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003. letter	Address (Partial) (1 page)	12/12/1994	P6/b(6)
004. envelope	Address (Partial) (1 page)	12/12/1994	P6/b(6)
005a. note	Phone Number; Personal; DOB (Partial) (1 page)	12/03/1994	P6/b(6)
005b. letter	Address; Phone Number (Partial) (1 page)	01/03/1994	P6/b(6)
005c. letter	Address (Partial) (1 page)	01/14/1994	P6/b(6)
006a. letter	Address (Partial) (1 page)	12/02/1994	P6/b(6)
006b. paper	Address (Partial) (1 page)	09/01/1994	P6/b(6)
006c. paper	Address (Partial) (1 page)	09/01/1994	P6/b(6)
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COLLECTION:
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First Lady's Office
Domestic Policy Council (Karen Guss)
OA/Box Number: 5931

FOLDER TITLE:
Wayne Moore [1]

2012-0820-S
ms483

RESTRICTION CODES

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WAYNE MOORE

Standard Form No. 65-B
December 1971
General Services Administration
F (41 CFR) 101-11.6

U.S. Government Messenger Envelope

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[illegible]	1 [illegible] WW	Karen	
NSC — Nancy ~~WW Ground Fl Soderberg~~		WAYNE MOORE FILE	
Nancy Hernreich 1st Fl WW			
~~Anne~~ Stock East Wing 2nd Floor			
Central Files	OEOB		
Rick Seidman G&F1 WW			
[illegible]			
[illegible]	1st Fl WW		
David Anderson	163		
[illegible]	187		

USE THIS SIDE FIRST

M E M O R A N D U M

TO: File

FROM: Karen Guss

DATE: 12/19/94

RE: Wayne Moore

Mr. Moore has sent a number of letters and documents to various members of the Administration about his Model 3 health care plan. I spoke to him on 12/16/94 and informed him that we were not at the stage to be considering such a detailed plan as his. He expressed an interest in continuing to have telephone contact. I explained that time contraints would make this impossible but that I hoped that I or someone else from the health policy staff could give him a call if we needed his help. He said that he would be pleased to help and that he appreciated that someone from the White House had given him a call.

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[001]

Wayne & Edna Moore

P6/b(6)

December 12, 1994

Ms. Karen Guss, First Lady Staff
Old Executive Office Bldg., Room 212
White House
Washington, D. C. 20500

Subject: Model-3 Health Care Reform - December 9 letter to Mr. Bentsen

Dear Ms. Guss:

You have barely received my December 2 letter with its numerous enclosures.

This is not a follow up. I thought you - and Mrs. Clinton - should receive copies of the enclosures.

***

Secretary Bentsen is the type of leader this country respects and appreciates. He doesn't deal in hype. Model-3 must stand on its own, without loud promotion. The Private Sector version needs a carefully assembled support cadre of large corporations with strong internal interest in group health care insurance and large group health care budgets to create self interest in the benefits Model-3 will bring them and their employees.

These corporations are not aware of Model-3. They need information **and** persuasion. Mr. Bentsen could initiate this process with a few top level phone calls. Economic Council personnel could follow up with top level educational conferences. Once persuaded, the corporations could enlarge the process by high level phone calls and lower level meetings with other corporations until the circle of supporters reached a ubiquitous level.

Extremely well funded public educational campaigns could then begin and be effective - with relatively minor individual expenditures by this assembly of corporate supporters and their labor unions. A health care buyers equivalent of last year's health care insurance sellers promotional campaign, **but with factual rather than emotional based presentations.** Just sell the public what the public already wants. It is all available in Model-3.

***

The White House - and the Democratic Party - have the infrastructure of party workers to support such efforts. Aggressive efforts centered in the White House would be the ideal

expediting force. There are no losers in Model-3. Insurance companies and providers can be helped by a Model-3 lead by strong individuals who favor industrial efficiencies rather than profit pressures - individuals who are in no way either anti-business or antagonistic toward individual voter freedoms of choice. There is room for **both** good profits and lower gross revenues in industries such as health care, where total lack of proper competition has created excess billing in every facit of every operating unit. Not only is downsizing possible. Innovative processes and procedures will be found throughout the entire trillion dollar health care budget. Profit, quality improvement and gross cost reductions can co-exist. Broader coverages should follow, not preceed, these changes and their expected double-digit savings.

Model-3 benefits to buyers and users of health care services are obvious. Once Model-3 is understood it will be overwhelmingly popular.

Internal White House support by Mrs. Clinton - even support by Dr. Shalalla - would be most useful.

If Secretary Bentsen can be persuaded to help as a private citizen all will gain. I hope Mrs. Clinton will find an opportunity to encourage his participation. I hope you can encourage her to do so.

Only two years are available. Health Care reform must either be revisited or history will record it as a failure. A very big failure. And our country will have gained no benefit from Mrs Clinton's enormous efforts. This health care initiative can be revived with close to zero expenditure of Administration political capital. Just encourage and support - and eventually take credit for a successful Model-3. Health Care Reform success may even make another four years available to expand its impact.

Thank you for the phone call that made this letter possible. It will be a pleasure to again hear from you. I believe in Model-3. I also believe in the political **and personal** value Model-3 can have for Mrs. Clinton.

Sincerely,

Wayne B. Moore

Wayne B. Moore

cc: One only - in confidence to a "large corporation". Your name and position removed. I know this letter can reach Mrs. Clinton.

enclosures: December 9 letter to Mr. Bentsen, December 12 letter to Mr. Panetta

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Wayne B. Moore
P6/b(6)

[002]

December 9, 1994

Mr. Lloyd Bentsen, Secretary
United States Treasury Department
White House, Washington, D. C. 20500

Subject: Model-3 Health Care

Dear Mr. Bentsen:

None of us want to see you "rust out".

This follow up letter on Model-3 is different than I expected to write.

If White House interest in Model-3, including your own interest, is favorable you may find my thoughts worth considering.

My background, abilities - **and my physical capacity** - are not suitable to guiding the final creation of Model-3 Health Care. I strongly believe in Model-3 and am convinced that Model-3 should be a part of this country's future. Model-3 will become either nothing (possible but I hope not probable) **or it will be THE dominant factor** in our country's health care future. To help it succeed and to guide its future would not demean even one with an illustrious career such as yours surely has been. A successful Model-3 will control 1/7 th of our country's economy and safeguard its citizen's future health. A trillion dollar annual cash flow to be used for the health of this nation. A permanent legacy requiring wise leadership.

Such a task should be a good rust preventative, but sadly pro bono publico as the saying goes. As I see it and based on White House support of Model-3, private sector Model-3 should be created by convincing a well balanced group of large companies - diverse sectors of the economy representative of health care buyers but **not** health insurers or providers - to form a for-profit corporation that in the opinion of a non-businessman would be the proper base for funding the full development of Private Sector Model-3 after they seek and obtain legislative authorization. Model-3 would then be developed into an operational system. In Time, either the original stock or new stock issues would be - **very profitably** - sold to the public.

Ideally the White House could start this process by gathering a carefully selected group of corporations in a conference to discuss their possible roles in such a consortium. These corporations AND THEIR LABOR UNIONS would mount the campaign to explain Model-3 to the public, present the results of their efforts to the Congress, and **only then fully**

commit major funds to develop and implement Model-3. A totally private sector action, initiated and then quietly supported by the Administration.

This concept came from "large corporation" questions regarding the possibilities for a private sector Model-3. **You should talk to them. I will provide copies of a November dated exchange of letters on request.**

Initial efforts would surely not be all consuming for any one individual. Hand holding to form the core should lead to a gravity driven down hill roll for the snowball. As operational status approached it would need leadership whose character gradually shifted from technical to include the business and financial capabilities suitable for an organization with cash inputs and outputs totaling a trillion dollars a year. My thought is that you might choose to provide that leadership, or not, depending on its appeal at the time. Otherwise stock ownership and/or deep satisfaction might be the chief or only rewards.

A very long shot? One must try. One must ask.

Obviously I am not in a position to offer anything beyond my belief in you as the best possible person to carry Model-3 beyond its present state, if and as your appraisal of Model-3 and its prospects are favorable. I cannot sell you this thought. You will be better informed than I on the political support that Model-3 might possibly acquire. You will have a better opportunity than I to obtain a detailed technical appraisal of the Model-3 potential from the corporation that has reviewed Model-3. I have not asked for such an appraisal, which I believe should be favorable. They may need persuasion. Their actions when politics become favorable will speak much louder than words. They were offered an opportunity to investigate. I hope - and believe - that they can be important to Model-3's future.

What I am suggesting to you is in the same vein - an opportunity to guide the shape of our country's future health care - or a waste of time - depending on your interests and your appraisal of Model-3.

Whether it includes Model-3 or not, I wish you a happy, prosperous and rust free future.

Sincerely,

Wayne B. Moore

cc: This is an offer to help our country. Perhaps a very few copies in the White House or Congress to spread the thought. All will know that you can say no - or suggest someone else.
enclosures: Brochure, letters to Rubin, Kasich, Van de Water

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Wayne B. Moore
[redacted]

[003]

December12, 1994

Mr. Leon Panetta
Chief of Staff
White House
Washington, D. C. 20500

Subject: Health Care Reform - December 9 letter to Secretary Bentsen

Dear Mr. Panetta:

Please read the enclosed letter to Secretary Bentsen.

The success of Model-3 Health Care is as much dependent on its leadership as on the benefits its features can bring to this country's future. It will be shaped as it grows.

Secretary Bentsen, I believe, is most highly respected for his integrity as well as his copious and varied abilities **by those who know him best.**

This is a high tribute that many prominent citizens have never earned.

***

Model-3 without appropriate leadership would never reach the high goals set for it. This past August I contacted the corporation that I thought would best carry Model-3 through its technical development. They listened. And asked many questions. I have no assurance that this corporation will undertake the task I had in mind. Time will tell, as will circumstances.

Now is the time to find new leadership to carry Model-3 through the quiet political and promotional steps that must occur **BEFORE** full technical development can be contemplated. For Model-3 this should not involve cold turkey efforts to force legislation through even a willing Congress. In 1994 an obviously unprepared Congress first tried to make the

ClintonCare horse into its own unique version of a camel, untimately destroying all versions they considered. Congress must be prepared. But more. Model-3 also must be prepared. Its features must be vetted by knowledgeable members of the private sector, then **sold to the public by these private sector advocates, not by government.** For Private Sector Model-3 a strong private sector base must exist, not just be talked about.

Simply being Model-3 is not enough. Being a successful Model-3 is the only acceptable goal. Two years to do it. Two years to create a legacy or wallow in failure. To hold a dead albatross or celibrate a victory. There is work to do - fast. Lets do it.

I hope your encouragement can support a decision by Mr. Bentsen that is favorable to the to the goals that President Clinton originally set for this country's future health care..

Sincerely,

Wayne B. Moore

cc: Mrs. Clinton, with December 9 letter to Mr. Bentsen

enclosures: December 9 letters to Mr. Bentsen and Mr. Rubin
December 2 and 5 letters to Mr. Kasich and Mr Van de Water

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Ms. Karen Guss
First Lady Staff
Old Executive Office Bldg.
Room 212
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[005a]

P6/b(6)

- engineer
2 yrs. in Washington 4-4
electronics background
Navy in San Diego
- how it's done, not what is done. When you see those, are they going to be effective?
- extremely simple + totally different + competitive.

P6/b(6)

To _____

Date _____ Time _____

WHILE YOU WERE OUT

M Wayne More

of _____

Phone P6/b(6)
Area Code Number Extension

TELEPHONED		PLEASE CALL	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

Message Appreciation of Model 3 health care

Operator

AMPAD EFFICIENCY® 23-023 CARBONLESS

To Karen

Date 12/1 Time 4:15 pm

WHILE YOU WERE OUT

M Wayne More

of _____

Phone P6/b(6)
Area Code Number Extension

TELEPHONED	✓	PLEASE CALL	
CALLED TO SEE YOU		WILL CALL AGAIN	
WANTS TO SEE YOU		URGENT	
RETURNED YOUR CALL			

Message Model 3
health care
(gave you message about 2 weeks ago)

Operator

AMPAD EFFICIENCY® 23-023 CARBONLESS

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Wayne & Edna Moore
P6/b(6)

[0056]

January 3, 1994

Mr. Gene Sperling, National Economic Council
White House
16ØØ Pennsylvania Ave., N. W.
Washington, D. C. 2Ø5ØØ

Subject: Health Care - A third approach.

Dear Mr. Sperling:

The enclosures describe "merely" a hands-off mechanism for motivating our existing Health Provider industry toward constantly more cost effective and higher quality service to our citizens. Congress should find relatively few details to debate in what is essentially only an efficient, passive, automated accounting and evaluation system.

It is also the foot in the door by which Managed Care and Single Player advocates can argue - and compromise - their positions AFTER the basic premise of universal care is fully committed. The foot in the door is an easier sale than a special interest dominated floor fight.

Details of coverage and funding can be legislated after the framework has been fully established - in law and in practice.

This planned interim period can also assure advocates of immediate welfare reform that the necessary base for universal health care coverage will be in place when it is needed. A parallel path without conflicts.

Others in the White House and Congress have received preliminary and incomplete versions of Model-3. From public comments on the general subject, I believe the concepts are having a favorable impact.

Cinizens can choose their own doctor. Cost efficency and quality of care will both be assured by intense nationwide market-place competition.

Special interests can debate their various positions freely within an established framework that assures, above all, that economic efficiency will dominate the evolution of our new health security system.

Liberals, Moderates and Conservatives alike should appreciate this separation of form and function. Clear underbrush THEN plant trees.

I hope you will concur. (Duplicate letter to Mr. Bruce Reed.)

Sincerely,

Wayne Moore

Wayne B. Moore

enclosures: MODEL-3 HEALTH CARE and SUPPLEMENT.
Political Benefits

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2012-0820-S
ms483

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE WHITE HOUSE
WASHINGTON

[005c]

January 14, 1994

Mr. Wayne B. Moore
P6/b(6)

Dear Mr. Moore:

Thank you for telling me about your approach to health care reform.

Judging by a brief look at the document, you have put an impressive amount of work in this. I will read it more closely in a few days, and will pass it on to a few other members of the health care task force.

It was good of you to share this with me.

Sincerely,

Gene B. Sperling
Deputy Assistant to the President
for Economic Policy

Aug 5, 1993 - ltr. ~~from~~ to First Lady
- talking w/ large corporation

Sept. 2, 1994 - ltr to. Panetta

October 14, 1994 - ltr to Panetta w/ proposal.
He is sending to me

Ms. Goss -

Please read this letter first, then the open letter to Mr. Gingrich (back of second sheet in brochure)

THEN review the brochure

MBm

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Wayne B. Moore
[redacted]
P6/b(6)

[006a]

December 2, 1994

Representative Newt Gingrich
Speaker-to-be
House of Representatives
Washington, D. C. 20515

Subject: **Budget saving reform** - Model-3 Health Care

Dear Speaker Gingrich:

Model-3 Health Care is an **anti-government-control** and **anti-special-interest** means for assuring nationwide health care **cost and care improvements** through the private sector.

Favorable responses have been received from members of Congress, CBO and the White House Staff, the American College of Surgeons and Governor Romer of Colorado, the only State Governor yet contacted. It is **Republican**, not Democratic, in philosophy.

The open letters at the front of the enclosed Private Sector Model-3 Health Care brochure should encourage you to read the entire brochure. **It reduces the Federal budget.**

Model-3 requires Federal approval. Its development can be funded EITHER privately or by Government. The private sector version is enclosed. The private version can be put in place **without cost to the taxpayers.** The only large corporation contacted has responded with interest and extensive questions regarding details. Their current interest is held hostage by uncertainty regarding Republican responses from Congress.

***

Model-3 is designed to convert our government-rules-driven health care industry into a tightly controlled market-place competitive system.

The efficiency-improvement steps within Model-3 should be taken BEFORE changes are made in either the amount or source of health care funding. It works to improve our health care system itself. Model-3 is an operational cost saver, unaffected by the source(s) of health care funding. Funding **laws** can change **while** it is being installed.

***

Operational Model-3 is so far off budget for Government that there is no budget . Just Federally legislated authority to act. It will provide better health care with a much lower share of our GDP for any and all methods of funding..

It will help balance the budget. It deserves your attention.

Sincerely,

Wayne B. Moore

enclosure: Private Sector Version - Model-3 Health Care brochure

GOOD BUSINESS PRINCIPLES

MODEL-3 HEALTH CARE

(M3 SYSTEMS)

PRIVATE SECTOR VERSION

....

CONSTANT EVALUATION

THE LOWEST OVERHEAD

ANY DOCTOR

BEST MOTIVATION

....

MOST HEALTH CARE - LEAST MONEY

THE VOTERS ' CHOICE

By Wayne B. Moore

"Your comment was extremely pertinent regarding the bureaucracy that can certainly strangle any form of healthcare. We will use many of your comments and suggestions."

American College of Surgeons.
March 17, 1994

Model-3 Health Care

is
dedicated
to

THE AMERICAN PEOPLE

for whom

IT WAS DESIGNED

The author has no ties to either Government, Industry, or any political party.

Ideally, Model-3 will be owned by the people themselves - A public corporation with wide-spread ownership.

Once there is sufficient political acceptance of its principles within Congress AND the Executive Branch, a corporation fully capable of developing and operating Model-3 - and already aware of Model-3 details - may find itself interested in converting a venture capital funded development of the Model-3 design into a fully operational entity.

Alternatively, Model-3 may obtain Governmental funding to achieve the same result.

Once fully developed and operational it will be the perogative of the initial funding source to sell securities to the public so that THE PEOPLE, not Government, may finally own Model-3 - and control their own health care.

MODEL-3 IS DEDICATED TO BEING OWNED

BY THE PEOPLE

NOT THE CONGRESS
NOT INSURERS
NOT HMOs

***

OPEN LETTER

Mr. Newt Gingrich
Speaker to be
House of Representatives
Washington D. C. 20515

Dear Speaker:

Model-3 does not have the arrogance to dictate to the American people or to their Congress appropriate levels for their health care coverage, or the source(s) of its funding.

Model-3 has one concern - that this nation's health care be suitable to the needs and wishes of its people. While others have devised rules and specified types and amounts of health care our people should have, Model-3 has ignored these problems. They are none of our business. Our people should have every possible personal choice.

Model-3 desires that each American should have the best and most effective health care BY OUR OWN DEFINITION that our resources will permit.

To this end, our health care system must be both efficient and competent, and must be defined by our own needs, not by rules or bound by limits dictated by others.

To achieve this goal, Model-3 finds it essential to make only two requirements of its funding sources.

1. All public or insurance funding entering the Model-3 system must be directed toward desired results, not to the means for achieving them. In this way Model-3 assures that doctor/patient relationships are restored to the doctor and patient, where Model-3 believes they belong. Otherwise competitive and innovative cost savings will be stifled and Model-3 effectiveness will be destroyed.

2. A minimum of one doctor visit per year is required to be available to all eligible individuals - with Congress to define the word eligible. If an individual pays an income tax, that individual pays a set sum, annually, for that visit . If not, Government pays. Sorry if this causes a problem. Legislation supercedes any words written in this letter, but ultimately this minimum universal coverage will be found both useful and cost effective.

Model-3 is designed to accept any actuarially sound funding type or source, or any combination of sources. Guide lines for defining acceptable limits that avoid outright insurance fraud should be covered by law. Competition then favors the best buys.

That is it. Model-3 stays out of all Congressional perogatives and hopes a maximum variety of choices will be permitted to each of our 50 states as well as to our people - from cash payments for the wealthy to at least one free annual visit for the indigent. And no penalties.

Details are in this brochure.

Wayne B. Moore

OPEN LETTER

Chairlady Nancy Kassebaum
Senate Labor and Human Resources Committee
United States Senate
Washington, D. C. 20510

Dear Chairlady Kassebaum:

Now that we can consider the values of self-determination in our personal lives, health care may be looked at logically.

Every reasonably intelligent person has need to develop the best possible relationship with his or her personal physician - or if necessary, with a newly selected doctor. Model-3 starts with this premise.

The chosen physician then ideally should be personally interested in the patient's needs. Since doctors are just as human as the rest of us, something must direct and focus that doctor's attention. Model-3 does that. It is called competition. In Model-3 it can be called fierce competition. Out of 650,000, doctors each of the remaining 649,999 will be your own doctor's direct competitor.

This brochure explains how this is done.

***

During the last two years our citizens have expressed a very strong desire for portable health care that could not be cancelled at the first expectation of illness. Your committee is a guardian of the interests of our people. Lets use this responsibility to guard these interests by requiring that every health care coverage be divorced from place of employment, geographic location, doctor choice or the state of an individual's health.

Model-3 cannot offer these freedoms and benefits, but **it surely can express their importance to those who have that power. Your committee should insist on their inclusion in all health care funding sources, nationwide.**

***

MODEL-3 DOES NOT <u>REPLACE</u> CHANGES IN INSURANCE AND TAXES.

IT MAKES THEM WORK.

Wayne B. Moore

OPEN LETTER

Chairman Robert Packwood
Senate Finance Committee
United States Senate
Washington, D. C. 20510

Dear Chairman:

The Federal Budget of our country is in deep trouble, as you well know.

Our national health care system is also troubled with misdirected rules and regulations as well as deficiencies in the methods used for its funding and its delivery.

The competition that makes the rest of our commerce and industry a paragon of efficiency is denied to our health care system in large degree because of its very personal nature.

In an attempt to compensate, many government rules and regulations strangle the efforts of conscientious health care providers, and many instances of incompetence and neglect are either undetected or tolerated by our health care institutions.

Our society has either failed to discover or failed to use corrective measures.

***

Model-3 Health Care has found a solution to this deviation from the competitive processes used by the rest of our society - a way to detour around the peculiar characteristics in the health care industries. Model-3 provides both professional freedom to health providers and total freedom to their patients who may wish to seek their own sources and methods of health care.

Model-3 is not only cost free to government. Model-3 replaces costly regulation by government, thus actually reducing our current deficit spending and our annual federal deficit.

Model-3 efficiencies and competitive pressures for industry wide cost reductions will actually **reduce the portion of our GDP now consumed by health care. Without punitive regulations.**

Your committee may hold the key to both better health care and lower health care costs both to our government and to our citizens. We are counting on the new attitudes in Congress to lead your committee toward this health care reform opportunity.

Please help our country to obtain and enjoy the benefits that Model-3 offers.

Wayne B. Moore

OPEN LETTER

Dr. Alice Rivlin
Director, Office of Management and Budgets
White House
Washington, D. C. 20500

Subject: Health Care Reform - the Model-3 alternative

Dear Dr. Rivlin:

I hope you have already seen the Model-3 Health Care information circulated within the White House. It has received the attention of Mr. Gore, Mr. Panetta and others.

