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HEALTHCARE REFORM 1993

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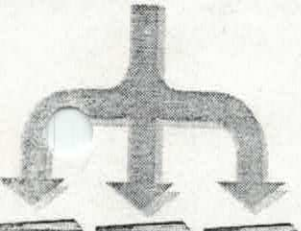
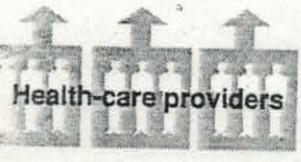
IOW THE PLAN WOULD WORK

der Bill Clinton's proposal, all Americans would
ve access to health coverage, regardless of
ome, employment status or pre-existing medical
nditions. Here is what they would have to do:

Corporate alliance

A corporate alliance could be formed by companies with 5,000 or more workers.





1. Enroll in an alliance

To control costs, Americans would be grouped into giant buying groups called alliances. These alliances would negotiate with health care providers for medical services at the lowest possible prices. Employers would be required to help employees purchase coverage in an alliance as part of their employee benefit package.

2. Pick a plan

All alliances would be required to offer identical basic coverage. Individuals would be able to choose from at least three plans to receive the basic coverage. Patients' out-of-pocket costs would vary, based on the type of plan they choose.

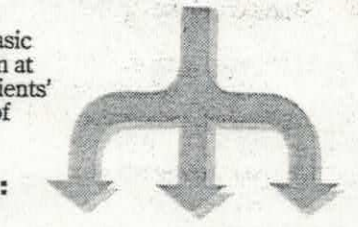
A Health Maintenance Organization (HMO): Patients opt for medical services provided by clinic-like operations or networks of affiliated physicians and medical support services. Choice of physicians may be more limited, while out-of-pocket expenses would be generally lower than with fee-for-services plans.

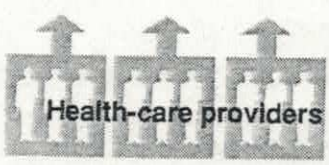
B Fee-for-service: This is the traditional pick-your-own-doctor and pay-as-you-go plan. Patients would get the most freedom of choice with this plan, but also pay the most.

C Hybrid plans: Patients can choose a combination of HMO and fee-for-service called a **preferred provider plan.** It would be more expensive than a HMO, but offer patients more control to choose physicians and treatments.

Regional alliance

A regional alliance would cover areas as large as a state or as small as part of a city.





HOW IT AFFECTS...

- **Elderly people:** Medicare benefits would expand to include home health care and prescription drugs. Medicare recipients would not have to join new insurance plans unless they wanted to or unless their states folded Medicare into the new plans.
- **Children:** All would be covered for preventive care, such as immunizations and check-ups. Also covered: eye exams and glasses for children under 18, dental check-ups and emergency dental care.
- **Women:** Some Pap smears and mammograms to detect cancer would be covered, but not as many as most doctors suggest. Prenatal care would be covered.
- **Poor people:** They would pay reduced premiums if their incomes are below 150 percent of the poverty line, currently $14,000 a year for a family of four.
- **Insured workers:** If they switched jobs they would keep their insurance and have any pre-existing health conditions covered.
- **Uninsured workers:** Workers would get insurance through their employers. Annual out-of-pocket costs would be limited to $1,500 for an individual or $3,000 for a family.
- **Part-time workers:** Those who work 10 to 30 hours a week in one job would get part of their health premiums paid by their employers.
- **Self-employed:** They would pay their own premiums, but they could deduct them on income tax returns.

WHAT WOULD BE COVERED

Basic benefits package	Limitations	A Health Maintenance Organization (HMO)	B Fee-for-service	C Hybrid plans	In network	Out of netw
Inpatient hospital	Private room only when medically necessary	Full coverage	Insurance pays 80%	Full coverage		Insurance pays 8
Professional services, outpatient hospital services		$10 per visit	Insurance pays 80%	$10 per visit		Insurance pays 8
Emergency services		$25 per visit	Insurance pays 80%	$25 per visit		Insurance pays 8
Preventive services						
■ Adults	Adult services include pelvic exams, cholesterol screening, mammograms	Full coverage	Full coverage, no deductible	Full coverage		Full coverage
■ Children	Childrens' services include immunizations, lead-poisoning tests, well-child visits, eye exams, glasses	Full coverage	Full coverage, no deductible	Full coverage		Full coverage
Hospice	As hospital alternative for terminally ill	Full coverage	Insurance pays 80%	Full coverage		Insurance pays 8
Home health care	As inpatient alternative; coverage reassessed at 60 days	Full coverage	Insurance pays 80%	Full coverage		Insurance pays 8
Extended care facilities (Skilled nursing, rehabilitation facilities)	As hospital alternative; 100-day limit per year	Full coverage	Insurance pays 80%	Full coverage		Insurance pays 8
Outpatient physical, occupational, speech therapies	Only to restore function or minimize limitations; reassessment at 60 days; additional coverage if improving	$10 per visit	Insurance pays 80%	$10 per visit		Insurance pays 8
Medical equipment, outpatient lab, ambulance		Full coverage	Insurance pays 80%	Full coverage		Insurance pays 8
Routine eye and ear exams, eyeglasses	Eyeglasses for children under 18	$10 per exam or one set of glasses	Insurance pays 80%	$10 per exam or one set of glasses		Insurance pays 8
Dental services						
■ Initial: Prevention	Only for under 18	$10 per visit	Insurance pays 80%	$10 per visit		Insurance pays 8
■ Added in year 2001: Restoration	No age limit	$20 per visit	$50 deductible; insurance pays 60%; $1,500 annual max.	$20 per visit		$50 deductible; insurance pays 6
■ Orthodontia	Only to avoid reconstructive surgery	$20 per visit	Insurance pays 60%; $2,500 lifetime max.	$20 per visit		Insurance pays 6
Prescription drugs		$5 per prescription	$250/yr. deductible; insurance pays 80%	$5 per perscription		$250/yr. deductib insurance pays 8
Mental health/ substance abuse						
■ Initial: Inpatient services	30 days per episode; 60 days per year maximum	Full coverage	Insurance pays 80%	Full coverage		Insurance pays 80%
Hospital alternatives	120 days maximum per year	Full coverage		Full coverage		Insurance pays 80%
Non-residential intensive services	120 days maximum per year		Insurance pays 80%			
Brief office visit for medical maintenance		$10 per visit	All outpatient; insurance pays 80%	All outpatient; $10 per visit		All outpatient; insurance pays 80%
Psychotherapy	30 visits maximum per year	$25 per visit	Insurance pays 50%	Doesn't apply		Doesn't apply
■ Added in year 2001: Inpatient services		Full coverage	Insurance pays 80%	Full coverage		Insurance pays 80%
Hospital alternatives		Full coverage				
Non-residential intensive services			Insurance pays 80%	Full coverage		Insurance pays 80%
Outpatient including 1-12 psychotherapy visits		$10 per visit	Unlimited visits; insurance pays 80%	$10 per visit		Insurance pays 80%

WHAT COVERAGE WOULD COST

mployers and employees hare premium cost

ayments would be divided into vo shares:

Vorkers would pay up to 20% of he premium through a payroll leduction.

