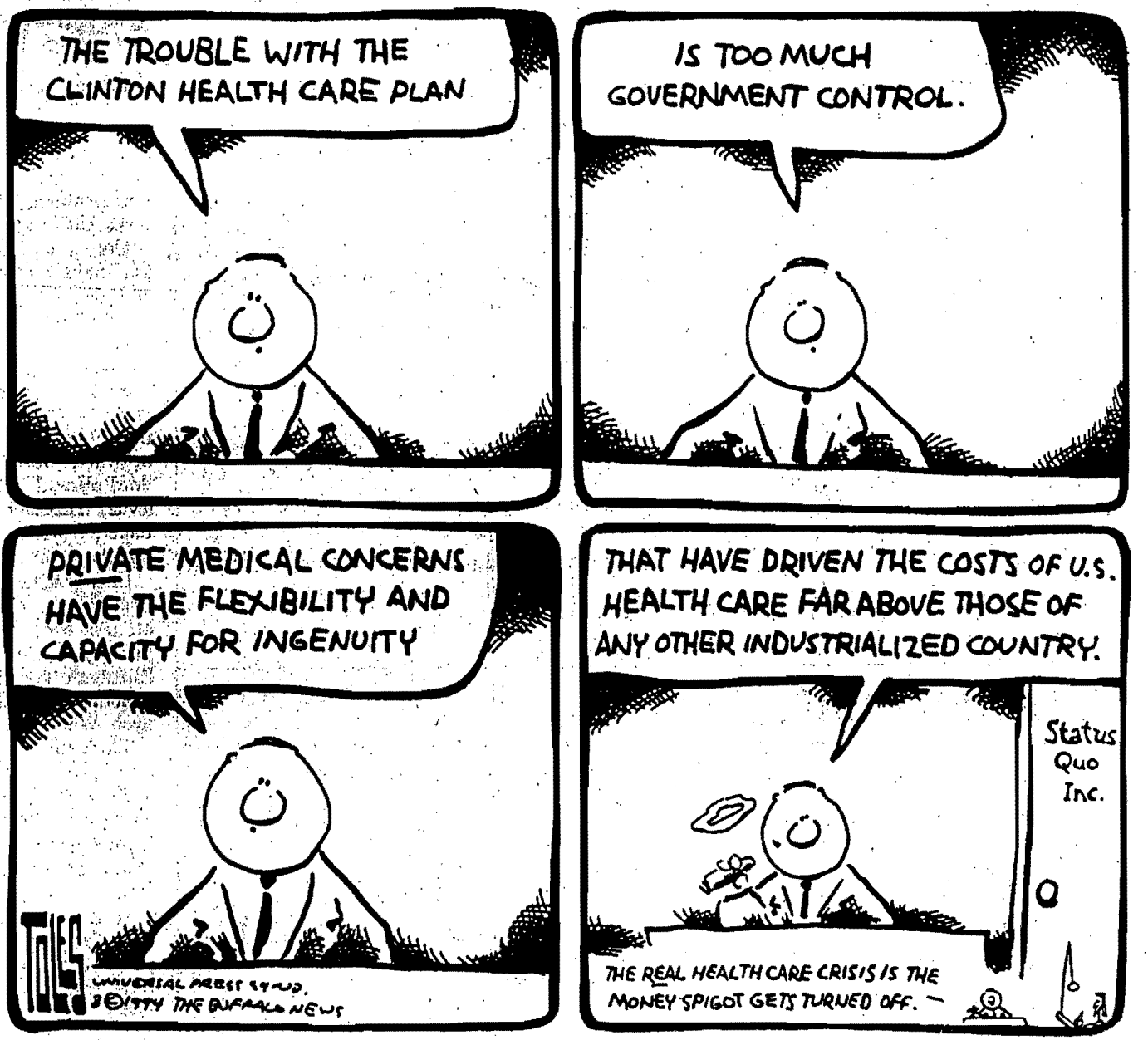
THE TROUBLE WITH THE CLINTON HEALTH CARE PLAN
IS TOO MUCH GOVERNMENT CONTROL.
PRIVATE MEDICAL CONCERNS HAVE THE FLEXIBILITY AND CAPACITY FOR INGENUITY
THAT HAVE DRIVEN THE COSTS OF U.S. HEALTH CARE FAR ABOVE THOSE OF ANY OTHER INDUSTRIALIZED COUNTRY.
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Another health-care ripoff: Drugs

Guest Column

by THOMAS PAINE IV*

The "hogs are feeding at the health care trough!"

In 1993, we paid more than $1 trillion for partial coverage of 85 percent of our people — far more than any other industrialized nation paid for full coverage of 100 percent of their people.

About 110 percent more than the Netherlands, 78 percent more than Germany, 74 percent more than Japan, 56 percent more than Canada.

Why are we paying more and getting less? Because virtually every person, every company, every profession that supplies goods and services to health-care facilities is "feeding at the trough" and ripping off the American people for billions each year.

A trillion dollars a year is more than enough money to provide full coverage for all of our people. We don't need more taxes, more government subsidies, more employer/employee contributions.

We do need a complete overhaul of the entire health-care non-system which includes federal regulations that will stop the hogs from feeding at the health-care trough.

In this week's essay, we turn our attention to the suppliers of prescription drugs. American companies routinely charge Americans more for drugs than they charge foreign citizens for the same identical drugs — often as much as 1,200-1,500 percent more!

Prescription drugs save lives — for those able to afford them. Exorbitantly-priced drugs take lives. The lives of those unable to afford them. It is ironic, but true, that drug companies, by overcharging Americans and undercharging foreigners, are killing Americans while saving the lives of foreigners!

Seventy-eight million Americans do not have insurance coverage that provides for prescription drugs. The victims for the gross overcharging by drug companies are elderly, the underemployed, the poor, the homeless — all those living below poverty-level incomes.

Vulnerable and defenseless, they are easy prey for the huge drug companies. Exorbitant drug prices force these victims to choose between food and shelter and prescription drugs. The prices of many drugs are so high that even the well-to-do cannot easily afford them.

Drug companies try to explain away their exorbitant prices by citing high R&D costs. But, many studies have shown that greed is the most common reason for the overpricing of prescription drugs.

To maintain the status quo, drug company political action committees funnel millions in "blood money" (literally!) to members of the House and Senate in campaign contributions (bribes). For decades, they have "bought" enough members of Congress to prevent passage of meaningful reform laws.

Political pressure form disgruntled voters may force the Congress to reform the health-care system this year. If so, these are the regulations needed to reduce drug prices and drug company profits to reasonable levels:

1. No American-made drug may be sold in a foreign country at a lower wholesale price than in America.

2. Drug companies suspected of overcharging will be audited by the Food and Drug Administration and, if guilty, prosecuted.

