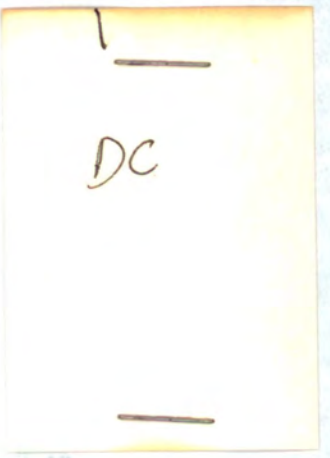
DC

CONVERSATIONS ON HEALTH
The Robert Wood Johnson Foundation
Washington, DC
Friday, March 26, 1993

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PRESERVATION

Conversations on Health: A Dialogue with the American People
The Robert Wood Johnson Foundation
Washington, D.C.
Friday, March 26, 1993

10:00am	Welcome	-- Stephen Trachtenberg, President, The George Washington University
10:05am	Opening Remarks	-- Steven A. Schroeder, M.D., President, Robert Wood Johnson Foundation
10:15am	Opening Remarks	-- Donna E. Shalala, Secretary, Department of Health & Human Services
10:20am	Overview of U.S. Health Care System	-- Dr. Schroeder
10:30am	Discussion of Ground Rules	-- Ken Bode Senior Correspondent CNN

PART I -- PEACE OF MIND

10:35am	• Frances Hightower, Tallahassee, FL
	• Jeffrey Heath, New York, NY
10:50am	Discussion
12:00pm	LUNCH
	Box Lunches can be picked up in back of room.

PART II -- DELIVERY SYSTEM REALITIES

1:00pm	• Dr. Joseph VonThron, Cocoa Beach, FL
	• Fritz Wenzel, Marshfield, WI
1:15pm	Discussion
2:25pm	BREAK

PART III -- CONTROLLING COSTS

2:40pm	• Richard O'Brien, Detroit, MI
	• Thomas W. Chapman, Washington, D.C.
2:50pm	Discussion
3:50pm	Closing Remarks -- Secretary Shalala -- Dr. Schroeder
4:00pm	Adjourn

Ken Bode Program Outline

Conversations On Health
A Project of the
Robert Wood Johnson Foundation
Washington, D.C.
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7:30 AM Registration table set up.
Press table set up.
- Student check

7:30 AM Live Truck parking.

8:30 AM Attendee registration begins. (22nd Street Entrance)

-Give name tags and information packet.

-Panelists & speakers directed to North Gym (Level 2) for 9:00 AM briefing.

-Foundation guests directed to Green Room.

9:30 AM Panelists & speakers briefed in North Gym
Briefing conducted by Dr. Schroeder & Nancy Kaufman.
Ken Bode should be introduced to panelists & speakers.

Briefing consists of review of site diagram and event, format, suggested tips: (be concise, keep remarks brief, stick to the topic, don't be afraid to disagree.)

9:45 AM Secretary Shalala and Mrs. Gore arrive GWU's Smith Center and proceed to holding rooms (219, 218) Meet with Dr. Schroeder, Ken Bodeand Nancy Kaufman to review agenda, list of panelists & speakers, logistics, etc.

9:50AM Panelists & Speakers escorted from North Gym to reserved seating area (stage right) by Elizabeth Appel.

10:00 AM Official call time for Washington D.C. forum.

-Panel I proceeds to seats on stage. (see attached list)

-Panel II & III are seated in audience. (see attached list)

-Speakers are seated near speakers platform.

10:00 AM Secretary Shalala, Mrs. Gore and Dr. Schroeder proceed to stage and introduce themselves to panelists and speakers.

10:05AM Dr. Stephen Trachtenberg, President, GWU welcomes "Conversations on Health" to campus. (Trachtenberg will speak from in front of stage using hand held microphone.)

10:10 AM Welcome & Introductions Dr. Schroeder

- Introduce Secretary Shalala and Mrs. Gore

- Acknowledge special guests (Elected officials, Cabinet Secretaries, etc.)

- Acknowledge RWJ Board of Trustees.

- Congratulate GW Colonial Basketball team on making the Sweet 16 (Trachtneberg didn't go to Seattle for game because of his involvement with "Conversations on Health."

- Outline day's program -- Three Sections to end by 4:00pm.

  - Panel I: Peace of Mind
  - Panel II: Delivery System Realities
  - Panel III: Controlling Costs

- Explain that Conversations On Health is an RWJ event, and not a public hearing. In order to accomodate the overflow an additional room is available for viewing the conference.

- Ask that all comments be brief in order to hear from as many people as possible; Won't be able to hear from everyone today, but will try to talk with as many people as possible.

- Ask everyone that is unable to ask questions to leave questions or remarks in "Comments" box at back of room.

- Introduce Secretary Shalala for opening remarks.

10:15 AM Secretary Shalala opening remarks.

10:20AM Overview of U.S. Health Care System Dr. Schroeder
Introduce Ken Bode, Senior Correspondent, CNN and Director, Center for Contemporary Media DePauw University.

10:30AM Discussion of Forum Groundrules Ken Bode

- Review format and length of each panel

- Speaker presentations will be followed by panel & audience discussion period.

- Encourage panelists to disagree with each other.

Part I - PEACE OF MIND

10:35 AM Short overview introducing 2 speakers. Dr. Schroeder
(More information on each speaker is available for review in press and attendee packets.)

10:38 AM Frances Hightower, Tallahassee, FL.

10:43 AM Jeffrey Heath, New York, NY
(Management Recruiters, Inc.)

10:48 AM Discussion period begins Ken Bode

- Thank speakers.

- Begin discussion period by directing question to panelist regarding issue related to speakers presentation.

- Proceed to direct discussion period.
(Discussion bounces between panelist & audience.)

- 5 people will be in audience with hand held microphones ready to reach people Bode directs questions to in audience.

- Look for cue from Nancy Kaufman to end discussion period. (Nancy will be seated in front row center.)

11:55 AM End discussion — Ken Bode
Deliver summary — Schroeder

12:00 PM Lunch

- Announce that Box Lunches are available in back of room for all guests. Guests should bring box lunches back to seats.

- Secretary Shalala, Mrs. Gore, Dr. Schroeder, Ken Bode, trustees and other invited guests proceed to green room (lower level).

12:55PM Panel II proceeds to stage

- Secretary Shalala, Mrs. Gore, Ken Bode, Dr. Schroeder proceed to stage.

PART II DELIVERY SYSTEM REALITIES

1:00PM Dr. Schroeder calls session to order. Introduce panel topic and first two speakers.

1:05PM Dr. Joseph Von Thron, Cocoa Beach, FL

1:10PM Fritz Wenzl, Marshfield, WI
(Executive Director Marshfield Clinic)

1:15 PM Discussion period begins — Ken Bode

- Direct first question.

- Lead panel/audience discussion.

2:20PM Look for cue from Nancy Kaufman to end discussion (Bode)

2:21PM Summarize Session (Dr. Schroeder)

2:25pm Break

Part III CONTROLLING COSTS

2:35 PM Call session to order, Dr. Schroeder to intro duce session entitled "Controlling Costs".

- Introduce speakers one and then two.

2:40 PM Richard O'Brien, Detroit, MI
(Vice President Corporate Personnel, General Motors)

2:45 PM Thomas W. Chapman, Washington, DC
(President & CEO Greater Southeast Health Care System)

2:50 PM Begin discussion period. Ken Bode

3:50 PM Lood for cue from Nancy Kaufman to end Discussion period ends Ken Bode

3:50 PM Ken Bode does overview of what we've heard during the day.

3:53PM Dr. Schroeder asks Secretary Shalala for Closing remarks.

3:55PM Dr. Schroeder asks Mrs. Gore for closing remarks.

3:57PM Dr. Schroeder gives closing remarks following Secretary Shalala.

4:00 PM Adjourn

4:10 PM Dr. Schroeder, Secretary Shalala, Mrs. Gore and Ken Bode stay on stage area for interviews.

4:20 PM Secretary Shalala and traveling party proceed to motorcade for departure.

4:30 PM Breakdown of room begins

HEALTH CARE TALKING POINTS

Summary

- Americans are getting killed by skyrocketing health care costs. What you're charged for health care is rising four times faster than your wages. That doesn't make sense -- and it threatens your family's future and the future of every business, large and small.

- President Clinton is committed to fundamentally reforming our nation's health care system. The Clinton plan will control your health care costs and provide security to every American family. We will preserve what is best in the American system -- the highest quality medical care in the world and the individual's right to choose a doctor.

- Within days of taking office, President Clinton established the Task Force on National Health Care Reform, chaired by First Lady Hillary Rodham Clinton, to develop a comprehensive health care reform proposal. Hundreds of health care experts -- doctors, nurses, professors and businesspeople -- have been brought in from around the country to work with officials from government agencies and White House staff in a series of policy working groups that have been set up to advise the Task Force. In addition, diverse panels of consumers and health care professionals will be brought in regularly to advise the working groups as they develop their recommendations.

- Powerful lobbies and special interests are already lining up to defeat any plan we develop. They oppose change because they profit from the waste and inefficiency of today's system. But we are committed to breaking the gridlock.

- The American people demand and deserve change now. Washington can delay no longer. Interest groups can obstruct us no longer. Without immediate reform, the annual cost of health care for American families will more than double by the end of the decade -- to a whopping $14,000 per family -- while workers will lose an anticipated $650 increase in their incomes.

- It won't be easy and it won't happen overnight. But we will stand with you and take on the special interests. No American will feel secure again unless we bring health care costs under control now -- and make it possible for your family to get ahead again.

Goals

The Clinton health reform proposal will:

- Control the rapid spiralling of your health care costs.
- Provide security and peace of mind, so that you don't have to worry about losing your insurance when you change jobs or being denied coverage because you're sick.
- Root out fraud and overcharges.
- Simplify the system and reduce paperwork.
- Maintain the highest quality medical care in the world and preserve your health care choices.

PHOTOCOPY PRESERVATION

STATEMENT OF PURPOSE

As the largest philanthropy in the nation devoted exclusively to supporting projects in health care, The Robert Wood Johnson Foundation has been involved over the past 20 years in seeking to improve the health and health care of all Americans, committing more than $1.3 billion during that period.

We come to these sessions with no preconceived notions on solutions (indeed, it would be premature to focus on solutions today) and with no illusions that the problems are simple ones or will have simple solutions. The Foundation's sole objective in these next few weeks is education: of ourselves, our policymakers at all levels of responsibility, and, most importantly, the American people.

If the experience of the Foundation over the last 20 years has taught us anything, it is that the problems facing the American health care system can best be addressed by a fully informed citizenry determined to work together to see that the wonders of American medicine, the envy of the world, are available to all.