Employers would pay the remainder, at least 80%

White House estimate of what coverage might cost for a basic plan

	Single individual	Two-parent household
Premium	$1,800	$4,200
Employer cost	–$1,440	–$3,360
Employee cost	$360	$840

The employer's share would be based on 80 percent of the average cost for a basic plan within an alliance. If an employee chooses a more expensive plan, the family must bear the extra cost for the coverage. An employer can opt to pay some or all of the employee's share of premiums.

Premiums

Each alliance would offer consumers a choice of health plans, with premiums based on four family types:

- Single individuals
- Couple without children
- Single-parent households
- Two-parent households

Actual rates would vary. No one would be charged more because of age, health or occupation. Alliances may adjust premiums to compensate plans that enroll a large number of high-cost patients.

ce: Chicago Tribune, KRT, Free Press

Detroit Free Pre

Comparison of International Health Care Systems

United States

Health Expenditures as % of GNP (1989): 11.8%

Annual Per Capita Expenditure: $2,354

What Is It?
Multiple-payer. Coverage for services is based on ability to pay or eligibility for public programs for the poor, elderly and the disabled. Covered services vary depending on the specific health insurance. Covered individuals seek care from the provider of their choice.

How is it financed?
Public and private sector financing of health care. The public sector, at both the federal and state level, finances programs to care for the poor, the elderly and the disabled. Private insurance and individual out-of-pocket payments finance care for people not eligible for public programs.

How is it administered?
The various public and private payers generally reimburse providers on a fee-for-service basis, i.e., the payer reimburses the provider for his/her charges. Other methods of administration include managed care arrangements wherein a flat rate is paid in advance for all services rendered by the provider. There is no coordination of activities between the different payers.

Mechanisms for cost control?
There are no comprehensive cost control mechanisms. Payers attempt to control their individual costs with a variety of mechanisms, including prospective and retrospective review of services.

Universal? No.

Supplemental insurance available? Not applicable.

Canada

Health Expenditures as % of GNP (1989): 8.7%

Annual Per Capita Expenditure: $1,683

What Is It?
National Health Insurance. Each of Canada's 10 provinces offers its citizens portable (i.e., recognizable in all other provinces) coverage for a mandated range of comprehensive health care services including hospital care, long-term care, physician services, X-rays and lab tests. In addition, other services are mandated for specific populations, e.g., prescription drugs for the elderly and welfare recipients, and dental care for children and welfare recipients. Citizens seek care from a public or private provider of their choice who is reimbursed on a fee-for-service basis from the provincial health agency.

How is it financed?
The federal government guarantees to cover approximately 40 percent of the costs of providing care in each province. The provinces finance the remaining amount. At both the federal and provincial level, funding comes from general revenues — taxes.

How is it administered?
Each province has a public agency responsible for providing coverage and reimbursing providers. This agency is accountable to the provincial legislature. The provincial governments negotiate annually with providers to determine physician fees and total operating budgets for hospitals.

Mechanisms for cost control?
"Global budgets" for health care expenditures; fixed hospital budgets; low administrative costs; and negotiated fees for providers.

Universal? Yes.

Supplemental insurance available?
Yes. Private insurance is available for things not covered by the national health insurance, such as a private room.

United Kingdom

Health Expenditures as % of GNP (1989): 5.8%

Annual Per Capita Expenditure: $836

What is it?
National Health Service. The government finances and delivers a comprehensive set of health care benefits to its citizens, including: prescription drugs, hospital care, long-term care, preventive care and some dental care. Every citizen is registered with a general practitioner (GP) in her/his community who acts as a "gatekeeper" for the health services the patient receives. The government operates and owns most of the hospitals and has put most of the country's doctors on salary. Roughly 9.3 percent of the population has private insurance (to cover elective surgery and avoid long waiting periods for such services) and there is a small system of private practitioners.

How is it financed?
General revenues — taxes. A small amount of health care is financed by the private sector in the form of private insurance.

How is it administered?
The national government allocates the health care budget among the regional health authorities which, in turn, plan the health services for the districts within their region and set hospital operating budgets. GPs are paid on a capitated basis — one fee for all services — that is negotiated with the government, with additional allowances for special preventive services. Doctors working within hospitals are salaried.

Mechanisms for cost control?
National budget for health care expenditures; government ownership and control of the delivery system; regulated provider fees; fixed hospital budgets; and low administrative costs.

Universal? Yes.

Supplemental insurance available?
Yes. A private insurance system is in place to permit people to avoid the long waits for elective surgery.

Germany (pre-unification)

Health Expenditures as % of GNP (1989): 8.2%

Annual Per Capita Expenditure: $1,232

What Is It?
Compulsory Social Insurance. All workers earning less than $33,000 are required to enroll in a "sickness fund" for themselves and their dependents that finances a comprehensive set of medical benefits, including: hospital care, preventive care, long-term care and dental care. People earning more than $33,000 have the option of enrolling in a sickness fund or purchasing private insurance with similar benefits. The unemployed receive federal and state subsidized coverage for membership in sickness funds. Retired persons also receive coverage from sickness funds. Citizens seek care from the provider of their choice.

How is it financed?
Workers and their employers are both legally required to contribute amounts set by the sickness funds. Workers earning more than $33,000 finance their care either by purchasing private insurance or enrolling in a sickness fund. The state and federal governments finance their obligations through general revenues.

How is it administered?
The bulk of sickness fund premiums is given over to regional associations of physicians. The sickness funds negotiate a fee schedule with regional associations for doctors operating outside of the hospital setting. Providers receive reimbursement from their regional association on a quarterly basis. Hospitals negotiate per diem rates with the sickness funds and pay their doctors on a salaried basis.

Mechanisms for cost containment?
Negotiated fee schedules for providers; fixed budgets for hospitals; state limits on hospital investments; and national caps on health expenditures.

Universal? Yes.

Supplemental insurance available?
Yes. Even those who are mandated to be covered by sickness funds can purchase private insurance for supplemental benefits.