3. Drug companies found guilty of price-fixing or excessively high profits shall be fined five times the amount of the "scam" as punitive damages. The money collected to be added to the health-care budget.

4. In determining fair prices, R&D costs shall not be considered as a manufacturing cost.

5. Instead of funding future R&D, which may or may not produce useful new drugs, the government shall repay companies for successfully completed R&D, which has produced new drugs. Such reimbursement to be at three times actual R&D cost to provide incentive for drug companies to invest in R&D, some of it not successful, therefore, not reimbursed.

6. New drug manufacturing processes then shall be declared community property. Rights to produce the new drugs given to all drug companies. This will eliminate propriety rights (monopolies) that make it possible for a company to charge whatever it wishes to charge for its own propriety drugs. Competition between companies will reduce prices.

All patients shall be informed, by doctors, by pharmacists, drug companies of the generic equivalents of all brand name drugs. The patient then can make an informed decision as to generic drugs at lower cost versus brand name drugs at much higher cost.

Every purchasing professional knows that the more you buy, the less you pay. The more purchasing power you have, the less you pay. Therefore, large purchasing coops are essential to getting good prices. Such coops should be staffed by experienced professionals, not bureaucrats or political appointees. Participation in purchasing coops should be mandatory, not voluntary, for all health-care facilities.

Everything the hospital buys should be on contracts and price agreements negotiated by the coop. The individual health-care facility is too small and has too little buying power to negotiate successfully with large manufacturers, suppliers, drug companies and insurance companies.

Price-fixing and exorbitant pricing that is too widespread, rampant, entrenched, to be controlled by the purchasing coops should be regulated by the government and violators prosecuted vigorously.

If we stop the "hogs from feeding," we can provide complete health care coverage for everyone at less cost than we now pay for partial care for 85 percent of the people.

Patching up the present health-care system will not do the job. Complete reform is absolutely essential. Call/write your congressmen. Demand complete reform in 1994 — and accept nothing less!

**Thomas Paine IV is the pen name of C.M. Farmer, a local resident, who is writing a book-length sequel to Thomas Paine's 1776 pamphlet, Common Sense.*

Focusing on the medical staff

by THOMAS PAINE IV*

Guest Column

In America, we are spending 14 percent of our Gross Domestic Product for partial health care coverage for only 85 percent of the population.

No other industrialized nation pays more than 9 percent of GDP for FULL coverage for 100 percent of its population. We pay 56 percent too much!

Why? Because the hogs are feeding, big time, at the health care trough! This includes just about everyone, every company providing either supplies or services to health care facilities.

Like the other major players in the huge trillion-dollar-per-year health care "scam," the members of the medical staff have developed, over time, their own unique and imaginative ways to share in the spoils of a non-system gone awry and out of control.

Some of their more lucrative scams are:

1) Unnecessary operations, procedures, tests. Studies have shown that more than 300,000 unnecessary operations are performed each year, resulting in tens of thousands of deaths from unnecessary surgery. This practice began years ago with tonsillectomies, progressed to hysterectomies and, today, to bypass heart surgery costing tens of thousands of dollars per patient.

2) Protection of incompetent doctors by other doctors who "take care of their own." It is virtually impossible to remove incompetent doctors from the medical staff. Incompetent doctors increase costs while inflicting pain, suffering, even death upon their hapless patients. And, this continues year after year.

3) Doctor-owned health care service companies provide services (lab, X-ray, emergency room, home health care) to health care facilities at exorbitant costs raking off billions in excess profits.

4) Medicare and Medicaid scams of every imaginable kind have resulted in more than doubling the projected cost of Medicare and Medicaid during the past 20 years.

5) American Medical Association Political Action Committees funnel millions of dollars in campaign contributions (bribes) to members of Congress all aimed at preventing meaningful reform of the current health care non-system.

6) Cozy, lucrative, informal arrangements with health care suppliers (drugs, equipment, supplies) provide doctors with expensive free fringe benefits — vacations, lavish parties, free goods, etc. — in return for specifying their overpriced goods and services for use in health care facilities.

7) The failure of doctors to practice preventive medicine increases health care costs. Preventive medicine, which reduces costs (income for doctors), is not in their best interest. And, has been largely neglected/ignored by doctors for decades. Studies show that 70 percent of all serious illnesses are caused by diseases that are preventable. Eight of every nine deaths are premature and preventable.

8) Many doctors, competent in the field of medicine but with little or no management training, inject themselves into management of health care facilities. A role for which they are ill-prepared — and with predictable results. Higher costs and bad management.

Any meaningful health-care reform enacted by the Congress should address these problems and correct them. Few, if any, of them are addressed in the reform plans I have reviewed thus far.

Mostly, we are reminded that we have "the best health care in the world." While this may be true, we also have the most expensive health-care system in the world. And removing the medical staff from the "feeding trough" will bring our health costs down by a substantial amount.

Another factor that increases the medical staff costs is the severe shortage of general practitioners. Demand exceeds supply thus increasing costs.

In 1993, 42,500 students applied for the 16,000 slots in the nation's 126 medical schools.

The Congress should take steps to double or triple the number of family doctors graduated each year. Years ago, government-subsidized A & M colleges were established, graduated well-trained farmers, resulting in American farmers becoming the most productive in the world.

A similar program should be established to train family doctors. Additional medical schools, low-cost tuition loans, family practice curriculum, commitment of graduates to return to home town general practice for a specified number of years in return for financial assistance.

Essential core business and management courses should be added as required study in all medical schools. This would prepare doctors for an active and effective role in management — not only in health-care facilities, but in their private practice as well.

While many of our doctors engage in none of the eight health care scams listed above, those who do add billions to annual health care costs.

These "bad apples in the barrel" are a discredit to the profession. To protect the reputation of their noble profession, reputable doctors should not hesitate to join others in their efforts to rid the profession of these professional scam artists.

**Thomas Paine IV is the pen name of C.M. Farmer, a local resident, who is writing a book-length sequel to Thomas Paine's original 1776 pamphlet, Common Sense.*

LAWYERS: ANOTHER PLAYER IN THE HEALTH CARE GAME
by Thomas Paine IV

The United States has the most lawyers per 100,000 population of any nation in the world, and thousands more are being added each year.

Chief Justice Warren Burger predicted, over 20 years ago, that if we continued adding to the lawyer pool at the same rate, the thousands of excess lawyers would descend upon the American people "like a plague of locusts". His prediction has now become a reality!

Forbes magazine reported last year that tort cases (damage lawsuits) cost consumers over 300 billion dollars per year in higher prices paid for goods and services. Higher prices made necessary by legal fees, higher insurance fees and payment of awards by the Courts.

