FAX TRANSMISSION

Department of Health and Human Services
Office of the Secretary

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COMMENTS:

DISEASE FROM SEX IS SEEN AS GROWING

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They often lead to pelvic infections that can cause infertility. The report estimates that each year 100,000 to 150,000 women become infertile as a result sexually transmitted diseases, accounting for 15 to 30 percent of the nation's infertility. But researchers at the Federal Centers for Disease Control and Prevention, on whose data the study's conclusions were based, cautioned today that infertility data were based on sketchy information.

Problems in Pregnancy

Pregnant women infected with a sexually transmitted disease can transmit the infection to their child during pregnancy or childbirth, causing miscarriage, stillbirth, premature delivery or other problems.

"We have known for some time about the disproportionate impact on women," said Patricia Donovan, the author of the report and a senior associate for law and public policy at the Guttmacher Institute, a nonprofit organization concerned with reproductive health.

More surprising, she said, was the degree to which the Federal program to combat sexually transmitted diseases is sometimes inconsistent in addressing the problem.

Priorities Are Questioned

"We didn't notice till now how closely it is focused on syphilis and gonorrhea, how it is focused on men, and doesn't focus on prevention," she said. "Given the fact that many of these diseases are viral in nature and can't be cured, the only way to prevent them is to prevent them from occurring in the first place."

Researchers have identified about 50 infections and syndromes that are sexually transmitted. The most common is chlamydia, a bacterial infection that infects four million people a year, but has been little studied until recently.

According to the report, many of the most serious problems for women are the result of undetected chlamydia and gonorrhea infections.

The incidence of gonorrhea, which rose from about 600,000 in 1970 to about one million from 1970 to 1975, decreased to about 690,000 in 1990, but still left the the United States a rate of gonorrhea infection well above those in other industrialized countries, according to the report. The incidence of syphilis, which, like gonorrhea, is a bacterial infection, has fluctuated from 91,000 new cases reported in 1970 to 69,000 in 1980 and back up to 134,000 in 1990.

Teen-agers and blacks are disproportionately affected by sexually transmitted diseases, the report said, because "these groups are more likely than whites and older Americans to be unmarried and therefore to have multiple sexual partners. In addition, teenagers who begin sexual activity earlier are more likely to have multiple partners.

The general increase in teen-age sexual activity puts even teen-agers with one partner at increased risk: a recent study in four Atlanta clinics found that 24 percent of adolescent women who had only one sexual partner were infected with chlamydia.

Many cases of gonorrhea or chlamydia lead to bacterial infection of the uterus, Fallopian tubes or lining of the pelvic organs, sometimes causing infertility.

"About one in nine women aged 15 to 44 are treated for pelvic inflammatory disease during their reproductive years," the report noted. "If current trends continue, one-half of all women who were 15 in 1970 will have had P.I.D. by the year 2000."

According to the report, those infected with some of the venereal diseases are also more vulnerable to infection by the human immunodeficiency virus, which causes AIDS, if exposed to that virus, known as H.I.V. Many of the sexually transmitted diseases are also linked to the same social factors as H.I.V., including the use of crack cocaine, which increases the number of addicted women willing to trade sex for drugs.

Common Sexually Transmitted Diseases

Chlamydia 4 million cases a year	Bacterial infection acquired chiefly through vaginal or anal intercourse. Symptoms include genital discharge, burning during urination; women may suffer pain in lower abdomen or pain during intercourse. Up to three-quarters of cases in women are without symptoms. Can be cured with antibiotics.
Trichomoniasis 3 million cases a year.	Parasitic infection most often occurring in female vagina and male urethra. Symptoms are often absent, especially in men. May include vaginal discharge, discomfort during intercourse, odor, painful urination. Can usually be cured with oral antibiotics.
Gonorrhea 1.1 million cases a year.	Bacterial infection of cervix, urethra, rectum or throat. Symptoms are often mild or absent, including discharge from penis, vagina or rectum and burning or itching during urination. Can be cured with antibiotics, but penicillin-resistant cases are increasing.
H.P.V. 500,000 to 1 million cases a year.	Viral infection spread by anal, oral or vaginal sex causes painless, fleshy warts in affected area. Warts can be suppressed by chemicals, freezing, laser therapy and surgery. Some strains are associated with cervical and other cancers.
Genital Herpes 200,000 to 500,000 cases a year. About 31 million Americans carry the virus.	Usually caused by virus, spread by skin-to-skin contact. Symptoms include itching or burning and blisters, usually in genital area. May recur. Causes painful open genital lesions, sometimes accompanied by swollen, tender lymph nodes in the groin. No cure, but antiviral drugs can alleviate outbreaks.
Hepatitis B 100,000 to 200,000 cases a year. About 1.5 million Americans carry infection.	Virus found in semen, saliva, blood and urine and passed through sexual contact, sharing drug needles and piercing the skin with contaminated medical instruments. Infection attacks the liver. Most infections clear up by themselves within eight weeks, but some individuals become chronically infected.
Syphilis 120,000 cases a year, of which 40,000 to 50,000 are infectious.	Bacterial infection usually acquired by vaginal, anal or oral sex with someone who has an active infection. Produces painless sores which disappear within weeks, but without treatment disease may eventually damage heart, brain, eyes, nervous system, bones and joints. Curable with penicillin.

Source: Alan Guttmacher Institute

The New York Times

Balt. Sun; 4-1-93

AIDS toll likely to top 25 million, editors told

By Douglas Birch
Staff Writer

The death toll from AIDS will soar past 25 million worldwide by 1997, earning it the grim title of history's most lethal epidemic, a Johns Hopkins medical researcher predicted yesterday.

"You probably want to know if there's a cure ahead, a vaccine, a light at the end of the tunnel," said Dr. John G. Bartlett, speaking in Baltimore to a gathering of newspaper editors. "Based on where we've been with this organism, I have to be pessimistic."

Dr. Bartlett, an AIDS expert and the head of infectious diseases at Hopkins Hospital, said scientists are likely to find ways to slow the ravages of AIDS, making it a "manageable" illness like diabetes.

But the human immunodeficiency virus, which causes AIDS, may attack the body's natural defenses too efficiently and mutate too quickly to be defeated outright, he said.

In the 14th century, the plague called the Black Death claimed the lives of an estimated 25 million people in Europe. About a quarter of the continent's population may have died in what is widely considered the most deadly epidemic on record.

At least 20 million people died worldwide in the flu pandemic of 1918-1919.

The physician was one of five Hopkins doctors who spoke to the American Society of Newspaper Editors, meeting this week at the Baltimore Convention Center. The doctors were asked to forecast the major medical stories of the next few years.

Dr. Bartlett said there probably will be new outbreaks of malaria and a vicious, recently discovered strain of tuberculosis. But not all his news was bad. Polio, he predicted, will someday be wiped off the face of the earth. Smallpox was the first, and so far, the only major disease eradicated, with the last case reported in 1976.

Dr. Solomon Snyder, Hopkins director of neuroscience, said new drugs to treat stroke and other illnesses may flow from research into the chemicals that brain cells use to talk to each other.

New machines, including advanced magnetic resonance imaging devices, will reveal details about how the brain learns and responds to injury, said Dr. Guy McKhann, director of the Krieger Mind-Brain Institute.

Wash. Times; 4-1-93

Students plan hunger strikes for Haitians

By Matt Neufeld
THE WASHINGTON TIMES

A coalition of area university students yesterday began a month of hunger strikes to demand that the Clinton administration change its policy of detaining more than 200 HIV-infected Haitians at Guantanamo Bay, Cuba.

President Clinton's position is "morally, legally and politically wrong," said Dee Hunter, a student at Howard University School of Law and a main protest organizer.

The series of hunger strikes will move from campus to campus and stretch into mid-April, students said at a news conference. Those who participate in the strikes, which will range in duration from one day to a week, will drink only juice and water.

Apart from Howard, the protest includes students at George Washington, American, Catholic and Georgetown universities, the University of the District of Columbia and the D.C. School of Law.

Members of the Washington Area Student Coalition for Haiti said they want the administration to free the Haitians from Guantanamo Naval Base and let them enter the United States like other refugees.

The Haitians are detained there under a law that allows the United States to bar foreigners who test positive for the human immunodeficiency virus, which causes AIDS.

"We are appalled and outraged" at the detainment of the refugees in "concentration-type camps" at the military base, said Mr. Hunter, backed by some 30 student leaders who appeared with him yesterday.

Some of the refugees are in poor health because of their condition and may die under "deplorable and inhumane" conditions, said Yewande Dada, 26, president of the Student Bar Association at Howard law.

About 50 Howard Law students and another 25 undergraduates at Georgetown began fasting at 6 a.m. yesterday. They plan to fast for one week.

American students plan to pick up the fast April 7 and pass it along to Georgetown Law Center students on April 14.

Georgetown undergraduates have built a "mock prison camp" in the middle of campus and dubbed it "Camp Clinton," said Todd Heyman, 21, a senior government major.

At least two students plan to stay in the "camp" around the clock until midnight tomorrow, Mr. Heyman said. An additional 300 students are also expected to fast for a day.

In other activities, students plan to rally on the Ellipse tomorrow morning with students from Yale and Harvard. Yale students held similar hunger strikes March 3, and students at Harvard, Brown and Stanford followed, Mr. Hunter said.

Mr. Hunter said he has contacted colleges in Northern Virginia and Maryland about participating and expects their support.

The Haitians have reportedly been fasting at Guantanamo since Jan. 29.

On Friday, U.S. District Judge Sterling Johnson Jr. of New York ordered the Clinton administration to "provide the level of adequate care" for refugees with HIV at the base or "medically evacuate such class members to a place [except Haiti] where adequate medical care is available within 10 days."

A White House spokesman did not return repeated telephone calls yesterday.

USA Today; 4-1-93

Health industries No. 2 in donations

By Judi Hasson
USA TODAY

Led by the American Medical Association, the health and insurance industries have spent $153 million on congressional campaigns over the 12 years since 1979, according to a new report from Citizen Action, a watchdog group.

That's second only to the combined finance, insurance and real estate industries.

Top recipients of money from 430 health-related political action committees are several lawmakers who will be influential in the debate on President Clinton's health-care reform plan.

Among them: Democratic Leader Rep. Richard Gephardt, D-Mo., who received $810,407; Rep. Pete Stark, D-Calif., $755,925; and Sen. David Durenberger, R-Minn., $944,677.

In a report Wednesday, Citizen Action, founded by consumer activist Ralph Nader, claims there's a "direct connection" between gridlock on health reform and the industry's campaign contributions.

"This is preventive medicine practiced by the health and insurance industries," said Citizen Action's Edwin Rothschild.

He said voters should ask their representatives if their position on health reform "has anything to do with campaign contributions from the health-care and insurance industries."

The AMA had no comment. Richard Coorsh, spokesman for the Health Insurance Association of America, said Citizen Action combines all insurance industry contributions, including areas like life and property insurance.

"To lump this all together and assume it to be a health interest is somewhat misleading," said Coorsh, whose group represents 270 insurers.

Rep. Ron Wyden, D-Ore., said the money health interests gave doesn't matter.

"Every one of these interest groups is going to have to accept reform," he said.

stage, or enthusiastic," he says. If the plan requires new spending, it will be "a very tough sell," Penny says.

"But for now, we can't do them any harm, because we don't have any ammunition."

▶ Vaccination program, 1A
▶ Prescription costs, 1B

STARK: 'We don't know what the plan is.'

Top-contributing PACs

The top five health and insurance industry contributors to congressional campaigns, 1979-92:

American Medical Association	$17.7 million
National Association of Life Underwriters	$7.4 million
American Dental Political Action Committee	$5.8 million
Independent Insurance Agents of America	$4.2 million
American Academy of Ophthalmology	$2.6 million

Source: Citizen Action

By Stephen Conley, USA TODAY

"My father died from the stress of taking care of the woman he loved."

Bill Keane

Tales of real life push health reform

By Timothy J. McNulty
Chicago Tribune

For Gore, debate over X-rays for his daughter.

WASHINGTON—At a conference of health experts in Boston, Harvard philosopher Amartya Sen referred to the death of his wife and his own experience with radiation treatments to make a point about rationing.

In a speech, economist Henry Aaron cited a series of medical tests he endured to explain the need to restrain treatments.

At the back of the auditorium, Rashi Fein, another economist, complained that all four of his grown sons lack health insurance.

In Washington, meanwhile, at a breakfast briefing aimed at polishing the industry's image, a drug company executive startled listeners when he said his mother's life had been "ruined" by what would now be an easily treated case of tuberculosis.

The experts trying to influence government choices are dealing from the heart as well as the head these days as the desire to reform the nation's health-care system is turning into a personal and intimate debate.

What might be mundane policy arguments in another field are transformed by surprisingly dramatic revelations of family tragedy and pain. Almost everyone has a story to tell.

"I speak to you today from 12 years of experience as the

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Health

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primary caregiver for my mother and aunt, both of whom had Alzheimer's disease," Bill Keane told the president's task force on health-care reform at a public hearing in Washington earlier this week.

As an advocate for the Long Term Care Campaign, Keane spoke plainly and movingly about the terrible emotional cost of caring for someone suffering dementia: "My parents spent their entire life savings on expensive, institutional, long-term care. My father died from the stress of taking care of the woman he loved."

Such shared understanding of the fault lines in the nation's health-care system ultimately may help President Clinton win support for his reforms in Congress.

But the fact that all the advocates and lawmakers have had personal experience—both good and bad—with doctors, hospitals, insurance companies and pharmaceutical costs may also create problems for Clinton. The members of Congress who will ultimately have to vote on any reform package have all been touched in one way or another, and as a result they are likely to have widely different priorities that they feel strongly about.

Dealing with the health-care system, the expense of it and the often limited access to adequate care, is so routine that no one from privileged policymaker to the most modest witness is spared.

Even as her task force on health care races toward an early May deadline, First Lady Hillary Rodham Clinton has been absent for the last two weeks because her 81-year-old father, Hugh Rodham, is clinging to life in a Little Rock hospital after suffering a stroke.

The jargon of "managed competition" and other health-care concepts being proposed by Clinton's reformers may be unfamiliar, but almost everyone can relate to the problems of crippling illnesses.

The president of the American Association of Retired Persons, Lavola Burgess, is a powerful advocate for the elderly. But when she described the need for a community support system at the task force hearing, she did so not in political but in very personal terms.

"I know my own mother could have stayed home two years longer if in this little Iowa town we had been able to have some kind of community-based care," Burgess said.

During the same hearing, Vice President Al Gore eagerly agreed with one witness who complained about [illegible] X-rays.

Gary Frank Petty, representing small business interests, told how a doctor ordered a needless X-ray for his daughter after she was hit in the throat with a basketball and started hyperventilating. A more senior physician at the hospital countermanded the order only after Petty complained, and thus saved him $129.

Gore recalled he had "almost the identical experience" with his own daughter, who was ordered to have

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Compromising positions?

IMAGINE, if you can, a trial in which the judge clearly favors the defendant, as do the jury and witnesses, all of whom acknowledge that they have preconceived opinions. The prosecutor is more interested in a settlement that gets him out of the courtroom than in making a case for justice. In fact, that scenario is playing now in a U.S. Senate committee room where an outdated and unfair military ban on gays and lesbians is "on trial."

Sen. Sam Nunn, D-Ga., an ardent supporter of the ban, presides; its supporters count on unfounded public fears about the impact of lifting the ban; and the Clinton administration, which took office vowing to lift the ban, is now acting like a prosecutor unwilling to make the case for justice.

On any rational grounds, the ban is untenable. Still the prospect of Congress agreeing to lift it isn't very promising. The prohibition unfairly punishes people not for public behavior, but for private inclinations; it rests on absurd, irrational assumptions about how homosexuals and heterosexuals behave under stress; and it wastes millions at a time when the Pentagon worries about budget cutbacks.

Supporters of the *status quo* clearly are taking advantage of the Clinton administration's political skittishness to strengthen their position at the expense of fairness and common sense.

The Senate and House ought at least to ensure that hearings on the issue are of real value to the American public. Extremists must not be allowed to monopolize them or turn them into some sort of Roman circus. They must be kept at an intellectual level that provides some understanding of issues — particularly the fears and needs of individual soldiers and officers. At this stage it behoves the advocates of gay rights to make their own case — strongly, rationally, prudently. They have captured the attention of a nation that values fairness and privacy but is nonetheless undecided how to balance the rights of people who declare themselves gay.

The Clinton administration has been indicating that it wants some kind of compromise that will ease, not end, the persecution against gays and lesbians in the military. Such a compromise would doubtless be viewed as "a step forward."

But how does one "compromise" such basic freedoms as the right to privacy? The right to hold a job and claim its benefits? To demonstrate one's patriotism? To live with respect and dignity? Experience demonstrates that it can't be done. Lifting the ban and writing a military code that prohibits inappropriate public sexual behaviors — heterosexual or homosexual — not private orientations, is the only responsible course for Congress and President Clinton. Let the hearings lead to such a "verdict."

COST OF GAY BAN

In 1990, 932 military personnel were discharged because they were gay, lesbian, or bisexual. What it cost to replaced them:

Cost of recruiting and training one service member	
Enlisted	$28,226
Officer	$120,772
Gay men and lesbians discharged, by rank	
Enlisted	920
Officer	12
1990 cost*	$27,417,184

*Does not include court, investigation or administrative costs

SOURCE: Government Accounting Office

A3852B Knight-Ridder Tribune

America's children at risk

EVERY SO often a research or lobbying group releases a thick study on the plight of American children. Bad and getting worse, it reports, and things in Florida are worse than the national average. Such studies become numbing; the problems that they define appear too huge.

Yet there is some hope in the latest dismal statistics. The extensive (and expensive) expansion of Medicaid over the last five years has reduced infant mortality and childhood deaths, according to the annual report from Kids Count, a project of the Center for the Study of Social Policy and the Annie E. Casey Foundation.

The report also finds that the poverty rate for children eased nationwide, dropping by a little less than a percentage point to 19.8 percent while climbing in Florida by 2 percent to 22.1 percent.

Beyond that, the news about high school graduation grew worse; violent crime among youth and teen pregnancy climbed, with Florida statistics generally worse than the national trend. The study ranked the well-being of Florida's children at 45th in the nation.

What to make of this? That Florida simply pays too little heed to the needs of its youngsters? Yes. Florida's stinginess made things far worse for the poor during the 1980s cutbacks in federal spending and recent recession.

But there's more at work here: When policy studies focus on children, they ignore the problems of the children's *parents* who have lost ground over the last 20 years. Family buying power would have declined to a crisis point if mothers had not entered the work force; now buying power is declining. Even as the economy inches back from recession, new jobs are not good jobs with benefits; they tend to be part-time or temporary jobs.

FAMILIES NEED HELP

These economic realities, coupled with social trends away from the creation of families, have left the nation's children at great risk. Indeed, the Kids Count study identifies three factors for risk — age, education, and mother's martial status. In Florida, 12.3 percent of births in 1990 were to unmarried teens who had not finished high school, while 25.1 percent were born to mothers with two of these "risk factors."

Young adults cannot be written off while (or if) America attempts to save their children. In simplistic terms, the best way to avoid poverty is to finish high school, marry, and then have children. In real terms, young adults need better targeted job training, guidance in building families, and assistance in such key areas as health care until they are standing on their feet, their children with them.

That means stronger and better government help; it also means stronger and better help and attention from all facets of American society, its companies, schools, churches, and social institutions.

ems wary of health-care plan

Task force PAC ties scrutinized

By Judi Hasson
USA TODAY

Some members of the White House task force on health-care reform work for Democrats in Congress who have received at least $4.6 million in contributions from the health-care industry over the past four years.

While it's standard practice to contribute money and ask to be heard on legislation, the connection raises a question of whether industry groups have found a voice in the highly secretive process.

"There is a real possibility of a conflict of interest," says Rep. William Clinger, R-Pa., who has been critical of the task force for holding its sessions, except a marathon Monday, in private.

A USA TODAY analysis found 133 task force staffers on loan from 68 members of Congress who received money from the health industry.

The task force has 511 people working on a plan to overhaul the health-care system.

The computer analysis compared a White House roster listing task force members' affiliations with Federal Election Commission reports of campaign contributions to members of Congress in 1989-92.

Clinger says having task force staff on loan from lawmakers who got health-industry contributions "raises more questions about the validity of the whole process."

Charles Lewis of the Center for Public Integrity says it raises other questions as well:

"It is a pipeline back to those interests," says Lewis.

"It's likely the industry knows exactly what's going on," he says.

Drew Altman of the Henry J. Kaiser Family Foundation, a health-care philanthropy, disagrees: "I just haven't seen anything about the process that would suggest it's a process dominated by interest groups."

Says White House spokesman Robert Boorstin, "I don't think there are any members on the Hill who have never taken a contribution from a health-related industry or interest group."

The Center for Responsive Politics, a non-partisan group, has reported the health-care industry contributed $14.4 million to members of Congress last year — a 32% boost over the previous election cycle.

Rep. Henry Waxman, D-Calif., who has loaned seven staffers — either from his office or from a health subcommittee he chairs — to the task force, received $305,950 from the health-care industry.

Waxman says that there's no correlation between his staffers and contributions he may have received.

"They are doing the best they can to give the benefit of their expertise to people looking to them for options as they develop their plan." Waxman said Wednesday.

And lawmakers say money doesn't necessarily talk.

"On this one, I think the general public is going to have more influence than the health-care industry," says Rep. Dan Glickman, D-Kan.

Glickman, who has a staffer on the task force, got $40,000 from the industry over four years.


UPI
WAXMAN


AP
ROCKEFELLER


AP
DASCHLE


AP
GEPHARDT


AP
HARKIN

The ties of politics and health care

Members of Congress with at least one staffer on the health-care reform task force headed by Hillary Rodham Clinton, and a look at contributions they received from health- and insurance-related political action committees in 1989-1992[1]:

Rep. Henry Waxman, D-Calif.	**$305,950**	**Rep. Daniel Glickman, D-Kan.**	**$40,000**
Sen. John Rockefeller, D-W.Va.	$274,172	Sen. Harris Wofford, D-Pa.	$37,375
Sen. Thomas Daschle, D-S.D.	**$264,249**	**Rep. Bob Clement, D-Tenn.**	**$32,650**
Rep. Richard Gephardt, D-Mo.	$257,289	Rep. Dave McCurdy, D-Okla.	$31,100
Sen. Tom Harkin, D-Iowa	**$231,304**	**Rep. Louis Stokes, D-Ohio**	**$30,700**
Sen. Max Baucus, D-Mont.	$173,650	Rep. Ronald Coleman, D-Texas	$29,450
Rep. Robert Matsui, D-Calif.	**$168,806**	**Rep. William Clay, D-Mo.**	**$28,700**
Rep. John Dingell, D-Mich.	$166,600	Rep. James Bilbray, D-Nev.	$25,800
Sen. Bill Bradley, D-N.J.	**$161,100**	**Rep. Pat Williams, D-Mont.**	**$25,700**
Sen. John Breaux, D-La.	$157,414	Rep. John Olver, D-Mass.	$25,350
Rep. Sander Levin, D-Mich.	**$143,672**	**Rep. Pete Peterson, D-Fla.**	**$24,900**
Rep. Benjamin Cardin, D-Md.	$140,600	Rep. Eva Clayton, D-N.C.	$23,000
Rep. Michael Andrews, D-Texas	**$131,600**	**Rep. Maria Cantwell, D-Wash.**	**$22,777**
Rep. Ron Wyden, D-Ore.	$115,018	Rep. Martin Sabo, D-Minn.	$19,350
Sen. Bob Graham, D-Fla.	**$112,239**	**Rep. Peter Deutsch, D-Fla.**	**$17,350**
Rep. Barbara Kennelly, D-Conn.	$105,900	Rep. Sam Gejdenson, D-Conn.	$16,870
Sen. Barbara Mikulski, D-Md.	**$102,735**	**Sen. Robert Kerrey, D-Neb.**	**$16,750**
Rep. John Bryant, D-Texas	$97,439	Rep. Jim Cooper, D-Tenn.	$15,500
Sen. Kent Conrad, D-N.D.	**$78,000**	**Sen. Patrick Leahy, D-Vt.**	**$15,000**
Rep. Peter Hoagland, D-Neb.	$71,837	Rep. Calvin Dooley, D-Calif.	$13,850
Sen. Daniel Inouye, D-Hawaii	**$60,493**	**Sen. Paul Wellstone, D-Minn.**	**$12,755**
Sen. David Pryor, D-Ark.	$60,000	Rep. Ted Strickland, D-Ohio	$9,957
Sen. Ben Nighthorse Campbell, D-Colo.	**$59,850**	**Sen. Daniel Patrick Moynihan, D-N.Y.**	**$8,250**
		Rep. John LaFalce, D-N.Y.	$7,850
Sen. Claiborne Pell, D-R.I.	**$58,700**	**Sen. Jim Sasser, D-Tenn.**	**$7,250**
Rep. Rosa DeLauro, D-Conn.	$57,978	Rep. John Conyers, D-Mich.	$4,185
Rep. Richard Durbin, D-Ill.	**$57,550**	**Sen. George Mitchell, D-Maine**	**$4,000**
Rep. Jack Brooks, D-Texas	$55,100	Rep. Neil Abercrombie, D-Hawaii	$3,100
Rep. Charles Stenholm, D-Texas	**$46,600**	**Rep. Ronald Dellums, D-Calif.**	**$2,500**
Rep. Mike Kopetski, D-Ore.	$46,350	Sen. Edward Kennedy, D-Mass.	$2,000
Rep. Louise Slaughter, D-N.Y.	**$44,200**	**Sen. Donald Riegle, D-Mich.**	**$1,000**
Rep. David Obey, D-Wis.	$43,700	Sen. Jeff Bingaman, D-N.M.	$0
Rep. Lewis Payne, D-Va.	**$42,987**	**Sen. David Boren, D-Okla.**	**$0**
Rep. Earl Pomeroy, D-N.D.	$42,528	Sen. Howard Metzenbaum, D-Ohio	$0
Rep. Jill Long, D-Ind.	**$41,875**	**Rep. Mike Synar, D-Okla.**	**$0**
Sen. Dale Bumpers, D-Ark.	$40,350		


USA TODAY
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1 - Through Oct. 14, 1992. Source: USA TODAY analysis of Federal Elections Commission data

The lack of details a concern

By Judy Keen
USA TODAY

Some Democrats in Congress are resisting White House efforts to enlist them in the early selling of President Clinton's health-care reform plan.

They want to know what's in the plan — so far only a medley of ideas, speculation and hints — and how it will be paid for before they take the political risk of touting it back home.

White House aide Ira Magaziner has virtually camped out on Capitol Hill to solicit Democratic support for the embryonic plan that's due May 3.

This week, he's been at the Capitol daily, recruiting dozens of House Democrats to sell reform when they're home April 5-13 for their Easter break.

"He's out there importuning members to go home during break and sell . . . the plan even though we don't know what the plan is," complains Rep. Pete Stark, D-Calif., chairman of a key health subcommittee.

"It shows a lack of understanding of the political system," Stark says.

But Magaziner, who Wednesday briefed the House Democratic Caucus and a group of mayors, gets praise from others for keeping them apprised and acknowledging that paying for reform remains elusive.

Fort Worth Mayor Kay Granger calls reform "a plan in progress. . . . They didn't have answers on costs because they're not there yet."

Though funding is "still being fleshed out," says Cleveland Mayor Michael White, "we have also indicated our willingness, once the policy decisions have been made, to . . . support the president's plan."

Magaziner described to House Democrats a card everyone will get providing access to their health "units" — the cluster of physicians to whom they would be assigned — and discussed malpractice reform and price controls.

Rep. Tim Penny, D-Minn., says the goal of White House short-on-detail lobbying may be to mute griping.

Penny says this is a pretty savvy political tactic.

"There's not enough detail for us to be alarmed at this stage, or enthusiastic," he says. If the plan requires new spending, it will be "a very tough sell," Penny says.

"But for now, we can't do them any harm, because we don't have any ammunition."

USA TODAY • THURSDAY, APRIL 1, 1993

1 down, 2 to go for economic package

By Richard Wolf
USA TODAY

A4

President Clinton needed 10 weeks from his inauguration to get the outlines of his economic package through Congress. That was the easy part.

The $1.5 trillion budget plan approved 240-184 by the House Wednesday and slated for final Senate approval today is just a first step. Two more are needed to successfully enact a five-year, $482 billion deficit-cutting scheme:

▶ Next up is the so-called "reconciliation" bill that includes a net $273 billion tax increase over five years, along with cuts in federal benefits.

▶ Spending cuts, including $106 billion from the military by 1998, must be implemented through 13 separate appropriations bills later this year.

Between now and then, the key variable will be whether Clinton's fellow Democrats in Congress have the political fortitude to turn a blueprint into a finished product without straying too far from the president's original plan.


USA TODAY

> "Pure pork, and metric tons of it. This is the same old crap right back through FDR."
>
> — Sen. Alan Simpson, R-Wyo.

"The job ahead of us is enormous, even with an effective ally like Bill Clinton," said House Ways and Means Chairman Dan Rostenkowski, D-Ill.

As Clinton's combination of deficit reduction and new investments weaves its way through the upcoming legislative labyrinth, all eyes will be on Democrats who say they want to support Clinton — but who also voiced support for a slew of non-binding amendments endorsing changes in the plan. Those amendments carry no weight with tax and spending committees.

"They're FYI," said Senate Finance Chairman Daniel Patrick Moynihan, D-N.Y. And while the Appropriations Committee is bound by total figures for various segments of the budget, Chairman Robert Byrd, D-W.Va., can divvy it any way he sees fit.

So far, Democrats have hung together on the tough votes, beating back Republican efforts to strip out the most controversial tax hikes and spending cuts. Senate Democrats spent Wednesday blocking changes to Clinton's $16.3 billion short-term spending package despite GOP objections.

"Pure pork, and metric tons of it," said Sen. Alan Simpson, R-Wyo. "This is the same old crap right back through FDR."

Most Clinton supporters expect Democratic unity to hold throughout the budget process.

"It will be tough, but I think there's still a fundamental commitment to moving the program forward," said House Budget Committee Chairman Martin Sabo, D-Minn.

But a number of factors could work against Clinton after Congress returns April 13 from a spring recess:

▶ The "honeymoon" granted new presidents will wane, lessening the pressure on Democrats to back Clinton against the wishes of their constituents.

"The base of support for Clinton's program is eroding rapidly as people find out what's in it," said Sen. Phil Gramm, R-Texas.

▶ The 1994 elections will inch closer, leading more lawmakers to focus on the political consequences of their votes — as did newly appointed Sen. Bob Krueger, D-Texas, who faces a special election next month, in voting against the budget blueprint.

"There will be a lot of 30-second commercials run about these votes," said Senate Majority Leader George Mitchell, D-Maine.

▶ Clinton's willingness to deal on elements of the plan — such as his agreement to delay fee increases on mining, grazing and timber interests and accept fewer cuts in agriculture subsidies — may embolden more House and Senate members to seek changes. Tops on the chopping block: energy taxes and higher levies on Social Security benefits.

"The Democrats in Congress have already started to tinker with the president's plan," said House Minority Leader Robert Michel, R-Ill. By year's end, "it may be unrecognizable."

911

The Washington Times

PAUL CRAIG ROBERTS

A health plan doomed to fail

President Clinton's health plan will fail, because it will drive up demand but not supply. The result will be price increases or rationing. Price increases, combined with the expanded coverage Mr. Clinton wants, can mean an explosive increase in health care expenditures. Rationing can mean a deterioration in the quality and timeliness of care or denying treatment in cases where the patient's prospects are not good or the cost exceeds the value of the person's life.

The "health care crisis" driving Mr. Clinton to come up with a health care plan is as old as sin. Fifty years ago, on March 15, 1943, Forbes magazine wrote: "Medical care costs money — more money than the majority of Americans can afford. The specter of medical expenses, which average $120 annually per family, haunts most homes; even a minor illness perilously rocks the family budget."

In those days, insurance was thought to be the solution. But as coverage spread and insurance was transformed into pre-paid health care, demand rose, and the price of health care moved higher. With Medicare and Medicaid, government has added tremendously to the demand for health care. Now Mr. Clinton wants to add the demand of 36 million uninsured Americans on the supply of health care services, and he doesn't want the price to go up!

Insurance, whether private or government, drives up the price of health care, because a "third party" pays the bill. The patient will demand all he can get, and the provider doesn't have to prescribe with the patient's budget in mind. Government programs, such as Medicare, simply load more demand on the system.

Inevitably, governments respond with fee schedules and lists of permissible charges in vain hopes of keeping the increase in demand from driving up prices. The public hears political demagogy against the "obscene" incomes and profits of doctors and drug companies. Less is said about the greed of the patients and the large sums spent on keeping people alive a few more hours or a few more weeks.

Rising costs are curtailing supply just at the time when Mr. Clinton wants to add 36 million more customers.

Recently, Mr. Clinton dishonesty blamed drug companies for the high cost of medicine. Drug prices are high because of the high-development costs — largely due to government regulation — and lawsuits claiming injuries. As the Wall Street Journal recently reported, there is no patent on the vaccine against measles, mumps and rubella, yet Merck is the only company willing to sell it in the United States. Indeed, the taxes alone on childhood vaccines exceeded the cost of the vaccines a decade ago.

While malpractice litigation, tort liabilities, and government regulation push up the cost of health care, "third party" payments and the aging of the population push up demand. With both cost and demand rising, the price has to go up.

Technology, too, plays a role in driving up both costs and demand. On the cost side, doctors and hospitals, forced to practice defensive medicine by lawsuits, employ ever more expensive diagnostic tests. On the demand side, a bum knee is no longer a reason to give up tennis. Instead, magnetic resonance imaging can discern damaged cartilage and arthroscopic surgery can remove it.

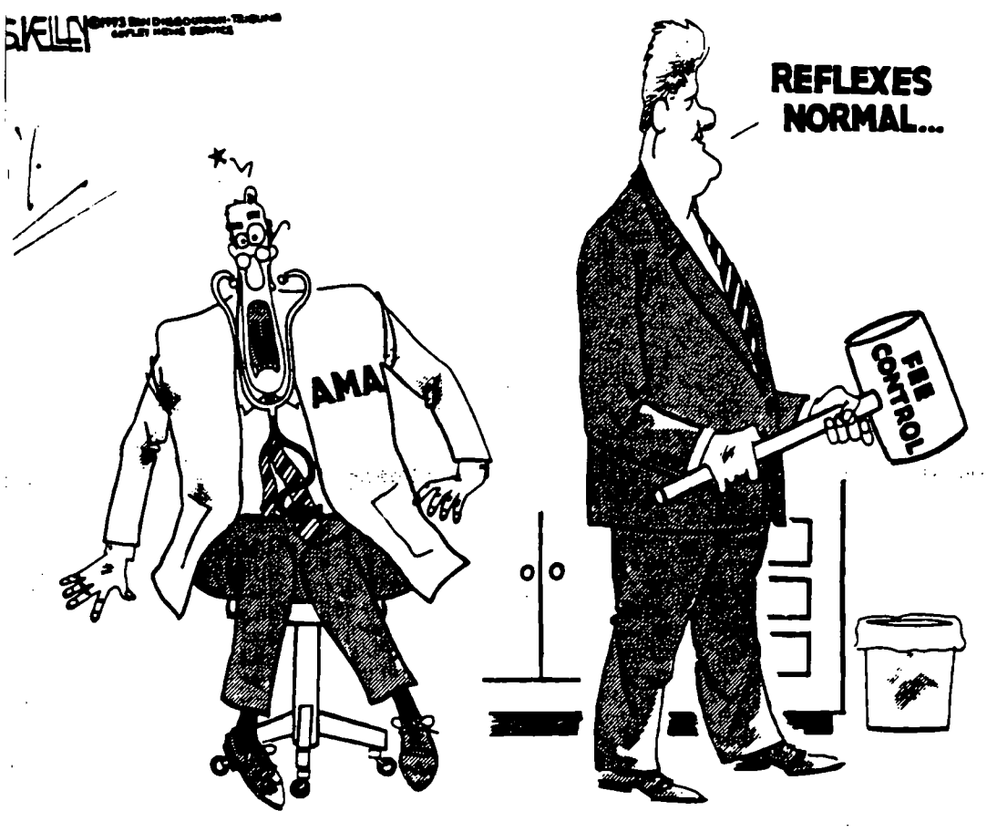
As we gain the knowledge and ability to free ourselves of ailments, spending on health care naturally rises.

Indeed, the public is being misled that a "health care crisis" exists because a rising percentage of national income is spent on health. Health is important to people, and as society becomes richer, people choose to spend more on health.

What will make us worse off is rationing schemes — such as the one Hillary Rodham Clinton is preparing for us in her secret, closed-door meetings — that deny the patient choice and the medical provider incentive. Government has never improved anything it has touched, and the more deeply it gets involved in our medical services the worse they are going to get.

Already doctors are diverted from patients by mountains of paperwork, and regulatory bureaucrats are now making it prohibitive for doctors to perform even simple tests such as urine analysis in their offices. The rising regulatory costs and disincentives are curtailing supply just at the time when Mr. Clinton wants to add 36 million more customers.

Paul Craig Roberts, an economist at the Center for Strategic and International Studies, is a columnist for The Washington Times and is nationally syndicated.



The Washington Times
THURSDAY, APRIL 1, 1993

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The Washington Times

Gnatcatch-22 at the forestry conference

It took God six days to make the world, but President Clinton is allotting just 24 hours to remake the Pacific Northwest.

His forest conference, held in Portland, Ore., April 2, is supposed to settle the fight between loggers and environmentalists over ancient forests, spotted owls, marbled murrelets and sockeye salmon. And somehow Mr. Clinton believes this one-day meeting — aimed at "issues delineation" — will produce a peace that has eluded everyone else for a decade.

Fat chance. Mr. Clinton will discover harmony in the Northwest as elusive as Richard Nixon found victory in Vietnam. Mr. Clinton's rumored strategy — the so-called "ecosystem" option — is no more likely to bring peace than Mr. Nixon's famed "secret plan" ended hostilities in Asia.

Time is indeed of the essence. Without resolution, logging will come to a standstill by fall; the Fish and Wildlife Service will be unable to finalize its owl recovery plan, and public timber harvests will remain in limbo.

The administration is pursuing a quick fix for another reason: to save the Endangered Species Act. This legislation is due for congressional reauthorization in 1993. Yet many savants view the spotted owl as hooting proof that the act spreads economic chaos. So unless the owl issue is settled before Congress considers reauthorization, pressure to weaken the law will mount.

In seeking a solution, Mr. Clinton faces a dilemma: Satisfying court demands for sufficient owl habitat would further damage the region's economy. Allotting the bird less than maximum, however, could require a legislative solution — asking Congress to declare what habitat is legally sufficient. This could have an unpredictable outcome.

Hence what seems simple — dividing the forests between loggers and threatened species — is not. Neither side wants compromise.

Loggers demand an end to uncertainty and a guarantee of timber sufficiency. They want Mr. Clinton to revise laws that permit virtually anyone with a word processor to appeal harvest plans. They insist timberland be sufficiently large to allow rational, long-range rotations. They believe the Endangered Species Act's prohibition against damaging habitat (the "taking" clause) should not apply to logging on private lands. And they want a guarantee that environmentalists will not come back next year, demanding more.

Environmentalists want a comprehensive solution, combining the recovery plans for owls, murrelets and salmon into one old-growth "ecosystem."

Mr. Clinton is tilting toward the environmentalists. Interior Secretary Bruce Babbitt is known to favor the ecosystem option. He recently introduced this strategy in setting aside habitat for 50 species, including a newly listed threatened bird, the gnatcatcher, in California. Describing his idea as "trail-blazing," he says the multispecies approach offers flexibility, allowing some economic activities to continue within threatened species' habitat.

This effort at compromise is laudable. Nevertheless, the ecosystem option is a gnatcatch-22: It will harm creatures, not help them.

"Ecosystem" is an environmental buzzword. There are more "ecosystem protection" bills bouncing through Congress than checks. Yet the idea is not new. The National Park Service embraced the same policy in 1968, averring that since parks were "comparatively self-contained ecosystems," management should stress "the concept of preservation of a total environment, as compared with the protection of an individual feature or species."

Unfortunately, this sexy-sounding policy was a dud, causing national parks to lose species at an even greater rate than nonpark lands. And the principle reason for this failure is that scientists didn't know what an ecosystem was.