Japan

Health Expenditures as % of GNP (1989): 6.7%

Annual Per Capita Expenditure: $1,035

What Is It?
Multiple-Payer Social Insurance. Citizens are required to belong to one of three types of social insurance plans providing a comprehensive set of medical benefits, including: prescription drugs, long term care, dental care and some preventive care. Consumers choose their provider, and the provider seeks reimbursement from the insurance plans. The three types of plans are: employer-based plans that cover 63 percent of the population; insurance plans for the self-employed and their dependents that include a national insurance plan for the poor with the government acting as the insurer; and a separate system that is a pool of funds to pay for the health care costs of the elderly.

How is it financed?
Employer-based plans are financed by premiums divided equally between the employer and the employee. Plans for the self-employed and their dependents are financed by premiums based on income, the number of people in the household and assets. The national health insurance plan is financed by the central government. The pool for elderly health care costs is financed by equal contributions from all of the plans.

How is it administered?
Each plan is responsible for the administration of health care services and reimbursement of providers. Reimbursement rates are based on a nationally set fee schedule negotiated by the government. The government also sets the scope of services that can be provided by the plans.

Mechanisms for cost control?
Government control of services and fees; retrospective review of claims submitted by providers for payment; low administrative costs.

Universal? Yes.

Supplemental insurance available?
Yes. Citizens may purchase insurance for supplemental benefits, such as a private room during a hospital stay and other incidental expenses.

HEALTHCARE REFORM 1993

Present Status

Health care consumes one out of every seven dollars spent in America., yet there are 37 million uninsured, and these figures are growing at an alarming rate. Clinton- the system is badly broken and it's time to fix it.

We must understand what is happening and why before we can construct a conceptual solution to the problem.
Our health care system is the leader in medical technology for the world, but it has become very costly and unwieldy

Between 1965 and1991 , health care spending rose from 5.9 to 13.2 percent of GDP, and at this rate it could hit 20% by the end of the decade. As companies pay more for health insurance, less remains for take home pay. Government is financially burdened and less is left for spending on items such as education society's ills, law enforcement, and infrastructure issues. Rising health care costs have been cited as a major roadblock to reducing the federal deficit. Federal outlays for health care (mainly medicare and medicaid) rose from 2.6% to 16% of its total expenditures from 1965 to 1992. during the same interval education expenditures stayed roughly the same at 6 to 7%, and defense expenditures fell from 9.7 to about 6% of Gross Domestic Product. Health care costs to American industry adds significantly to its difficulty maintaining international competitiveness.

Ever since World War II, Americans have considered good health care a right., something the people should recieve when they need it. We also think that we should have health care with the level of

technology that science can make available to us. The problem is that the feeling that people should have health care on demand fosters the illusion that health care is free, or at least we shouldn't have to pay for it.

Health care should ideally provide universal insurance coverage with no one denied essential care. It should allow freedom of choice, with people free to choose their doctor, and the doctor being able to choode the best treatments. It should control costs .

The dilemma is that a system that provides unbounded benefits for all of us as individuals will hurt all of us a a sociely, crimping private incomes and burdgeoning government. Yet we all feel uneasy at placing limits on care for family, friends, or almost anybody. Ours is a society highly sensitive to individual rights and ever optomistic about the possibilities of improving life.

No health care system can achieve all these goals. Universal coverage, with absolute freedom of choice would make costs uncontrollable. We can control costs only if some people or some treatments are not covered by insurance. We either make these choices directly or tolerate a system that makes these choices for us. These issues touch us in a personal way and also makes us rethink our role in our society as a whole.

In the present health-care debate, we must try to come to an understanding of the sometimes ambiguous and difficult-to-define nature of modern medicine.
Every medical breakthrough was once hailed as a triunph of science and a gift to humanity. Now we see more and more often that it also makes medicine more costly and beaurocratic.
In this increasingly complex system the patient too often feels that he or she is recieving less of personal attention that high quality care must have.

Patients still crave the caring continuity of a doctor patient relationship- to be able to reach out to some one you know, and who knows you in a time of need. This generates the feeling and delivery of efficient and appropriate care.

Our health care problem is not that we are less healthy, or that we are hugely unhappy with our medical care. We are, despite the big problems of urban violence and epidemic serious disease such as AIDS, healthier than ever. Life expectancy has risen since 1950 from 68 to 76 years. Over 80% of Americans feel they're satisfied with their personal health care.

Health COSTS are the big problem, not the quality or availability of care. A basic cause of the spending explosion is the combination of generous insurance, increased demand for medical services, and the availability of high-tech medicine.
High-tech medicine does provide spectacular benefits, and, in many cases, prevents the more expensive or functionally restricting natural course of diseases. It also provides new opportunities to add to quality and comfort of life. All these high-tech treatments, however, do raise the total costs of health care.

A Harvard economist attributes roughly half of the recent increases in health spending to new medical technologies.. He cites much of the remainder stems from rising population and inflation.

Health Care Elsewhere

include LWV handout

Other countries have a history of doing a better job at controlling health care costs. In 1991 when the US spent 13.2% GDP, Germany spent 8.5%, France 9.1%, Japan 6.6% and Britan 6.6%.

These differences were achieved, however, by; limiting spending by providing less health care, and by paying less to those providing the care. There are tighter price controls in all these situations. Doctors earnings are a smaller, hospitals are more stringently managed, and there has been less technology available or demanded.

In these countries, less care is provided by a variety of mechanisms. In Britan, many aging hospitals are overcrowded, and patients are routinely, though often informally denied the most advanced treatments. They often have limited access to those treatments we would deem routine due to lack of hospital beds, specialist time, and hospital budgetary constraints. (Kidney dialysis and heart surgery, for example are performed at much lower rates than in the US.)

Other societies have also controlled health care costs because the values of their particular society are different. They are more accepting of death, are less enthusiastic about heroic life saving technologies, and are less hostile to restrictions on care. They choose, in some way or another, by habit or conscious decision, or lack of knowlege of availability, to use fewer "units" of health care. Other societies practice and consume medicine in ways that we would reject.

Despite previous spending records, many countries now face annual health care expenditure increases more similar to ours. For the last several years, Canada has had an annual per capita rise in health-care spending very similar to our own. West Eruopeans are struggling over how to shrink their cradle-to-grave welfare states. France has cut benefits in their state medical insurance by $5 billion, and plans to make patients pay more of the bill. Britan is reevaluating its National health service, splitting pruchasers of health-care from providers. The Swedish government is selling hospitals to private operators. The German system, one of the models for the Clinton proposal, is experiencing runaway costs, with

the nationwide "sickness fund" system having a deficit of $6 billion last year.
The demand for more health care is increasing in these other countries and technology is now more universally available, also feeding the rising costs of health-care in other nations once thought to have a better control on health spending.