PHOTOCOPY
PRESERVATION

CONVERSATIONS ON HEALTH

March 26, 1993
Washington, DC

PART 1: PEACE OF MIND

SPEAKERS

Frances Hightower
Tallahassee, Florida

Jeffrey A. Heath
President
Management Recruiters
New York, New York

PANELISTS

Virginia Trotter Betts, JD, MSN, RN
President
American Nurses Association
Washington, DC

Marca Bristo
Access Living
Chicago, Illinois

Lovola Burgess
President
American Association of Retired Persons
Washington, DC

Becky Cain
President
League of Women Voters of the U.S.
Washington, DC

John Clowe, M.D.
President
American Medical Association
Chicago, Illinois

Kathleen Diamond
Founder and Executive Director
Language Learning Enterprises, Inc.
Washington, DC

Barbara Garcia
Executive Director
Salud Para La Gente
COSSMHO Board of Directors
Watsonville, California

Jack Harris, D.D.S.
President
American Dental Association
Washington, DC

Robert E. Patricelli
Chair, Health and Employee Benefits Committee
U.S. Chamber of Commerce
Avon, Connecticut

Senator Cindy Resnick
National Conference of State Legislatures
Arizona State Senate
Phoenix, Arizona

John Sweeney
President
Service Employees International Union

SPEAKER PROFILES

PANEL I: PEACE OF MIND

Frances Hightower

Frances Hightower is a 59-year-old resident of Tallahassee facing many dilemmas common to Americans taking care of elderly parents. Over the past decade, her family's medical problems have had a dramatic effect on her life, as she has had to give up her career, move, and mortgage her, her brother's, and her family's homes.

Her 85 year-old mother suffers from Alzheimer's disease and other related disorders. She is incontinent and unable to bathe, eat, or transfer without assistance. Her 86-year old father was attacked in his home last year by an intruder, suffering a concussion from which he has never fully recovered. The resulting, persistent vision problems, dizziness, vertigo and other physical ailments leave him ill-equipped to care for himself or his wife. Ms. Hightower's 62-year old brother, a diabetic who suffers from mental retardation, also lives with her parents.

The financial strains of caring for her mother have been immense. Her mother's condition does not meet the criteria to qualify for Medicare "skilled" nursing home care, and her monthly income of $1337, from state retirement and social security, puts her over the income bracket to qualify for Medicaid by just a few dollars.

In 1992, Ms. Hightower's hopes were raised when the State of Florida's Eldercare program began providing 35 hours a week of personal assistance for her mother a week through a Nursing Home Diversion Program. However, the number of hours of care was reduced to 20 in September due to budget cuts, and, soon, because the program is being moved under Medicaid, she will no longer be eligible for care through this program at all.

Last year, Ms. Hightower spent more than $20,000 on caregivers for her family, including someone to live with her parents. The money she collected from mortgaging the family's homes can only be stretched for a few more months, yet while her funds are diminishing, her family's needs will only continue to grow. She cannot afford to place them in nursing homes, but she will not be able to keep them in their own home for much longer.

As devastating to Ms. Hightower as the cost is the amount of time and energy she has had to devote to her parents' care. In 1983, she left her job in Washington as Staff Director at the National Academy of Sciences and now works as a public information specialist at the Department of Professional Regulation in Florida. Currently, her life revolves around caring for them or paying for their care. She spends 20 to 30 hours a week engaged in such tasks as, paper work, arranging or accompanying her parents on

doctor's visits, dealing with insurance or health care providers, or monitoring her parent's medication. It is a constant job, and yet, according to Ms. Hightower, she still always feels like her efforts are inadequate.

As she faces the future, Ms. Hightower is very concerned, not only about her plight, but that of thousands of other caregivers who share similar emotional and financial burdens.

Jeffrey A. Heath, President, Management Recruiters

Jeffrey A. Heath is President of Management Recruiters, a Manhattan-based executive search firm. He has owned the business for twelve years, employing seven full-time and two part-time employees. The firm specializes in filling middle and upper level management positions.

The firm has always provided insurance for its employees, even though its premiums have risen 500 percent since 1981. However, in the face of New York State's community rating law, Mr. Heath's insurance carrier has notified him several weeks ago that they are terminating coverage effective April 1st. Since that time, Mr. Heath has been exploring possible alternative insurance coverage and has found that his family rates could cost $11,500 per year (up from $3500 under the current policy) and individual rates may rise as much as $2,400. Given these costs, the company is still uncertain how to provide coverage after April 1st.

Mr. Heath will discuss how, prior to five or six weeks ago, he shared a certain sense of complacency concerning his and his company's health insurance situation. As with many Americans, he took for granted many aspects of his health care situation, including the availability of insurance coverage. The termination notice, however, has forced him to spend enormous energy and time researching possible alternative coverage and has awaken him to the precarious insurance situation that many Americans face.

Mr. Heath is particularly concerned with the impact that the new community rating law in New York state will have on small businesses. As Mr. Heath points out, the only sector of the economy that has shown the ability to generate jobs recently is small business, and it is important to ensure that the burden of paying for health care reform does not fall disproportionately on their shoulders.

Mr. Heath is also concerned with the speed with which New York state's law went into effect and the limited amount of time that it allowed companies and insurance carriers to prepare for the changes it entailed. He is hopeful that any national reform will allow adequate time for businesses and individuals to plan and adjust their coverage.

AMERICAN NURSES ASSOCIATION

REPRESENTS:	2.1 million registered nurses through its 53 constituent state and territorial associations and its more than 200,000 members.
MEMBERS:	The ANA is a professional association for nurses as well as the strongest labor union for the nursing profession.
TODAY'S SPEAKERS:	Virginia Trotter Betts, President
SCOPE OF INFLUENCE:	Effective lobbyist on nursing issues, strong grass roots efforts at both the Federal and state levels, and ability to mobilize quickly, forefront on political and legislative issues.
APPROACH TO REFORM:	Committed to our plan
SUMMARY OF POSITION:	The ANA supports health care system that assures access, quality and services at affordable cost. The financing mechanisms must be employer based with minimal co-payments. The benefit package must provide prevention, health screening, extended and long term care, and mental health benefits. Nurses want to be "empowered." Believe they need to be protected in managed competition system.
POSITION ON PLAN:	Supportive
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Mrs. Clinton, Alexis Herman, Office of Public Liaison
PET ISSUES:	Access, wellness and care, empowerment
HOT ISSUES:	

mbb 3/25

Virginia Trotter Betts, J.D., M.S.N., R.N., President, American Nurses Association

Virginia Trotter Betts is the current President of the American Nurses Association (ANA), the nation's leading professional organization representing the major health care, practice, and work place issues of the nation's two million registered nurses. Mrs. Betts is a nurse attorney on sabbatical from her position as a senior research fellow at the Vanderbilt Institute for Public Policy Studies while she serves in her position as president of ANA. She is the president and CEO of HealthFutures, a health and nursing consulting firm specializing in utilizing nurses to address the complex issues inherent in the health care delivery system, and she is the past president of the Tennessee Nurses Association.

In her 20 year career as a professional nurse, Mrs. Betts has worked as a staff nurse, a clinical specialist in psychiatric mental health nursing, an administrator, a researcher, a policy analyst, a nurse attorney, a consultant, and an entrepreneur. Mrs. Betts has completed Postdoctoral Studies in Health Policy at the Institute of Medicine at the National Academy of Sciences as a Robert Wood Johnson Health Policy Fellow.

CONSORTIUM OF CITIZENS WITH DISABILITIES

MEMBERS:	Coalition comprised of over 75 consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities and their families. Over 42 national organizations are members of CCD's Health Task Force including may disease organizations.
TODAY'S SPEAKER:	Don Smith, Parent Advocate Marca Bristo, President and CEO, Access Living
REPRESENTS:	The Consortium represents more than 43 million Americans with disabilities include individuals with physical and mental impairments, conditions, or disorders, severe acute or chronic illness which limit or impede their ability to function.
SCOPE OF INFLUENCE:	Significant grassroots potential
APPROACH TO REFORM:	Non specific. Some constituent members back single payer approach.
SUMMARY OF POSITION:	Acute care benefit should be comprehensive and include long-term care services. Significant concerns regarding the responsiveness of managed care to people with disabilities. Reform must ensure non-discrimination and fully participation by people with disabilities, appropriateness of available services (particularly for younger disabled individuals) and equal access to health services.
POSITION ON PLAN:	Wants to be a part of the discussion and a player in health care reform.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Transition, OPL, Shalala
PET ISSUES:	Comprehensive benefit package, Long-term Care
HOT ISSUE:	Non-discrimination of benefits, Special needs of population

Marca Bristo, Consortium for Citizens with Disabilities, President and Chief Executive Officer, Access Living

Ms. Marca Bristo is the President and Chief Executive Officer of Access Living and is a nationally recognized leader in the disability rights movement. In 1979, she helped to found Access Living as Chicago's only non-residential independent living program for people with disabilities.

Ms. Bristo became disabled in 1977 when she suffered a spinal cord injury as the result of a diving accident. She is past president of the National Council on Independent Living (NCIL), which she co-founded, and served on the congressionally appointed Task Force on the Rights and Empowerment of Americans with Disabilities, which crafted the ADA. Ms. Bristo chairs the Illinois Public Action Council board,
is a board member of both the Rehabilitation Institute and Donors Forum of Chicago. She is co-chair for the Campaign for Better Health Care in Illinois, and a 1991-1992 participant in Leadership Greater Chicago. Ms. Bristo holds two degrees: a bachelor of arts in sociology from Beloit College, and a bachelor of science in nursing from Rush College of Nursing.

AMERICAN ASSOCIATION OF RETIRED PERSONS

MEMBERS:	34 million Americans over age 50.
REPRESENTS:	Provides legislative advocacy, research, information programs and community services as well as providing such membership benefits as mail order prescription drugs, supplemental insurance policies and travel discounts. Has chapters in all 50 states.
TODAY'S SPEAKER:	Lavola Burgess, President
SCOPE OF INFLUENCE:	Has financial strength, huge membership base, influential in media and on hill (although damaged somewhat by their strong backing of catastrophic). Lack of unifying principles of membership undermines their effectiveness.
APPROACH TO REFORM:	Blended approach of single payer, employer based and tax incentives. Remain open.
SUMMARY OF POSITION:	Four goals for reform: universal access to affordable quality health care and long-term care, system-wide cost containment, prescription drugs, and fair and affordable financing. Benefits package should include preventive, primary, acute, transitional and long term care. Cost containment through global budget.
POSITION ON PLAN:	Open to Administration plan, as long as comprehensive.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Transition, OPL, Ira Magaziner, President Clinton
HOT ISSUES:	Long term care and prescription drugs, seniors bearing financial burden without added benefits.