The word signifies nothing that can be drawn on a map. Ecosystems are not things, but biological processes in evolution, in which each species plays a role. And society has so altered these processes that we cannot delineate precisely the ecosystem of one species, much less several. We do not know what creatures' evolutionary requirements are, and thus cannot say what habitat they will need over time.

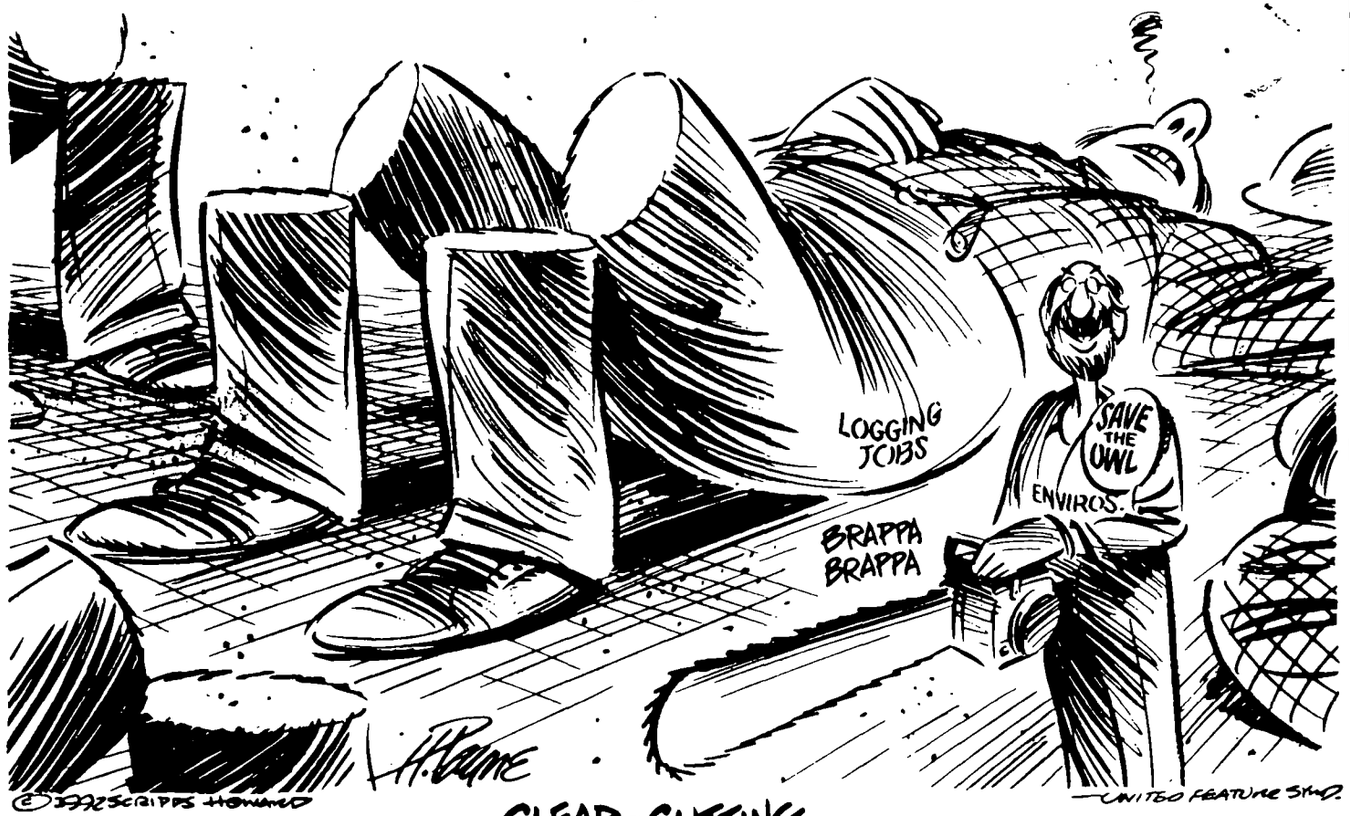
Consequently, a Northwest "old-growth ecosystem" preserve might not protect its resident populations. And unlike individual species recovery plans, it offers no quantifiable way to measure success. Federal accountability, already inadequate, would vanish entirely.

So how should Mr. Clinton solve the owl problem?

In the Bible, King Solomon resolved a dispute between two women who both claimed the same baby as their own. He suggested cutting the child in two, giving half to each woman. The real mother, horrified, renounced her claim to prevent her child's death. And thus did Solomon expose the impostor.

Likewise, if both sides in the owl dispute put the Earth first, they might agree on a truly holistic solution — such as the "new forestry," which calls neither for pure wilderness nor for intensively managed forests, but for selective harvesting to promote biodiversity.

But if everyone remains polarized, a Solomonic solution may be the only option. Mr. Clinton would be forced to cut the baby in half. And no one would like what remains.



CLEAR-CUTTING

Alston Chase is a nationally syndicated columnist specializing in environmental issues.

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HealthCare Compare Falls 30%, Killing Theory Such Firms Can Thrive in Clinton Health Drive

HEARD ON THE STREET

By Sara Calian
Staff Reporter of The Wall Street Journal

NEW YORK – In the treacherous health-care sector, **HealthCare Compare** became the latest casualty, plunging 30% yesterday as analysts yanked their buy opinions on the stock.

The sell-off killed the recently popular theory that if any stock could thrive in Clinton's brave new world of health care, it would be companies in the business of helping cut health-care costs.

The stock plunged 5⅝ or 30% to 12⅞ as investors bailed out on volume of 10.8 million shares. Trading was 14 times the normal daily pace, making the stock the most active issue on the Nasdaq market. The sell-off was sparked when the company disclosed late Tuesday that it's uncomfortable with 1993 estimates that exceed $160 million in revenue and earnings of $1.10 a share.

This health care cost-management company is far from attractive even at the reduced price, several analysts say. The stock has been gradually sinking this year as investors worry about President Clinton's pending health-care plan. And now, analysts say, trust in the company's earnings growth pattern has been broken.

"A month ago at a big analyst meeting, the company reassured everyone on Wall Street that everything was fine," says Paul Wick, vice president and portfolio manager for J.& W. Seligman & Co. "This news has completely shot their credibility."

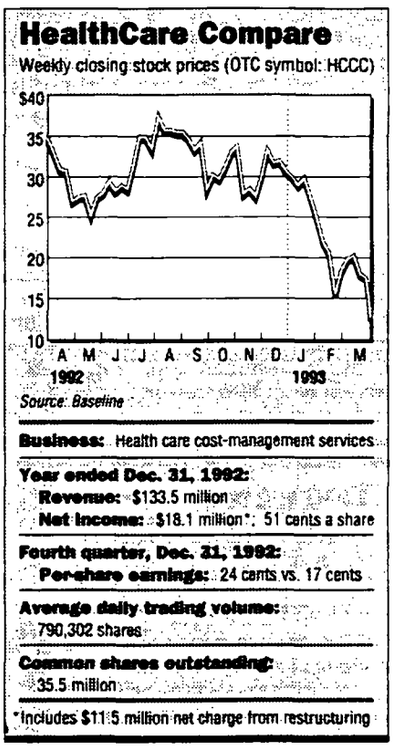
The company offers "utilization review" services, which monitor whether health care is appropriate. For its "preferred provider organizations" programs, it is hired to set up networks of hospitals that agree to cut standard rates. Competition seems to be growing. The company said that "at Alta Health Strategies, Employee Benefit Plans and [among] State Farm individual policyholders, the ramp-up of closed contracts" has been slower than expected. There is also some weakness in enrollment in its Federal Employee Health Benefit Plan.

"Candidly, I can understand where investors' nervousness is coming from," says Joseph Whitters, chief financial officer of the Downers Grove, Ill., company. "We try to be on top of getting information out as quickly as we can. Fundamentally, the business we anticipated to come on from major third-party distributors hasn't come on as quickly as we expected."

Yesterday, a slew of analysts downgraded the stock and lowered profit estimates to around $1.05 a share; some previously were looking for $1.20 a share. Mr. Whitters says: "It's fine that's where the consensus is falling." Profit was 84 cents a share in 1992 before a merger-related restructuring charge.

HealthCare Compare's news was an extra bruise atop a barely healing wound for investors in health-care stocks.

"We already have an environment where it is hard to find buyers—and to give the Street [another] reason to sell makes it even worse," says Dirk Godsey, analyst with Hambrecht & Quist, San Francisco. "It was especially hard news, because Healthcare Compare could have been up with the other health-care stocks that rebounded a little."



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This might lure some investors who think the stock looks cheap at 12⅞, down from a 52-week high of 38. The stock is trading at about 12 times this year's new estimates.

But in this case, cheap doesn't equal attractive, says Anne Anderson, president of Atlantis Investment, a growth-stock research concern. "I don't think this is the lowest price on the stock," she says. "The stock will probably bounce up a little, but it seems like they are having trouble getting customers to sign on to their plan – and I wouldn't be surprised if this turns out to be only the first negative announcement."

Montgomery Securities analyst Leonard Yaffee says growth "has been curtailed significantly" for the preferred provider organization that is the company's "critical business segment." He adds: "The company has built up an enviable PPO network and it might be an attractive stock as a takeover candidate, but that is a different kind of play."

Six insiders at HealthCare Compare sold 170,000 shares early last summer at 25¼ to 36⅝, as reported in August. And there was more selling in late 1992, according to filings with the Securities and Exchange Commission. All told, 10 executives or directors sold 2.6 million shares in 1992, at prices higher than today's. There has been hardly any insider selling reported this year.

HealthCare Compare's stock hasn't seen the last of its rocky ride, predicts Mr. Yaffee, who adds: "Legislation will present an even tougher competitive environment for the company, whatever form it takes."

–Alexandra Peers contributed to th article.

Coal Industry Is Expected to Win Victory In Treasury's Proposal for Energy Tax

By Rick Wartzman
Staff Reporter of The Wall Street Journal

WASHINGTON—In a big victory for the coal industry, the Clinton administration is expected to propose switching the point of collection for its energy tax from the mine to the electric utility.

The change is likely to be announced within the next few days, when the Treasury releases additional details of the broad-based levy on energy.

Shifting to the utility means that coal would be taxed at roughly the same point in the production process as natural gas, according to Clinton advisers.

To ensure that the tax is ultimately paid by consumers—thereby promoting conservation — the Treasury is looking for a way to induce state regulators to pass along the levy. One strong possibility is that the federal government would withhold certain tax breaks for utilities unless the regulators approved a pass-through. Because the tax breaks help hold down rates for customers, it's in the interest of the regulators to see that the utilities take advantage of them.

In its original plan, released in February, the Treasury had said the energy tax would be imposed on coal at the mine mouth. But industry executives made a persuasive case in meetings with administration officials that such an approach would be impractical, and they urged that the utility be considered as an alternative.

First, they argued, it isn't standard practice to sample coal at the mine. This means that many coal companies would have to install expensive equipment to calculate the energy tax.

In addition, existing taxes on coal royalties, severance taxes, Black Lung taxes and state production taxes are typically based on dollar value or on tonnage. The energy tax, which is to be based on the heat content of fuel as measured in British thermal units, would therefore result in an unintended compounding of the price of coal.

Furthermore, a tax collected at the mine wouldn't automatically be passed on to coal customers and, in turn, end-users of energy. Many contracts, according to the National Coal Association, "do not allow either the tax or related costs to be recovered" by the producer.

Officials at the coal association, the industry's main trade group, said yesterday that they hadn't heard about any change in the administration's original plan. But Clinton aides indicated that, barring any last-minute reversal, the shift to the utility would occur.

One advantage of the new arrangement for the government is that it should be easier to collect the tax; the coal association says there are only about 150 coal-burning electric utilities, compared with some 3,000 mines. There may be some political dividends as well. A number of powerful lawmakers, including Sen. Robert Byrd (D., W.Va.), have coal interests in their home states.

Wall St. Jrnl.; 4-1-93

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HEARD ON THE STREET

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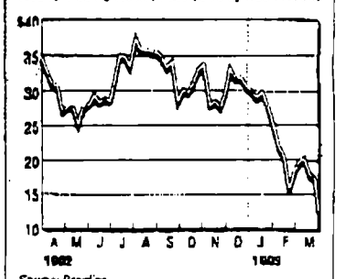
HealthCare Compare

Weekly closing stock prices (OTC symbol: HCCC)



Source: Baseline

Business: Health care cost-management services

Year ended Dec. 31, 1992:
Revenue: $133.5 million
Net income: $18.1 million*; $1 cents a share

Fourth quarter, Dec. 31, 1992:
Per-share earnings: 24 cents vs. 17 cents

Average daily trading volume:
780,302 shares

Common shares outstanding:
35.5 million

*Includes $11.5 million net charge from restructuring

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—Alexandra Peers contributed to this article.

L.A. Times; 4-1-93

In a Reversal, Investors Rush to Buy Health Care Stocks

■ Securities: Pessimists turn into optimists as White House hints that price controls are dead.

By CHRIS KRAUL
TIMES STAFF WRITER

After weeks of dumping health care issues, investors have been aggressively buying health care stocks in the last two days on signs that the industry may avoid harsh government imposed price controls.

In addition to signs that at least one influential member of the Clinton Administration has deep reservations about price controls, the market also reacted favorably to news that the world's largest pharmaceuticals concern, Merck & Co., has proposed a plan for limiting increases in drug prices that may be agreeable to the Clinton Administration.

Merck Chief Executive Dr. P. Roy Vagelos has suggested limiting price increases for each of Merck's drugs to no more than the rise in inflation, plus 1%. Previously, Merck and nearly a dozen other drug companies had pledged to freeze or limit increases in the average price of all of a company's drugs.

On Wednesday, health care stocks finished mixed after trading higher for most of the day. Merck fell $0.50 to $35.375 after rising $1.375 on Tuesday. Glaxo rose $0.25 to $18.25, and Johnson & Johnson finished $0.625 higher at $42.625. American Home Products added $0.50 to 66.125. But Abbott Labs fell $0.25 to $25.75.

The health care industry has been bracing for inclusion of some kind of price controls or government review in the Administration's health care reform package due out in early May. Clinton has singled out drug companies' excessive profits for special criticism in recent weeks, causing drug stocks to fall precipitously.

But Ira Magaziner, the Administration's chief health care adviser, acknowledged in a speech Monday that price controls are "unpleasant policies . . . fraught with difficulties" and termed efforts to use them during the Nixon Administration ineffective.

Although drug companies are constrained by antitrust laws from agreeing among themselves to cap prices, many industry observers expect other manufacturers to come forward with proposals similar to Merck's because of Merck's influence and the desire to avoid government-imposed price reviews or controls.

"That's a reasonable assumption because drug companies are scared enough of punitive government action that they would want to head it off by some voluntary pricing move," said Kenneth S. Abramowitz, a health care analyst with Sanford C. Bernstein & Co.

Officials at several drug companies, as well as the Pharmaceutical Manufacturers Assn. in Washington, declined to comment on the Merck proposal, fearing that it would put them afoul of federal antitrust laws that prohibit price-fixing.

But one major drug company official who asked not to be identified described the Merck proposal as "very interesting. . . . A lot of companies might look at that kind of cap and find it a very interesting place to go with all of this."

PMA spokesman Dave Emerick said the proposal conforms to the industry's preference for "self-imposed price controls."

Merck first presented its proposal to Sen. David Pryor (D-Ark.), who as chairman of the Senate special committee on aging has made an issue of drug costs because many elderly citizens' Medicare policies do not cover prescription drugs.

A spokeswoman for Pryor said the senator believes that the Merck offer was a "sincere effort" but that he was withholding further comment until the Clinton health care reform package is out in May.

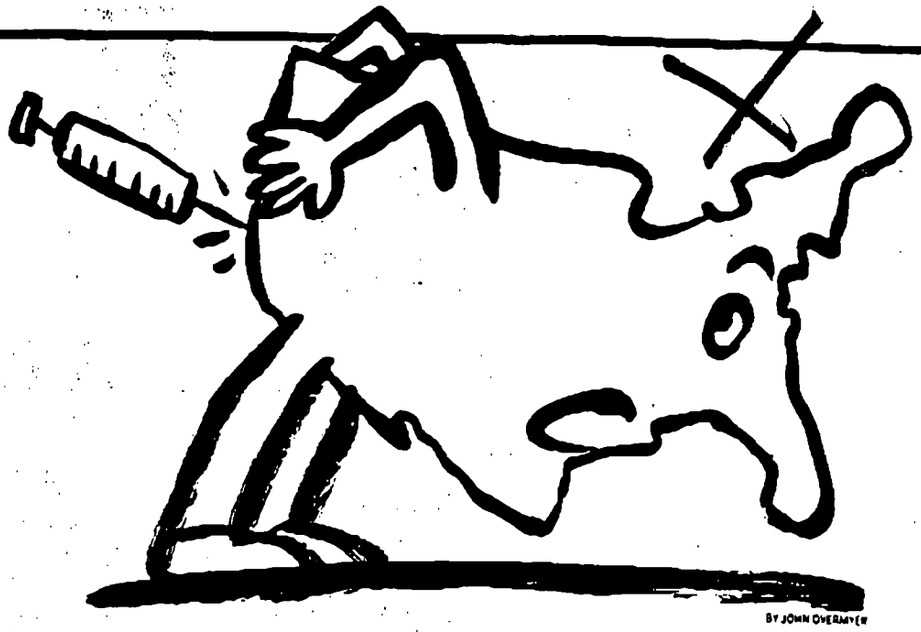
Price cap pledges such as Merck's do not address the issue of how new drugs are priced. Those prices have become a sensitive political issue, particularly when the drugs are developed with the aid of government grants, said U.S. Rep. Ron Wyden (D-Ore.), chairman of the oversight House subcommittee on regulation, business opportunities and technology.

Wyden introduced a bill last month that would force drug companies to disclose "pricing formulas" to Congress on drugs developed with grants from the National Institutes of Health or other government agencies. Drug price review panels would also be created by the Wyden bill.

"I think Merck is responding to big-league pressure on the pricing issue and I would expect that others in the industry would follow Dr. Vagelos' lead on this," Wyden subcommittee staff director Steve Jenning said.

Joseph A. Califano Jr.
Wash. Post; 4-1-93

The Last Time We Reinvented Health Care



BY JOHN OVERMYER

As the president, Hillary Rodham Clinton and Congress set out to reinvent health care in America, they are wise to consult widely, since we got into much of the *current* mess by acting on the best of intentions without foreseeing the worst of unintended effects.

The hand of government in shaping health care grew strong in the 1960s—and herein lie the most important lessons for the Clintons and Congress. In 1960 Congress passed the Kerr-Mills Act—sponsored by the powerful Oklahoma senator and the Arkansas congressman who chaired the House Ways and Means Committee—to get health care to poor rural Americans. The legislation required the federal government to pay 50 percent to 80 percent of the funds states spent for medical assistance to the needy aged, with the poorest states targeted to receive the highest federal match. The Kerr-Mills package covered everything from hospital, surgical and physician care to drugs and (a special need of the elderly rural poor) false teeth. To the dismay of Kerr and Mills, by 1964 five large industrial states (California, New York, Massachusetts, Michigan and Pennsylvania) with only 32 percent of the over-65 population, grabbed 90 percent of the Kerr-Mills dollars.

When Lyndon Johnson asked Congress to enact Medicare for the elderly, he seized upon the angry frustration of Ways and Means Committee Chairman Wilbur Mills. Johnson and Mills cooked up the idea that Kerr-Mills could be changed to cover welfare recipients and other "medically indigent" individuals without regard to age. That, Johnson told Mills, would get funds to "poor mamas and babies" in rural and southern states, and limit the share going to big industrial states. To enhance the attractiveness of the program, Johnson added coverage of nursing home care.

Thus was Medicaid born, with little appreciation of the imminent aging of America (accelerated by the health care provided by Medicare and Medicaid) or the separation of family generations that a mobile society would encourage. LBJ and Wilbur Mills would turn in their graves to learn that today Medicaid spends almost a third of its $140 billion on nursing homes, having created a $75 billion-a-year industry—up from less than a billion dollars in 1965, when the program was enacted. And they would chortle to learn that Medicaid is eating up the budgets of the big industrial states.

The ripple of unexpected consequences did not end there. To pry Medicare and Medicaid out of the Senate Finance Committee, Johnson had to agree to pay hospitals on a cost-plus basis, and doctors' fees that were "reasonable," "customary" and "prevailing" in their communities, thereby giving physicians the power to raise their own fees.

When LBJ asked what that compromise would cost, he was told, "Half a billion dollars." "Only $500 million," Johnson snapped. "Get the bill out!" His single-minded focus on access for the poor and elderly led him to grossly underestimate the price of giving hospitals and doctors the keys to the federal Treasury.

The next unpleasant surprise came from our well-intentioned effort to increase the number of physicians. We feared that with too few physicians to handle the increased demand from the new federal programs, the price of their scarce services would rise. Over the opposition of the American Medical Association, we rammed through legislation to increase competition by doubling the number of doctors graduating from medical school each year from 8,000 to 16,000. We have since discovered that more doctors only mean more care and higher health care costs. Even our determination to democratize access to the best medicine by training more specialists bit back, as we have learned that more specialists mean more referrals to specialists and a spiraling medical bill.

To arrest booming costs, LBJ and every president since have sought reform of the health care system, trying everything from price controls to promoting health maintenance organizations and managed care. To hold down doctors' fees, Medicare established a list of procedures for reimbursement, capping the amount to be paid for each one. That effort created gigantic insurance company bureaucracies to play catch-up with doctors who simply created additional procedures and performed them more frequently. When the Johnson administration ended, there were 2,000 medical procedure payment codes. Today, there are about 7,000, most with subcategories.

Stunned by the explosion in high-ticket technology and the expansion of hospitals well beyond necessary capacity (prompted by the Hill-Burton Act, which financed hospital construction, and by Medicare, which reimbursed capital costs), in 1974 Congress passed the Health Planning Act, requiring hospitals to obtain certificates of need before they could increase the number of beds, build new wings or buy new equipment.

Surprised again! When the government tried to eliminate almost a half-million unnecessary hospital beds, the cumbersome certificate-of-need program became an incentive for hospitals to resist. They feared that if circumstances changed (say, because of an AIDS or TB epidemic), they would never get permission to expand.

Next came the attempt to hold down hospital costs by creating Diagnosis Related Groups (DRGs), to limit lengths of stay and intensity of care for Medicare hospitalizations. The result: Doctors ratcheted patients up to the highest-intensity care they could, and hospitals hiked up charges to private plans that don't have DRG limits in order to compensate for the Medicare shortfall.

A current fashion is managed care. By curbing unnecessary hospitalization, surgery and tests, managed care has helped contain costs, but it has also been a driving force in making America's health care system the world's most expensive to administer (at a cost close to $200 billion annually).

The point of this recital is not to show how Congress and past administrations have played "Abbott and Costello Go to the Doctor" for the past 30 years, or even to purge myself by confessing my own long list of sins and miscalculations in health care policy tinkering. The point is to alert the Clintons, who embody the first real chance since Lyndon Johnson to make health care available to more Americans, and Congress, which has the best shot in a generation to do something sensible in this area, that the principle of "caveat emptor" applies to reinventions of the health care system finely tuned by the best and brightest policy wonks.

The writer was special assistant for domestic affairs to President Lyndon B. Johnson and secretary of health, education and welfare under President Carter. He is now president of the Center on Addiction and Substance Abuse at Columbia University.

L.A. Times; 4-1-93 p. 1

Health Care Price Controls May Backfire, Experts Warn

■ Policy: The Administration is considering the idea, but economists say it could actually increase costs.

By SARA FRITZ
TIMES STAFF WRITER

WASHINGTON—Price controls did not work for Presidents Jimmy Carter, Richard Nixon and Franklin D. Roosevelt—or even for the ancient Babylonians. And if President Clinton tries to use them to curb the rise in health care costs—as some of his advisers are suggesting—he is also likely to meet with failure.

That is the almost unanimous judgment of economists and market experts. Although the idea of mandating an end to runaway health care costs is tempting, it is a siren's song that will lead to chaos, massive evasion of the rules and—ultimately—to even higher costs, they say.

While its final plans will not be announced until early May, the Administration is known to be considering a proposal to impose controls on the prices charged by doctors, hospitals, insurers and pharmacies—at least for a few years, until other reforms take hold.

Vice President Al Gore said earlier this week that without price controls, health care costs would surely rise from 14% to 20% of the gross domestic product by the year 2000. "That's why cost controls represent such an important part of reform," Gore said.

In remarks following an address to the American Business Conference on Monday, Ira Magaziner, the Adminstration's chief health care adviser, acknowledged that price controls are "unpleasant policies . . . fraught with difficulties" and said efforts to use them during the Nixon Administration were ineffective.

While he said no decision had been made to institute such controls, Magaziner called the likelihood that health care costs would grow 11% a year without them an unpleasant alternative.

But even Gore's and Magaziner's apparent willingness to consider price controls has stunned not only

■ RELATED STORY: B7

many of the Administration's allies in Congress but economists from all across the political spectrum.

Some have speculated that perhaps the Administration's real strategy is simply to threaten controls in an effort to gain voluntary price restraints.

"I can't believe they are going to do it. I can't believe they are that stupid," said Barry Bosworth, who was the mastermind of Carter's unsuccessful effort to restrain prices. "The health care industry is the best example of an industry where price controls won't work."

Bosworth is not the only one-time proponent of price controls who has spoken out against them in recent days. C. Jackson Grayson, who chaired Nixon's price commission between 1971 and 1973, wrote a piece for the opinion page of the Wall Street Journal saying: "Price controls will make things worse. Believe me, I've been there."

To many liberal and conservative economists alike, history demonstrates that price controls do little or nothing to restrain inflation, are not easily enforced, require an unwieldy government bureaucracy and always end up distorting the markets they are intended to control.

"Almost by definition, if you believe price controls will work, you are not an economist," said Edmund F. Haislmaier, a policy analyst at the Heritage Foundation, a conservative think tank, who has studied the history of controls. "If Clinton's advisers decide to do this, it will show that they've learned nothing from history."

The first known experiment with general wage and price controls occurred in ancient Babylonia under the Code of Hammurabi. As demonstrated by the more recent examples of general price controls under Nixon and Carter, they have always been blamed for fueling inflation instead of restraining it.

Yet despite the unpromising history of controls, polls show that a majority of Americans would like to see restraints imposed on fees charged by doctors and other health care providers. A recent Louis Harris poll published by the Kaiser Family Foundation found that 76% of Americans favor short-term controls.

Sen. Bob Kerrey (D-Neb.), who made health care reform the centerpiece of his failed 1992 presidential bid, said he fears that Congress and the President will respond to public sentiment and ignore the experts.

"It's possible for us to pass a piece of legislation and make things worse," Kerrey said. "That's particularly true if you listen to the polls. . . . Price controls are very popular today."

Insiders said Clinton and his top advisers are considering price controls because they see no other way—short of raising taxes—to realize the $50 billion in savings necessary to finance health insurance coverage for all Americans without raising taxes.

"There aren't any other options for controlling prices in the short term," said Bill Custer of the Employee Benefit Research Institute.

Because Administration officials are considering imposing price controls at the same time they are revamping the health care system, they argue that historical comparisons do not apply. In all other instances, they said, prices skyrocketed when controls were lifted because the market was fundamentally unchanged.

According to White House sources, the President's health reform advisers are considering three alternative means of restraining health care prices: an outright freeze on all prices at existing levels; a cap on insurance premiums combined with a rule prohibiting insurers from cutting benefits, or a decree that health care providers must charge all patients the same fees that they now receive from the government for treating Medicare patients.

While all the alternatives would have profound consequences, economists said an outright freeze would be the most difficult to enforce. Inevitably, it would require a massive government bureaucracy, they say.

Grayson recalled that he began Phase II of Nixon's program with three pages of regulations and ended with 1,534 pages because the government was forced to rule on many requests for exemptions. He said that he once had to rule whether frozen horse sperm was a raw or processed farm product.

"To price regulate one-seventh of the American economy is not an easy thing," said Uwe Reinhardt, professor of economics and public affairs at Princeton University and a member of Clinton's health care reform task force. "It will quickly turn into a nightmare. Before long, they will be issuing a new regulation every day."

Reinhardt noted that a freeze unfairly rewards those who are charging high prices at the time the controls are imposed.

But economists also said they see problems with the other two approaches. Medicare reimbursement rates are artificial and bear no relationship to actual costs, they argue, and a cap on insurance premiums would surely drive some insurers either out of the business or into bankruptcy.

According to Bosworth, price controls can only be effective in an industry with a clearly defined product and a long pricing history. And, he noted, health care is a field of rapid innovation where most services can be defined in many different ways.

If the government sets fees for a visit to a doctor's office, for example, economists predicted that doctors will simply require patients to make more appointments, thus defeating the purpose of price controls. If the government sets drug prices, they predicted, pharmaceutical companies will make minor modifications in their products to justify raising prices.

Haislmaier argued that price controls also would stifle development of genuinely new drugs. "Price controls in fact encourage manufacturers to shift resources from research and development to marketing," he said.

Reinhardt questioned why the Administration does not simply require doctors to publicly disclose their fees, which would encourage patients to chose cheaper physicians and discourage price increases. Currently, he noted, patients have no idea what they will be charged before they visit a doctor.

Because so few experts support price controls, some questioned whether the Administration has been threatening to enact them in an effort to win voluntary restraint. "The easiest thing to do is threaten price controls, but not actually do it," Reinhardt said.

In response to the Administration's threats, at least 10 major pharmaceutical companies have announced plans to voluntarily restrain their price increases. On March 12, the Pharmaceutical Manufacturers Assn. submitted a letter to the Justice Department requesting an antitrust exemption so the voluntary plan could be carried out.

Bosworth said the Administration's threats may be fueling inflation. He suggested that health care providers are quietly raising their prices now in anticipation of price controls.

Whether all this criticism will deter the Administration remains to be seen. "Some kids can't be told not to touch the stove—they have to touch the stove to learn that it's hot," Haislmaier said.

Wall St. Jrnl.; 4-1-93

Study Finds Unfairness In Sex-Disease Programs

By a WALL STREET JOURNAL *Staff Reporter*

NEW YORK – A medical study has found that while women are more susceptible than men to infection by and long-term consequences from sexually transmitted diseases, most federal funding to fight such diseases goes toward programs for men.

According to the Alan Guttmacher Institute, a New York-based health research group, the federal program channels most of its funding to clinics where men obtain services. Moreover, the federal program dealing with such diseases, which is administered by the Centers for Disease Control and Prevention, has traditionally focused primarily on syphilis and gonorrhea. Those diseases account for almost 75% of the program's budget, but make up only 10% of the number of cases of sexually transmitted diseases reported in the U.S. each year, the study said.

The Alan Guttmacher Institute recommends that the government redirect national priorities and funding toward preventive care programs for women.

The CDC says it has already begun doing that. Last fall it launched a campaign to encourage state and local health departments, which get treatment money from the CDC, to put more of an emphasis on treatment and prevention for women, according to Dr. Judith Wasserheit, director of the CDC's Division of STD-HIV Prevention. How much CDC funding these health departments get, Dr. Wasserheit said, may well depend on how much of an emphasis their programs place on women.

N.Y. Times; 4-1-93 p. 1

1 in 5 in U.S. Have Sexually Caused Viral Disease

By FELICITY BARRINGER
Special to The New York Times

WASHINGTON, March 31 — More than one in five of all Americans, or 56 million people, are infected with a viral sexually transmitted disease like herpes or hepatitis B, according to a study made public today. Such viral infections can be controlled but not cured, and often recur.

Moreover, the study by the Alan Guttmacher Institute estimated that even more Americans were likely to contract a sexually transmitted disease sometime in their life, and that these diseases would have the greatest effect on women and people under the age of 25.

In reaching these conclusions, the report noted that 12 million new sexually transmitted infections occur each year, two-thirds of them to people under 25, and one-quarter to teen-agers. The most common are bacterial infections like gonorrhea or the lesser-known chlamydia, which spread quickly but are treatable with antibiotics.

While information on the prevalence of venereal disease has been known to public health experts, it has largely escaped general notice, in part because of the public's focus on AIDS.

The report found that sexually transmitted diseases affect women disproportionately, both because women tend to show fewer symptoms — and thus go untreated for longer periods — and because Federal and state programs to combat such diseases tend to be in clinics that mostly treat men.

Sexually transmitted diseases also pose a special threat to women because

Continued on Page B9, Column 1

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COMMENTS:

Wash. Post; 4-2-93

Health Experts Skeptical About Immunization Plan

By Amy Goldstein and Spencer Rich
Washington Post Staff Writers

B1

Medical experts in the Washington area said yesterday an ambitious new campaign by the Clinton administration to vaccinate all the nation's young children may be largely unable to increase immunization rates in the area, which has performed poorly for years.

Pediatricians and public health officials hailed the comprehensive campaign announced yesterday, which seeks to have the federal government buy all vaccines and distribute them free. The campaign also will try to increase public awareness and the accessibility of immunizations that are a cornerstone of children's health.

But in public clinics and private offices, doctors said their own experience in the metropolitan area has proved how difficult it can be to ensure that children aged 2 and younger get the medicine they need to avoid measles, mumps, whooping cough and other dangerous illnesses.

"Vaccines are available. The problem is, the kids are not available," said Francis Palumbo, a pediatrician who works in a large Northwest Washington practice where most of the patients have health insurance and well educated parents.

The District has one of the nation's worst immunization rates, with only 39 percent of the children properly vaccinated by age 2, according to a recent survey by the federal Centers for Disease Control and Prevention (CDC). In Maryland and Virginia, as in many other states, slightly more than half the toddlers had been immunized, according to the CDC survey.

The millions of unimmunized U.S. children are the focus of the campaign announced yesterday by Secretary of Health and Human Services Donna E. Shalala, which will cost about $1.5 billion in 1995 when it takes effect fully. Shalala said financing of the government purchase of vaccines will be included as part of the overall health reform package to be sent to Congress.

The most far-reaching feature is a plan in which the federal government would, starting in 1995, buy all the vaccine necessary to inoculate babies and toddlers against nine childhood diseases. The vaccine would be distributed free to public health clinics and

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IMMUNIZATION, From B1

physicians, including private doctors whose patients now pay for such shots.

The federal government would be authorized to spend up to $1.1 billion for the vaccine, but would negotiate the actual price with the drug industry, which strongly dislikes the plan.

Full sets of vaccines cost about $244 a child if bought privately, but the government buys them for half that amount when purchasing for public distribution.

The program also calls for $300 million to be used to hire employees and extend hours at public clinics and to send workers into neighborhoods to find unimmunized children. In addition, the program includes $152 million to start a national, computerized system that would keep track of which children have received shots and be used to help notify families in which children fall behind on their medicine.

"Proper immunization is the right thing to do and the smart thing to do," Shalala said, noting that fewer than two-thirds of U.S. children have been immunized fully by age 2.

Sen. Nancy Landon Kassebaum (R-Kan.), the senior Republican on the Senate Labor and Human Resources Committee, said the administration's vaccine plan "misdiagnosed the problem. . . . The real problem is that too many parents do not know the value of immunizations" or do not know where their children can get them easily, she said.

Locally, several health officials said that they already received free vaccines through state agreements with the CDC and that supplies have been adequate.

"The immunization problem in this country is not the availability of the biological materials, it is bridging the gap between where the children are and where the shots are," said Joshua Lipman, the health department director in Arlington, where an estimated 45 percent of the babies and toddlers are immunized fully.

Richard Levinson, chief of preventive health services for the D.C. Commission on Public Health, said the District's outreach efforts have intensified, with only limited results.

> *"The problem is, we could not motivate people to come up."*
>
> — Richard Levinson

In a special campaign by the commission last year, city workers and volunteers traveled to all eight wards on Saturdays, knocking on parents' doors and offering free immunizations at schools and other neighborhood centers. The campaign reached 1,200 children, a fraction of the expected number.

"We knew where they were, we knew what was needed," Levinson said. "The problem is, we could not motivate people to come up."

Levinson praised Clinton's plan for a tracking system, predicting that it would help his office find individuals who need shots.

Diane Dwyer, who supervises the immunization program for the Maryland Department of Health and Mental Hygiene, said tracking systems raise questions of confidentiality and pose logistical problems. She noted that 78,000 children are born in Maryland each year, and that 90 percent of the state's children who are immunized get their shots in private doctors' offices, many of which do not have computerized records.

Dorothy Anne Richmond, a pediatrician at a children's clinic at Georgetown University Medical Center, said that even if tracking identifies unimmunized children, "How do you get them to come to a clinic or a [mobile immunization] van?"

Georgetown has circulated such a van since last fall in poor neighborhoods of Southeast Washington, but Richmond said she was not sure it has made a dent in the immunization rate there.

Shalala did not say yesterday how the $1.1 billion for vaccine purchases would be funded. The details will be included in President Clinton's national health plan, which officials said yesterday may be postponed two weeks until mid-May because of the illness of Hillary Rodham Clinton's father.

Officials said federal government would phase out the purchase of all vaccine once every child is covered by health insurance. Shalala also said the administration will seek to extend permanently the National Vaccine Injury Compensation Act, funded by an excise tax on vaccine, which provides compensation for rare instances in which children are injured by the vaccines.

Wash. Times; 4-2-93

Shalala touts free shots for children

FROM COMBINED DISPATCHES A6

Free vaccinations would be available to all American children beginning in 1995 under a $1.1 billion immunization program announced yesterday by the Clinton administration.

Health and Human Services Secretary Donna Shalala said financing of the government purchase of vaccines against nine childhood diseases will be included in the health care reform package to be sent to Congress later this year.

"Children are America's greatest resource, and protecting them should be viewed as a basic function of government, on par with protecting our water, our air and our food," Miss Shalala said.

"This is an attempt to immunize every preschool child, not just poor children," Miss Shalala said in reply to questions about why federal money was being used to pay for shots for children from middle-class and wealthy families.

In a message to Congress, President Clinton said his legislative proposal would spare children "the deadly onslaught of infectious diseases" and tear down "the financial barriers to immunization."

Republican senators criticized the proposal as well-intentioned but misguided.

"We should target limited resources to areas where we can do more good, namely improving vaccine delivery," said Sen. John C. Danforth, Missouri Republican.

Sen. Nancy Landon Kassebaum of Kansas said that "with this same $1 billion, we could nearly triple the number of community health centers."

Children's advocates applauded the plan to distribute the vaccines to private physicians and health clinics, but displeased drug companies said they might spend less to find new, lifesaving vaccines.

"We have no intention of destroying the research base of the American drug industry," Miss Shalala said at a news conference, flanked by prominent Democratic lawmakers and Marian Wright Edelman, president of the Children's Defense Fund.

Mrs. Edelman said the bill would mean "hard-pressed American families will no longer have to confront impossible choices between immunizing their children and buying groceries, heat or other necessities."

But the leading vaccine makers, who have tried to dissuade the government from making itself the sole purchaser of childhood vaccines, said the specter of price controls might discourage them from seeking new vaccines for maladies from ear infections to AIDS.

Ronald Saldarini, president of Lederle-Praxis Biologicals, the largest vaccine maker, said "it throws us into doubt" over how much to invest on new vaccines.

Fewer than 63 percent of all children get all the shots needed by age 2 to safeguard them against polio, measles, mumps, rubella, diphtheria, tetanus, whooping cough and other infectious diseases, Miss Shalala said. Immunization against these childhood diseases takes a dozen shots and three doses of oral polio vaccine.

The White House said the cost of fully vaccinating one child has soared in the private sector from $23.29 in 1982 to $244.10 in 1992. The cost of vaccine bought for public programs has jumped from $6.69 to $122.28.

About half of youngsters now get their shots free in public clinics and half in private physicians' offices.

Mr. Saldarini agreed the current immunization system is "broken" but said the money would be better spent repairing gaps in the existing delivery system.

Miss Shalala said she believes drug companies would pay for distribution.

School attendance laws ensure that 98 percent of American children get vaccinations by the time they start school, but in some cities only 10 percent of infants and toddlers are immunized, according to federal figures.

N.Y. Times; 4-2-93

Drug Companies Warn Administration Against Vaccine Program

By PHILIP J. HILTS
Special to The New York Times

WASHINGTON, April 1 — Fearing a prospect of lower prices, drug company executives said today that they might slow or stop development of new vaccines if the Clinton Administration goes ahead with its plan to have the Government buy vaccines for all children.