Health Care Reform U S A

Health care in the United States is derived from a heritage of a special relationship between the people who provide health care and those who recieve it. This was for centuries a charitable exercise that supported the sick and ministered to their needs, principally in dying.
Just prior to the twentieth century, physicians and hospitals began to provide services that altered the natural course of disease. With new and inventive medicines and surgical procedures, curative interventions occurred to an amazing degree. With this change, health care services became expensive, beyond the reach of even generous incomes.
An insurance industry then arose to provide coverage availability to all. This insurance coverage was based on employment and was supplemented by numerous federal, state, and local programs for those who were not employed. In this environment, the insurer recieved monies from either the employer or the purchaser and paid the bills to the providers of health care(physicians and hospitals.). With the rising cost of health care since the 1960's this total coverage insurance became increasingly expensive, and for most, unaffordable.

In the 1970's and 1980's, insurance companies began collecting data enabling them to identify, and insure at lower cost, those people least likely to need health care and therefore representing a "good risk".

As this scrutiny intensified, a community of people who were high risk and therefore uninsurable arose.

Clinton and his advisors want to totally restrusture a $912 billion industry that comprises 14 percent of the US economy. Clinton wants a comprehensive health-care plan which guarantees coverage that cannot be taken away. The details of the plan have been submitted, are under scrutiny and discussion, and most probably will be changed in detail. He is willing to compromise on many details, all except for his guarantee of permanent, comprehensive coverage. This would be the largest social intervention by government since Social Security.

Clinton's Health Security Act promises to provide peace of mind through; the secutity of guaranteed coverage that cannot be taken away, lessen amounts spent by business on health care, and provide relief for the federal deficit.
At worst, the propoosed plan will mean more paperwork in an already inundated office environment, more bureaurocracy, higher taxes, if the "savings" side of the plan doesn't work, and the very worst, another entitlement that our future generations will have to pay for.

Clinton's Health Security Act would cost 700 billion over five years. The plan promises to guarantee a generous, minimum package of health insurance to all Americans. The 37 million uninsured would be covered either through
their employer or through expanded welfare subsidies The basic package of benefits would be comparable to that offered by most corporations and would include extra benefits for primary and preventative care.

Clinton is making an initial effort toward finding a balance between the demands of freedom of choice and less cost by proposing a system that provides somewhat less freedom for patients and

doctors, and somewhat more cost control. He wants to convince Americans that his plan will provide the same or better health care coverage at the same or less cost for the vast majority of Americans.

Clinton plan handout

Clinton's six points of the plan promises: Security, Simplification, Savings, Quality, Responsibility, and Choice.
He plans to provide security of coverage despite change in employer.
He plans to provide simplicity in the reduced paperwork that his national plan would provide.
He assures that the plan will produce savings, as it certainly must if the Americal health-care system is going to deliver more services with few added taxes.
The plan promises quality medical care through more governmental control, and while reducing the cost of the system.
Responsibility relates to the necessary monetary contribution of individuals and industry, the need to modify our lifestyle, and address society's ills.
Choice refers to assurance that patients would retain the ability to choose which doctors they see and that a doctor would continue to be able to choose which treatments he or she feels is most appropriate and effective.

Clinton's Proposal expects to balance the finances of the plan from 1995 to 2000 as follows:
Revenue sources would include

70 billion in a cigarette tax over five years

35 billion in taxes on corporations that opt out of the health plan

124 billion in medicare cuts

114 billion in medicaid cuts

47 billion in cuts to federal workers, military and veterans

51 billion tax windfall from increased workers wages passed on to them

from corporate health cost savings.

The plan's proposed expenditures include

169 billion in subsidies to provide coverage of low income workers.

80 billion for long term care

72 billion for drugs for the elderly

29 billion for expanded public clinics

91 billion to be spent on budget deficit reduction.

These figures will no doubt be adjusted in the months to come as the discussions, and compromises continue to whittle away at the details of the proposed plan.

Clinton's plan proposes two levels of cost containment; the new untested idea of "managed competition" (the best governmental oxymoron since Military Intellegence) and a backup system of strict governmental regulation. Clinton and his advisors hope competition will slow the growth of health spending without the need to use the regulatory measures they propose. But no one knows whether managed competition will work on a nationwide scale as no other nation has tried it. It has worked in areas such as Minneapolis-St. Paul and Southern California, but it may not work as well in the much larger national arena.

The primary mechanism the Clinton Plan will ues in an attempt to get the health-care system's spending under control, then, is this unproven economic theory of managed competition. This is designed to create price competition among doctors, hospitals, and health-insurance companies.

The health-care industry has historically avoided competition between the price and value of its products because there has been no real bargaining between consumers (patients) and "providers" (doctors and hospitals), and also because third parties (employers or the government) actually pay the bills.
American medicine has therefore allowed both patients and doctors to largely be insensitive to the cost, value, and necessity of the care that is given and received.

This means the health-care market tends to be dysfunctional when it comes to controlling costs. Consumers rarely know what a specific medical service should cost and rarely price-shop, since they want to seek the best treatment, not the cheapest. Consumers also rarely know what insurance policies offer the best value, caught in the conundrum of premiums, deductables, co-payments and restricted coverages. Employers also often have problems sorting out the available options of premiums. Some insurance companies tailor their policies to discourage high risk patients in favor of younger, healthier people, shunting unfairly the expensive-to-cover high-risk patient to companies like Blue Cross and Blue Shield,(who, by law are required to insure all applicants).

Clinton's plan for provision of services hinges on the interplay of three key elements. (1) the Core Benefit Package, (2) Health Alliances , and (3) Health Care Provider Plans

The <u>Core Benefit Package</u> would be provided to all, including those with pre- existing conditions, high risk patients, and to others now commonly denied coverage by some insurance companies
This core benefit package would be defined explicititly for employers, insurance companies, and consumers alike, establishing an easily understood, fully comparable product for the health-insurance industry. That would make it possible for consumers, employers and alliances to comparison shop.

The health alliances would be large quasi governmental organizations created by the states that would represent consumers in a given region. They would collect premiums paid by employers, individuals and the federal government, and use those premiums to bargain for and purchase health insurance coverage for all their enrollees. Companies with more than 5000 employees would be allowed to buy their own insurance or to self-insure. These health alliances would provide more bargaining power and more expertise in selecting health care coverage for smaller companies, self-employed workers and the unemployed. These health alliances would substantially assume the financial role now played by private health insurance companies. As a result the health insurance industry would be forced to downsize, at the cost of thousands of jobs. in the insurance industry.

On the other side of the managed competition "playing field" would be the health care providers organized as plans. The plans would be formed by combinations of doctors, hospitals, and insurance companies. These provider plans would bargain on issues of quality, quantity and price of service every year with the health alliance providing the health services defined in the core-benefit package to the health alliance enrollees.
The bargaining would force the plans to bid on the basis of a fixed annual payment per enrollee- about $1800 for each individual and $4200 for a family.