Model-3 provides several benefits.

- It avoids ALL OF THE COSTLY CONTROLS **rejected by the voters.**
- Model-3 supports EVERY ONE OF THE BENEFITS offered by ClintonCare.

***

- Model-3 **tightly controls health care providers and insurers.**
- **The Federal Budget PAYS NOTHING for operational Model-3.**
- **Providers and insurers, NOT GOVERNMENT, pay all Model-3 costs.**

***

Even the front end start-up costs of Model-3 can be paid by private sector sources if the Private Sector Version of Model-3 is implemented. **Achieve all of the Health Care Reform goals of the Clinton Administration with <u>NO</u> impact on the Federal Budget.**

***

Model-3 has two purposes, **secondary and PRIMARY.** It seems that they are often confused at first introduction to Model-3. Model-3 must function under non-health care industry management.

Secondary functions: **(Low cost services, paid by - but not run by - insurers and providers.)**

- Accounting and patient evaluation of ALL health care transactions.
- Negotiation with insurers of the terms of all health care policies offered to the public. (only dishonest or actuarially unjustified policies are rejected)
- Automated transfer of insurance and tax funded money - bill payment services.

Primary functions: (Run by non-health-industry management, at no charge to Government)

- 900 number information to the public on all insurance policies. (Paid by the public. Emphasizes relative value ratings of various policies.)
- 900 number information on **every** doctor within each local area. (Paid by the public.)
- National competition between all providers of health care. (Enforced by a bonus/penalty payment system).

Model-3 offers benefits to all sectors of our society.

Health care industries are forced to **minimize** their drain on our GDP. Government health care costs and functions are drastically reduced, **LOWERING** the federal budget. Advertising and sales overheads of both insurers and providers are cut sharply - by law. Nationwide, the efficiencies of health care providers are substantially enhanced by the extent and accuracy of Model-3 treatment-effectiveness information - and its enormous analytical capabilities. This increase in knowladge and associated competition allows simultaneous cost cuts AND enhanced provider profits - and better health care for our people.

Accurate actuarial data and lower provider costs created by Model-3 will enable insurers to safely offer better coverages at less cost. I hope you will like it. Your support of Model-3 will help our country. Health care is the 800 pound budget AND deficit gorilla. Model-3 reduces the health care share of our GDP and saves money for us all. Lets make it work.

Dr. Rivlin, your job will be made easier by Model-3.

Sincerely,

Wayne B. Moore

MODEL-3 HEALTH CARE

CONTENTS

PRIVATE SECTOR VERSION

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ESSENTIALS OF MODEL-3

INDEX

PRIVATE SECTOR VERSION
OF
MODEL-3 HEALTH CARE

This Private Sector Model-3 Health Care brochure is essentially the same as the preceding Governmental version. The contents and index page numbering is identical as are the thought sequences. Nominclature has been adjusted and text somewhat expanded for the convenience of readers interested in the private sector formation of Model-3.

It is obvious that the results of any system of any kind that had been formulated by any government would differ substantially from the results of a like type of system formulated in the private sector. Model-3 defines and describes a generic new form of competition which could operate under either circumstance.

The reader is entitled to his or her opinion as to which sponsorship would be best for our country.

******

Model-3 as formulated within the private sector has many advantages. It would be more business-like in its operation. It would be under a more professional internal management. Regulated (probably by necessity), it would have the dual benefits of, first, control by some type of public utility commission determined to protect the public interest, and second, the performance efficiencies of private sector management.

On the negative side, Model-3 would, as its first efforts, be required to sell itself solidly to the public and then to press the Federal Government - or state governments - for legislation licensing a Model-3 Health Care monopoly. This should still be easier than directly selling both Republicans and Democrats in Congress on anything dealing with clean cut and properly organized health care reform.

To counter the greatest possible level of Congressional resistance, Model-3 would need very wide-spread public support of its concepts and principles. Support for both of these tasks could best, and probably only, be obtained by first having wide-spread and strongly motivated advocates within its own formative structure. Supporters of Model-3 will require solid internal convictions from start to finish. Firm beliefs are the most durable form of motivation.

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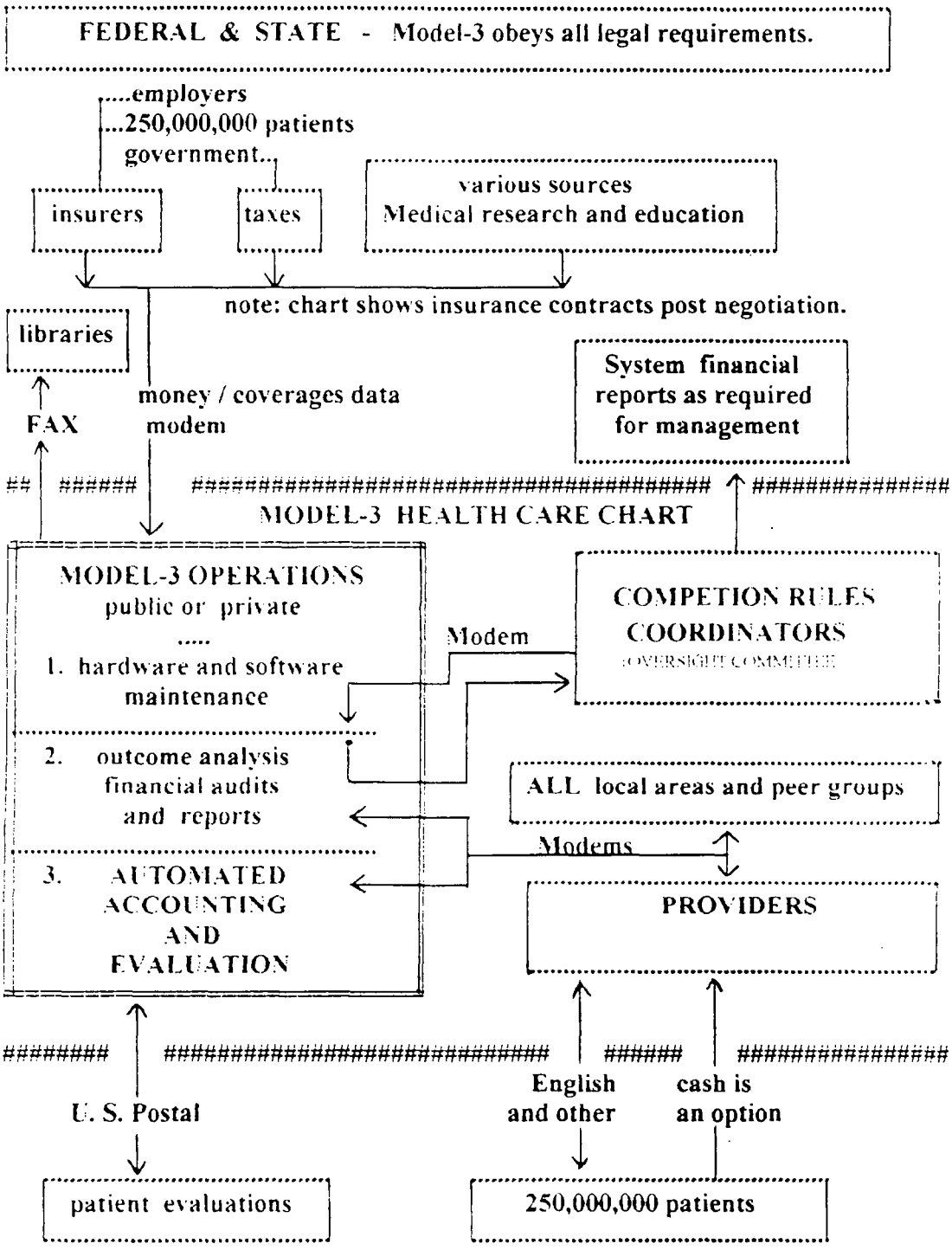
Wayne B. Moore
P6/b(6)

[0066]

MODEL-3 HEALTH CARE CHART



MODEL-3 --- A NATIONAL HEALTH CARE UTILITY
(one trillion dollars annually)

Given today's strong public desire for an improved national health care system, most of the real selling needed for Model-3 may already be done. Final public approval would seem to be dependent on only two factors:

1. The existence of a well financed, adequately described sequence of actions - a low risk scenario - to deliver better health care to the American people.

2. The development of a well conceived and massive campaign to sell this scenario to the public with sufficient follow through to assure its success.

The public should be eager to buy a properly explained and solidly backed private sector Model-3 Health Care reform.

******

Federal approval would be dependent on sufficiently strong public approval. A big enough siedge hammer ALWAYS works. Otherwise it simply is not big enough. The solution - simply overkill at the start.

It should be easier to sell a few large and intelligent corporations on a sound project than to single-handedly sell an entire 100,000,000 plus population of less knowledgable voters. Just make sure the project is sound for these corporations **and the nation.** They **both** will respond.

******

Preparation for this task is thorough study of the Model-3 Health Care Reform as described in the existing Model-3 literature. In this, overkill will also be useful. The Model-3 chart is simple. The ramifications are, for our society, truly enormous. Look for the defects. They also need study. **Find and use the benefits.**

Wayne B. Moore

October 16, 1994

MODEL-3 HEALTH CARE

FOREWORD

Feedback loops are used to make stereos cheaper and better, to help car manufacturers meet smog regulations and make better brakes - and are used in many other forms and situations to solve difficult problems in inexpensive ways. They use operating results to inexpensively control the internal processes of many of the things we use in our everyday lives.

Selecting the wrong feedback loop can be as harmful as the proper loop would be beneficial.

.....

MODEL-3 uses market forces and citizen-VOTER-patient approval ratings in what I believe to be an effective feedback loop design. It is simple in concept. The responsibilities for proper actions are well defined. It is not intrusive. There are consequences for both good and bad performance which will reach and can improve every aspect of the Health Care industry. AND THE VOTERS - are - IN CONTROL.

It is flexible. There can even be penalties for doctors who prescribe unnecessarily expensive drugs - either by the patient evaluation route or by incorporation of drug costs in the direct billing by the prescribing doctor, who would then be billed by the druggist for prescription drugs. (example of flexibility, no recommendation intended.)

The design of feedback loops is a specialty. Neither politicians nor lawyers, who both are highly skilled in their own specialties, typically organize their thinking along lines that simplify the processes they must deal with. On the contrary, their value lies in assuring the correctness of every detail. If they are wrong the stiuation is usually uncorrectable. They deal in step by step process, not in assuring automatic achievement of specified goals. The result - everything in a government dominated by lawyers costs too much.

Market forces are by their nature feedback loops of classic simplicity. They work.

Model-3 will work.

It will give our country - and you, the reader - cheaper and better health care.

CONCEPT HISTORY

MODEL-3

THE NAME MODEL-3 of course connotes the thought "not Canadian, not big Alliances and bidding wars." (Even Clinton Care has abandoned these thoughts, prevalent when Model-3 was named.)

It also has, for me, a more personal meaning.

Many years ago I was told "It won't work. It is theoretically impossible - but you can try." and so I designed a device with multiple feedback loops that countered all of the perceived problems to reach this impossible goal.

The device was complicated. It required frequent adjustment. It was expensive. It was impractical to the point of being commercially completely infeasible. Its only virtue was that it was better than what had previously been available.

A second model was designed. It also worked. It cost only half as much and required less maintainance. The feedback loops were simpler. It still would not have been commercially feasible.

The third model - MODEL-3 - cost about one-seventh as much as the first model. It was not only commercially very feasible, but also, unlike the first two models it could be scaled for much heavier duties, from controlling the motion of ounces to controlling tons. Its single feedback loop was directed at the desired end result; no interim criteria were controlled.

The lesson. Feedback loops are powerful and can be trusted, BUT improperly directed they are expensive, hard to control and without excessive attention to detail they will require constant tinkering and adjustment. In feedback loops simple is better and very simple is very much better.

.....

Several years later the project office in which I worked had a problem. A large Government missile contractor was in difficulty on its advanced missile development project. I was asked to find the problem and correct it.

I was allocated one assistant. After a cursory study of the situation I created a different type of feedback loop. Multiple components went into the missile design in question. Each

had its own problems and its own schedule requirements. Management had been swamped

with detail and depended on individual engineers to solve each of the multiple component problems.

The solution was quite similar to that of Model-3 Health Care. I devised a simple form with a center line down the middle of each sheet. Each line on the sheet was labeled with the name of a single component. The horizontal position of the center line was the scheduled date for delivery of the component named on each line. (each component had a different date). If the engineer in charge of a component named on a specific line believed that the delivery date would slip 3 weeks a line was drawn from the center to a point 3 weeks to the right. And an explanation was written to the right of that slippage prediction.

There were several large sheets. The project was large. My assistant was a friendly and conscientious chap. He never criticised. He just asked questions, constantly, all day long, as he visited each individual engineer. If a component was to be ahead of schedule the line was drawn a proper distance to the left of center. There was no explanation required.

Each day the division manager reviewed each sheet. No effort was made to tell him what to do. The problems were given immediate attention. They were fixed - rapidly. The project was restored to its proper schedule, WITH NO DIRECTION TO THOSE IN CHARGE.

THE MANAGER WAS FIRED. His assistant told me later that if the feedback loop I used had been in use 6 months earlier the manager would not have been fired - he probably would have been promoted.

Wayne B. Moore

OVERVIEW
OF
MODEL-3 HEALTH CARE

.....

THE MODEL-3 SYSTEM

MODEL-3 Health Care has two functionally, organizationally and legislatively independent parts.

THE MISSION OF PART ONE is to assemble a nationally competitive and locally cooperative network of health care providers capable of offering the best and most cost effective health care in the World. Every provider would be motivated through an array of financial rewards and penalties based on the cost and effectiveness of their performance.

THE MISSION OF PART TWO is to be a depository - a bank - in which funds from the various funding entities are assembled into a single pool for disbursement to health care providers. It has no control function.

PART ONE of the Model-3 system is a single NATIONWIDE paperless accounting and evaluation network which all health care providers are required to use. All providers transmit billing statements through this computerized system. Services are analysed, evaluated, and payment is made within this single, fully automated system.

PART TWO of the Model-3 system connects a negotiating team to all participating alliances and insurance companies. These negotiating teams establish terms between insurers and Model-3 operations and code coverage details into the individual records of each insured

person, enabling Model-3 to operate as a fully nationalized single payer system without inhibiting any managed care variables. The system accepts all types of fund sources and any mix of premiums and taxes and should be digitally coded in standardized form when delivered to Model-3. The actuarial oversight of the Model-3 negotiating team would assure the fairness of all contracts offered to the public by all insurers who reinsure with Model-3 and thus participate in funding our national health care system. The public will appreciate the effects of this control.

MODEL-3 OPERATING COSTS

PROVIDERS receive accounting services through Part One.

INSURERS receive clerical services and reinsurance through Part Two (with recourse for actuarial errors).

Both should pay. Model-3 central finances only startup costs, which can be recovered on an amortized basis from operating profits.

Both Part One and Part Two of Model-3 are designed to work equally well as governmental departments or agencies, subcontractors to government, or even private sector corporations. Full flexibility is preserved.

PRIVATE SECTOR FUNCTIONS

All provider functions are in the private sector

In the private sector Model-3 captures all of the cost effectiveness and user friendly features of single payor health care for basic medical care delivery. Neither provider nor patient is affected by the origin of the coverage. Only its existence counts. There are no intrusions from oversight of provider methods as required by other health care systems.

These intrusive features are replaced in model-3 by a more effective automated evaluation and fee adjustment system that pits every care provider against its counterparts ntionwide. San Diego competes with Tampa, Phoenix, Des Moines, Pittsburgh, Buffalo, etc. for financial rewards based on both cost and quality of care, on a doctor by doctor basis. Within local areas full collaboration is forced to cut costs.

This nationwide competition is established with a single unified software package that encompasses both a provider billing and payment system and a data compilation and evaluation system. The combination provides unique opportunities for cost savings since both aspects are instantaneously available to each other, without human intervention. Results, not methods, are judged and controlled. Local doctor committees monitor and force changes in improper methods within their local area.

The motives for this local action are financial and can be as severe as a national oversight committee deems necessary. This national high level committee establishes quality of results and cost of care criteria and determines the nature and severity of the financial rewards and penalties used to motivate competitive behavioral changes. Once the nature and severity of pressures are determined by the committee they are incorporated in the system software and are automatically and uniformly applied nationwide.

NO FEDERAL CONTROL OF METHODS to achieve maximum results or minimum costs are permitted within Model-3. Doctors retain the right to be responsible for their own actions, and are motivated by the dual financial forces of patient treatment results and cost effciencies on the one hand and local area peer review of their methods on the other.

ONLY LOCAL PROFESSIONAL COLLEAGUES WITH FINANCIAL SELF INTEREST are given an authorized right to force professional, ethical and financial standards on any medical care provider. All local area providers will lose revenue if this function is not conducted effectively. Strong motivation for strong professional discipline.

The cost savings should be very substantial. The combination of provider freedoms and very strong financial pressures for performance improvement can create a truly superior and cost effective medical care industry. The basic tax-supported services require no alliances, insurance companies or other intermediaries, yet the system can accept these organizations for supplemental coverages without affecting the efficiency of the basic care delivery system - and with no impact on the Federal Budget. Model-3 accepts tax covered funding at any level from zero to 100 percent of our national health care. Patients can select any doctor, nationwide.

MODEL-3 (M3) SYSTEM FUNCTIONS

The concepts of Model-3 require that enabling legislation prohibits insurance or tax based health care coverages defining treatment methods. Only the conditions for which treatment is covered may be specified.

1. M3 systems develops and furnishes all accounting and evaluation software used in both the central computer and in the private sector provider terminals of the Model-3 system. Provisions are made in this software for providers to add internal provider data at their terminal(s) that is inaccessible outside of the provider's offices, but accounting and evaluation routines are fully M3 systems furnished.

2. M3 systems controls, manipulates and maintains the central processing and data banks that are used for both bill paying and for all system evaluation processes.

3. M3 systems designs evaluation methods, incorporates them in the system software, mails evaluation forms to patients, receives them, pays providers for all billable services to their patients, and accepts zero charge billing into the system to enable evaluation of treatments that providers perform on a cash basis - which is permissible in the Model-3 system.

4. M3 systems operates the 900 line information system.

5. M3 systems operates the insurance negotiating functions, with their own information network for the use of our citizens. All part two functions are within the Model-3 (M3) systems sphere of operation.

Vertually all Model-3 central functions are accomplished within the central computer other than negotiating with insurers. Negotiating will be labor intensive but need for this function will peak during initial operational set up and decline rapidly thereafter.

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NOTE: (This note is deals with practical considerations within Model-3. It is not intended to specify the nature of Model-3.)

Model-3 defines Model-3 (M3) systems as any entity that operates the Model-3 central system.

The only authority that can define M3 systems is the authority that controls - and finances - Model-3 during and after its developmental stages. This authority to be effective would of necessity operate under Federal and / or state level legislation defining the nature of the Model-3 franchise and also setting rules to be followed by funding sources that would be consistent with Model-3 requirements. For Model-3 to operate as designed this legislation could not permit any funding source to define either allowable or non-allowable medical treatment methods. This requirement will require substantial public support in order to pass both Congress and

presidential approval.

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THE SYSTEM AT WORK

EXAMPLE 1. PUMPED UP INCOME.

Doctors often schedule frequent patient visits in small time slots to pump up income if billing is computed on a pay-per-visit basis.

With Model-3, natiowide frequency-of-visits data can be instantly available as part of the normal data base, including specific frequency of visits statistics of each individual doctor. Since each bill is received and evaluated within the same software package, M3 systems can automatically, at no extra cost, code a ratio of the two numbers into the data for that billing statement and adjust pay rates accordingly. (Formulae need not be linear.)

This alone is not sufficient. A parallel quality review is required and must be included in the software to analyse both outcome of treatment and patient appreciation levels. This is the patient evaluation part of the system. The Doctor's historical record and other fee adjustments are combined to determine the final size of the check.

As the check for each bill is prepared (after patient evaluation data is received) the rate adjustments can be coded onto the computer generated check that pays for the service, also at no extra cost and with no extra work for anyone. The doctor can observe the sad coded reduction in the check size and mend his ways. Or he can be pleased at the record and the check size. Immediate pressure or gratification. Experience will establish the magnitude of fee adjustment required for successful enforcement.

Note that all billing follows network rules. This does NOT mean that HMOs are confined to this form of internal accounting. Salaries for doctors are the perogatives of their employer. HMOs, like all other providers, would be strongly motivated to make their internal decisions consistent with the financial motivations devised by the National Oversight Committee. **(Now called "competition Rules Coordinators")**

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A WORD ABOUT evaluation codes:

With 24 values between, "A" can equal the highest standard percent

increase and "Z" the greatest percent penalty and an appropriate letter can be entered in a standard sequence (10 letters=10 rate adujstments) on each check, either front or back. As this coded information is already public knowledge - the 900 number data - no confidential data is revealed during check processing.

Accounting systems that do not combine evaluation and payment systems in one software bundle are denied this powerful tool.

Computations can reduce evaluation data to national norms and the spreads between high and low achievers. From this it is simple in the Model-3 system to provide every peer group with quarterly summaries of each doctor's current adjustment record relative to national norms, with a group summary of the combined doctors' results. This combined figure is the overall adjusted fee level applied to all doctors in the peer group. Every provider and every peer group will understand the origin of the fee ratings and the efforts required to improve performance.

It becomes instantly apparent from this automatically generated report which doctor increases and which doctor reduces the income of the entire peer group, and what aspect of his behavior is involved. All 650,000 of the nations doctors will know just what causes their income to vary. All will know that a colleague and not M3 systems has created the problem. Intelligent peer groups will take swift corrective action, with zero cost to taxpayers and no bidding wars. Similar adjustments are applied to entire local areas. Still at no cost to taxpayers and with no paper consuming and costly bidding wars.

The existence of 650,000 direct competitors precludes any possibility of anti-trust type collusions. (In Model-3, fee adjustments for different specialties - surgeons vs primary care - is compensated by standard offsets so that the same variables can be used for all.)

It falls on the national rate control committee to alter the relative and actual adjustment levels to directly, correctly and adequately motivate doctor behavior in all individual

aspects of their practices - with no second guessing of their methods. Conscientious committee members will insist that this process be altered as needed to direct incentives toward proper goals and to establish minimum financial pressures consistent with the required type and rate of performance improvements - nationally.

Peer groups will judge the effectiveness of each doctor's methods, including his potential for causing malpractice suits, to protect their own income. Tort reform may be needed but is entirely outside of Model-3 details.

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EXAMPLE 2. TEEN PREGNANCIES.

Teen pregnancies have been rated as the very most important of our social problems.

Model-3 provides an automatic, cost free means for transmitting rewards linked to local area improvements in such community wide matters as pregnancy rates. Fee adjustments can be coded at virtually no cost into every check prepared to providers within each area.