The comments came at the same time that the Secretary of Health and Human Services, Donna E. Shalala, announced at a news conference here that the Government intended to go ahead with a plan to buy vaccines for all American children, and to seek out all those who are not immunized.

In sending his proposed legislation to Congress today, President Clinton called the program an urgent measure.

The $1.1 billion Administration plan is intended to insure that all children are fully immunized by age 2.

Fearing Lowering of Price

Dr. Ronald J. Saldarini, president of Lederle-Praxis Biologicals, a division of the American Cyanamid Company and the largest producer of vaccines in the United States, said today that he feared that if the Government became the sole purchaser of vaccines, which it now buys at a discount, the result would be an overall lowering of price.

"If I can't be sure that the purchaser will allow me to price my product in a way consistent with recovery of my investment and the years I put into the effort of developing a vaccine, I may be unwilling to consider further development of vaccines," Dr. Saldarini said.

Lederle-Praxis is developing several new vaccines, Dr. Saldarini said, including one for herpes, one for childhood ear infections, or otitis media, and one for infant diarrhea caused by rotaviruses, a major killer in most of the world.

"The development of these vaccines will be slowed or abandoned," he said, if the Administration's plan goes forward and prices are cut more than the company wishes.

Lederle-Praxis now sells vaccines for polio, pneumococcal pneumonia and bacterial meningitis, and a combined vaccine for diphtheria, pertussis and tetanus.

> Fearing a drop in price, companies talk of halting new vaccines.

Dr. R. Gordon Douglas, president of the vaccine division of Merck & Company, said the Government not only paid a lower price but was also an unreliable buyer. "The Government gets interested in vaccines when there is an epidemic," he said, citing the measles outbreak of 1989-91. "Then their interest wanes, and comes back only when there is another epidemic."

A company must commit a decade of work and money to a vaccine, Dr. Douglas said, including building plants for manufacturing. Therefore, he added, it cannot afford an uncertain market or buyer, like the Government with its unpredictable budget process.

Both Dr. Douglas and Dr. Saldarini said they would now carry the battle to Congress.

Plan Called Crucial

In contrast, Dr. Howard A. Pearson, president of the American Academy of Pediatrics, said the Administration's plan was crucial to the health of American children.

"We need to address the fact that the immunization rate for preschool children is abysmal, nationally probably less than 50 percent," Dr. Pearson said. "We are now seeing the re-emergence of diseases like whooping cough and measles, which should be matters for the history books only."

Children go without protection for several reasons, Dr. Pearson said. "At least one of them is the cost of vaccines," he said. "There are also long lines at the public clinics and other barriers."

While as many as 95 percent of American children are immunized by the time they enter school at age 5 or 6, 40 percent fail to get vaccines for illnesses like polio, measles, pertussis and meningitis.

Secretary Shalala said the consequences of not passing the comprehensive package could be devastating. "Look what happened when measles returned, from 1989 to 1991," she said. "More than 55,000 children were stricken, resulting in much needless suffering and tens of millions of dollars in avoidable medical costs."

Under the new plan, the Federal Government would buy all vaccines, for about $1 billion a year, and then turn them over to state and local clinics and doctors offices to be given out free. The campaign would begin in 1994 and 1995, and would be phased out when and if a comprehensive health-care overhaul package covering all Americans is passed.

The plan is being sponsored by Senators Edward M. Kennedy of Massachusetts and Donald W. Riegle Jr. of Michigan, both Democrats, and by Representatives Eva Clayton of North Carolina, John D. Dingell of Michigan, Louise M. Slaughter of upstate New York, Henry A. Waxman of California and Ron Wyden of Oregon, all Democrats.

Currently, the buyers of vaccines include states, clinics and private doctors, who pay a wide range of prices. The cost of the total vaccine package to private doctors averages about $245 a child. State health departments pay about $120 for the vaccine.

Another major provision of the proposal, which would cost about $300 million a year, is a plan to hire nurses and other health-care workers to seek out children who are not immunized.

The bill, the Comprehensive Child Immunization Act of 1993, also provides money for the National Vaccine Injury Compensation Program, under which the families of children who suffer debilitating or deadly side effects would be compensated.

Wall St. Jrnl.; 4-2-93

Drug Concerns Express Anger at Plan For U.S. to Buy Childhood Vaccines

By HILARY STOUT
Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON – Drug companies reacted angrily to the Clinton administration's proposal to make the government the sole buyer of childhood vaccines, claiming that such a measure would threaten their profits and consequently their research investment.

Health and Human Services Secretary Donna Shalala unveiled the proposal, which would provide free immunizations to all children in the U.S. before their second birthday. She said the administration is submitting legislation to authorize the HHS secretary, beginning in fiscal 1995, to buy as much vaccine as is needed and give it to states and federal health clinics.

States would in turn distribute the vaccines to private doctors and public health facilities, which would offer it free to all children. They could charge for the administration of the shot but not the vaccine itself. The administration fee would be waived if a family couldn't afford it.

The department estimates that the vaccine purchases will cost $1 billion annually, although the cost ultimately will depend on the prices the government negotiates with manufacturers. The financing method will be specified when the president unveils his plan to overhaul the health-care system in May. The government already spends more than $400 million on various immunization programs for poor children, and Mr. Clinton previously proposed spending $300 million in the current fiscal year to improve and expand the system for delivering vaccines.

The legislation is "a sound and cost-effective investment in America's future health and productivity," Ms. Shalala said. "It will become a cornerstone of the administration's national health-care reform plan." The program would be phased out when a comprehensive health-care plan is put into place.

But the companies who make childhood vaccines weren't enthusiastic. "What this universal purchase is directed to be is an attempt to control our prices, and this impacts our consideration of vaccines we currently have under development which are going to cost us a significant amount of money in development and in new facility construction," said Ronald Saldarini, president of Lederle-Praxis Biologicals.

"If I can't be sure the purchaser is going to allow me to price the product" as the company sees fit, he added, "I may be unwilling to consider that investment or further development."

J.P. Garnier, president of North America Pharmaceuticals, a unit of SmithKline Beecham, said the company was planning to invest more than $10 million in a new manufacturing facility for pediatric vaccines. But now, he said, "We're not going to go ahead with our investment until we know more about the way the purchasing system will be administered."

Mr. Garnier was worried that the government would ask for bids from all vaccine makers and accept one, putting the others out of business. If the government contracts with multiple vaccine producers, he said, his company would be less adamantly opposed to the measure.

The companies praised other aspects of the bill, which would give grants to states to set up a national tracking system to make sure all children get the appropriate shots at the recommended ages. "We are encouraged that the administration is proposing such a system," Merck & Co. said in a statement.

Currently, fewer than 63% of two-year-olds in the U.S. have received all the immunizations recommended for children of that age, Ms. Shalala said, and in some inner cities the vaccination rate is as low as 10%. As a result, diseases that were thought to have been eradicated have recently returned to strike tens of thousands of children. Between 1989 and 1991, more than 55,000 people were stricken with measles because of inadequate vaccination.

Joining Ms. Shalala in announcing the immunization program were a throng of Democratic lawmakers and Marian Wright Edelman, president of the Children's Defense Fund, which has long pushed for a universal immunization program.

"We cannot allow children to die of diseases that should never occur, and we cannot afford to treat children for crippling conditions that we can prevent," said Rep. Henry Waxman (D., Calif.). Rep. Louise Slaughter (D., N.Y.) added, "Wellness is cheaper than illness." But she also said, "I don't want to make it just a cost-prevention idea. Basically, it's humane."

Asked to respond to the drug industry's complaint that universal government purchase would stifle their profits and research, Sen. Edward Kennedy (D., Mass.) said, "The most profitable industry in the country is pharmaceutical companies."

Balt. Sun; 4-2-93

U.S. would track child vaccinations

Monitoring linked to free-shot plan

By John Fairhall
Washington Bureau

WASHINGTON — If your young child isn't vaccinated, the government is going to come calling.

Immunization legislation announced yesterday by the Clinton administration would provide free vaccines to every American child and authorize a national tracking system to make sure that all children are protected against disease. Beginning at birth, a child's immunization history would be entered into a state-based, nationally linked computer system, enabling authorities to monitor vaccinations.

Parents of pre-schoolers who haven't had their shots would be reminded by public health officials, who could send a letter, drop by, or call.

But the legislation contains no enforcement provisions. And the bill was vague on the question of how the government would negotiate a price for the vaccine it would buy from drugmakers.

Under the Clinton measure, the federal government would be the sole purchaser of vaccines, providing them at no cost to private doctors and public health clinics. In drafting the bill, congressional and administration officials discussed creating a board that would negotiate prices, but the measure presented yesterday left that up in the air.

Federal officials said they hoped parents would want to take advantage of the immunization program, which would cost up to $1.5 billion a year beginning in 1995 and would provide free vaccine to all children, regardless of family income.

Many American children do not receive their shots before their second birthday, and the immunization rate for poor children in some big cities is as low as 10 percent.

> *"This keeps a promise that we made to you."*
>
> **DONNA E. SHALALA**
> **To Marian Wright Edelman**

While hardly anyone of either political party disagrees with the need to reverse this trend, there is an ideological split even within the Clinton camp over the idea of making vaccines free to all children.

On one side are generally liberal thinkers like Marian Wright Edelman, head of the Children's Defense Fund and a close friend of the Clintons. She strongly pushed the idea of universal, government-sponsored vaccinations, and was the only official of a private group invited to join Health and Human Services Secretary Donna E. Shalala at yesterday's news conference outlining the legislation.

Acknowledging Ms. Edelman's role, Ms. Shalala said to her: "This keeps a promise that we made to you."

On the other side are moderate Democrats such as Will Marshall, president of the Progressive Policy Institute, an arm of the Democratic Leadership Council, which Mr. Clinton formerly headed. Mr. Marshall supports free vaccines for poor children and the administration's plans for restraining vaccine prices but doesn't believe the government should be doing for middle-class families what they can afford to do for themselves.

Mr. Marshall recalled that during his campaign for president, "Bill Clinton made much of the idea of reciprocal responsibility," of a "compact" between government and citizens delineating each of their responsibilities.

"I'm skeptical that the government needs, in effect, to substitute for the individual responsibility of parents," Mr. Marshall said.

But a Clinton political adviser, Paul Begala, defended the no-charge approach. One of the beauties of the Social Security program is its universality, he said. "Everybody pays, but everybody gets it."

Congressional supporters of the legislation, who joined Ms. Shalala at the news conference, also defended the idea.

Democratic Sen. Edward M. Kennedy of Massachusetts said "it has to be universal; otherwise you create all kinds of gaps and restrictions, and it adds to the bureaucracy" to devise a program with distinctions based on income.

Either a board, or a "permanent procurement panel" might be formed, said Dr. Alan R. Hinman, assistant surgeon general and director of the National Center for Prevention Services. Ultimately, the vaccine program will be absorbed under health care system reforms that the administration is now planning, Mr. Hinman and other officials said.

Reuters

Donna Shalala, secretary of Health and Human Services, with Sens. Donald W. Riegle and Edward M. Kennedy, sponsors of bill.

L.A. Times; 4-2-93

Funds for Vaccine Plan Unsettled

■ Health: A tax to pay for the $1.1-billion free immunization program for children is expected to be part of broader reform package.

By CONSTANCE SOMMER
TIMES STAFF WRITER

WASHINGTON—Clinton Administration officials have not decided how to pay for a proposed $1.1-billion program announced Thursday that would provide free vaccinations for all American children.

Under the Comprehensive Children's Immunization Act, which was formally submitted to Congress, the government would buy vaccines from manufacturers and distribute them to private doctors and public clinics across the country.

While Administration officials declined to specify what kind of tax they favor to pay for the program, they said that it would be included in the larger national health care reform package scheduled to be unveiled in May.

The vaccines program would "become a cornerstone in the Administration's national health care reform plan," said Secretary of Health and Human Services Donna Shalala, "a plan that will emphasize prevention and provide all Americans with the security of knowing that their basic health care needs will be met."

Although the President and other officials have publicly discussed such plans before, the proposal marks the Administration's first step into regulation of an industry that so far has flourished in an unregulated open market.

But what the Administration touted as the next, great step in children's welfare met strong opposition from the pharmaceutical industry, which protested that the new law would dry up their profits and force severe cuts in industry spending to develop new vaccines, if not force them out of the immunization business altogether.

"You have to be able to afford the luxury of serendipity and that can be expensive" said Pamela Adkins, director of communications for Merck & Co., a vaccine-manufacturing firm. "Science is not a logical thing and you never know where your next breakthrough is going to occur."

Dr. Ronald J. Saldarini, president of Lederle-Praxis Biological, a division of the American Cyanamid Co., warned that, if the Administration's plan passes Congress, his company might be forced to abandon research it is now conducting on vaccines for herpes, AIDS and infant diarrhea. "If I can't be sure that the purchaser will be sure to allow me to price the product at a price commensurate with my investment, I may not want to make that investment."

Government officials charged that vaccine costs must be reined in after a decade in which the public saw the prices of some childhood immunizations rise more than 1,000% in three years.

"Much of this price increase in recent years has been from the approval of new vaccines and for the support of the compensation program for children with vaccine reactions," Rep. Henry A. Waxman (D-Los Angeles) said at a press conference announcing the Administration plan, "but the end result for parents is the same—they have to dig deeper to provide basic protection."

Industry executives said that the dramatic price increases followed a wave of liability suits in the 1980s, when parents of children who suffered lasting damage from allergic reactions to vaccines began filing damage suits against manufacturers. In response to industry concerns, Congress passed a law in 1986 in which the government assumed all liability costs for those children in exchange for a vaccine excise tax levied on the manufacturers.

According to figures from the federal Centers for Disease Control and Prevention, the vaccine for diphtheria, whooping cough, and tetanus—just one of several childhood vaccines—cost private physicians 45 cents per dose in 1983. This year, the cost is $5.40.

The excise tax was in effect from 1988 to 1992 and added $4.56 to the cost for a dose of the vaccine in those years only. It is not included in the $5.40 cost this year.

Currently, about 95% of American children are immunized by the time they start kindergarten. Full immunization is mandatory for school enrollment. But experts pointed out that the danger time for exposure to childhood illnesses such as the German measles and whooping cough is between birth and two years of age. For such toddlers, the immunization rate hovers at about 60%, dipping down as low as 10% in some inner city neighborhoods.

USA Today; 4-2-93

Clinton calling the shots

Wants to have all children vaccinated by 2

By Judi Hasson
USA TODAY 5A

The Clinton administration announced an ambitious plan Thursday to track the health history of all babies in the USA to ensure they are vaccinated by the age of 2.

The plan, to start in 1995 and cost $1.1 billion a year, calls for states to set up computer registries to make sure children get vaccines — to overcome the low vaccination rate of existing free programs for the poor.

The federal government will buy the drugs and distribute them free to public clinics and private doctors.

"This is an attempt to immunize every preschool child, not just poor children," said Health and Human Services Secretary Donna Shalala, when asked why federal money would supply vaccines to children whose families can afford them.

The key is setting up state-run registries based on birth certificates. Every time a child goes to a doctor or a hospital, the child's medical record would be checked by computer.

The USA has one of the worst immunization records in the Western Hemisphere; fewer than 63% of all 2-year-olds are fully vaccinated, and the rate is worse in some large cities.

By 5, most catch up; schools won't admit a child without a proper vaccination record. But that's too late for the vulnerable years when diseases like measles, mumps and whooping cough are most threatening.

"A lot of the patients we want to get have a lot of other priorities," says Marlene Kelley of the Washington, D.C., Public Health Commission. "They are concerned about violence, a roof over their heads and food on the table."

By Tim Dillon, USA TODAY

SHALALA: 'This is an attempt to immunize every preschool child, not just poor children,' says Health and Human Services secretary.

Ronald Saldarini, president of Lederle-Praxis Biologicals, the USA's largest vaccine producer, points out that free vaccines are available for the needy now.

Saldarini — whose firm is freezing vaccine prices this year — says the government's plan to negotiate prices, then buy up all vaccines, will cut into industry profits used for research into vaccines for AIDS, hepatitis and other diseases.

But Shalala said, "We have no intention of destroying the research base of the American drug industry."

Saldarini says the problem of low vaccination rates is not a lack of free supplies, but an inability to deliver them to people who don't know their children must be vaccinated or where to go for vaccinations.

"Where is the logic in buying everything if what you were already buying you can't effectively deliver?" he said. "In a time of a mounting deficit ... it is inappropriate to use public funds to pay for children who can afford to pay."

San Antonio has had a computerized vaccination system for seven years. It has raised the immunization rate of children under 2 to 70% from less than 50%, says health commissioner Fernando Guerra.

"For us, immunization is an everyday thing," he says. "In a matter of minutes, a child who shows up in an emergency room can be tracked to see if immunizations are up-to-date."

Clinton's plan must be approved by Congress, which is expected to face heavy lobbying by drug makers.

Republicans called the plan well-intentioned but misguided. Sen. John Danforth, R-Mo., said, "We should target limited resources to areas where we can do more good, namely improving vaccine delivery."

▶ Today's debate, 12A

WHEN TO VACCINATE

The vaccination schedule recommended by the American Academy of Pediatrics:

- ▶ **Birth:** Hepatitis B.
- ▶ **1-2 months:** Hepatitis B.
- ▶ **2 months:** Diphtheria-tetanus-pertussis, polio, haemophilus influenza type B.
- ▶ **4 months:** DTP, polio, haemophilus.
- ▶ **6 months:** DTP.
- ▶ **6-18 months:** Hepatitis B.
- ▶ **15 months:** Measles-mumps-rubella.
- ▶ **15-18 months:** DTP, polio.
- ▶ **4-6 years:** DTP, polio.
- ▶ **11-12 years:** MMR.
- ▶ **14-16 years:** Tetanus-diphtheria.

USA Today; 4-2-93

Vaccinations for all

On another subject, USA TODAY believes child immunization is worth the cost.

At long last, at least half the battle to immunize the nation's children against dangerous diseases has begun.

A plan unveiled Thursday by Health and Human Service Secretary Donna Shalala would make vaccines available to all kids, without cost. If Congress agrees, $1 billion yearly — $4 for each person in the country — will go to purchase vaccines and distribute them free to doctors and health clinics.

That's one way to reduce high costs that have pushed vaccines out of the reach of millions of families.

But prices are only half the problem.

In the 11 states that already have vaccine purchase plans, the average immunization rate is 63%, only a little better than the national average. The reason: Regardless of price, vaccines don't reach children in areas with poor health care.

The problem has grown particularly acute as financially strapped governments have cut back on public health outreach programs. One result: outbreaks of measles and tuberculous that have struck every part of society.

Getting the word to parents that vaccinations are vital and making them easily available will be difficult. Yet details of how the government will achieve its goals, and what the cost will be, are lacking. So, too, is an explanation of how the government will avoid stiffling research to develop new vaccines.

With the government as lone producer of vaccines, prices will be controlled and companies may be left with little incentive to invest in new research.

The administration is on the right track. But if the war against unchecked childhood diseases is to be won, the president must fight the whole battle — and let the public see his plan.

Wash. Post; 4-2-93

Children's Advocates Fear Tougher Times In Keeping Momentum

Loss of Two Hill Panels Adds to Problems

By Barbara Vobejda AID
Washington Post Staff Writer

At the height of a successful campaign to draw attention to the needs of children, advocates are bracing for what they fear are rougher times as they attempt to translate public support into real improvements in children's lives.

More than 900 children's activists who gathered in Washington yesterday said that while they are buoyed by the heightened attention to the problems and by the election of President Clinton, they are facing a much more difficult second phase. Their progress could come to a halt, they fear, by lack of funding; resistance to change from school systems, social service agencies and other institutions, and continuing distrust that government programs can solve the seemingly intractable problems.

That challenge is intensified by the dissolution this week of two high-profile panels dedicated to the developing children's movement. The House Select Committee on Children, Youth and Families was officially dissolved Wednesday as part of this year's congressional reorganization, and the presidentially appointed National Commission on Children headed by Sen. John D. "Jay" Rockefeller IV (D-W.Va.) ends five years of work with the culminating summit that brought together activists here yesterday and today.

"This is the hard part," said Cheryl D. Hayes, executive director of the commission, which released a list of recommendations in 1991. "How to do it, who has to do what. I think that's going to be very challenging."

"This is a watershed, a new era for kids' issues," said James Steyer, president and founder of Children Now, a California advocacy group. "The first mission we had was to tell people that children are in trouble. The second thing is, we have to show some results."

Complicating that task, some advocates said, is the lack of cohesive national leadership on the issue.

"All these programs are great, but there is no glue," said David S. Liederman, executive director of the Child Welfare League of America.

Others said they were hampered by a sense of public and political helplessness at the enormity of the problems, including poverty, drug abuse, disintegrating families and poor schools.

"Fatalism continues to be a millstone," said William H. Foege, executive director of the Task Force for Child Survival and Development at the Carter Center of Emory University in Atlanta.

At the same time, expectations have been raised by Clinton's attention to the children's agenda and the work of Hillary Rodham Clinton, who served as chair of the Children's Defense Fund before the presidential campaign.

"I've never felt better about the possibility and probability of children's programs being done quickly," Rockefeller said. He cited several policies recommended by his commission that have been endorsed by Clinton, including an expanded earned income tax credit, health care reform, expansion of Head Start, immunization and heightened enforcement of child-support orders.

Underscoring the administration's support was the announcement yesterday by Health and Human Services Secretary Donna E. Shalala that the federal government would fund a program to immunize all the nation's children.

Still, many believe there is little reason for such optimism.

"No, we've not made progress," said Rep. Patricia Schroeder (D-Colo.), who chaired the House select committee. "We know there is more poverty than ever before. We know violence is worse than ever before. As a nation, we could be held guilty of criminal neglect of children. Everybody loves them to death, until we get to the funding door."

Schroeder is particularly troubled by the lack of congressional committees devoted to children, leaving jurisdiction for the issues spread between several unrelated panels. "Everybody's talking about quality," she said, referring to a debate on increased funding for Head Start. "You think [the] Ways and Means [Committee] is going to spend a lot of time looking at the quality of Head Start?"

> ***"As a nation, we could be held guilty of criminal neglect of children. Everybody loves them to death, until we get to the funding door."***
>
> —Rep. Patricia Schroeder (D-Colo.)

Susan Bales, a spokeswoman for the National Association of Children's Hospitals and organizer of the 250-member Coalition for America's Children, said she is worried that the high-profile initiatives already announced by the Clinton administration—expanding Head Start and child immunization—will be the first and last policy successes.

"Those of us watching health care, welfare reform and other changes on the congressional plate don't hear a lot about children," Bales said. "Are children going to be the symbol or are they going to be sustained through the rest of this?"

In light of the potential problems, some are advocating a shift in focus from public policy solutions alone to a much greater reliance on citizen activism.

They envision a grass-roots movement built around individuals lobbying bosses for family-friendly workplaces, for example, or organizing inner-city basketball leagues, much like the environmental movement relies on individuals committed to recycling and energy conservation.

They believe such a movement would be possible because of the success in building public awareness of the problems affecting children and linking those to the economic future of the nation.

"That connectedness of issues of children to the broader interests of society and the future has been an important maturing of public consciousness, giving it greater depth and power," said Doug Nelson, director of the Annie E. Casey Foundation, which supports work in this area.

Opinion polls bear out the heightened support. A poll taken in February and released this week indicated that, when asked what would do the most to stimulate the economy over the long term, respondents ranked investment in children's health and education first.

N.Y. Times; 4-2-93

Clinton May Not Meet Deadline on Health Plan

A20

By ROBERT PEAR
Special to The New York Times

WASHINGTON, April 1 — President Clinton probably cannot meet the deadline of May 3 that he set for sending Congress a detailed plan for reshaping the nation's health-care system, Administration officials said today. The delay reduces the chances that the proposal will become law this year.

Health care remains a top priority of Mr. Clinton, and he fully intends to send Congress a detailed legislative proposal to control health costs and guarantee insurance coverage for all Americans, the officials said.

But several factors have delayed the proposal, they said.

Hillary Rodham Clinton, head of the President's Task Force on National Health Care Reform, has been in Little Rock, Ark., tending to her father, Hugh Rodham, since he suffered a stroke on March 19.

Drafting of a detailed proposal has also been delayed by the overwhelming complexity of the task and the unwieldy nature of a decision-making process organized by Ira C. Magaziner, the coordinator of the task force, the officials said.

No Crisp Decisions

The task force has a staff of more than 500 people, organized into more than 30 groups, which meet periodically to analyze options. Administration officials said the policy-making process had brought together articulate, opinionated people to debate alternatives, but had not produced the crisp decisions needed to translate a broad vision of health policy into concrete, detailed legislation.

Hillary Clinton's absence and a big task put a panel behind schedule.

In writing health-care law, Congress and the Administration want to be precise because thousands of lives, millions of jobs and billions of dollars will depend on their decisions.

In appointing the 12-member task force, Mr. Clinton said its assignment was to "prepare health-care reform legislation to be submitted to Congress within 100 days of our taking office." The 100-day period ends on April 30. Mr. Magaziner and other White House officials have been saying for weeks that the legislation would be ready by Monday, May 3.

Some officials said today that they were hoping to complete work on the proposal by late May or early June. Others said July or August was a more realistic goal. The timetable depends, in part, on the course of Mr. Rodham's illness, which is uncertain, they said.

'Aiming for Early May'

George Stephanopoulos, the White House communications director, said, "We still hope to finish the bulk of the work by May 3," but he refused to say when drafting of the legislation would

spokesman for the task force, said, "We're still aiming for early May, but Mrs. Clinton's father's illness hasn't made it easy."

Experienced civil servants and lobbyists for the health-care industry say Mr. Clinton and Mr. Magaziner were naive to set such a tight deadline for such an ambitious task. But a top Administration official defended the deadline, saying that Federal employees would not be working so hard without it.

In an address to Congress on Feb. 17, Mr. Clinton said he wanted comprehensive health-care legislation passed "this year — not next year, not five years from now, but this year."

In early March, Representative Dan Rostenkowski, the Illinois Democrat who is chairman of the Ways and Means Committee, said Congress was likely to pass such legislation next year, not this year.

On Sunday, the House majority leader, Representative Richard A. Gephardt of Missouri, voiced uncertainty about whether Congress could meet Mr. Clinton's goal of passing such legislation this year. The health-care bill "will be the toughest bill since the Social Security Act" was passed in 1935, and "it will be just as important," Mr. Gephardt said on the NBC News program "Meet the Press."

'Going to Take Our Time'

"We're going to take our time to do it," Mr. Gephardt said. "We're going to listen to the American people."

It is impossible for outsiders to know whether Mr. Clinton, on Feb. 17, truly believed that Congress would pass a comprehensive health-care bill this year, or whether he was simply trying to put pressure on Congress. But since then the legislative strategy of his Administration, gleaned from cocktail party chatter and candid comments by White House officials speaking on condition of anonymity, has become more clear, and that strategy no longer assumes passage of a big health-care bill this year.

If Congress fails to act this year, health care will surely be an election issue in 1994. That may help Mr. Clinton because lawmakers will want to show voters that they have responded to public concern about soaring health costs.

Some Administration officials say that a lawsuit filed against the task force, seeking access to its meetings and documents, has also slowed its work, because lawyers must scrutinize its sessions for compliance with a Federal court order.

Mr. Magaziner said he originally recommended a May 31 deadline for sending legislation to Congress. But he said Mr. Clinton insisted on the earlier deadline.

By his own account, Mr. Magaziner is a novice in dealing with the numerous Federal agencies and Congressional committees responsible for health policy. Before coming to Washington, he was an international business consultant whose clients included Volvo, General Electric and Corning.

A staff member of the task force said, "You'll soon see a midcourse correction in the policy-making process.

Wall St. Jrnl.; 4-2-93 p. 1

CLINTON AIDES PUSH a broad health-benefits plan that may irk the elderly.

Administration officials want to make the benefits package in the president's health-reform plan as generous as a good union health package. They tell House Democrats they want to include coverage for an array of preventive services and a prescription-drug benefit. But officials doubt they can afford to add prescriptions to Medicare.

A rich benefits package is critical to winning support of labor and other constituencies, officials believe. But some lawmakers worry about angering elderly voters even as Clinton's budget seeks to squeeze billions in savings out of Medicare. A benefit that excludes people over 65 isn't "sustainable ethically, morally, politically or any other way," warns the American Association of Retired Persons' John Rother.

Hillary Rodham Clinton's continuing absence from Washington due to her father's illness may postpone the May 3 release date of the health plan.

Wash. Post; 4-2-93 p. 1

Study Questions AZT Ability to Slow AIDS

European Findings Challenge American Beliefs About Drug

By David Brown
Washington Post Staff Writer

Preliminary results of a large European drug trial suggest that people in the early stage of human immunodeficiency virus (HIV) infection get little, if any, benefit from the use of AZT, the main medication for their disease.

The findings run counter to the belief among most American AIDS experts that AZT delays the onset of AIDS and should therefore be prescribed before symptoms develop and when the only evidence of infection is blood-test abnormality.

A group of European scientists reported in The Lancet, a medical journal scheduled to be published Saturday, that treating asymptomatic HIV patients with AZT did not delay either AIDS or death during a three-year period of observation. Persons taking the drug showed a slightly lower risk of developing AIDS or dying within one year of starting treatment, but that advantage was gone two years later. At the same time, persons on AZT had a higher risk of side effects—such as anemia and nausea—than persons not taking the drug.

The trial is expected to receive more attention than most because it contains more "end points"—clinically identifiable developments such as death or progression of a person's illness from early infection to AIDS—than all four similar American trials combined, and because it lasted longer. Both of those facts add power to its conclusions, reducing the chance that they are wrong.

A full report of the results of the "Concorde" trial—so called because, like the airplane of the same name, the study is largely an Anglo-French collaboration—is expected in several months.

"I think it's going to be a very

See AZT, A14, Col. 1

AZT, From A1

unpalatable result, and perhaps an unpopular result," said Ian Weller, a professor at University College, London, Medical School, and the head of the English part of the study. "I think some people are not going to believe it."

The head of the division of AIDS at the National Institute of Allergy and Infectious Diseases cautioned against using the abbreviated report of the Concorde trial to change medical practice.

"It is premature to make any conclusion until we have had an in-depth look, and even then many patients may opt for the short-term benefits," Daniel Hoth said. "It's not like 1988, when you only had one bullet in your gun. Now there are alternative therapies that a person can try when AZT stops working."

AZT, whose formal name is zidovudine, was the first drug found to be effective in slowing the course of HIV infection, and is still the most common one in use. Burroughs Wellcome Co., the drug's maker, sold $388 million worth of AZT in 1992, $195 million in the United States.

Several other so-called anti-retroviral agents, however, have entered practice since AZT was approved in 1987, and there is evidence that treatments combining them or using them sequentially may be especially useful in slowing HIV disease.

The Food and Drug Administration, among other influential agencies and groups, currently recommends that a person start taking AZT when his or her so-called CD4 count drops below 500 cells per microliter of blood. CD4 cells are a subclass of infection-fighting white blood cells. The normal count is 1,000 to 1,300.

Earlier U.S. trials have shown that AZT lengthens the period between the appearance of AIDS and death. Some other studies have shown the drug also delays the onset of AIDS in asymptomatic persons with CD4 counts below 500, or those with mild symptoms (such as weight loss, fevers and diarrhea).

Those latter studies however, together had 186 end points—

See AZT, A15, Col. 1

AZT, From A14

death or progression to AIDS—compared with 346 in the Concorde group. None of the U.S. studies lasted longer than two years and four months, and several were stopped early when the AIDS-delaying advantage was found in order to let all patients to go on AZT.

In the Concorde trial, 1,749 persons were randomly assigned to take either AZT or a placebo until they developed any symptoms of their infection. At that point, patients in the placebo "arm" of the trial were also given AZT.

After three years, 18 percent of each group had progressed to AIDS, which is the stage of the disease characterized by unusual cancers and infections. In that same period, 8 percent of the AZT group and 7 percent of the placebo group died.

The study did find that after one year, the CD4 cell count in the treatment group was slightly higher—by about 30 cells per microliter—and slightly fewer people in that group had progressed to AIDS. This was explained as the result of a small but immediate rise in CD4 cells when AZT is begun.

"These biological changes that you see do not have a clinical payoff," Weller said yesterday, arguing that too much significance has been made of CD4 counts as measures of health in previous HIV studies.

Several U.S. AIDS researchers yesterday said the study may have little impact here because it is sufficiently different from American studies that they may not be viewed as comparable.

Among the differences in the Concorde study was that 40 percent of the patients in both AZT and placebo arms had CD4 counts above 500 at the start of the trial, and consequently were "healthier" than even the healthiest HIV patients getting AZT under current guidelines. Also, the dose of AZT given in Concorde differed from that in some of the American studies (higher than some, lower than others) from which the guidelines were formulated.

Wash. Post; 4-2-93

A Flurry of Appointments Due at Justice

The Justice Department drawing board is beginning to look a lot like that chalkboard that TV football analyst **John Madden** uses to describe the plays on Sundays.

But finally, we're going to see some action in a trio of announcements expected today. The leading candidate for the No. 2 spot, Washington attorney **Charles F.C. Ruff**, was dropped last week after the Senate Judiciary Committee raised concerns that focused on nonpayment of Social Security taxes for a domestic worker.

Now sources say Harvard Law School professor **Philip B. Heymann**, who headed the criminal division during the Carter administration and helped on the transition, will be named deputy attorney general. Close behind, Rose law partner **Webster Hubbell** of Little Rock, Ark., as expected, will get the No. 3 slot, deputy attorney general. Yale law professor **Drew Days** will become solicitor general.

Now two others high on the list for assistant attorney general jobs are said to be still shifting about.

Sources say Boston lawyer **Eleanor D. Acheson**, who had been penciled in to head the Office of Legal Policy, may head the office, but not necessarily as an assistant attorney general.

Associate White House counsel and Duke Law School professor **Walter Dellinger**, talked about for the Office of Legal Counsel at Justice, may move instead to deputy solicitor general under **Days**.

Sources say the moves would obviate the need for approval by the Senate Judiciary Committee, where the candidates could be asked about nonpayments of Social Security taxes for domestic workers.


CARL STERN

The White House insists that the Social Security concerns in both cases are minor and "not disqualifying" in either case.

Sources say Dellinger, for example, had paid Social Security taxes for a cleaning woman for years until the woman retired. The elderly woman continued to work for an hour or so a week. Dellinger paid her about $25 per week, but no Social Security taxes.

Before the **Zoe E. Baird** debacle, Dellinger voluntarily paid $911 in back payments for a four-year period. Acheson is said to be in a similar situation. Sources say both could very well end up going to Justice and assume the spots they were originally penciled in for.

Meanwhile, word is that veteran NBC-TV reporter **Carl Stern**, who covered Justice and the Supreme Court for 26 years and who was made an offair correspondent 18 months ago, has emerged as the leading contender for Justice Department spokesman. If picked, Stern would join a department he once regularly probed under the Freedom of Information and Privacy acts.

Also, a new name has emerged as a candidate for the legislative affairs job: **Charles L. Kinney**, chief floor counsel to Senate Majority Leader **George J. Mitchell** (D-Maine). A 19-year staff counsel on the Democratic Policy Committee, Kinney also worked with the Judiciary Committee for many years.

Wirth Approved for State

■ The Senate Foreign Relations Committee, with hardly a peep from committee Republicans, yesterday approved on a unanimous voice vote the nomination of former Colorado senator **Timothy E. Wirth** as counselor to Secretary of State **Warren Christopher**—a job that will become undersecretary for global affairs.

Rumors of Republican "questions" about Wirth's ties to savings and loan and junk bond figures apparently evaporated as ranking minority member Sen. **Jesse Helms** (R-N.C.) said he was satisfied with Wirth's answers.

Lengthy Battle Winding Down

■ A long-standing battle over a key Agriculture Department post appears to be ending with **Ellen Haas**, now head of Public Voice, a consumer advocacy group on food safety issues, seen as the likely pick to be assistant secretary for food and consumer services.

Haas and **Shirley Watkins**, director of nutrition services at the Memphis City Schools, were reportedly strong contenders for the job, which is seen as extremely important: The holder oversees big money, about $35 billion in food programs, including the food stamp and school lunch programs.

HHS Inspector General Named

■ **President Clinton** yesterday named **June Gibbs Brown**, a former inspector general at the Department of Defense, NASA and the Department of the Interior, to be inspector general of the Department of Health and Human Services. Brown is now inspector general of the Navy's Pacific Fleet at Pearl Harbor, Hawaii.

McHugh Going to World Bank

■ In the all-things-come-to-those-who-wait category, former New York representative **Matthew F. McHugh**, who had been in a battle royal with Washington lawyer **Ruth Harkin** to run the Agency for International Development—a battle both lost—has landed a job.

McHugh, who has been vice president and university counsel at Cornell University since leaving Congress in January, will become counselor to the president of the World Bank, starting in May.

—Al Kamen

Wall St. Jrnl.; 4-2-93

U.S. Officials, European Researchers Clash Over Early Treatment With AZT

By Marilyn Chase
Staff Reporter of The Wall Street Journal

A trans-Atlantic debate has erupted over using Wellcome PLC's drug AZT to treat asymptomatic patients infected with the AIDS virus.

The controversy pits an Anglo-French research group against U.S. health officials who have advocated such treatment.

The study, called the Concorde Trial, concludes early AZT treatment fails to prolong three-year survival rates. The study examined 1,750 symptom-free people infected with human immunodeficiency virus, which causes AIDS. Half received AZT, and half got a placebo or dummy drug until the onset of symptoms, when they switched to AZT. After three years, the survival rate was 92% in the early treatment group and 93% in the deferred treatment group.

"There was no significant difference in clinical outcome between the two therapeutic strategies," said Concorde researchers Jean-Pierre Aboulker of Villejuif, France, and Ann Marie Swart of London, previewing their work in a letter to the British journal Lancet this week.

Similarly, Drs. Aboulker and Swart found "no significant difference" in the patients' progression to full-blown AIDS. However, the study did show that patients treated early maintained higher levels of disease-fighting white blood cells of the immune system, known as CD4 cells. Their failure to link this sign with better survival "casts doubt on the value" of CD4 cells in judging antiviral drugs, they asserted.

In Rockville, Md., the U.S. Food and Drug Administration – which has blessed the notion of early care when CD4 counts fall below 500, or about half the normal level – reacted quickly.

"No one has ever seen AZT as a home run," said FDA Commissioner David Kessler in a telephone interview. "It is, at best, a solid single. But when you're four runs behind in the ninth inning, you take a single." Further, he upheld monitoring of CD4 cell levels as a window on immune health.

U.S. officials jumped on the Concorde claims. Certain AIDS activists have argued, despite studies to the contrary, that AZT's benefits aren't worth the toxicity, mainly bone marrow suppression. U.S. officials cautioned against abandoning the drug, while noting AZT's flaws are "no surprise" to anyone following treatment trends.

FDA has acknowledged the long-accepted view that AZT's benefits may subside after 12 to 18 months as the virus mutates to evade the drug's effects. However, "this study does not call into question the clinical importance of AZT in treating symptomatic HIV disease," the FDA stressed in a position paper.

The office of Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases, issued a statement from an HIV conference in Albuquerque, N.M., urging patients to take the report in context. Wellcome PLC in London and its U.S. unit in North Carolina both issued statements challenging the Concorde's study methodology.

What isn't clear is how much impact the Concorde study will have on the AIDS treatment in the U.S., where AZT's role as a solo treatment has already been markedly eroded as patients embrace newer antivirals or combination treatments. Indeed, many U.S. doctors now accept the view – propounded by a NIAID study a year ago – that patients benefit by switching to a second drug, Bristol-Myers Squibb Co.'s DDI, after just four months on AZT. A third antiviral drug, Hoffmann-La Roche's DDC, is used in combinations with, or as an alternative to, AZT.

"No patient or doctor should change their use of AZT" based on the Concorde study, urged Daniel Hoth, director of NIAID's Division of AIDS. Further, he suggested the Concorde's study design is outdated, because AZT as a solo drug isn't the ideal of AIDS care. "Today's world is different; we have more treatment options," he said. NIAID has called for a state-of-the-art conference this summer.