This "plague" is nowhere more evident than in the health care field where "ambulance-chasers" are, more often than not, lawyers instead of newspaper reporters, as in the past.

In 1992, the legal profession added over 29 billion dollars in damage awards alone to the cost of health care in the United States. Add to that the skyrocketing malpractice insurance premiums and the extra tests and other procedures being done by doctors to protect themselves from possible malpractice suits and the total is well over 100 billion dollars per year!

And, the costs continue to increase each year. In 1987, damage awards were 16 billion dollars, increasing to 29 billion dollars by 1992—an increase of 81% in just five years!

Lawyers are another of the many "hogs feeding at the health care trough". A major contributor to the extra 56% Americans pay for partial health care for 85% of the population, as compared to what other industrialized nations pay for full coverage for 100% of the population.

Tort reform, including malpractice lawsuits and damage awards reforms, are long overdue. As a first step, malpractice award guidelines, similar to the sentencing guidelines already in use in criminal cases, should be formulated and put into use.

Malpractice awards should be limited to the actual medical expenses, the actual loss of income by the patient, legal fees of no more than 25% of medical expenses and loss of income combined. Awards for pain and suffering should be given to the patient; awards for punitive damages added to the health care budget.

Secondly, a Small Claims Court, similar to the Small Claims Courts now used for civil suits, should be set up to handle all claims of $10,000 or less. This would reduce court time and prevent minor cases from cluttering up the regular court system. Equally important, a Small Claims Court would discourage over-zealous lawyers from esculating these small cases into million dollar cases.

The AMA(American Medical Association) recommended six changes in the way malpractice suits are handled. (The Clinton Plan includes five of these six recommendations--but no caps on total awards)

The changes recommended above plus those recommended by the AMA would do much to dampen the enthusiasm of ambulance-chasing lawyers. The number of frivolous suits would be reduced, awards for serious suits reduced, malpractice insurance premiums reduced, unnecessary tests and procedures no longer performed as protection against possible malpractice suits.

The various legal PACs will, of course, spend millions in an attempt to prevent any meaningful malpractice reforms. Since the President, the First Lady, the Vice President and a majority of the members of Congress are lawyers, these PACs will undoubtedly receive a "sympathetic ear" in Washington!

Only an aroused, angry electorate(YOU, me and millions of others!)can pressure the members of Congress to do what must be done. We have one strong weapon the PACs don't have. We can throw the bums out of office in November, if they don't enact substantive health care reforms this year!

The Congress is now working through the various health care reform proposals. The PACs--all of them--are busy trying to brainwash everyone into believing reforms are not needed. Let your voice be heard! Call or write your Congressmen immediately.

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BAD MANAGEMENT: ANOTHER HEALTH CARE CRISIS
by Thomas Paine IV

Bad management is another of the many underlying root causes of high health care costs in America today--56% higher costs for partial coverage for 85% of the people than other countries pay for full coverage for 100% of their people.

What causes bad management? Hard work, low pay, incompetent people. Management pay scales in the health care industry are less than half as high as for equivalent positions in industry. Good people go where the money is--and the good management salaries are NOT in health care.

In addition to the low pay, management of a health care facility is hard work. There are no clear lines of authority and responsibility, as in an ordinary business. Medical and nursing personnel, with little or no management training/expertise, inject themselves into management decision-making. Creating havoc within the facility, they often succeed in intimidating the management staff to such an extent that generally-accepted management principles are abandoned to keep the medical/nursing staff off their backs, assuage their giant egos.

A frequently-expressed comment in management circles is that doctors consider themselves to be somewhere between man and God--and closer to God. Heaven help the management person who has the temerity to challenge/question the management ability of a doctor! This, despite the fact that few have had any management training whatsoever.

Due to the low pay, the hospital CEO with an MBA from a top college is a rarity. Most have a Masters in Hospital Administration followed by a one-year internship--a course of study nowhere close to being equivalent to an MBA program at a top college. (I know this for certain, having studied Hospital Administration at a good college!) The emphasis is more toward learning "health care management" than upon general management. And, there is a world of difference between the two!

Cost accounting and effective cost control are virtually non-existent. The perception is there; the performance, the results are not. Often, when expenses exceed income, the room rates are simply increased enough to make up the difference. The method for establishing the patient charge for a new procedure is to check what others are charging, select a price somewhere in the middle--neither higher nor lower. Annual budgeting is a "comedy of errors"! Three to six months of expensive time

and effort by the CEO, CFO, PA and department managers preparing an annual budget with as much as a third of it in contingency funds for non-specific purchases. Often, at the end of the year, no more than 25% of the total budget has been spent for what it was budgeted for. When notices go out about the next year's budget, everyone gets busy trying to spend any monies left in last year's budget, whether they need the items or not! The rationale being that if you don't spent it all this year, you won't get as much next year!

The typical chief financial officer(CFO) has an under-graduate degree in Business or Accounting, but IS NOT a CPA, as he should be. This explains the deficiencies described above. The low pay scale makes it difficult to get a CPA.

The typical purchasing agent is little more than a glorified storeroom clerk--accepting requisitions, placing orders, checking in stock. Professional purchasing practices are noticably absent. The PA usually reports to the CFO, not to the CEO, as in industry. Given his lack of training and his position in the "pecking order", there is no way that the PA can do his job well. Even a well-trained PA has problems doing a good job. A full year of my time was wasted at the medical center in "friendly persuasion" and in organizing the department before we succeeded in saving 29% per year on $20,000,000 in purchases!

Other top management positions suffer from the same deficiencies, the same obstacles to good management, the same low pay, the same inadequately-trained management personnel.

What can/should be done? Pay good managers what they are worth. Hire good management people. Add more management courses to medical/nursing school curriculums, set up higher hiring standards and adhere to them. Abandon present methods; implement generally-accepted management, accounting, cost accounting, purchasing practices in all areas.

One of the largest industries in the country--over 1 trillion dollars per year--health care facilities are perhaps the second-worst-managed businesses in the country. Second only to government operations.

Health care costs are 50% higher than they should be for what we receive, and increasing at three times the annual inflation rate. If any Fortune 500 company was managed even half as badly, "heads would roll" immediately!

Obviously, bad management is another major factor contributing to THE high cost of health care in America.

Thomas Paine IV is the pen name of C.M. Farmer, a local resident, who is writing a book-length sequel to Thomas Paine's 1776 pamphlet, Common Sense.

The Richmond Register

Commentary

Monday, March 14, 1994

Will Congress procrastinate?

Guest Column

Every industrialized nation, except the United States, provides universal health care for all of its citizens.

The cost of this universal health care is from 6 percent to 9 percent of the nation's Gross Domestic Product (GDP).