Depending on the chosen fee change weighting, doctors, in self interest would be motivated to work actively in the community to sponsor educational or other programs that will reduce teen pregnancy rates. Even, if their fee adjustments were sufficiently great, they might contribute substantial time and money to the effort. The prestige associated with contributions by the medical profession would make them doubly valuable. Note that rewards would only be available for AREA WIDE improvements. No single doctor would influence this data enough to gain financially by changing his personal practice. By working cooperatively on the community problem he could substantially increase his income.

notes: (pregnancies AND general)

1. Aborted pregnancies are still pregnancies, and should be counted as such.

2. Doctors will not be coerced or their methods dictated if Model-3 methods are used. They will simply be rewarded for success. This applies to community services that act to reduce the need

for medical services - as in reducing teen pregnancies - even though no specific cause and effect link is required. This control can be used cost effectively for it will not be coded to cost more than a chosen portion of the reduction in medical care savings that are achieved by reduced need for medical services.

3. The number of all pregnancies, the age of each mother, and the total medical costs incurred in each local area will already of necessity be available in the Model-3 data bank to enable accurate evaluation of changes in the number of teen pregnancies. The data is collected at the Model-3 national operating level. It is not tabulated under local control.

4. General comment: There is a preoccupation with the amount and cost of health care that could advisedly be postponed if the form of the new health care system was fully independent of these aspects and only presented to the public as being based on its superior cost and quality control features along with its innate capacity to accommodate every financing method and every level of care within our financial capability. The advantage: fewer disagreements and faster progress to the desired ideal.

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POLITICAL BENEFITS OF MODEL-3 HEALTH CARE

With every proposed new design for our health care system, the industry will chafe at the restraints and realignments required.

However, Model-3 changes are less severe and less intrusive.

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MODEL-3 SHOULD BE EASILY SOLD TO THE AMERICAN PEOPLE. All changes are in the structural relationship between care providers and M3 systems, with zero disruption in the existing doctor/patient interfaces. In addition, Model-3 supplies comparative data to patients to help them select medical providers best suited to their special needs.

INSURANCE INDUSTRY ADJUSTMENTS WOULD BE LESS CONTROVERSIAL. Their segment of business would fall quite readily within the existing pattern of supplementary insurance now offered to medicare recipients, leaving far less ground for disagreement than the current range of interests and problems under the various managed care proposals.

THE EXECUTIVE BRANCH should, if it examined Model-3 in detail, be pleased with the ease, simplicity, strength and inherent cost effectiveness of the controls available in Model-3. Its efficiencies can also be useful in combination with the alliances so much desired by Managed Care proponents. It avoids the time and money spent on local area bidding wars, yet offers much more complete and controllable competitive pressures.

CONGRESS SHOULD FIND MODEL-3 POLITICALLY DESIRABLE. There is no need in Model-3 to sell constituents on a new and complicated way of "managing" the health care most of us already receive. The polital risks and complexities of the pure managed care system simply do not exist in the Model-3 system. With fewer changes from our present system, even later modifications would become much easier, less costly and far less damaging politically.

Citizens who travel state-to-state would find full and easy access - no barriers - to immediate medical attention in any medical facility. Long distance Doctor-to-Doctor Computer-to-Computer communications is also a built-in capability of Model-3 due to its nationwide network.

I believe the constituents of most members of Congress would even prefer to pay more to get a simpler, less politically front-ended system such as Model-3. Model-3 does not require a special form of budget. Its powerful market place competitive pressures will force continual cost reduction efforts - entirely within the Private Sector. Call it tax or premium, the public will appreciate the lower cost for equal or better coverage.

THE CONGRESSIONAL BUDGET OFFICE may even be pleased to find Model-3 efficiencies sufficient to lower our annual deficit by lowering the true costs within our present insurance laden health care industry. Private sector M3 even removes front end costs.

CBO OFFICIALS will also find that the entire direct M3 systems overhead cost of controlling the health care industry is small enough to be fully chargable to individual health care providers as simply an accounting charge for handling their individual billing statements. Affordable private sector user fees rather than ANY Federal Government expense for the national health care accounting and evaluation process. (more details later).

COST ANALYSES BY THE CBO will show that the clerical coding of reinsurance used by Model-3 is a convenient, accountable and low cost way of interfacing ALL FUNDING with the national Model-3/medical provider network. This interface eliminates the need for numerous insurers to deal with numerous small and large health care providers and in itself offers a substantial reduction in clerical overhead for both M3 systems and the providers themselves. The CBO will also recognize the clout that M3 systems will have while negotiating terms with each of these regional insurers. Model-3 is the ONLY buyer of health care insurance.

The CBO will recognize that all functions originally called Government in Model-3 can be privatized a la the Postal Service, subcontracted to or even created by some single organized group of private sector corporations - at any time, now or in the future.

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PRIVATE SECTOR BENEFITS

PATIENTS WILL APPRECIATE Model-3 900 number phone information for the data it provides on each local doctor's background, professional history and specialties, and the frequently updated performance ratings that Model-3 makes fully and locally available to any requesting citizen. They will appreciate the fact that they are permitted - actually, required, - to express their satisfaction (or disappointment) in each medical service in a way that fully guarantees that this confidential information is not in any way available to influence their relationship with their doctor. (this is one of the two feedback loops used to control private

sector responses to patients' needs).

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GOOD DOCTORS WILL APPRECIATE the freedom from constraints on their professional judgements - and the new patients and increased income they will gain from the 900 number publicity.

BAD DOCTORS may hate Model-3 for it would either cut their income, force them toward improvement, or contribute to a decision to quit medical practice entirely.

ALL INDEPENDENT DOCTORS will benefit by peer group relationships which never interfere with their independent ownership of their present businesses, but which provide to even the smallest office many if not most of the operational advantages now available only in large HMOs. M3 systems will provide them with knowledge of their own weaknesses and strengths, and the support of financially interested colleagues - and an efficient accounting and pay delivery system. All of these now only exist in HMOs or large group practices.

Suddenly small practices can compete on an even playing field. In Model-3 no doctor is limited in making the most appropriate referrals - without either geographical or affiliation restrictions. Every doctor in the country is part of the same accounting system. Payment for referred services is automatic. Every doctor is even equal in the advertising benefits of the 900 number information system - the business producing arm of Model-3. Their incomes, relative to HMO physicians, will depend solely on their effectiveness in providing quality care and in controlling their overhead costs.

Their local area is organized to minimize any limits in cooperative use of expensive, under-utilized high tech facilities. Small practices will be on an even financial footing in such referrals - by mandate, since M3 systems controls the entire payment system.

As doctors move from HMO to private practice, or the reverse, their records move with them. They have immediate free publicity from the Model-3 900 number information system whether they practice in an HMO or under their own name. Their records are their own, in Model-3 files, unmodifiable except for updates to change addresses, upgrade education or to change specialties and other purely historic and/or personal matters. Full freedom of action with full support from Model-3.

Patient freedom improves because doctor freedom is increased.

Costs to the financial pool of Model-3 for pay-for-service practices and insurance

controlled per month/per patient payments are forced toward each other, since the doctor evaluation system will be based on per doctor efficiency analyses in both cases and effectiveness in treating patients will at once become the only cost governing factor. Even then, the inherent pay rate scale of the evaluation system will lower Model-3 pool payments to physicians who do not rank competitively high.

Insurance companies could even negotiate with both customers and Model-3 using premium rates based on either national averages or local area statistics since both are readily derived from data that is inherently essential to Model-3 operation. This option, used wisely, could greatly simplify and perhaps reduce insurance company risks and thus also decrease insurance company cost levels

Such savings would reduce national health care costs as well. Bear in mind that all such data analysis is already a necessary part of a single data bank and that relatively little extra data processing time would be required.

LABOR UNIONS WIN with Model-3. Individual members can choose any doctor they wish. Contract negotiation rights are not destroyed. Model-3 maintains a continuous competitive pressure on every health care provider to increase their quality/cost ratio. Insurers compete on substance, not hype. No other system combines such freedom to innovate with such comprehensive pressure to perform effectively. CONTRACT TERMS WILL BE BETTER BECAUSE MODEL-3 IS A MORE EFFICIENT HEALTH CARE SYSTEM.

ALL UNIONS SHOULD JOIN THE FIGHT for this economically superior - and simpler - national healthcare system.

ALL EMPLOYERS, LARGE OR SMALL, who employ labor union members - or any non-union labor - will benefit by ANY system, Model-3 or not, that is capable in any manner of providing superior health care, complete freedom of choice and lower cost. Model-3 challenges any one to propose such a system and open it to competition, detail by detail, with Model-3.

THE ESSENTIALS
of
MODEL-3 (M3) HEALTH CARE

SUMMARY

Model-3 Health Care is a SINGLE NATIONAL SYSTEM created either by federal law or by joint action OF ALL 50 STATES. It has only one, over-riding, purpose.

Model-3 creates an operating system which unalterably guarantees consumers (patients, citizens, voters) their SOLE - EXCLUSIVE - RIGHT to evaluate and guide changes in the cost and the quality of the health care they receive. It accepts all types of coverage and every possible form of funding. These decisions are deliberately excluded from Model-3 itself to reduce legislative complexities and ensure that coverage changes do not disturb the system..

Model-3 has motivations that force private industry to strive for excellence in the delivery of health care to patients, nationally, and specifies that neither the desire of government bureaucrats nor the desire of insurance companies can (1) deprive any patient his right to choose his own doctor or (2) deprive any doctor and his patient (together) the right to choose the type of treatment best suited to the patient's needs.

It also provides specific means for pooling all fund sources so that the health care delivery system does not carry the present substantial clerical and collection costs of dealing with multiple sources of funds. Health care providers bill the Model-3 fund pool only. This pool is a repository for both tax monies and insurance premium funds. Its operations benefit in several ways by economies of scale.

In Model-3 the delivery of health care is insulated from every possible overhead cost and its operating methods are monitored for effectiveness and efficiency by local area peer professionals whose own income is dependent on lowering treatment costs and increasing treatment effectivness throughout their entire local area. M3 systems only retains control of the AMOUNT of financial pressure applied to all providers to maximize the industry's rate of improvement in every aspect of its operation. These pressures can be adjusted as needed.

Insert Pages - 16a and 16b

MODEL-3 UNIVERSAL COVERAGE

Model-3 requires that every citizen declared eligible by Congress be guaranteed a minimum (specified by Congress) of not less than one annual doctor visit per year. Congress should cover this care for taxpaying citizens by an added annual tax of (suggested) $50.00 to taxpayers and an equivalent amount tax free to indigents. It is estimated that cost of indigent coverage will be returned by reductions in emergency room costs now cost shifted within the industry. This tax could of course be adjusted to absorb the cost of one annual visit for indigents - say to $65.00 annually, and could be progressive or not as Congress wished.

This annual visit coverage will be cumulative. 5 years, 5 visits, etc. to encourage indigents to delay visits until needed. They are not lost to the future if not used within 12 months.

To understand what is meant by "every citizen" it is necessary to provide a definition. Congress, not Model-3, must define the limitations between types of individuals qualified for inclusion in Model-3 and those who are not.

A non-health care illustration will help. Many people wish to board an airplane. Some are eligible, others are not. Those eligible are admitted through a gate - definition by Congress. Some who are passed through the gate (taxpayers) are pre-identified. Others (indigents) are not. All are admitted to the plane. As they board their names are recorded by an attendant. All, including the indigent, are now identified. (They are known to Model-3.)

Model-3 calls those eligible according to Congress " universally eligible" for specified amounts of health care. Universal coverage. It is up to the individual to apply for health care. Those eligible will then also be identified. Ineligible individuals (visitors? illegal aliens?) will not be admitted to Model-3. It is up to Congress and each health care provider to define methods for dealing with this fringe, basically emergency, type of situation. Emergency care of ineligible individuals should be based on philosophy, not on budgetary considerations. Model-3 can easily accumulate statistical data including cash payment or non-payment data on medical care of ineligibles as an isolated category if that becomes appropriate.

This is true universal coverage. 100 percent, not 99.xx percent coverage. The framework is in place, to be expanded however and whenever Congress can muster the votes.

More information - read pages 10 and 11, Community ratings section, Model-3 Health Care Supplements brochure.

Insert Pages - 16a and 16b

MAJOR MODEL-3 SOFTWARE REQUIREMENTS

1. The tabulation of medical procedures, products and services with accompanying definitions of ancillary costs and treatment availables.
2. The tabulation of data related to 250,000,000 potential patients, including insurance coverages - an augmented national phone book. An operational Model-3 would expect insurance companies to supply modem-transmitted data on insurance coverages as each contract was submitted to Model-3 negotiators, eliminating a large part of these tabulation costs.

Note: Patient historical data will eventually be huge, but will accumulate through time. Software structure must accommodate it.

Relatively minor but still big software requirements include:

1. Tabulation of data relating to 650,000 physicians and their equivalent in other aspects of the system such as drug companies and insurers.
2. Descriptive material and identification coding of every negotiated insurance contract type and source admitted to the Model-3 funding pool.
3. Control routines providing Model-3 two way access between:
   - Model-3 operations and provider terminals
   - Model-3 operations and insurers and other fund sources
   - Model-3 operations and the oversight committee.
   - All providers (for referral type communications)
4. Networking software.
5. Analytical software such as that offered by Telescan, Inc. and described in the (7 page version) Model-3 Systemwide Advantages section of the Model-3 Supplementary brochure.

None of the above items involve writing a unique type of software. Every one is an application specific adaptation of presently known and successful applications software. Their only distinguishing characteristics in Model-3 are the size of the total data flow, the magnitude of the data bases and the linkage routines between treatments, patients, outcome research and the billing/evaluation/payment cycle. I believe the linkage routines would be managable.

INSERT PAGES 16 C & D

TELESCAN REFERENCE EXPLAINED

EXPLANATION OF THIS CAPABILITY: The computer used to transcribe these notes has another program in its memory. This program is totally unrelated to the subject of health care, but it offers the opportunity to describe a very valuable by-product capability of the software system that only a single, nationwide, all inclusive accounting and evaluation system such as used by Model-3 can offer.

There are literally thousands of stocks that this program, called ProSearch (from Telescan, Inc.) has made available for analysis by thousands of investors. This program can evaluate up to 118 different kinds of facts for each stock, with numerical limits imposed on each separate fact in one single evaluation. Each Telescan's customer can decide how to analyse the entire list of stocks for any of these 118 different facts, alone or in combination, in one single analysis for this entire stock-group data base. This can be done (during evening and night hours only) at a cost of considerably less than $100.00 per month on a flat rate, with no time-use limit and no limit on the number of analyses, for each Telescan customer who elects to use the service. Telescan, Inc. says that searching 14 thousand stocks using 10 criteria and transmitting a full report would take less than one minute. The cost for each analysis for full time nightly use would be less than one cent. Unbelievable. 14000 stocks, 10 criteria, less than 1 cent cost.

Health care deals with millions of people and thousands of doctors. It also has a trillion dollar annual budget. The nationwide medical analysis equivalent to the described stock data analyses. would cover millions of statistical data relationships and over 100 facts regarding each individual. The cost per analysis could be called pocket money. In addition to the obvious governmental use of such analyses for health care pay adjustment purposes, there is no technical reason that ANY provider would be refused use of this capability for his or her own research into methods to competitively improve his or her professional and business operational methods. Such use is the back bone of the competitive improvement programs that the Model-3 reform method provides for both the health care and the health insurance industries.

These things can be done. Ask any programmer at IBM, Novell, Oracle, Hewlett Packard, EDS, Microsoft and others in the industry.

SUMMARY

Model-3 protects the interests of GOVERNMENT - PATIENTS - DOCTORS and INSURERS

In Model-3, Government does not lose control because patients judge their own health care. Model-3 gives government an even larger "big stick". The National Competitive Rules Coordinators have complete control of the severity of competition, and are allowed to decide the nature of the results (not methods) doctors - and hospitals - must achieve. They decide what judgements patients must make in evaluating their health care, **and if the industry does not improve, they can change the rules.** Through them, government has a place - and stays in it. What is important to government - maximum progress along the national path to cost efficiencies and quality of care - is judged by statistical analyses of cost/cure ratios and from the subjective and factual information gained by statistically analyzing 100% patient reviews of their health care experiences. This process is completely under nationwide control, as are the pay adjustments that will motivate providers to change any behavior that is not conducive to a top level pay scale.

Remember. Pay adjustments, and government control, can be as severe as necessary to optimize the pattern **AND** the rate of improvement within the entire health care industry.

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STILL, patients remain the judge and jury. Their judgements dominate the information that government is REQUIRED to use as a basis for every motivating element in its control functions. Government can't say what is good or bad. Patients have the true control - their doctors work for THEM, with no government control of methods. Health care ala Wal-Mart. Wal-Mart learns from customers. So can doctors.

Remember: Government must, in Model-3 Health care, stay OUT of all decisions regarding the nature of health care that any provider furnishes for any patient. Those doctors who do not cure patients, those who do not provide the type of service that their patients want OR need, those who ignore or do not understand their patients' problems **or consider treatment costs** will soon have severe financial problems. (1) Their rate of pay will be cut. (2) The dissatisfaction of their patients will be published for all to see. Old patients will leave and new patients will not go to any doctor whose poor records have been publicized.

You bet that the patient will remain in control. The division between government and patient control is very precise. In Model-3 the government defines only the rules of competition. The patient is the umpire. When the umpire says "out" his word is final.

FIRST STEPS

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GOOD WORKMEN first assemble the necessary tools and then do their work.

POOR WORKMEN use an available pair of pliers instead of the wrench that should be used - and in the process, often ruin the product.

ESSENTIAL TOOLS for this program should not be different than those of any other efficient and effective health care plan. They are:

1. Both definition and individual identification of elegible patients, and

2. The most efficient and direct nationwide accounting and operations evaluation system that can be devised.

PROPERLY DESIGNED these tools will function correctly under any logical plan for national health care delivery. Thus they can - AND SHOULD - be developed, put in place and tested before making changes in today's medical delivery system.

WHEN BOTH ARE IN PLACE and fully tested Model-3 or any other National medical care delivery system could be selected and would be much easier to sell and much faster and simpler to implement.

COMPETITION, AUTOMATION and SIMPLICITY

NO SYSTEM THAT deals with 250,000,000 customers, countless providers, and many products and services can be called simple.

Every duplication of effort makes simplicity more remote.

Every layer of supervision makes the effort more costly.

Every rule makes the front line effort less responsible.

THEREFORE, FULL AUTOMATION and the impossible goal:

MODEL-3 REMOVES DUPLICATION:

One national computerized accounting network.

One automated verification and evaluation system.

One set of rewards and penalties.

One set of organizational regulations.

One fully integrated software package.

MODEL-3 MINIMIZES SUPERVISION:

Federal (and state)government can define only coverages, not medical methods.

States (only) regulate providers by licensing limitations.

MODEL-3 MOTIVATES - THE MARKET PLACE REGULATES.

A performance adjusted payment system forces providers to compete nationally. Every profit center, every physician, must strive to excel or face the prospect of lower income - or even loss of opportunity to practice within the national health care system. Tampa, Phoenix, San Diego and other cities are in direct competion for ever more effective and cost efficient ways to serve their public.

Providers are never in competition locally. Thus they will use shared equipment and facilities, and any other cooperative method to improve effectiveness and lower costs within their own area. Any local fraudulent practices will impact area income by puffing area cost data, AND MOTIVATE OTHER DOCTORS TO EXPOSE AND STOP THE PRACTICE. This is a very potent anti-fraud and malpractice control part of Model-3.

DATA ORGANIZATION

WITHIN THIS SYSTEM local areas would be formed and grouped demographically, rural with rural and city with city.

WITHIN EACH AREA peer groups of doctors would be organized. (Large HMOs would keep internal records by areas, peer groups and doctors.)

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EACH DOCTOR would be affiliated with and identified with a single peer group, within a single local area. (HMOs could comply)

EACH SUCH PROVIDER of medical services would own or have access to a computer, M3 systems furnished software and a national network connecting all providers with each other as well as with M3 systems.

REFERRALS to other providers would be automatically transmitted to these other medical offices via the national computer network (simply by entering a numerical network address through the first provider's computer keyboard). (HMOs could comply)

Model-3 central systems would receive all statements of services performed through the same network, coded properly at the locations where the services were performed.

THE ACCOUNTING SYSTEM would be coded to analyse the performance of each area and peer group and each provider in both cost and quality, and would provide for 100% M3 systems-to-patient-to-M3 systems confirmation of services performed and satisfaction received.

AUTOMATED check preparation would complete the service cycle.

THE GOAL - All computerized, all transparent and seamless data processing between keyboard entry of data at each provider profit center and M3 systems check preparation, with the evaluation process, also automated, interposed prior to payment. THE ONLY EXCEPTION - manual assistance in mailing and coding M3 systems/patient evaluation forms and responses.

NOTE: Model-3 system operation has been called "government" throughout
It is now labeled Model-3 or M3 systems to better describe private operations.

PROVIDER REQUIREMENTS

PROVIDER REQUIREMENTS

1. USE MODEL-3 SYSTEMS furnished computer accounting software to guarantee systemwide software compatibility.

> NOTE: Computer hardware for each profit center could be either separately owned or jointly owned by several small profit centers, with communication by phone or fax. Intel 80486 computers should be more than adequate to handle the expected software. Data storage for larger profit centers (example, Kaiser Permanente), would be at least nominally in line with present needs.

2. MEET STATE licensing requirements, both business and medical.

3. PARTICIPATE in local peer groups whose membership would be subject to group disciplines. (ELIGIBILITY only after meeting accounting and licensing requirements)

> NOTE: PEER GROUPS should not be formed until both the standard accounting and patient identification systems are in place, tested, and fully operational. Only then will the impact of the new accounting system be fully understood by participants. Only then can the data be available to properly analyse peer group performance.

PRIVATE SECTOR OGANIZATION

MODEL-3 ORGANIZATION is a four level competitive pyramid: National, Local Area, Peer Groups and Individual Physicians. While "national" could be "statewide" that would greatly reduce the competitive pressures of the Model-3 system. Given 50 states of equal area and population, all doctors would have 50 times the competition in a national system. Powerful. There would be one, not fifty, accounting systems - probably with incompatible software. Citizens would only have unrestricted access to doctors within a single state since the accounting systems would block wider access. One national Model-3 is better than 50 state Model-3

Nationally all Model-3 providers are competitive. Locally all providers are cooperative. Distant competitors cannot easily cooperate nor can they take business from each other. They are forced by Model-3 to be better providers in every way to gain relative income. Locally all providers share in the benefits of having good colleagues. Model-3 forces providers to help each other to by sharing facilities and advice for mutual profit. They also are motivated to rid their groups of poor performers because low levels of performance within peer groups - and local areas - adversely affect the incomes of these two levels of collaboration. Every provider in a local area gains financially if the area has both adequate useful capacity and limited excess capacity and uses capacity efficiently.