Lovola West Burgess, President, American Association of Retired Persons

Lovola West Burgess of Albuquerque, New Mexico, is the current President of the American Association of Retired Persons (AARP), a national organization representing persons 50 years of age or older. In addition to her responsibilities as AARP president, Ms. Burgess serves as Chair of the AARP Andrus Foundation's Board of Trustees. She also represents AARP on the Medicine-Business Coalition of New Mexico, and served on the Policy Advisory Committee of the New Mexico State Agency on Aging. Until recently, she represented the Association on the Governor's Health Care Cost and Access Commission and the New Mexico Medicaid Advisory Committee.

A native of Clarksville, Iowa, Mrs. Burgess has been a teacher of English and journalism in Iowa schools and also has worked as a reporter on local newspapers.

LEAGUE OF WOMEN VOTERS

MEMBERS: LVW's membership includes just under 100,000 members (male & female).

REPRESENTS: LWV's primary constituency is female voters within the United States. There is a state league in every state. Additionally, they have approximately 1042 local leagues.

TODAY'S SPEAKER: Becky Cain, President

SCOPE OF INFLUENCE: The Voter, LWV's quarterly publication, is sent to approximately 125,000 individuals, including members and donors.

APPROACH TO REFORM: Flexible if universal.

SUMMARY OF POSITIONS: Primary goals are universal access and cost containment. A basic level of care should be provided including disease prevention; health promotion and education; primary care, including prenatal and reproductive care; acute care; long term care; and, mental health care.

Reform should include reduction of administrative costs, regional planning with regards to allocation of personnel, facilities, and equipment; use of managed care; malpractice reform; and, consumer accountability.

Opposed to any reform that is based solely on a market based plan.

Increased taxes to finance a basic level of health care acceptable.

POSITION ON PLAN: Supportive, wait and see.

INTERACTION W/ TASK FORCE AND WORKING GROUPS: Transition, requested meeting with Administration, not yet scheduled

LWV's President, Becky Cain, met with Judy Feder during the Transition. More recently, they have been attempting to schedule a meeting for Cain with Administration officials.

	Carol Rasco invited to speak at Health Care Conference on May 17th in Washington, D.C.
PET ISSUE:	Universal access, cost containment
HOT ISSUE:	They are opposed to reforms based solely on a private market model without any government intervention.

Becky Cain, President, League of Women Voters

Becky Cain, a native of West Virginia, was elected to a two-year term as President of the League of Women Voters in June of 1992. She has served on boards and won accolades in a variety of public service areas, including the environment, education and women's issues. In 1992, she received a statewide award recognizing her leadership abilities in activities contributing to the advancement of women. She is a member of the West Virginia Election Commission and of the advisory board to the Center for Environmental Learning. She is also a member of the American Bar Association's National Advisory Commission on Election Law.

AMERICAN MEDICAL ASSOCIATION (AMA)

MEMBERS:	Approximately 300,000 physician members
REPRESENTS:	Federation of 50 state medical associations and the District of Columbia, county, metropolitan societies and over 80 national medical specialty societies
TODAY'S SPEAKER:	John Clowe, M.D.
SCOPE OF INFLUENCE:	Influential with Congress; large campaign contributors; able to generate significant press coverage; major grassroots network
APPROACH TO REFORM:	Universal employer mandate with Medicaid reforms
SUMMARY OF POSITION:	Universal access to care through an employer mandate and Medicaid reform, insurance market reforms, particularly community rating, and elimination of preexisting condition restrictions. Want the right for organized medicine to negotiate with federal agencies and regulatory programs and at the local level with managed competition entities. Want professional liability reform; freedom of patients to choose their physician and system of health care delivery; quality assurance through practice parameters and outcomes research; administrative cost reduction; establishment at the federal level of a minimum benefits package (with repeal of state mandates); and decreased regulation.
POSITION ON PLAN:	Considering
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Transition, Secretary Shalala, Ira Magaziner, OPL, Workgroup members. Vice President Gore and Sec. Shalala addressed Annual Meeting.
PET ISSUES:	Malpractice reform, administrative simplification
HOT BUTTON ISSUES:	Cost and Price controls, Restricted physician choice, Loss of professional autonomy

John Lee Clowe, M.D., President, American Medical Association

Dr. Clowe, a family practitioner from Schenectady, New York, became president of AMA in June 1992. Dr. Clowe began his service to organized medicine in 1963 as a delegate to the Medical Society of the State of New York from Schenectady County and is a past president of that society.

A member of the Board of Directors of the New York Political Action Committee, Dr. Clowe also serves on the Executive Committee of the Medical Liability Mutual Insurance Company. Dr. Clowe, past president of the American Academy of Family Physicians, Schenectady County, is the diplomate of the American Board of Family Practice and a charter fellow and member of the American Academy of Family Physicians. He is also an attending physician in family practice at St. Clare's and Ellis Hospitals in Schenectady, an attending and an associate in medicine at the Albany Medical College in Albany. He served as chief school physician of the city of Schenectady and as health officer of the town of Niskayuna.

Kathleen Diamond, Founder and Executive Director, Language Learning Enterprises, Inc.

Ms. Diamond, formerly a foreign language teacher, founded Language Learning Enterprises (LLE), which provides foreign language training, translation, and/or interpreters in 1979. It began as a very small, home-based company with one full-time employee and five part-time teachers, LLE and has grown to a staff of six full-time staff and over two hundred full to part-time employees. Ms. Diamond has struggled to provide health insurance coverage for her employees at reasonable cost. After attempting to develop a fair plan with 12 different insurers, Ms. Diamond ultimately designed her own method of covering her full-time employees. A monthly stipend is available to all full-time staff to go towards paying for coverage, be it through a spouse or other non-employement based health insurance.

NATIONAL COALITION OF HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATIONS [COSSMHO]

MEMBERS:	350 Hispanic community based organizations and 1,000 individuals.
REPRESENTS:	350 Hispanic community based organizations, organized in thirty-five regional health coalitions, and 1,000 individuals who are providers of health and human services to Hispanic communities.
TODAY'S SPEAKER:	Barbara Garcia, Executive Director of *Salud Para La Gente*
SCOPE OF INFLUENCE:	Primary mission of 30 year old organization is be national action forum to improve health and well-being of Hispanic communities. Has an annual budget of $3.9 million -- 47% from HHS grants, 24% foundation funds, and 29% corporate and other funding.
APPROACH TO REFORM:	Managed competition
SUMMARY OF POSITION:	Access for all; Mental health and prevention services (to be mandated of insurers too); Elimination of "pre-existing" condition" insurance clauses; Portability of insurance benefits; Choice of provider; Bilingual consumer information that includes quality measures; Cultural and linguistic competency standards for providers and institutions Vocal supporter of $2/pack cigarette tax; refuses funding from tobacco/cigarette companies.
POSITION ON PLAN:	Supportive depending upon degree of consumer choice for both provider and plan.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Transition; Working Group for Underserved
PET ISSUES:	Consumer choice (provider, plan); Provision of Consumer Information; Pharmaceuticals
HOT ISSUE:	The exclusion of Hispanic-sensitive objectives and Hispanic-specific provisions in federal programs.

AMERICAN DENTAL ASSOCIATION

REPRESENTS: The American Dental Association (ADA) represents a total of 139,620 dentists, with 73% of U.S. dentists members of the ADA.

MEMBERS: Members of the ADA are represented in every community across the United States.

TODAY'S SPEAKER: Dr. Jack Harris, President

SCOPE OF INFLUENCE: grass roots, active, strong advocacy

APPROACH TO REFORM: Noncommittal

SUMMARY OF POSITION: The primary criteria for the ADA is universal access and inclusion of dental benefits in the core package. Their financial package is employer based, provides coverage for indigents, small employer relief through HIPCS and risk reinsurance pools, and co-payments. The ADA is for the protection of all working people from financial ruin as a result of illness, education services and access to preventive dental services for children.

The ADA believes dental services are not a cost problem.

POSITION ON PLAN: wait and see

INTERACTION W/ TASK FORCE AND WORKING GROUPS: Transition, Workgroup Members, OPL

PET ISSUES: Inclusion of dental services in the benefits package

mbb 3/25

Jack H. Harris, D.D.S., President, American Dental Association

Dr. Jack H. Harris lives in Pearland, Texas and practices periodontics in Houston. He has served for six years as President of the American Dental Association. His numerous other past positions with the ADA include serving on the Quality Assurance Committee and a committee to develop policy on HIV infection. He is a past president of the Texas Dental Association and has been a member of the Texas House of Representatives since 1985.

U.S. CHAMBER OF COMMERCE

MEMBERS:	215,000 businesses and organiztions
REPRESENTS:	The U.S. Chamber of Commerce is the largest organization of businesses. Over 90 percent of Chamber members have less than 100 employees.
TODAY'S SPEAKER:	Robert E. Patricelli, President and CEO of Value Health, Inc.
SCOPE OF INFLUENCE:	Strong Grassroots network, influential with Congress
APPROACH TO REFORM:	Managed Competition
SUMMARY OF POSITION:	The Chamber's "Guidelines for Health Care Reform" support: employer "contributions" only if there is an appropriate subsidy for low-wage workers and their employers; comprehensive managed competition strategies, covering both private and public programs; national core benefits package, stressing individual cost sharing; regional purchasing groups for small businesses and individuals, with flexibility to allow business coalitions to serve this function and insurance market reform; and cost containment to limit cost increases to the growth of GNP. Limit tax deductibilty of premiums for employees (but not for employers). HIPC participationlimited to firms of no more than 100 employees.
POSITION ON PLAN:	While not fully supportive, they have not been overly antagonistic toward the Administration. However, already concerned about increased taxes in the President's economic package.
INTERACTION W/ TASK FORCE:	Transition, Ira Magaizner
HOT ISSUES:	Mandate without subsidy; Undercutting self-insurance option; Destructive regulation of premiums; Scale, timing, and tax--look at in context of whole economic package.

Robert E. Patricelli, Chairman, U.S. Chamber of Commerce Health and Employee Benefits Committee

Robert E. Patricelli is a member of the board of directors of the U.S. Chamber of Commerce and chair of its Health and Employee Benefits Committee. He is President and CEO of Value Health, Inc., one of the nation's leading providers of specialty managed health care services in such areas as mental health, substance abuse and prescription drugs. From 1977 to 1987, Mr. Patricelli served in a variety of positions in Connecticut General Corporation and its successor, CIGNA, most recently as executive vice president of the parent company and president of its $1 billion health care group. He has also held numerous positions in the federal government at a U.S. Senate subcommittee, the Department of Health, Education, and Welfare, and the U.S. Mass Transportation Administration.