In America, we are paing 14 percent of GDP, $940 billion per year, for health care for 85 percent of our people. We pay from 56 percent to 89 percent more for health care for 85 percent of our people than other nations pay for 100 percent of their people! In America, 15 percent of the population, 38 million people, have no health care coverage, millions more do not have full coverage, virtually none have security — risking loss of coverage when changing jobs or it they have a serious medical problem.

Despite the already exorbitant cost of health care in America, the costs continue to skyrocket. If the present trend is allowed to continue, the cost of health care will double by the year 2000, to $1.88 TRILLION per year! And, the deficiencies of the present system will remain.

The present health care crisis is simply one more in a long list of serious social and economic problems that were created, neglected and/or ignored by the "Do Nothing" presidents and Congresses of the '80s. This list includes a $4 trillion national debt, 300-plus billion per year deficits, a welfare system gone awry, millions homeless, under or unemployed, tens of thousands of family farms bankrupted/sold, an educational system that doesn't educate, an AIDS epidemic that an early-on tuberculosis-type program could have prevented, 200 million guns with no registration and controls, violent crime at its highest level ever — and increasing, illegal drugs more readily available than prescription drugs and an out-of-control health care system.

The Declaration of Independence states that, "When any form of government becomes destructive, it is the right of the people to alter or abolish it." The taxes and duties imposed, in 1776, by the British government upon the Colonists pale in comparison to the miser, pain and suffering now being inflicted upon the American people by their own destructive government! The time has come to "alter" or "abolish" it.

In 1992, the voters made a good first step by electing a new president, 14 new senators, 116 new representatives. But, the job is only half-done! In November, 33 senators and all 435 House members must run for re-election — and the voters (YOU, me and everyone else!) — will have an opportunity to finish the job by removing several hundred more career politicians from office.

Majority rule is no longer to be found anywhere in the U.S. Congress, which is controlled by a few "Good Ole Boy" career politicians elected prior to 1976 — 24 senators and 67 House members.

This minority controlled the Congresses of the '80s and continues to control it today. To regain control of the Congress, we must "retire" the good ole boys who have outlived their usefulness — long ago!

Any health care reform bill that they are forced by public opinion to pass this year will be "watered down," ineffective and expensive. The "best bill that money (PAC money!) can buy!" Medical, legal and insurance PACs will funnel millions in "campaign contributions" (bribes) to buy the votes of those who control the Congress.

Only one thing has any hope of changing this scenario: An avalanche of millions of phone calls and letters to Congressmen — especially the ruling minority — threatening them with automatic retirement after the November elections if they continue to do nothing.

The surest way to get results is to UN-elect several hundred members of Congress, bring in new people to solve our many domestic problems.

In future essays, underlying root causes of the health-care crisis, various reform plans proposed, recommended reforms will be discussed.

**Thomas Paine IV is the pen name of C.M. Farmer, a local resident, who is writing a book-length sequel to Thomas Paine's 1776 pamphlet, Common Sense.*

RE: 20 RULES FOR GOOD WRITING

THIS SHOULD BE REQUIRED READING FOR ALL GOVERNMENT REGULATION WRITERS!

REQUIRED MEMORIZATION: #1, #2, #6, #7, #8, #14, #15, #18, #19!

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20 rules for good writing

WRITER'S DIGEST SCHOOL

1. Prefer the plain word to the fancy.
2. Prefer the familiar word to the unfamiliar.
3. Prefer the Saxon word to the Romance.
4. Prefer nouns and verbs to adjectives and adverbs.
5. Prefer picture nouns and action verbs.
6. Never use a long word when a short one will do as well.
7. Master the simple declarative sentence.
8. Prefer the simple sentence to the complicated.
9. Vary your sentence length.
10. Put the words you want to emphasize at the beginning or end of your sentence.
11. Use the active voice.
12. Put statements in a positive form.
13. Use short paragraphs.
14. Cut needless words, sentences, and paragraphs.
15. Use plain, conversational language. Write like you talk.
16. Avoid imitation. Write in your natural style.
17. Write clearly.
18. Avoid gobbledygook and jargon.
19. Write to be understood, not to impress.
20. Revise and rewrite. Improvement is always possible.

CJ — re: CLIA

I have sent this draft to VP Correspondence Office. They want to send out an approved ltr. Could you please review? I am out of here in a day.

Charlotte

FACSIMILE TRANSMISSION REQUEST

ADDRESSEE: (Name, Organization, Address)	FROM: (Name, Organization, Address)
Charlotte Hayes Phone:	Barbara Cooper Phone: 690-7063

TOTAL PAGES: (Without Cover)	ADDRESSEE'S FAX MACHINE PHONE NUMBER: (If Known)	DATE:
1	456-5557	5/5/94

REMARKS:

Attached is suggested language to respond to the letter from John Griffin. Please let me know if I can help in any other way.

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Your concerns about qualification requirements for supervisory personnel under the Clinical Laboratory Improvement Amendments (CLIA) regulations are similar to those voiced by many others. Over 55,000 comments on personnel issues were received during the 60-day comment period following the publication of regulations on supervisor and high complexity testing personnel.

As you may know, the Health Care Financing Administration (HCFA) is responsible for management of the survey process for laboratories. In any new program as large and complex as CLIA, there will be implementation problems that need to be addressed as they arise. The interpretation of the regulatory requirements regarding academic degrees and training for laboratory personnel were some of the earliest problems and issues dealt with as CLIA was being implemented.

In your letter you asked about actions of the Clinical Laboratory Improvement Advisory Committee (CLIAC) at a December, 1993 meeting. The primary function of the Committee is to advise and make recommendations on the technical and scientific aspects of CLIA. At the December meeting, the Committee heard a summary of the comments on the personnel requirements in the CLIA regulations and generally accepted those comments. Based on comments to the February, 1992 and January, 1993 regulations and determinations made by the CLIAC on this and other issues, the Department will be making further changes to the rules, targeted for publication in 1994.

The current rules on personnel qualification for general supervisors qualify individuals who have taken and passed the HHS (HEW) technologist proficiency exam and have six years experience subsequent to passing the exam. If you have successfully completed this exam, under CLIA, you would qualify to serve as a general supervisor.

[redacted] if you are not proficient
[redacted] at your position the organization/department will

3-29-94
Charlotte

APR - 6 1994

DEAR V.P. AL GORE :

I recently read in my ASMT (American Society for Medical Technology) newsletter that at the Dec 14th 1993 meeting on CLIA 88, the grandfather claus for general supervisors and certain high technical testing was discarded. Is this what occurred ? If yes, I would have serous concerns as to where you are getting your information about this field and what kind of ethical background the committee is working with.