Peer groups are organized, and quality of services are analysed to establish the fee adjustments appropriate to reward or penalize the entire group for the net total effect of member performance. It then becomes the responsibility of the group to work with deficient performers in the group to improve their performance. Failure in this effort certainly will impact the income of the entire peer group - and may result in expulsion of the offender(s).

FRAUD RELATED billing excesses should quickly become obvious within the peer group involved - and quickly dealt with to preserve both income and reputations within the group.

Similar motives will exist in the entire local area since the area also will have performance level ratings which will affect fee adjustments in the entire area. Organizational rules will permit expulsion of an entire peer group from participation

in the national health care program in that local area.

Provision will be made for committees at both the peer and the overall local area to work within their organizations in correcting deficiencies, including any cost-increasing fraudulent practices by individual doctors.

THE ULTIMATE PENALTY - expulsion of a member or an entire peer group - is severe.

IN MODEL-3 NON MEMBERS CANNOT PARTICIPATE

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MOTIVATION and COMPETITION

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MEDICAL CARE PROVIDERS should want:

Patients,

Adequate fees,

Freedom from administrative rules and regulations

Freedom from limits imposed on their medical judgement.

Freedom of choice in making referrals.

GOOD PROVIDERS deserve all of these. Others do not.

MODEL-3 HAS TWO MOTIVATIONAL TOOLS to financially reward good providers and penalize performance deficiencies. They can both be used in proportion to the need to motivate efforts toward excellence - as defined by M3 systems. This proportionality means that whatever pressure is required is available.

.....

TOOL #1 - PUBLICITY

MAKE PHYSICIAN PERFORMANCE RECORDS PUBLIC so that patients can better select the best doctor for their particular needs. Only normalized data showing relative performance would be made public. Sharply restrict other advertising for covered services.

The patient supply problem is solved with fairness to all.

No administrative interference is involved. (details later)

Doctors are motivated toward quality. Strongly motivated.

TOOL #2 - ACCEPTABILITY TO PEERS

FORMATION OF PEER GROUPS must of necessity be by mutual agreement. Doctors run businesses as well as provide medical care. If some in their peer group over-price their services or are incompetent, the cost of services for the entire group will be unduly high. Group organizers will negotiate to get participants who do not pose this problem. After formation, the entire group will seek ways not affecting their own income to make every unit in their group AS COST EFFICIENT AS POSSIBLE. Who can know better than peer group members what changes will enhance group performance?

THE THREE FREEDOMS listed above are inherent in the MODEL-3 system.

MODEL-3 SYSTEM CONTROL

NO PARTICIPATION in private sector medical or financial decisions and no restrictions on the form of medical treatments for covered medical needs.

FULL CONTROL of private sector accounting methods - both financial and medical - standardized by M3 systems furnished software and a national computer network. IT IS ESSENTIAL that this software does not permit external access to internal files, either M3 systems or provider station, except for very explicitly authorized purposes. All network transmissions must follow approved protocol. Breaches of internal privacy would be fatal.

STRICT CONTROL of peer group organizational form, functions and limitations.

CONFIRMATION BY 100% direct-to-M3 systems patient verification of services performed including yes/no responses to appropriate quality control questions.

AUTOMATED FRAUD and quality control analyses based on these fully automated confirmations, with payments delayed until patient confirmations have been received.

AUTOMATED COMPARISON of relative performance between areas of similar demographics, for use in reducing or increasing local area payment levels according to both cost per patient and quality of delivery relative to other similar areas.

> NOTE: Preventive and successful treatment vs neglect and improper treatment should have much greater impact on per patient costs than would fee differences. One of the benefits of the test period would be to evaluate these and similar factors prior to detailed definition of the bases for fee adjustment protocol.

IF GOOD MEDICAL PRACTICES HAVE A LARGER-THAN-FEE-CHANGE COST IMPACT the effect of the entire program will be dramatically different than otherwise, regardless of the form of the final system.

M3 SYSTEMS CONTROL OF INFORMATION

MODEL-3 ACCOUNT SYSTEM FEEDBACK is designed to provide clear cut information by which the quality of medical service can be statistically measured. This information holds the key to NATIONWIDE evaluation of provider performance. Without this tool MODEL-3 concepts would be impossible.

Another benefit is inherent in any data bank that permits NATIONWIDE evaluations of this nature. Quite impersonally and impartially the data can be converted to forms useful to patients in their quest for the doctor most suitable to their needs.

MODEL-3 PROVIDES this information, at no cost to the health care system, through unlisted 900 number telephone lines accessed by fax or computer and paid for by the requesting persons.

PUBLIC INFORMATION ON DOCTORS

MODEL-3 WOULD PROVIDE INFORMATION to enable the public to determine the results other patients had obtained through the use of doctors in their immediate area. This information would be a required service in all Libraries and Doctor's offices.

The information would include a brief description of the doctor's specialties and historical background. The biographical data would be within a limited number of words, and would be a part of the data each doctor would supply to M3 systems via the accounting network. Provision would be made for periodic but not frequent revisions. Peer groups might be required to certify this data. Note that employer/employee or HMO relationships are NOT relevant to doctor data.

MODEL-3 WOULD ALSO limit advertising beyond the 900 line data to an on-request statement (which could be as detailed and elaborate as the doctor or his institution wished) to be given out in office or by mail to requestors only.

Notices of new offices or office locations would be allowed as specifically defined by M3 systems, over a specified time period. No other mass mailings or mass media advertisings of any nature would be permitted. NO MORE HYPE IN MEDICAL ADVERTISING.

USE OF THE 900 LINE DATA FOR DOCTOR SELECTION BY PATIENTS should be wide spread and a very effective motivation for doctors to meet patient's needs. Other

advertising would be strictly limited.

ACCOUNTING SYSTEM

.....

THE ACCOUNTING SYSTEM should include code numbering of all patients, physicians and profit centers.

EACH PROVIDER ISSUED BILLING STATEMENT should include:

Number coded identification of

The patient,

The physician,

The profit center.

RECOMMENDATION: each personal identification code number would PERNAMENTLY include, at a minimum, home or business zip code and date at the time the health care number is assigned (to confirm identifications). Other code elements obviously will be required.

Number coded definition of type of service rendered.

Number coded service outcome.

EXAMPLES: 1=successful completion, 2=referral to (numbered profit center) for (numbered procedure), 3=continued treatment scheduled, 4=continued treatment required but refused, 5=unsuccessful completion, 6=death.] It should be possible to limit the code to one digit numbers.

Automated referrals would follow from entering the referral code

(=2) into the system. This code would require a scheduling

response from the receiving referenced center, and a mailed confirmation from that center to the patient. Only after completion of the required service, including ancellary services ordered by the referenced center, would the M3 systems receive a comprehensive billing statment, combining the referring physician and all subsequent services. This final bill would be triggered by the completion code used in the completion of services report - and also by time limits - interim bills permitted for lengthy treatments.

THE SOFTWARE should provide complete freedom to add privacy-protected and confidential internal records at each station, fully identified with billing data, but organized in any manner convenient to the health care provider. (Intended for private sector but could help patient verification tasks also.)

.....

PERFORMANCE ANALYSIS

GRADE the cost/performance of each physician,

GRADE THE QUALITY of each physician based on patient responses.

COMBINE both analyses with others within the peer group for a group rating.

COMBINE all peer group ratings in a local area to obtain an area rating.

COMBINE all local area ratings to obtain a national norm.

USE the present medicare fee structure to convert percentage data to dollar amounts.

CONSIDER comparing local area median incomes with provider fees.

.....

TECHNOLOGY EXISTS to construct this network and meet these goals, and today's state-of-the-art technology is being upgraded very rapidly in both capability and cost effectiveness through improvements in both hardware and software. Model-3 will use these available capabilities, hopefully to achieve very substatntial cost savings.

SPECIFICATIONS COVERING THE SOFTWARE must cover a variety of contingencies too detailed for these few pages. The capability of the dual patient and doctor reporting system must be used for fraud control as well as performance evaluation. The automatic rate adjustment system must be sufficiently flexible, and provide for sufficient ease of modification to permit refinements as experience dictates. The patient reporting sequence must also have this flexibility. There are many other facits that merit mention. Some inevitably have been overlooked. Others simply are not included in these few paragraphs.

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MOTIVATION BY FEE ADJUSTMENT

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METHODS: Performance analysis as used in Model-3 almost demands that a pay-for-service accounting system be utilized. National patient/doctor analysis would be impossible without this requirement.

It should be noted that this requirement applies ONLY to the national network.

Accounting methods and compensation systems within any one profit center need not be so limited. Salaries, bonuses and fees in any combination can be used as desired within the financial stucture of each individual medical care provider. The system only requires that these internal details be isolated from the network data, with pay-for-service accounting used exclusively in all network transmissions.

HMOs will be certain to use this internal freedom.

GOALS: There is an ultimate, completely cost-effective and treatment-appropriate method for delivering health care. No one, either professional or non-professional, should pretend to the ability to fully define such a process. The goal of MODEL-3 is to permit professionals in every local area the freedom to seek this ideal goal independently, and to provide for large numbers of direct competitors the reward/penalty environment to encourage its pursuit. There is no other, hidden agenda except that non-provider system overhead be minimized.

MODEL-3 MOTIVATION is created by fee adjustments based on data accumulated entirely through the nationwide network.

To do this effectively those charged with software specification details must have both flair and knowledge. Humans have pervasive characteristics that can be used to influence behavior. Organizations have functions that must be recognized and performed. Patients have needs that are both physical and psychological. Budgets have limitations that must be met. Weaving a control system that leads large groups of people to competitively manipulate many factors to both your and their benefit is not a simple task, but it can be done and is being done in today's American industry.

Doing this in health care is the challenge demanded by Model-3.

> NOTE: Ideally Congress will enact legislation to establish Model-3 as proposed in this presentation.

ALTERNATIVELY each state could independently enact uncoordinated but similar Model-3 legislation. The consequences would be that:

1. There would be 50 almost duplicate accounting systems. Costs would skyrocket.
2. Out-of-state insurance coverage would not be easily transferred between the 50 states. Out of state coverages would at least be very awkard.
3. Nationally compatible evaluation data would be next to impossible.

A SECOND, MORE EFFECTIVE ALTERNATIVE TO FEDERAL LEGISLATION OF MODEL-3 would involve joint action by the 50 states to collectively institute a nationwide Model-3 system of health care. The effect of this action would be essentially identical to a federally defined Model-3..... The major difference would be in the details of the actual state legislative agreement and in the nature and composition of the single oversight committee that the states would collectively create - and the costs associated with coordinating and implementing a 50 state legislative agreement involving control of Model-3 details.

Nevertheless, if federal action does not provide the essential features of Model-3 the 50 states should be actively encouraged to create this money saving joint effort Model-3 alternative. Contacts with various state governors on this subject may soon be appropriate to enlarge their

support for a federally authorized Model-3 system.

FEE ADJUSTMENT LIMITS

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FEE ADJUSTMENTS can be made very simple - as simple as just the ratio of total annual billing vs total number of patients. Efficiency would be rewarded. Market place motivation would be in effect. The National Operating System would be equally simple. No effort, just set the rate adjustment formula and wait for the response as each medical provider attempted to compete for higher fees. Model-3 principles would be satisfied (somewhat).

MORE COMPLEX CONTROLS could also fulfill Model-3 principles. Provider services could be adjusted by age and sex of patients vs treatment outcome or any other way - or based on the preferred decorations in provider waiting rooms.

THE POINT: Model-3 principles are flexible.

The full range of control is available within the National Operating System to dominate any desired element of provider behavior throughout the entire Health Care industry - fully automatic, no memos, no paper, no individual attention. Complete, no exception, no escape control, Nationwide, of the entire industry, from Tampa to San Diego, with no complaints of favoritism.

HMOs on a level economic playing field with the one doctor office.

MILLIONS of patients, judging thousands of doctors. M3 systems setting fee differentials. The market place motivating doctors. Very simple --- Non intrusive and very effective

A national oversight committee controls the nature of evaluations and the severity of fee adjustments. (Now called **"COMPETITION RULES COORDINATORS", this committee would be constructed to closely represent the interests of the general public in addition to posessing the requisite analytical skills.)**

DATA PROCESSING

.....

THE AUTOMATED ACCOUNTING SYSTEM SOFTWARE must be capable of receiving two inputs and producing two outputs.

DATA IS RECEIVED and stored:

1. from providers in the form of billing statements.

2. from patients as confirmation of care received and as evaluation of service.

NOTE: M3 systems-to-patient information request mailings are generated by billing statements, mailed to patients, and analysed on return. Portions of this process, if not fully automated, are expected to be the only non-automated elements in the normal service-to-payment cycle. Lack of patient response will result in automated notices to the provider who must do the follow up - outside of Model-3 - prior to receiving payment.

DATA IS PROCESSED:

1. to match patient and doctor inputs.

2. to add the new performance data to prior inputs from that doctor and that patient.

3. to evaluate doctor performance and adjust motivational fees.

4. to compute payment rates applicable to the services billed.

5. to update doctor performance data for 900 line distribution.

FULLY AUTOMATED RESULTS ARE ACHIEVED:

1. The provider is paid by computer generated check.

2. Computer-generated/area-sorted 900 line information is transmitted on request.

M3 SYSTEM OPERATIONS

MODEL-3 SYSTEM OPERATIONS are user friendly. The system is designed to be installed in measured sequences.

PARTICIPATION BY HEALTH CARE PROVIDERS would be voluntary. Those who did not qualify by either choice or necessity would simply not participate in the National universal health care program. Eventually they would be out of business.

PRELIMINARY PERIOD:

1. Software is prepared, tested and distributed to providers together with specifications indicating hardware requirements and instructions for mandatory peer group formation.

2. Providers are notified that participation requires adoption of the accounting methods established by the software.

3. Providers are given time to adjust to the accounting system.

4. Health Security cards are distributed.

PRELIMINARY OPERATIONS PERIOD:

1. Billing is processed without rate adjustment. Model-3 leaves the subject of base rate levels open to resolution as enabling legislation evolves. Many alternatives exist.

2. Performance data would be accumulated and relative ratings would be made available to every provider. Providers would begin to adjust their operations to obtain better performance rating.

3. Mild fee adjustments would be implemented. As experience dictated rate adjustment formulae would be modified and overall percent impact would be increased until equilibrium with need was achieved. The pace of adjustment would be sufficiently slow to prevent harm to the industry. Transition in the billing process will be smoothed by planned interim procedures which, while inefficient, will follow well defined and readily accomplished adjustments. Discussion of the process will be more appropriate as Model-3 implementation becomes imminent.

FULL OPERATIONS PERIOD:

1. Rate adjustment factors and formulae would stabilize. Providers would either improve performance in step with national achievement averages or fall by the way side. The market place can be cruel.

PLEASE NOTE THE SIMILARITY BETWEEN MODEL-3 AND THE WELL TESTED METHODS USED TO CONTROL ELECTRIC, GAS AND TELEPHONE COMPANIES.

> Note that utility rate adjustments do motivate. In utilities government alone judges utility operating decisions. Model-3 does better. The single medical care product - health care - is judged for every delivered service, by every served customer. SEE ADDENDUM A. Page 46

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MODEL-3 SYSTEMS NETWORK COSTS

THE MAGNITUDE of the overall system data transfer and analysis workload obviously cannot be analysed without precise data. However, a first guess for visualization purposes only may be appropriate here. Suggestions for hardware would be out of place.

MANPOWER FOR THIS OPERATION would be minimized.

Except for manual assistance in the mechanical process of mailing evaluation notices and coding the returns - not included in this estimate - the processing of provider statements, including data analysis and the M3 systems payment cycle, will be hands off and 100%

automated.

FAILURE to receive satisfactory patient verification responses should trigger an automated M3 systems-to-provider notice through the national computer network. Followup should be made only by the provider, who would have to clarify the situation prior to any further M3 systems action regarding payment for the services in question.

FULL PROGRAM DEFINITION must treat this specific subject in detail. There are several questions, including questions of fraud that must be answered. It should be part of the software specification effort to assure that instructions for treating any problems such as these that cannot be resolved within the automated system itself are included as both unambiguous and fully definitive text in the software itself.

EQUIPMENT COST will depend on the number of computations involved. Preliminary benchmark numbers can be obtained by using arbitrary initial numbers.

.....

ARBITRARILY SAY that:

1. There are 650,000 physicians in this country.

2. Each physician sees an average of 10 patients a day.

3. Computers used in these comments (intel 486 processors) are totally inappropriate for actual use. They are simple a familiar example.

4. Arbitrarily say that these computers can analysie one typical pay-for-service transaction per minute, including both billing data and evaluation data and the associated sorting and data storage tasks..

NOTE: Intense activity is now being devoted to massively parallel supercomputer developments and interactive network software suitable for Model-3 usage. One such developer is Oracle systems, with a single unit that might equal the several thousand 486 computers used in this illustration. Surely these new developments would be more cost effective than the illustrations

on this page.

5. 1440 minutes in a day, and 140 minutes of daily down time per 486 computer, leaves 1200 minutes per day for computations.

6. 650,000 times 10 divided by 1200=5416 Intel 80486 type computers required. $2000 times 5416=about $11,000,000 cost. for visualization purposes only.

7. DATA STORAGE costs will be higher. Using $1 per megabyte, 1000 bytes for each service billed, 10 times 650,000 services per day, storage costs for this data would be $6500. Times 300 days per year=$2,000,000 for one year. Times 10 for 10 years (excessive) = $20,000,000. Times 2 for backup of data = $40,000,000. Times 2 for equal amounts of patient evaluation data = $80,000,000 total estimated cost of data storage hardware. This is $122 per physician. (Paid by the government, but is small enough per physician to be easily recovered by a nominal one time - or annual - rental for software.)

This is $11,000,000 + $80,000,000=$90,000,000 or $140 worth of M3 systems computing equipment per physician to automate Model-3 central data processing for the entire health care system of this country. A reasonable annual fee per physician should cover the entire M3 systems budget!

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900 NUMBER INFORMATION LINES - COSTS

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PUBLIC INFORMATION 900 # operations would be financially self sufficient. Data cost would be an integral part of the basic analyses for the system. The actual telephone usage charges would be paid at the delivery location, by the requesting citizen. Charges could easily be set to provide a profit for this service.

IN PRACTICE local distributing points could access the needed data on competing physicians only once, (with quarterly updates) and use the office copier to fill the expected stream of requests. Final customer charges could, within controlled limits, also include a small profit for Libraries and Doctors who distributed the data.

SUPPLEMENTAL INSURANCE

SUPPLEMENTAL INSURANCE as used in this document is defined specifically as any health care insurance that is included - after negotiation of contract details - in Model-3 funding. Such funding would obviously and inevitable be supplemental - an addition to tax based funding

INSURANCE COMPANIES (and alliances if used) would be permitted to sell supplementary insurance to both individuals and groups, but would be required to purchase re-insurance from Model-3 systems for all such policies.

The reinsurance transaction would be negotiated between M3 systems and the Insurance Companies on terms giving M3 systems reasonable profit on the necessary data processing required for various associated tasks, including coding the records of each individual covered. A recourse clause covering losses would also be required for each transaction.

Reinsurance costs should be more than counterbalanced by the increased efficiencies of the health care industry and the lowered cost of an efficient, unified accounting system. Further, this unification of the basic and supplemental insurance would greatly simplify implementation of any legal changes that progressively altered the limits of the basic Health Security coverage.

THE EFFECT of this process would be to extend the billing simplicity - and more important, the analytical adequacy - of the Model-3 system to any and all alliance or insurance, national or state-by-state methods of health care financing.

INSURED CARE

PLEASE NOTE:

MODEL-3 is the only system yet proposed publicly under which adequate data can be assembled to maintain a feasible nationwide quality and cost competition between health care providers.

Nationwide competition is the only way that thousands of competitors can be forced to seek medical delivery methods superior to all others.

.....

SUPPLEMENTAL INSURANCE as presented on the previous page is an essential part of Model-3.

SUPPLEMENTAL INSURANCE is also a necessary introduction to our comments on Managed Care. It should be read as a part of the Managed Care discussion.

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NOTE: "Managed" Care was valid wording when it was written (in 1993). It meant alliances and bidding wars. Now it means HMOs. In the following pages the word "Managed" has been changed to "insured". ("Insured" as opposed to tax based care.)

TRANSITION TO INSURED CARE

.....

SUPPLEMENTAL INSURANCE operates under insured care in a manner that preserves the efficiencies of Model-3 and permits the flexibilities of private enterprise to deliver variable levels of insurer covered health care. Model-3 is the bridge between health care and insurers.

THIS VARIABILITY in insurance coverage is one of the benefits that alliances featured in the 1993 version of ClintonCare. Model-3 with Supplemental Insurance, becomes a tax based **and** insurance based health care hybrid **without the use of alliances and bidding wars.**

THERE COULD BE many transition methods proposed. Among them would be starting with a zero level for Model-3 tax based coverage and using Insured Care as a funding source for all health coverage.

ALTERNATIVELY Model-3 could fully cover a tax-based safety net as described by President Clinton (in 1993) - universal, adequate, cost effective Health Security - while Alliances (1993 thinking) were formed and became fully and effectively operable. The transition to insured care would then be a process of transferring individual items of the basic care package to the Insured Care system until Model-3 became simply a name for the Nationwide Network that accomplished the accounting and competition functions of the health care system. (ClintonCare concepts have changed, somewhat out-dating these thoughts.)

THE PRIME PURPOSE of Model-3 is to provide the most efficient and effective system for operations control of the medical provider industry.

MODEL-3 AND INSURED CARE ARE COMPATIBLE

FULL FLEXIBILITY can be obtained by putting Model-3 operations control in place as a required accounting system before attempting to achieve the Health Security goals of universal and adequate coverage. Using the sequence described under M3 SYSTEMS OPERATIONS Model-3 can be implemented faster, and with less political and economic termoil than Insured Care. **In all respects the hybrid is better than only tax-based or insurer-based care.**

HOWEVER, STAND ALONE TAX-BASED CARE, compared to stand alone Insured Care will be easier to sell, faster to install, and will deliver more care at less cost than Insured Care.

SAMPLE PATIENT QUESTIONAIRE

NOTICE: YOUR DOCTOR will not be paid until you return this questionaire. YOU must pay your doctor unless you return this report (or your credit may be affected).

NOTE: Questions are illustrative OF METHOD only.

PLEASE BE TRUTHFUL. (government) will use your answers. YOUR DOCTOR will never see your report on his performance. Truthful answers will help government help your doctor - and other doctors - to serve you better at lower cost.