Concorde's three-year observations overshadow three earlier U.S. studies suggesting early treatment can delay the onset of AIDS or AIDS-related complex in the short term. But it confirms findings of a fourth study from the Veterans Affairs department showing scant effects on long-term survival.

"We know resistance develops in people after about a year," said David Feigal, director of FDA's division of antiviral drug products. "They're choosing to present the bottom line – what happened after three years. We need to see more data to know if there were early effects – at one year, 18 months, and two years – showing differences in progression."

Wash. Post; Wash. Times; 4-2-93

36 Haitians With AIDS Virus to Get Treatment in U.S.

Associated Press AID

Thirty-six of some 250 Haitian refugees infected with the AIDS virus and detained at the U.S. naval base in Cuba will be brought to the United States for treatment, the Justice Department said yesterday.

The department said, however, the action was taken to comply with a court order issued last week and does not represent a change in policy.

"The government will comply with the order regarding a limited number of the Haitians who have tested positive with the HIV virus currently on Guantanamo," the department said.

The U.S. government has detained about 250 refugees at the U.S. base in Guantanamo Bay, Cuba, for more than a year because either they or relatives accompanying them have HIV, the virus that causes AIDS. Authorities have said the 250 have legitimate political asylum claims.

Last Friday, U.S. District Judge Sterling Johnson Jr. in New York gave the government 10 days to comply with his ruling that the government must provide medical treatment for those refugees or send them where they can be treated.

The judge did not say where the refugees should be taken for treatment but specified that they should not be returned to Haiti.

The order covered two classes of Haitians, those with T-cell counts below 200 and those whose T-cell counts are 13 or lower, the department said. The T-cell count for a healthy person normally runs from 800 to 1,200.

"Under the terms of the order, 36 Haitians will be brought to the United States as soon as appropriate arrangements can be made," the department said. "This action is taken to comply with the court's order and does not represent a change in general policy."

The number of refugees in Guantanamo who have developed AIDS symptoms had been in dispute. A lawyer representing the Haitians, Joseph Tringali, said there are 35, while the government had said earlier that there were 15 to 20. The department's decision to bring 36 to the United States indicates it was acceding to Tringali's figure.

Johnson said in his March 19 ruling that government officials acknowledged in testimony earlier this month that the refugees were not receiving adequate treatment for their condition. Assistant U.S. Attorney Bob Begeliter told Johnson that military doctors could not treat the refugees because of their weakened condition.

The judge also wrote that the government has ignored its own doctors who recommended that refugees with AIDS should be moved from the camp. In the past year, the government has allowed 22 AIDS-infected Haitians into the United States on an emergency basis for treatment.

PROTEST FOR HAITIAN DETAINEES

BY ANDRE LUNG FOR THE WASHINGTON POST

Wash. Post; 4-2-93

Georgetown University senior Mike Bishop is among the demonstrators taking turns in a cage at the school's Red Square to protest the detainment of several hundred Haitians at Guantanamo Bay Naval Base in Cuba. The Haitians, many of whom have the virus that causes AIDS, are seeking asylum in the United States. Twenty-five Georgetown students are staging a three-day hunger strike in support of the Haitians.

USA Today; 4-2-93

NEW MEDICINE: The National Institutes of Health's Office of Alternative Medicine is inviting practitioners to conduct ground-breaking studies of treatments from homeopathy to concoctions for cancer — but they must be willing to cooperate with people experienced in conventional research, expert advisers were told Thursday. Dr. Joseph Jacobs, director, says letters of intent to apply for 20 $30,000 "seed grants" should be submitted by April 30; projects will be funded by September. The meeting continues today.

Wall St. Jrnl.; 4-2-93

Smoking Rate in U.S. Rises For First Time in 25 Years

By a WALL STREET JOURNAL *Staff Reporter*

NEW YORK – The rate of smoking in the U.S. increased slightly in 1991, the first rise after steadily declining for 25 years, according to a new federal study.

Smoking experts blame the interruption in the decline in part on the steady growth of discount cigarettes, which now comprise nearly one-third of all sales.

In 1991, 25.7% of the adult population smoked, compared with 25.5% in 1990, according to a survey released yesterday by the Centers for Disease Control and Prevention in Atlanta.

"We are very discouraged," said Michael P. Eriksen, director of the Office on Smoking and Health at CDC. Until 1991, smoking rates had fallen without interruption since 1966, when 42.6% of the population smoked. Data for 1992 won't be available for 12 months.

Mr. Eriksen said heavy promotional activity by the cigarette industry also played a role in the upturn. The tobacco industry spent $3.9 billion on advertising and promotion in 1991, an 11% increase from a year earlier, the CDC said.

The CDC study also found that slightly more than 33% of people living below the poverty level smoke, while only about 14% of college graduates smoke.

Wash. Times; 4-2-93

CDC reports reversal of smoking decline

ATLANTA — The percentage of Americans who smoke failed to decline for the first time in a quarter-century, and the rate actually increased among blacks and women, federal health officials reported yesterday.

Wide availability of discount cigarettes and $3.9 billion in tobacco advertising are responsible for the reversal, the Centers for Disease Control and Prevention said in calling for more cigarette tax increases to halt the trend.

The figures for 1991, the latest for which statistics are available, mark the end of 25 years of steady decreases in smoking. And they mean the United States won't meet a national health objective — only 15 percent of Americans smoking by the year 2000.

The CDC found that 25.7 percent of Americans — 46.3 million people — smoked in 1991. In 1990, 25.5 percent smoked, the lowest level since the CDC began counting in 1955. But more blacks — 29.2 percent versus 26.2 percent in 1990 — and more women — 23.5 percent versus 22.8 percent — smoked in 1991, it said.

Wall St. Jrnl.; 4-2-93

AIDS EXCLUSION: The American Civil Liberties Union and a South Carolina organization for people with AIDS filed a lawsuit in federal court against South Carolina's insurance risk pool. The suit alleges that the risk pool, which insures people who have been turned down by private health insurers, violates the Americans with Disabilities Act by denying coverage to people with AIDS. State lawmakers exempted people with AIDS when they created the pool. James C. Gray, attorney for the insurance pool, said the program is complying with the state law.

USA Today; 4-2-93

AIDS TREATMENT QUESTIONED: The standard early treatment of giving the drug AZT to people infected with the AIDS virus has been questioned in a European study. The study, by the Medical Research Council of Britain and the French National AIDS agency, found there was no evident benefit in taking AZT early. The study, published in the journal *Lancet*, compared two groups of HIV-infected patients, one in which the drug was started during the symptom-free period and one in which it was withheld unless symptoms developed. There was no real difference in the rates of progression to AIDS or death for the two groups.

HHS RADIO
FOR THURSDAY, APRIL 1, 1993

The feed consists of two stories in English and one story in Spanish.

First -- The Clinton Administration announced today the "Comprehensive Childhood Immunization Act of 1993" -- a new initiative to protect all American children against preventable diseases. Health and Human Services Secretary Donna Shalala says this initiative is a major step to ensuring that all children live healthy lives.

Second -- The Food and Drug Administration has announced approval of a combination vaccine against four serious childhood illnesses. The diseases are diphtheria, tetanus, whooping cough and bacterial influenza type b, the leading cause of meningitis. FDA's Dr. Drusilla Burns says the vaccine is safe, effective and gives children the protection they need.

And in Spanish.....

Third -- The Centers for Disease Control and Prevention is recommending that the elderly get immunizations against tetanus. This recommendation stems from the death of an unvaccinated 80-year-old women exposed to tetanus. CDC's Catherine Konnon says it is important that doctors and other health care providers regularly review and update patient immunizations.

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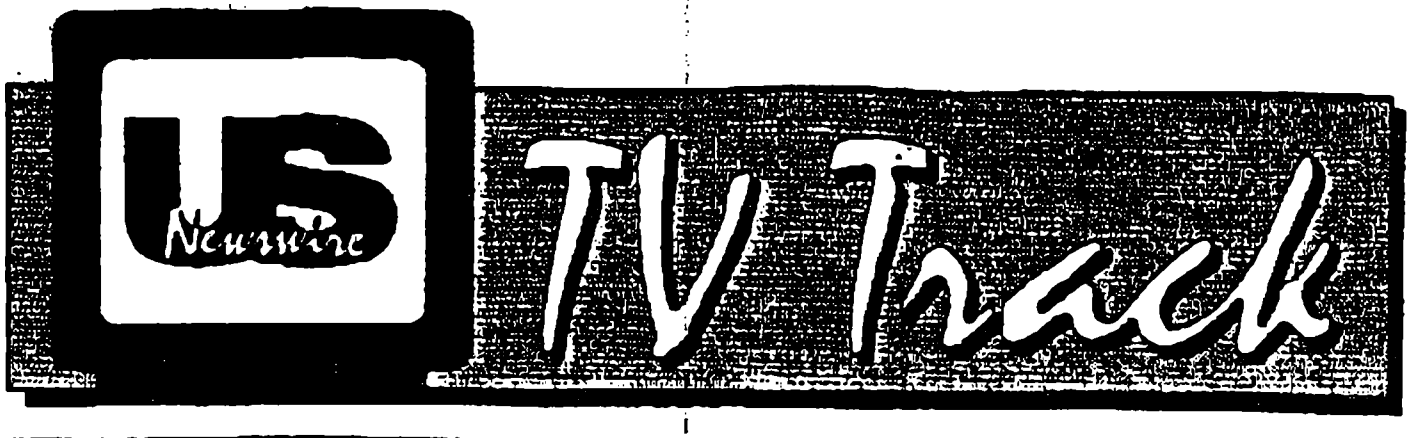

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NETWORK HEADLINES
Thursday April 1, 1993

ABC World News Tonight

1	Clinton Sees Link Between US Future, Russian Reforms			
	Brit Hume	Washington		2:20
2	Struggling Russians Embarrassed by Some Kinds of Aid			
	David Ensor	Moscow		2:00
3	Serbs Will Defy UN on Aid Deliveries			
	Peter Jennings	New York		0:30
4	Moslem Boy Rescued by Serbian Officer			
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5	Bosnia Accuses Serbs in World Court			
	Peter Jennings	New York		0:15
6	Defense Rests in LA Police Beating Case			
	Judy Muller	Los Angeles		2:00
7	Fugitive Suspect in Tower Bombing Asked for Political Asylum			
	Peter Jennings	New York		0:20
8	Four Charged in Murder, Terror Conspiracy; Abu Nidal Links			
	Al Dale	No Location		2:00
9	Congressional Panel Holds Hearings on Anti-Abortion Violence			
	Bettina Gregory	Washington		1:35
10	Task Force Rules Out Price Freeze on Doctors, Hospitals			
	Peter Jennings	New York		0:20
11	Clinton Unveils Child Immunization Plan			
	Peter Jennings	New York		0:15
12	Government Survey Finds Number of Smokers No Longer Shrinking			
	Peter Jennings	New York		0:20
13	FCC Votes to Cut Costs of Cable TV Service			
	Steven Aug	Washington		2:00
14	FCC Allows TV Networks to Syndicate Shows			
	Peter Jennings	New York		0:15
15	Doctors Find Bullet Killed Actor Brandon Lee			
	Peter Jennings	New York		0:15
16	Compromise on California Bird May be Model for Development			
	Barry Serafin	Los Angeles		4:00
17	Executives at Computer Company Subject to April Fools Pranks			
	Ken Kashiwahara	Los Angeles		1:45

CBS Evening News

18 Cable TV Rates Curbed by FCC; Most Rates to Go Down 15%
Rita Braver Washinton 2:00
19 Justice Department Announces Indictments of Abu Nidal Members
Connie Chung New York 0:25
20 Sept. 14 to be Trial Date for World Trade Center Bomb Suspects
Connie Chung New York 0:20
21 King Trial Defense Rests Before Calling on Three Witnesses
Bill Whitaker Los Angeles 2:35
22 Korean Merchants in L.A. Preparing for Possible Riot Repeat
Bill Lagattuta Los Angeles 2:30
23 Senate Republicans Threaten to Block Clinton Job Plan
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24 Clinton Starts Pitching $700 Million Plan to Aid Russia
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25 Mafia Members Testify in Congress on Ties to Pro Boxing
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26 Brandon Lee Death Caused by .44 Caliber Bullet from Blanks Gun
Connie Chung New York 0:15
27 N. Korea Ignores U.N. Deadline to Comply with Inspection
James Hattori Tumen, N. Korea 2:25
28 As Forest Summit Approaches, Loggers Deal with Alienation
John Blackstone Oregon 3:25

NBC Nightly News

29 FCC Orders Rate Cuts by Cable TV Companies
Irving R. Levine Washington 2:00
30 Clinton Says Aid to Russians is in America's Self Interest
Andrea Mitchell Washington 2:05
31 Massive Restructuring Required to Help Russia's Economy
Jim Maceda Moscow 2:00
32 Free Child Immunization Program in Conn. Still Misses 40%
Bob Kur New Haven, Conn. 2:45
33 Reno Proposes Legislation to Safeguard Abortion Clinics
Tom Brokaw New York 0:15
34 European Study Finds AIDS Drug AZT Does Not Prolong Life
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35 Government Reports Smoking on Rise After 25 Year Decline
Tom Brokaw New York 0:15
36 Stray Bullet Kills 13-Year-Old Atlanta Girl
Mary Alice Williams Atlanta 1:55
37 Four Members of Terrorist Group Abu Nidal Arrested
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38 Italians Fed Up with Gov't Corruption; Arrests to be Made
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No Reporter New York 4:30

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COMMENTS:

L.A. Times; 4-5-93 p. 1

Shape of New Health Plan Is Emerging

By EDWIN CHEN
TIMES STAFF WRITER

WASHINGTON—Shortly after President Clinton named her to lead the drive on health care reform, First Lady Hillary Rodham Clinton described the herculean task as a "march toward facing reality."

This month, she and the President hit the painful homestretch.

Working day and night since Jan. 25, more than 500 analysts have assembled an exhaustive array of options.

Now it's time for the President and Hillary Clinton to begin trimming from that wish list, making the first of perhaps hundreds of decisions that will enable planners to put the finishing touches on a proposal expected to be as far-reaching as the Social Security Act of the Franklin D. Roosevelt era.

"It's time to get serious, get down to brass tacks," said one White House official.

Some fundamental choices have not been made, and many key details will be left to the administrative rules-making process later, sources say.

"There's still a tremendous amount of uncertainties, many different alternatives, many different points of view," said Princeton University sociologist Paul Starr, a senior analyst with the White House Task Force on National Health Care Reform, chaired by the First Lady. "Things are far from being settled."

Still, the broad outlines of the reform plan are emerging, making it possible to describe in general terms the kind of health care landscape Americans will encounter in years to come.

For many, the contrast will be startling.

At a fundamental level, the Clinton reform plan will create a new health care system and lay down a set of financial incentives aimed at steering people into health maintenance organizations, preferred provider organizations and other forms of provider networks designed hold down costs.

While many such networks already exist, especially in California, most Americans are not familiar with how they operate.

Under them, consumers, rather than going to doctors on a fee-for-service basis, have a lower-cost alternative of visiting primary-care physicians who are members of the network. These general practitioners will also serve as "gatekeepers" whose authorization must be obtained before patients go to more expensive specialists.

The key to making this concept work nationally is the creation of government-certified regional health insurance purchasing cooperatives. Most Americans would be grouped into the large cooperatives, with consumers able to choose from a variety of insurance networks—ranging from HMOs to traditional fee-for-service plans that allow the patient to choose any physician.

All the networks would have to provide a basic benefits package now being designed by the White House. Consumers who opt for the more generous plans, such as fee-for-service, will probably pay significantly more to get it, and employers are unlikely to make up the difference, as many do now.

The idea is to create cooperatives that will represent consumers in bargaining with health networks "to make sure they get the best choices and the best deals," Starr said.

In creating the cooperatives, the Administration intends to allow Americans to continue to use their current doctor after the physician moves into a new provider network, says Ira Magaziner, the task force's day-to-day manager. Others may select new doctors and hospitals in the networks.

Further details of how such cooperatives will work—especially in rural areas—are being developed behind closed doors in a "war room" at the Old Executive Office Building adjacent to the White House, where schedules are so busy that meetings have been known to start at 10 p.m.—even on weekends.

But other elements of the plan are known. Within the federal system, states will be given considerable latitude. In small states and rural states, where size rules out the existence of more than one provider network, states may be empowered to set statewide rates in an arrangement known as a single-payer system.

"This is not going to be as monolithic as people think," said Sen. John D. (Jay) Rockefeller IV (D-W.Va.), a key White House confidante. "There's going to be great flexibility and autonomy at the state and local levels," said Sen. Harris Wofford (D-Pa.), another key congressional voice on health policy.

Barring unexpected hitches, the Clinton plan also will:

- Guarantee that a uniform package of basic benefits will be available to everyone, although not all the uninsured will get this coverage right away. Among the basic benefits would be hospital and doctor services, including mental health care, and some prescription drug coverage.
- Create a standardized insurance form and bar insurers from refusing to cover people with pre-existing medical conditions, in order to enable people to change jobs—and insurers—without fear of losing coverage.
- Enact tort reforms to reduce medical malpractice litigation.
- Impose a price freeze on private-sector medical providers while the system of cooperatives is phased in, a process that could take three to five years.
- Phase in a requirement for employers to provide workers with health insurance, with government subsidies to help small businesses.

Companies could operate their own health insurance programs, provided they offer the basic benefits package, Magaziner has said. Workers could choose their company plan or select a competing health network from those offered by the local purchasing cooperatives, and their company would pay most of the costs.

- Provide for long-term care, with phased-in coverage starting with less expensive forms of home care.
- Incorporate worker's compensation programs into the new health care system.

Senior health policy analysts have spent more than 20 hours briefing the President on these and other details.

But he put off making key decisions during Hillary Clinton's absence from Washington. The First Lady flew back to the capital on Sunday, ending a 16-day vigil at the bedside of her father, Hugh Rodham, 82, who had a massive stroke and is in critical condition in a Little Rock, Ark., hospital.

Because of Hillary Clinton's prolonged absence, Administration officials concede, the President's self-imposed May 3 deadline for introducing his health care reform agenda is likely to slip.

Also unclear is to what extent the President's legislative proposals will contain key details. Debate is raging within the task force over which elements should be omitted and left instead to the administrative rule-making process once legislation is approved.

"Things are far, far from being settled," Starr said.

For instance, the Clinton proposal will stipulate coverage for prescription drugs, but it may not address generic drugs, which are cheaper than brand-name products, leaving the issue for a new national health care board that Clinton has said he wants to create.

Clinton's proposals may also require mental health coverage but leave it to the board set the level of benefits. Also undecided are the makeup, tenure and precise duties of such a health care "supreme court," including its authority to set and enforce national medical-spending budgets.

The biggest decision facing the President and Hillary Clinton is how to pay for the reforms. Administration analysts say it will cost $30 billion to $90 billion to provide insurance coverage to the 37 million uninsured Americans.

And the faster the Clintons want to achieve universal coverage, the more money the plan will require in the beginning.

Task force planners will present 20 financing options to the President and First Lady. Among them are an assortment of tax increases, including levies on alcohol, tobacco and guns; on hospitals and other medical providers, and on employer-provided health benefits that exceed those in the government-designed basic package.

Health benefits are now entirely tax-exempt. Task force members are also debating a value-added tax.

Complicating the task for the Clintons and their legions of analysts is the extraordinary degree to which even a small change in one element of the plan can skew every other element. "It's a complicated series of tough decisions," said Health and Human Services Secretary Donna Shalala.

Each decision will have financial implications that may require a complete recalculation of the overall plan. "Every small change will have ripple effects across the board," said a White House official.

"The devil's in the details, and we struggle with those details," Starr said.

For example, it's one thing to dictate universal coverage, but what benefits will be in a basic insurance package that will be available to all? How quickly can universal coverage be phased in? Which groups will be brought in first—poor women and children, or uninsured middle-class workers?

The Administration also wants to broaden the role of primary-care physicians, nurses and physician-assistants, especially by diminishing the role of high-priced specialists. But no specific incentives have been decided on to achieve that.

And to try to ensure that the quality of medicine does not suffer, the Administration intends to draw up guidelines to help doctors and patients make better informed decisions about treatment alternatives. But just how to gather, judge and disseminate data on medical matters needs to be worked out.

Also facing the President and Hillary Clinton are such weighty decisions as how quickly to phase out Medicaid and enroll its beneficiaries into the large consumer purchasing cooperatives.

Balt. Sun; 4-3-93

HEALTH COMMISSION FLOODED WITH MAIL

75,000 people write first lady telling of woes

By John Fairhall
Washington Bureau

WASHINGTON — The only thing more amazing than giving birth to her daughter in a hospital lobby was the bill Janis Moss Light received afterward.

The hospital not only charged the 36-year-old Frederick woman for a fetal heart monitor and an IV that weren't used during the birth, but also tacked on a surcharge of about $300 for delivering Hannah in the lobby on New Year's Day.

"A surcharge for delivering in the lobby?!?" Mrs. Light wrote in a letter to first lady Hillary Rodham Clinton on Feb. 2. "You would think that the fee would be reduced given that I so magnanimously gave up a private room."

Mrs. Light isn't the only one writing to the White House to detail her frustration with the country's health care system. More than 75,000 letters have poured into Mrs. Clinton or the task force on health care reform that she is heading.

Some letters are intensely personal and painful to read, baring the agony and frightening cost of caring for very ill or injured relatives. Others, like the one written by Mrs. Light, mask their anger with humor.

They are a vivid reminder of the high expectations that people have as they wait for the Clinton administration to complete its health reform package.

The task force originally hoped to be finished with the plan by May 1. But completion has been delayed by at least a few weeks partly because of the absence of Mrs. Clinton, who has been with her gravely ill father in Arkansas.

Many of the letter writers are undoubtedly sympathetic to Mrs. Clinton's plight.

Brenda L. Robinson, who lives in Calvert County, sent in 24 pages to the White House, documenting the severe maladies afflicting her son, Ricky, now 2 years old. He has had stomach surgery, repeated infections and has spent at least 14 months in hospitals. And the bills have exceeded the lifetime, $1 million limit on the family's insurance plan.

How will they pay future bills? They don't qualify for Medicaid, the medical program for the poor, and have rejected well-wishers' advice that they "become destitute" to be eligible.

WILLIAM O. HOTZ SR./STAFF PHOTO

Janis Moss Light of Frederick wrote to the panel that she was billed a surcharge for having her baby in the hospital lobby.

"We appeal for ourselves personally," she wrote to the president and Mrs. Clinton, "and for each and every citizen of the United States, for you to do something about our current health care system: to help those who desperately need assistance and cannot afford it."

The letters are read and responded to by a team of 20 White House volunteers. But some have more impact than others, as Jennifer L. Arnold, 33, of Bowie, discovered when she wrote to Mrs. Clinton to complain about her family's inadequate health insurance.

With three young children, and her husband, a truck driver, providing the only income, the Arnold family can barely afford to pay the out-of-pocket expenses required by his insurance policy.

"The health insurance we receive through the company he works for is ridiculous," she complained in a neatly handwritten, four-page letter dated Feb. 15. "We must meet a yearly $750 deductible *per person* before we receive any benefits."

To Mrs. Arnold's surprise, the task force invited her to a meeting. For two hours on March 25, the 33-year-old housewife and nine other ordinary people griped about the health care system while 10 members of the task force staff listened.

The staff tested attitudes about higher taxes to pay for the cost of covering 35 million uninsured Americans. One letter writer who attended, a salesman from Montgomery County, recalled being asked: "Would we be willing to pay an extra eight to 10 percent in federal income taxes in order for everyone to have a basic health-care package?"

The salesman's answer: an unqualified no.

They were also asked what they thought of Oregon's health reform plan, which will expand the Medicaid program to cover many insured people but eliminate payment for some kinds of costly care, a form of rationing.

What the administration plans to do remains to be seen. Staff members gave no clue in their meeting with the citizens, according to Mrs. Arnold.

But she and others who took the time to write clearly expect action. Many noted in their letters that they had never written any government office before.

A woman from Crofton wrote of the absurdity of an insurance plan that will pay a fortune to hospitalize her husband, who had a heart transplant in 1988, but not for a nurse to come by the house and help keep him well enough to avoid the hospital.

"This was ludicrous, but it was the rules," she said. "I understand the need for rules limiting certain services, but if there had been a process to look at certain cases to justify bending the rules, a lot of money could be saved and used in other ways."

Aimee Y. Cooksey, 64, of Forestville in Prince George's County, began her letter simply, "Dear Hillary." She described two common problems, the high cost of many prescription drugs and the difficulty unemployed people have obtaining affordable insurance.

"My husband is 65 years old and retired," she wrote. "He has Medicare but without a prescription card. Each month we pay out of pocket for his non-generic prescriptions an amount of $312. He has Parkinson's Disease and needs these four kinds of medications for the rest of his life."

They also pay $300 a month for her insurance, which is a continuation of the policy her husband had until he retired nearly a year ago. But the policy will increase to $700 beginning in June. Should she drop her coverage and gamble that nothing will happen until next year, when she turns 65 and is eligible for Medicare?

HEALTH CARE REFORM

Reno Gazette-Jrnl.; 3-27-93

Shalala: System urgently needs change

■ Advocates concerned: Some fear less aid for special groups.

WASHINGTON (AP) — Health and Human Services Secretary Donna E. Shalala said Friday Americans have no choice but to reform the entire health care system because "we're killing our children."

"We're talking about what it means to be an American," she told a health-care forum that spotlighted an issue President Clinton has placed near the top of his agenda.

"We actually don't have a choice," she said after participants in the meeting outlined shortcomings of the current system, including a relatively poor infant mortality rate and endemic health problems in the inner cities.

"We're destroying our economy, but we're also killing our children," said Shalala, who attended the session along with Tipper Gore, wife of the vice president.

■ Urging action: Dr. Steven A. Schroeder, president of the Robert Wood Johnson Foundation, sponsor of the forum, said black men in Harlem have a lower life expectancy than men in impoverished Bangladesh.

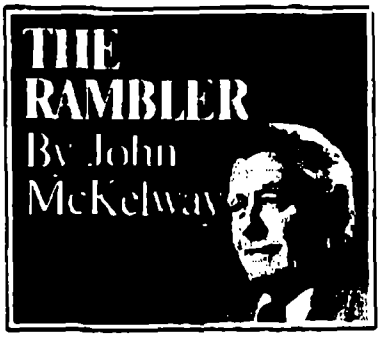
Also addressing the group were a quadriplegic woman who fears health reform might lead to diminished services for the disabled and a small businessman who said a New York law designed to make health insurance more affordable has backfired.

■ Clinton gone: Hillary Rodham Clinton, who heads the administration health care reform task force, remained in Little Rock, Ark., this week because of the serious illness of her father.

The task force will hold a marathon hearing Monday to hear from a parade of consumer, health and business groups. Each witness will have three minutes to speak.

Wash. Times; 4-3-93

Better health care in formless reform



Dear Hillary's Health Care Task Force:

You know, I've been wondering what you all were doing about the health care and all that and got to thinking I have some suggestions.

One reason a lot of people don't have any care whatsoever is that they don't like to go see doctors and go through a lot of stuff before they actually do see the doctor.

For one thing, I mean, you almost always have to fill out a form.

These forms are pretty much all the same. They ask for the same stuff over and over.

Like maybe, you know, you put your name down with your address and where you were born and your mother's name and where she came from and then a bit further down and below all the above you are asked, "Name of patient."

Then it is all the same stuff all over again and finally you are asked to sign in several different places even when you have come to see the doctor because you can't seem to make your right arm, below the elbow, move either to the right or left.

So you sign with your left and then the insurance company refuses to pay the bill because it can't read the signature of the patient or who it was that said it would be all right for your medical records to be released to the wind — or someplace.

I think it would be a good idea if the task force came up with a rubber stamp that people could wear around their necks.

It would have your name and address and social security number and all the telephone numbers Miss Hillary might think you would need if you had to see a doctor.

I mean, you know, I wouldn't mind going to see the doctor if all I had to do was to stamp some piece of paper one of his nurses shoved at me.

I think with a rubber stamp you wouldn't be asked a lot of silly questions.

I remember I went to see a dentist once to get four teeth pulled so I could get some radiation from a doctor who had a big machine someplace else, and I was filling out this long form from the dentist and I came to the question, "Do you use more than one pillow?"

I almost walked out on the dentist and the radiation man and all the insurance companies when I saw that one. But they caught me and I never did get the time to ask somebody why I had to tell the dentist about the pillows because I was filling out a form.

Anyway, if we could just stamp a short form with the rubber stamp, we could save a lot of the money it takes to buy all the paper it now takes just to give you something to do while you are waiting to see the doctor.

But I'm ready to go you one better. Why not, when you are just born and there in the hospital doesn't a government tattoo artist come around and give you a Social Security number on your bottom.

Hope I've helped you all out a little bit.

N.Y. Times; 4-4-93 p. 1

Florida Blazes Trail to a New Health-Care System

By LARRY ROHTER
Special to The New York Times

TALLAHASSEE, Fla., April 3 — The Florida Legislature approved a sweeping overhaul of the state's overburdened health-care system early today, making Florida the first state in the nation to combine free market competition and government regulation in a way similar to the Clinton Administration's plans for controlling soaring medical costs.

Overcoming obstacles posed by lobbyists who sought to gut the proposal with hundreds of amendments, Gov. Lawton Chiles, the author of the plan, won bipartisan support for his package after three days of marathon deliberations in the State Capitol and threats to call lawmakers back for a special session if the plan was voted down. The difficulties the Governor faced provide a glimpse into the resistance that President Clinton is likely to confront in his roform efforts.

Mr. Chiles said he hoped that Florida's embrace of a system of managed competition, in which large numbers of people and businesses buy health care from organized networks of doctors and hospitals, would be a model for other states as well as Washington. "We would like to be able to chart the way for the Federal Government," he said.

Biggest State Experiment

Other states have taken steps toward broad changes in their health-care systems, including Hawaii, Oregon, Vermont and Minnesota. But Florida's plan, combining coverage of all residents with a far-reaching effort to control health costs, is taking place on a larger scale than anything seen elsewhere.

In part, Florida's lawmakers were pushed to act by the soaring health care spending, which rose to $38 billion last year from $9.4 billion in 1980. Another factor was the size and composition of the state's population. Florida's 13.5 million residents include the highest proportion of elderly people in the country, as well as large numbers of immigrants and rural and urban poor. In addition, businesses with 50 or fewer employees, the companies most affected by rising health-care costs, account for 95 percent of all jobs in the state.

As a phalanx of lobbyists representing hospitals, insurance companies, doctors, drug manufacturers, pharmacists, malpractice lawyers, laboratories and other interests watched from the Capitol rotunda here, both houses of the state legislature authorized the cre-

Continued on Page 26, Column 3

From The Boston Globe page 1

Clinton aide eases stigma of mental health care

By Elizabeth Neuffer
GLOBE STAFF

WASHINGTON – Today, Robert O. Boorstin looks out of his office at a view all Washington power-mongers covet: the gleaming West Wing of the White House.

Five years ago, Boorstin, now 33 and one of the point men for the administration's health care task force, stood in a room with a very different view: He was an uninsured patient at Belmont's McLean Hospital for the mentally ill.

It was April 1988. Michael S. Dukakis had just won the New York Democratic presidential primary, and Boorstin – a top campaign aide who was a diagnosed manic-depressive – unexpectedly had a second manic episode. Not only did he suffer the indignity of being arrested by hotel security while hallucinating, but Boorstin's insurance company refused to pay his way to McLean, saying his mental health benefits had been exhausted.

"The insurance company turned me down, and I almost overnight became a crusader and advocate for people with mental illness," said Boorstin, whose twin brother, Louis, had to put up $18,000 before McLean's would admit him. "Health care is the most personal political issue."

As the White House's Task Force on National Health Care Reform races to overhaul health care, stories like Boorstin's bespeak the personal touches the Clinton administration is bringing to that effort.

Vice President Al Gore brings the tragedy of his son's near-fatal injury. Hillary Rodham Clinton has the heartache of her ill father. And Boorstin, a member of the task force's mental health working group, brings the perspective of being manic-depressive, a condition that affects millions of Americans.

"Hopefully, what I represent is that the treatment of mental illness is not only cost-effective, but also can make people who would have once been thrown away by society into productive and useful members," said Boorstin, who speaks about his illness with the blessing of the Clinton administration in the hope that he can remove some of the stigma that surrounds mental health problems.

He added, musing, "I used to wonder if I was going to spend the rest of my life going in and out of the mental hospital. . . . Now, I wander in and out of the White House."

For Boorstin and others, the difference between then and now, between "sanity" and "insanity," lies in a fairly recent scientific revolution: the discovery that many mental health problems are prompted by a chemical imbalance in the brain, and that treatments exist for mental illnesses that are as effective as those for physical illnesses.

According to a National Institute of Mental Health study released last week, 80 percent of all manic-depressives improve with treatment.

Not surprisingly, given Boorstin's own experience, the Clinton health plan is likely to reflect that perspective. Mental health benefits covered in the health plan are expected to focus on helping the mentally ill be independent through drugs and therapy, rather than the more costly alternative of institutionalization.

"The hospitalization in McLean cost $14,000 for three weeks," said Boorstin, using his own case as an example. He estimates that the cost of those three weeks is roughly equal to what he has spent in the last 4½ years in drug and outpatient therapy.

Insurance companies also offer far less coverage for mental illness than physical illness. When Boorstin found that his insurance carrier, New York Life, refused to pay for his stay at McLean, he sued. The fight took four years, and they settled. But now, he adds, "they cover my mental illness as they would cardiac illness."

Boorstin devoted the next three years to working for a national group on behalf of manic-depressives.

He has not had a manic-depressive episode since April 1988, when he was placed on a combination of mood-stabilizing drugs and therapy. But he remains watchful for a recurrence, and his staff is on the alert for warning signs. His pill box, filled with the mood-stabilizing drugs, including lithium, that he must take, is never far from hand.

The White House doesn't worry about Boorstin. His condition has long been known to the president and Mrs. Clinton. Boorstin joined the Clinton campaign as a member of its communications staff before the New Hampshire primary.

"We see his condition as what it is, a condition that is eminently treatable," said White House spokesman George Stephanopoulos, a close friend from the Dukakis campaign, who watched Boorstin go through his second breakdown. "It isn't something that precludes people from doing good work."

In fact, Boorstin has a resume many Democrats would covet. As a child, he bicycled around Beverly Hills, handing out McGovern for president leaflets. He graduated magna cum laude, and made Phi Beta Kappa, at Harvard University in 1981. He was editor

him a political boost in Moscow, elevating him from a streetfighter struggling for advantage with such figures as Vice President Aleksandr Rutskoi and parliament Speaker Ruslan Khasbulatov to an international diplomat who dines as an equal with the American president at the Seasons in the Park restaurant.

Mulroney, himself making his valedictory on the world stage by playing host to the summit, sought to press home that idea, pointedly arguing that the "summit ought to send the Russian people a message of confidence."

Though American politicians, and even former President Richard M. Nixon, have argued for a major US commitment to Russia and, in turn, to the survival of Yeltsin, the American public is deeply suspicious. A New York Times/CBS News Poll taken last week showed that, by a 2-1 ratio, Americans oppose providing economic aid to help Yeltsin remain in power.

But Clinton feels he has little choice right now, and yesterday he committed the United States to aiding the "long-term process of development in Russia." He finds Yeltsin's belief that "the communists want to take revenge, to take Russia back" to the Soviet past a frightful thought, considering the 20,000 strategic and tactical nuclear weapons still on Russian soil. In fact, the president called the summit meeting "an historic chance to improve our own security."

Not incidentally, the success of Clinton's economic plan depends in part on cutting Pentagon costs, and so he has to blunt the possibility of the emergence of a threatening regime in the old Soviet Union. He and his advisers calculate that Yeltsin is his last, best hope.

"It's a question," says Lawrence Goldman, an Oxford University historian who specializes in American affairs, "of 'holding onto nurse' for fear of what is worse."

e Harvard Crimson, then went to Kings College, mbridge University, and landed a job as a porter at The New York Times in 1985.

To friends and colleagues there, he never seemed a likely candidate for depression. Energetic and humorous, the curly-haired Boorstin seemed to bounce through the Times newsroom, like a high-powered cherub.

Few knew that Boorstin had days when his depression was so overwhelming it was all he could do to write a single word.

"I had long bouts of crying, feelings of worthlessness and hopelessness," Boorstin said in an interview last week. "There were days that I couldn't get out of bed to go to work, and other days when I would show up early at work and be able to write three stories a day."

Then, on a July day in 1987, Boorstin came to Washington as a Times reporter. He left a few days later in the throes of a severe breakdown.

"I had what is known as a messianic vision. I thought I was the son of Christ. . . . I called my parents, who flew down to Washington. On the steps of the Jefferson Memorial, I told them how the world was shaping up, what would happen in the history of the world, and how I would fit into it," Boorstin recalls. Such episodes are typical of manic-depressives when they are not on proper treatment, Boorstin said.

A few days later, in a green-walled room at New York City's Payne Whitney Hospital, Boorstin found the answer to the years of dark depression that dogged him: He was a manic-depressive, prone to suffering emotional highs and lows that, if not treated properly, can lead to hallucinations.

"The first thing I said, was: Do I ever get out of here?" said Boorstin.

"I was terrified, but relieved. Terrified, because I had a mental illness, but extremely relieved, because I had been driving my family up the wall for five years, crying uncontrollably, thinking about killing myself . . . finally there was an explanation for it."

Now, the nation's mental health community is looking to Boorstin to help roll back years of discrimination against the mentally ill, both by example and through policy.

The last Washingtonian to have his mental health aired in public was Thomas S. Eagleton, who was forced to withdraw as a vice presidential candidate in 1972 as a result of having shock treatment for depression.

During the Clinton campaign, Boorstin stunned longtime friends by openly telling the national press of his manic-depression. He was recently on a national radio show, discussing how he schedules naps into his day, so as to better regulate his illness.

On Friday, Boorstin spoke in a room packed with health and consumer advocates in detail about his experience with mental illness.

Such openness has its repercussions. The FBI, checking Boorstin for his White House security clearance, recently called Dr. Jerome Rogoff, Boorstin's former therapist in Massachusetts.

"They asked: Is he going to do something outlandish?" Rogoff said in a telephone interview. "I told them, as long as he takes his medication faithfully, he is perfectly trustworthy. He's brilliant, hard-working, dedicated and extraordinarily creative."

Now that Boorstin is working for the Clinton White House, he hopes to make a difference, for the administration and for manic-depressives.

"I once tried to jump out of a window," Boorstin recalled. "But luckily for me – and perhaps unluckily for the Republicans – the windows in mental hospitals don't open more than 3 inches."

Looking at a reporter's bemused glance, he added, "And my current office is on the first floor."

From The Boston Globe page 2

Senate liberals take lead in pushing jobs stimulus bill

By John Aloysius Farrell
GLOBE STAFF

WASHINGTON – An old voice roared anew on the Senate floor last week, back from exile after 12 years of Republican rule: the voice of the unrepentant liberal.

As President Clinton's $16.3 billion jobs bill came under fierce attacks from Republicans and some conservative Democrats, it was the Senate's liberals – especially the Senate's five female Democrats – who went to war for Clinton. "What is wrong with bike paths and swimming pools?" asked Sen. Patty Murray, a freshman Democrat from Washington, when Republicans complained that the bill would fund "pork barrel" projects at a time of fiscal crisis.

"We are not talking about private golf courses and private swimming pools – those will be there next summer for those who can afford to use them," Murray said. "We are talking about municipal swimming pools and bike paths for kids who cannot afford any other kind of activity.

"This will provide something for them to do so they aren't breaking into your car and your house in the next several years," Murray said, acerbically addressing the "captains of industry" in the ranks of her opponents.

"Pure pork, and metric tons of it," griped Sen. Alan Simpson, the Republican whip from Wyoming. "This is the same old crap right back through FDR."

Conservatives like Simpson are trying to gut the $16 billion bill, to be financed by government borrowing.

Clinton hopes the stimulus bill will give an immediate boost to the economy, enabling it to survive the depressionary effects of the big tax hikes that Congress will pass to reduce the deficit.

But the bill also was designed to win over the liberal wing of the party. In contrast to Jimmy Carter, who started in Washington by promoting moderate policies that alienated Democratic liberals, Clinton has begun with an agenda that delights the left. It includes progressive tax increases, liberal positions on gay rights and abortion, deeper cuts in defense funds and new domestic spending.