This health-care delivery system, then, would run like HMO's do now, selling care at a fixed, pre-negotiated price. Under the proposed plan, the option for fee for service care would exist only under the price schedules established by the alliances. Many experts see this regulated fee for service medicine as the end of medicine as an industry of self employed professionals.

Clinton's plan may force some doctors and hospitals out of the system. Some older doctors might retire rather than to undergo the

organizational hastles and restrictions of working for a provider group. Hospitals left out of groups may close entirely, unable to compete and buy the newest medical equipment, or offer the most advanced procedures. This lack of convenient local hospital care would be felt by patient populations as a significant treatment inconvenience.

The managed competition structure has a backup system, should it fail to control costs. This is the entirely new form of governmental price control, the global budget. This is an estimate of what it should cost, in any given year, to provide the standard health insurance plan to all Americans. The formula for the global budget would be set by Congress and enforced by a newly created National Health Board. The Board would then compute target budgets for each state based on the number of enrolled consumers.
Regulation would allow the feds to intervene in the bargaining between any alliance and any health plan, through the establishment of "caps" on premiums, and would allow the Feds to penalize state governments for non-compliance.

Issues

Major questons in Clinton's Health Security Act, or any other proposed plan must address: (a) the generation of funds to run the program, (b)cost controls,, and (c) the maintenance of quality of care in a national system. The issues of health-care value of expanding high technology , and our views on our health and ageing also need to be addressed more aggressively.

(a) The generation of funds to run the program

The Clinton plan is based on the assumption that there is enough waste in the system to pay for universal coverage for the poor and the uninsured without raising taxes (except for the proposed tax on tobacco). The administration has not stated how much waste they think there is The Administration also has never stated how much it thinks it would cost to provide health coverage for the 37 million uninsured, or the amount it would cost to insure the estimated 22 million underinsured. If the administration's analysts are wrong, the costs of providing health care to the uninsured and the underinsured would ultimately require new taxes.

Sen. Moynihan, the Democratic chairman of the Senate Finance Committee describes the financial plan as "fantasy". There is a need to see concrete results from the administration's cost proposals before-not after-the money is spent on new proposals.

(b) Cost controls

Some of the projected costs of Clinton's plan are unrealistic as are the anticipated savings. The average premium suggested for individuals and for a family-probably won't cover the costs of the generous benefit package. The long term care costs are estimated to be too low by half. The tax windfall projected as employers pass on health cost savings to workers in the form of increased wages will be offset by the projected 30 million jobs lost from small business if the proposed plan is implemented.

The regulatory "global budget" portion of the plan would set national spending limits for the first five years of the reform. It allows spending to rise annually by a formula including cost of living and population increases. This formula would allow spending to rise to 1.5 trillion by the year 2000, saving an estimated 700 billion This is really a small saving compared to the expected 10 trillion in spending over this 7 year period.

If the plan works, it will force doctors, hospitals and health insurers to decide how to control their own costs or face this direct regulation. The annual budgets will simply set a target for negotiations between alliances and their provider plans. If a provider plan fails to control its costs and goes over the price it negotiated the year before, it absorbs the loss.

Opinions by the economic and medical establishment over cost controls vary. Some say that budget limits are necessary and sensible and that no nation has been able to keep costs down without some type of budget cap. The American Medical Asso. opposes the notion of limiting health care costs through governmental regulation. Michael Bomberg of the Federation of Health Systems says that Clinton's attempt to control private sector spending may well be unconstitutional.

The Congresional debate will also revolve in large part around the issue of cost controls.
Some liberals support the "single payor system" that would turn government into a national health insurer, negotialting annual fees through medical assotiations like the Canadian system.
Conservative Democrats and the Republican leadership in the House favor managed competition without global budgeting, allowing the restructured health-care market to determine national spending levels without limits set by government. They feel a plan with mandated insurance limited to catastrophic coverage to individuals and families would encourage more choice individual responsibility and cost consciousness.
Conservatives favor tax deductable "medical savings accounts" which would avoid both managed competition and cost controls.

(c) Maintenance of quality of care in a national system

If the Clinton Plan or one like it becomes a reality, loss of our expected quality of care is likely. The relationship we have with our doctor is at risk of being disrupted--your doctor may join a plan you do not choose to join. That is a real loss of quality of care if you have a chronic and/or serious medical condition.

Quality of care has a real risk of being eroded also when physicials make decisions with too great a concern on the costs of the optimum management.

Studies on governmental cost controls over existing health-care programs show that stringent cost containment eventually does impinge on the quality of care.

Dr. James Todd, executive vice president of the AMA states that "what has been found in other countries when the government takes over health care are longer waiting lists, deterioration of facilities, and a marked slowdown in the adoption of new technologies. Its an economic model that does not deal with the real world of doctor-patient relationships

(d) Health-care value of high technology

As the national health-care tab expands, the value of high-tech medicine comes under scrutiny. Analysts are discovering that we could possibly do without much of the high tech medicine available without unfavorably affecting the quality of health care.
Technology has achieved spectacular gains in the last few decades, including vaccinations, antibiotics, and drug treatments for common previously deadly conditions. Surgical advances and innovative instrumentation have saved lives and added quality of life to many others.
But these advances have had a suprisingly modest effect on the population as a whole.

The greatest advances in public health have come not from new technologies for treating illness but from social changes that helped people avoid illness. Analysts point out that low-tech, community-oriented measures could temper the demand for costly treatments, by reducing the burden of disease. It is estimated that about 70% of treated diseases are preventable, including for example some infectious diseases (measles, AIDS), lung cancer, and heart desease. The attack on infectious disease has contributed significantly to the increase in life expectancy in America since the turn of the contury.(from 47 to 75 years), but 90% of this progress occurres during the first half of the century, before modern medicine and its technology was into full swing. The real breakthroughs were better housing, hygiene and nutrition.

Modern medical treatment, has had little effect in recent attacks on cancer and heart disease. Americans at any age are as likely to die of cancer today as they were in 1971. The only big successes of modern medicine have come from prevention. Diet and lifestyle changes have been the main reasons death from heart disease has dropped, only 3,5% of this drop was due to bypass surgery.

The Clinton plan has some serious flaws in its theoretical basis. The health industry, as one seventh of the economy is simply too large to be managed by government. There will be tremendous problems of creating and implenenting a system that involves such sweeping changes to the health-care industry and government. The history of state and federal efforts to contain costs is one of failure. Adding beaurocracy to cut down on beaurocracy is a move always under suspect. Bureauocracy tends to mushroom. Our Representative Peter Hoekstra recently confirmed that the "the Clinton plan would expand government significantly, adding at least 75 new state and federal government agencies and commissions to oversee the health-care system. He doesen't believe the addition of government beaurocracy, in a time where voters and governmental officials are calling for shrinking the size of government, is a step in the right

direction." Health alliances will control more money than most states with less accountability.