Please fill ONE circle for each answer. The left circle always means very unsatisfactory. The circle farthest right will always mean very satisfactory. Circles near the center mean less extreme opinions.

DOCTOR'S OFFICES:		
VERY DIRTY	OOOOOXOOOOO	VERY CLEAN
POORLY EQUIPPED	OOOOOXOOOOO	WELL EQUIPPED
VERY MESSY	OOOOOXOOOOO	VERY NEAT
COURTESY:		
DOCTOR	OOOOOXOOOOO	
NURSE	OOOOOXOOOOO	
RECEPTIONIST	OOOOOXOOOOO	
YOUR HEALTH:		
BEFORE VISIT	OOOOOXOOOOO	
AFTER VISIT	OOOOOXOOOOO	

REASON FOR VISIT: check one only

ROUTINE CHECKUP	O
ACCIDENTAL INJURY	O
SUDDEN ILLNESS	O
CHRONIC ILLNESS	O

NOTE: INSERT REFERRAL SHEET IF APPROPRIATE.

Would you like to change doctors?

YES-UNHAPPY OOOOOXOOOOO NO - I'M HAPPY

Signature_____Date_____

REFERRAL SHEET:

NOTE: THIS PAGE added to basic questionaire only if the billing involved additional tests, hospitalization, etc.

YOUR DOCTOR required the following tests and treatments.

PLEASE MARK EVERY TEST AND TREATMENT RECEIVED OR NOT RECEIVED.

	RECEIVED	NOT RECEIVED	(LO SATISFACTION HI)
TEST FOR_____	O	O	OOOOOOOOOOO
TEST FOR_____	O	O	OOOOOOOOOOO
TEST FOR_____	O	O	OOOOOOOOOOO
TEST FOR_____	O	O	OOOOOOOOOOO
TREATMENT------	O	O	OOOOOOOOOOO
TREATMENT------	O	O	OOOOOOOOOOO
TREATMENT------	O	O	OOOOOOOOOOO
TREATMENT------	O	O	OOOOOOOOOOO
HOSPITAL DAYS------	O	O	OOOOOOOOOOO

Your Doctor is responsible for selecting referral Doctors and Hospitals. Are you satisfied with his selections?

VERY UNHAPPY OOOOOXOOOOO VERY HAPPY

PRIMARY CARE Doctors would be required to hold billing statements until completion of tests and treatments ordered - but no longer than a specified time such as 4-6 months, and would forward billing for tests and treatments. Later care would start the time period clock again.

SOFTWARE would track this requirement. No special attention would be required. The requirement would make software more complex, but would be do-able. The system would be programmed to track performance each time a referral request was completed, and to automatically bill when every request was completed or cancelled or the clock time had expired.

NOTE that this segment of the software would be performed at provider stations and would not complicate the M3 systems central software. The benefit would be to consolidate evaluations as well as payments, potentially resulting in a more accurate evaluation as well as more cost effective operation of the Model-3 central system. Bill forwarding would be done automatically at the Primary Care Doctor's computer station. Checks would be directed to the performing organizations. Note that software specifications would have to be quite detailed on this subject.

******

FURTHER THOUGHTS

AREA SIZE:

1. TRAVEL DISTANCES and population densities should dominate area size decisions for obvious convenience reasons.

2. FOR ANALYTICAL reasons, homogenous populations, both cultural and economic, should be a goal, subordinated to travel distances and population densities.

3. ANALYTICAL GROUPINGS of similar areas should be totally unrelated to geography, but should be made and used for the sole purpose of leveling the analytical field to assure that rural areas are performance rated together with other rural areas as well as against their own past performances, high income areas with high income areas, high density population areas with high density population areas.

4. THE RELATIONSHIP between dissimilar area groups (rural, city rich, poor, etc.) should be subject to frequent high level review.

PEER GROUP SIZE:

1. PEER GROUPS IN HIGH DENSITY AREAS should be restricted in numbers of members so that an individual profit center cannot underperform significantly without impacting the income of the entire group. A minimum size should also be imposed to assure that the group is isolated from domination by crony cliques. First guess, aim at 60 doctors and 30 profit centers or 100 doctors or less and one HMO per average size peer group.

2. PEER GROUPS WITHIN RURAL AREAS should be exempt from minimum size regulations. Even a single profit center in a remote region should be treated as a peer group if the territory covered is designated (as it should be) as an independent area for analytical purposes. Such analytical treatment permits special rules covering unusual travel costs, etc. - such rules would have wide latitude and should be made at the start of the program and by the highest levels of decision making.

.....

PEER GROUP/AREA RELATIONSHIPS:

1. EVEN IN REMOTE, one provider supported areas, the peer group should be restricted to and identified as being in a single local area to facilitate analysis.

2. REFERRALS SHOULD BE PERMITTED without restriction between areas. It is

proposed that the accounting system be fully keyed to the provider first contacted by the patient. This accomplishes two things.

1. The initial, referring provider, and his peer group are rewarded or penalized by his referral choices.

2. The patient is not denied the best treatment sequences for non-medical reasons of any sort.

.....

NOTE: REFERRAL KICKBACKS should be illegal with heavy penalties.

.....

Even HMO outside referrals would fit the accounting system for other HMO services - or contracted services by individual specialists - without paperwork outside of the automated national network. Such transactions would be "seamless and transparent" in both data entry and final billing. Properly prepared software would cause no need to exit the normal analytical cycle to accommodate the existence and special needs of HMOs.

Inter-area referrals would complicate software, but not excessively. Keyboard entries should not be affected, since all data regarding physicians and profit centers would already be in the NATIONAL accounting system.

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ADDENDUM A. April 18, 1994. Ref. page 34.

At the option of each state Peer groups will be required, within time limits, to report (1) their intended methods to correct excessive evaluation deficiencies of both individual members of the group and the group itself and (2) to report completion of the proposed actions. States would have the options of creating requirements for these actions including approval and participation rights before and during the correction process and the establishment of penalties for non-compliance with these requirements up to and including possible revocation of license(s).

Note: Adenda to be written.

1. Privacy issue. Model-3 as presently described will have patient records summarized as records of billable medical visits, tests and treatments such as surgury. The privacy issue is of concern to many. When this note is finalized it will contain specific divisions of records so that ALL will be either protectable by means controllable by patients or placed in files without patient identification for statistical evaluation or billing verification purposes. Protection methods will follow the rules of Bank ATMs and are already in mind.

2. Composition of National Oversight Committee. When legislation is enacted implementing Model-3 Health Care by either the Federal Government or by the coordinated action of the 50 states (an unlikely and clumsy way to circumvent bad Federal legislation) an appropriate decision will be made as to the Oversight Committee. In any event there should be at least subcommittee non-voting minority representation by major associations of physicians and by citizens not identified with the insurance industry, the medical care industry or any branch of state governments or the federal government. For both political and practical reasons Model-3 preferrences regarding this committee is subject to the situation when enabling legislation is being formulated.

END

THANK YOU FOR YOUR ATTENTION

Wayne B. Moore

THANK YOU FOR READING ABOUT

MODEL-3 HEALTH CARE

WITH

VOTERS IN CONTROL

Wayne B. Moore

MODEL-3 HEALTH CARE

SUPPLEMENTS

*****

I Condensed Summary (one page)

II FACT SHEETS

How YOU will benefit from Model-3
Why Model-3 is important
What makes Model-3 work
Government (only) guides and motivates
Patient power
Doctors listen
Universal coverage
Any doctor
Non-cancellable and pre-existing conditions
Single payer
Wall Street Journal Chart (Ban to Sanctions - 1494 times)

III Disclaimer (Model-3 is not a UWSA document)

IV Model-3 Systemwide Advantages (seven pages)
Model-3 software and its benefits)

V Community Ratings ala Model-3 (eighteen pages)

(I through V are separate documents, together for convenience)

****

"Your comment was extremely pertinent regarding the bureaucracy that can certainly strangle any form of healthcare. We will use many of your comments and suggestions."

American College of Surgeons.

If you agree, tell your Congressman AND Senator. It will help.

CONDENSED SUMMARY

MODEL-3 HEALTH CARE

August 15, 1994

In health care, the patient SHOULD come first. That is what health care is all about.

In Washington, bureaucrats have devised health care reform methods (quote Wall Street Journal, June 27, 1994) that include the words "ban, enforce, fine, limit, obligation, penalty, prison, prohibit, require, restrict, sanction" These words appear up to 1494 times in the plans Congress is trying to pass. Ordinary citizens deserve better. Bureaucrats should NOT control our health care. Certainly our doctors should not be treated worse than our lawyers (who make these laws).

Model-3 Health Care defines a system of health care that controls both our health providers and our health insurers more tightly than any of the bureaucratic plans now in Congress. And none of these words are used even once.

Model-3 has an automated accounting and evaluation system that closely tracks the performance of ALL providers and insurers. The evaluations are by every patient. Each of us must verify each treatment and indicate its effectiveness. Doctors, in Model-3, have full freedom to treat their patients in any way that is acceptable to their patients. If they serve their patients **economically** and effectively their pay increases. If they don't they are paid less.

Doctor's statistical results are publicized to help our citizens select the physicians most suited to their needs. Competitiom to find patients and to be paid well for their services will be fierce. The cost of Model-3 operations is much lower than any possible bureaucratically controlled health care - advertising, sales, accounting and other overhead costs are a small fraction of those in any system that pays clerks and salesmen to do the jobs that Model-3 does better by computer and no-labor-cost patient evaluations. Competition cuts costs still further.

These lower costs mean that billions WASTED IN OTHER REFORM PLANS can instead pay for more and better health care or can lower health care payments for each of us.

Model-3 saves many billions of health care dollars each year. Its your money.

Details are available.....**(OVER**.....or next page**)**

"Your comment was extremely pertinent regarding the bureaucracy that can certainly strangle any form of healthcare. We will use many of your comments and suggestions."

American College of Surgeons.

If you agree, tell your Congressman AND Senator. It will help.

FACT SHEET 1

Model-3 health care_____Model-3 Health care

HOW MODEL-3 BENEFITS YOU

The short answer: Model-3 saves your money - by forcing insurers and doctors to compete just like Kmart and Wal-Mart. And doctors serve YOU. Model-3 keeps government, insurers and even HMO supervisors off your doctor's back. Believe.

The correct answer: 1. Model-3 computerizes almost all of the accounting tasks now done by hand in both the health insurance and the health care industries. No paper. Money flows smoothly by computer to pay providers for your health care. It saves a bundle.

2. Model-3 includes a very strict competion between doctors all over the country - nationwide - that rewards with higher pay any doctor that does better than others by their patients. That makes doctors work smarter, to help you better, to increase the smart doctor's pay. Doctors will pay attention. Each will constantly strive to serve you better.

3. Model-3 publishes each doctor's record in this competition, along with other personal information, so that you can decide before you choose **your** doctor which one might be best for you. That makes doctors work smarter to get more patients.

4. Model-3 prohibits government interference with your doctor's decisions on what drugs to prescribe for your treatment. That keeps doctors from threats of punishment if they don't prescribe treatments exactly as the law (written by lawyers for insurers and drug companies) says they should. The reforms now being pushed through Congress use the words "ban, enforce, fine, limit, obligation, penalty, require, restrict, and sanction" up to 1494 times according to the Wall Street Journal. This chart is available.

5. Model-3 allows you ;to buy any insurance from any insurance company, with only one safeguard. Model-3 calculates the actual value of each dollar you pay for insurance against the odds that the insurer will either earn too much or too little. Only fair value policies will be permitted. Under Model-3 everyone is treated fairly.

6. Model-3 **immediately** provides a very small coverage to every U. S. citizen. This admits you into the system. Congress can then simply increase that coverage or not as it wishes. Gone are the debates about 90% or 95% universal. Everyone is in. It doesn't break either your bank or the government's because it is small - and **everyone is in.**.

7. It is technical, but Model-3 provides special circumstances that make it easier to make every policy portable and to eliminate exclusions for pre-existing illnesses. You save money and gain each of these advantages. Details are available.

FACT SHEET 2

Model-3 health care_____Model-3 Health care

? WHY IS MODEL-3 IMPORTANT ?

The short answer: To protect us from something far worse. See fact sheet # 11.

The correct answer: Everyone says that there are 650,000 physicians in America. Senator Rockefeller refers to 2, 500,000 "paper shufflers in our health care industry." Let's take the Senator's word for it. There are supposed to be 250,000,000 people in this country. With four people to each family that makes 62,500,000 families in USA.

Not to bore you, that is one "paper shuffler" in the health care industry for every 25 families in our nation. Suppose that every family had, on the average, 2 doctor visits a year. That would mean that each paper shuffler would work one full week to do the paper work for just one 15 minute doctor visit.

Lets be generous. Some of these do other adminisrtrative things too. But still, that leaves nearly 4 paychecks paid to people who **don't** give you health care for every doctor that **does** give you health care. Wal-Mart would go broke if only 1 employee in 5 did the actual work and the other 4 just kept track of what they did. These numbers are still unfair, because we left out tests and assistance in surgery, building maintainance, etc., but we're getting there. There is too much fat in our health care delivery system.

Model-3 gets the fat out.

Model-3 has several other benefits. It removes the paperwork that takes your doctor's attention away from you. It removes the billing and collecting functions from their administrators. It saves **every** insurance company the need to verify the correctness of every bill they receive from either doctors or policy-holders. It makes it unnecessary for insurers to advertise their policies - Model-3 does all the computing to determine just what each policy holder will get in return for each dollar spent on each policy sold in the entire country - and publishes the facts. Everyone saves money. Every insurer is treated alike. No favoritism.

Details of Model-3 methods are available.

FACT SHEET 3

Model-3 health care_____Model-3 Health care

WHAT MAKES MODEL-3 WORK

?????

The (very, very) short answer: **Everything is computerized.**

The correct answer:

1. Model-3 sets up an efficient plan for creating competition between individual health care providers and also between individual insurance companies.

2. Then it creates - by its computer-automated accounting and evaluation system - an accurate way to evaluate the performance of every provider and insurer in the country.

These together provide Model-3 the means for guiding providers and insurers **without** making their decisions for them. Then Model-3 simply pays those who give the patient good value for each insurance or tax dollar more than Model-3 pays to those who give poor value for each patient insurance and tax dollar. More money for good values. Doctors will listen.

Simple. It works for Kmart and Wal-Mart. If Kmart gives the best value for the fewest dollars, it gets the business and the profits. If it doesn't then Wal-Mart gets them.

Details of Model-3 methods show that Model-3 will work, and why. Model-3 gives each provider and each insurer more freedom than any other reform plan that has been publicly offered. In spite of this, government **and patients** have stronger and more precise ways for controlling health care providers than any other plan. As for insurers, their cost of doing business is so much lower under Model-3 that it will noticably lower health care costs. In addition, insurers are allowed the freedom of submitting ANY insurance contract to Model-3. Any such plan must only prove fair value by completely impartial standards to be accepted by Model-3. NO competition by insurers OR providers is stifled by restrictive Model-3 rules. **There are none. The customers, our citizen/patients, decide what serves them best.**

In Model-3 single payer tax based coverage is equally acceptable.

Details of Model-3 are available.

FACT SHEET 4

Model-3 health care_____Model-3 Health care

GOVERNMENT (only) GUIDES and MOTIVATES

In health care, government should foster three proper and essential goals. (1) The industry must be honest, (2) It must serve the American public well, and (3) government should not (in Model-3 it MUST not) intrude in any way on the legitimate rights of any of our citizens. The question is: How does government do this under Model-3.

The short answer: Government motivates (but in no way forces) each insurer and provider to satisfy its customers. In Model-3 government only serves. It **cannot** command.

The correct answer: In Model-3, government defines the nature of achievements that must be met to satisfy two goals. It motivates - never forces - all participants -

(1) Toward maximum improvement in the health of each patient for each dollar of cost taken from that patient's pocket. This applies to both the insurer and the provider.

(2) Toward maximum patient satisfaction regarding each service performed.

Government sets competitive rules under which all members of each industry compete with each other to maximize their pay - based only on (1) and (2) above.

The prohibitions:

Government cannot define **any** treatment method as covered or not covered. Every health care coverage, from any tax or insurance source, MUST be defined only in terms of covered conditions and never in terms of methods used to correct those conditions.

Government may motivate, but cannot force or demand any standard of behavior or performance by any provider. (Model-3 also sets fair value rules impartially for all insurers.)

The words "ban, enforce, fine, limit, obligation, penalty, prison, prohibit, require, sanction" are never used for control of anything in Model-3. Only others use these words.

Model-3 is the private sector way. Government only informs and motivates.

Details of Model-3 methods are available.

FACT SHEET 5

Model-3 health care_____Model-3 Health care

PATIENT POWER

The questions: What power ? Over who or what ? **If you get power, who loses it, Is it important to you for them to lose it ? If you get power will you keep it ?**

The short answers: (1) The power to select and control your own health care and those who give it to you. (2) Government bureaucrats and elected officials, insurers and drug manufacturers lose power. (3) **YES, VERY** (4) IN Model-3 it is written into law. **You will.**

The correct answer: Model-3 requires that only you can be the judge of the quality of your own health care. It requires you to enter that information on a confirmation form that you must mail to government before your doctor can be paid. Instead of setting rules that can only be enforced after someone "blows the whistle" by a malpractice law suit, Model-3 removes all of the today's restrictions and punishments. Who wants to wait for malpractice law suits ? Model-3 keeps close track of patient dissatisfactions. If satisfaction is (statistically) too low, the doctor's pay is cut. If it reaches the point of predicting malpractice suits, other doctors in the area are pressured (yes that is the right word) into correcting the situation. And they are given the power to do just that. Patients then permanently have the power to identify both good and bad doctors. And other doctors - doctors who live and work in the same community - are required to correct the problems that patients have identified. You still can sue. Fewer will.

Each state now licenses doctors. They already have authority to withdraw licenses of doctors with serious behavior problems. This remains as a backup to the Model-3 professional review. The Model-3 review, and the patient information that requires it is avaliable (statistically) in public libraries. States obviously may use it as they wish. Be assured doctors will listen to their patients. Patients will be in control. They will remain in control.

Note that statistical data on patient satisfaction earned by each doctor is published. It is provided at every public library. The library gets this information through a 900 line and those requesting it pay a small fee. The information they get will include personal information that each doctor provides to help new patients choose doctors who might best fit their needs.

This is an important subject and justifies more than one page of discussion. More information can be provided on request. For those who do not ask, please be assured. Doctors will benefit. Their Malpractice insurance costs will drop through the floor because problems will be caught very early. Doctors will learn. And patients will always and truly **keep their power** - as promised. Details are available.

FACT SHEET 6

Model-3 health care_____Model-3 Health care

DOCTORS LISTEN

The question: Will they really ?

The short answer: You bet.

The correct answer: Doctors receive checks for all services through the Model-3 accounting system - the fastest and cheapest payment method ever devised. Every check will have, on its face or on the back, a list of letters that match a code that all doctors will receive - and which you better believe they will use - to learn how to increase their income by serving you better.. Each letter will be a grade for one kind of measure of their performance.

Cost per patient for tests relating to their pattern of illnesses will surely be one rating inserted by government. The question will be "which doctor had more cures for less cost?". No required cost levels, just which is better and therefore gets better pay. Length of waiting time for appointments will certainly be a question for patient comments. General satisfaction (again, statistically - no patient names) will be another. Different words will be used, but this is the general idea. Government will choose the questions, and change them until they get the right results. Each doctor's results will be published to guide patients toward the right doctor.

Yes, doctors will listen to their patients' problems. If patients are not pleased with the results, doctors will get fewer patients, and will be paid less for serving those they do get.

Model-3 mails questionaires to patients after each doctor visit. The patient must fill out these questionaires before the doctor can be paid. Doctors will be asked to follow up if the questionaire is not received. When they are paid, doctors will know exactly how their pay was computed. So much as a normal payment for a particluar service, so much less for lower quality of performance and so much more for higher quality. Doctors will know just what to do to get happier patients, and they will do it. Simple. Wal-Mart works hard to please their customers in both price and quality, and they have found it very profitable.

Model-3 pays all doctors from a single "bank" that holds deposits from insurers, with the status of each policy holder identified. There is no medical treatment record attached to these deposits - patient identifications are separated from their medical records. This general process is called reinsurance. Model-3 is a reinsurer for all insurance companies.

Details are available.

FACT SHEET 7

Model-3 health care_____Model-3 Health care

UNIVERSAL COVERAGE

The questions: What is 100% ? When and how do we get there ? Can we afford it ?

The short answers: 100% means 100%. We get there immediately. The **amount** of coverage is very small until Congress increases it, so we can afford it. The first time ANYONE asks for health care, they will get it AND will be admitted into the system for one doctor visit only - free of charge unless already prepaid..

The correct answer: Under any circumstances, the first time after Model-3 is in effect that a doctor appointment is requested it will be provided, free of charge unless already prepaid. Thereafter, one annual doctor visit will be free for those below a specified income minimum. For most, coverage for the visit will already credited, even before the first visit. After the first visit, coverage will depend either on already purchased insurance or on taxes enacted by Congress. Model-3 recognizes both tax based and insurance based coverages.

How is this done ? Model-3 provides, at a minimum, that every U. S. citizen will receive one annual doctor visit, either prepaid or free. Every citizen who pays an income tax will have this tax increased $50.00 annually if their tax is already equal or greater than this amount. Each dependent will enter the system with another $50.00 added to the wage earner's annual tax. This is the only tax that Model-3 requires. Indigent citizens will receive this annual visit free of charge. Tax laws can readily be amended by Congress to adjust these amounts.

Note that non-tax-paying citizens will not appear in Model-3 files when a first visit is requested, but will be automatically covered for this visit. When such a visit occurs the individual will be automatically entered into the system. 100% coverage exists before and after that visit. Records simply improve when it occurs. Congress will be required to maintain contingency funds for this purpose. Beyond the single free visit for indigents, Medicaid will pay into Model-3 until Congress provides other means of funding. No cost shifting. Everything is on the books. Congress can also expand tax-based health service in any manner it sees fit. Once the Model-3 system is in place, cost reductions will be known and true affordability **rather than bureaucratic dreams** can be used to govern sensible legislation.

In addition to this tax based universal coverage, the Model-3 accounting system is designed to accommodate ANY fair value insurance plan that can be devised. Each state now controls regulation of insurers. Any state approved insurance contract may be offered for admission to Model-3. When negotiators analyse and accept its fair value, it will be admitted.

Details are available.

ANY DOCTOR

The question: What is "any" doctor.

The short answer: Any doctor. If you live in Alaska and vacation in Miami, Phoenix, San Diego or Chicago you are covered just as you would be at home. Even in Hawaii you can go to the local library, ask for a listing of local doctors, review their qualifications and the satisfaction level of their patients, make a decision and ask for an appointment. It is that simple, and that universal. The short answer matches the long answer. Both are correct.