National Conference of State Legislatures ("NCSL")

REPRESENTS: Legislatures of 50 states, territories & possessions

MEMBERS: 7400 individual state legislators and staff

DISTRIBUTION: all 50 states, Guam, Puerto Rico, American Samoa, Mariana Islands, Virgin Islands

SCOPE OF INFLUENCE: NCSL has a well organized bipartisan membership; it is very influential in state legislation and reform policy; its lobbying arm represents interests of state legislatures before Congress and Administration.

APPROACH TO REFORM: managed competition/HIPC model

SUMMARY OF POSITION: supports universal coverage; encouragement of purchasing cooperatives; establishment of minimum benefit package with emphasis on preventive and primary care; national health care budget; state regulation of allocation of technology; administrative simplification; malpractice reform

POSITION ON PLAN: very supportive, with two exceptions:

(1) NCSL stopped short of endorsing "managed care" because of concerns by rural legislators and inner city legislators about the possibility (impossibility?) of managed care working in underserved areas; and

(2) NCSL feels that the federal government should develop an expedited waiver process by which states can receive waivers (for 3 - 4 years) of requirements under Medicaid, Medicare, ERISA and other federal laws to implement state enacted programs that expand access to health care.

INTERACTION W/ TASK FORCE AND WORKING GROUPS: NCSL representatives have met with the Intergovernmental Affairs Office to receive a briefing on the Task Force; Ira Magaziner addressed 150 NCSL leaders on March 11; four state legislators and seven legislative staff members have been added to working groups.

Senator Cindy Resnick

Senator Cindy Resnick is currently the Arizona State Senate Minority Leader, the first woman to serve in this position in Arizona history. Elected to the Arizona Senate in 1990, she was Chairman of the Senate Health, Welfare and Aging Committee and Vice Chairman of the Commerce, Labor Banking and Insurance Committee. Senator Resnick previously served four terms in the Arizona House of Representatives.

Senator Resnick is the acknowledged legislative expert on Arizona's Medicaid demonstration program, AHCCCS. Since 1983, she has helped guide the development of its managed care component and pushed to expand coverage to pregnant women and children. She is currently spearheading a legislative effort to bring universal access to health services.

In 1992, Senator Resnick was selected to serve as Chairman of the Health Committee for the National Conference of State Legislatures (NCSL), following a one-year term as Vice Chairman. NCSL is the national organization representing the interests of all fifty state legislatures, and it is Senator Resnick's responsibility to develop and guide policy on health-related issues and to lead lobbying efforts for states interests in Congress.

SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU)

MEMBERS:	More than one million members in U.S., Canada, and Puerto Rico
REPRESENTS:	Public employees make up one-half of membership. With more than 400,000 members working in hospitals, nursing homes, and HMOs, largest union of health care workers.
TODAY'S SPEAKER:	John J. Sweeney, President (See attached biography)
SCOPE OF INFLUENCE:	Large, fairly influential. Largest union is in California.
APPROACH TO REFORM:	Support establishment of purchasing cooperatives
SUMMARY OF POSITION:	Same as AFL-CIO (Support universal access through regional purchasing and delivery system with enforceable budget. Community rating for all. Consumer choice among plans. Quality assurance system including development of practice guidelines, health outcomes research and technology assessment)
POSITION ON PLAN:	Supportive, assuming key concerns addressed plans.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Transition, Mrs. Clinton, Ira Magaziner
HOT BUTTON ISSUES:	No employer opt out of HIPC; no taxation of employer-provided benefits

MBB 3/25

John J. Sweeney, President, Service Employees International Union, AFL-CIO

John J. Sweeney has been President of SEIU since 1980, representing a wide variety of blue collar, clerical, and professional workers in the public sector. SEIU's membership includes people working in health care, building maintenance and light industrial jobs. With the affiliation of the 50,000 member National Hospital Union, SEIU is now the largest health care union in the AFL-CIO. Sweeney is also a Vice President of the AFL-CIO, and chairs the Health Care Committee. He is also a member of the National Leadership Commission on Health Care.

PEACE OF MIND

Message: The Clinton Administration's reform proposal will provide security and peace of mind, so that you don't have to worry about losing your insurance when you change jobs or being denied coverage because you're sick. We must **act now** to provide the peace of mind to all Americans who live in fear of losing their coverage. No American will feel secure again unless we bring costs under control -- and make it possible for families to get ahead again.

THE GROWING RANKS OF THE MIDDLE-CLASS UNINSURED:

- ♦ As costs continue to skyrocket, today's uninsured are increasingly working, middle-class families.
  - Over one million (1.067) of those who lost health insurance in 1991 were Americans earning between $25,000 and $49,000. [Himmelstein and Woolhandler, "The Growing Epidemic of Uninsurance", 12/92]
  - Seventy percent of the uninsured are above the poverty level. [OMB Director Darman, testimony to House Committee on Ways and Means, 10/91]
- ♦ Hundreds of thousands of Americans are losing their health care coverage each year.
  - 100,000 Americans move into the ranks of the uninsured each month. [Washington Post, 1/26/93]
- ♦ Those who still have insurance have seen their benefits cut.

MIDDLE CLASS FEAR LOSING INSURANCE:

- ♦ Millions more live in fear that tomorrow they will be uninsured or, worse yet, uninsurable.
  - 61 percent of Americans worry a great deal that health insurance will become too expensive for them to afford. 48 percent of Americans worry that benefits under their current health care plan will be cut back substantially. [Kaiser/Commonwealth/Harris, 4/92]
- ♦ And millions more Americans are afraid to change jobs for fear of losing coverage.
  - Thirty six percent of Americans earning between $30,000 and $50,000 reported that they or someone in their household stayed in jobs they wanted to leave because they were afraid of losing their health care coverage. ["Health Benefits Found to Deter Job Switching," New York Times, 9/26/91]

PRE-EXISTING CONDITION EXCLUSIONS:

- One of the most distressing flaws in our current system of health care is that **those in greatest need of care** are **least able to obtain it. Nowadays, insurance companies only provide insurance once they've made sure you don't need it.** We must demand that insurance companies change the underwriting practices which serve to avoid risk instead of provide insurance.

  - One in twenty Americans has been denied coverage for a pre-existing medical condition. [Kaiser/Commonwealth Harris, 4/92]

EMERGENCY ROOM CARE:

- In many cases, the emergency room, the most expensive care in the world, delivers the treatment of last resort for the uninsured. Here people do not receive primary care or preventive care. They become sicker and require even more expensive care in the future.

  - Forty-three percent of the 99 million patients seen in emergency rooms in 1990 had minor ailments that could have been treated elsewhere. [Robert Wood Johnson Foundation]

- Uncompensated care increases costs to an already overburdened system. The cost of uncompensated care is shifted to those who do have health insurance causing them to pay more.

CHILDREN: IMMUNIZATION AND PREVENTIVE CARE:

- Nationwide access to health care and immunization for infants and toddlers is a key goal of health reform.

  - **A child in Miami, who had contracted bacterial meningitis, incurred over $46,000 dollars in medical bills. The disease could have been prevented with a $21 inoculation.** [Robert Wood Johnson Foundation]

  - Preschoolers are less likely to be immunized for DPT and polio today than they were 20 years ago. [Robert Wood Johnson Foundation]

- Lack of insurance and access to primary care -- especially pre- and post-natal care -- leads to higher infant mortality and morbidity rates as well as high costs for preventable illnesses. We have to begin to refocus our health care system on preventing illness and injury rather than just on treating them.

Theme 1:

We need to make the U.S. health care system more responsive to the needs and preferences of the people it serves.

An estimated 43 million Americans, living in inner city and rural communities, remain seriously medically underserved because of special needs or circumstances.

> They are overwhelmingly poor or low income, and many are children or women of childbearing age.

> Many are uninsured, but 60% already have some form of insurance (principally Medicaid).

> Many live and work in areas with too few providers of care.

> Others face serious non-financial barriers to care (such as language, homelessness, or physical disabilities), or have complex health problems, or are undocumented immigrants.

> They frequently depend on hospitals and emergency rooms for even basic care, because of severe shortages of appropriate primary health care services in their communities.

Theme 2:

Basic health services are the right of every American. At present, this means everyone must have some kind of insurance coverage; instead, even people with coverage feel threatened by the potential loss of their health insurance.

Two out of every three workers indicate they would choose health benefits if they could choose only one employee benefit. Pension benefits came in a distant second place.

61% of Americans are concerned that health insurance will become so expensive that they won't be able to afford it.

Half of insured Americans are worried that benefits under their current health plan will be cut back substantially.

Nearly 22 million Americans said that they themselves, someone else in their family, or both, had been refused health care during the last year because they didn't have insurance or couldn't pay.

22% of the uninsured who said their health was fair or poor did not contact a physician in 1989.

Theme 3:

Higher taxes, higher insurance premiums, and higher medical bills are the price all of us pay because 35 million Americans don't have health insurance. The uninsured are everyone's problem.

In 1991, hospitals spent 6% of their gross revenue -- $13.5 billion -- on care that was not paid for (uncompensated care).

People who live in the nation's 2,147 "medically underserved" counties have higher mortality and morbidity than do the residents of better-served counties. For example, had the rates for various conditions been the same in underserved counties as in non-underserved counties, each year:

> 39,000 fewer infants would be born at low birthweight and

> 4,601 fewer infants would die. Also, we'd have:

-- 46,309 fewer cases of immunizable diseases -- a 96% drop nationally

-- 38,687 fewer cases of hepatitis -- a 40% drop

-- 46,817 fewer cases of tuberculosis -- a 56% drop

PRIMARY CARE

Theme 4:

Insurance systems should assure access to primary care as well as hospital care. Access to primary and preventive care can both improve health status and reduce total health costs.

Poor preschool children are five times more likely to be hospitalized with asthma and four times more likely to be hospitalized with a severe ear, nose, throat infection than non-poor children. Most of these hospitalizations could have been avoided if appropriate ambulatory care were available.

Theme 5:

The nation needs reorientation toward the prevention of disease, injury, disability, away from high-tech "fixes."

Preschoolers are less likely to be immunized for DPT and polio today than they were 20 years ago.

Some 500,000 premature deaths a year and $22 billion are directly attributable to cigarette smoking and other uses of tobacco.

In 1988, 100,000 deaths and $85.8 billion in health care costs were linked to abuse of alcohol.

Estimates are that 25 to 40% of patients in general hospital beds are being treated for complications of alcoholism.

Drug abuse cost the system $58.3 billion in 1988 for care, treatment, and rehabilitation, as well as for lost productivity and crime enforcement.