No governmental regulation should be passed that would purposely and selectively eliminate jobs (most of which are over the age of 40). Grandfather clauses are common place. The two main ways of becoming educated in a field or job, is formal education and the other is on the job. In the medical field we need to talk about competency (the ability to run a test correctly) and proficiency (the ability to achieve correct results). Neither of these are possible within the laboratory without on the job training and a few years of experience, regardless of the degrees. In my 30 years in this field I have seen things that have me convinced that attitude plays an important roll. I would rather have an "on the job" trained person with experience and a good attitude than a "formal educated" person with a so/so attitude. Don't get me wrong, my objective is always to hire a formal educated person with a good attitude and experience, but that is an administrative decision of common sense and in no way needs to be regulated to us.

By now I'm sure you have guessed that I am one of those people you are trying to eliminate. Well I would like to give you a little back ground on myself. I was train as a Lab Tech. in the Army at Fort Sam Houston in 1966. Had one year of on the job training at Fort Leonard Wood Hospital in 66/67. Went to Vietnam for a year working at camp dispensaries. Finishing off my enlistment I worked at Fort Bliss Army Hospital 68/69. All the time I was in the army I would spend extra hours working in the lab. Instrumentation was just starting and I loved this field. For the past 25 years I have worked for William Beaumont Hospital Corporation. 11 years at their 1000 bed hospital and 14 years at their 200 bed hospital. I have been the midnight supervisor for the past 10 years. I took and passed the HEW in 1977, and received an associate of arts degree just before I started raising my family 1976 (both kids are just a few years from starting college).

In the March 1994 MLO magazine, page 82, there is a panel responds to the question on who should put what after their name (HEW, MT, CLS) and why. What makes this relevant to what I am discussing with you is some of the answers. Linda Blacklidge stated, "Even when HEW certification is considered equivalent to MT(ASCP), the initials MT can only be used by individuals who have graduated from an approved medical technology program, but there are many laboratorian without equivalent qualifications who make significant lab contributions". Ted Street feels many laboratorian demonstrate potential as high, if not higher, then some MT's.

To sum this matter up (if possible). The Grandfather claus should be in CLIA 88. Whether you have no degree, Associate, Bachelors, or for that matter, a PH.D., if you are not proficient and or competent at your position the organization/department will

remove you. CLIA 88 requires competency testing and that's great, but for the government to declare who should and should not work by definition is discriminatory.

This subject and laboratory field is very near and dear to me. I would be willing to discuss with you any matter that would help you in this or any other CLIA 88 regulation.

Before closing I would like to explain that I have total responsibility in hiring for my shift. I have 5 available MT positions and over the last ten years I have hired all MT (ASCP) except for 1 CLS (NCA). My staff is a great team that I'm proud of. Why no HEW or other none MT personnel ? Because like I said earlier "everything being equal, I will pick the most qualified". As would any supervisor and that is called responsible self management without regulation !!

THANK YOU

John H. Griffin

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OR

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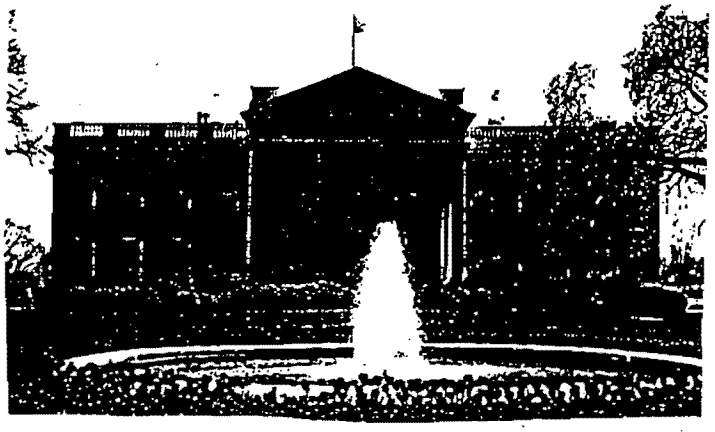
THE WHITE HOUSE

WASHINGTON



Fax Cover Sheet

DATE: 5/5 **TIME:** 3:45 pm

TO: D. Bergsten / B. Mason

PHONE: _____ **FAX:** _____

FROM: C. Hagen

PHONE: 202-456- 559 **PAGES AFTER COVER:** _____

COMMENTS: for attached letter - We still need to pass it through one other step before it goes but I wanted you to see it.

Fiscal Analysis of 7.31.94 Plan

07/31/94

11:05 PM

CR pool 500, NO MANDATE, no premium caps, abbreviated transition

	1995-1999	1995-2004
Subsidies	246	601
Medicare Savings	(54)	(250)
Medicaid Savings	(131)	(518)
State Medicaid MOE	(85)	(303)
PHS/AHC/GME	28	88
Long Term Care	5	48
Medicare Drug	18	92
Subsidy Administration	*	*
Tobacco Tax	(28)	(60)
High Cost Plan Tax	(3)	(60)
Net Other Revenues	(32)	(127)
Net Deficit Effect	(37)	(489)

DRAFT

% OF POPULATION COVERED:

1997-2000: 87-89%

2001-2004: 86-88%

Fiscal Analysis of 7.18.94 Plan

07/31/94

11:02 PM

CR pool 500, NO MANDATE, no premium caps

	1995-1999	1995-2004
Subsidies	300	885
Medicare Savings	(54)	(250)
Medicaid Savings	(131)	(518)
State Medicaid MOE	(85)	(303)
PHS/AHC/GME	29	91
Long Term Care	5	48
Medicare Drug	18	92
Subsidy Administration	*	*
Tobacco Tax	(28)	(60)
High Cost Plan Tax	(4)	(88)
Net Other Revenues	(39)	(151)
Net Deficit Effect	10	(254)

% OF POPULATION COVERED:

1997-2000: 92-95%

2001-2004: 89-91%

Model 7.31.94	SUBSIDIES FOR MEDICAID POPULATION AND MEDICAID SAVINGS												
07/31/94													
10:10 PM		Fiscal Years											
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	1995-1999		1995-2004
Subsidies for Medicaid Population													
Non Cash		12.9	13.9	15.1	16.3	17.6	18.9	20.3	22.0	23.8	58.1		160.7
Cash		13.8	15.0	16.2	17.5	18.9	20.3	21.8	23.7	25.6	62.5		172.8
Total		26.7	28.9	31.2	33.8	36.5	39.2	42.2	45.7	49.4	120.6		333.5
Medicaid Savings		0	24.6	50.2	56.3	63.3	70.1	77.1	84.4	91.9	131.1		517.90
NET		26.7	4.3	(19.0)	(22.5)	(26.8)	(30.9)	(34.9)	(38.7)	(42.5)	(10.5)		(184.4)

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Net New Federal $ per newly insured person