The correct answer: Even professionals are just beginning to realize the enormity of information that can be held, organized, evaluated and made quickly available to huge numbers of individual computer terminals located anywhere, over the entire world.

Model-3 holds in one memory (with backup, of course) the records of every citizen who has ever had health care in the United States. Depending on Congress this could include its territories, and even embassies world wide. Technology would permit inclusion of any area selected by Congress. Only when no longer needed will these records be removed.

Every doctor or other kind of qualifying health care provider can also be held in the same very large memory. The records of every type of insurance and tax coverage can also be held, as can all of the evaluations of doctor visits made by each patient to each doctor.

The cost of such enormous memories is already low, and getting constantly lower. While agreeing that this can be somewhat an act of faith, it can be supported by comparison with large banking and other institutional computer systems. The Anchorage resident would have just as good health care coverage on vacation as at home. Model-3 records will be available nationwide. State-of-the-art computers and memory can do this job.

FACT SHEET 9

Model-3 health care_____Model-3 Health care

NON-CANCELLABLE AND PRE-EXISTING COVERAGES

The question: Will Model-3 provide portable, non-cancellable coverage without penalty for pre-existing conditions ? (On this page call it "full" coverage.)

The short Answer: Insurers would have to offer "full" coverage and probably would do so only if required by Congress since their problems would be both severe and complex. On the contrary, tax based health care can be very simple. Model-3 is easily capable of providing "full" coverage based on funding from any source or sources whenever it is available.

The correct answer: Model-3 is probably - maybe the only - practical reform method that can efficiently accommodate this type of health care coverage. It already has an inherent need for computer capability and computer memory capacity to handle the most complex analyses that might be required to distribute the "adverse selection" loads equably between insurers, policy holders and individual health care providers. A community rating brochure is available that discusses this problem at length.

This brochure deals with the complexity of this particular problem in a detailed review of various community rating methods of adjusting premiums and risks to all covered citizens in spite of their very large differences in health care needs. Both insurers and doctors have very difficult problems in dealing with this question. The larger the popluation included in each **individual** insurer or provider, the easier this problem becomes. Model-3 has the largest possible covered population. As a re-insurer, it includes all citizens in a single "bank" of funds.

This might be considered a complete answer to this problem. It is not. Citizens wanting insurance coverage could be asked to pay a single rate. The very health conscious 30 year old athlete would pay as much as a very sick 90 year old. The athlete would then pay some of the bills for the 90 year old and likely would never use a dime's worth of health care.

In a population of only two people, the athlete would pay half of the the entire health care bill. For a population of millions the penalty costs for the athlete would be more reasonable, but they would still be there.

To make the answer a bit more complex, athletes - all of them - could pay one rate and 90 year olds could pay another. The real answer is still more difficult. But for any solution, Model-3 has the largest population, its methods would be more accurate than any that a smaller population could produce, and Model-3 already can do all of the essential data analysis.

More details are available in the community rating brochure.

FACT SHEET 10

Model-3 health care_____Model-3 Health care

SINGLE PAYER

The question: To be or not to be.

The short answer: Managed care or single-payer. Model-3 never knows and never cares where money comes from. Money always comes from a source that specifies its use. Model-3 complies. No problem. Model-3 at its inception isolated funding from its users.

The correct answer: Model-3 is designed to include a team of negotiators who review every insurance contract submitted by any state or federally licensed insurer. If the contract offers policy holders fair value it is described in a report that is made available to the public and is admitted to the single pool of funds that is used within Model-3 to pay all health care costs for the nation.

From that time forward insurers are required to provide and maintain lists of covered individuals and Model-3 has in its memory the coverages and the individuals covered by that contract. Model-3 reinsures the risk under whatever community rating rules are applicable. There remains no need to associate the individual insured with the original source of funds. Single payer tax funding is no different to Model-3 than would be an insurance source. For single payer, Model-3 would only require a sufficiently large pool of tax based funds to provide the specified coverage. Every eligible patient would automatically be covered for the standard coverage provided by the fund.

All insurer negotiators could be fired. The country would have the cheapest possible health care system. If funding limits permitted it could still be the best possible system, but we all know that it would not reach that point of perfection. Someone would complain about costs.

In Model-3 there are other possibilities that should be given serious thought.

A single payer system would have a single-plan-fits-all type of coverage. Model-3 can handle that, but would our entire population be satisfied ? No, absolutely not. The negotiating team should be rehired and allowed to review any and all insurance contracts that are offered. Those with fair value should be admitted into the system. Anyone wishing added coverage above the single payer limit should be permitted to buy it. Those wishing to pay cash - above their single annual tax based doctor visit - should also be allowed to do so. That is the American way. **IT MAKES NO SENSE TO BLOCK AMERICANS WHO SIMPLY WISH THE FREEDOM TO PAY FOR SERVICES - ANY KIND OF SERVICES - THAT THEY WANT TO BUY. Model-3 allows them to do this within the Model-3 system. It should be legal. It does not prevent single-payer coverage. Details are available.**

THE WALL STREET JOURNAL MONDAY, JUNE 27, 1994

Removing Our Freedom

Individual freedom is one factor that appears to have been omitted from our raging health care debate. What limits would a given law place on doctors, patients and insurers? The National Taxpayers Union Foundation, based in Washington, rated eight health plans now under consideration in Congress (identified by the names of their chief sponsors). The first category tallies the frequency of words in each plan that suggest government restriction or punishment. (This matters because the words selected are ones that send signals to the courts.) The second category estimates the plans' costs. The third counts career limits placed on medical professionals, and the fourth registers price controls. "While the concept of government-provided security is alluring," the foundation's report advises, "it is also one which history tells us to regard skeptically."

HEALTH CARE BILL	Gramm/ Santorum	Nickles/ Stearns	Rowland/ Bilirakis	Michel/ Lott	Chafee/ Thomas	Cooper/ Breaux	Wellstone/ McDermott	Clinton
WORD COUNTS								
"Ban"	0	0	0	0	0	0	0	1
"Enforce"	1	10	39	43	37	10	2	83
"Fine"	0	2	3	3	12	0	1	6
"Limit"	19	30	53	48	80	68	33	231
"Obligation"	1	1	7	4	13	6	3	51
"Penalty"	5	9	21	23	64	5	2	111
"Prison"	0	1	3	2	1	0	1	7
"Prohibit"	5	6	6	9	19	6	7	47
"Require"	54	93	244	321	482	151	103	901
"Restrict"	1	9	3	10	19	2	1	35
"Sanction"	0	3	13	4	21	1	8	21
TOTAL	**86**	**164**	**392**	**467**	**748**	**249**	**161**	**1,494**
CHANGE IN FEDERAL SPENDING, 1999 (in billions)	**–$26**	**–$27**	**–$2**	**–$3**	**$30-$90**	**$32**	**$702**	**$608**
CAREER LIMITS								
Racial/ethnic/geographic	0	0	0	0	0	1	0	4
Limits *on going into* particular specialties	0	0	0	0	0	2	1	2
PRICE CONTROLS	**No**	**No**	**No**	**No**	**No**	**No**	**Yes**	**Yes**

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b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[0006c]

THANK YOU FOR YOUR INTEREST IN MODEL-3 HEALTH CARE.

Model-3 Health Care [redacted] P6/b(6)

September 1, 1994

Everyone is urged to fax or copy these fact sheets. Please spread the word. No charge if you do the work. Good luck.

Note: Model-3 Health Care has been an independent project, unsupported financially or otherwise by any special (or even objective) interest of any kind.

In particular, statements addressed to UWSA were included as an aid to UWSA members who were given this material for review. Some members who have not followed health care reform may benefit by this added detail. **No one in UWSA had any Model-3 information prior to April, 1994.**

Model-3 welcomes UWSA interest, and that of all other patriotic Americans. Model-3 has as its objective gaining for all Americans the benefits and efficiencies of private sector competition in an atmosprere that provides them **with all of the freedoms that are traditional in our society.**

Financial or other support IS NOT REJECTED. Any support for Model-3 objectives should be useful to our nation. It would be welcome.

September 1, 1994

Your comment was extremely pertinent regarding the bureaucracy that can certainly strangle any form of healthcare. We will use many of your comments and suggestions.

American College of Surgeons.

If you agree, tell your Congressman. It will help.

MODEL-3 SYSTEMWIDE ADVANTAGES

USWA members: June 24, 1994

It is important to understanding Model-3 that both the power and precision of Model-3 accounting and evaluation processes be fully recognized. These notes will outline the manner and describe the detail in which the Model-3 data base operates to enable the Model-3 system to accomplish its intended results.

Once the capabilities are understood it is important also to understand and draw a proper line "in the sand" between legitimate governmental concerns and the concerns of the patients who MUST "come first". Properly drawn, this important line prevents intrusion from either side into the legitimate concerns of the other. This line is also drawn in the notes to follow.

Wayne B. Moore

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MODEL-3 SYSTEMWIDE ADVANTAGES

Model-3, as described in its brochure, emphasizes the benefits to every element of our society. The individual who is better served, the doctor who is relieved of paperwork and expensive accounting and recordkeeping activities as well as of present restrictions imposed on his professional decisionmaking perogatives, congressmen who can then separate their concern over funding health care from the politics of defining the details of doctors' daily lives, insurers who can relax their concern that the health care system cannot accommodate any uncomplicated, simple, actuarially sound insurance plan that they might wish to offer, the Congressional Budget Office that can relax its worry over the cost of big government domination of every individual patient/doctor decision - all can simply let our people go about solving their own health care problems in the traditional, democratic (small D) way. The brochure deals with operational internal Model-3 structure. These notes will discuss Model-3 operational capabilities.

Just one example. Model-3 provides the **ONLY** practical and proper method now being proposed for creating the health treatment outcome statistics necessary to guide the **medical profession** in evaluating its own treatment methods. It is the only existing reform proposal that provides the essential data base to enable **competitively motivated, private market place, self-improvement** within the medical and the insurer industries of our country.

EXPLANATION OF THIS CAPABILITY: The computer used to transcribe these notes has another program in its memory. This program is totally unrelated to the subject of

health care, but it offers the opportunity to describe a very valuable by-product capability of the software system that only a single, nationwide, all inclusive accounting and evaluation system such as used by Model-3 can offer.

There are literally thousands of stocks that this program, called ProSearch (from Telescan, Inc.) has made available for analysis by thousands of investors. This program can evaluate up to 118 different kinds of facts for each stock, with numerical limits imposed on each separate fact in one single evaluation. Each Telescan's customer can decide how to analyse the entire list of stocks for any of these 118 different facts, alone or in combination, in one single analysis for this entire stock-group data base. This can be done (during evening and night hours only) at a cost of considerably less than $100.00 per month on a flat rate, with no time-use limit and no limit on the number of analyses, for each Telescan customer who elects to use the service. Telescan, Inc. says that searching 14 thousand stocks using 10 criteria and transmitting a full report would take less than one minute. The cost for each analysis for full time nightly use would be less than one cent. Unbelievable. 14000 stocks, 10 criteria, less than 1 cent cost.

Health care deals with millions of people and thousands of doctors. It also has a trillion dollar annual budget. The nationwide medical analysis equivalent to the described stock data analyses. would cover millions of statistical data relationships and over 100 facts regarding each individual. The cost per analysis could be called pocket money. In addition to the obvious governmental use of such analyses for health care pay adjustment purposes, there is no technical reason that ANY provider would be refused use of this capability for his or her own research into methods to competitively improve his or her professional and business operational methods. Such use is the back bone of the competitive improvement programs that the Model-3 reform method provides for both the health care and the health insurance industries.

These things can be done. Ask any programmer at IBM, Novell, Oracle, Hewlett Packard, EDS, Microsoft and others in the industry.

SUCH A SYSTEM

A - PROVIDES DATA THAT:

1. Could scare you out of your wits. (privacy worries some people)

2. Could cost so little that every statistic so badly needed by the insurance AND the health care provider industry would be obtainable without a fairy god mother to fund the search. (Ask about the value of

this data AND ITS COST both now and under any reform plan now proposed in Congress. The cost will shock you.)

First, let us allay the privacy fears that might trouble UWSA members.

1. Model-3 has safeguards that can separate names and other purely identifying data from being included in any such search.
2. As in bank accounts accessed by ATMs, Model-3 personal identification numbers are under control of individual patients, not government.
3. PIN numbers can be changed by any individual who wishes at any time he or she wishes.
4. Doctors and insurers can obtain full access to statistical data **without gaining access to personal identifications.**

Second, let us consider what can be done with this information.

1. Data for any state, any region, any city, any rural area can be isolated at any time **AND COMPARED WITH THE WHOLE COUNTRY.**

2. Analysis of this data can provide an anonymous review of the medical records of all Phoenix citizens and find out the annual cost of treatment for each of those who are diabetic, compare it with equivalent costs in San Diego, find out the type of treatment (statistically) used in each city and the degree of relief (statistically) experienced in each city. All at a cost that would not even seriously hurt the pocketbook of one doctor or an average income diabetic patient. And the analysis could be expanded Nationwide. What a way to get information to guide operational improvements for each provider - and the whole nation ! All 650,000 physicians in the system learn how to improve from each other !

Fears that Model-3 might reveal the personal health record of any individual citizen, or create a police state mentality in the health care industry (The concern of one member) are entirely misplaced. On the contrary , such problems actually can occur when insurance clerks evaluate and approve medical decisions in advance. It will happen in non-Model-3 managed care - including jail sentences and fines for doctor [misbehavior]. Under ClintonCare both fines and prison terms are specifically identified as proposed penalties.

Model-3 turns any desire of big government to create such a situation into a completely

impossible dream. Any attempt by the Federal Government to control Model-3 medical procedures is openly, directly and emphatically prohibited by Model-3. Patients, not insurers, not government, not supervisors, are in control. Patients can work directly with their doctors to get the best possible care and doctors will be motivated to listen. Model-3 controls costs and quality of results by pure market place competition, not by ANY kind of external control over medical decisions. Doctors respond only to their patients and professional peers.

B - PROVIDES UNIVERSAL COVERAGE THAT:

1. Gives immediate, 100% (restricted but affordable) universal health care coverage. Described more fully in the Community Rating brochure.

Model-3 is not pre-occupied with the present discussions of how much and what kind of funding will be included in our national health care system. Model-3 first establishes as a base the ingredients that permit ANY coverage to be delivered to ANY patient in the most efficient manner possible. (This should be the initial concern of Government.)

Part of this base is the identification of every patient entitled to health care of any nature.

Take a non-health care example to reasonably define universal coverage. A crowd of people want to get on a passenger plane. The plane is large enough to accept them all as passengers. They enter a gate to separate them from those who are not eligible to board the plane. All who have passed through the gate are universally covered by their eligibility to board. They are **UNIVERSALLY COVERED but none are identified.**

The universally covered crowd lines up to enter the plane. Someone asks each their name and address, and writes it down. They are now **BOTH COVERED AND IDENTIFIED.**

Model-3 grants immediate coverage for one doctor visit a year to every person in the crowd identified by Congress as eligible. When they ask for their first visit they are identified.

There are conditions. To support this coverage, Congress must amend the income tax laws to require $50.00 annually added to the income tax of everyone already above the non-taxable income level. For families that is $50.00 for each family member. Congress obviously has the power to amend this example health care entry fee. In any case, this amount is credited against future health care coverage so that each individual admissible to universal coverage receives value for their tax dollar. All tax payers are pre-identified for health care

coverage of one doctor visit per year.

Those whose incomes are below this taxable limit are identified when they request an appointment for their first doctor visit. They also can be pre-identified if they apply but do not immediately request an appointment. Congress must provide an omnibus first visit fund to cover this low income group. If not used the fund AND the unused credit both accumulate annually. In any event, these people, if sick, will most certainly be treated for their illness through either medicaid or by cost shifting. Model-3 simply puts this coverage on the books.

This subject is covered in more detail in the Model-3 Community Rating brochure.

C - PROVIDES COMMUNITY RATING CAPABILITY THAT:

1. Uses the extensive Model-3 data bank and analytical capabilities to precisely define any complex community rating of premium levels that are appropriate to the risk factors involved. Described more fully in the Community Rating brochure.

Forget just one premium level for all eligible individuals - the entire population of our country. Forget two groups - or three. Actuarial determinations are possible to optimize community rating formulae in any way that analyses and government decree determines to be appropriate. This highly political subject, in Model-3 legislation, would be appropriately deferred while the system was being fully implemented and initial data bank information was accumulated. A clear example of gaining universal coverage in a system that was politically created in measured steps. The initial Model-3 legislation should not disturb ANY insurance or tax based coverages in our present health care industry. First the system is established AND MADE EFFICIENT. Then our economic capacity to provide larger amounts of UNIVERSAL care will be understood, and the politically sensitive process of who covers what for how much can be tackled in the light of certain knowledge of the problems each step will or will not create for insurers, doctors, patients - and government. **LET US NOT FORGET. EVERY step that modifies one seventh of our economy will entail problems. Let us not step blindly into them. AND LET US NOT ENTER HEALTH CARE REFORM WITHOUT FULL REVIEW OF ALTERNATIVE METHODS SUCH AS MODEL-3 HEALTH CARE ! ! !**

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SUMMARY
Model-3 protects the interests of
GOVERNMENT - PATIENTS - DOCTORS and INSURERS

In Model-3, Government does not lose control because patients judge their own health care. Model-3 gives government an even larger "big stick". Government has complete control of the severity of competition. Model-3 also allows government to decide the nature of the results (not methods) doctors - and hospitals - must achieve. Government decides what judgements patients must make in evaluating their health care, **and if the industry does not improve, government can change the rules.** Government has a place - and stays in it. What is important to government - maximum progress along the national path to cost efficiencies and quality of care - is judged by statistical analyses of cost/cure ratios and from the subjective and factual information gained by statistically analyzing 100% patient reviews of their health care experiences. This process is completely under government control, as are the pay adjustments that will motivate providers to change any behavior that is not conducive to a top level pay scale.

Remember. Pay adjustments, and government control, can be as severe as necessary to achieve the nature **AND** the rate of any improvements that government (probably HHS) desires.

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STILL, patients remain the judge and jury. Their judgements dominate the information that government is REQUIRED to use as a basis for every motivating element in its control functions. Government can't say what is good or bad. Patients have the true control - their doctors work for THEM, with no government control of methods. Health care ala Wal-Mart. Wal-Mart learns from customers. So can doctors.

Remember: Government must, in Model-3 Health care, stay OUT of all decisions regarding the nature of health care that any provider furnishes for any patient. Those doctors who do not cure patients, those who do not provide the type of service that their patients want OR need, those who ignore or do not understand their patients' problems **or consider treatment costs** will soon have severe financial problems. (1) Their rate of pay will be cut. (2) The dissatisfaction of their patients will be published for all to see. Old patients will leave and new patients will not go to any doctor whose poor records have been publicized.

You bet that the patient will remain in control. The division between government and patient control is very precise. In Model-3 the government defines only the rules of competition. The patient is the umpire. When the umpire says "out" his word is final.

AND DOCTORS - how will they fare ? Doctors, under Model-3 have advantages as well. Model-3 specifically places into law the requirement that only doctors and their patients may control the nature of medical methods for the treatment of illnesses. Doctors make their own treatment decisions free of the dictates of insurers and bureaucrats. Their constraints are severe but fair. They lose patients if their results, on the average, are not satisfactory. They lose income if their results **or their cost efficiencies** are statistically below average.

They gain advantages from the advice of their colleagues who also lose income if a "peer group" member is statistically ineffective. Society gains nationally by this peer review because it forces doctors everywhere - to the advantage of their entire profession - to weed out peer members who lack the capacity, or the will, to meet professional standards.

Since doctor ratings are controlled by the overall cost of the cure rates they achieve rather than the cost of individual treatment decisions they will make their decisions on this basis. This professional attitude will prevail because this is even the goal of the remote government agencies that set rules now. No one quarrels with the nation's goals. In Model-3 control methods, not goals, are changed. Funding coverages are defined in terms of patient problems, not in terms of the procedures used to cure them. **Fundamental** philosophies are set straight.

Everyone initially objects to any change affecting their daily lives. Doctors may worry about Model-3, but as they study (and work under) its provisions they will find them very much to their advantage. Their professional satisfaction will be much higher than it is today.

Instead of flunkies subservient to the will of insurers and bureaucrats (partially true even now) doctors can unashamedly be the professionals that their training should equip them to be. Their prestige will grow with this freedom, as will their income as society recognizes the improved performance that informed competition will bring to the profession. If this is not true, government has the power within Model-3 guide lines to adjust the rules. Even bureaucrats are capable of understanding statistics. This, not defining "acceptable" medical methods, is their specialty. Doctors will be helped, not hurt, by their decisions. When they fully understand its analytical capabilities, Doctors, Patients, Bureaucrats AND Insurers will find that they can live withModel-3.

In Model-3, both government interests and the interests of patients are well guarded. And doctors have full freedom to practice their professional skills. They will fail or succeed entirely on the merits of their own behavior. Insurers compete freely in open markets. This has been the American way throughout our history. A win/win/win/win situation. Four wins. Nothing lost. It works. We should preserve it at all costs.

Wayne B. Moore Last print, August 29, 94

FACT SHEET 11

Model-3 health care Model-3 Health care

THE WALL STREET JOURNAL MONDAY, JUNE 27, 1994

Removing Our Freedom

Individual freedom is one factor that appears to have been omitted from our raging health care debate. What limits would a given law place on doctors, patients and insurers? The National Taxpayers Union Foundation, based in Washington, rated eight health plans now under consideration in Congress (identified by the names of their chief sponsors). The first category tallies the frequency of words in each plan that suggest government restriction or punishment. (This matters because the words selected are ones that send signals to the courts.) The second category estimates the plans' costs. The third counts career limits placed on medical professionals, and the fourth registers price controls. "While the concept of government-provided security is alluring," the foundation's report advises, "it is also one which history tells us to regard skeptically."