Street and domestic violence add $5.3 billion to U.S. health expenditures.

About 400,000 people die each year by not using life-saving technology such as seat belts and smoke detectors

Theme 6:

Universal access to immunizations for infants and toddlers is a key goal of health care reform. Immunization is crucial to maintaining children's health. And, universal access to immunization is a possible strategy for better linking very young children to the primary care system.

Theme 7:

Our health care system needs to assure that more primary care providers practice medicine in rural and low-income areas, to prevent reliance on hospital emergency rooms for routine care.

43% of the 99 million patients seen in emergency rooms in 1990 had minor ailments that could have been treated elsewhere.

CHRONIC

Theme 8:

Individuals of all ages with chronic health care problems should not have to bear the total costs of their health care. Insurance systems should not be designed to deny or discourage coverage for the chronically ill.

Nearly half of the chronically ill say that the expenses from their health problems pose a financial hardship on their family.

Theme 9:

Access to home care support services for the chronically ill is a growing problem. Social choices are necessary to decide how much the chronically ill must rely on informal care from friends and family and how much we are willing to spend to provide formal home care services.

Currently, access to formal services is very uneven across the country. Extending access to home care for all individuals with chronic illnesses would be very expensive.

More than a third of the chronically ill say that it is more effort to use services than they are worth.

Nearly one-quarter of the population is very involved with the care of a relative or close friend who is limited in major activity because of a chronic condition

Two-thirds of people who needed assistance in all activities of daily living received no paid assistance in 1989.

Aetna Life & Casualty has reported a $78,000 per case savings from its Individual Care Management Program by using home care for victims of catastrophic accidents.

Theme 10:

Many important aspects of "health" and "healing" relate to a person's environment and the supports found there, like housing, transportation, or social services. The medical care/health insurance system cannot provide all of these. Yet, the health care system must work effectively across social domains to improve health for all.

SATISFACTION AND AUTONOMY

Theme 11:

People often feel cut off from the decisions made about their care. Better quality health care -- and fewer malpractice suits -- depends in part on better communication between doctors and patients.

A survey of people residing in 10 countries found that Americans are the least satisfied with their health care system.

A third of Americans are "very satisfied" with the "quality of their own medical care" in 1990, down from half in 1973.

Only a quarter of Americans are "very satisfied" with their arrangement for paying for medical care, compared with 40% 20 years ago.

Theme 12:

People need skills to help them take more responsibility for their own health care, including self-care, to use the health care system appropriately, and to know what question to ask regarding plans for their own (or a family member's) care.

Theme 13:

Critically ill people sometimes get more care than they really want. We need to apply the full court press of medical technology much more sparingly -- only to people who want and can benefit from it.

28% of all Medicare expenditures are used in the last six months of life.

PATIENT CHOICE

Theme 14:

Many Americans may prefer expensive fee-for-service arrangements for medical care. The extra costs of fee-for-service medicine should be borne by the individuals who choose it.

Over 90% of surveyed HMO members were satisfied with their primary care physician, but they prefer to receive their care in a physician's private office than in a health center.

Theme 15:

People who join HMOs and other systems of managed care should have the right to change systems when dissatisfied. The ability to "vote with your feet" is crucial to maintaining quality and responsiveness.

Physicians affiliated with managed care systems are more likely to feel that they have the resources to treat patients than physicians working in other settings, but they are less likely to feel that they have control over their work schedule.

* What do Americans want from health care reform?

* Are Americans satisfied with their interactions with the health care system?

* Do hospital patients and their families believe anyone cares about or listens to their wishes?

* How do we get -- and keep -- Americans involved in health care reform, a domain so coveted by high-stakes special interest players?

* Who do we want to entrust our personal health care to? "Choice" is not just an economic issue.

* Should "advance directives" be required in every state at the time of hospital admission, if not before, so that critically and terminally ill people do not receive more care than they and their families want?

PHOTOCOPY
PRESERVATION

DELIVERY SYSTEM REALITIES

Message: As both patients and doctors spend more time **battling the bureaucracy** than they spend with one another, and **fewer family doctors** enter the profession, the long honored **doctor-patient relationship is being destroyed.** Our health reform plan will restore and protect this essential relationship -- so that doctors, not bureaucrats, make health care decisions -- as it also reduces paperwork and simplifies the health care delivery system.

- Doctors and patients alike are frustrated with a complicated, confusing, and heartless health care bureaucracy.

- Insurance company micromanaging, the "paper hospital," and the fear of malpractice suits has bred disenchantment and cynicism in a profession devoted to caring for people.

  - Forty percent of doctors tell pollsters that if they had to choose a career again, they would not enter medical school. [Barry Siegel, L.A. Times Magazine, "The Disappearing Doctor," 3/3/91]

- And the disfunctions of the current system have high costs. In 1992, Consumer Reports estimated that we would spend $200 billion -- nearly a quarter of total health care spending -- on overpriced, useless, even harmful treatments and bloated bureaucracy.

INSURANCE COMPANIES MICRO-MANAGE HEALTH CARE DECISIONS

- David Mechanic, Director of the Institute of Health Care at Rutgers, said of the current health care system: "In order to preserve the mirage of a private system, we have created the most bureaucratic, regulated system of any in the world."

- In our current system, bureaucrats -- not doctors -- decide what care a patient will receive. This insurance company micro-managing erodes a doctor's ability to properly care for a patient. Doctors feel a loss of professional autonomy in a system in which their professional opinion is supplanted by the insurance industry's desire to make a profit.

THE "PAPER HOSPITAL"

- Today's "paper hospital" -- the paperwork caused by the tangle of rules, restrictions, and hundreds of disparate claim forms which govern health insurance decisions -- is a nightmare to all who deal with it, patients and doctors alike.

  - Medical groups say every visit to the doctor generates at least 10 pieces of paper. [NYT, 3/27/91]

- U.S. doctors and hospitals fill out more than 400 varieties of the same form. [Washington Post, 1/3/93]

- Consumer Reports estimated that, in 1992, we wasted about $70 billion on administrative inefficiency and needless paperwork -- or roughly 10% of all health care spending that year. [Consumer Reports, 7/92]

♦ The added costs of administering this complex system waste doctors' time, add to health care expenses, and distract health providers from practicing medicine.

- The AMA estimates that the average doctor's office devotes 80 hours a month to pushing paper. [NYT, 3/27/91]

- Hospitals spend 20 percent of their budgets on billing administration -- compared to only 9 percent in Canada. [Consumer Reports, 7/92]

- To run a health plan covering 25 million people, Canada employs fewer administrators than Massachusetts Blue Cross, which covers 2.7 million. [Consumer Reports, 7/92]

MALPRACTICE LIABILITY

♦ The risk of malpractice suits compels some doctors to order hospitalizations, procedures, and tests which may be inappropriate and dangerous.

- It is estimated that more than 25 percent of U.S. babies are delivered by a Cesarean section -- twice the appropriate rate. [Consumer Reports, 7/92]

- It is estimated that 27 percent of hysterectomies, 20 percent of pacemaker implants, 32 percent of carotid enterectomies, and 14 percent of coronary artery bypasses are inappropriately performed. [GAO, 6/91]

♦ And added liability costs and unnecessary treatment add costs to the system.

- The American Medical Association estimates malpractice costs at $38 million ($10 billion in premiums, $28 billion in defensive medicine) -- about 4% of overall health spending.

  [**NOTE:** The AMA study and the concept that malpractice liability is a major cost-driver have both drawn criticism. HHS puts the cost of malpractice at less than 1 percent of total outlays.]

♦ However, experts stress that, savings notwithstanding, it is important to explore a **fairer and more effective system** for identifying, compensating, and deterring injury from medical malpractice.

THE DISAPPEARING FAMILY DOCTOR

- The declining number of family doctors and primary care physicians and the trend towards a physician work force dominated by specialists has detrimental effect on the health care delivery system.

- As a result, already underserved urban and rural areas continue to suffer shortages of general practitioners.

DOCTORS CHOOSE SPECIALIZED CARE OVER FAMILY PRACTICE

- Many doctors, facing heavy debts from medical school, are discouraged from becoming family doctors and primary care physicians.

  - Despite the lack of family practitioners and primary care doctors, **80% percent of new physicians are specialists.**

  - Graduating medical students, on average, have racked up $56,000 in debt and this amount frequently rises during low-paid residencies. [National Journal, 9/5/92]

  - The median income of a family practitioner is $93,000, but for anesthesiologists and surgeons the figure is $200,000. Cardiovascular surgeons in group practice in 1990 averaged about $500,000. [National Journal, 9/5/92; Medical Group Management Association Study]

- Even doctors acknowledge the problem. A 1991 editorial in the Annals of Internal Medicine said: "Given the number of subspecialists already in practice, there are not enough highly specialized cases to go around... We cannot continue to practice this way, when cost containment is the dominant health policy issue of our times."

UNDERSERVED AREAS SUFFER FROM LACK OF PRIMARY CARE

- Studies have found that generalists are far likelier to practice in rural and inner city areas -- places faced with chronic shortages of doctors. [National Journal, 9/5/92]

- Lack of primary care -- especially a lack of pre-natal and post-natal care -- leads to higher infant mortality and morbidity rates and higher costs for preventable illnesses in areas with acute shortages of family doctors.

CONVERSATIONS ON HEALTH

March 26, 1993
Washington, DC

PART 3: CONTROLLING COSTS

SPEAKERS

Richard F. O'Brien
Vice President
General Motors

Thomas Chapman
President
Greater Southeast Healthcare System
Washington, DC

PANELISTS

Joan Claybrook
President
Public Citizen
Washington, DC

Richard J. Davidson
President
American Hospital Association
Washington, DC

The Honorable James Florio
National Governors' Association
Governor, State of New Jersey

Rhoda Karpatkin
President
Consumers Union
Yonkers, New York

Brian Marcotte
Manager, Health Plan Contracts and Services
Marriott Corporation
Washington, DC

Mark Novitch, M.D.
Vice Chairman
The Upjohn Company
Kalamazoo, Michigan

Ian Rolland
Chairman and CEO
Lincoln National Corporation
Ft. Wayne, Maryland

Kate Villers
President
Families USA
Washington, DC
(pending)

Alexander J. Walt, M.B., Ch.B.
President
American Board of Medical Specialties
c/o Dept. of Surgery, Harper Hospital
Detroit, Michigan

Raul Yzaguirre
President
National Council of La Raza
Washington, DC

SPEAKER PROFILES

PANEL III: CONTROLLING COSTS

Richard F. O'Brien, Vice President, General Motors

Richard O'Brien was appointed vice president of General Motors Corporate Personnel in June of 1992. Prior to this, he was vice president of the Industrial Relations Staff and of Personnel Administration and Development. He is responsible for developing policies and administering GM's compensation planning and personnel departments, which includes responsibility for the corporation's health benefits policy.