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Baseline uninsured	38.3	38.8	39.3	39.5	39.9	40.4	41.1	41.9	42.6	43.3	44
Net Newly insured											
HSA	0	0	5.9	15.8	39.9	40.4	41.1	41.9	42.6	43.3	44
7.18.c	0	0	0	17.5	21.5	21.6	22.5	20.8	18	16	12.4
Subsidies											
HSA	0	0	11	37	98	121	128	144	164	181	197
7.18.c	0	0	0	66.2	113.5	119.9	128.0	123.1	117.4	112.2	105.1
Medicaid savings + State MOE											
HSA	0	0	4	16	44	66	74	83	93	104	116
7.18.c	0	0	0	45.7	80.8	89.9	99.9	110	120.5	131.4	143
Net new Federal $ per newly insured persons											
HSA	0	0	1187.45	1329.11	1353.38	1361.39	1313.87	1455.85	1666.67	1778.29	1840.91
7.18.c	0	0	0.00	1170.62	1521.89	1390.56	1247.96	630.02	-170.38	-1201.53	-3059.67

Net Effect of 7.18 plan on Average Private Health Insurance Premiums, vs. Baseline, in 1997

2004

	Community Rated Firms	Experience Rated Firms	Private Sector Aggregate
Benefit Package	-3%	-3%	-3%
Medicaid Cost Shift	+1%	-0.5%	+.5%
Risk Adjustment	-2.2%	+2.2%	0
High Cost Plan Assessment	+0.4%	0	+0.2%
Uncompensated Care	-5%	-5%	-5%
Small Firm Exemption	0	0	0
Administrative Load			
500+	na	0	0
100-500	-2.5%	na	
< 100	-22.5%	na	-1.5%
Academic Health Centers	+1.75%	+1.75%	+1.75%
Cafeteria Plan Restrictions	+1%	+1%	+1%
NET EFFECT	**-8.55**	**-3.55%**	**-6.05%**

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 1

(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
MANDATORY OUTLAYS										
Medicaid										
1 Discontinued Coverage of Acute Care	0	0	-24.6	-36.7	-41.0	-45.8	-51.2	-56.9	-63.1	-69.7
2 State Maintenance-of-Effort Payments	0	0	-19.1	-23.4	-25.5	-27.7	-30.1	-32.7	-35.5	-38.6
3 Disproportionate Share Hospital Payments	0	0	-6.8	-10.2	-11.3	-11.6	-18.8	-20.7	-22.9	-25.2
4 Offset to Medicare Prescription Drug Program	0	0	0	0	-0.7	-1.5	-1.7	-1.9	-2.0	-2.2
5 Increase Asset Disregard to $4000 for Home and Community Based Services	a	a	a	a	a	a	a	0.1	0.1	0.1
6 Administrative Savings	0	0	-0.3	-0.5	-0.5	-0.6	-0.7	-0.8	-0.8	-0.9
Total - Medicaid	0	0	-52.8	-70.8	-79.0	-87.2	-102.5	-112.9	-124.2	-136.5
Medicare										
7 Part A Reductions										
Inpatient PPS Updates	0	0	-0.8	-2.3	-4.2	-6.4	-7.1	-8.1	-8.9	-9.8
Capital Reductions	0	-0.8	-1.0	-1.2	-1.6	-2.1	-2.2	-2.4	-2.7	-2.9
Disproportionate Share Hospital Reductions	0	0	-1.1	-1.4	-1.5	-1.7	-1.8	-2.0	-2.2	-2.5
Skilled Nursing Facility Limits	0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3
Long Term Care Hospitals	a	a	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4
Medicare Dependent Hospitals	a	0.1	0.1	0.1	a	a	0	0	0	0
8 Essential Access Community Hospitals										
Medical Assistance Facility Payments	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Rural Primary Care Hospitals (RPCH) Pmts	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2
9 Part B Reductions										
Updates for Physician Services	-0.4	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-1.0	-1.1
Real GDP for Volume and Intensity	0	0	-0.3	-0.8	-1.6	-2.5	-3.3	-4.2	-5.3	-6.6
Eliminate Formula Driven Overpayments	-0.8	-1.0	-1.3	-1.8	-2.3	-3.2	-4.2	-5.5	-7.1	-9.1
Competitive Bid for Part B	a	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3
Competitive Bid for Clinical Lab Services	a	-0.2	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6
Prohibition of Balance Billing	a	a	a	a	a	a	a	a	a	a
Laboratory Coinsurance	-0.7	-1.1	-1.3	-1.4	-1.6	-1.8	-2.0	-2.3	-2.6	-2.9
Correct MVPS Upward Bias	0	0	0	0	-0.2	-0.6	-1.4	-2.6	-3.9	-5.5
Eye & Eye/Ear Specialty Hospitals	a	a	a	0	0	0	0	0	0	0
Nurse Pract/Phys Asst Direct Payment	0	0	0.1	0.2	0.3	0.3	0.4	0.5	0.7	0.8
High Cost Hospitals	0	0	0	-0.5	-0.8	-0.8	-0.8	-0.9	-1.0	-1.0
Permanent Extension of 25% Part B Premium	0	0.6	0.9	1.3	0.6	-1.0	-2.8	-5.0	-7.7	-9.8

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 1

(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
10 Parts A and B Reductions										
Home Health Copayments (20%)	-0.7	-3.4	-4.2	-4.6	-5.0	-5.4	-5.9	-6.4	-7.0	-7.6
Medicare Secondary Payer	0	0	0	0	-1.2	-1.8	-1.9	-2.0	-2.2	-2.3
Home Health Limits	0	0	-0.3	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.0
Expand Centers of Excellence	0	-0.1	-0.1	-0.1	-0.1	-0.1	a	a	0	0
Risk Contracts (Waive 50/50 Rule)	a	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6
Extend ESRD Secondary Payer to 24 Months	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2
11 Medicare Outpatient Prescription Drug Benefit	0	0	0	0	6.4	14.8	16.2	17.6	19.2	21.0
Total - Medicare	-2.4	-6.7	-10.3	-14.3	-14.8	-14.2	-19.3	-25.9	-33.4	-41.0
Other Health Programs										
12 Vulnerable Hospital Payments	0	0	0	0	0	1.3	1.3	1.3	1.3	1.3
13 Veterans' programs	0	1.5	4.2	10.8	10.9	11.3	11.7	12.1	12.6	13.0
14 Long Term Care Program										
15 Home and Community Based Care ($48 bil. cap)	0	0	0	1.8	2.9	3.6	5.0	7.9	11.4	15.4
16 Life Care										
17 Academic Health Centers	0	0	7.0	8.0	9.1	10.3	11.3	12.3	13.3	14.3
18 Graduate Medical and Nursing Education	0	0	4.0	5.8	6.9	7.6	8.2	8.9	9.6	10.4
19 Medicare Transfer - Graduate Medical Education	0	0	-2.2	-2.4	-2.5	-2.6	-2.8	-2.9	-3.1	-3.3
20 Medicare Transfer - Indirect Medical Education	0	0	-4.5	-4.9	-5.4	-5.9	-6.5	-7.2	-7.9	-8.7
21 Women, Infants and Children	0	0.3	0.5	0.5	0.5	0.5	0.6	0	0	0
Total - Other Health Programs	0.0	1.8	9.0	19.6	22.5	26.2	28.8	32.4	37.2	42.4
Subsidies										
22 Persons between 0-200% of Poverty	0	0	46.1	66.8	74.6	83.2	93.0	103.6	115.3	127.8
23 Pregnant Women and Kids 0-240% of Poverty	0	0	17.6	24.7	26.4	28.3	30.1	31.7	33.4	35.0
24 Temporarily Unemployed	0	0	0.0	5.0	7.1	7.7	8.3	9.0	9.8	10.6
25 Presumptive Eligibility										
Total - Subsidies	0	0	61.7	94.1	106.0	117.4	129.9	143.3	157.9	173.2