HEALTH CARE BILL	Gramm/ Santorum	Nickles/ Stearns	Rowland/ Bilirakis	Michel/ Lott	Chafee/ Thomas	Cooper/ Breaux	Wellstone/ McDermott	Clinton
WORD COUNTS								
"Ban"	0	0	0	0	0	0	0	1
"Enforce"	1	10	39	43	37	10	2	83
"Fine"	0	2	3	3	12	0	1	6
"Limit"	19	30	53	48	80	68	33	231
"Obligation"	1	1	7	4	13	6	3	51
"Penalty"	5	9	21	23	64	5	2	111
"Prison"	0	1	3	2	1	0	1	7
"Prohibit"	5	6	6	9	19	6	7	47
"Require"	54	93	244	321	482	151	103	901
"Restrict"	1	9	3	10	19	2	1	35
"Sanction"	0	3	13	4	21	1	8	21
TOTAL	**86**	**164**	**392**	**467**	**748**	**249**	**161**	**1,494**
CHANGE IN FEDERAL SPENDING, 1999 (in billions)	**–$26**	**–$27**	**–$2**	**–$3**	**$30-$90**	**$32**	**$702**	**$608**
CAREER LIMITS								
Racial/ethnic/geographic	0	0	0	0	0	1	0	4
Limits on going into particular specialties	0	0	0	0	0	2	1	2
PRICE CONTROLS	**No**	**No**	**No**	**No**	**No**	**No**	**Yes**	**Yes**

COMMUNITY RATING and "PATIENT POWER"

ala

MODEL-3 HEALTH CARE

These notes describe the community rating dilemma and attempt to show the extreme flexibility of Model-3 in dealing with the subject through computer programming adjustments. Those familiar with community rating mechanisms and also with today's computer hardware and software capabilities will quickly recognize the ease with which the basic faults of single category community rating can be overcome, even in a community as large as this nation's entire (100% of citizens) population.

The book "Patient Power" describes goals that health care reform can readily accommodate. Thanks probably to the pressure of this book, even Clinton Plan advocates are introducing the Patient Power objectives into their legislative proposals (without changing their oppressive oversight methodology).

Model-3 is designed, on the other hand, to be **DELIBERATELY INCOMPATIBLE** with the oversight methods of Big Government. Customers replace Big Government as the **ONLY** way to control the behavior of medical care providers. And just like Wal-Mart, doctors will learn to respond to their customers, who will then be patients, not Big Government. Model-3 also can and will easily embrace the cash-to-your-own-doctor goals of Patient Power. Its design make these adjustments very easy.

Those reading the Model-3 Health Care brochure will quickly understand these comments and realize that Model-3 is the ONLY **SURE** way to

PUT - AND KEEP - PATIENTS FIRST

To United We Stand, America: **COMMUNITY RATING** June 30, 1994

The Model-3 Health Care material you have been reviewing, including its brochure, was prepared to define the internal elements of the system and the nature of its functions.

Both UWSA reviewers and those in Government and the health care industry who already have reviewed this material can properly ask themselves about the impact of Model-3 in relation to our society as a whole. What adjustments will be required to level the playing field between the diverse groups of Americans that live in the North, the South, the City, the small rural towns, the ghettos, the suburbs, in peaceful communities, in those torn with violence?

In particular there is the question of a nationwide competition between those serving these diverse areas and within them the old, the young, the very old and the very young. Can the Model-3 system adjust its funding and its services equitably between such a diverse population and yet retain full advantage of its single pool of resources and its single evaluation system? Is its evaluation method adaptable? Can a country as large as ours be served as a single unit?

These notes assume that **universal health care** will become a reality at some mimimum or greater level of care - BUT ONLY **because it is economically impractical to do otherwise.** Note that Model-3 is not presented as a moral or humanitarian solution to anything. It may be just that, but our society - any society - will succeed based on the **practicality** of its institutions. Should the society be moral or humanitarian **the operation of these institutions** will reflect these qualities. Model-3 is neither sensitive nor is it insensitive. The Model-3 design is only created to maximize society's opportunity to choose..

Model-3 capability to deal with this subject is primarily a question of flexibility and the nature of the operating alternatives that it supports, particularly within its use of community rating methods.

Community rating in its simplest form simply says that everyone pays an equal amount for a given amount of health care coverage even though some sectors of society will receive a great deal of care and other sectors will need little or none. Any successful health care system must find some way to deal with the basic unfairness of such a concept. The built in flexibility of Model-3 makes it an ideal vehicle for solving just such problems. **The following pages discuss this subject.**

Thank you for your attention and your interest.

Wayne B. Moore.

MODEL-3 HEALTH CARE - COMMUNITY RATINGS

GENERAL

There are special considerations that must be addressed when applying Community Ratings to any funding source for Health Care. Community rating allows the inclusion of unhealthy and healthy individuals in the same "community" of those covered for their health care needs. Inclusion of these unhealthy individuals is called adverse selection. It forces the fund source to pay the larger health care costs of these individuals and thus has an "adverse" effect on the payouts the fund source is required to make.

1. The smaller the base of the participating individuals, the greater the risk to the fund source (even including bankruptcy) due to adverse selection of covered individuals. For this reason Alliances that have a large population of policyholders on a non-selective admission basis are more able to utilize community ratings than would a very small insurer which at the extreme might actually be bankrupted by the misfortunes of a very few policyholders.

2. There are three obvious non-functional elements and three essential functional elements in any of today's publicly proposed health care programs - either insured or tax supported.

NON-FUNCTIONAL (Senator Rockefeller calls them "2.5 million paper shufflers").

a. Governmental bureaucratic analysists

b. Policy makers who decide for both patient and doctor what is correct, even if not necessarily good, treatment procedure. (They create Instruction Manuals that replace medical training)

c. Insurance clerks who decide after 72 second study of computer screens what each doctor can or cannot do for his patient - thus making the doctor's success rate a function of an insurance dollar rather than a doctor's experience, knowledge

and on the scene judgement. (The most costly because the most ignorant method of health care)

FUNCTIONAL

a. Funding source(s)
b. Health care provider(s)
c. Patient(s)

One or more of these three functional elements - source of funds, provider or patient - must shoulder the burden of community rating risks, very large for small systems, but very small when the size encompases a large population of patients that have not been selectively admitted to the system. Large alliances were the initial solution to this problem

3. Alliances have many drawbacks, among which is the apparent necessity for excessive bureaucratic controls with a variety of damaging effects on the liberties AND overhead costs that they entail for the provider side of the system.

4. There are three risk alternatives, one for each functional element, that are inherent in the use of community rating.

a. The insurance industry suffers and must compensate by either restricting participation to organizations with extremely large non-population-selected bases, by allowing exorbitant premium levels or by inviting high insurer bankruptcy rates. None of these alternatives are attractive.
b. The patient population suffers and must be content with the high premiums and very unfavorable breadths of coverage that would safeguard the insurer.
c. The provider(s) would be required to absorb the added risk or would be permitted to refuse treatment to high risk patients. Only extremely large HMO type organizations could serve the public properly and still function profitably under this type of risk environment.

Many of our citizens prefer the atmosphere and personal relationships of single doctor offices. Many doctors also prefer this environment. Our country was created in an atmosphere of freedom of choice. It would appear to be a valuable asset, worthy of preservation. **MODEL-3** permits this and other freedoms without penalty to the country and without penalty to insurers, patients or doctors. NOTE: HMO consolidations already demonstrate adverse selection concern versus size.

ANOTHER SOLUTION. Just save enough money to pay for reasonable amounts of health care - say $6000.00 a year, and buy cheap, high deductible (say $6000.00 annual limit) insurance. If you use less than $6000.00 worth of care per year you keep part of your savings. If you use more that $6000.00 worth of care you are insured for that catastrophy.

Simple for the wealthy. Harder for the middle class, and **impossible for those struggling just to pay their rent and grocery bills.**

Model-3 can accommodate those who prefer paying cash **above a very minimum of universal coverage that simply admits everyone into the system. Simply write this into law. Have faith. Model-3 can accommodate this preference with (a) either tax or insurer paid coverage (not with cash) for just one doctor visit a year under universal care (b) tax-deductible medical savings (c) cash payment for health care to an insurance-deductible level of $6000.00 and (d) catastrophic insurance above that level. The basic coverage just enters these wealthier individuals into the Model-3 system at very low cost (recovered with the first annual doctor visit) and guarantees the indigent access to a doctor for one annual checkup.** This basic coverage creates the Model-3 machinery for universal care. Added coverage is then just a matter of providing the additional funds - which are all optional.

NOTE: The balance of these notes assumes that these conditions will be met:

1. A security card (imaginary or real) including age, sex, zip code identifiers will be issued to every American with this data duplicated in the Model-3 data bank.
2. Name and address of the holder will be protected from this data by an identification number and pin number (used **and protected** as banks protect ATM accounts).
3. That the age, sex and zip data will be augmented by medical data that then is protected in the same manner from association with names and addresses.
4. That the first medical visit will add a list of :
    1. medications and
    2. adverse health conditions

   that will be used statistically for community rating and other purposes by Model-3, and for medical reference by the doctor selected by the individual owning the card.
5. That at each significant later visit the doctor will either affirm or alter item 4 data by additions/corrections entered into Model-3 data bank.
6. That these additions/corrections plus essential treatment

details, test data and results will be included with the financial essentials and will constitute the provider's bill for each health care incounter.

7. That Model-3, in its developmental stage, will design a patient confirmation and evaluation form to verify physician entries on each billing statement and that the patient evaluation will verify these facts as well as billing financial details.

8. (Hopefully) this form will be easy for the patient to complete and mail, and also fully readable by the central computer.

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MODEL-3 - IMPACT ON COMMUNITY RATINGS

Model-3 does not change community rating problems. It simply solves them easier.

Model-3 can establish minimal universal health care as quickly as it can legally and practically be implemented, and at a cost and simplicity that will surprise the reader as it is described below. No fuss about the terrible effect on our federal budget or our worried small business owners. Its flexibility then allows Model-3 to handle, as needed, quite complex adjustments to community ratings, all as a matter of the software that runs the system. A no hands solution. Patients evaluate and verify everything. They control AND motivate.

Model-3, once given this minimal universal care, has the potential with proper implementation and through its reinsurance methodology, to provide much lower insurer risks through community rating than would even the largest imaginable regional alliance. Under universal coverage its base can be the entire population of the United States. Model-3 could absorb the non-selection risks of this population with minimal, even negligible actuarial loss. Only if the proper cummunity rating adjustments were not made, and community vs selective actuarial risks were NOT absorbed by Model-3 would any of the insurer, patient and provider penalties of adverse selection in small populations have any impact on any element of our society. Model-3, with these software adjustments also applied to evaluation criteria, can deal effectively and entirely within its controlling software with the community rating adverse risk problems that plague the smaller local area based community rating methods. The size of its national base and and the advanced nature of today's computer programming can avoid most if not all of the cumminity rating problems that force other proposals to impose large alliances and other devices on today's already complex money flow network - the network that moves **your** premiun money through the costly hands of Senator Rockefeller's 2.5 million paper pushers in

the various accounting departments that control your doctor's paycheck - and **your** health care.

Model-3 does not need either these expensive competitive schemes or these complicated and costly accounting and individual treatment approval processes. Both are no longer needed.

Without the Model-3 Health Care System (or its equivalent) there is no escape from the today's clumsy handling of the adverse selection dilemma. One could be tempted to say that Model-3 or a close look-alike becomes the inevitable alternative to the very high cost and unsatisfactory situation that Congress now faces in its evaluation of more expensive reform alternatives. While single payer proposals would of course solve the community rating problem there would, in its place, be the costly imposition of bureaucratic domination of the entire provider industry. The harmful effects of this solution are well known.

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Nationwide community rating can also cause other problems for Model-3, as discussed above. Model-3 must consider these effects on the evaluation system it uses. Fortunately this also is easily accomplished - automatically, no human hands required.

Doctors in small practices must accept the penalties of excessive frequency of visits versus cures if their individual practices are restricted to high risk populations such as the elderly. Patient evaluations can be skewed by this type of adverse selection to the very great disadvantage of the doctors that have, and perhaps even prefer, this type of practice.

The actuarial risks can be handled by segregating the data from each group. There remains, in Model-3, the potential problem of skewed evaluations. These would impact providers, particularly small ones. Special adjustments in the evaluation process is not only possible, it is relatively easy, and can be done on a continuing basis, not as an arbitrary devision by population blocks such as would be used for premium differentials. Premium rates are established before the fact of adverse occurances. Evaluations are accomplished as after the fact judgements. There is a vast difference. It is managable. The details would appear in computer software. They are not necessary to this discussion, but a sample situation should be mentioned. The short answer is, however, keying the diagnosis by type into the evaluation equation, and using precautions against skewed diagnoses. Since it would be done on a national rather than an individual basis, the process relative to the huge base to be managed would have miniscule effects on the system's budget. This would also be true of other software adjustments.

The prime Model-3 problem in spite of correct community rating methods is the admittedly very wide range of patient populations among individual providers. Here the impact

of adverse selection that would harm small insurers is very greatly magnified. Model-3 grades by performance evaluations. If every patient of a one doctor practice (the extreme case) had terminal cancer, that doctor would be in danger of quickly ending his career under unfair evaluation methods. This may be one reason that AMA has favored managed care in which their membership might be somewhat shielded from the consequences of adverse selection. However, shielding doctors from responsibility to lower their career risks is not the way to a responsibile society. In this patients are the sufferers. Patients are no longer first.

Fortunately these problems can be addressed in Model-3 through ingenuity rather than through the use of vast numbers of analysts and clerical workers sifting through individual doctor/patient files as a basis for costly bureaucratic micro-management. Today the software potential for swiftly sorting through immense quantities of detail can duplicate the analysis of thousands of humans. Model-3 can then compensate for skewed evaluations with great ease - and no micro-management of doctor decisions. (and with guaranteed uniform responses)

Model-3 has the only known data base with nationwide capabilities for such a process.

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In our society special consideration is given disadvantaged individuals. Persons struggling to buy food and pay rent are not asked to pay income taxes. Disabled persons receive preferential treatment to assist them in normal living. We would not have it otherwise.

Any society that ignores the misfortune of others would be a very poor society indeed. Even our own wealthy would not enjoy their environment under these circumstances. The question of whether we show compassion is not IF. It is how and how much. Helping others must be done with effective dollars, not dollars that are wasted in non-functional and ineffective ways. **The amount of health care actually delivered** depends as much on using efficient methods as on the amount of funds that are made available.

Let us consider the health care methods proposed by Model-3 for three reasons:

(1) Because Model-3 wastes the fewest dollars.

(2) Because Model-3 health care is constantly monitored **by the customer** and is totally self-adapting to society's changing needs.

(3) Because it is the **ONLY** way to actually **PUT PATIENTS AHEAD OF BUREAUCRATS.** (Who even now control our doctors' methods.)

Social philosophy dictates what this country's health care benefits really should achieve, and social philosophy should reflect the views of all members of that society. Obviously major

amounts of research would be required to make such an appraisal.. (A UWSA member plebecite could provide this data.) Actual operations under Model-3 would later do the same, since there is permanent and continuous data feedback built into Model-3 competition methods.

Lacking such research, let us define an imaginary but plausible **and achievable** set of tax + insurance + cash health care coverages and see what they would achieve under Model-3. The following Model-3 proposal is based on a slightly modified version of "people Power". The reader should find no difficulty in substituting his or her own set of coverages and deriving a subjective guess on the value of his or her own concepts under Model-3 methodology.

Any reader who is also a member of UWSA will quickly recognize the service to this country of a tabulation (in percentages) of citizens that wish to permanently take control of their own health care so that government will be unable to hamstring the doctor who serves them.

There are other ways that a UWSA plebecite can contribute. Perhaps the most useful would be any proposal UWSA members might make for changes in the Model-3 "PROPOSAL NUMBER ONE" that follows. Proposal Number One was not written as the be all and end all list of benefits that Model-3 is advocating. Model-3 believes that its system of consumer evaluations are the best chance we will ever have to disband the oversight forces that now dominate the oppressive structure that doctors deal with in their decisions regarding patient treatment methods. **Proposal number one allows the Model-3 system to immediately complete a 100% universal coverage goal on such a minimum basis that no one can find reason to question its cost.** It continues today's funding methods with the inevitable Congressional additions of portability and access without regard for present problems, which Model-3 fully approves. It allows the "Patient Power" handling of cash-for-care.

Model-3 PROPOSAL NUMBER ONE expects and approves future changes in health care funding. It merely postpones these changes until the system is established. In this way the effort to **very rapidly create** the system is not impeded and full availability of the system's cost and quality improvements will occur at an earlier date. It makes sense to first introduce the **right** operating system and then use its cost and quality benefits to expand its usefulness to society.

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Note: Model-3 is an independent activity unknown to UWSA during its development. It is neither sponsored nor supported in any way by UWSA. The author believes that Model-3 is, however, totally consistent with the basic premise of UWSA, which places the constitutional rights of citizens to control their own destiny as a primary goal of American society. It wsould surprise the author if this view were not overwhelmingly supported by all of our citizens, in and out of Government. Minimal data appears to confirm this view.

MODEL-3 PROPOSAL NUMBER ONE

This proposal is minimal, not necessarily optimal
(Model-3 accommodates many alternatives)

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Immediately upon full implementation of complete Model-3 health care system capabilities:

1. Guarantee EVERY American (100% , not 99.9% , of our citizenry) one (just one) visit annually to the doctor of their choice. Only indigents receive this visit at no cost. This can be justified economically. It should save a great deal of cost shifting. Taxpayers are required to deposit $50 for this visit whether used or not.

   a. This saves many indigent visits to emergency rooms by establishing a contact with a (gatekeeper) primary care physician, lowering at least some of the costs of care for the indigent and removing this one visit from their medicaid costs.

   b. The annual visit credit will be cumulative. In 5 years, five visits. At age 50, the right to 50 paid visits will accumulate if not previously used.

   c. Everyone earning enough to have $50 with-held from their annual pay would have $50 of their with-holding refund diverted to their Model-3 health care account. (This sum is not refundable, but **could** be used to reduce an insurance premium.)

   d. Free AND cumulative annual visits would be provided to individuals having less than $50 with-held from annual earnings.

   e. Those with unearned income would have an equivalent sum added to their income tax - if their income tax exceeded $50.

   f. This initial annual visit will not cover the services of specialists. Specialists will be permitted to charge an extra fee (suggested $50) for any service not resulting from a referral by a licensed physician. This should be optional, but the intent is to discourage inappropriate and unproductive use of specialists and should be made clear by the specialist when the appointment is requested.

2. AFTER the first doctor visit, today's Medicaid rules apply. The only difference, welfare health care payments will be made directly to Model-3 and normal Model-3 billing and evaluation is applicable. Model-3 readily accommodates future changes. Change **should** occur in this process..

3. Treat disability health care in an equivalent manner - AFTER the first annual visit (to a general practicioner or equivalent).
4. Allow the insurance industry to continue today's practices **without ANY change** during the Model-3 preliminary period described in the Model-3 brochure.
5. Modify insurance AND tax support for health care in any way Congress may choose after Model-3 operations are fully and finally implemented.
6. Permit any individual to pay cash for health care up to a limit of $6000 annually. PROVIDED that a zero cost bill is entered through the normal Model-3 billing process, allowing a normal evaluation cycle to be completed. Patients, not bureaucrats, will control our doctors.
7. Modify the tax code to allow tax free accumulation of medical savings.
8. Allow private catastrophic insurance.

****

There is plenty of room in this process for individual states to control future changes in insurance within each state. Two Model-3 benefits, however, would be permanently retained.

1. No citizen would be denied out-of-state use of his or her in-state health coverage. This is one benefit that Model-3 community rating provisions would not be permitted to modify. Note that this provision includes the option of an in-state physician to refer patients for out-of-state specialized treatment. This is essential to the concept of freedom of physicians from external control of their professional decisions.
2. No bureaucrat or insurer would have ANY power over patient/doctor treatment decisions. Abuses by any doctor of a doctor's right to make medical decisions would be subject to the Model-3 peer review, PERMANENTLY, with evaluation by patients the automatic enforcer of these reviews. Peer review could result in anything from approval to mild recommendations - or to the pressing of malpractice charges or expulsion from the peer group itself. Peers are motivated to do this review thoroughly and very objectively. If rate adjustments to the peer group prove to be insufficient motivation for thorough action, Model-3 allows for increasing them.

****

IMPLEMENTATION - SEQUENCE

1. Fund immediate Model-3 feasibility studies, gradually expanding them - based on positive interim feasibility conclusions - to include software and hardware evaluation and preliminary design until the system was fully certified as ready for full testing.

2. Follow Model-3 brochure procedures as quickly as legal authorization can be obtained.

3. AFTER Model-3 is in full operation have the Government Accounting Office (GAO) and the Congressional Budget Office (CBO) evaluate all aspects of Model-3 operations. Make prompt responses to every question and every suggestion for change. Model-3 is designed to thrive on change based on patient evaluations. Suggestions (underline intended!) from the government should also be accepted if deemed appropriate by the affected providers.

4. AFTER GAO and CBO evaluations, implement a Congressional review of all funding methods, with intent to modify the overall character of the funding process and coverages in any manner it deems appropriate. (This will happen anyway with any reform plan. UWSA must continue its vigil.) NOTE that States now have the right to change insurance regulations. These rights would remain during and after the Model-3 preliminary phase-in period.

******

EFFECTS OF IMPLEMENTATION

The financial effect of this implementation of Model-3 Health Care will be minimal in immediate economic costs, as explained in the Model-3 brochure. There should be substantial near term savings. Patient Power (referred to as Gramm Santorum) is the lowest cost of the Wall Street Journal (June 27, 1994) listed congressional proposed health care reform plans. Patient Power misses the intense provider competition cost benefits of Model-3. Patient Power would save $26 billion annually. Adding Model-3 savings to this $26 billion would save another $100 billion. This is enough to provide substantially better health care with even greater savings than any other plan that has been suggested. Keep Patient Power or use any other plan and still save an additional $100 billion for the chosen proposal.

With these cost savings in mind, it may be useful to list the effect of the above "Model-3 Proposal Number One" on this country's health care recipients. It should be a revealing list.

1. All of today's health care coverages will remain effective for optional use.

2. All Americans will have full and immediate access to any health care in the nation for any of his or her present health care coverages, with choice of hospital as well as doctor.

3. Every American (100%, not 99.9% of our citizens) will be enrolled in the nation's health care plan (with a personal account credited for one annual visit). As soon as insurance or tax coverage is created by fund tranfers to Model-3 this coverage belongs to

the individual covered. It is portable and is governed only by the conditions of its funding.

4. Every American whose income is below the proposal's taxable amounts amounts will be credited with one free doctor visit. If this credit is not used during the calendar year, this visit will remain available for later use. The purpose of this minimal free health care coverage is to admit every American into the system, and to guarantee each citizen at least access to a doctor to establish the contact.

5. Any American who wishes to follow the Phil Gramm self-insurance can have non-taxible medical savings accounts and use them in conjunction with catastrophic insurance to pay cash for health care. All aspects of the health care alternatives recommended in the book "PATIENT POWER" will be available. Yet no one is compelled to use savings and pay cash. Some Americans need other methods. Model-3 adapts to the needs of all of our people - as long as health care coverage remains cost efficient, portable, permanent and NOT dominated by bureaucrats, insurers or providers. **Your** health care is controlled by **you** - and you alone.

Model-3 would allow Patient Power funding methods with just one change. Everyone would receive one visit to a freely chosen doctor annually (if desired), and would be compelled to pay for this visit out of earnings unless income was below the very limited standards described above.