Mr. O'Brien will be discussing the impact of the rising cost of health care on General Motors' finances and operations. GM is the largest single provider of health care in the private sector in this country, responsible for nearly 1.8 million employees, retirees and their family members. GM shares the concern of the country's large businesses that the increasing share of GNP taken up by health care is crowding out sales, investment and jobs in the non-health care sectors of the economy. They are also particularly worried about the discriminatory effect that health care costs have on companies with older workers and large numbers of retirees.

O'Brien will discuss how companies particularly feel the effects of these rising costs when competing in the international arena. For instance, when BMW opens a plant in Spartansburg, South Carolina, it has an automatic competitive advantage because of the differences in the health care structure between Germany and the United States. GM has no such advantage when it operates abroad. As an additional illustration of this competitive disadvantage, at its transmission plant in the Detroit area, health care costs exceed $5.00 per hour. Across the border at its transmission plant in Windsor, Canada, they are only $1.50 per hour -- or a difference of $7000 annually per employee. Health costs add $1400 per car to the cost of each automobile GM produces, as calculated under new accounting procedures effective this year.

The projected continued upward spiral of health costs is of utmost concern to G.M. If changes are not made in the health system, O'Brien projects that auto production in this country could decline by 800 to 900,000 units, costing as many as 120,000 jobs. The $300 billion (5 percent of GNP) projected increase in national health expenditures by the turn of the century is larger than the value of the annual contribution to GNP by the entire U.S. automobile industry.

These facts and figures demonstrate, according to O'Brien and numerous other representatives of corporate America, the need for immediate reform to preserve the ability of America's corporations to compete in today's global economy.

Thomas W. Chapman, President/CEO, Greater Southeast Healthcare System

Thomas Chapman has been president of the Greater Southeast Healthcare System (GSHS) since 1981. He was previously President of the Greater Southeast Community Hospital, a 450-bed urban hospital under the auspices of GSHS. His board memberships include the D.C. Hospital Association, of which he is immediate past chair; the Group Health Foundation Minority Training Program, where he is current chair; and The Healthcare Forum.

GSHS is the parent company for a network of hospitals, nursing homes, home care services, pharmacies, medical office buildings and community outreach programs in the Washington D.C. area. He has seen first hand the structural incentives to increase costs that are inherent in hospitals and other health delivery systems and he has direct experience with the difficulties involved in managing large, complex organizations.

Chapman believes there should be three primary focuses for reducing health care costs:

- o Reducing preventable and avoidable hospital admissions
- o Reducing extensive hospital-based speciality and high tech care
- o Refocusing existing and new resources on social and health care services stressing prevention

To achieve these goals, Chapman will discuss GSHS's philosophy that reform must take a long-term rather than the short-term view of health care and must effectively involve communities and citizens as partners. GSHS has implemented several community based programs that embody these principles effectively: (1) The Breast Cancer Screening Community Project which involves community based education, referral and mammography screening; (2) The Neighborhood Blood Pressure Screening and Education Project which for eight years has used 400 volunteers in churches, barbershops and other community organizations to screen community residents and refer those with high blood pressure for treatment; (3) The Serving Spoons Project, a volunteer-based program that provides nutrition and socialization to hospitalized frail elderly who would otherwise be in nursing homes.

Chapman believes that health reform must be community based and that strategies must be designed to reach beyond traditional health institutions to respond directly to the problems of the people who ultimately end up in the health care delivery system as expensive and difficult problems.

AMERICAN HOSPITAL ASSOCIATION

MEMBERS:	5,300 hospitals
REPRESENTS:	Umbrella organization for hospitals of all sizes and ownership types nationwide. It is the largest hospital trade association in the country.
TODAY'S SPEAKER:	Dick Davidson, President
SCOPE OF INFLUENCE:	Individual hospitals are major employers and therefore have substantial influence in districts.
APPROACH TO REFORM:	Support the development of health care networks based around hospitals. Very nervous.
SUMMARY OF POSITION:	Coverage through a core benefit package in a pay-or-play system. Delivery reform through community care networks similar to managed care. Concerned that managed competition will drive hospitals to be the lowest price vendor and threaten their mission orientation. Do not support a global budget but might support a "bottom up" budget through capitation of payments. Advocate antitrust reforms to permit easier coordination/collaboration between hospitals.
POSITION ON PLAN:	Their plan is similar in many ways to Administration plan. Supportive, wait and see.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Transition, OPL, Ira Magaziner
PET ISSUE:	Universal access
HOT ISSUE;	Cost controls which shift costs

Richard J. Davidson, President, American Hospital Association

Richard J. Davidson became President of the American Hospital Association in 1991, after 22 years as president of the Maryland Hospital Association. Davidson is actively involved with many local, state, and national health care policy committees, and he has served as a consultant to the Robert Wood Johnson Foundation and the Pew Memorial Trusts. Before joining the Maryland Hospital Association in 1969, he was director of education for the Maryland-D.C.-Delaware Hospital Association and was a secondary school teacher and principal.

GROUP:	National Governors Association ("NGA")
REPRESENTS:	Governors of the 50 states, American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the Virgin Islands
MEMBERS:	Governors of the 50 states, American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the Virgin Islands
DISTRIBUTION:	all 50 states, American Samoa, Guam, Northern Mariana Islands, Puerto Rico and the Virgin Islands
SCOPE OF INFLUENCE:	NGA represents the Nation's Governors collectively and in a bipartisan manner before Congress and the Administration.
APPROACH TO REFORM:	managed competition/HIPC model
SUMMARY OF POSITION:	NGA supports state-organized purchasing cooperatives; core benefits package; federal minimum tort reform standards; limitations on tax-deductibility of health insurance; single claim form/electronic billing; established goals for growth of national health care expenditures; annual report to the states by the federal government.
POSITION ON PLAN:	NGA supports the tenants of managed competition, but it has never taken a position on single-payor, play-or-pay, etc., or on any health care proposal of President Bush.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	The Governors (most but not all) had a three-hour meeting with the President at the White House on February 1 to discuss health care reform, and the following morning the President addressed them the at the Marriot Hotel. Four Governors work with the Task Force as NGA representatives: Governors Romer (D-Col), Campbell (R-SC), Dean (D-Vt) and Mickelson (R-SD). These Governors met with Mrs. Clinton on February 2 and March 3, and met with Ira Magaziner and Judy Fader on March 24.

GOVERNOR JIM FLORIO
New Jersey

Governor Jim Florio is the first-term Democratic Governor from New Jersey, and a former member of the U.S. House of Representatives. While in Congress he served on Rep. Waxman's (Energy and Commerce) Subcommittee on Health, and was active on health care issues.

NEW JERSEY BACKGROUND

The Pharmaceutical Industry:
New Jersey has the largest concentration of pharmaceutical companies in the United States.

- New Jersey is the home such industry giants as Merck, American Home Products, Bristol-Meyers-Squibb, Johnson & Johnson, and Schering-Plough.

- Over 70,000 New Jersey residents are employed in the drug industry.

Rate Regulation and Provider Taxes:
The state formerly had a very heavily regulated health care system, including a provider tax. However, the Court ruled against the State in a suit over the use of provider taxes. As a result, the legislature passed, and the Governor signed, a bill that called for major deregulation of the state health care system. Today, New Jersey no longer regulates the rates of hospitals or other providers, nor does it tax providers. The only major pieces of state regulatory apparatus that remain are professional licensure and Certificate of Need authority.

TODAY'S TESTIMONY

Governor Florio, testifying on behalf of the **National Governors Association**, is likely to make the following points:

- Systemic reform is needed, and the Administration and the Foundation should be encouraged in their efforts to improve health care for all Americans

- State flexibility will be important within the national framework, to allow states to build on their experiences and to adapt the program to best fit the needs of their state.

Testifying on behalf of his New Jersey constituency, he may mention Medicaid, and may -- sensitive to the concerns of the drug companies -- affirm that while everyone should to do their part, no single industry should bear undue burden in controlling costs.

CONSUMERS UNION

MEMBERS:	5 million members
REPRESENTS:	Non-profit organization established in 1936 to provide consumers with information and advice on goods, services, health and personal finance. Membership includes magazine subscribers in all 50 states. Advocacy offices in Washington D.C., Austin, TX and San Francisco, CA.
SCOPE OF INFLUENCE:	Readership among middle and upper middle class. Viewed as authority on value for the dollar. No real grassroots operation or cohesive grassroots constituency.
APPROACH TO REFORM:	Strong and historic single payer advocate
SUMMARY OF POSITION:	To meet needs of consumers, reform plan must provide universal quality health care regardless of age, income, employment or health status; contain costs with a national budget and administrative simplification; fair financing; public accountability and maintain consumer choice. Concerned that managed competition will not work to control costs and could lead to a multi-tier health system with restricted consumer choice and large out-of-pocket expenses. Reform plan should allow states sufficient flexibility to experiment with single-payer approach if they so desire.
POSITION ON PLAN:	Share President's objectives but not approach. Wait and See.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Transition, OPL
PET ISSUES:	Universal access, single system for all citizens
HOT ISSUE:	Inequity in system

Rhoda H. Karpatkin, President, Consumers Union of United States, Inc.

Rhoda H. Karpatkin is President of Consumers Union of Unites Stated, Inc., the nonprofit product-testing and consumer advisory organization that publishes Consumer Reports, a monthly magazine with over five million subscribers. Ms. Karpatkin joined Consumers Union in 1974. Since that time, CU's work has grown in many directions. CU has opened advocacy offices in San Francisco, California and Austin, Texas, and expanded its Washington office. Consumers Union's Consumer Policy Institute was founded for special research projects. Several new publications have been launched: Zillions for school-age children, Consumer Reports Travel Letter, and Consumer Reports on Health.

In 1986, Ms. Karpatkin renewed Consumers Union's concern with poverty-related issues. CU has been engaged in a number of projects related to health care, housing, financial and other issues affecting low-to-moderate income consumers.

Ms. Karpatkin is a graduate of Brooklyn College and Yale Law School. She had been Consumers Union's legal counsel for 16 years.

Brian Marcotte, Manager, Health Plan Contracts and Services, Marriott Corporation

Brian Marcotte is responsible for overseeing the medical cost management of Marriott's health plans for 84,000 covered employees at a cost approaching $200 million in 1992. Marriott's health plans include a point-of-service plan, several indemnity plans and 103 HMOs. Mr Marcotte came to Marriott in 1989 to manage the health plan contracts and assist in the selection of a vendor for its self-funded point-of-service plan. Prior to comming to Marriott, Mr. Marcotte was Director of Health Risk Management for Health Management Strategies, a subsidiary of Blue Cross/Blue Shield of the National Capital area.