Many members of congress are questioning whether the Clinton plan is too expensive and unwieldy-and are considering less ambitious alternatives.

Conservative Democrat Jim Cooper of Tennessee has announced his rival plan termed "Clinton Lite" Many top whitehouse aids feel that this plan is close to what will be the conclusion of the ongoing debate.

This differs from the Clinton Plan in that the poor and near poor recieve substantial coverage, while insurance for others is optional but easier to obtain and more affordable. Elderly care is unchanged. The plan sets no targets for what employers are required to pay. There would be taxes on employers offering lavish health benefits to help pay for low income family subsidies. Medicare would be trimmed by only one quarter of the Clinton plan to generate the remaining funds neeed to pay for most remaining subsidies. There would be an important element of mal-practice lawsuit reform missing from the Clinton plan. The Plan would specifically exclude limits on insurance premiums and exclude the "huge and unfunded entitlements"-- coverage of prescription drugs for the elderly, new benefits for early retirees and the disabled, and subsidies for small business to help defray insurance costs.

(e) Issues on health and ageing

The very sick account for most of health care spending. Per year the sickest 1% of patients account for about 30% of health spending, and the sickest 5% of patients account for 58% of costs. The healthiest 50% of Americans account for only 3% of healthcare costs.

The over 65 age group in this country is growing steadily, and with the expected increases in longevity, this groups numbers will

mushroom even more dramatically. This population now comprises about 13% of the nation's population, yet they account for more than one third of all health-care spending. They fill 40% of all hospital beds and consume twice as much prescription medication as all other age groups combined.

The health expentitures of this group, growing at this pace, will overwhelm any savings the proposed plan can achieve in health care costs in just a few years.

Without dramatic research breakthroughs in the management of the chronic ailments of the elderly, the immediate future of exploding health-care costs seems certain. Advances in battling the incidence of disability in the elderly population are needed and could provide significant savings to the health-care total.

The $124 billion in proposed medicare cuts will exasperbate this problem. Medicare reinbursement to physicians is already too low to cover the expense of the delivering of the needed care in many circumstances. The plan's funds to provide community and home based services will be far short of what will be needed to provide this care.

The solutions offered to the cost problem generally depend on how one accounts for the explosion of the costs. Although there is waste in the system, it is incidental to the basic forces driving up costs. Everyone agrees that there's waste in the system, but nobody knows how much. some areas suspected are: Paperwork-there's a ton of this from 1300 insurers, all with their own claim forms. It is estimated that going to a government system of a single payor(like Canada) may save $50 billion each year in costs.Greed and Profiteering - in 1991, doctors incomes totaled 74 billion. Drug companies profits in 1992 were about 12 billion.Unneeded surgery and tests- several studies have concluded one seventh or more procedures and tests are done. Malpractice suits and Defensive medicine- malpractice premiums and procedures done to lower a

doctors exposure to be sued incurr cossts estimated at about 37 billion annually

Ira Magiziner says of the new plan that "'there's going to be a tremendous one time savings, and that the plan will knock out waste without compromising care." Even if substantial waste is eliminated, the relief may only be temporary, Economists agree that if there's waste, it can be squeezed out only once. If paperwork costs were cut by $50 billion, and doctors incomes dropped by one third, $25 billion, the savings would only offset one year of the annual $75 billion rate of rising health costs.

Controlling waste will save money only in the short haul. But these factors add only relatively little to the whole cost problem.

We are a health obcessed society, and so are uncomfortable with the idea of death. In our intense effort to prolong life, we have made much more difficult the task of defining the mission of American medicine. Doctors rationally know that death is a continuing part of life, but also have been scientifically trained to refuse to give in to any known cause of death.

Americans have demonstrated a growing acceptance of their own mortality, as evidenced by the growth of Hospice and the use of living wills, or as in this state "advanced directives". In other countries, there is more acceptance of death, and fewer questions asked concerning when to stop treatment of the terminally ill.

Conclusions

Credit is due to Clinton for his persistence in bringing our attention to this critical issue. He has announced that the details of his Health Security Act are subject to negotiation, with the exception of universal coverage. It is my hope that ,the opportunity for real

change that can strengthen the system will not be lost through compromise and politics.

The health care debate is so morally discomforting precisely because it poses questions few of us want to face, either as individuals or as a society.

Health care reform should rethink the meaning of "progress". Rationing should be viewed not only as necessary, but also as a symbol to the need to reconsider our outlook on unrestricted improvements in health and longer life. Any health system that hopes to control costs must impose some limits.
Only fundamental changes of this kind will allow our nation to cope with the coming economic and social pressures on the health-care system. Failure to make these changes in our concept of health will leave us with a medical system with the same short and long term outlook as we have now.

High tech medicine creates a paradox; the more it extends life, the more it raises the cost of living longer.
Medical advances can be cost effective in treating individual illnesses, while raising a persons lifetime health costs.
Todays successful bypass surgery patient may have a heart attack in a few years or develop cancer.
The problem is that there is no discipline on spending, its hard to know in advance who this spending will benefit, and patients expect the best care the medical system can give.

In reducing the contribution of high tech medicine to the escalating total cost, the challenge is to reduce the relatively high number of procedures that studies show are either unwarranted or avoidable. This is certainly preferable to the specter of rationing necessary lifesaving technologies.

Experts feel that doctors need to know more about the costs and benefits of particular treatments. This outcomes-based management would eliminate some waste, but for real cost control, we must reduce the need for high tech intervention. This has already begun with existing health plans and employers concentrating more on prevention to lower costs, often with dramatic results.

Within limits, decreases in reimbursement may encourage cost reducing technical innovation and full use of facilities to achieve economies of scale. Excessive reductions require decreases in the quality of care.
It is imperative that we develop quality assessment programs without which it is impossible to evaluate the opposing views of administrators, providers, and patients about the effect of reductions in payment on the quality of care.

An article in Harpers magazine by Dr. Willard Gaylin points out several key issues. He points out that the present discussion on health care represents relatively narrow quibbles over policy, where the real debate should center about the more essential questions of our attitudes toward life and death, the goals of medicine, the meaning of "health", suffering versus survival, who shall live and who shall die (and who shall decide).
Unless we address such basic issues, we stand little chance of solving our nation's health-care crisis.
The fundamental contradiction of the Clinton plan is that if you promise everyone access to whatever medical care he of she wants, you will enormously increase the total amount the nation spends on health care- the very costs to be brought under control.