NOTE: PATIENT POWER, page 111 starts a discussion titled " A Further Agenda for Change". There can be no quarrel with the objectives defined under this heading. It at least in part, this chapter is a littany of current problems caused by federal regulations which increase the cost and reduce the freedoms of choice that now distort logical decisions in the purchase of health care by all of us in the private sector. (Who **isn't** in the private sector? Just the bureaucrats that tell us what we **can't** do.) Patient Power objects to this regulation. Model-3 ends it. Permanently.

The Model-3 evaluation process replaces that bureaucracy. The personnel would no longer be needed.. In the Model-3 insurance selection process, negotiators analyse the actuarial soundness of ANY submitted policy and admits to the choice of our citizens those policies that are financially sound and are not padded with high overhead or excess profits. Model-3 negotiators work by rules of cost efficieny and honesty of factual statements. They will not baby sit our citizens. Model-3 will vindicate "PATIENT POWER" statements by providing the same patient power and FREEDOM FROM GOVERNMENT CONTROL in the health care decisions of patients AND their doctors that patient power provides in the control of money. Patient Power provides the goals, Model-3 extents the control of patients through the entire health care process by defining

their power AND responsibilities - and thereby replacing AND saving the salaries of what Senator Rockefeller calls "2.5 Million paper shufflers".

In our society Congress is permitted the right to modify any rule or regulation, but in Model-3 the very basis for rules and regulations are placed in the control of the voter (patient). As Model-3 becomes effective the private sector must still be vigilant. No one has ever said that tomorrow we must go back to sleep. "Patient Power" is correct. We must be watchful. Health Care will be with us always. Guard it carefully. Neither Model-3 nor the writers of "Patient Power" can change it all today.

****

PATIENT POWER, the book.

No proposal to United We Stand, America would be complete without further comments on this useful and interesting book. Model-3 is designed to provide a vehicle for achieving just such objectives as are outlined in this book. Model-3 concentrates on the means for achieving goals, and by its very character puts the structure rather than goals in cement - by prohibiting and replacing the present practices that would prevent achievement of desirable PATIENT POWER end results. Model-3 discusses goals as POSSIBLE rather than absolute. The philosophy - be sure that essentials are not trampled, then allow our citizens to define THEIR OWN specific desires and needs.

PATIENT POWER, on the other hand, is specific in defining goals but problems remain in methods suggested for their achievement. These methods need discussion. There are alternatives that Patient Power has overlooked, and problems that can be avoided.

The goals of Patient Power authors need not be abandoned to reshape their methods. On page 29 and 30 of Patient Power there is a list of seven items that are tabulated under the heading of "how patient power would function".

In this list, briefly, the first three items say that patients rather than third parties would buy health care, Physicians would no longer serve primarily as agents of third parties and hospitals would no longer serve primarily as agents. Every goal is stated properly and its achievment would put patients first.

The next three items in the list say that insurers would insure and reimburse policyholders for adverse health events, that employers would be agents rather than buyers of health care and would monitor performance of competing insurers and that Government would

not serve as insurer but would pay insurance premiums [to private insurers] for indigent policyholders. Insurers are a large part of the control mechanism that dominates the behavior of our health care providers. With them in their present position, no matter who selects and pays for the specific policy, the doctor will do as he is told BY THE INSURER. This is **HALF** of the prime problem that patient power should correct. Failure to remove this half leaves no opportunity to correct the other half. Government control of the medical profession cannot be prevented if it retains control of the institutions that control the provider.

"Patient Power" leaves Government still in control.

These second three items on the Patient Power list removes any opportunity for putting VOTERS in control of their actual health care. Patient Power defines the goals but then turns the solution right back to the very forces - financially powerful forces - that now stand between the patient and his doctor. What Model-3 does is to provide a gate for funds from ALL sources to flow to providers, but at the same time provides an impenetrable barrier between the fund SOURCE and the provider that is authorized to use it. This is key to actual Patient Power.

In Model-3, every dime of money allocated by any insurer - or by Government - is placed in a pool that can be drawn on only for use in the account of a patient. The patient alone has the right to this money, and the patient only can decide what provider of services he will use. In Model-3 the patient also is the ONLY judge of his or her own satisfaction. The patient is in control of his own health care at EVERY point, from beginning to end. Nothing is left out.

If statistically a provider loses the approval of his patients it affects his colleagues. They, as well as he, lose money because of his failures. They have the proper professional knowledge as well as the right to judge below par performance. Their actions should start with offers to help with advice, and proceed toward stronger action until the sub par performance is corrected. If this is impossible they have the obligation to refuse him access to their peer group. In Model-3 a provider MUST be a member of some peer group. Otherwise he cannot bill Model-3 for his services. He is out of business. Note that States can oversee this process for fairness as well as to assure adequate and appropriate group actions. While patients start the process by their reviews, only professionals can pass judgement. States then can review the results to determine their fairness and adequacy. At every stage there are appeal opportunities. Only the patients are anonymous, each as one small part of a statistic that motivates the provider toward cost reductions and quality improvements during his entire career. But patients start the ball rolling. Their evaluations have financial strength. They control the entire health care provider industry. If a doctor has 1000 patients and one rates him unsatisfactory he will not be affected. If 900 patients rate him unsatisfactory he will improve or go out of business. A jury of 1000 is pretty much impersonal and tamper proof. If 900 patients are unhappy it goes on the

public record. New patients will be hard to find.

The patient does have power. He also controls the nationwide competition of Model-3. When Tampa doctors find a better way to deliver health care their ratings will go up. They will be copied. Other doctors across the country will also improve. The entire nation will see its costs go down and its quality of care improve. 250,000,000 American citizen jurers will have made the difference. Wouldn't it be criminal to NOT use this wonderful information source to help our country develop the best health care system the World has ever known?

> Model-3 forces the publication of this information. Patients can then discuss the information they have BEFORE decisions now made by others can be put into effect. They will know about doctors. They will know about hospitals. They should know also about outpatient options and long term care facilities. Model-3 not only says that this information should be public. It defines a reliable and convenient method for publishing the information required for the system to function efficiently. If "patient power" is used, money flow is controlled more closely by the patient than it is at present. Health Care and the patient/doctor relationship is not. Let us think this one problem through before we agree that reform would serve its proper function of "puting the patient first".

The seventh item on the list restates the basic premise of the book by saying that Government would facilitate the goals on the demand side by encouraging citizens to follow the principles defined in the book. This list is followed by a recital of Singapore methods and results. I certainly and sincerely admire this example. Many times I have noted the behavior of our society and - in very many ways - have regretted the differences beteen our society today and the society I remember as it existed when as a young adult I went through the travail of the 1930s.

Remembrance will not restore these times. It will require work. If changes in health care could restore character to our society I would change health care for this purpose alone. I believe more fundamental changes - probably unacceptable changes - would be needed. I doubt that our society can emulate Singapore without drastic and very authoritarian changes in the way we live our daily lives. I believe even the authors of Patient Power will agree.

Every true goal of Patient Power can be accepted in full by Model-3. The methodology that would make Patient Power work is not presented by the authors. Model-3 offers defensible methods without destroying the admirable goals that Patient Power offers. Model-3 also avoids destroying the equally strongly defended goals of others who also wish to improve our society in other ways through improvement in our health care system. Model-3 is the

partner that these reform proponents - all of them - need to accomplish their objectives. It should be adopted. Dreamers set goals. Our Federal Government has been known to dream in the past. Much of the presently proposed legislation is based on the hopes and dreams of big government bureaucrats. Such changes threaten to repeat the ten to one cost estimate errors that plagued Medicare. If this contry progresses to health care reform implementation it will require more than dreams to guide a trillion dollar budget into an effective and efficient system.

Model-3 would restructure a large part of today's bloated oversight system. Sadly jobs would be lost. Not sadly, society would expand access and provide better health care for our citizens. This would create jobs. I sympathize with those in government and the insurance industry who would have to leave their employment - even those who would be transferred to more useful tasks - yet change will be better for most of them and will certainly benefit the entire country if meaningful and effective health care reform is achieved.

Additional detail relating to the societal aspects of Model-3 implementation should be backed by funded feasibility studies. It seems quite improbable that such studies would have negative results for Model-3. Technology is here. It is efficient. It should be used. The cost savings, added patient satisfaction, quality of care improvements and the increased fairness of health care in our society as a whole would be enormous.

With adequate help from UWSA Model-3 may yet succeed. Already an alert ear can spot phrases that were lacking in the words used before Model-3 was offered to Congresspeople and to the Administration. For example Senator John Breaux, of Louisiana, recently said in a Senate Finance Committee hearing (very loose paraphrase) that provisions for an efficient system should precede other considerations that were being discussed. Unheard of till recently. Right on, Senator. Lets hope this idea will spread. Otherwise we can face a real mess.

Wayne B. Moore

NOTE: (Don't miss the Wall Street Journal chart on the next page.)
Please don't use **OUR** money to (quote next page) "ban, enforce, fine, limit, obligation,penalty, prison, prohibit, require, restrict, sanction " (thank goodnes, end quote). It is the American people who come last, not first, when Senator Rockefeller's 2.5 million paper shufflers use these words to restrict **US AS WELL AS OUR DOCTORS. The doctor patient relationship should be sacred. I hope very much that UWSA can help deliver this message.**

Wayne B. Moore Last Print August 31, 1994

THE WALL STREET JOURNAL MONDAY, JUNE 27, 1994

Removing Our Freedom

Individual freedom is one factor that appears to have been omitted from our raging health care debate. What limits would a given law place on doctors, patients and insurers? The National Taxpayers Union Foundation, based in Washington, rated eight health plans now under consideration in Congress (identified by the names of their chief sponsors). The first category tallies the frequency of words in each plan that suggest government restriction or punishment. (This matters because the words selected are ones that send signals to the courts.) The second category estimates the plans' costs. The third counts career limits placed on medical professionals, and the fourth registers price controls. "While the concept of government-provided security is alluring," the foundation's report advises, "it is also one which history tells us to regard skeptically."

HEALTH CARE BILL	Gramm/ Santorum	Nickles/ Stearns	Rowland/ Bilirakis	Michel/ Lott	Chafee/ Thomas	Cooper/ Breaux	Wellstone/ McDermott	Clinton
WORD COUNTS								
"Ban"	0	0	0	0	0	0	0	1
"Enforce"	1	10	39	43	37	10	2	83
"Fine"	0	2	3	3	12	0	1	6
"Limit"	19	30	53	48	80	68	33	231
"Obligation"	1	1	7	4	13	6	3	51
"Penalty"	5	9	21	23	64	5	2	111
"Prison"	0	1	3	2	1	0	1	7
"Prohibit"	5	6	6	9	19	6	7	47
"Require"	54	93	244	321	482	151	103	901
"Restrict"	1	9	3	10	19	2	1	35
"Sanction"	0	3	13	4	21	1	8	21
TOTAL	**86**	**164**	**392**	**467**	**748**	**249**	**161**	**1,494**
CHANGE IN FEDERAL SPENDING, 1999 (in billions)	**–$26**	**–$27**	**–$2**	**–$3**	**$30-$90**	**$32**	**$702**	**$608**
CAREER LIMITS								
Racial/ethnic/geographic	0	0	0	0	0	1	0	4
Limits on going into particular specialties	0	0	0	0	0	2	1	2
PRICE CONTROLS	**No**	**No**	**No**	**No**	**No**	**No**	**Yes**	**Yes**

Ms Guss -

This letter was harsh, as was the letter to Dr Magaziner. HHS and the good doctor need to realize what they have been doing - especially to our country and incidentally to our President and his wife.

S/Ben

(Good staff reading. Spare Mrs. Clinton.

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007a. letter	Address (Partial) (1 page)	09/12/1994	P6/b(6)

COLLECTION:
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Wayne B. Moore
P6/b(6)

[007a]

September 12, 1994

Mr. Christopher Bladen
Deputy to the Deputy Assistant
Secretary for Health Policy
Office of the Secretary
Department of Health and Human Services
Washington, D. C. 20201

Subject: Health Care Reform - Model-3 Health Care

Dear Mr. Bladen:

Thank you for your June 24, 1994 letter in response to my letter and enclosures on Model-3 Health Care. There are times when prompt replies are important - and other times when replies are best sent when the subject matter is best responded to. Your apology for a slow reply was appreciated. It says something for your courtesy. However, I consider your timing most appropriate and appreciate the timing of your reply.

This letter is also timed to meet a need which I see as critical. Model-3 supports the patient benefits espoused by ClintonCare. **The methods for their attainment** differ drastically.

I hope you won't mind me using this opportunity to discuss philosophy. There are few times when philosophy should be the centerpiece of a large undertaking. Normally - and most successfully - this occurs when the effort is still small. I think health care reform may be one of the few times when advance discussion of philosophy can contribute to a large undertaking.

******

Good organizations do not self destruct. They work hard to excel. They sell their product. They defend their abilities to perform in the face of external threats.

Call this institutional bias - call it essential to survival, and call it good.

In the entire subject of health care, HHS has the right to consider itself the central authority for the entire country. Yet, **if one is objective,** HHS although large in itself, is merely the focal point that oversees the well-being of a very large health care industry. It is now taking on the insurance industry as well. If HHS does what it deems best for growth of its own operations it may actually destroy the external organisms that it is designed to preserve - at a very high economic price for our country as well as almost certain stultification of this nation's health care industries.

The nation is spotting this flaw in ClintonCare.

Those charged with designing health care reform, quite understandably I believe, have been trapped in this self defeating course of action. They have overlooked the effects of perfectly normal, but in this case harmful, **institutional bias.**

One does not succeed by weakening the institutions that one should nurture, **but only outsiders would be likely to spot this problem.** In the formative stages of health care reform plans they were not afforded that opportunity. Now not only Model-3 has spotted the problem, Congress, small business, large companies and many ordinary, unattached citizens have also spotted it. Therefore the already strong and growing nationwide opposition.

Methods that are endemic to ClintonCare have failed to gain acceptance. All of ClintonCare goals can be met by other means. They should be. ClintonCare methods should be replaced with the proven methods that have built this great country. **These are:**

1. **Market-place nationwide competition. (ala Wal-Mart, Kmart)**
2. **Freedom to innovate in business and professional matters.**
3. **Pressures of public opinion and common law in matters of behavior.**
4. **Income based motivations. Do better, earn more.**
5. **Freedom to fail if performance standards are unsatisfactory.**
   (adequate consequences for below average performance)

Government controls competitive criteria and pressure levels.
Patients (only patients) judge adequacy of service. (You bet doctors will listen.)

Model-3 uses these traditional and well proven methods in the knowledge that these principles have made our United States the greatest nation on earth. DO NOT DESTROY THEM.

****

Model-3 Health Care embraces the goals of universal health care that cannot be

taken away. **It adds one word** not used in your letter - **AFFORDABLE .** The words "cost containment" in your letter refer to the costs of private sector industry. They say nothing about the loss of opportunity to accomplish cost containment through innovations or about the clumsy overheads used for "creating" efficiencies by adding overhead payrolls. ClintonCare only refers (1494 times) to the results of NOT FOLLOWING GOVERNMENTAL DIRECTIONS. Think of the lawyers that will be hired. Affordability is destroyed by these methods.

Our country has thrived on a private sector built by the power of strengthening through self reliance rather through fear of reprisal - of motivation rather than repression. While other countries have failed due to private sector repressions by dictatorial governments our nation has grown strong through the self-reliance of our productive citizens. Our citizens are even now rejecting ClintonCare because it strengthens the control agencies that designed it rather than the industries that it is attempting to improve. Although most cannot articulate it, I believe many see in ClintonCare a parallel to the slippery slope that welfare has travelled.

ClintonCare puts our health care providers and health insurers on intellectual welfare by telling everyone just what is proper and what is not - and by demanding that the entire nation accept government's definition of the word "proper"..... It uses words like "ban, sanction, fines and prison." They read like the serfdom of the middle ages.

Would these words make you proud of your country ? Model-3 does not **need** them. Model-3 harnesses rather than suppresses the brains of 650,000 medical professionals who are rewarded for successful innovations rather than simply permitted to avoid punishment if they are consistently willing to say "Yes sir, Master" to rules that govern their professional decisions.

The Clinton Administration may well rise or fall on the public perception of these two approaches to the design of 1/7 of our CDP and the mental bias they depict.

****

What I have written above is not a full expose of this dual-path pair of philosophies. I hope that you will guide your own thoughts along these lines and understand by that means what I have meant to lead you toward. The country is beginning to react - and will continue to react to these philosophical differences as they think through the complex details of ClintonCare.

I hope HHS can be guided along the same path the public has begun to follow.

I rest my philosophical case for Model-3. My economic case, my quality care case and

my political case are simply a matter of grinding out the numbers. They all point to Wal-Mart as the analogy for Model-3 and dictatorial, costly, military procurement methods of control for the ClintonCare analogy.

I have worked under both systems. The contrast does not flatter ClintonCare.

Military procurement invented $700.00 toilet seats.

Repeat. ClintonCare goals are unimpeachable. Its methods will self-destruct - hopefully before the humiliating cycle of enactment and repeal that followed catastrophic health care insurance legislation, otherwise by lowering our quality of care or bankrupting the country.

If you agree I wouldn't mind having you circulate the above paragraphs. It helps to solicit the opinions of others.

****

Copies of this letter will include an attached condensed summary of Model-3 concepts.

Senator Packwood's copy will include a full set of Model-3 literature, (90+ pages), with the request that his staff make copies of that literature available to other senators as a courtesy. (I am unfunded and mailing costs have a very restrictive effect on my efforts.) This is my first mailing to Senator Packwood and I hope he will be tolerant of my imposition. Congressional budgets should surely cover the copying costs for this list or, if Senator Packwood or others consider it appropriate, the costs for a larger distribution.

Sincerely,

Wayne B. Moore

cc: Dr. Shalalla
Senator Packwood (with a full set of Model-3 literature)
Senator Boren, Breaux, Dole, Kassebaum, Mitchell

enclosure: Condensed Summary, Model-3 Health Care

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007b. letter	Address (Partial) (1 page)	04/25/1994	P6/b(6)

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Wayne B. Moore
[redacted]

[0076]

April 25, 1994

Dr. Ira C. Magaziner
Senior Advisor to the President for Policy Development
White House
Washington D. C. 20500

Note - Calling a spade a spade letter. Wbm

Dear Dr. Magaziner:

I appreciated your response to the Model-3 Health Care brochure and supplement. Your efforts and those of Mrs. Clinton to thoroughly and intensively study the full breadth of the health care and health care insurance industries of this country, and to meticulously tabulate the good and the bad aspects of each is a monumental task for which the country should be grateful.

Many aspects of our present health care system, not the least of which are on the funding side, need attention and corrective action.

As you know, having reviewed the details of the Model-3 brochure, Model-3 attacks the more fundamental aspects required to correct the many failures of our present system. Although the infamous Arlen Specter chart was intended as critical, it has its good points. Without such an overview the enormity of the problem would escape most of our population.

The Model-3 Health Care plan was written to cut through the serious flaws of this bureaucratic nightmare. There is no popular groundswell of objection to the much publicized and well understood goals of universal, adequate and affordable care. The defects that are causing serious deteriation of public support for the plan President Clinton has introduced to Congress are entirely unrelated to these laudable objectives.

Your letter of April 11, 1994 clearly identifies these defects as quite fundamental in nature. Your letter has eight paragraphs. In them there are 12 references to actions or desires of the President, of these 8 say the President (or he) wants, he will or the government will.

No where in your letter do you indicate an understanding of the reasons for the steady deterioration of public support for your plans for the American People. I believe you will find, in the following paragraphs, most of the reasons for this unfortunate situation.

Everyone appears to think in terms of the word "power" when defining the critical questions of : Whose wants? and How they will be fulfilled?

The American public relates the word power with its opposite. FREEDOM.

Every time a bureaucrat is given the right to select ANYTHING three things happen:

1. The bureaucrat is paid for his services.
2. Taxes go up.
3. The American People are denied FREEDOM to do their own selecting.

Model-3, at its inception, undertook the listing of the powers the American People should retain (or acquire) in any revision of the way health care is delivered in this Country.

1. The typical American citizen - who VOTES for presidents - wants the right, with his doctor, to decide what treatments are appropriate to curing his ills.

Representative Ron Wyden can recite the reasons in great detail. Horror stories about medically untrained insurance people deciding, case by case in 72 second computer screen reviews, what a doctor can or cannot do for his patient. He has many personal experiences to relate.

2. That same American wants assurance, also, that NO money will be diverted to pay a bureaucrat or insurance company employee for services that he wishes to, can and should perform better himself, for free. In this, BOTH his freedom and the money saved are important.

3. He wants to evaluate his own health care quality. He knows the most about it. He will do it for free. People thrive on responsibility. Allow our voter/patients this courtesy.

4. He wants to choose his own doctor - not which plan and have access only to the doctors within that plan. A most important freedom. Go to any doctor in the nation.

5. He wants to know enough about the doctors in his local area to make intelligent choices. Decisions regarding HIS particular health problems can best be made by doctors (especially gatekeepers) with the right background and record of success. He wants - and needs - this protective information. A professional front can hide both ignorance and incompetence.

6. He wants doctors who are motivated by self interest to provide the services he needs in the most cost effective manner in relation to the success of the services received.

7. He wants doctors who are evaluated on a personal performance basis by competent peers who are strongly motivated to clean up any health care delivery problems that influence the health care HE receives. People thrive on responsibility. Give it to doctors and motivate them (even force them with severe penalties) to use it.

The American voter sees freedoms escaping his grasp when any PAID BY VOTERS bureaucrat or insurance company employee performs these services for him.

And he sees his tax bill going up - because you are not using 250,000,000 free helpers.

You can get legislation passed - easily - to achieve the President's wants if you also tend to the wants of the voters who elected him. Popular approval will guarantee it. And you can get the best, most cost effective health care system in the World by the same process.

All of the wars in American history were fought against some form of denial of someone's freedom. The feeling runs deep. We are not an aggressor nation. It is one of the best and strongest traditions of our country. Please recognize why this same desire to control one's own destiny is the force you are - literally - tearing down when the principles listed above are ignored. Rethink "the President wants." into "The people want." You, the nation, President and Mrs. Clinton - will all benefit. The desire for freedom is powerful. You can use it.

I hope you will study the ways in which Model-3 Health Care addresses these important problems. Get a better product that costs less and preserve these much desired freedoms for the public all in one stroke. Popular and successful programs win elections - and the converse.

Sincerely,

Wayne B. Moore

enclusures: copies of letters to and/or from

Ron Wyden and Richard Gephardt, House of Representatives
Dr. Paul A. Ebert, American College of Surgeons
Governor Roy Romer, State of Colorado

cc: Gene Sperling, Deputy Assistant to the President
Vice President Al Gore
Dr. Ebert
Governor Romer
Dan Rostenkowski
Senator David Boren