PHARMACEUTICAL MANUFACTURERS ASSOCIATION

REPRESENTS: More than 100 firms that produce drugs in the U.S., including Mercke, Searle, Bristol-Myers Squibb, Pfizer, Inc. Is a nonprofit scientific and professional organization.

TODAY'S SPEAKER: Mark Novitch, M.D., Vice Chair, Upjohn Company

SCOPE OF INFLUENCE: Ability to mobilize quickly, powerful lobbyist, advocates for the drug manufacturing industry, effective grass roots, significant financial resources and substantial clout in Congress

APPROACH TO REFORM: Pro managed competition without price regulation

SUMMARY OF POSITION: The PMA Board supports a managed competition approach to comprehensive healthcare reform including the following.

- inclusion of prescription drugs
- prescription drug benefit to Medicare beneficiaries
- Medicare prescription drug coverage to at least 100% of poverty level.

In principle, managed competition is bad for them because of formulas, but this is much more preferrable than government rate regulations and, in combination with a new mandated drug coverage, they endorse this approach.

Support antitrust relief in order to negotiate with an industry trade group.

Oppose cost control package both in the short and long term. Want voluntary price controls.

POSITION ON PLAN: Supports Managed-competition approach to health care reform, but very nervous about what else will be in plan.

INTERACTION W/ TASK FORCE AND WORKING GROUPS: Ira Magaziner, Transition, Public Liaison, David Cutler of the Task Group

PET ISSUES: Prescription drug benefit, small business relief, managed care, utilization review, medication, voluntary price controls and competition.

HOT ISSUES: Drug price review board, national formula, cost control

mbb 3/25

Mark Novitch, M.D., Pharmaceutical Manufacturers Association, Vice Chairman, Upjohn Corporation

Dr. Mark Novitch, as Vice Chairman of the Board of Upjohn, is responsible for a number of divisions of the Kalamazoo-based pharmaceutical firm. He oversees pharmaceutical control, regulatory affairs, strategy and public relations. Prior to joining Upjohn in 1985, he was in the Food and Drug Administration, serving in numerous capacities including Acting Commissioner from September 1983 to July 1984.

HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA)

MEMBERS:	270 Members
REPRESENTS:	Trade association for nation's commerical health insurance companies.
TODAY'S SPEAKER:	Ian Rolland, Chair and CEO, Lincoln National Corporation
SCOPE OF INFLUENCE:	Gradison is well-liked, but have lost the 5 big insurers recently
APPROACH TO REFORM:	Support general managed competition framework
SUMMARY OF POSITION:	After regularly opposing any kind of comprehensive reform, now in a negotiating position. On access, would require employers to offer, but not pay for, a plan, and offer a payroll deduction so that employees can purchase the coverage. On cost containment, would require uniform rate setting for providers, but managed care should be primary vehicle for achieving sustained systemwide cost savings. Insurance reform, including no pre-exsisting condition limits. On HIPCs, HIAA likes existing association type schemes. Believes HIPCs should be tried but should compete against other pooling arangements. Want federal preemption of state anti-managed care laws. Support a tax cap. Opposed to global budgets.
POSITION ON PLAN:	Willing to work with us.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	Transition, Ira Magaziner, Workgroup members
HOT BUTTON ISSUES:	No monopoly power for HIPCs--allow employer opt-out; Extent of community rating mandated; caps on premiums; allow supplemental insurance

mbb 3/25

Ian M. Rolland, Chairman of the Board for Health Insurance Association of America; Chairman and CEO, Lincoln National Corporation

Ian M. Rolland is Chairman of the Board of Health Insurance Association of America, is chairman and chief executive officer of Lincoln National Corporation, a Fort Wayne, Indiana, insurance company. He also is the chairman and chief executive officer of the Lincoln National Life Insurance Company and a director of several Lincoln National affiliate companies, including American States Insurance Companies and Employers Health Insurance Company.

Mr. Rolland has served on boards of numerous professional organizations and is now Chairman of the Board for the Health Insurance Association of America (HIAA). HIAA is a Washington, D.C.-based trade association representing approximately 240 of the nation's leading commercial health insurance companies. He holds a bachelor of arts degree in mathematics and economics from DePauw University and a master's degree in actuarial science in 1956 from the University of Michigan.

FAMILIES USA

MEMBERS:	No number available.
REPRESENTS:	American families--Families USA, a liberal health care consumer advocacy group working for affordable, high-quality health care and long term care.
TODAY'S SPEAKER:	Kate Villers, Co-Founder
SCOPE OF INFLUENCE:	Combines sophisticated grassroots activism with media savvy. Reports well reported in Media and on Capitol Hill (effectively promotes agenda while maintaining non-partisan, quasi-academic stance). Active coalition builder
APPROACH FOR REFORM:	Solid support for Administration approach
SUMMARY OF POSITION:	•universal coverage •basic benefits comparable to those of most Americans •quality standards •cost-containment •long term care
POSITION ON PLAN:	Totally behind the Administration
INTERACTION W/ TASK GROUP:	Transition, Ira Magaziner, Office of Public Liaison
PET ISSUES:	•universal health coverage •quality care •long term care
HOT ISSUES:	

AMERICAN BOARD OF MEDICAL SPECIALTIES

MEMBERS:	600,000 practicing physicians, 435 board certified practicing physicians
REPRESENTS:	25 Boards including AMA, specialty societies, medical colleges. Certifies and approves the creation of new medical specialties.
TODAY'S SPEAKERS:	Alex J. Walt, M.D., President
SCOPE OF INFLUENCE:	Not significantly influential. Prohibited from lobbying.
APPROACH TO REFORM:	No stated approach, interested in process
SUMMARY OF POSITION:	Preserve standards of certification. However, accreditation and certification should not be used as gatekeepers to control specialty mix and geographic distribution of mix.
POSITION ON PLAN:	No position taken. Move away from specialties may be threatening.
INTERACTION W/ TASK FORCE AND WORKING GROUPS:	None
PET ISSUES:	Board certification and accreditation.

mbb 3/25

Alexander J. Walt, M.D., President, American Board of Medical Specialties

Dr. Alexander J. Walt, a surgeon, is President of the American Board of Medical Specialties, a federation of the 24 specialty boards responsible for evaluation and certification end certification of residents at the end of their graduate training programs. He is also Chairman of the Board of Regents of the American College of Surgeons. Dr. Walt is Director of the Comprehensive Breast Center of the Detroit Medical Center/Wayne State University and Professor of Surgery at Wayne State University. He has been a member of the university faculty since 1961 and served as chair of the department of surgery from 1965 to 1988. During these years, much of his professional work was carried out at the Detroit Receiving Hospital, an inner city trauma and emergency hospital serving primarily indigent patients.

Dr. Walt was born in Cape Town, South Africa, and served in World War II. He completed medical school after the war and completed post-graduate training in England and a surgical residency at the Mayo Clinic.

NATIONAL COUNCIL OF LA RAZA

MEMBERS: Umbrella organization for 150 affiliated Hispanic Community-based organizations.

REPRESENTS: Largest constituency-based national Hispanic organization which improves life opportunities for Hispanic Americans through applied research, policy analysis and advocacy, capacity building assistance for community organizations, public information and special projects. There programs reach over 2 million Hispanics annually.

TODAY'S SPEAKER: Raul Yzaguirre, President

SCOPE OF INFLUENCE:

APPROACH TO REFORM:

SUMMARY OF POSITION: Health care reform must address demographic and socioeconomic conditions of Hispanic Americans. Should reduce structural elements and policies that create barriers to access to both the private and public insurance systems for Hispanic Americans. Universal access is key but special outreach efforts are necessary to ensure real access for this population which often shies away from contact with official offices.

POSITION ON PLAN: Noncommittal

INTERACTION W/ TASK FORCE AND WORKING GROUPS: Transition

PET ISSUES: Universal access, Outreach to promote use of services

HOT ISSUE: One size fits all plan insensitive cultural and socioeconomic differences.

Raul Yzaguirre, Board Member, National Coalition of Hispanic Health and Human Services Organizations, President, National Council of La Raza

Raul Yzaguirre, President of National Council of La Raza, has been a national advocate for Hispanic Americans for over 35 years and has worked with the National Council of La Raza since 1974. He is an expert in the fields of civil rights, immigration, community development and the socioeconomic status of Hispanic Americans.

After serving in the U.S. Air Force Medical Corps, Mr. Yzaguirre founded NOMAS, the National Organizations for Mexican American Services in 1964. A grant to NOMAS from the Ford Foundation led to creation of what is now the National Council of La Raza (NCLR). An advocate for Hispanic Americans and a national umbrella organization for 150 formal affiliates, NCLR seeks to create opportunities and address problems of discrimination and poverty in the Hispanic community. Headquartered in Washington, DC., NCLR has field offices in Los Angeles, California; Chicago, Illinois; Phoenix, Arizona; and McAllen, Texas.

Mr. Yzaguirre serves as Chairperson of the Independent Sector, a non-profit coalition of over 850 corporate, foundation and voluntary organizations.

HEALTH CARE COSTS

Message: Urgency. It is important to stress what these costs mean for American families and business, the consequences of inaction, and why we must act now.

COSTS TO FAMILIES:

- **American families** are getting killed by skyrocketing health care costs.
  - Health care spending per capita has skyrocketed from $1,063 in 1980 to $3,160 in 1992 -- a 197% increase. [CRS based on HCFA and Bureau of Economic Analysis]

COST TO BUSINESS:

- **Small businesses** are hit proportionally harder by these rising costs than are large businesses. **Small business** premiums are high to begin with and drastically increase if one employee falls ill.
  - Small businesses have experienced annual health benefit cost increases of 20 to 50% recently. In 1991, one-third of small business owners experienced health care cost increases of more than 25%. [Washington Post, 1/26/93, Arthur Andersen, 7/92]
- **Large businesses**, and American competitiveness, suffer too under added costs to their products.
  - American Telephone and Telegraph spends $3 million a day on employee health benefits. [Christian Science Monitor, 11/21/91]
  - For the first time in American history, health care costs exceed business after-tax profits. [Health Care Finance Review, Winter 1991]
  - Health benefits consume 8% of payroll today. Left unchecked, they will consume as much as 17% by the end of the decade. [Karen Davis, Johns Hopkins University, 1992]

THE CONSEQUENCES OF INACTION/WHY WE MUST ACT NOW:

- **Families:** Rising at four times the rate of wages, health care costs threaten to bankrupt the families of this Nation. **We must act now** to free American families from the burden of health care costs.