While compromises with conservative Democrats like Sen. Sam Nunn of Georgia are likely in the coming months to move Clinton back to the center of American politics, items like the stimulus bill secure the president's base among the party's liberal activists.

Bound by party loyalty, only a half-dozen Democratic senators strayed from the pack last week. One who did – Sen. Robert Kerrey of Nebraska – offered a warning that Democratic victory in the 1992 elections was owed to voters who believed Clinton was, as he said, a "different kind of Democrat."

"The old ways of helping will no longer work," Kerry warned. "We have erected a complicated and porous safety net that has institutionalized poverty."

Sen. Robert Byrd, a Democrat from West Virginia and floor manager of the legislation, relied on the Senate's most liberal Democrats to take on the GOP in the oratorical exchanges.

And as a sign of the changes occurring in Congress, the key voices included the five Democratic women: Sens. Barbara Mikulski of Maryland, Dianne Feinstein and Barbara Boxer of California; Carol Moseley Braun of Illinois and Murray.

"If there was ever a need for an injection of public moneys into a local jurisdiction, it is in South Central Los Angeles," said Feinstein, defending a $7 million proposal for a swimming pool and recreation center for the riot-torn area. Feinstein said she was "incensed" that her Republican opponents called such projects a sop to "special interests."

"No tobacco company has called me. No big oil company has called me," Feinstein said. "A lot of children that might have Head Start are for it . . . maybe some babies that want to be immunized; people out of work who like to be able to have their unemployment compensation extended.

"There are many worthwhile projects," said Feinstein. "They employ people. They build our community infrastructure. They do just the very thing that many of us believe that government should do."

When Murray took the floor, she proudly said that "the highest paying job I had before I came to Washington, D.C., paid $23,000 a year. I know what it's like to fear losing my job. I know what it's like to fear losing health care benefits. . . . I know what it's like to hope the bills come late because the money is not there to pay them."

The Wennberg insight into health care

COMMENTARY

BUCKLEY

From page E1

will stay just about the way they are."

Now the videotape (graphically titled "Choosing: Prostatectomy or Watchful Waiting") tells the patient all of this. Four out of five men prefer themselves to make the decision whether to proceed with an operation, but they wish to be informed. To the extent that exposure to the videotape causes one or 100 or 100,000 men not to have an operation they would otherwise meekly submit to, then that much money, that many resources, are unspent, available for other purposes.

Dr. Wennberg uses a nice metaphor. The doctor is standing alongside a conveyor belt that rolls past him carrying balls of three colors, black, white and gray. The black balls need hospital treatment — about them there is no ambiguity. They represent patients who have had a stroke, or a heart attack, or have been shot and wounded. The white balls definitely do not need hospital care: They have a common cold, or poison ivy, or whatever. The problematic balls are the gray ones. Some doctors would send these patients to the hospital; others would prescribe medicine and tell them to take treatment at home.

It is the purpose of the Wennberg Center to enlighten the judgment of those who decide. And it is critical to the understanding of his insight that the judgment is not exclusively medical. It is the judgment also of the patient, who himself needs to make the decision after scanning the evaluative material.

It is not an exaggeration to call the "outcomes movement" what Dr. Arnold Relman, then editor in chief of the New England Journal of Medicine, has termed it: the third revolution in health care — the dawn of a new "era of accountability in medicine."

As the country, with bated breath, awaits the word from Mount Hillary, the attention is drawn to medical insights, and the keenest detected from this lookout is that of Dr. John Wennberg. As so often happens in science, a tiny anomaly catapulted him into what seems most fearfully obvious, on reflection, but nobody got around to noticing it.

What triggered the Wennberg Insight was an anomaly he and an associate stumbled upon. In Morrisville, Vt., 65 percent of children routinely had their tonsils removed. In Middlebury, Vt., 7 percent of children had their tonsils removed.

Now if you stare at that disparity, you begin to wonder what is going on. One possibility is that the doctors in Middlebury aren't very good about treating children. Or if you begin at the other end, you toy with the possibility the doctors in Morrisville are throat-fetishists who sate themselves on children's tonsils. The orderly thing to do, obviously, is to inspect the population of the two towns and ascertain whether there is a marked difference in the health of young adults. Well, there isn't.

In Morrisville, Vt., 65 percent of children routinely had their tonsils removed. In Middlebury, Vt., 7 percent of children had their tonsils removed.

You are driven to explore yet another possibility, namely that the doctors in Morrisville are exploiters of ignorant parents, and regularly recommend tonsillectomies even though they know that they are in fact medically unnecessary. With extreme caution, you probe that possibility, and discover that that suspicion is ridiculous: The doctors in Morrisville are splendid, true-blue types.

What you are left with is a difference in a medical culture in two towns less than a couple of hours of driving distance apart. You then ask yourself: How is it possible that the medical community of Middlebury has failed to communicate to the medical community of Morrisville that it is perfectly safe to reduce the number of tonsillectomies by about 90 percent?

The scales fall from the eyes, and at this point Dr. Wennberg, professor of epidemiology at the Dartmouth Medical School, recognizes there is a sociology of medicine the development of which is of enormous practical importance, hence his founding of the Center for the Evaluative Clinical Sciences. A study of those optional medical procedures — which should be the objects of more critical scrutiny, both by doctors and by patients — could theoretically result in saving one-third or more of all health-care expenditures on medicine of dubious value.

Dr. Wennberg's center is engaged now in producing videotapes. It is only a beginning, but already one tape is available to men, usually in their 60s or 70s, who have to decide whether to have a prostatectomy.

"If given the choice," Dr. Wennberg tells you, "men like to make the decision whether to submit to surgery or whether not to do so. In the case of a prostatectomy, they need to weigh the 'offset.' A percentage of those who have the operation, although very small, will suffer incontinence; a few, impotence. Probably the operation means the loss of one month of a man's life. On the other hand, a very large percentage of those who have the operation experience the great relief of better urine control. A number of those who go to the urologist to complain about their condition are going to get worse in the years ahead. A small number are going to get better even if they reject treatment. And some

see BUCKLEY, *page E4*

William F. Buckley Jr. is president and editor at large of National Review and a nationally syndicated columnist.

The Wennberg insight into health care

Debilitating price controls

The White House is signaling that it wants to impose price controls on the health care industry, a move that threatens to undermine a system that, whatever its faults, remains the best in the world.

If the trial balloons about price controls being floated by Bill Clinton's advisers are true, and are implemented by Congress, then get ready for health care rationing and shortages — waiting periods for surgery, fewer rooms available, premature dismissals from hospitals and a lot worse.

White House adviser Ira Magaziner has drafted several options for Mr. Clinton to consider that would freeze prices charged by all hospitals, doctors, medical labs, equipment makers, nursing homes and health insurance companies. And both he and Vice President Al Gore, among others in the administration, have been sending signals through a variety of leaks and public statements that this is what the president is likely to propose.

The reason: The plan as presently devised would sharply escalate health care demands, as the uninsured are given access to health care benefits, without a corresponding expansion in health care supply. Mr. Magaziner has been telling groups that the reforms will not slow health care costs for several years and that price controls are the only answer.

If you think price controls can be slapped on the health care industry without lessening the supply and quality of the nation's health care, think again.

That's what the government thought when it tried price controls during the Nixon and Carter administrations, with disastrous economic results. That's also what happened when bureaucrats attempted to allocate gasoline supplies in the 1970s, producing long lines at the gas pump, regional and spot shortages, price gougers, and, eventually, worsening the price spiral.

Government price controls have never worked. Indeed, they have always made things worse, distorting markets, reducing incentives to expand supplies, and inevitably hurting businesses and consumers alike.

Yet White House insiders who are crafting the Clinton proposals, without any direct input from the medical industries that will be affected, have been unable to come up with a plan that does not place enormous inflationary pressures on the entire health care system.

Donald Lambro, chief political correspondent of The Washington Times, is a nationally syndicated columnist.

see **LAMBRO**, *page E4*

LAMBRO

From page E1

The debate over health care reform — if you can call what the secretive, closed door, White House task force is doing a debate — begins with the very questionable premise that America's health care system is a mess that can only be fixed by more government controls, regulations and taxes.

And that may be the fatal mistake in the administration's approach to the task of finding a way to provide medical insurance to those who do not have it.

The underacknowledged reality in all of this is that medical care in the United States has made extraordinary advances in virtually every area, saving more lives, extending longevity, and, yes, substantially cutting health care costs through new surgical procedures and miraculous drugs.

The cost-cutting technological advances in surgical procedures alone are awesome. For example, the development of laparoscopic surgery has dramatically cut hospital stays for gall bladder operations from up to eight days to one day, and recovery periods from up to six weeks to one week.

The result, says the U.S. Surgical Corp., has been to eliminate 3 million days of hospital stays, 2.5 million weeks of insurance reimbursements, while boosting productivity by 100 million hours. Similar benefits have been applied to numerous other operations. This is the way to reduce costs.

Meantime, the pharmaceutical industry has been under fire from Arkansas Sen. David Pryor and the Clintons for rising drug costs, and there are cases where prices have been raised too high.

But a revolution in new pharmaceuticals, which amount to about 7 percent of the nation's total health bill, has extended the lives of millions of people with heart conditions and other maladies who would be dead now or forced to undergo risky surgery were it not for new drugs that are on the market.

Rarely mentioned is the degree to which these new drugs have eliminated or reduced the need for hospitalization and thus have saved billions of dollars in added health care costs. One study of an anti-asthma drug found its use resulted in 96 percent fewer trips to emergency rooms and 62 percent fewer hospital admissions — saving about $3 billion a year.

We have developed the most modern medical system in the world, one that has made extraordinary technological advances in saving lives. Undoubtedly, there is much that still needs to be done to improve it.

But imposing top-to-bottom price controls on the health care industry is not the way to make it better. That, in the end, is going to drive the best and the brightest out of the business and destroy everything that is good about American medicine.

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ation of 11 Community Health Purchasing Alliances. As envisioned by Mr. Chiles, these new state-chartered regional cooperatives will help employers negotiate to obtain the best care at the cheapest price and decide what kind of care plans can be offered on the market.

As a result, 2.5 million uninsured residents in the nation's fourth-most populous state should be able to obtain what Mr. Chiles has described as "full access to quality, affordable health care." People already enrolled in health care plans will be able to remain with those programs, although some premiums are expected to rise initially. Eventually many insurers are expected to participate in the purchasing alliances.

"I don't think there will be immediate savings," Mr. Chiles, a Democrat, said shortly after the State Senate passed the package at 1 A.M. today. "But I do think there will be people getting health care who never had a chance to get it before, and there will be small businesses that will be able to cover their people that they were not able to cover before."

Mr. Chiles said that although health care costs would not immediately drop, "I don't think we will see the 15 to 20 percent increase in premiums that we have seen every year for the last five years." He added, "We have got to stop the spiraling increases, and then we'll talk about savings."

Questions Still Not Answered

Many practical questions remain unanswered. Because Florida's approach is untested, no one knows how much the system will cost or save. Nor is it clear what the minimum benefits will include and what sort of treatment guidelines will be applied to doctors who choose to take part in the system.

"This is an experiment," said Doug Cook, director of the state's Agency for Health Care Administration and Mr. Chiles's chief adviser on health issues. "We're going to have to see how it works as we go along. This is the first shot across the bow, and there aren't any guarantees."

Mr. Cook acknowledged that the initial phase of the program will require additional investment by both the state and Federal Government to provide coverage to people now uninsured. He said he expected that Washington would agree to increase its aid.

But the bill's backers here, who included both conservative Republicans and liberal Democrats, argue that universal access to health care will eventually reduce costs. Through the large volume they are expected to generate, the 11 local health-care alliances would be able to obtain the best price for consumers, while insuring a steady flow of business to participating doctors.

One Stumbling Block

Mr. Chiles's package nearly foundered as a result of arguments over how much authority the purchasing alliances should be granted. On Thursday night, the Florida Senate voted down a plan that would have allowed the cooperatives to decide what type of health-care plans would be offered to employers, establishing that a minimum of three types of plans be made available.

Opponents of Mr. Chiles's plan objected both to the broad grants of power to the alliances and the Governor's insistence that he be allowed to appoint the majority of the 17 members of the boards supervising each cooperative. With so much government participation, "you are in fact creating a system that leads to socialized medicine," Alberto Gutman, a Miami Republican and chairman of the Senate Health Committee, said in an interview. "You are setting up a one-payer system that is like a utility, and I have never seen the price of a utility go down."

Doctors and their allies favored a much weaker form of organization, in which the purchasing alliances would serve primarily as information clearing houses for individual businesses looking for the coverage best suited to their needs. In the words of Dr. Mathis L. Becker, chairman of the Florida Medical Association's Council on Legislation, the cooperative should be "a place to come in and get a bunch of brochures."

But through old-fashioned negotiation and repeated reminders that the Federal Government might impose a top-down solution that did not take Florida's needs into account, Mr. Chiles was able to win over most of those who had opposed his plan. Of the 10 state senators who voted against the plan, several were liberal Democrats concerned the overhaul did not go far enough.

Mr. Chiles was willing to compromise, for instance, on the thorny issue of whether Medicaid recipients and state employees should automatically be enrolled in the purchasing alliances. State employees will be allowed to choose whether they want to join. And recipients of Medicaid, the joint state and Federal program for the poor and disabled, will be put into a separate pool so that, as Mr. Gutman put it, "the costs to non-Medicaid people do not increase."

Both Photos for The New York Times

The Florida Legislature approved a reform of the state's health-care system yesterday. Lobbyists worked the rotunda on Friday as the Senate debated the system at the Capitol in Tallahassee.

Balt. Sun; 4-3-93

Insurers profit as Medicare wrongly picks up bill, panel hear

By John B. O'Donnell
Washington Bureau

WASHINGTON — The federal government is losing as much as $500 million a year by paying thousands of medical bills for the elderly that private insurance companies should be paying, a Senate subcommittee was told yesterday.

And there is a backlog of more than $1 billion paid out by Medicare that the government should try to recover from the private insurers, witnesses said.

"We're not talking about chicken feed," Sen. William V. Roth Jr., a Delaware Republican, commented.

Sen. Joseph I. Lieberman, chairman of the Subcommittee on Regulation and Government Information of the Senate Governmental Affairs Committee, said, "There is no magic bullet" for eliminating erroneous payments, "but there is a serious problem."

For years, the Health Care Financing Administration, which administers Medicare, has been trying to come to grips with the problem.

The erroneous payments cover medical bills for people over 65 who are eligible for Medicare but also are covered by private insurance, generally through an employer for whom they or their spouses work. In such cases, the private insurer is supposed to pay the medical bills. In some of those cases, Medicare then pays for what the private insurer refuses to cover.

The Health Care Financing Administration, headquartered in Woodlawn, hires insurance companies to process its Medicare claims. In Maryland, Blue Cross/Blue Shield of Maryland, the state's largest health insurer, handles hospital bills for Medicare while Pennsylvania Blue Shield handles doctors' bills.

The erroneous payments are made when the insurance company handling Medicare claims does not know that an elderly patient has private insurance. Medicare relies on the patient and the hospital or doctor for that information, which often is not provided.

There is no incentive for an insurance company that processes Medicare claims to check its own records to see if a claimant is one of its subscribers, since that would mean that it has to foot the bill.

An official of the General Accounting Office, Leslie G. Aronovitz, said efforts to determine if claimants had private insurance "may be hampered by a conflict of interest on the part of contractors. In many instances, it is the private insurance business of the contractor that is the primary payer for claims" filed by Medicare recipients.

Carol J. Walton, director of the Health Care Financing Administration's Bureau of Program Operations, said her agency was authorized by Congress four years ago to obtain information from the Social Security Administration and the Internal Revenue Service on Medicare beneficiaries. Using that, it has been able to identify payments that insurance companies should have made. Since December, it has demanded reimbursement of $270 million from insurance companies for erroneous payments that date back as far as 10 years.

A lawyer for the Travelers companies, a private insurer that also does a substantial business as a Medica contractor, said his company recei ly received more than 2,000 "rei bursement demands."

One was for five claims totalin $104.28. The cost of processing t claim "will probably exceed the $1 that is demanded of us," Jam Michener said.

Senator Lieberman, a Connec cut Democrat, cited a New Yo State demonstration program as guide to developing a solution. Ne York developed a computer netwo that ties together the subscriber da bases of private insurers so that i formation on patients' insurance ca be checked at the time patients a filling out Medicare claim forms.

Linda Ryan, director of the pr gram, said the network had enabl New York to avoid the "very costl task of building its own data base.

Wash. Post; 4-5-93

A 'Living Example' for Health Care

Federal Employees Program Has Strong Advocates, Firm Critics

By Spencer Rich
Washington Post Staff Writer

While Congress and President Clinton search for a miracle cure to the nation's health care ills, some observers believe an over-the-counter remedy already exists: the Federal Employees Health Benefits Program (FEHBP), created in 1959.

The program is "a living example, in many ways, of the currently red-hot concept of 'managed competition,'" said James Morrison, who once headed the program.

Health planners "are out of their minds" if they don't put the program "high on their list of models to emulate," said Walton Francis, author of the Washington Consumers' Checkbook magazine's 1993 guide to FEHBP benefits.

Their enthusiasm stems from the fact that, over the past dozen years, the program's average premium cost per person apparently rose about 3.5 percentage points less per year than private-sector premiums for large firms.

But questions have been raised about how well FEHBP really controls cost growth and whether it is a sterling example of managed competition.

For one thing, said Rep. Jim Cooper (D-Tenn.), a key sponsor of managed competition legislation, it lacks some features that theorists of managed competition, such as Alain C. Enthoven, believe must be included. "The menu shopping system is an early and important version of managed competition," Cooper said, "but we need to improve it." Enthoven agreed: "It is not full, managed competition."

Advocates argue that the FEHBP avoids heavy federal regulation while holding down cost growth by forcing different insurers to compete for customers by providing the best service at the lowest premiums.

Its format, said the Heritage Foundation's Robert E. Moffitt, is designed to help consumers compare options and choose the best.

Every year the government lets each employee or retiree enroll in one of a dozen or more health plans, each with different benefits and premiums. Some are fee-for-service plans, such as Blue Cross's high- and standard-option policies; some are managed-care plans, such as the Kaiser-Permanente and Group Health Association HMOs.

The government pays an average of 72 percent of the premiums, although the figure differs from policy to policy. The enrollee pays the rest. Depending on the plan, a single person's out-of-pocket monthly premium in the District can be as low as $29.60 or as high as $179.51. Insurers compete to win sales by giving the best value for the money through holding down wasteful services.

But critics note that, although FEHBP premiums have risen less rapidly than in private-sector health plans, FEHBP average premiums per enrollee nonetheless have grown extremely quickly, rising at an average of 10.8 percent a year since 1980—compared with 14.4 percent for large-firm private-sector plans and 9.7 percent for Medicare, according to an analysis by the consulting firm Lewin-VHI.

That is much faster than Clinton considers acceptable.

Nevertheless, FEHBP admirers point out that it has many of the basic features of a competitive system. Said Blue Cross-Blue Shield Vice President Harry Cain: "The customers can and do focus very heavily on price."

Jeannette Williams, 73, of Bethesda, knows the FEHBP system well. A federal retiree, she is a volunteer counselor for the United Seniors Health Cooperative here, advising others on which plan to choose.

Every winter, Williams said, she looks at a menu of plans published by the Office of Personnel Managment (OPM) and chooses from one of 10 national plans and more than a dozen HMOs in this area that participate in the FEHBP system. Federal workers and retirees elsewhere in the country have similar options.

Using program brochures and published benefit guides, she can compare what she will get from each plan for the money she will pay. Although all offer basic benefits such as doctor and hospital care, some have better dental and mental health packages, co-payment requirements or other features.

Regardless of ill health, age or previous medical history, she knows that no plan may turn her down, throw her out or charge her more than a standard price, which is identical for anyone buying that specific policy from that insurer.

For example, the out-of-pocket premium for a single person who selects the Blue Cross standard option plan "is $45.41 a month, whether you live in New York or Boston or D.C. or Oshkosh," explained Curtis Smith, OPM's director of health and retirement benefits.

"Every year there's open season,"

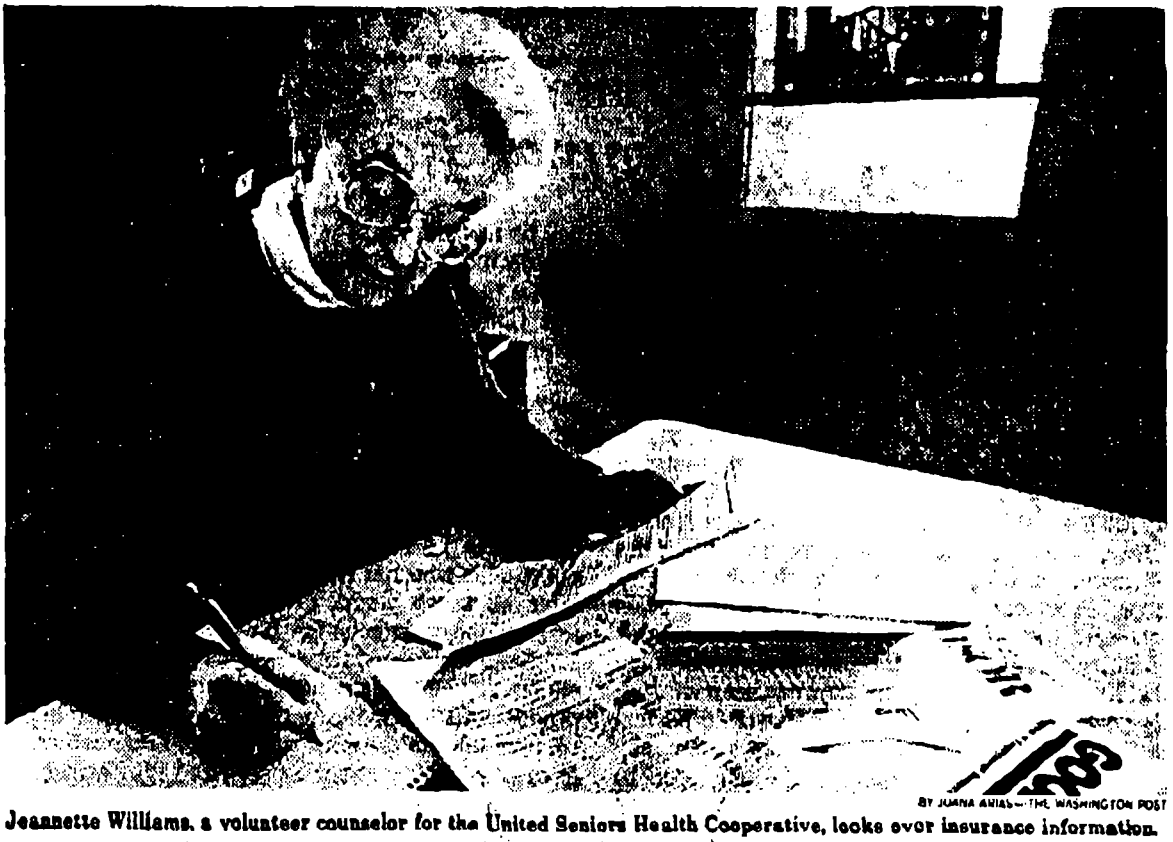
WHAT'S MISSING?

MANAGED COMPETITION FEATURES IN FEHBP

- Individual choice of many plans
- Plan must accept all applicants
- No exclusion for health status or pre-existing conditions
- Competition among plans based on price
- Right to switch plans
- All those in any one plan pay same rates

MANAGED COMPETITION FEATURES NOT IN FEHBP

- No standardized benefit packages
- No risk adjustment
- Employer subsidy or tax subsidy not limited to the price of lowest-cost standard package



BY JUANA ARIAS—THE WASHINGTON POST

Jeannette Williams, a volunteer counselor for the United Seniors Health Cooperative, looks over insurance information.

a time when enrollees can change policies, said Williams. This year she stayed with the Blue Cross standard option. Williams said she likes the "dental, prescription drugs and preventive checkups" in her Blue Cross plan. It is by far the most popular policy in the FEHBP, purchased by about 1.5 million of the 4 million current or retired federal workers nationwide who buy policies each year through FEHBP, Smith said. The 4 million policies cover 9 million people, including dependents.

James Firman, president of United Seniors Health Cooperative, said the ease of comparing features has been greatly exaggerated by advocates of the system. "Consumers are faced with an overwhelming array of choices. There are thousands of features to compare. It is impossible for the average person to make a truly informed choice. It would be much simpler if they had a relatively small number of standardized benefit packages that each company would provide. Then in comparing premiums you would be comparing apples and apples—not apples, oranges, kiwis and kumquats."

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Many experts agree that the FEHBP has many features that Enthoven and others say are essential to successful managed competition.

However, critics such as Dennis Snook of the Congressional Research Service said the FEHBP lacks some features that advocates of managed competition contend are crucial to fostering true competition.

A key missing element is a "risk adjustment" system: If some insurers have few high-risk enrollees and others have many, the government (or another sponsor of a similar "menu" system) should be able to shift some premium funds from the former to the latter to even out the unfair burden. Otherwise, insurers will seek to earn profits by "cherry-picking" the lowest-risk enrollees rather than by improving efficiency.

Also missing is a requirement that every insurer offer the same standard benefit packages so that enrollees can easily compare the premiums and benefits.

The FEHBP also lacks what Enthoven calls a key incentive for enrollees to shop for the best buy: a requirement that only the cost of the lowest-priced standard policy be subsidized by the employer.

If enrollees want a more costly standard plan or one with a wider package of basic benefits, they should pay extra, according to Enthoven. If employers pay all or nearly all of the premium for any policy, individuals are likely to shop carelessly or choose a policy with rich benefits and high premiums. That also would put less pressure on insurers to deliver the best service for the least money.

Far from including this essential feature in the FEHBP, the federal government's share of any premium is not limited to the cost of the lowest-priced standard package but is a percentage of the total premium. Federal employees can choose a more expensive plan, knowing they will not have to pay the entire extra cost. This undermines price competition, critics assert.

Moreover, FEHBP results over the past dozen years, as measured by the Congressional Research Service and Lewin-VHI, provide little evidence that this hybrid of managed competition can achieve the cost controls Clinton wants.

According to the research service, large-firm private-sector health premiums per employee rose at a 14.2 percent annual rate and FEHBP premiums at 10.8 percent from 1980 to 1992. A 10.8 percent growth rate far exceeds what Clinton and most economists deem acceptable.

But Edwin Hustead, former FEHBP chief actuary now with Hay-Huggins, a consulting firm, said the apparent lower FEHBP growth may be partly an illusion. In the early 1980s, the OPM forced plans in the FEHBP to cut benefits and reserve levels; as a result, in 1985-86 the plans substantially reduced premiums. But since 1986, private-sector and FEHBP premiums have risen at virtually the same annual rate: 14.5 percent and 14.3 percent.

Wash. Times; 4-3-93

GOP set on voice in health reform

By Lee Bowman
SCRIPPS HOWARD NEWS SERVICE

Congressional Republicans, largely excluded from the president's task force on health care, are preparing to have their say later this spring when President Clinton's plan reaches Capitol Hill.

They still hope the White House will turn to them for help in preparing the plan before its unveiling.

But if that doesn't occur, separate Republican task forces in the House and Senate are honing their own health reform plans to be ready roughly at the same time as the White House proposal.

"There are two things Republicans can do with health care — work towards a solution or hurl rocks at those who are seeking a solution. The Republicans we have worked with definitely want a solution," said Sen. John Chafee, Rhode Island Republican and leader of a GOP health care task force for the past three years.

The White House task force led by first lady Hillary Rodham Clinton has expanded to more than 500 advisers — including 139 aides to key congressional Democrats — since it was established in late January.

Although leaders of both parties have suggested that solving the health care problem should be a bipartisan effort, no Republican congressional staffer has been included on the working groups. GOP lawmakers and staff have met with Mrs. Clinton and task force experts on several occasions, however.

"They have treated us as more of an intake valve, just like other interest groups they've tried to stroke," said one senior Republican aide. "They would say they involved us, but mostly it's been an opportunity for us to spill our guts so they can figure out how to work some concerns in and pick a few of us off."

Democrats hold majorities in both houses of Congress, but Republicans believe they might be able to attract enough conservative Democrats to an alternate plan to at least bring the Clinton team to the bargaining table.

"No one seems to be considering the rank-and-file members who haven't really gotten focused on this yet. There's really a vacuum on this issue in the House on both sides, but especially among the Republicans," said one House Republican legislative assistant.

For instance, one Gallup poll of 150 new and veteran members of Congress conducted in December found more than a third of Democrats undecided on whether they support a national health budget or price controls on medicines.

"There's no way this can go through without Republican support, or stay passed without Republican support once the middle class sees what this might cost them in money or benefits," said a Senate aide.

Balt. Sun; 4-3-93

Morrison no longer interested in top Social Security job

By John Fairhall
Washington Bureau

WASHINGTON — James Morrison, the choice of Health and Human Services Secretary Donna E. Shalala to head the Social Security Administration in Woodlawn, has withdrawn from consideration, citing frustration with the lengthy White House personnel process.

The search for a commissioner now must begin again, said an HHS official who asked not to be identified.

Rep. Kweisi Mfume, a Democrat who represents the Woodlawn area, said he and other House members he would not identify are urging Ms. Shalala to consider Janice L. Warden, a deputy Social Security commissioner. He termed her a "rising star" at the agency and said it would be a "shame" if she weren't considered.

The Clinton administration has been slow to fill a number of top jobs in government, although the pace has been picking up. White House officials had no immediate comment on Mr. Morrison's case.

"Regrettably, I have concluded that the process required to reach a final decision for presidential nominations is simply too lengthy and too uncertain" for a "self-employed business person," Mr. Morrison said in a letter Tuesday to Ms. Shalala. "Therefore I respectfully request that you and President Clinton not consider me further for this position."

Mr. Morrison, 57, is a lobbyist for organizations such as the Blue Cross and Blue Shield Association. He disclosed the letter yesterday when contacted by a reporter, but would not comment.

Social Security employs 14,000 people at its Woodlawn and downtown Baltimore offices. The commissioner's job pays $115,700 a year and is being filled on an acting basis by Louis D. Enoff, principal deputy commissioner.

Mr. Morrison, a Democrat, was associate director of the federal Office of Personnel Management during the Reagan administration. He worked at the Office of Management and Budget under President Carter.

Wash. Post; 4-3-93

AMA Urges U.S. Marketing of RU-486

Reuter

The American Medical Association yesterday joined feminists and other doctors' groups to urge the European maker of RU-486, the so-called abortion pill, to start the process that would put it on the U.S. market.

Noting that RU-486 may have other medical uses besides abortion—including possible treatment for breast cancer, gynecological cancers and a hormone disorder called Cushing's Syndrome—the group said the French pharmaceutical house Roussel-Uclaf and its German parent Hoechst AG should make the drug available in the United States.

"We call on the manufacturer of RU-486 to take the steps necessary to have the drug formally presented to the [Food and Drug Administration] for investigative and research purposes in this country so that any possibility that political considerations can limit the appropriate treatments available to our patients is eliminated," the AMA said in a statement.

The statement was part of a news conference that included participation by the American College of Obstetricians and Gynecologists, the National Organization for Women, the National Abortion Rights Action League, the Feminist Majority Foundation and Physicians for RU-486.

Daniel Stone of Physicians for RU-486 said the FDA has invited Hoechst AG and Roussel-Uclaf to apply for "New Drug" status and has offered to expedite processing of the application, but the drug maker has not responded.

Rep. Ron Wyden (D-Ore.) said at the news conference that one way to prod the drug's manufacturer to import it would be to strip it of the U.S. patent on RU-486 if it does not take steps to make the drug available.

Wyden praised recent moves by Hoechst AG and Roussel-Uclaf and the FDA commissioner, David A. Kessler, but said that the patent investigation might be launched as a last resort to prevent any "backsliding."

"I want to see clinical trials in the next three to four months," Wyden said in a telephone interview. "I want to see a commitment to apply for a license, a commitment to market [the drug] in this country.

The threat of U.S. competition was also presented as a possibility, and the Feminist Majority Foundation noted the announcement in New York on Thursday that a New York state laboratory had developed an equivalent drug to RU-486.

RU-486 is an "antihormone" that blocks the action of the natural hormone progesterone, which in turn causes an embryo to become detached from the uterine wall.

AGENCE FRANCE PRESSE

NOW President Patricia Ireland speaks at news conference organized by Physicians for RU-486. Several groups want drug's maker to seek U.S. approval.

Wall St. Jrnl.; 4-5-93 p. 1

Cigarette Burn

Price Cut on Marlboro Upsets Rosy Notions About Tobacco Profits

Response by Philip Morris To Cheap Brands' Gains Spells Market Turmoil

The Stocks Take a Battering

By Eben Shapiro
Staff Reporter of The Wall Street Journal

NEW YORK – Tobacco Road is no longer paved with gold.

Philip Morris Cos., the powerful marketer that made Marlboro one of the richest and best-known brands on earth, has consistently underestimated smokers' desire for discount brands. Now, the company has set out on a painful and risky counter-strategy that is likely to trigger a price war and may permanently reduce the profitability of the world's most lucrative consumer market.

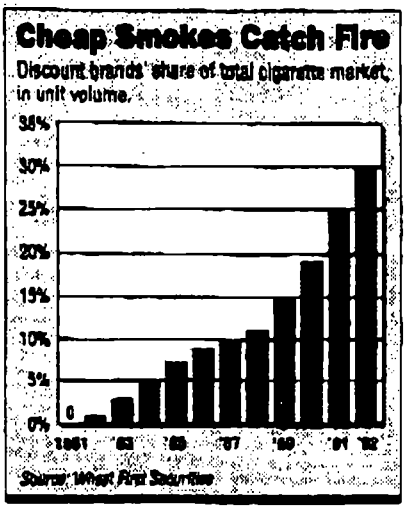
Philip Morris's Stock

Bargain hunters are tiptoeing toward Philip Morris stock but are waiting for it to stabilize following Friday's 23% plunge. Separately, antismoking advocates are targeting one of tobacco's last and highest-profile advertising venues: the huge billboards at baseball stadiums. Articles on pages C2 and B3.

Philip Morris said Friday it plans to cut the price of its premier Marlboro brand by as much as 20% and forgo any increases on other major brands – even as it intensifies efforts in the discount business. The move will cost the company billions of dollars in profit.

For Philip Morris, the belated bid is a capitulation to a new reality: Many smokers have moved beyond the brand-loyal days when they would rather fight than switch. After spending billions of dollars over decades to forge Marlboro in the mythic images of the Old West, Philip Morris now must shoot it out on price.

The effort will roil the rest of the tobacco industry, given the company's No. 1 role, with 42.3% of the $44 billion domestic tobacco market. RJR Nabisco Holdings Corp.'s No. 2-ranked tobacco business may have to match the price cuts for its own Winston, Salem and Camel brands.



Smaller rivals such as Brown & Williamson Tobacco Corp., a division of B.A.T Industries PLC, and Liggett Group Inc. could be even more harshly affected.

"The game is over," contends Gary D. Black of Sanford C. Bernstein & Co., one of the few Wall Street analysts who have been bearish on Philip Morris. "The No. 1 player is saying that prices were too high." With people kicking the habit, he warns: "The risk is that everybody is going to be throwing gobs of money at a shrinking base of smokers."

Changing Habits

For makers of consumer goods, the action is a milestone in marketing, the most dramatic evidence yet of a fundamental shift in consumer buying habits. More and more, shoppers are bypassing household names for the cheaper, no-name products one shelf over. "This shows that even the biggest and strongest brands in the world are vulnerable," says marketing consultant Jack Trout. "Marlboro Country can only come at a certain price."

Philip Morris says its counterattack will result in a 40% decline in pretax profit in its U.S. tobacco business this year – a drop of about $2 billion. That apparently marks the first decrease in U.S. tobacco profits in the company's history. The U.S. unit is the company's single largest profit contributor, providing a huge $5.2 billion in pretax earnings last year and almost half of total earnings.

So far at least, Philip Morris's move affects only its U.S. business. The company's newly issued 1992 annual report says that "our world-wide tobacco business has greater opportunities now than ever before." And Philip Morris said Friday that investors are "overlooking the growth and improved profitability of our other businesses."

Nonetheless, Wall Street retaliated against Philip Morris's announcement Friday. Traders dumped more than 34 million shares, knocking nearly $13 billion in a single day off the company's already depressed stock-market value. That marked a 23% one-day plunge and contributed to a 68.63-point drop in the Dow Jones Industrial Average Friday. It left institutional investors in the widely held equity grappling with whether to get out or hang tough. It also prompted the quick filing of at least three shareholder lawsuits accusing the company of misleading investors.

Wall Street also drubbed other tobacco

Continued From First Page

stocks Friday, sending share prices down in double-digit percentages for RJR, Liggett owner Brooke Group Ltd., American Brands Inc. and Loews Corp., which owns Lorillard Inc.

At Philip Morris, which supplies the world with dozens of other household brands including Velveeta cheese, Oscar Mayer bacon, Post Raisin Bran and Miller Lite, the new effort puts considerable pressure on Chief Executive Officer Michael A. Miles and on William I. Campbell, head of the tobacco unit.

Mr. Miles, a much-praised food marketer, emerged from the company's Kraft General Foods side in September 1991 to become the first nontobacco executive to be named its chairman and CEO. He had already been put on the defensive by an earlier 20%-plus drop in the stock price since last fall. Mr. Miles declined to be interviewed, leaving Mr. Campbell, president and chief executive of the Philip Morris USA, to face analysts and handle the press.

Wall Street didn't greet him all that kindly. "Bill Campbell has done a shoddy job of keeping abreast of the market," charged Ronald Morrow, a Smith Barney, Harris Upham & Co. analyst who had been bullish on Philip Morris until the Friday morning announcement. "If Marlboro doesn't regain share, Bill is going to be looking for work," he predicted.

Misjudging the Market

For Mr. Campbell, it was the second time this year that he has publicly admitted the company misjudged the market. In January, he told analysts he was "surprised" by the rapid growth in cheap cigarettes last fall. But he played down the significance of a 5.6% drop in Marlboro shipments for 1992, the steepest slide in the brand's history. He said growth was slowing in the discount market.

On Friday, he admitted he was wrong and disclosed that, in the first quarter, Marlboro shipments were down 8% from a year earlier. "The news has gone from good to bad in a very short time," he told fund managers. Later in the day, he added: "This market has moved very quickly. We don't see it today the way we saw it in January."

William I. Campbell

Philip Morris's inventory began building to dangerous levels in the wholesale pipeline late last year, as the company encouraged distributors to load up on Marlboro to avoid a Jan. 1 price increase. The backlog worsened in January, when Philip Morris pushed distributors to take on new packs of Marlboros emblazoned with Marlboro Adventure Team coupons. Then in March, it tried to spur volume again by announcing a small price increase for April, hoping wholesalers would rush to put in new orders before the higher prices kicked in.

But with warehouses already brimming, Philip Morris found far fewer takers than usual. "It was a smack of reality," says Steven Rosenthal, president of Bonanza Trading Associates, a New York distributor. His Bronx warehouse is still packed with more than twice its usual inventory of Marlboros. (It is unclear if or how wholesalers will be reimbursed for the lower value of their inventories.)

Banking on the Future

Philip Morris maintains it has little choice but to launch the new offensive and contends the strategy, though painful in the short term, will ultimately lead to accelerated growth. Some marketing experts agree.

"It is the job of market leaders to create profitability in the industry," says Gary Stibel, founder of New England Consulting Group, a marketing-consulting firm. Adds Leo J. Shapiro, a marketing expert in Chicago: "This is a good investment for Philip Morris. It behooves a major player to bring up its market share."

Discount brands now make up 36% of the market in unit terms, by Philip Morris's latest calculations, and are expected by some tobacco analysts to hit 50% by decade's end. These brands typically bring in only a nickel a pack in profit, compared with about 55 cents a pack for Marlboros. They cut $1 billion from industry profits last year alone. Once Philip Morris cuts Marlboro's price, analysts fret, it may never head back up again. On Friday, analysts slashed earnings estimates for the company by 20% to 30% for 1994, when the new plan is supposed to be producing results.

But Mr. Campbell contends: "When we make Marlboro more affordable, it will grow."