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 1

(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Public Health Initiative										
26 Biomedical and Behavioral Research Trust Fund										
27 Health Services Research	a	0.2	0.3	0.5	0.6	0.6	0.6	0.6	0.6	0.7
28 PHS Core Functions	0.1	0.2	0.3	0.4	0.5	0.6	0.6	0.7	0.7	0.7
29 Health Promotion/Disease Prevention	0	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2
30 Development of Community Health Groups	0.1	0.2	0.4	0.5	0.4	0.3	0.2	0.2	0.2	0.2
31 Investment in Infrastructure Development (Loans)	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
32 Supplemental Services Grants	a	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3
33 Enabling Grants	0	a	0.2	0.4	0.4	0.4	0.5	0.5	0.5	0.5
34 National Health Service Corps	0	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.3
35 Mental Health/Substance Abuse Grants	a	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
36 School Health Grants	a	0.1	0.2	0.4	0.5	0.6	0.7	0.7	0.7	0.8
37 Occupational Safety/Health Grants	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
38 Indian Health Service	0	0	1.4	1.5	1.6	1.8	1.9	2.1	2.2	2.4
Total - Public Health Initiatives	0.3	1.2	3.6	4.4	4.8	5.2	5.5	5.8	6.0	6.3
MANDATORY OUTLAY CHANGES	**-2.1**	**-3.6**	**11.2**	**33.0**	**39.5**	**47.4**	**42.4**	**42.7**	**43.4**	**44.4**
DISCRETIONARY OUTLAYS										
39 Veterans' programs	1.2	-1.5	-4.2	-15.4	-15.9	-16.6	-17.2	-17.8	-18.5	-19.2
Administrative Expenses										
40 Administrative Costs	0.5	0.9	1.0	1.0	1.0	1.0	1.1	1.1	1.1	1.2
41 Costs to Administer the Mandate	0	0	0	0	0	2.0	2.0	0	0	0
42 Planning and Start-Up Grants	0.1	0.4	0.6	0.3	0	0	0	0	0	0
Total Studies, Administrative Expenses	0.6	1.3	1.6	1.3	1.0	3.0	3.1	1.1	1.1	1.2
Studies, Research, & Demonstrations										
41 Department of Labor Programs	a	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2
42 Women, Infants, and Children	3.0	3.4	3.5	3.6	3.7	3.8	3.9	4.0	4.1	4.2
43 EACH/MAF/Rural Transition Demonstrations	a	0.1	0.1	0.1	a	a	a	a	a	a
Total Studies, Research, & Demonstrations	3.0	3.7	3.8	3.9	3.9	4.0	4.1	4.2	4.3	4.4
DISCRETIONARY OUTLAY CHANGES	**4.8**	**3.5**	**1.2**	**-10.2**	**-11.1**	**-9.6**	**-10.0**	**-12.6**	**-13.1**	**-13.6**
TOTAL OUTLAY CHANGES	**2.7**	**-0.1**	**12.4**	**22.8**	**28.4**	**37.8**	**32.4**	**30.2**	**30.2**	**30.7**

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(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
RECEIPTS										
44 Increase in Tax on Small Cigarettes	0.7	2.7	4.5	6.1	7.6	7.4	7.1	6.9	6.8	6.7
45 1.75% Excise Tax on Private Health Ins Premiums										
46 Addl Medicare Part B Premiums for High-Income Individuals	0	0	1.5	1.3	1.6	2.1	2.6	3.4	4.3	5.5
47 Increase Excise Tax on Hollow-Point Bullets	---------- Negligible Revenue Loss ----------									
48 Include Certain Service-Related Income in SECA/ Excl Certain Inven-Related Income from SECA										
a) General Fund Effect	0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
b) OASDI Effect	0	0.1	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3
49 Extend Medicare Coverage & HI Tax to All State and Local Government Employees	0	1.6	1.6	1.5	1.5	1.4	1.4	1.3	1.2	1.2
50 Impose Excise Tax with Respect to Plans Failing to Satisfy Voluntary Contribution Rules										
51 Provide that Health Benefits Cannot be Provided thru a Cafeteria Plan/Flex Spend Arrangements										
52 Extend/Increase 25% Deduction for Health Insurance Costs of Self-Employed Individuals										
53 Limit on Prepayment of Medical Premiums	---------- Negligible Revenue Gain ----------									
54 Non-Profit Health Care Orgns/Taxable Orgns Providing Health Ins & Prepd Health Care Svcs	a	a	a	a	a	a	a	a	a	a
55 Trmt of Certain Ins Companies Under Sect 833	0	0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
56 Grant Tax Exempt Status to State Ins Risk Pools	a	a	0	0	0	0	0	0	0	0
57 Remove $150 million Bond Cap on Non-Hospital 501(c)(3) Bonds	a	a	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
58 Qualified Long-Term Care Benefits Treated as Medical Care; Clarify Tax Treatment of Long-Term Care Insurance and Services	0	a	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2
59 Tax Treatment of Accelerated Death Benefits Under Life Insurance Contracts	a	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
60 Incr in Reporting Penalties for Nonemployees	0	a	a	a	a	a	a	a	a	a

TABLE 1. UNOFFICIAL ESTIMATES OF THE FEDERAL BUDGETARY EFFECTS OF OPTION 1

(No Mandate, Full Subsidies up to 100% of Poverty, Unconstrained Subsidies)

(By fiscal year, in billions of dollars)