  - Without reform, experts estimate that the annual cost of health care for an American family will more than double by the end of the decade -- to a whopping 14,000 per family -- while workers lose an annual $655 in income. [Families USA and OMB]

- **Jobs:** These costs are passed on to consumers stagnating the economy, slowing job growth and hurting our competitiveness abroad.

  - Failure to adopt a cost-control strategy could result in the loss of 1.5 million jobs over the next five years. [Ken Thorpe, University of North Carolina, 8/92]

- **Workers:** If health care costs and wages continue to increase at their current rates, a worker's salary will soon seem like a fringe benefit to his/her main source of compensation -- health care insurance.

  - Some estimate that, by the year 2000, the average employer could be paying $20,000 a year for each employee's health benefits. [A. Foster Higgins cited in Christian Science Monitor]

  - Workers have lost 58 percent of wage increases since 1980, and will lose 100 percent in coming years, because of rising health benefit costs for employers. [Henry Aaron, Brookings Institution, 1992; President's Advisory Council on Social Security, 12/91]

WHY THE NATION IS CONCERNED

Theme 1:

The continued rise in U.S. health care costs is the biggest factor motivating health care reform. High health care costs threaten everyone, including:

a. Workers who must pay more out-of-pocket or who have lost family coverage

If health cost inflation is not brought under control, Americans will be devoting more than $1 of every $6 they earn to health care by the year 2000.

Working families could have increased their personal savings by nearly $12,000 from 1980 to 1992, if health care cost inflation had been held to the economy-wide level.

More and more employers have dropped coverage for dependents in an effort to reduce their costs. From 1982 to 1988 the proportion of medium- and large-sized employers paying the full costs of dependent coverage fell 25%.

b. Workers afraid to change jobs and lose coverage and

Entrepreneurs afraid to strike out on their own, unable to obtain coverage

One in five Americans say they or a family member are locked in their jobs because new work offers limited or no health insurance.

c. Retirees seeing their health benefits cut back or eliminated

If current trends continue, the Medicare trust fund is projected to be exhausted in the year 2002.

At least two dozen U.S. companies have abandoned health benefits for at least some of their retirees.

Two-thirds of employers have made changes to their retiree medical plan in the last two years or intend to make changes by 1993. The most common changes are raising retiree contributions (47% of employers making or intending to make change), increasing cost sharing (40%), and tightening eligibility requirements (21%).

d. People with serious diseases like AIDS who see their health benefits disappear

e. The elderly who are today paying as much -- or more -- for health care out-of-pocket than before Medicare

f. Businesses who see profits and U.S. competitiveness threatened

g. Labor unions who see potential wage increases eaten up by rising health benefits costs

From 1986 to 1992, total real compensation (wages and fringes) of American workers was constant. Actually, wages and salaries fell, but the rising cost of fringe benefits made up the difference.

h. And the traditionally vulnerable groups, the poor and uninsured

The number of uninsured Americans increased by 50 percent between 1980 and 1991 (from 24 million to 35 million people).

In 1991, 85% of the uninsured were employed or dependents of workers; only 15% were unemployed or not in the labor force.

More than half (53%) of all people in poverty are not covered by Medicaid.

Theme 2:

Health care costs government a lot, too.
-- federal, state, and local

Without significant health care reform, U.S. health expenditures are expected to top one trillion dollars by 1995 -- over $4,000 for every American.

In 1990, the United States spent $2,566 per capita on health care, compared to $1,770 spent by Canada, $1,486 spent by Germany, and $972 spent by the U.K. Health outcomes in the U.S. were at best comparable to those in other countries.

States spent an average of 13.6% of their total budgets on Medicaid in 1991.

Of 1991's health care expenditures, 38% went to hospitals; 19% to doctors; and 8% to drugs.

Between 1982 to 1989, physician income, adjusted for inflation, rose by 23%, compared to a 9% increase for all full-time male workers. Average physician income in 1990 was $164,000. Average income of surgeons was $236,000, compared to $103,000 for general practitioners.

Theme 3:

Rising health care costs impose tradeoffs on society.

> ***more money spent on health care means less for education, new jobs creation, the environment, or higher salaries***

If health care reform had been enacted in 1980, and cost containment achieved, the dollars we would have saved in 1992 could have:

Hired over 7 million public school teachers

-or-

Almost totally eliminated the amount added to the federal debt in 1992.

In the last decade, state spending fell for elementary, secondary, and higher education, welfare, and highways -- while rising 40% for health care.

Theme 4:

The "costs" problem depends on your perspective

> ***to policymakers it's the nation's nearly one trillion dollar annual health care bill***

> ***to the poor elderly, it's having to choose between buying medications and food***

> ***to physicians and hospitals, it has become a paperwork nightmare.***

When asked to list the top two problems in their respective countries' health care systems, more than half of the U.S. doctors (55%) mentioned access to care. In Germany and Canada, few did (5% and 1%).

More than 5 million Americans 55 and older say that they have to choose between buying food and paying for medication.

Almost half (44%) of physicians would be willing to forego 15% of their fees if delays or disputes in processing insurance forms were significantly reduced.

Theme 5:

The health care system itself poses implicit and explicit tradeoffs

> ***more high-tech care versus improvements in basic care or prevention***

> ***more affluent, better insured groups now receive more care than the poor and uninsured***

HIGH TECH

In 1991, the U.S. had four times as many magnetic resonance imaging (MRI) machines per million people than in the former West Germany, and seven times as many as in Canada.

PREVENTION

Only about half of all employer-based health insurance plans cover childhood immunizations.

Every dollar spent on measles immunization saves $11.90 in later medical costs.

Every dollar spent on prenatal care saves three dollars in health care costs.

Every dollar spent on smoking cessation saves $15.26 dollars over a working lifetime.

Theme 6:

The conclusion is that the problems are so widespread that fundamental reforms are needed to control costs.

Only 6% of the general public, 23% of physicians and 9% of corporate executives believe that only minor changes are needed to improve the U.S. health care system. An overwhelming majority believe that fundamental changes are needed.

Theme 7:

While we may need an overall management framework to control health costs, micromanagement approaches -- like multiple levels of claims review and excessive paper work -- may actually increase costs.

In many states, it costs physicians more to bill Medicaid than they receive back in payment for their services.

In 1987, insurers' administrative costs were twice as high in the U.S. as in Canada or the U.K. (5% of U.S. health spending, vs. 2.5% elsewhere).

Theme 8:

Costs-access-quality are intertwined.

INTERNAL MOMENTUM

Theme 9:

Our current health care system has its own momentum: training physician specialists or building and equipping huge medical centers virtually guarantees these capacities will be used.

In 1990, over 900 hospitals offered open heart surgery. One fourth of those hospitals do less than 50 Medicare cases per year; 200 cases is considered a minimum in insuring quality. (Medicare cases are usually about half the total)

35 cities had more than 5 hospitals performing open heart surgery.

Only 15% of senior medical students indicate a preference for a generalist physician career (1992).

70% of U.S. physicians are specialists.

Theme 10:

Recent studies indicate that American health care costs more than care delivered in European countries not only because we provide more services, but also because our "inputs," wages and prices, are higher.

Theme 11:

One central element of efforts to reduce costs is a commitment to rethink the types of physicians being trained. Over two-thirds of new physicians are specialists even though all evidence suggests we currently have too many specialists. Experience also shows that specialists charge more and prescribe more tests and procedures.

For every 100,000 Americans, we may spend at least $810,000 in unnecessary coronary artery surgery annually.

For every unnecessary bypass surgery -- at about $30,000 each -- we could pay instead for two full-time home health aides for a year.

EFFECTS ON HEALTH CARE DELIVERY

Theme 12:

Cost control will require changes in health care delivery not just the payment system, like

- ***fewer questionable surgical procedures***
- ***fewer complex diagnostic procedures***
- ***more generic drugs***

Nearly three-fourths of prescription drug expenditures (73%) are paid out-of-pocket.

In fact, reducing unnecessary care is the least "painful" path to cost reductions.

One commonly-cited source of unnecessary care is "defensive medicine" -- excessive ordering of tests and procedures by physicians in an effort to fend off malpractice suits. In fact,

- physicians' perceptions of the risk of being sued are about 30 times higher than the actual risk
- still, in response to this exaggerated perception, in the last 10 years, 90% of physicians have increased their time doing paperwork, and over 80% have increased the number of tests and procedures ordered

Theme 13:

Health care providers should have incentives to organize medical care in efficient delivery systems. The burden of inefficiency, fraud, and abuse should not be borne by taxpayers.

Physicians affiliated with managed care (employed by an HMO or employed by a physician group or other organization that contracts with an HMO, IPA, PPO) are more likely to report feeling that they could hospitalize patients, keep patients in the hospital, and order tests and procedures than physicians working in other settings.

Overall, affiliation with managed care has not caused many physicians to be unhappy with medicine as a career or to feel that they cannot practice quality medicine.

HMO physicians are least likely (71%) to believe they have the freedom to care for patients unable to afford fees, and physicians in managed care settings somewhat less likely than physicians not in managed care to believe they had this freedom.

Theme 14:

Fraud, waste, and abuse should be discouraged, but rooting them out won't generate enough money to fund a national health plan.

BROAD QUESTIONS

* What proportion of our national economy do we want to spend on health care?

* How much health care is "too much"? Is "too much" a function of the dollars spent or the kinds of services they are spent on?

* If we're spending too much, what are we willing to give up?

* What would providers be willing to trade off, in order to be relieved of some of their paperwork burden? (The "Hassle Factor")

* As the U.S. economy shifts away from heavy industry to smaller, information-age employers, does employment-based insurance still make sense? Is it the most affordable and efficient way to provide coverage?

* Does the amount of effort required to review all health service charges and eligibility and covered services save enough to warrant the resources needed to do it? Would a more selective approach that required review only for "high ticket" items (ie. surgery, long-term care) result in overall savings?

NARROW QUESTIONS

* Should we revitalize the public health infrastructure as part of health care reform?

* How much professional staff time is devoted to documentation, rather than patient care? In the nursing home? In the hospital? In the doctor's office?

* Are teaching hospitals' higher costs -- attributed to the expense of training residents, etc. -- justified, when we may have too many specialists already?

* Would it make sense to put Medicaid on a sliding income-based scale -- rather than all-or-nothing -- in order to try to reverse incentives not to work?

* People with disability insurance can lose benefits if they return to work. Can we change these "perverse incentives" under health care reform?

* Should health care reform include incentives for healthy lifestyles -- not smoking, wearing seatbelts, obtaining preventive services?

CONVERSATIONS ON HEALTH

March 26, 1993
Washington, DC

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