The Marlboro marketers began trying out the price-cut strategy in a month-long test last December. In Portland, Ore., they shaved 40 cents from the price, to below $2 a pack, and saw Marlboro's market share quickly rise four percentage points. That was encouraging, given the two-point decline in Marlboro's domestic share, to 22.2% last year.

In February, marketers were further convinced a cut was needed when they attended a gathering of Philip Morris brass in Scottsdale, Ariz. There, at myriad Circle K convenience stores, fluttering banners beckoned to patrons stocking up on beer and Twinkies to "Move to Austin," the stores' own private-label smokes – at just 89 cents a pack. "You couldn't get out of the hotel driveway without running into Austins," Mr. Campbell says.

Austins have become one of the best-selling brands at Circle K in just a few months. Adding to Philip Morris's chagrin was the identity of Austin's maker: Forsyth Tobacco Co. – owned by RJR, Philip Morris's biggest rival.

RJR is one big reason the Marlboro man has been forced into this shootout. While Philip Morris is the undisputed leader in full-price cigarettes and dwarfs RJR's 29% market share, RJR has moved out ahead in discount brands.

The foes have long taken sharply different approaches. RJR's R.J. Reynolds, based in the heart of tobacco country in Winston-Salem, N.C., relies on its sales force to push volume through retailers and wholesalers. Philip Morris, with headquarters on Park Avenue in New York, is known for marketing prowess and an ability to cultivate a desirable image for its brands. This raises the risk that for some smokers, the cut in price could sully the brand's mystique. The company had always held Marlboro above the fray, even as RJR used heavy discounts for its Camel brand to pick up new smokers last year.

When the low-priced cigarettes first emerged a little more than a decade ago, both companies all but ignored them. At the time, Liggett & Myers resorted to private-label brands in a nearly desperate effort to stay in business as sales of its Lark and L&M lines faltered. It was able to charge about a dollar a pack by throwing out the huge costs of advertising and promotion.

Michael A. Miles

The larger rivals scoffed. They had spent billions linking cigarette brands to sexy imagery and illusions of the high life.

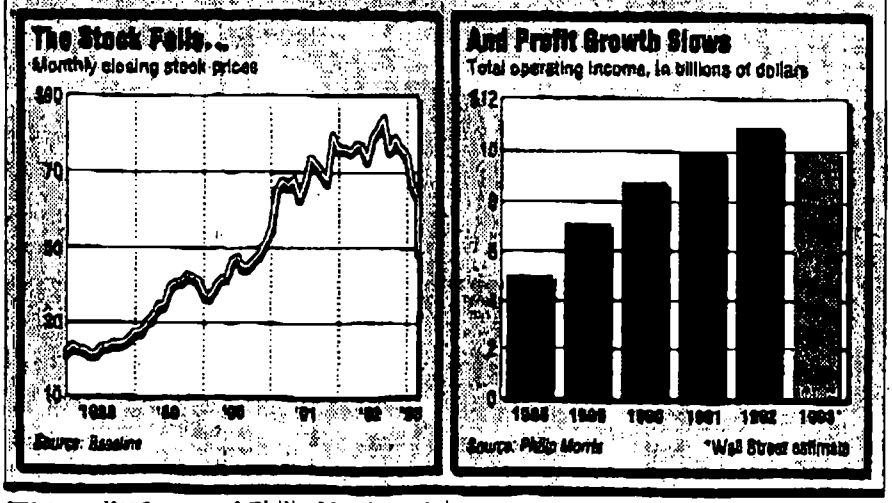
But Philip Morris and RJR managed to drive away an increasing number of customers by routinely raising prices semiannually by a combined 10% or more. Cigarette makers blame taxes for the steep increases, but data provided by the industry's own lobby, the Tobacco Institute, show they aren't the whole picture; from 1980 to 1991, taxes doubled to 45 cents a pack while prices nearly tripled to an average of $1.74 a pack. They rose to the $2 mark last year.

'Dance of Death'

Discount brands, starting at zero in 1981, passed 7% of all cigarettes sold in 1985, doubled their share in the next four years, and have since more than doubled again. Much of the later growth, however, reflects an entry into the discount market by Philip Morris and RJR themselves – even though that has meant sacrificing high profit margins and hurting their own full-price brands.

"They are in a mutual dance of death that is strangling their full-price business," Tony Regensburg, a tobacco indus-

Price Erosion Hurts Philip Morris



try consultant, says of Philip Morris and RJR.

Mr. Campbell acknowledges that Philip Morris has been "a reluctant competitor" in discount cigarettes because of the effect on premium brands. "For us it's always been a kind of damned if you do, damned if you don't situation," he says.

At the low end, RJR has been the more aggressive rival, seizing control of one-third of the discount business last year. Philip Morris had a 27% share of it. RJR stepped up its presence in the pennies-a-pack market in 1987, when it created Forsyth Tobacco to make a house brand of cigarettes for Kmart Corp.

Forsyth operates out of the same building in downtown Winston-Salem that houses RJR's regular staff and uses the same factories.

RJR's centerpiece in discounts is the bargain-basement Monarch brand. But it has also gained share — though little profit — by accelerating the move into a portfolio of customized, under-a-buck brands that it makes for even the smallest store chains.

As part of its pursuit of the discount business, RJR last year began bypassing traditional tobacco distributors and going straight to convenience-store chains and gas stations, offering to create house brands for any willing customer. While filling up at one of the 800 gas stations owned by BP Oil Co., for example, smokers can pick up a pack of Highway cigarettes for as little as 69 cents a pack, made expressly for the British Petroleum Co. subsidiary by RJR's Forsyth.

Wild for Jacks

A few months ago, the 165-outlet Sheetz Convenience stores chain began selling its own line of cigarettes, Jacks, in a simple white pack emblazoned with the face of a playing card. Made by RJR and selling at 99 cents a pack, Jacks were an immediate hit and now account for half the Altoona, Pa., chain's cigarette business. Jacks even outsells RJR's own Camel and Winston lines at Sheetz stores.

One small consolation for RJR: Jacks also outsells Marlboro there.

Philip Morris reluctantly decided to grab a piece of this action last year, even though RJR isn't exactly getting rich on it: Last year RJR's sales rose 5% to $6.16 to $2.11 billion. Until last year, Philip Morris had been cautious, selling the $1.50-a-pack Cambridge brand but mostly avoiding the 99-cent wars. Yet retailers say that over last summer, Philip Morris made an all-out assault on the discount category, pursuing customers like QuikTrip Corp., based in Tulsa, Okla.

The bestselling cigarette at QuikTrip's convenience stores isn't heavily promoted Marlboros but the chain's own cut-rate Bronson line. It fares so well that Philip Morris offered special discounts on a variety of brands and other incentives to persuade QuikTrip to let it manufacture the brand. QuikTrip dumped Bronson's maker of nine years, Liggett Group.

"Philip Morris came to us with a package that was pretty compelling," says Wyatt Phillips, QuikTrip's vice president, marketing.

Narrow Margins

Now, Philip Morris says it will "intensify its efforts to obtain market share in all industry segments and will take prompt action to expand the distribution of its discount brands." It pledges to "achieve a leading share in discounts."

The company may get some help from smokers. Last week, the Centers for Disease Control and Prevention in Atlanta said the rate of smoking in the U.S. increased slightly in 1991, the first rise after declining for 25 years. The CDC said it was partly a result of discount cigarettes making smoking affordable.

After gaining a combined 60% of the discount business, Philip Morris and RJR have set about trying to raise prices. They apparently had hoped both to increase the profits on the generics — to perhaps 15 cents a pack from a nickel — and to push more smokers back to full-price brands. Since August, in an apparent coincidence, both tobacco giants have raised the wholesale price of their cheapest smokes four times for a total of 40%, analysts say.

It hasn't worked. The chain stores are fuming. "It irritates me to no end," says Louie Sheetz, marketing vice president of the convenience-store chain. He vows to switch to a smaller, hungrier supplier if RJR tries to force through another increase on his store brand. "We are going to have Jacks at a low price forever," he declares.

that price increases on the private labels haven't stuck, for which he blames a new round of reductions by RJR. But he all but disavows the company's statement that it will push harder in discounts, focusing instead on his plans for Marlboro. The new strategy again aims for narrowing the price gap between discount brands and Marlboro — but this time by cutting prices on the high end.

The company insists the Marlboro move isn't an outright price cut. Philip Morris will use coupons and price cuts in some markets to whack Marlboro's price tag by 40 cents a pack. It will also lure smokers with special promotions: Buy three packs, get two free. For its other major brands, such as Virginia Slims, Benson & Hedges and Merit, it says it will forgo "any further price increases . . . for the foreseeable future."

The result of all this, the company contends, ultimately will be an upturn in Marlboro sales, market share and profit. But RJR has already vowed to compete aggressively, and it and lesser rivals could keep prices so low in their discount labels that Marlboros could remain unattractive to many smokers.

Other threats persist. For one thing, there is the continuing possibility that tobacco companies could someday be held liable for smoking-related illnesses. A more pressing concern to the industry is the Clinton administration's plan to raise the excise tax on cigarettes from the current 24 cents a pack could wipe out the 40-cent break that Philip Morris wants to deliver on Marlboro. Even though the tax would go on private labels, too, it could push Marlboro's price back over $2, sending more smokers in search of cheap relief.

Indeed, tobacco experts say the most likely consequence of the new push is simply lower profits and, perhaps, permanently lower prices on Philip Morris's franchise brand. "It is risky," says Mr. Rosenthal of Bonanza Trading. "It may create permanent and insidious downward pricing pressuring on their most profitable brands."

It isn't clear just how low Marlboros and other mainstay brands will have to go to lure smokers back to the full-price fold. The answer may be alarming given avid smokers like Douglas Crandall. A railroad machine operator and lifelong smoker in Barstow, Ill., he started out puffing Marlboros years ago in the Army, back when he could buy them for just 28 cents a pack at the PX. He got out of the service and later switched to Camels.

But nowadays he is content to smoke three packs a day of G.P.C. Approved, a buck-a-pack brand made by Brown & Williamson. Forget about brand loyalty and image. "A cigarette is a cigarette," Mr. Crandall says.

Wash. Post; 4-3-93

Court Lets North Dakota Enforce Abortion Law

Limits, Modeled on Pennsylvania Statute, Require Counseling and 24-Hour Wait

By Joan Biskupic
Washington Post Staff Writer

The Supreme Court yesterday refused to stop North Dakota officials from enforcing a law requiring women to receive counseling and wait 24 hours before obtaining an abortion.

By a 7 to 2 vote, the court rejected a request by the state's only abortion clinic to stop the law from taking effect while it is being challenged in the lower courts. Justices Harry A. Blackmun and John Paul Stevens dissented.

At the same time, a statement in the case by two other justices signaled that the federal courts may have to give greater scrutiny to abortion restrictions imposed by states in the future, reviewing each one on a fact-specific, case-by-case basis to see if it creates an "undue burden" on a woman's right to end her pregnancy.

The approach could make it harder for states simply to adopt regulations that have been upheld in another state. For example, in states where women must travel long distances to an abortion clinic, a waiting period might require a woman to find overnight accommodations, miss an extra day of work and, in the court's view, be more onerous.

In a statement concurring with yesterday's action, Justice Sandra Day O'Connor wrote, "[A] law restricting abortions constitutes an undue burden, and hence is invalid, if in a large fraction of the cases in which the law is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion."

She was joined by David H. Souter in the order in *Fargo Womens' Health Organization v. Schafer*. They wrote separately specifically to reject an approach by the U.S. Court of Appeals for the 8th Circuit that would require parties challenging an abortion statute to show that it would be unconstitutional in all circumstances.

The overriding issue is how far states may go in regulating the abortion right and how much they ultimately may infringe on *Roe v. Wade*, the 1973 ruling that made abortion legal nationwide.

The Supreme Court in a 1992 Pennsylvania case lowered the standards of *Roe* and permitted abortion restrictions that earlier had been struck down under *Roe*. Since that ruling in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, lower courts have struggled to interpret its new test that women must not face an "undue burden" in exercising their right to end a pregnancy.

Because the court permitted Pennsylvania's requirement that women be counseled on fetal development and alternatives to abortion and wait 24 hours, other states, including North Dakota, have tried to enforce similar laws.

Scott Heller, a senior attorney at the Center for Reproductive Law & Policy, which challenged the North Dakota statute as unconstitutional, said, "We now know that there are at least four justices who believe that under *Casey* a factual assessment of abortion restrictions are [sic] required," referring to Blackmun, Stevens, O'Connor and Souter. "Once Justice [Byron R.] White retires, we are likely to get a fifth justice to take the same position."

However, Carol Long, political action director of the National Right to Life Committee, said it is impossible to predict how the court would rule on the merits of any regulation.

The court has not sent clear signals. Last December it refused to review a Mississippi case involving a waiting period law. Abortion rights advocates contended that rural Mississippi women, relatively poorer than their Pennsylvania counterparts, faced a greater "burden" under the law.

SANDRA DAY O'CONNOR
... urges "undue burden" test on state restriction

N.Y. Times; 4-4-93

Man Guilty of Killing Two in Sudafed Tampering

Special to The New York Times

SEATTLE, April 3 — Joseph Meling, who was accused of lacing Sudafed capsules with cyanide to kill his wife and collect her $700,000 insurance policy, was found guilty on Friday of murdering two people.

The two victims died in 1991 after buying the tainted capsules in local stores, but Mr. Meling's wife, Jennifer, survived taking the capsule and testified on his behalf.

After deliberating three days, a Federal District Court jury found Mr. Meling (pronounced MAIL-ing) guilty of 11 charges, including two of murder by product tampering, as well four of product tampering with the intent of causing harm, three of insurance fraud and two of perjury.

Mr. Meling shook his head when Judge William L. Dwyer read the verdict. His lawyer, Cyrus Vance Jr., said the verdict would be appealed. Mr. Meling will face the possibility of life in prison at his sentencing on May 21.

Prosecutors said Mr. Meling, a 31-year-old insurance salesman, gave his wife the poisoned decongestant and placed other tainted capsules on shelves in local stores to divert suspicion. The deaths prompted the manufacturer of Sudafed, the Burroughs Wellcome Company, to recall the capsule form of the product nationwide.

The verdict was a victory for the Government prosecutors, who did not want to see the case go unresolved as did the Tylenol tampering in Chicago in 1982. Seven people died in that case.

During the five-week trial, prosecutors relied on circumstantial evidence. There were no fingerprints on the Sudafed packages and no trace of cyanide in the Melings' apartment. But the prosecutors raised doubts about Mr. Meling's motives and character.

In a two-year investigation, the prosecutors built a case based on wiretapped telephone conversations in which Mr. Meling frequently tried to dissuade his wife and other family members from cooperating with Federal investigators. In urging his 29-year-old wife not to meet with Federal investigators, he was overheard telling her, "You're sleeping with the enemy."

Among the Government's strongest evidence was the signature of a bogus name they said Mr. Meling wrote on a "poison register" when he bought the cyanide. Handwriting experts linked the signature to Mr. Meling's handwriting.

Karen Armstrong, a jury member, said the circumstantial evidence was enough to convince her that Mr. Meling was guilty. "In wiretaps, I could hear the total disrespect he had for his wife and his mother," she said. "I could hear it in his voice. I feel bad for his wife because she gave up everything for him."

During the trial, prosecutors described Mr. Meling as an abusive man "devoid of moral and social values" whose troubled eight-year marriage was marked by his inability to hold a job. Mr. Meling often disparaged his wife in public, they said.

Wife Rushed to Hospital

On Feb. 2, 1991, Mr. Meling urged his wife to take a Sudafed capsule to stop her snoring, prosecutors said. When she became unconscious, he rushed her to a hospital.

An Assistant United States Attorney, Joanne Maida, said the only reason she survived was that Mr. Meling asked emergency room doctors if they had considered the possibility that his wife had been poisoned by cyanide.

Mrs. Meling, who was in a coma for two days, filed for divorce soon afterward. But the couple reunited several months later, before Mr. Meling was arrested in August 1992.

Mrs. Meling, a teacher, was an abused woman "molded like putty by her husband," Ms. Maida said. On the witness stand, Mrs. Meling said she was testifying for her husband because she loved him. But in later testimony, she conceded, "I hope my husband is innocent and that I married the right man."

In a statement released Friday, Mrs. Meling expressed sympathy for relatives of the two people who died from the poisonings. They were Kathleen Dancker, 40, of Tacoma, and Stanley McWhorter, 44, of Lacy, near Olympia. Mrs. Meling's father, Gary Lindbo, said of his daughter, "She can begin to heal now and become honest."

HHS RADIO
FOR FRIDAY, APRIL 2, 1993

The feed consists of three stories in English and one story in Spanish.

First -- The Centers for Disease Control and Prevention report that smoking prevalence among adults has remained the same following a continuous decline over the past 25 years. CDC's Dr. Michael Ericksen says anti-smoking efforts must be increased.

Second -- April 1993 is National Child Abuse Prevention Month and the Department of Health and Human Services is challenging all Americans to take responsibility for preventing child abuse and neglect. HHS' Emily Cooke says communities must unite and work together to solve this problem.

Third -- The Clinton Administration has announced the "Comprehensive Childhood Immunization Act of 1993" -- a new initiative to protect all American children against preventable diseases. Health and Human Services Secretary Donna Shalala says this initiative is a major step to ensuring that all children live healthy lives.

And in Spanish.....

Fourth -- The National Eye Institute reports that although treatments for a common, sight-threatening complication of diabetes are 95 percent effective, 8,000 people still go blind each year. NIH's Dr. Frederick Ferris says the loss of sight from diabetic retinopathy is primarily because of failures to have annual eye exams.

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Friday April 2, 1993

ABC World News Tonight

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	Peter Jennings	Portland	2:00
2	Environmentalists and Timber Industry Can't Find Common Ground		
	Brit Hume	Portland	2:00
3	Spotted Owl is Forest's "Canary in Coal Mine"		
	Peter Jennings	Portland	0:20
4	Logging Towns Marked by Economic Uncertainty		
	Barry Serafin	Portland	2:40
5	Owl Controversy Not Sole Cause of Timber Industry's Woes		
	Ned Potter	Portland	1:55
6	Unemployment Rate Unchanged in March		
	Peter Jennings	Portland	0:25
7	Durenberger Indicted for Falsifying Expense Account		
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8	Yeltsin's Foes Fault his Pushiness but Public Thinks He's Boss		
	John Donvan	Moscow	2:15
9	Bosnian Cease-fire Ends After Four Days		
	Peter Jennings	Portland	0:10
10	Perot/Clinton Truce Ends Over Alleged Snub of Military Officer		
	Cokie Roberts	Washington	1:20
11	Health Care Task Unlikely to Meet Proposed Deadline		
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12	Study Finds AZT Does Not Successfully Delay Onslaught of AIDS		
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13	Interior Secretary Dedicated to Jobs and Environment		
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CBS Evening News

14 Senate Republicans, Citing Waste, Block Vote on Clinton Jobs Bill
Bob Schieffer Washington 2:40

15 Logging Industry, Environmentalists Argue at Timber Summit
Susan Spencer Portland, Ore. 1:45

16 Yeltsin to Look for U.S. Support at Vancouver Summit
Connie Chung New York 0:25

17 Western Firms Find That Investment in Russia is Risky Business
Anthony Mason Moscow 2:30

18 Durenberger Indicted, Says He'll Fight Charges
Connie Chung New York 0:20

19 New Device Which Reads Brain Waves is a "Super Lie-Detector"
Rita Braver Washington 2:00

20 Auto Racing's Kulwicki Thought to be Dead in Plane Crash
Connie Chung New York 0:20

21 New Study Questions Effectiveness of AIDS Drug AZT
Dr. Bob Arnot New York 2:30

22 Two Lawyers Complete Four Days of Talks with Koresh
Connie Chung New York 0:20

23 "Working Press" at King-Assault Trial Includes a 12-Year-Old
Cinny Kennard Los Angeles 2:40

24 Millions Watch Guests on TV Talk Shows Expose Innermost Secrets
Richard Threlkeld Los Angeles 4:15

NBC Nightly News

25 Loggers and Environmentalists Face-off at Forest Conference
Tom Brokaw Portland 0:35

26 Clinton Says No Easy Answers for Jobs vs. Industry Debate
Andrea Mitchell Portland 2:10

27 Logging Towns Trying to Cope with Timber Industry Changes
Roger O'Neil Sweet Home, Ore. 2:15

28 Clinton Says GOP Opposition to Economic Plan Hinders Recovery
Tom Brokaw Portland 0:25

29 Sen. Durenberger Charged with Falsifying Expense Account
Tom Brokaw Portland 0:20

30 Most Americans Think Domestic Issues Take Precedence Over Russia
John Cochran Washington 0:10

31 Economic Expert Jeffrey Sachs Says Clinton Must Back Russia
Tom Brokaw Portland 2:25

32 Unemployment Rate Remains at Seven Percent in March
Tom Brokaw Portland 0:20

33 LA Preparing Itself as Rodney King Beating Trial Approaches End
John Gibson Los Angeles 1:30

34 Mother Launches Grass-roots Peace Campaign in Northern Ireland
Ed Rabel Dublin 2:05

35 Oregon Youth Writes Politicians to Lobby for Health Care Reform
George Lewis Oregon 3:30

36 Women's Basketball Ranks High in Popularity but Low in Equality
Mary Alice Williams Atlanta 1:45

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Health-Reform Tenets Emerge As Task Force Deadline Nears

By Marilyn Milloy
WASHINGTON BUREAU

Washington — With all the nail-biting and hand-wringing over President Bill Clinton's still-evolving health-care reform plan, administration officials last week began offering this comfort: You may be in for change, but good things are coming in the bargain.

Vice President Al Gore assured physicians last week that "a better deal all around" is in store. Now the White House health-care reform task force is scrambling to try to make good on the promise — amid distressing political and fiscal realities that are almost certain to frustrate its best efforts.

There have been doubts about whether the panel can make its May 3 deadline — its chairwoman, Hillary Rodham Clinton, was with her ill father in Little Rock, Ark., for the past couple of weeks. But administration officials have left few doubts about the direction they're headed, although a host of issues, including how to finance the proposal, have yet to be resolved.

Simply put, the health-care system as most Americans know it will be turned on its head. Every citizen, including the nearly 37 million uninsured, would have access to care, mainly through their employers.

No individual could refuse coverage, and the government would pick up the costs for the unemployed and ease the burden for financially hard-pressed small businesses.

Everyone would likely have to cover the part of the premium their employers don't, the amount based perhaps on salaries. But a health-insurance card would entitle everyone to coverage even if they moved, and only one claim form would be required.

The basic benefits package, as officials envision it, would be comprehensive, comparing favorably with some of corporate America's better plans — with coverage included for an unusually wide array of preventive-health treatments, many chronic mental-health problems, prescription drugs and some long-term care, as well as typical hospitalization and routine medical and dental care.

A national health-spending limit would be imposed, and health-care delivery would be revamped.

Small-business owners, the self-employed, unemployed and those on Medicaid — and perhaps, much later, self-insured corporations — would be organized into large purchasing groups that would bargain for the best-priced and highest quality plan among competing networks of doctors, hospitals and insurance companies resembling health-maintenance organizations. Incentives would be offered to get doctors to serve rural and underserved communities.

Doctors would have the flexibility to be associated with a variety of health plans, including a traditional fee-for-service plan, giving patients the freedom to choose their doctors.

Though Clinton has expressed a desire to put cost restraints on the health industry first, consumers will likely have to play a part, too.

Consumers who buy extra insurance for benefits exceeding the basic package, for instance, may be taxed on the costs of the extra coverage. And the tax deductions that businesses take for the cost of their health insurance could be limited to the value of the standard package charged by the least-expensive HMO.

Doctors, insurance companies and hospitals, meanwhile, will likely see some kind of short-term cost controls on fees and premiums. Dramatic reform of malpractice laws would be the prize for doctors.

Officials have said they need from $30 billion to $90 billion to pay for the program, depending on how fast they want to phase it in. And figuring that out — four years as opposed to seven, for instance — depends a lot on the president, who in one internal memo has already been schooled on the phase-in's impact on "1996 election politics."

Clinton has said he would favor increasing cigarette taxes to cover some of the cost. Raising taxes on alcohol, guns, pollutants — anything that contributes to bad health — is still very much in the running.

The administration is also looking at "recapturing" savings the industry would make on the overhauled system. Taxing new premiums collected by the insurance companies is a possibility, as is taxing the new profits hospitals would get from no longer having to give emergency care to people who are unable to pay. "Every time you move just one small piece, the whole complexion of the plan can change," said Robert Boorstin, a task-force spokesman. "But nobody said this was a tidy process."

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Reserve unit at Selfridge to disband

Some of 80 soldiers will be reassigned

BY L. L. BRASIER
Free Press Staff Writer

An Army reserve unit of more than 80 soldiers at Selfridge Air National Guard Base will be disbanded Sept. 15, the victim of federal budget cuts.

The 2372 Signal Detachment Unit is made up of soldiers who specialize in communications systems, many of them designed for wartime and battlefield strategy. The unit is part of the 123rd U.S. Army Reserve Command.

"There are no major wars or conflict, so what we're seeing is downsizing. ... This unit, and others, will cease to exist," Major Ed Angevine, an army reserve spokesman, said Sunday. He didn't reveal details on other expected closings.

Angevine said the Army Reserve would try to help those reservists who hope to continue their military careers by placing them in other units, although all may not find new jobs.

The unit is planning a ceremony, honoring its past and current soldiers, although a date has not been set.

The disbanding of the unit comes as military spending is slashed nationwide. K.I. Sawyer Air Force Base in the Upper Peninsula is on a list of bases to close, with a loss of 3,000 jobs, and in Battle Creek, 800 people will lose their military employment.

A: Selfridge, the Michigan Air National Guard grounded its 127th Tactical Fighter Wing squad from flying over community parades during national holidays, part of a budget-cutting measure.

FAX TRANSMISSION

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COMMENTS:

SECOND OPINION

ABIGAIL TRAFFORD

Wash. Post; 4-6-93

Two Cabinet Voices, One Echo: Violence Is a Public Health Issue

Watch out. Here come Health and Human Services Secretary Donna E. Shalala and Attorney General Janet Reno. The two have joined forces to pursue a common but elusive goal: Reduce the toll of violence and drugs in the streets and in the family.

They plan to do this by making the nation understand that violence is a public health issue. They even speak in echo of each other. In separate interviews, they said:

The growth of violence and substance abuse is a health problem as much as a criminal problem.

— Reno

People are beginning to change their thinking and look at violence as a health problem.

— Shalala

HEALTH CARE REFORM

The attorney general made an unprecedented appearance last week at the first public meeting of the President's Task Force on National Health Care Reform. It wasn't exactly like Anwar Sadat going to Jerusalem, but it's been unusual in Washington for the nation's chief cop to show up at a medical meeting. What's more, Reno is not even a member of the health task force.

Her presence suggests a partnership developing between the departments of health and justice to deal with such issues as drug and alcohol addiction, family violence and murder. Reno threw down the gauntlet to doctors, nurses, hospital administrators and all those who seek to influence the shape of the country's new health system.

"What responsibility do we have for a 13-year-old who is acting out—doing things that forebode terrible problems for the future, who could be treated by proper emotional, psychological support at this point?" she asked. "A counselor for that 13-year-old, who works with him day by day, is as important perhaps to that child as the inoculations [he received] at [age] 2 and 6 and 8."

With this attitude toward violence, the Clinton administration is refocusing the war against drugs and crime away from punishment and toward prevention. During the 1980s, the Reagan/Bush team relied largely on the criminal justice system to clean up the streets and attempt to stem the flow of illegal drugs in this country. Now, while no one is denying the role of police and prosecutors, the administration is challenging the medical profession to design effective anti-violence strategies as part of health-care reform.

Actually, the health care community has been ahead of official Washington in recognizing the medical connection with violent crime. The Centers for Disease Control and Prevention in Atlanta has long tracked deaths from homicide and considers violence a preventable public health problem. Last year, the Journal of the American Medical Association devoted an entire issue to violence and labeled bullets a "pathogen" like viruses and bacteria. More recently, in a broadcast editorial on April 2, JAMA editor George D. Lundberg called for federal "sin" taxes on the sale of firearms and ammunition to help pay for the medical costs of violence.

In the medical model of illness, violence is a disease of behavior. Wielding guns and knives leads to trauma just as smoking leads to lung cancer and alcoholism leads to cirrhosis of the liver.

The possibility of cooperative efforts between HHS and the Department of Justice would be welcome news to health workers who staff emergency rooms and substance abuse clinics that treat those felled by gunshot wounds or addicted to drugs. "We need to take a new tack," said Lundberg. "We have to get data from the public health community on what to fix and when to do the interventions."

There's the rub. Unlike a vaccine that prevents polio, there is no penicillin for wife-beating, no coronary bypass surgery to block the need for crack, no MRI scanners to detect the abscesses of rage and despair.

But there are plenty of statistics showing that public health strategies, and what Reno calls "edu-care" early in children's lives, can help prevent some of the problems.

Undaunted, the Reno-Shalala duo appears ready to tackle this gray zone where medicine and law overlap. They both recognize that the place to start is with the health of the family and the environment in which children are raised. Reno learned first-hand about family stress when she became the legal guardian of 15-year-old twins after the death of their parents, who had been Reno's close friends. "I think raising children is the single most difficult thing to do," she said. As a prosecutor in Dade County, Fla., she worked with doctors at Jackson Memorial Hospital and saw the health costs of crack and AIDS in the neonatal intensive care units.

Shalala had equally raw experiences in her work with the Children's Defense Fund and the Committee for Economic Development that studied the health and education needs of impoverished children.

It may be that these two unmarried women will be the ones to galvanize their respective departments to improve the lot of children and parents. All in the name of health care reform.

Of course, no new money or grand programs have been announced by the departments of health and justice.

But the towering Reno (6 feet, 2 inches) and diminutive Shalala (5 feet) make an unlikely but effective partnership. They both appeared last week at a conference of the Financial Women's Association, and as the HHS secretary told the group: "Between Janet and me, we probably control most of the government.

"I should say, the guys don't know it yet."

Yet. ■

Wash. Times; 4-6-93

TB, HIV studied together

Trials will target people with both

ASSOCIATED PRESS

The federal government announced plans yesterday for the first major U.S. study of drug treatment strategies for people infected with both tuberculosis and the AIDS virus.

"This study will provide state-of-the-art treatment . . . and answer important questions about the management of these patients," said Dr. Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases.

Up to 650 persons with active tuberculosis and the human immunodeficiency virus (HIV) will be enrolled in the clinical trials. Dr. Fauci said a significant proportion of the patients will likely be in New York City, where TB, especially the drug-resistant variety, is a persistent and growing problem.

The U.S. Department of Health and Human Services also announced a $2.1 million, five-year grant to Johns Hopkins University to evaluate the effectiveness and appropriate use of AZT, ddI and other drugs used in treating HIV-related illnesses.

Preliminary results of a major European drug trial suggest that people in the early stages of HIV infection get little benefit from the use of AZT. A group of European scientists reported their findings last week in the Lancet, a medical journal.

"While drugs have been reviewed for basic safety and effectiveness before they go on the market, these further studies should help physicians make the best treatment choices," said HHS Secretary Donna E. Shalala.

In the clinical drug trials involving HIV-infected people with TB, the government will evaluate the benefit of adding a new drug for TB treatment, levofloxacin, to the usual four-drug therapy used in geographic areas where the disease is drug resistant.

People who live where drug-resistant TB is not common can also enroll in the trial and will receive the four-drug regimen without levofloxacin.

"TB has re-emerged in the United States as a serious public health problem and disproportionately affects the most vulnerable in our society," Miss Shalala said. "To contain the further spread of this disease, we must identify persons with TB and treat them successfully."

TB is an airborne disease, primarily of the lungs. Because of their weakened immune systems, persons with HIV are particularly vulnerable to reactivation of latent TB infections as well as new TB infections.

TB transmission occurs most frequently in crowded environments such as hospitals, prisons and homeless shelters — places where HIV-infected people make up a growing proportion of the population, HHS said.

BALTIMORE EVENING SUN - APRIL 2, 1993 11A

2 ex-SSA chiefs work for groups that scare elderly about benefits, U.S. senator says

Associated Press

WASHINGTON — Two former Social Security commissioners work for groups that raise money by falsely telling senior citizens that their retirement benefits under the system are in jeopardy, Sen. Daniel Patrick Moynihan says.

Mr. Moynihan, chairman of the Senate Finance Committee, criticized the former commissioners for joining organizations that he said "extort" contributions from the elderly with alarming letters.

At a hearing yesterday, Mr. Moynihan, D-N.Y., read from one mailing that said a $1,000 reward was offered for information "leading to the arrest and conviction of any person (s) illegally interfering with or destroying the enclosed Documents."

Mr. Moynihan said the groups raise cash by suggesting the Social Security trust funds are being "looted" and abandoned "and that they will be abandoned" too.

The senator criticized former Social Security Commissioner Dorcas R. Hardy and former acting Commissioner Martha McSteen for joining organizations that he said have "terrified" seniors with their mailings.

Health and Human Services Secretary Donna E. Shalala told Mr. Moynihan she shared his outrage that the former officials would "put our most vulnerable citizens through such agony." She said it was "unethical and outrageous."

Ms. Hardy and Ms. McSteen served during the 1980s. Ms. McSteen is president of the National Committee to Preserve Social Security and Medicare, a group founded by James Roosevelt, a son of President Franklin D. Roosevelt.

Ms. Hardy is identified in a recent mailing as director of legislative affairs for the National Center for Privatization and its "special project," Americans for Social Security Reform.

Both testified during their tenures to the solvency of the Social Security trust funds, which had a surplus of $51 billion in 1992 and $331 billion in reserve at the end of the year.

William R. Ritz, spokesman for the National Committee to Preserve Social Security, acknowledged problems with the organization in its early days, but he said Ms. McSteen was brought in to "clean up the organization's image. It has taken four long years and she has done that."

"We just don't send out those kinds of mailings," Mr. Ritz said.

Ms. Hardy was on vacation this week and could not be reached for comment.

A mailing from Ms. Hardy's organization says: "In a few years, as the number of retirees grows, there won't be enough cash in the accounts to pay the benefits . . . There is still time to avoid a Social Security catastrophe, but time is running out."

The letter goes on to say that the benefit checks the nation's senior citizens expect to receive next month or next year are not in jeopardy. "But in the coming years the problem will grow so huge that it will hurt every retiree and taxpayer and be front-page news," it says.

The letter asks recipients to send $10, $15 "or any amount" to the group.

A Moynihan aide said the committees are just two of several organizations that send such mail to senior citizens. The aide said some have mistakenly sent Mr. Moynihan money because one group quotes the senator so frequently in its mailings.

Wash. Post; 4-6-93

Clinton Aide Says Health Plan Precepts Are Set

By Christopher B. Daly
Special to The Washington Post

BOSTON, April 5—Using satellite technology, White House aide Ira Magaziner told a health care reform conference today that President Clinton's task force has reached agreement on the basic principles of a national health plan and is about to fill in the details.

Addressing a daylong conference organized by Sen. Edward M. Kennedy (D-Mass.), Magaziner also said the task force will probably miss its May 3 deadline by a week or two but that the administration plans to submit legislation by the end of May.

Magaziner said the task force plan will guarantee health care to all individuals, whatever their health, employment or economic status, from cradle to grave. It will allow a maximum of choice while cutting bureaucracy, reducing costs and improving quality, he said.

The conference was designed to allow Massachusetts health care providers to offer their ideas to representatives of the Clinton task force. Responding to questions via a two-way video hookup, Magaziner said the plan will provide new incentives—including higher pay—for doctors to enter primary care, such as family medicine or pediatrics, rather than medical specialties.

An issue of special concern in Boston is the fate of large teaching hospitals, which typically charge more for the same procedure than community hospitals because they are training new doctors.

The conference was held at New England Medical Center, a training facility of Tufts University Medical School. Among those attending were the chiefs of the teaching hospitals affiliated with Harvard, Boston University and others.

"I think we recognize the important role that is played by the teaching hospitals, and we're not going to want to see that role diminished," Magaziner said, promising continued federal support.

Kennedy, who organized the conference with the White House's blessing, said in an interview that he believes "the president is on the right track." He applauded Magaziner's "extraordinary outreach," saying he had never worked so closely with the executive branch.

Kennedy had arranged for a staff member to attend each of the specialized sessions during the conference, which drew an overflow crowd of more than 600 health specialists. Those same staff members serve on the White House task force, providing a link between the medical community, the senator and the president.

Kennedy aides acknowledged that the conference would have political benefits as well for the senator, who is up for reelection next year, by allowing him to connect with an important constituency. But they said the conference also reflected Kennedy's prominence in the 20-year debate over health care reform.

N.Y. Times; 4-6-93 p. 1

Poll Says Public Favors Changes In Health Policy

By ROBIN TONER

Fired by a sense of crisis, a majority of Americans say they are willing to accept substantial changes in their health-care system, including government price controls, new taxes and longer waits for non-emergency appointments, according to the latest New York Times/CBS News Poll.

They have high expectations for President Clinton's promised health-care plan, the poll found, and they consider changes in health care an issue at least as urgent as the Federal deficit, which is near the top of the public's agenda.

In general, a majority of Americans seem ready for far more government involvement in the health-care system if that involvement can control costs and guarantee coverage for all, the poll shows.

Ambivalence Over Trade-Offs

Still, the survey found numerous signs of confusion and ambivalence toward some of the trade-offs that health-care reform may mean; as a result, it is a rough sketch of the challenge facing the President and Hillary Rodham Clinton, who heads the task force on health care. The task force is expected to produce a plan sometime in May.

While crucial decisions have yet to be made, Mr. Clinton has said he favors an approach known as managed competition, under which doctors and patients would be encouraged to join health maintenance organizations or

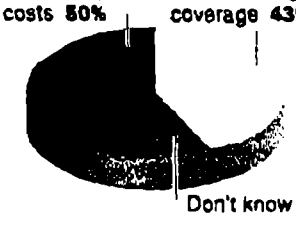
Continued on Page A20, Column 5

The New York Times | CBS NEWS Poll

Priorities on Health Care and Its Costs

The public wants all Americans to have health insurance coverage, and costs to be controlled.

Which should the Government be more concerned about — guaranteeing health-care coverage for all Americans, or controlling costs?



Americans are also willing to accept some personal limit s to achieve these goals . . .

If it would reduce your health-care cost, would you be willing or not willing to choose a doctor from a list instead of going to see your current doctor?		If it meant you would be guaranteed of always having health-care coverage, would you be willing to give up choosing your own doctor?	
Willing	53%	Willing	59%
Not willing	42%	Not willing	37%

And they are prepared to pay more taxes.

Would you be willing or not willing to pay more in taxes to provide health-care reform?

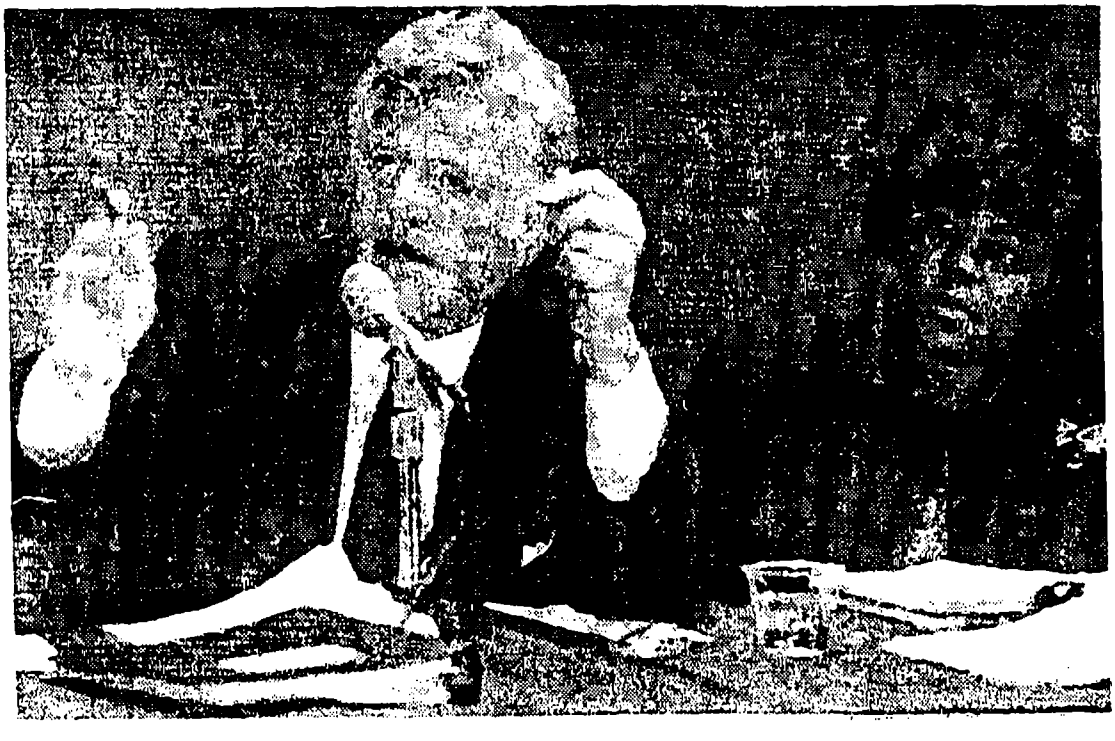
Willing	58%
Not willing	37%

But the public also wants the Government to intervene.