In the end we must confront the deeper and more challenging reasons for escalating health-care costs: our unbridled appetite for health care and our continuing expansion of the definition of what constitutes health.

The greatest part of the cost increase may be best understood as the result not of the failures of medicine, but its successes. The increase in costs is a product of the expanding capabilities of medicine.

The efficiency experts favor businesslike principles that, if applied will solve the cost crisis. But these principles have flaws.
The first misconception is that costs can be controlled by reducing the self serving nature of health-care providers, and cutting the fat out of the system. But every large system has fat and are somewhat inefficient; examples are the airlines, the automobile industry and the steel industry.

The second is the need to limit "halfway technologies" that extend the life of the patient without actually curing the disease. But, since we all have the terminal disease called life, all medical technologies are halfway technologies.

The third argument is that if more money were spent on preventive medicine, we could solve the problem of health-care costs. Dr Gaylin presented an interesting analysis of this issue. A measles shot costs $8, whereas hospitalization for a child with mealses costs $5,000. But when you try to extend the economical analysis of the individual case to the entire system, it becomes that the rational for prevntive medicine is not an economic one. The child who would have died from polio or measles will eventually grow up to be a very expensive old man or woman.
Preventative care drives up the ultimate cost of health care to society by enlarging the population of the elderly and the infirm. This position only points out that the use of preventative medicine for long term health cost control is, in his opinion, irrational. The proper argument for preventative medicine is that it allows individuals to lead healthy and productive lives.

The real causes driving up costs are:
The increase in morbidity rates due to good medicine;

The expanding concept of health;
The seduction of technology, and
The deception of the marketplace model; and the unique makeup of the American character.
The understanding of these concepts is important and must be used in our conceptual solution to our present and future health care cost and delivery problems.

(1) The increse in morbidity rates due to good medicine---Good medicine increases, not decreases the percentage of people with illnesses in our population. Good medicine keeps people alive, thereby increasing the number of sick people in the population; patients who are killed by their disease are no longer part of the population. We have more persons with heart disease, diabetes and hypertension than there are in Iraq, Nigeria or Columbia, for example.

(2) The expanding concept of health---Health today does not mean what it did 100 years ago. As more is discovered about how the body works, the more we can apply this knowlege to fix what may not have formerly been considered a disease. Clinical experience and later refinements in technology tend to extend its use to broader groups of patients than initially anticipated. As we begin to find treatments to delay the ageing process, we reclassify various aspects of ageing as "diseases". These all make demands on the health-care dollar.

(3) The seduction of technology and the deception of the marketplace model.
The physician, patient and family are seduced by technology , in commonplace situations (like the recently heated debate over the appropriateness of routine fetal monitoring), and in the decision making in matters of life and death.
Decision-making becomes distorted whenever exteme risks are involved, and our perceptions of probability vary significantly

depending on the setting. (Nicki's brother David's views on terminal care and treatments.) Exceeding the speed limit while driving carries a greater risk of a fatal accident, yet this well publicized fact does not affect the speed most drivers drive. The possible consequence seems too remote.

But perceptions change in a hospital setting. If a doctor sees no sign of a tumor on X-Ray, and if he tells a patient that a CAT scan might pick up 1% of tumors that X-rays miss, the patient will not accept the rational that this further test is probably not worth the additional cost of the CAT scan. As the patient, we would demand that additional test, although the stastical validity of doing so, compared to slowing down on the highway, makes no sense.

Death in the hospital setting has greater reality, and people will think little of the cost to defend against it, so long as the money doesn't come directy out of their own pockets. In health matters, people are willing to pay substantially more money for relatively small improvements. When what is being improved is life expectancy, the rules change.

Medical technology will continue to be expensive because it usually pays to market a 1% improvement even though it might be 100% more expensive. Because of the health arena in which this occurs, the demand will likely be there.

Because this special approach we take to medical technology is so unique, the marketplace in medical technology will never follow classical patterns. The usual forces of supply and demand don't work with the same predictability in medicine. Highly specialized technologies controlled by small groups of manufacturers do not respond to the marketplace in the same way that mass produced items do.

(4) <u>The American character</u>---. The health-care crisis is most critical in America because we are the leading high technology culture and because of the American character.

Americans are not willing to take their place in waiting lines for care. Americans tend to want problems solved completely and

immediately. There is less positive feedback, or satisfaction whether as an individual or as a nation in simply putting up with a nagging problem. Perhaps this is a part of our frontier heritage, Americans refuse to believe there are limits, even to life itself. " An example is the struggle in America to define such terms as "death with dignity" which really means death without dying, and "grrowing old gracefully" which means really living a long time without ageing. Dying in one's sleep at ninety two after having won three sets of tennis from one's forty year old grandson that afternoon and having made love to one's wife twice that evening- this is about the only scenario most American men will accept a fufilling their idea of death with dignity and growing old gracefully.

The surest ways to contain health-care spending are to limt access to health care and to rethink out ever-expanding concept of health Present examples of managed care are seen best in today's HMO's. Here the bulk of savings are achieved by cutting back on expensive, unprofitable facilities (neonatal centers, burn centers, ER's, etc.). This is a cruel, hidden form of health-care rationing, counting on municipal and university hospitals to take up the slack.

The important step in controlling health-care costs is to admit that rationing of health care is necessary. The implementation of rationing can be best understood by dividing it into three areas.

(1) Access- how do we decide who gets to recieve a scarce health resource
(2) Egress--how long may someone recieve the granted health resource
(3) Allocation--what medical services can the system as a whole provide to everyone.

Access --We can no longer leave decisions about who has access to medical care to the marketplace. Access to scarce health-care must be set up on an equitable basis which will likely mean there is full

coverage for everyone This will help prevent the use of influence, power, position, and money to buy access to life sustaining services. We must as a society and as individuals be more sensitive to the needs of the whole population requiring special services. In a recient article in the New England Journal of Medicine about lessons learned from the national end stage renal disease program, access was a major concern, as the demand for dialysis far exceeded the availability of long term dialysis..That inequity persists even today, some 25 years after the start of the national program. The history of the dialysis program indicates that" without a consensus that there are ethically acceptable criteria other than medicaal efficacy for selecting patients for lifesaving therapy, neither the public not the medical profession will support explicit rationing.

Egress --Once access to a specific health treatment is accessed, the next perhaps even more diffcult decision is if and when that access should end. Every new technology, however expensive, quickly becomes part of the therapudic norm, From the patients' view the access to this treatment is no longer a privilege, but a right. We as a society can and have had debates over what we as a society will spend, for a supercollider, for example,and we must now apply some of these lessons to medical ethical questions.