NO MANDATE	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
61 Post-Retirement Medical/Life Insurance Reserves			---------- Negligible Revenue Effect ----------							
62 Tax Credit for Practitioners in Underserved Areas	a	-0.1	-0.2	-0.2	-0.2	-0.1	-0.1	a	a	a
63 Increase Expensing Limit for Certain Med Equip	a	a	a	a	a	a	a	a	a	a
64 Tax Credit for Cost of Personal Assistance Svcs Required by Employed Individuals	0	a	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
65 Disclosure of Return Information to State Agencies			---------- No Revenue Effect ----------							
66 Impose Premium Tax with Respect to Certain High Cost Plans										
67 Limit Exclusion for Employer-Paid Health Benefits										
68 Indirect Tax Effects of Changes in Tax Treatment of Employer & Household Health Ins Spending										
TOTAL RECEIPT CHANGES	0.7	4.2	7.3	8.5	10.3	10.7	10.8	11.2	11.9	13.0
DEFICIT										
MANDATORY CHANGES	-2.8	-7.8	3.9	24.5	29.2	36.7	31.6	31.5	31.5	31.4
TOTAL CHANGES	2.0	-4.3	5.1	14.3	18.1	27.1	21.6	19.0	18.3	17.7
CUMULATIVE DEFICIT EFFECT	2.0	-2.3	2.8	17.1	35.2	62.3	83.8	102.8	121.1	138.9

SOURCES: Congressional Budget Office; Joint Committee on Taxation

NOTES:

The figures in this table include changes in authorizations of appropriations and in Social Security that would not be counted for pay-as-you-go scoring under the Budget Enforcement Act of 1990.

Provisions with no cost have been excluded from this table.

a. Less than $50 million.

174 43.5 50.5 94 137.5

(DRAFT - 7/22/94)

THE MITCHELL PLAN:
Responding to the Concerns fo the American People

Senator Mitchell's health care plan is a moderate and reasonable approach that will move this country toward universal health coverage in a defined time frame. And it does so without a mandate or a government takeover of our health care system. It addresses the criticism of the Presidents plan by building in a deliberate way on the best elements of our current system and targeting resources to maximize their impact in extending coverage as quickly as possible to those who currently lack protection. The Mitchell plan preserves the right for more businesses to self insure, allowing their employees to continue with the plans that are satisfied with today. It builds in extra protections for small businesses and working Americans to ensure that insurance is available. It strengthens coverage for seniors by including a prescription drug benefit under Medicare and establishing a new home and community based long-term care program. It is fiscally sound with built in protections for the federal budget.

CUTS BUREAUCRACY AND REGULATION:

- Replaces large mandatory government alliances with voluntary purchasing pools to help small businesses and individuals get affordable insurance coverage.

- Eliminates intrusive government cost containment mechanism relying on more market-oriented approach.

MINIMIZES DISRUPTION TO CURRENT SYSTEM:

- All firms with more than 500 employees are allowed to self insure rather than firms with more than 5,000 employees under the President's plan. Many more firms that sponsor their own high-quality plans and are effective at controlling costs will have the opportunity to continue to do so.

- Eliminating mandatory alliances gives people and businesses more choices in how they purchase insurance coverage including the opportunity to stick with plans they are satisfied with today..

PROVIDES EXTRA PROTECTION FOR SMALL BUSINESSES:

- By eliminating the employer mandate, the Mitchell bill addresses one of the major concerns about the President's plan -- namely that such a mandate would hurt small businesses imposing a financial burden they could not handle and costing numerous jobs.

- It provides new targeted subsidies to help the most vulnerable small businesses afford private insurance coverage.

- Should voluntary efforts not achieve universal coverage, the fall-back trigger mechanism would exempt firms with fewer than 25 employees, protecting those businesses least able to handle the burden of providing insurance coverage to their workers. Even for those businesses with more than 25 employees, the Mitchell plan dramatically scales back how much they would be asked to contribute. Under the plan, employers and employees would split the cost of insurance evenly, a significant reduction from the 80/20 requirement of the President's plan.

FISCALLY SOUND WITH ADDED PROTECTION TO THE FEDERAL BUDGET:

- The plan pays for itself through realistic savings to the Medicare and Medicaid programs, an assessment on high cost insurance plans and an increase in the tobacco tax by 45 cents per pack.

- To provide ironclad protection to the federal budget, the plan provides a fail-safe mechanism to ensure that the cost of reform does not exceed the savings and revenues in hand.

RELIES ON MARKET ORIENTED COST CONTAINMENT:

- Rather than an intrusive government sytem for controlling costs by regulating insurance premium increases, it fosters market forces and harnesses them to keep costs down. By placing an assessment on high cost plans, it encourages plans to lower their premiums and employers and individuals to choose more efficient, better priced plans.

(DRAFT - 7/22/94)

THE MITCHELL PLAN:
Preserves the Best Elements of the President's Plan

Senator Mitchell's plan includes the elements that the American people want most out of health care reform. While any of these features were included in the President's plan, the Mitchell plan acomplishes these goals in a volunatry way, with less government involvement, building gradually but deliberately on our current system, with the least disruption possible. It provides affordable insurance for working families with security of coverage that can never be taken away. It expands choices of doctors and insurance plans and ensures high-quality care. Finally, like the President's plan, it preserves and strenghten coverage for older Americans under Medicare.

ACHIEVES PRESIDENT'S GOAL OF UNIVERSAL COVERAGE:

- It ensures that all hard working American families have the insurance protection that they deserve.

PROVIDES PROTECTION TO THE MIDDLE CLASS:

- By capping household insurance expenses at 8% of income and providing targeted subsidies to middle class families, the Mitchell plan insures that insurance protection is within everyone's reach.

REFORMS INSURANCE MARKET:

- The plan embraces the consensus insurance reforms that enjoy overwhelming support in the Congress. It levels the playing field for small businesses and indviduals by community rating premiums for firms with fewer than 500 employees and individuals.

- It eliminates abusive insurance company practices by guaranteeing issue and enrollment, eliminating preexisting condition exclusions and lifetime limits and open enrollement.

- It establishes voluntary purchasing pools to help small businesses and individuals negotiate rates only large companies can get today.

ENSURES HIGH-QUALITY CARE:

- The core benefits package will emphasize primary and preventive care to help keep people healthy not just treat them once they become sick.

- A portion of each premium will be earmarked for medical research to encourage the technological advancements and improvements that have made American medicine the finest in the world.

PRESERVES AND STRENGTHENS COVERAGE FOR SENIORS:

- The Medicare program is preserved and the benefits seniors enjoy today will be expanded to include coverage for outpatient prescription drugs. Starting in 1998, Medicare will cover the cost of prescription drugs with a $500 deductible, 20% copay and a cap on out-of-pocket expenditures.

- In addition, the Mitchell plan establishes a new home and commuinty-based long-term care program to give older Americans and those with disabilities additional options for care.

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