Should the Government set limits or stay out of how much doctors charge?		Should the Government require companies to provide health insurance for all their workers or should this be left up to the individual company?	
Set limits	72%	Required by Government	54%
Stay out	23%	Left up to the company	41%

Based on nationwide telephone interviews with 1,368 adults conducted March 28-31.

The New York Times



Continued From Page A1

similar prepaid plans, which provide a range of services for fixed monthly premiums. In effect, Americans would accept greater limits on their choice of doctors in return for lower costs and security of coverage.

A majority in the poll said they would accept, in general, some restrictions on their choice of a doctor if it brought those benefits. But most Americans also said they had a doctor now whom they considered their own, and a majority said they would pay extra to keep that doctor.

Similarly, a majority said that most doctors overcharged, but that their own doctors' fees were reasonable.

Resistance to Rationing

And, while most Americans say their health-care system was in a crisis because of rising costs, an overwhelming majority — 74 percent — said they were satisfied with the quality of their care. This held true regardless of sex, race or income.

In another reflection of the high value that people put on health care, the poll found an aversion to the idea of rationing. Only 33 percent were willing to give up "having certain expensive treatments like organ transplants covered by insurance" to reduce their health-care costs. Fifty-seven percent rejected this trade-off.

Such findings suggest the political conundrum that some analysts see at the heart of the health-care debate: The public wants the current quality of care, at a lower cost and with the assurance that they will never lose it.

The nationwide telephone poll of 1,368 adults was conducted March 28-31 and had a margin of sampling error of plus or minus three percentage points.

The survey found support for several measures under consideration by the Clinton task force, including these:

¶Fifty-four percent said the Government should require companies to provide health insurance for all their workers; 41 percent said it should be left up to the individual company. Support for that mandate was stronger among women and Clinton voters, and weaker among among men and those who voted for President George Bush or Ross Perot.

¶Fifty-five percent favored additional sales taxes on cigarettes and alcohol to discourage their use.

¶Seventy-two percent said the Government should set limits on how much doctors can charge patients; even Bush voters backed these limits.

¶Seventy-eight percent backed price controls on prescription drugs.

¶Fifty-eight percent said they were willing to pay additional taxes to improve the health-care system, even beyond the increased taxes needed for deficit reduction.

Adjustments Acceptable

The poll also found majorities willing to make adjustments in their health-care arrangements if it would reduce their costs. Fifty-six percent said they would be willing to wait a longer time to get a non-emergency appointment with a doctor, for example. But that dropped to 44 percent among those 65 years of age and over.

The people want quality care, at a lower cost.

Fifty-one percent said they would be willing to pay a higher deductible on their insurance coverage. And 48 percent said they were willing to join a group where all their health-care services would be covered for a fixed fee, even if some expensive tests are more difficult to obtain.

The idea of prepaid fixed-fee medicine, as practiced in health-maintenance organizations, is increasingly familiar to people; 25 percent said someone in their household was a member of an HMO. Fifty-four percent said that if they had to choose, they would prefer a fixed-fee system, while 36 percent said they preferred the current system of paying a separate fee for each service they use. Support for fixed-fee medicine tended to be lowest among the old.

Fifty-nine percent of the respondents said they favored a different model, one that Mr. Clinton has rejected: a Canadian-style system of national health insurance paid for with tax money. But that dropped to 36 percent when it was described as costing everyone an additional $1,000 a year in taxes, even though it would free them and their employers from any other premiums for basic health coverage.

Basic Benefits Package

Many questions in the survey tried to get people to set priorities for health-care reform. For example, 50 percent said the Government should be most concerned about controlling health costs, while 43 percent said its chief concern should be guaranteeing health-care coverage for all Americans. People who described themselves as liberals were more likely to stress universal coverage, as were women.

The poll also sought the public's views on what should be covered by the basic benefits package that is expected to be guaranteed to all Americans under the Clinton plan. It found strong support for the big-ticket item of nursing home and other long-term care; 65 percent said it should be covered. But

mediate, comprehensive coverage for it, although the President is committed to making a start.

The survey also found that 80 percent supported the coverage of mental health care. But only 43 percent said the basic plan should cover programs to help people quit smoking, drinking or abusing drugs; 53 percent said those programs should be paid for directly by the people who use them.

Only 26 percent said the plan should cover fertility treatments for couples who cannot have children. And only 23 percent said it should cover abortions, while 72 percent said those costs should be paid for directly by the woman who have them. The abortion question followed the question about fertility treatments, and may have been influenced by it.

Acutely Personal Impact

In many ways, the survey showed the acutely personal impact of rising health-care costs and the spreading insecurity about health insurance, all of which helps explain the support for change. A fourth of the respondents said that someone in their household had been without health insurance sometime over the past year. A third said that someone had continued working in a job they wanted to leave because they feared losing their health insurance. And 30 percent said someone in their home had taken one job rather than another because it had a better health plan.

The middle class is right in the middle of the problem: 44 percent of the total sample said the employer of someone in their household had cut back on health benefits or made the wage earner pay a higher share of the cost in recent years. Fifty-seven percent of those earning from $30,000 to $50,000 a year had that experience.

Still, there was evidence that some people remain insulated from the true cost of health care: 42 percent said the last time there was a hospitalization in their family, nobody in the family saw the bill.

The public's ambivalence — and the way their personal and political views can collide — was perhaps most clear in the attitude toward doctors. By a nearly 2-to-1 ratio, people said that most doctors' fees were unreasonable and that doctors were just trying to "make as much money as they can."

But when were asked about their own doctors' fees, their opinions reversed: by 2 to 1, people said their own doctors' fees were usually reasonable. In this, their attitudes are reminiscent of the distinctions they draw with Congress: they dislike the group as a whole, but not their own lawmaker.

N.Y. Times; 4-6-93

Official Virtually Rules Out Taxing of Health Benefits

By ADAM CLYMER
Special to The New York Times

BOSTON, April 5 — President Clinton will not try to help pay for his health-care program by taxing "in any significant way" the health insurance benefits that workers receive from their employers, one of his top health-care planners said today.

The official, Ira C. Magaziner, staff coordinator of the President's Task Force on National Health Care Reform, said that taxing the benefits, frequently mentioned as a major source of financing for the program, would be "foolhardy" because it would make "a significant portion" of the public worse off, rather than better.

Mr. Magaziner spoke from Washington by television satellite to a group of about 700 doctors, educators and community and labor leaders who were meeting at the New England Medical Center here with Senator Edward M. Kennedy, Democrat of Massachusetts. He said Mr. Clinton hoped to see that all Americans were guaranteed "very comprehensive" health care that included coverage of many costly services, from mental health treatment to long-term care of the elderly.

When Mr. Magaziner was asked how the Administration wanted to pay for its plan, in particular for covering the millions of Americans who now have no health insurance, he said: "We just haven't made decisions yet on that. We have laid out a whole series of options."

But when Joseph Flaherty, president of the Massachusetts A.F.L.-C.I.O., asked whether making workers' health insurance benefits taxable was one option, Mr. Magaziner said it was not. "I think I can say categorically," he said, "we are not going to tax, in any significant way, the benefits that have been won by workers in this country through negotiation over the years."

The basic system that the Administration intends to propose is known as managed competition. It envisions large numbers of people grouped together in cooperatives that would use their size to bargain with insurers for a basic insurance plan at the lowest possible rate.

Individuals would choose among different options for medical service, including health maintenance organizations and other arrangements. If they chose a plan that offered more than the basics, they would pay extra. Many advocates of managed competition, including most of its Republican supporters, argue that to make the system work it would be necessary to tax benefits beyond the minimum level in order to discourage excessive coverage.

Health insurance benefits now go untaxed. They are treated as a deductible business expense by employers and are not regarded as income to workers. Union leaders have been adamantly opposed to any taxes on such benefits.

The Administration's position on taxing benefits is linked to the breadth of the system it is considering. When Mr. Flaherty raised the question, Mr. Magaziner suggested that taxes might be imposed in some cases, but only on extremely generous insurance plans.

"If you have a very comprehensive plan, as we are hoping to do," he said, "and that therefore, what you are taxing is if people are spending money on cosmetic surgery or spending money on wanting to have a hotel suite every time they went to the hospital, that may be appropriate."

In effect, Mr. Magaziner appeared to suggest that the Administration would agree to tax insurance benefits beyond a basic plan but would set the basic plan generously enough so that the threshold was very high.

When pressed about particular services to be included, Mr. Magaziner generally avoided answering. "We are about to begin in the next week the decision-making about what's actually going to go into the plan," he said.

But he indicated that a decision had all but been made on mental health services.

"With respect to mental health," Mr. Magaziner said, "our view is that mental health and physical health clearly should be treated as one. Basically, there should not be treatment of mental health as an afterthought. And so we are looking in our comprehensive benefits package to treat them all in the basic package."

His answers about long-term care for the elderly were more general. He said that long-term care was "on the table" and that the Administration would "try to take steps in the direction of providing better long-term care."

"We are going to do something that will enhance long-term care," he said. "We just don't know exactly yet what the structure of that package will be."

Mr. Magaziner said the Administration's proposals would be made within "about a week or two" of its original May 3 deadline.

Senator Kennedy and Mr. Magaziner both said the Administration wanted to get the legislation passed this year, but most lawmakers consider the chances of meeting that target remote.

Assessing Cost And Quality

If it would reduce your health-care cost, would you be willing or not willing to give up having certain expensive treatments like organ transplants covered by insurance?

Willing	33%
Not willing	57%

On the whole are you satisfied or not satisfied with the quality of health care available to you?

Satisfied	74%
Not satisfied	24%

Do you think most doctors' fees are usually reasonable or are most doctors just trying to make as much money as possible?

Reasonable	31%
As much money as possible	57%

Do you think your doctors' fees are usually reasonable or are most of your doctors just trying to make as much money as possible?

Reasonable	48%
As much money as possible	21%

Based on nationwide telephone interviews with 1,366 adults conducted March 28-31.

Wash. Post; 4-6-93

Governors Seek Right to 'Opt Out' of Federal Health Cost Controls

By Dana Priest and Ann Devroy
Washington Post Staff Writers

A12

Representatives of the nation's governors yesterday asked the Clinton administration to allow states to implement health care reform measures that differ from the managed competition approach the president favors and to "opt out" of federally set short-term cost controls if they are "too onerous or unrealistic."

In a meeting with top staff members of the administration's health care task force, four governors said the federal government, not the states, should be responsible for enforcing any short-term cost controls, and that states should have the option of requesting that any controls be removed early, according to the governors' internal working documents, which they used in the briefing.

The papers do not define what is meant by "onerous or unrealistic" controls, but the options being considered by the administration's health care task force would require a large, new bureaucracy to implement and enforce private-sector controls, presumably at added cost to states.

States should also be given a chance to opt out of using price controls if they have alternative approaches that "meet the general goals of the national cost control strategy," the briefing papers state. "This may include states that have their own well-developed [doctor and hospital] rate-setting systems or those that may want to accelerate other forms of long-term cost containment.

Clinton, a former governor who is unlikely to forget his dealings with the federal Medicaid bureaucracy, has said he wants to give states maximum flexibility in implementing health reform. He has made no final decisions, however.

"The president has always stressed the need for state flexibility," said health care task force spokesman Bob Boorstin.

But administration officials say flexibility would be permitted only within the framework of certain federally established goals. For instance, while some states might choose to use a single-payer, Canadian-style approach, they would still be required to make a federally mandated standard package of benefits available to all state residents.

The meeting yesterday included governors Roy Romer (D) of Colorado, Carroll A. Campbell Jr. (R) of South Carolina, Howard Dean (D) of Vermont and George S. Mickelson (R) of South Dakota, all proponents of health care reform within the National Governors' Association.

The meeting followed the enactment in Florida of a major health reform bill that uses market competition and government regulation to guarantee access to care for all residents while aggressively controlling costs.

"What has happened in Florida is a very good sign because it demonstrates that states are committed to reform," said Boorstin.

But Florida is atypical. Most other states have not yet found politically acceptable ways to curb rising health costs and guarantee coverage for the uninsured. Financial rewards for states that meet health spending limits and quickly insure the uninsured is one of the options under consideration by the task force.

Citing the fact that managed competition has no proven track record—it does not exist in any significant form anywhere in the country—and implementing it may prove difficult for some states, the briefing paper says that "rather than develop a compromise that may not work, the federal government should allow for different, coherent proposals to develop in different states."

The governors also asked the administration to allow most Medicaid recipients to purchase health benefits through the proposed regional health insurance purchasing cooperatives where most other Americans would buy health coverage under the administration plan.

The cooperatives would bargain with health networks of doctors, hospitals and others to provide a standard package of benefits for an annual fixed fee.

Wash. Times; 4-6-93 p. 1

Hillary's effort may backfire

Federal job title would bar her from campaigning

By Paul Bedard
THE WASHINGTON TIMES

If first lady Hillary Rodham Clinton dodges an open-meetings lawsuit by gaining a federal job title, she will be barred from political campaigning, even for her husband, according to new court documents.

In an appeal filed March 22 challenging a federal court ruling forcing her to open her health care task force meetings to the public, Mrs. Clinton argued that she is essentially a federal employee and thus meets rules letting her hold the meetings in secret.

Arguing against Mrs. Clinton's appeal in court papers filed yesterday, an attorney for the Association of American Physicians and Surgeons said that if the first lady gets her way and is designated a federal worker, even if unpaid, she will be barred from campaigning under the Hatch Act, which prohibits most federal workers from participating in partisan politics.

Mrs. Clinton also would be in violation of the Kennedy Act, an anti-nepotism law, said attorney Kent Masterson Brown.

"The first lady would be prohibited from participating in any future political campaign of her husband," Mr. Brown said.

In the latest twist of a federal law-

see **HILLARY**, *page A10*

HILLARY

From page A1

suit seeking to open Mrs. Clinton's health care reform task force to the public, three groups suing the White House also charged the first lady with practicing policies similar to President Nixon's efforts to hide his Oval Office tapes.

"Any claimed need for secrecy is fictitious, illusory, and purely politically motivated," said new appeals documents filed by the Association of American Physicians and Surgeons Inc., one of the three groups that won a suit forcing Mrs. Clinton to open her health care task force meetings.

The group, along with the National Legal and Health Policy Center and the American Council for Health Care Reform, filed papers yesterday countering a White House appeal of their secrecy lawsuit.

The three groups also filed their own appeal of a federal District Court judge's decision in their secrecy lawsuit that let the 500-person working group helping Mrs. Clinton's task force develop health care legislation meet behind closed doors.

At issue is a March 10 ruling by District Judge Royce C. Lamberth ordering Mrs. Clinton to open fact-finding meetings of her health care reform task force to the public. The judge, however, also ruled that the task force's satellite working groups could meet in secret.

In his opinion, Judge Lamberth said Mrs. Clinton is not a federal worker despite her chairmanship of the task force and her membership on the group requires that it meet in public to comply with the Federal Advisory Committee Act. The act demands that presidentially appointed task forces including even one nonfederal employee must meet in public.

But Mrs. Clinton has refused calls to open up her group and has held only one public session, during which witnesses were given just three minutes to present their case.

Her task force is working on a potential $150 billion health care reform package that some officials said could result in a new 7 percent payroll tax. The three groups filed suit to gain access to the task force.

In their appeal of Judge Lamberth's decision, Mrs. Clinton's attorneys argued that the "first lady's role on the task force is that of a public servant, the functional equivalent of an officer or employee."

Mr. Brown charged in yesterday's filing that Mrs. Clinton's Justice Department and White House attorneys are tying to win a special exemption to skirt federal sunshine laws.

Hillary Rodham Clinton

He also charged that Mrs. Clinton is ducking requirements to make public the policy papers drafted by the task force.

Mr. Brown compared her efforts to those of Mr. Nixon, who went to court during the Watergate controversy to keep his Oval Office tapes secret. Mr. Nixon claimed that executive-privilege provisions let him keep the tapes secret because they dealt with confidential conversations between government officials and the executive branch — the same case argued by Mrs. Clinton.

A hearing on the appeals of Judge Lamberth's ruling is not scheduled until late April.

Meanwhile yesterday, the director of the Association of American Physicians and Surgeons expanded the attack on the secrecy surrounding Mrs. Clinton's health care reform task force.

"One black, 3-inch notebook was all the information the government is making available to the public," Dr. Jane Orient said in Seattle.

"Why is it a secret? Why aren't they letting us know about it? Why isn't it open to public discussion?" she asked.

Her group has asked the White House to turn over policy papers and other documents used to draw up its reform package, which is due May 1, but the request has been refused. Dr. Orient said her group would go back to court to force the White House to comply with Judge Lamberth's demand to make all policy papers public.

"We believe we are in full compliance with the court order," said Bob Boorstin, spokesman for the first lady's task force.

"I find it somewhat peculiar they would say such a thing without giving us a chance to place papers in the public reading room," he said. "The papers are being made available as they are passed through the process."

Mr. Boorstin was referring to White House plans to open up a small public reading room in which policy papers would be made public.

Wash. Times; 4-6-93

500-worker ceiling eyed for health plan

By Karen Riley
THE WASHINGTON TIMES

C-1

President Clinton's health care task force appears to have settled on a maximum of 500 employees for companies to be eligible for the new regional buying cooperatives he envisions in his emerging plan to revamp the nation's medical insurance system.

Ira Magaziner, responsible for the day-to-day work of the task force, emphasized companies of 500 or fewer in a meeting yesterday with some of the nation's governors, according to Douglas M. Cook, director of Florida's Health Care Administration.

That would mean that companies with 500 or fewer workers would have to abandon their existing plans and join the regional cooperatives known as health-care-purchasing cooperatives. Companies that exceed the size could continue to offer their own health plans.

These government-sanctioned purchasing cooperatives would bargain with groups of health care providers for the best health plan for their members.

Bureau of Labor Statistics figures show that 99.8 percent of all companies have fewer than 500 workers and that those companies account for 78.6 percent of all jobs.

The task force has been considering company sizes ranging from 100 to as many as 1,000 workers.

"It seems clear to me that we're well on our way to a [cooperative] size of 500 employees," said William Bennett, chairman of the Self-Insurance Institute of America in Irvine, Calif.

His organization has argued for keeping the size requirement as low as possible to allow more companies to keep their self-funded plans.

"The fear is [not] being able to have some control over your destiny," he said. "If a company is thrown into a [buying cooperative], they would have no control whatsoever."

An earlier reform plan by House Democrats who are members of the Conservative Democratic Forum contemplated a company size of 1,000 in a buying cooperative. They argued that a large cooperative would be able to negotiate a good rate and also be diverse enough to spread the risks — there would be enough healthy members to counterbalance costs incurred by members with chronic or expensive medical proble

Mr. Magaziner also told the govern yesterday that the president would pose a so-called "SuperMedicaid" gram that would provide free or virtu free medical care for everyone with income of up to 200 percent of the erty level, which is about $14,000 f family of four. The federal governm would pick up the added cost.

Medicaid, funded by the states and federal government, currently is a able only for those at the poverty l who are on welfare.

Persons who earn more than 100 cent of the poverty level but less than percent would be charged a modest based on a sliding scale calibrate their income.

Balt. Sun; 4-6-93

Identity 'security' card likely in Clinton health plan

Associated Press

15A

WASHINGTON — President Clinton's plan to reform health care is likely to include a universal identity card that may use Social Security numbers to keep track of patients, say White House and congressional aides involved in drafting the package.

Ira Magaziner, coordinator of the president's health care task force, says a "health security card" could be part of the plan Mr. Clinton expects to give Congress this spring.

Two congressional aides with ties to the task force, both speaking on condition of anonymity, said Social Security numbers were being considered as the identification number for the cards.

More than 200 million Americans have Social Security numbers. All parents who want to claim a child as a tax deduction must now get a Social Security number before the baby's first birthday.

One of the congressional aides said the medical ID card would likely apply first to patients who receive free or assisted medical care under the plan. Eventually, every consumer could get a health card. An estimated 37 million Americans currently do not have health insurance.

Privacy experts contend that use of Social Security numbers could compromise the confidentiality of a patient's medical history in this age of computerized, womb-to-tomb records.

"It's not a secure identifier," said Evan Hendricks, editor and publisher of the *Privacy Times*, a biweekly newsletter in Washington on privacy issues. "If your Social Security number falls into the hands of unscrupulous person, it can potentially ruin you financially or otherwise.".

It's not clear how sophisticated the medical ID cards would be — as simple as a plastic card with a name and number or something closer to the cards for automatic bank teller machines.

A congressional aide said the cards could be used by doctors and hospitals to call up a cardholders' medical records, such as their insurance benefits, from a computer.

Mr. Magaziner told consumer and health advocacy groups Friday that a "smart card" carrying the card holder's detailed medical history in a microchip was several years away.

Smart cards, he said, "could serve a lot of good uses in health care. . . . People would have their patient information with them. On the other hand, one has to resolve certain security issues."

Critics say employers, creditors or insurance companies could obtain medical information and use it to deny someone a job, credit, or life or car insurance.

USA Today; 4-6-93

Group: Health plan still 'hatched in dark'

The group that forced President Clinton's health-care reform task force to hold public meetings charged Monday it is still withholding information.

Reform plans "are being hatched in the dark," said Jane Orient, director of the Association of American Physicians and Surgeons, after the group filed documents in Washington's U.S. Court of Appeals asking that all task-force meetings, including drafting sessions, be open to the public.

Last month, federal Judge Royce Lamberth ruled the task force — chaired by Hillary Rodham Clinton — had to open its fact-finding meetings to the public and must release related documents. The ruling allows policy recommendations to be drafted behind closed doors.

Hillary Clinton, after 2½ weeks at her ailing father's bedside in Little Rock, returns to health care today with a speech at the University of Texas. (Opinion USA, 11A)

Wall St. Jrnl.; 4-6-93 p. 1

Clinton's health care plan is expected to include a universal identity card that may use Social Security numbers to keep track of patients, according to White House and congressional aides involved in drafting the package. Separately, a group of doctors charged that the White House task force is continuing to keep its records secret.

Wall St. Jrnl.; 4-6-93 p. 1

BUT COST CONCERNS block any bigger long-term care climb.

"It's not an inexpensive policy. How many will be able to afford it?" asks Lauran Bocian, a Knight-Ridder official. Transco Energy, Mitchell Energy & Development, Ryder System and Southern Co. aren't interested. High premiums turn off Southwest Airlines and Houston Lighting & Power. Lockheed and Hughes Aircraft cite cost and tax uncertainties, as deterrents.

Hughes also waits to see what the government does on health care and tax policy. Chevron met last week with a member of Hillary Rodham Clinton's health-care task force, which is looking at options including federally subsidized long-term care for poor people.

USA Today; 4-6-93

The Clinton administration is on the right track with its proposal to provide free childhood vaccines for all children at a cost of $1 billion annually, USA TODAY said Friday in an editorial. Readers responded:

Free vaccines the least U.S. can do

A lot of people don't realize the importance of vaccinating their children, and that puts all our children at risk. As a nursing student and a white, middle-class mother of four, I am very much in favor of free vaccines for all children in the U.S.

Kaye Robert
Casper, Wyo.

Won't increase vaccinations

I am definitely opposed to the Clinton administration proposal. Vaccine is already freely available in public-health field offices.

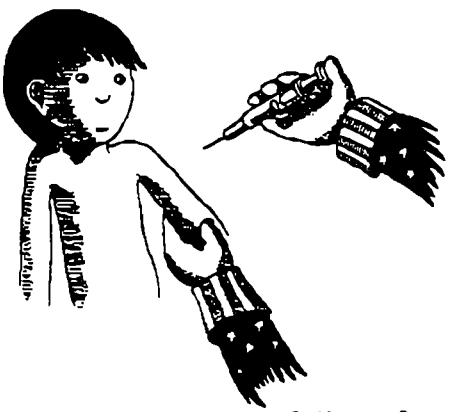
This program would not increase the number of children vaccinated; it would only increase the spending.

Cassandra Kuypers
Albuquerque, N.M.

Parents should be able to choose

After struggling for 31 years to care for my tragically vaccine-damaged son, Scott, and in light of the vaccine proponents not fully disclosing serious flaws related to vaccine safety and vaccine procedures, I am adamantly opposed to tax dollars providing or tracking children's vaccinations.

The government's own records reflect that 23,384 post-vaccine "adverse events" occurred between 1990 and 1993, hundreds of which were deaths.



By Margaret Scott

As of March 8, over 3,000 vaccine injury and death claims await adjudication in the U.S. Claims Court. Already, there is a $171.9 million shortfall of funds for the devastated families who have proved their cases and await relief.

In view of these circumstances, Congress would be seriously remiss to fund President Clinton's mass-immunization proposal.

Above all, parents must have the freedom of choice whether or not to vaccinate their children.

Marge Grant
Beaver Dam, Wis.

More vaccine education needed

As a pharmaceutical representative, I sell vaccines and I'm in hospitals all the time.

Although there are clinics all over Long Island that already distribute vaccines for free, many of the pediatricians I sell the vaccines to tell me they have patients who recently lost jobs and are too proud to go get the vaccines free. Some actually let their children go without vaccinations. Others don't realize the vaccinations are necessary, or they fear the vaccines.

A number of states across the nation — including Michigan — distribute vaccines free, but studies show that this has not increased vaccination rates. Just because it's free doesn't increase rates. Education has to be more widespread to let people know the importance of vaccines and where they can get them.

I also don't believe that my tax dollars should pay for vaccinations for children from wealthy families that can afford them.

John Jacobs
Farmingdale, N.Y.

One in a series of close-ups on President Clinton's appointees for the Cabinet and other top administrative positions

USA Today; 4-6-93

Surgeon general nominee 'has that magic power'

By Mimi Hall
USA TODAY

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Joycelyn Elders doesn't mince words.

"You sold our children to the tobacco industry," she railed at Arkansas lawmakers after they rejected a tax on cigarettes last month. "I guess (I'll go) be surgeon general and raise the federal cigarette tax $2."

Strong threats from a woman who still faces a Senate confirmation hearing before she officially can call the job of surgeon general hers.

But waiting quietly doesn't come naturally to Elders, who has found herself in the strange role of appointee-without-confirmation, while waiting for current Surgeon General, Antonia Novello, to leave in June.

While she waits, Elders, a 59-year-old pediatrician who heads Arkansas' Department of Health, is blazing a trail around the country, speaking in two dozen states since her nomination last December.

Those speeches often include pitches for controversial causes such as sex education in schools, as well as health care for the poor and services for children "treated like biodegradable trash."

Elders, a sharecropper's daughter who earned a medical degree, is clearly wasting no time. And she doesn't rein herself in for a group of senators — or the president.

"He's had five years of me," Elders says with a laugh. "President Clinton knows what he's getting."

In Arkansas, Elders has made front-page news with her crusades against teen pregnancy and AIDS since then-Gov. Clinton named her state health director in 1987.

A health-care advocate who has angered conservatives with her straight talk and support for providing condoms in schools, Elders' crusading style attracted national attention long before Bill Clinton took the national stage.

Liberals call her a godsend. Conservatives call her a dangerous extremist.

"With Joycelyn Elders," says Little Rock columnist Max Brantley, "you've bought controversy."

THE ELDERS FILE

Age: 59

Position: Surgeon general

Number of employees: 6,000 doctors, nurses, social workers and others members of the Commissioned Corps of the Public Health Service who work in federal prisons, public health clinics, Native American programs and other facilities.

Background: Educated at Philander Smith College, Little Rock, Ark., and Arkansas Medical School, Little Rock. Now is director of Arkansas Department of Health at $124,000 a year.

Purpose: The surgeon general's primary role is to serve as a spokesperson, promoting public awareness of important health issues.

In Little Rock, Joycelyn Elders stories are legend.

Standing before reporters on the day she was appointed state health chief, Elders started a firestorm when she was asked whether she favored providing condoms in school-based health clinics.

"Well, we're not going to put them on their lunch trays," she said. "But, yes."

And in January 1992, Elders infuriated conservatives when she told an abortion rights rally in Little Rock that abortion foes need to get over their "love affair with the fetus."

Says Jerry Cox of Little Rock's conservative Family Council: "Her advocacy of abortion has really caused more controversy than anything else. I wonder how adequately she can represent all the American people as the nation's doctor."

It's not just Elders' views than rile some opponents: It's her take-no-prisoners style.

Last year, Elders characterized abortion foes as part of "a celibate, male-dominated church, a male-dominated legislature and a male-dominated medical profession."

That prompted *Arkansas Democrat-Gazette* editorial writers to remark: "The doc is political correctness on wheels. Even those she attacks should give her credit for spunk . . . Keep talking, doc. We don't have to agree to enjoy the spectacle."

Opponents acknowledge Elders has the courage of her convictions.

Says Anne Dierks, former president of Arkansas Right to Life and a longtime Elders opponent: "I admire the spunk and the courage that she has. I dislike the policies she promotes, but I don't dislike her. I admire her for standing up for what she believes in."

That trait could make her one of the most influential surgeon generals ever, supporters say.

Says Stanford University professor Birt Harvey, former head of the American Academy of Pediatrics: "She speaks very forcefully . . . like the Southern Baptist preachers speak. She has that magic power."

All the national attention still stuns Elders a little.

The oldest of eight children, Elders was raised in the small farming town of Schaal, Ark., where her parents worked in the fields.

Growing up, she never saw a doctor, Elders says, and it never even occurred to her she could become one.

But there always was something "a little different" about Elders, says her younger brother, the Rev. Chester Jones of Little Rock.

He was amazed when she went off to college, at a time when segregation forced black people in Arkansas to use "colored" restrooms.

"I don't know where she got that from that she wanted to go to college," he says. "But once she broke through that line, she was like a missionary, coming back and telling us we could go, too."

Jones became a preacher; another brother, a veterinarian. "She was the inspiration," says Jones.

Elders says she never planned to attend Philander Smith College and went only because the school offered her a scholarship.

After college, she enlisted in the Army and became a physical therapist. While in the Army, Elders ap-

By Spencer Tirey, AP

FACING HEARINGS: Joycelyn Elders has been nominated for surgeon general post.

USA Today; 4-6-93

Novello not slowing down in final days

By Carrie Dowling
USA TODAY

7A

While Joycelyn Elders works her way into the surgeon general's office, Antonia Novello is working her way out with a stepped-up crusade against tobacco and alcohol abuse.

Novello was appointed by President Bush to a fixed four-year term in March 1990 and could have kept her job until 1994. She agreed to resign if President Clinton would let her stay through June 30 so she could finish her tours and speaking engagements.

"A lot of the projects I was working on were planned six months ahead, and they were very gracious to let me stay until June," she says.

Among her concerns: the easy access minors have to chewing tobacco.

"Tobacco is tobacco whether you smoke it, chew it or spit it," she says. She contends the USA can expect an oral cancer epidemic in 20 years if parents don't take smokeless tobacco seriously and if lawmakers don't make it harder for youngsters to get.

Novello, the first woman and first Hispanic in her post, will travel to New York and Los Angeles this month to urge doctors to pay more attention to the health needs of poor and immigrant Latinos.

Her main goal is to finish the office's second comprehensive report on AIDS. The first was published in 1987 under her predecessor, C. Everett Koop.

"This one will be geared toward education and prevention in non-judgmental, realistic and sensitive language," she says.

Finally, she wants to finish reports on vaccinating children and on the dangers of teen drinking.

"Before I go, I want people to never forget that underage drinking is a big, big problem in this country."

plied and was accepted to the University of Arkansas' medical school. It was during those years, says her brother, that he noticed a change.

Home for a visit in 1957, Elders agreed to take a couple of her younger siblings to the local drive-in.

When they arrived, "they told us we would have to park in the back because we were black," Jones says. "Joycelyn decided she was not going to park back there, so she went and parked in middle. And they came and told her to move back and she got into this, 'I'm not going to move back. I have the right to be here.' "

At the time, Jones was surprised: "It shocked me that she would question customs and traditions that we were used to."

Elders laughs about the story and says only, "I don't think of myself like that."

In Little Rock, Elders is a regular fixture at local high school football games; her husband, Oliver, is a coach. Their sons are grown. Elders' mother-in-law, who has Alzheimer's disease, lives with the couple.

When she leaves Arkansas in June, Elders predicts "they'll miss me — like you miss somebody that's been sticking you with a pin."

Wash. Post; 4-6-93 p. 1

Abortion Coverage Proposed

Administration Seeks End to Ban Affecting Federal Worker Plans

By Stephen Barr
Washington Post Staff Writer

The Clinton administration, in another reversal of Reagan-Bush policies, is proposing to allow federal employee health insurance plans to offer coverage for abortions.

Under a decade-long ban, health insurance coverage for abortions has been allowed only if a woman's life is endangered by her pregnancy. The strict ban has been enforced by a provision attached to the Treasury Department-Postal Service appropriations bill.

"The provision has been proposed for deletion" in President Clinton's budget, which is scheduled for release Thursday, a spokesman for the Office of Management and Budget said.

"The budget will also say that the administration will work with the Congress to develop an approach that is consistent with federal and state laws," the OMB spokesman said.

The decision is the latest in a series of steps the Clinton administration has taken to break with Reagan-Bush abortion policies. Two days after taking office, Clinton overturned five abortion restrictions, including the "gag rule," which had prevented abortion counseling by anyone but physicians at federally funded clinics. More recently, the administration indicated it will not seek reauthorization of the Hyde Amendment, named for Rep. Henry J. Hyde (R-Ill.), which forbids the use of Medicaid money to pay for abortions.

Carolyn Kroon, president of Federally Employed Women, applauded Clinton's decision, saying the ban discriminated against women in the civil service and their female dependents by denying them access to complete health care coverage.

Because federal workers pay a part of their health insurance premium, Kroon said, the government "should not be able to limit how they use their health care."

Under the ban, abortions are not covered for any reason, including rape or incest, except "where the life

See ABORTION, A22, Col. 2

ABORTION, From A1

of the mother would be endangered if the fetus were carried to term."

The ban also forbids the use of federal funds to pay administrative expenses "in connection with any health plan under the Federal Employees Health Benefits Program which provides any benefits or coverage for abortions."

Because Congress must join Clinton in lifting the ban, it was not clear yesterday how soon abortion coverage might be available to federal workers.

The Office of Personnel Management (OPM), which oversees the Federal Employees Health Benefits (FEHB) Program, did not include abortion coverage as a proposed benefit in its "annual call" letter sent to insurance companies on March 31. Each insurance carrier in FEHB would have to decide whether to offer abortion coverage as part of its plan.

Asked about FEHB procedures, an OPM spokesman replied, "The sooner Congress acts on the proposal, the better the chance of having some extended abortion coverage available in January 1994."

More than 9 million federal workers, dependents and retirees are covered by the FEHB program. In 1980, FEHB financed 17,000 abortions, including about 3,400 in the Washington area. The abortions cost the government $9 million.

The latest national figures available, from September 1991, show that there are more than 953,000 women employed by the government, with approximately 630,000 of them under the age of 45. The figures are for the executive branch and do not include women employed by the U.S. Postal Service.

The controversy over using federally aided health insurance plans to pay for abortions began in 1980, when the House approved a provision sponsored by the late representative John M. Ashbrook (R-Ohio) that prohibited such coverage. Ashbrook's ban was sidetracked later that year when the Senate refused to go along.

A year later, however, the House, voting 253 to 167, affirmed its support for Ashbrook's ban. President Reagan's director at the Office of Personnel Management, Donald J. Devine, then moved to eliminate abortion coverage from the FEHB program. "The president has long opposed the use of taxpayers' funds to pay for abortions," Devine said in a Sept. 24, 1981, statement.

Within days, federal employee unions went to court to nullify Devine's decision. Faced with two lawsuits and a judge's order in a third case supporting non-emergency abortion insurance coverage, Devine relented and accepted general abortion coverage.

But in 1983, Devine was able to declare victory. The Senate agreed to the House ban on abortion coverage when it voted on a huge funding bill designed to keep the government operating through the end of fiscal 1984.

The provision has remained in the budget since then, primarily because congressional Democrats doubted they could get Congress to override a veto by Presidents Reagan and Bush.

Devine's decision to bring the Reagan administration's antiabortion policy into the federal workplace created a furor at the time. "It was being fought because it eliminated abortions but also because it was a dangerous precedent," Kroon said. "If you can take this away, what else is going to be next—that's where a lot of people were coming from."

Devine could not be reached for comment yesterday.

Staff researcher Barbara J. Saffir contributed to this report.

N.Y. Times; 4-6-93

Associated Press

First H.I.V.-Positive Haitians Arrive From Guantánamo Bay Naval Station

Sixteen Haitians infected with the AIDS virus arrived in Miami yesterday from Guantánamo Bay, Cuba. They were the first arrivals under a ruling last month by Judge Sterling Johnson Jr. that the United States must either provide medical treatment for them at Guantánamo Bay or send them elsewhere for treatment. Frantz Rico greeted Lieu Main at the Catholic Conference office in Miami.

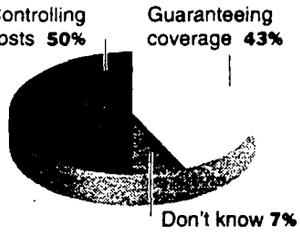
Support Found for Broad Change in Health Policy

The New York Times | CBS NEWS Poll

Priorities on Health Care and Its Costs

The public wants all Americans to have health insurance coverage, and costs to be controlled.

Which should the Government be more concerned about — guaranteeing health-care coverage for all Americans, or controlling costs?



Americans are also willing to accept some personal limit s to achieve these goals . . .

If it would reduce your health-care cost, would you be willing or not willing to choose a doctor from a list instead of going to see your current doctor?		If it meant you would be guaranteed of always having health-care coverage, would you be willing to give up choosing your own doctor?	
Willing	53%	Willing	59%
Not willing	42%	Not willing	37%

And they are prepared to pay more taxes.

Would you be willing or not willing to pay more in taxes to provide health-care reform?

Willing	58%
Not willing	37%

But the public also wants the Government to intervene.

Should the Government set limits or stay out of how much doctors charge?		Should the Government require companies to provide health insurance for all their workers or should this be left up to the individual company?	
Set limits	72%	Required by Government	54%
Stay out	23%	Left up to the company	41%

Based on nationwide telephone interviews with 1,368 adults conducted March 28-31.

The New York Times

Continued From Page A1

similar prepaid plans, which provide a range of services for fixed monthly premiums. In effect, Americans would accept greater limits on their choice of doctors in return for lower costs and security of coverage.

A majority in the poll said they would accept, in general, some restrictions on their choice of a doctor if it brought those benefits. But most Americans also said they had a doctor now whom they considered their own, and a majority said they would pay extra to keep that doctor.

Similarly, a majority said that most doctors overcharged, but that their own doctors' fees were reasonable.

Resistance to Rationing

And, while most Americans say their health-care system was in a crisis because of rising costs, an overwhelming majority — 74 percent — said they were satisfied with the quality of their care. This held true regardless of sex, race or income.

In another reflection of the high value that people put on health care, the poll found an aversion to the idea of rationing. Only 33 percent were willing to give up "having certain expensive treatments like organ transplants covered by insurance" to reduce their health-care costs. Fifty-seven percent rejected this trade-off.

Such findings suggest the political conundrum that some analysts see at the heart of the health-care debate: The public wants the current quality of care, at a lower cost and with the assurance that they will never lose it.