Allocation -- What medical services can our society afford to provide to everyone? We cannot meet every American's health needs. Limited resources will force us to make tragic choices among competing health needs..

These are not medical choices, but rather moral and ethical ones best made by all of us.

The state of Oregon has set a sort of precident for us, attempting to provide "basic health care" to everyone Not all services could be included. It was decided what would be included by a series of heated public discussions and debates. They accomplished having a discussion about new technologies,medical priorities, how much health care they can afford, and what it means to be healthy.

We presently, in general, don't believe limits are necessary. The Robert Wood Johnson Foundation asked respondents what restrictions might be acceptable on insurance to cut costs; 75% rejected limiting transplants; 70% opposed limiting choice of doctors or hospitals; 60% opposed restricting specialized services to regional medical centers requiring an hours driving time.

An exasperated newsweek writer covering the health-care issue wroth that he's sick of all the incomprehensible health-care jargon. He says" Lets just pass a single payer with a high deductible fully means tested global budget HNO plan and get on with life". I'm sure many share his views, but also hope that all these issues and their implications for this nation's health future areunderstood and discussed before this or any other conclusions are reached.

The basic question of any reform is where responsibility should lie.

WHAT I BELIEVE

In addressing the health-care crisis, we must focus on what we can and need to do on a national, community and personal levels.

As a nation, we must become aware and educated and responsible about the crisis in the costs of health care. We must become aware of how rising costs hamstring our efforts to reduce our national budget deficit, and how these escalating costs hamper our businsess' competitiveness nationally and in the world market.
The uninsured and underinsured numbers of our population must have some degree of coverage. This will most likely be a program funded by taxation in some form. The present proposal cannot generate nearly enough funds to cover this portion of its targeted goals through wringing fat out of the system or the proposed cuts in

medicare or medicaide, while at the same time keeping up with the pace of even a drastically slowed expansion of health-care costs. The federal government must streamline medicaid and medicare to make it more equitable, efficient , more user sensible for both provider and consumer, while finding a way to lessen the abuse and the fraud in this system.

The federal government will probably then regulate how much money for health-care a region will get annually , which must be used by that region's communities, with all the efficiency they can muster, for the delivery of these programs for the uninsured. This should be the main focus of a national plan.

Managed competition already has been working well in many areas of the country with admirable results recently. Here costs increases have been held to levels of increase as low as only slightly above inflation rates, dramatically lower than the double-digit figure national cost increase averages of the last decade.
It is important to note that these controls have been developed by market forces within the existing health care delivery system, without federal government restructuring and the threat of global budgeting. A federally run system of managed competition would not be as sensitive to local situations and needs, and therefore not as successful in finding effective solutions to health-care's problems.
The federal management of other public programs has been less than sterling or efficient, and there is no reason to believe that throwing away the present system in favor of a federal plan will produce any different results.
Much of the existing system's experience and resultant improvements and growing efficiency should be preserved and kept as springboard for future changes.

As a commumity, we find perhaps our greatest strength in managing health care costs, access and value. Here, working with other individuals, (fellow consumers) local health-care providers(doctors,

hospitals and other health professionals), businesses and local insurance organizations we have the possibility of making the greatest strides in restructuring our thinking about what we spend for our health care and how we care to consume it. Locally we have the best chance to identify and find the best solutions for our unique combination of factors that define our health situation.
Through this open community forum of everyone; consumers, providers, local insurance and local government, we will best be able to openly and publically address the sensitive subjects of rationing access and allocation of services. As a community we have the best chance to effectively address the issues of the high medical costs incurred by crime and violence, drug abuse, alcoholism, AIDS, teenage pregnancy, and other leading social issues that have an impact upon health. Participation in the process of making these painful but necessary questions is the only way to arrive at conclusions everyone understands and accepts.

Each one of us must take a personal responsibility to address the heath- care crisis. We must first educate ourselves as to the causes of how things got where they are. Each of us must become aware of the costs of the medical services we demand .
We must educate ourselves in the concepts, the problems and the uncomfortable situaton of the never clear cut answers to rationing of care. Each of us must then apply this information to personally consume less health care .
We must take the responsibility to make ourselves healthier persons, rather than to cling to the notion of the right to a health unconscenous lifestyle expecting someone else to pay for the "repair and maintenance" costs.
We must become more comfortable with the concept of having "enough" care, without demanding all there is possible to be provided, regardless of the cost or small chance of increased beneficial outcome.
We must accept the need to give more money toward the national need to insure the un and underinsured.

We must become involved in our community's efforts to coordinate all the facets of the health system. We must continue to involve ourselves with finding solutions to society's ills that take such a toll on health costs control. Most importantly, these isues must be addressed and understood now.

No medical system can give us everything we want--lower costs, more medicine, universal coverage and total freedom. We cannot have an ideal system, but we can work toward a less imperfect one.

Benefit Package
Low Cost Sharing

	Cost Sharing	Limitations
Overall		
- Deductible	None	
- coinsurance	$10 per visit	
- Out-of-pocket max		
Individual	$1,500	
Family	$3,000	
Inpatient Hospital	Full coverage	Private room only when medically necessary
Professional services, outpatient hospital services	$10 per visit	
Emergency services	$25 per visit	Waived in emergency
Preventive services, including well-baby, prenatal	Full coverage	Services limited to periodicity in Table 1
Hospice	Full coverage	As hospital alternative for terminally ill
Home health care	Full coverage	As inpatient alternative; coverage reassessed at 60 days; added coverage only to prevent institutional care
Extended care facilities (SNFs, rehab facility)	Full coverage	As hospital alternative; 100 day limit
Outpatient physician, occupational, speech therapy	$10 per visit	Only to restore function or minimize limitations from illness or injury; reassessment at 60 days; additional coverage only if improving
DME, outpatient lab, ambulance	Full coverage	
Routine eye and ear exams, eyeglasses	$10 per exam or 1 set glasses	Eyeglasses limited to children only
Dental services		
- Initial: Prevention	$10 per visit	For <18 only
- Additions in 2001:		Remove age limit on prevention
Restoration	$20 per visit	
Orthodontia	$20 per visit	Only to avoid reconstructive surgery
Prescription drugs	$5/prescription	
Mental health/substance abuse		
Initial		
Inpatient services:	Full coverage	30 day/episode; 60 day/year max
Hospital alternatives:	Full coverage	120 days maximum
Brief office visits for medical management:	$10 per visit	no limits
Psychotherapy:	$25 per visit	30 visits maximum
2001		
Inpatient services:	Full coverage	
Hospital alternatives:	Full coverage	no limits
Outpatient incl. 1-12 psychotherapy visits:	$10 per visit	