The nationwide telephone poll of 1,368 adults was conducted March 28-31 and had a margin of sampling error of plus or minus three percentage points.

The survey found support for several measures under consideration by the Clinton task force, including these:

¶Fifty-four percent said the Government should require companies to provide health insurance for all their workers; 41 percent said it should be left up to the individual company. Support for that mandate was stronger among women and Clinton voters, and weaker among among men and those who voted for President George Bush or Ross Perot.

¶Fifty-five percent favored additional sales taxes on cigarettes and alcohol to discourage their use.

¶Seventy-two percent said the Government should set limits on how much doctors can charge patients; even Bush voters backed these limits.

¶Seventy-eight percent backed price controls on prescription drugs.

¶Fifty-eight percent said they were willing to pay additional taxes to improve the health-care system, even beyond the increased taxes needed for deficit reduction.

Adjustments Acceptable

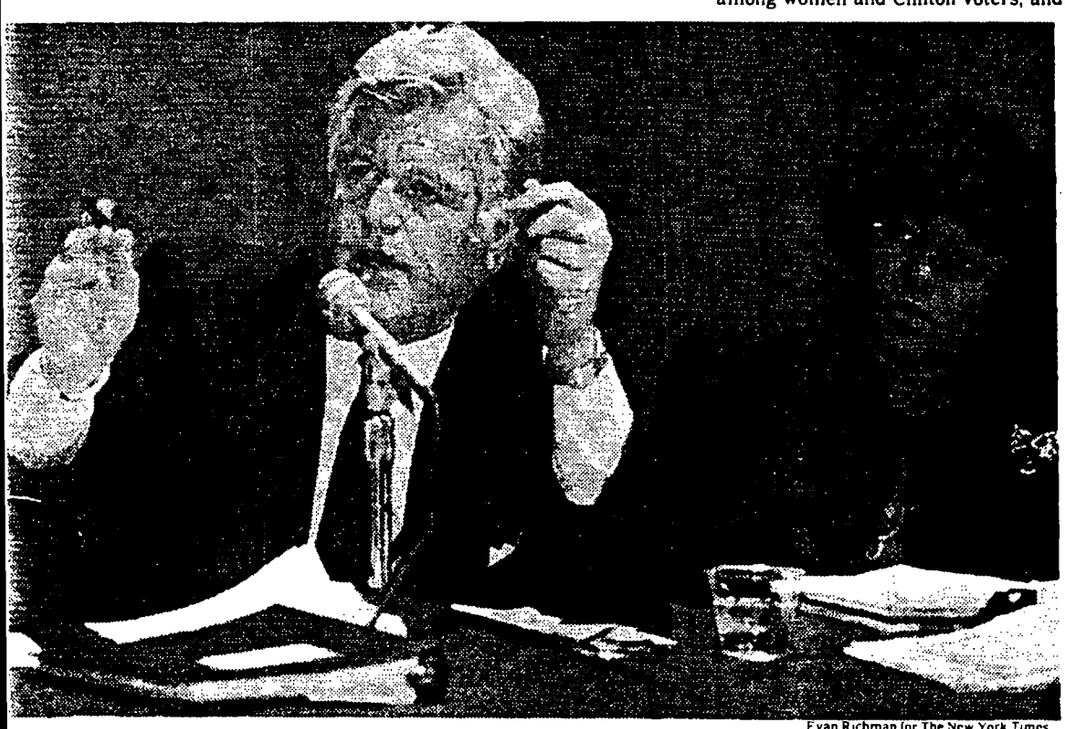
The poll also found majorities willing to make adjustments in their health-care arrangements if it would reduce their costs. Fifty-six percent said they would be willing to wait a longer time to get a non-emergency appointment with a doctor, for example. But that dropped to 44 percent among those 65 years of age and over.

> The people want quality care, at a lower cost.

Fifty-one percent said they would be willing to pay a higher deductible on their insurance coverage. And 48 percent said they were willing to join a group where all their health-care services would be covered for a fixed fee, even if some expensive tests are more difficult to obtain.

The idea of prepaid fixed-fee medicine, as practiced in health-maintenance organizations, is increasingly familiar to people; 25 percent said someone in their household was a member of an HMO. Fifty-four percent said that if they had to choose, they would prefer a fixed-fee system, while 36 percent said they preferred the current system of paying a separate fee for each service they use. Support for fixed-fee medicine tended to be lowest among the old.

Fifty-nine percent of the respondents said they favored a different model, one that Mr. Clinton has rejected: a Canadian-style system of national health insurance paid for with tax money. But that dropped to 36 percent when it was described as costing everyone an additional $1,000 a year in taxes even though it would free them and their employers from any other premium for basic health coverage.



Evan Richman for The New York Times

Senator Edward M. Kennedy speaking yesterday at a meeting of about 700 doctors, educators and community and labor leaders at the New England Medical Center in Boston.

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Basic Benefits Package

Many questions in the survey tried to get people to set priorities for health-care reform. For example, 50 percent said the Government should be most concerned about controlling health costs, while 43 percent said its chief concern should be guaranteeing health-care coverage for all Americans. People who described themselves as liberals were more likely to stress universal coverage, as were women.

The poll also sought the public's views on what should be covered by the basic benefits package that is expected to be guaranteed to all Americans under the Clinton plan. It found strong support for the big ticket item of nursing home and other long-term care; 65 percent said it should be covered. But long-term care is so costly that few expect the Clinton plan to provide immediate, comprehensive coverage for it, although the President is committed to making a start.

The survey also found that 80 percent supported the coverage of mental health care. But only 43 percent said the basic plan should cover programs to help people quit smoking, drinking or abusing drugs; 53 percent said those programs should be paid for directly by the people who use them.

Only 26 percent said the plan should cover fertility treatments for couples who cannot have children. And only 23 percent said it should cover abortions, while 72 percent said those costs should be paid for directly by the woman who have them. The abortion question followed the question about fertility treatments, and may have been influenced by it.

Acutely Personal Impact

In many ways, the survey showed the acutely personal impact of rising health-care costs and the spreading insecurity about health insurance, all of which helps explain the support for change. A fourth of the respondents said that someone in their household had been without health insurance sometime over the past year. A third said that someone had continued working in a job they wanted to leave because they feared losing their health insurance. And 30 percent said someone in their home had taken one job rather than another because it had a better health plan.

The middle class is right in the middle of the problem: 44 percent of the total sample said the employer of someone in their household had cut back on health benefits or made the wage earner pay a higher share of the cost in recent years. Fifty-seven percent of those earning from $30,000 to $50,000 a year had that experience.

Still, there was evidence that some people remain insulated from the true cost of health care: 42 percent said the last time there was a hospitalization in their family, nobody in the family saw the bill.

The public's ambivalence — and the way their personal and political views can collide —— was perhaps most clear in the attitude toward doctors. By a nearly 2-to-1 ratio, people said that most doctors' fees were unreasonable and that doctors were just trying to "make as much money as they can."

But when were asked about their own doctors' fees, their opinions reversed: by 2 to 1, people said their own doctors' fees were usually reasonable. In this, their attitudes are reminiscent of the distinctions they draw with Congress: they dislike the group as a whole, but not their own lawmaker.

Poll Says Public Favors Changes In Health Policy

A1 - ✓

By ROBIN TONER

Fired by a sense of crisis, a majority of Americans say they are willing to accept substantial changes in their health-care system, including government price controls, new taxes and longer waits for non-emergency appointments, according to the latest New York Times/CBS News Poll.

They have high expectations for President Clinton's promised health-care plan, the poll found, and they consider changes in health care an issue at least as urgent as the Federal deficit, which is near the top of the public's agenda.

In general, a majority of Americans seem ready for far more government involvement in the health-care system if that involvement can control costs and guarantee coverage for all, the poll shows.

Ambivalence Over Trade-Offs

Still, the survey found numerous signs of confusion and ambivalence toward some of the trade-offs that health-care reform may mean; as a result, it is a rough sketch of the challenge facing the President and Hillary Rodham Clinton, who heads the task force on health care. The task force is expected to produce a plan sometime in May.

While crucial decisions have yet to be made, Mr. Clinton has said he favors an approach known as managed competition, under which doctors and patients would be encouraged to join health maintenance organizations or

Continued on Page A20, Column 5

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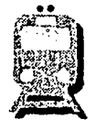
Inside the Spending Package

Democrats say the $16.3 billion spending package now stalled by a Republican filibuster in the Senate would give the economy a lift, creating more than 200,000 temporary jobs, even as it helps rebuild national assets like highways and airports. Republicans say the measure is laden with pork-barrel projects and that the economy doesn't need a jolt of more deficit spending.
Here are some of the programs on which the Administration has proposed to spend the money. Estimates of the number of full-time jobs they would create, when available, are in parentheses.*



PUBLIC WORKS AND TRANSPORTATION
$4.4 billion

Amtrak $187.8 million, including at least $43 million to renovate stations and buildings in 20 cities (1,450 jobs).

Airports $250 million for improvements, mostly repaving and extending runways (800 jobs).

Dam $70,000 to paint and repair gate seals at the dam powerhouse at the J. Strom Thurmond Lake, in Georgia and S. Carolina.

Mass transportation $270 million for "discretionary" grants to local transit authorities, mostly to buy buses and maintain rail lines (6,000 jobs).

Highways $3 billion parceled out by formula to the states. California would get about 10 percent; Texas, 7 percent; New York and Ohio, 4 percent (13,100 jobs this year; 45,200 in fiscal 1994).

SOCIAL WELFARE
$9.1 billion

Nutrition $98 million for programs for pregnant women and infants, and for food banks for the poor (300 jobs).

Student loans $1.9 billion to make up shortfalls in college student-aid program.

Inner-city schools $735 million for summer and fall programs (89,000 jobs).

Head Start $556 million for summer programs (50,000 jobs).

Immunization $300 million to immunize children (250 jobs).

Veterans hospital $250,000 to install electronic light ballasts in the Grand Island, Neb., Veterans Administration hospital.

Military cemeteries $32 million to build roads, repair buildings and clear grave sites, including $740,000 to repair flood damage at the cemetery in Riverside, Calif. (700 jobs).

URBAN AND RURAL DEVELOPMENT
$3.8 billion

Meat inspection $4 million to hire new inspectors (160 jobs).

National Arboretum $2 million to replace water pipes.

Cities $2.5 billion for community development grants.

TECHNOLOGY
$631 million

Information $64 million to plan an "information superhighway," using and improving existing public television equipment and other communications facilities (30 jobs).

ENERGY AND ENVIRONMENT
$1.4 billion

Methane gas $6 million to recycle methane gas from coal mines, landfills and farm-animal dung (120 jobs).

Sewage treatment $845 million to build sewers and treatment plants (fewer than 16,500 jobs).

Fish $50,000 to study large river populations of the sicklefin chub in Montana; $75,000 to prepare atlases of freshwater fish in Louisiana, Illinois and Florida.

*A job is defined as one person working for one year; some figures represent the sums of many temporary or part-time jobs.

Source: House of Representatives

The New York Times

Continued From Page A1

needed to break the filibuster.

Mr. Clinton's chief lobbyist, Howard Paster, was more circumspect, saying only that negotiations were the business of the two party leaders, Mr. Mitchell and Mr. Dole, not the White House. Both remarks were departures from earlier statements by Senate Democrats, who said the spending measure should be passed virtually as written, or not at all.

The parties are fundamentally at odds over the proposal. Although both sides agree it is a minuscule amount of money to filibuster over, especially compared with the $1.5 trillion Federal budget, the specifics have been overwhelmed by political and philosophical considerations that defy easy bargaining.

More broadly, the delay calls into question the White House's early confidence that one-party Government would be a smooth affair. To the contrary, the filibuster sends a message that any disputed legislation — and all of Mr. Clinton's tax and spending proposals fall into that category — cannot be assured of passage unless it can attract 60 votes in a Senate that has only 57 Democrats.

Democrats, led by Mr. Clinton, say the bill and the programs it creates are urgently needed to prop up a sagging economy, and they point to the March unemployment report, which showed a slight decrease in jobs. The package would spend $4 billion for additional unemployment benefits and billions more to create jobs, most of them temporary, for construction workers, manufacturers and inner-city youngsters.

Republicans say the money would be wasted in part on low-priority projects and political pork, including things like a $6 million proposal to capture escaping methane from landfills and cow manure and a proposed allotment for a film on early Louisiana culture. Even worse, they argue, it would raise the Federal deficit because none of the spending would be offset by corresponding cuts in other Federal programs.

The Administration normally might have won over some Republicans with small compromises, but the opposition was calcified early in the debate, when Senate Democrats used parliamentary tactics to prevent Republicans from even offering amendments. That left them with the filibuster option.

Senator John H. Chafee of Rhode Island, one moderate Republican who can occasionally be pried from his more conservative colleagues, said today that he doubted he or other Republicans could be lured to Mr. Clinton's side this time.

Another of Mr. Dole's allies, Senator Mitch McConnell of Kentucky, said, "Our feeling is that we've gone this far now and that we ought to stick with it."

Tonight, Mr. Dole said the Republicans were insisting on a pared-down spending package that would include $4 billion in extended unemployment benefits, about $3 billion in highway and mass-transit money, roughly $1 billion in summer jobs for inner-city teachers and youths and $300 million for childhood immunizations.

> A Republican filibuster cannot be broken.

Even more troubling for Mr. Clinton and Mr. Mitchell is that the Republicans want all of those programs, save the unemployment benefits, to be offset by new cuts in Federal spending. The White House has argued that such cuts would defeat the purpose of the bill — to pump new money into the economy — and that further spending cuts that can pass the Congress are in any event almost impossible to find.

Complicating matters is the requirement that any agreement between the White House and the Republicans has to pass the House of Representatives, which strongly supports the original spending package and may be disinclined to accept Republican-directed cuts.

Tonight, Mr. Dole said he and Mr. Mitchell were considering setting aside the filibuster, at least briefly, to pass another measure raising the Federal debt ceiling and allowing the Government to sell enough bonds to finance operations through next autumn.

Official Virtually Rules Out Taxing of Health Benefits

By ADAM CLYMER
Special to The New York Times

BOSTON, April 5 — President Clinton will not try to help pay for his health-care program by taxing "in any significant way" the health insurance benefits that workers receive from their employers, one of his top health-care planners said today.

The official, Ira C. Magaziner, staff coordinator of the President's Task Force on National Health Care Reform, said that taxing the benefits, frequently mentioned as a major source of financing for the program, would be "foolhardy" because it would make "a significant portion" of the public worse off, rather than better.

Mr. Magaziner spoke from Washington by television satellite to a group of about 700 doctors, educators and community and labor leaders who were meeting at the New England Medical Center here with Senator Edward M. Kennedy, Democrat of Massachusetts. He said Mr. Clinton hoped to see that all Americans were guaranteed "very comprehensive" health care that included coverage of many costly services, from mental health treatment to long-term care of the elderly.

When Mr. Magaziner was asked how the Administration wanted to pay for its plan, in particular for covering the millions of Americans who now have no health insurance, he said: "We just haven't made decisions yet on that. We have laid out a whole series of options."

But when Joseph Flaherty, president of the Massachusetts A.F.L.-C.I.O., asked whether making workers' health insurance benefits taxable was one option, Mr. Magaziner said it was not. "I think I can say categorically," he said, "we are not going to tax, in any significant way, the benefits that have been won by workers in this country through negotiation over the years."

The basic system that the Administration intends to propose is known as managed competition. It envisions large numbers of people grouped together in cooperatives that would use their size to bargain with insurers for a basic insurance plan at the lowest possible rate.

Individuals would choose among different options for medical service, including health maintenance organizations and other arrangements. If they chose a plan that offered more than the basics, they would pay extra. Many advocates of managed competition, including most of its Republican supporters, argue that to make the system work it would be necessary to tax benefits beyond the minimum level in order to discourage excessive coverage.

Health insurance benefits now go untaxed. They are treated as a deductible business expense by employers and are not regarded as income to workers. Union leaders have been adamantly opposed to any taxes on such benefits.

The Administration's position on taxing benefits is linked to the breadth of the system it is considering. When Mr. Flaherty raised the question, Mr. Magaziner suggested that taxes might be imposed in some cases, but only on extremely generous insurance plans.

"If you have a very comprehensive plan, as we are hoping to do," he said, "and that therefore, what you are taxing is if people are spending money on cosmetic surgery or spending money on wanting to have a hotel suite every time they went to the hospital, that may be appropriate."

In effect, Mr. Magaziner appeared to suggest that the Administration would agree to tax insurance benefits beyond a basic plan but would set the basic plan generously enough so that the threshold was very high.

When pressed about particular services to be included, Mr. Magaziner generally avoided answering. "We are about to begin in the next week the decision-making about what's actually going to go into the plan," he said.

But he indicated that a decision had all but been made on mental health services.

"With respect to mental health," Mr. Magaziner said, "our view is that mental health and physical health clearly should be treated as one. Basically, there should not be treatment of mental health as an afterthought. And so we are looking in our comprehensive benefits package to treat them all in the basic package."

His answers about long-term care for the elderly were more general. He said that long-term care was "on the table" and that the Administration would "try to take steps in the direction of providing better long-term care."

"We are going to do something that will enhance long-term care," he said. "We just don't know exactly yet what the structure of that package will be."

Mr. Magaziner said the Administration's proposals would be made within "about a week or two" of its original May 3 deadline.

Senator Kennedy and Mr. Magaziner both said the Administration wanted to get the legislation passed this year, but most lawmakers consider the chances of meeting that target remote.

Assessing Cost And Quality

If it would reduce your health-care cost, would you be willing or not willing to give up having certain expensive treatments like organ transplants covered by insurance?

Willing	33%
Not willing	57%

On the whole are you satisfied or not satisfied with the quality of health care available to you?

Satisfied	74%
Not satisfied	24%

Do you think most doctors' fees are usually reasonable or are most doctors just trying to make as much money as possible?

Reasonable	31%
As much money as possible	57%

Do you think your doctors' fees are usually reasonable or are most of your doctors just trying to make as much money as possible?

Reasonable	48%
As much money as possible	21%

Based on nationwide telephone interviews with 1,368 adults conducted March 28-31.

Clinton Turns Inward in His Search For a Nominee to the Supreme Court

By STEPHEN LABATON
Special to The New York Times

WASHINGTON, April 3 — In a marked departure from his recent predecessors, President Clinton appears to be far more involved in the selection of a new Supreme Court Justice and is relying less heavily on the choices of White House aides.

White House officials say Mr. Clinton, a former law professor and Attorney General in Arkansas, is largely thinking about candidates on his own, working from his years of building acquaintances with judges and politicans. Aides say he has also been considering several people he approached to become Attorney General.

Among the candidates whose names have been mentioned by Administration officials are Gov. Mario M. Cuomo of New York; Judge Judith Kaye, who last month became the chief judge of New York's highest state court, and Judge Patricia Wald, who sits on the United States Court of Appeals in Washington.

Progressive Candidate Sought

The officials say Mr. Clinton is looking for a progressive on social policy, civil rights and privacy issues. He has a strong preference for someone who would be able to forge coalitions in a fractured and changing Court, a conciliator along the lines of former Associate Justice William J. Brennan Jr. And he specifically does not want to select a liberal version of Justice Antonin Scalia, who has staked out constitutional positions so extreme that he is often a lone voice.

So far, Mr. Clinton has been making calls to friends and advisers about whom to appoint. He has also been ordering his legal staff to provide him with background material, including opinions, writings and speeches, on several possible candidates. He has apparently not interviewed anyone yet.

Presidents Ronald Reagan and George Bush, who made six appointments to the nine-person bench, played a much more passive role in their selections and relied heavily on the recommendations of their senior advisers.

An Intellectual Interest

In contrast, Mr. Clinton has long showed a strong intellectual interest in the Court and its workings. One of his first visits in Washington after being elected was to the Court, where the same charm that he used effectively to woo voters apparently worked on several Justices, who came away impressed with the new President.

Two weeks ago, Justice Bryon R. White said he would retire in early summer after 31 years on the Court. Mr. Clinton has moved slowly and cautiously in selecting the first Democratic appointment to the High Court since Thurgood Marshall was chosen by President Lyndon B. Johnson in 1967.

David Jennings for The New York Times

Judge Judith Kaye, whose name has been mentioned as a possible Supreme Court nominee.

In part, the selection process by the President has moved slowly in part because Hillary Rodham Clinton has been preoccupied by the emerging health package which she has been formulating and by the declining health of her father, who suffered a stroke last month. Mrs. Clinton, who has a wide circle of friends who are judges and lawyers, played a leading role in picking Arkansas judges as well as the Attorney General, Janet Reno. She is expected to be important in the search for Supreme Court nominees.

The White House has decided to wait until at least May or June at the earliest to announce its choice to succeed Justice White on the theory that a replacement is not needed before the Court reconvenes in October. It also calculates that politically it would be better to keep short the amount of time between nomination and confirmation to reduce the likelihood of a campaign to block confirmation.

Another Retirement Near

Finally, there is strong speculation that another Justice may soon retire, which could permit Mr. Clinton to fulfill his pledge to promote more women and minorities to the Court as well as to justify the selection of a white male.

Three weeks ago, Justice Harry A. Blackmun said in a speech in Boston that he did not think he would remain on the Court much longer and that he did not want to be asked to retire. Justice Blackmun, who is 84, is second in seniority to Justice White. There is strong speculation among lawyers and Court watchers that Justice John Paul Stevens, who turns 73 this month, will also retire in the next few years.

Mr. Clinton is described as being acutely aware of the fact that, unlike Justices who sat in earlier Courts, the current Justices had mostly been either lower court judges or mid-level Justice Department officials. In other times, the Court has consisted of former governors, ambassadors, senators, and even a former President (William Howard Taft, who was Chief Justice from 1921 to 1930).

The President's choice will clearly embody a political calculation about which constituencies the nominee would most please. During the election, he complained that the Federal judiciary suffers from a shortage of women and minorities that threatened to put it out of touch with society.

Bush Appointments Assailed

"The narrow judicial appointments of George Bush have resulted in the emergence of a judiciary that is less reflective of our diverse society than at any other time in recent memory," Mr. Clinton wrote in The National Law Journal before the Nov. 3 election. "I strongly believe that the judiciary thus runs the risk of losing its legitimacy in the eyes of many Americans."

The Bush and Reagan Administrations put a premium on youth, hoping that their choices of generally conservative judges for the Supreme Court would outlive the more moderate members.

Mr. Clinton has signaled his intent not to take the age of any potential nominee into consideration, although he no doubt wants a Justice who can promise a lengthy career on the Court. When he was asked two weeks ago at his first news conference if the age of a potential nominee would be a factor, the President said: "On the age issue, I will not discriminate against people who are older than I am." Mr. Clinton is 46.

White House aides have tried to portray the search in a wider context. "What you have to understand is that unlike his predecessors, Clinton is a lawyer and he has taught Constitutional law," one Administration official said.

"He spent a formative time of his life as a student at Yale Law School, a law professor at Arkansas and the Attorney General of Arkansas. This is someone who can read opinions for himself, someone who stayed up late reading the opinions of John Marshall and wants to select a Justice whose opinions, like those of Marshall, withstand the test of time."

HHS RADIO
FOR MONDAY, APRIL 5, 1993

The feed consists of one story in English and one story in Spanish.

First -- The Department of Health and Human Services has launched the first U.S. study to assess treatment for persons infected with both tuberculosis and the HIV virus. HHS' Dr. Lawrence Deyton says the study will provide state-of-the-art treatment and answer important questions about the management of these patients.

And in Spanish.....

Second -- While the cause of Multiple Sclerosis is still not understood, there has been a recent focus on new MS treatments that have fewer side effects on MS patients. Dr. Henry McFarland of the National Institutes of Health says researchers now pay more attention to treatments that target specific areas of the immune system.

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2	Clinton Expresses Disappointment Over Block of Stimulus Bill		
	Brit Hume	Washington	1:50
3	Yeltsin Promises Siberia a Large Portion of US Aid to Russia		
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4	Today Marks the One Year Anniversary of War in Sarajevo		
	Charlie Glass	Sarajevo	3:00
5	Many Journalists Covering Sarajevo's War Were Killed or Wounded		
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6	Mubarak Says WTC Bombing Preventable if US Heeded His Advice		
	Peter Jennings	New York	0:20
7	Europe's Hoover Co. Promised Free Airline Flights, Can't Deliver		
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11	Judge Expects Rodney King Trial Arguments to End This Week		
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Linda Douglass Washington 1:30

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18 With War a Year Old, UN, US Consider Additional Pressure on Serbs
Jim Stewart Washington 2:10

19 After Latest Killing of FL Tourist, Chiles Requests Federal Help
Connie Chung Florida 0:25

20 Jurors in King Beating Trial Will View Testimony from 1st Trial
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21 Mock Trial of James Earl Ray Results in "Not Guilty" Verdict
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23 Use of Radiation Therapy for Cancer Often Worse Than the Disease
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25 National Debt at $4.23 Trillion
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26 Opening Day Finds Baseball Facing Racial Discrimination Charges
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27 Baseball-Starved South Florida Welcomes Marlins at Opener
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Jim Miklaszewski Washington 2:10

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31 Summit Successful; Yeltsin Back in Moscow with $1.5 Billion
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32 New Evidence in King Trial may be Major Setback for the Defense
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Kenley Jones Tampa Bay 2:20

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Medicare Will Go Broke In 1999, Trustees Warn

'Significant Worsening' in Fund's Economic Health Seen

By Spencer Rich
Washington Post Staff Writer

The Medicare hospital trust fund, which pays benefits to 35 million elderly and disabled patients, will run out of money in 1999, trustees of the system warned yesterday.

"These new estimates show a significant worsening in the economic health of the Medicare program," said Health and Human Services Secretary Donna E. Shalala in releasing the annual report on the financial condition of the Social Security system, which also pays retirement benefits to more than 41 million Americans from a separate trust fund.

The report also said that while Medicare has very serious immediate financing problems, the separate Social Security retirement and disability funds are healthier and will remain solvent until 2036.

Shalala said the perilous condition of the hospital trust fund, which paid out $85 billion in 1992, reflects "many of the problems we see across the board in our health system today, and they are another demonstration of the need for system-wide change." The Clinton administration is drafting a plan to overhaul the health care system that it hopes to announce next month.

The problems to which Shalala referred are the runaway increases in spending for health care—whose costs are rising at more than 10 percent a year—and the 37 million people without health insurance. President Clinton has said repeatedly that unless health care inflation is slowed, the economy could be crippled.

Last year, the system's trustees projected that the Medicare hospital trust fund would go broke in 2002. But William Toby Jr., acting administrator of the Medicare program, said that spending for home health and nursing home services has been rising faster than expected, in part because of increased efforts by the states to help the elderly make use of these benefits where possible.

In the past, Medicare taxes have never generated enough funds to assure the trust fund of long-term solvency, although revenue had appeared to be sufficient to cover costs for a decade. Now the solvency outlook has dropped to six years and if economic conditions are somewhat worse than projected by Social Security actuaries, the fund could be exhausted in 1998, the trustees said.

"The trustees urge the Congress to take additional actions designed to control hospital insurance program costs through specific program legislation and as a part of enacting comprehensive health care reform," the report said. Besides Shalala, the trustees are Treasury Secretary Lloyd Bentsen, Labor Secretary Robert B. Reich, and two public trustees, Stanford G. Ross and David Walker.

Social Security and Medicare are funded by the Social Security payroll tax of 7.65 percent each on employees and employers, of which 1.45 percentage points goes to the Medicare hospital fund. Social Security projects that during the next 75 years the costs of hospital benefits will be almost three times the revenue received by the hospital fund at current tax rates.

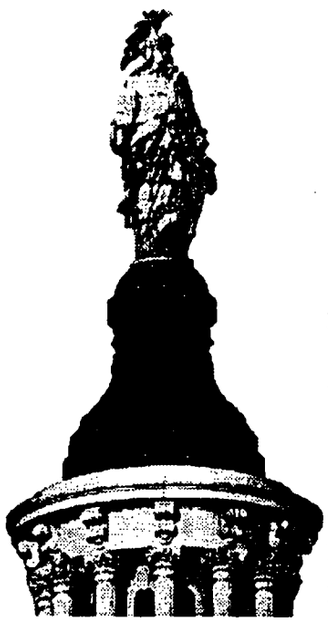
The Social Security old-age and disability programs, which paid about $290 billion in benefits in 1992, are in far better shape. Although the disability fund will run out of money in two to four years, the trustees said that can easily be remedied by shifting some funds from the healthier old-age fund. The combined funds are expected to remain solvent until 2036, and could last until 2067 (the end of the standard long-term 75-year evaluation period) by raising the payroll tax rates on employers and employees less than three-quarters of a percentage point each, the trustees said.

Robert J. Myers, former chief actuary of the system, said, "The financial status of the Social Security program remains favorable but quick action should be taken to restore the financial health of the hospital insurance program, without waiting several years until general health reform is achieved."

The Storm Over Dome Of Capitol

Who's to Bring Down Statue for Cleaning?

By Don Phillips
Washington Post Staff Writer



Only in Washington could restoration of a prominent bronze statue evolve into a tug of war involving members of Congress, the National Guard, the Architect of the Capitol, the private helicopter industry and the secretary of defense.

The Statue of Freedom, 14,985 pounds of crowning glory, is to be moved from atop the U.S. Capitol May 9. Who will lower it by helicopter 287 feet to ground level for cleaning for the first time in almost 130 years?

So far, the National Guard is winning. George M. White, Architect of the Capitol, chose the Guard instead of private-industry proposals, and handpicked crews have been training for weeks in Meridian, Miss., in anticipation of approval from Defense Secretary Les Aspin. He has the final say and is under a last-minute lobbying blitz.

At a base near Meridian, Guard troops are using huge, double-rotor CH-47D Chinook helicopters to lift concrete blocks weighing even more than the 19-foot bronze statue.

"It would be a great training mission, and it wouldn't cost the taxpayers a lot of money," said Rep. G.V. "Sonny" Montgomery (D-Miss.), who is chairman of the House Veterans Affairs Committee and suggested using the Guard. "If they're not doing it up here, they'll be lifting other things for the government."

The Mississippi Guard does have a reputation. On June 14, 1986, it rescued embarrassed Texas Guard colleagues who failed in 18 tries over two days to replace the "Goddess of Freedom" statue atop their state Capitol. The Texas Legislature named the Mississippi Guard crew "honorary Texans."

Enough already, said officials of the private helicopter industry, which has many precision lifts to its credit.

Frank L. Jensen Jr., president of Helicopter Association Inter-

See STATUE, A13, Col. 1

Capitol's Statue A Storm Center

STATUE, From A1

national, said the Guard would spend far more money than the $60,000 that Erickson Air-Crane of Central Point, Ore., would charge.

Saying the Guard would cost taxpayers practically nothing "is a stupid rationalization, absolutely stupid," Jensen said. Just moving the helicopters from Mississippi to the District would cost more than Erickson's entire fee, he said, not to mention the lengthy training.

The mere fact that the Guard feels a need to practice so intensely is "cause for concern," Jensen said.

Also at issue is whether a military helicopter is the right machine for what everyone involved calls a delicate operation.

The bronze statue and its cast-iron base, modeled in plaster by American sculptor Thomas Crawford in Italy and cast in bronze at the shops of Clark Mills on Bladensburg Road here, have survived lightning, wind and birds. To be dropped accidentally by helicopter would be embarrassing.

Once lowered to the Capitol plaza, it is to be cleaned with water or blasted with crushed walnut shells, then treated with chemicals to restore its original green color. The project, financed with $750,000 in private donations, is to take four months.

The statue is of a robed woman with one hand on a sword and the other holding a wreath and resting on a shield. Its designed headdress, a liberty cap similar to those worn by Rome's emancipated slaves, was changed to a helmet with eagle head and feathers when Secretary of War Jefferson Davis, soon to become president of the Confederacy, objected.

Erickson officials, backed by most of the Oregon congressional delegation, said their S-64F Skycrane, which looks like a flying Erector Set, is perfect for the job because its third pilot faces backward and can look down at an object being moved. Chinook pilots have no view of the cargo and rely on radio instructions.

Erickson also uses a load-suspension system designed to steady a load even when the helicopter twists or swings.

Montgomery scoffed, saying Skycranes are so old that the Mississippi Guard has grounded them and has eight for sale. He said he resents the fact that "all of a sudden," the helicopter industry wants to upset what he called yearlong plans to use the Guard.

"That's so shameful," Jensen said, "that an elected representative has to shove something down the taxpayer's throat that doesn't make sense."

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Officials at Texas Siege May Wait A Week Before Trying New Tactics

By William Claiborne
Washington Post Staff Writer

WACO, Tex., April 5—Federal authorities said today that they have lost faith in messianic cultist David Koresh's reported fixation with Passover as the event that would end the 37-day armed standoff here. But they said they may have to wait seven or eight days anyway before trying any new tactic to end the siege.

Referring to optimistic predictions by two of the Branch Davidians' lawyers that the standoff may end after Passover, which according to Jewish tradition began this evening, FBI spokesman Richard Swensen said: " 'After Passover' can be an indefinite period of time. I don't have any faith whatsoever in any specific time frame that David has laid out to anybody."

On Sunday, Jack Zimmerman, attorney for Koresh disciple Steve Schneider, said, "Were we not on the eve of Passover they'd be out by now."

Swensen said he does not know whether, for the cultists, Passover lasts seven or eight days, and added, "We're frankly still up in the air as to even when Passover begins to David."

The standoff, he added: "will end, hopefully after Passover and hopefully right at the end of Passover. But it will end in David's time frame."

Swensen said federal negotiators probably would initiate talks with the Davidians during Passover, however long it lasts. But Zimmerman and Houston attorney Dick DeGuerin, who represents Koresh, said they would not return to the compound until called by the cultists when they are ready to leave.

The "mainstream" Davidian Seventh-day Adventists, a splinter group from which the Branch Davidians broke, today issued a statement advising reporters here not to "expect or predict anything apocalyptic to transpire during this Passover week. The Destroying Angels will not pass over during this Passover week."

Norman Archer, chairman of the group's Waco headquarters, said Koresh's group observes Passover from this evening until sunset April 12. His sect, he said, does not observe Passover, but believes that, during some future Passover week, the Destroying Angel will "slay the wicked" as a prelude to the return of Jesus Christ.

Federal officials said today that Jesse Amen, 40, an itinerant California fruit-picker who slipped into the encircled compound March 26, left yesterday apparently because he could not get along with Koresh's followers.

Amen, who told the FBI that his father's name was Lord Lightning Amen, is jailed without bail on a charge of interfering with the duties of police officers.

Swensen said that, apart from saying that Koresh had washed his feet, Amen provided investigators with "zero" information about his 10 days in the compound.

"Mr. Amen made no sense about anything he said with us," Swensen said.

Amen was the 36th person, including 21 children, to leave the compound, where Koresh and more than 90 followers have been barricaded since a Feb. 28 gun battle during which four agents of the Bureau of Alcohol, Tobacco and Firearms and an undetermined number of cultists were killed when ATF agents tried to search for illegal weapons.

Health Reform Fever?

Pollsters Take the Public's Temperature on Various Proposals as the Debate Progresses

By Dana Priest
Washington Post Staff Writer

PHOENIX

The thought of paying higher taxes does not sit particularly well with Ronald Wilson and Cheryl Davis. But it is something these two Arizonans might consider, as long as the money were applied to improving the country's health care system.

"I guess I would be willing to pay higher taxes if reforming the system now costs less in the long run," said Davis, a secretary. "Someone has to pick up the tab. If we can pick it up while it's cheaper, that's better."

"It depends—what will I be getting for the taxes?" asked Wilson, an engineer. "I'm not interested in the government providing health coverage for everyone."

Their qualified responses illustrate one of the most daunting obstacles the Clinton administration faces in health care reform: selling a new plan to the vast majority of middle-class Americans, and to a lesser extent, senior citizens, who receive good health coverage from their employers or Medicare. These are the people who may be asked to give up some benefits and pay more in taxes to finance coverage for low-income individuals and many of the 37 million people without insurance.

To map out a political strategy, President Clinton and Hillary Rodham Clinton, chairwoman of the President's Task Force on National Health Care Reform, have kept a close eye on public opinion polls ever since health care reform burst onto the political scene following the surprise 1991 upset victory in Pennsylvania of Sen. Harris Wofford (D), who made health care the cornerstone of his campaign.

It was Clinton, sensing the importance of the middle class's health care concerns, who forced President George Bush to address the issue during the campaign debates. Since the election, pollsters, including some working with the Democratic National Committee, have periodically sampled public opinion. The aim is to identify the "hot button" issues that Americans will insist be part of any proposal and to determine the kinds of trade-offs people are willing to make for the sake of a more stable system.

A survey published last month by the Henry J. Kaiser Family Foundation indicates that there is some acceptance by the public that major health care reform will require individual sacrifice.

Those sentiments were echoed by most of the 17 middle-class Phoenix residents recently interviewed at length in groups of twos or threes by The Washington Post. The people in this small sample were either employed and received good health insurance from their employers or retired and on Medicare. They represented a range of educational and occupational backgrounds, including some in health care-related fields.

Arizona was chosen because the characteristics of its population reflect the nation as a whole. It is also one of a handful of states—California, New York and Minnesota among them—where independent polling organizations recently have conducted statewide surveys so that ancedotal responses can be compared with statistical data.

Public vs. Experts

In a 1992 poll by Louis Harris & Associates for the Flinn Foundation, a nonprofit philanthropic group in Arizona, 54 percent of Arizonans said they would be willing to pay additional taxes to provide medical care for those without insurance. The poll surveyed 1,999 Arizonans.

But twinned with this support is the feeling, at times insistent, that the doctors, hospitals, insurance companies and drug makers who have benefited financially in the 1980s should be limited in what they can earn in the 1990s and beyond. While generally distrustful of big government, people in Arizona seem to want government to control health care prices.

"It has to be everywhere, from the person who makes the screw for the wheelchair on up," said Rhonda Savoia, a service representative for Blue Cross Blue Shield of Arizona who was interviewed about her personal feelings on health care reform. "I believe in free enterprise, but there's a point at which you have to limit what they can charge."

John Rotunno, 91, a retired vaudeville performer, explained his views on prices at a local senior center: "Someone's making a lot of money," he said. "Tell President Clinton to get the FBI to find out where the money's going . . . I paid $800 for my little hearing aids, and you know damn well they didn't cost $800 to make."

> I guess I would be willing to pay higher taxes if reforming the system now costs less in the long run. Someone has to pick up the tab.
>
> Cheryl Davis
> Phoenix secretary

According to the Arizona survey and a national poll taken by Harris several weeks earlier, about 47 percent of Arizonans and 43 percent of the nation "strongly agree" with setting doctor and hospital rates; in addition, 28 percent of Arizonans said they "agree somewhat." Some 46 percent of Arizonans and 45 percent of the nation "strongly agrees with setting prices for prescription drugs"—with another 27 percent of Arizonans agreeing somewhat; and 45 percent of each group "strongly agrees" with setting rates insurers can charge for health policy premiums—an additional 31 percent of Arizonans agree somewhat.

In the more recent Kaiser survey, 78 percent of the 1,255 adults questioned said they support limits on annual insurance-premium increases, and 76 percent support emergency

1/3

Today's debate is on **WAR IN FORMER YUGOSLAVIA** and whether arming the Bosnians would help bring peace.

Press the U.N. to lift Bosnian arms embargo

OUR VIEW **The U.S. should work to end the U.N. arms embargo to help level the battlefield for Bosnian Muslims.**

If the United States does what it should, Bosnian Muslims may soon get a crack at a fairer fight.

Secretary of State Warren Christopher said Monday the U.S. is ready to consider pressing the United Nations to lift an arms embargo on Bosnian Muslims unless Serbs accede to a peace plan.

He should push hard. Serbs have thumbed their noses at repeated U.N. efforts to bring peace to the region. Perhaps they'll respond better to the threat of a better-armed enemy.

So far, Bosnian Muslims have been fighting with both hands tied. The embargo, imposed in 1991 against former Yugoslavia to slow an assault on Croatia, has left them virtually defenseless.

Bosnian Serbs, meanwhile, claimed the Yugoslav army's military riches — 1,000 tanks, thousands of armored vehicles, 400 combat aircraft, 200 helicopters and 28 warships and submarines.

The Muslims have no aircraft, only a few mortars, a few pieces of heavy artillery and a half dozen tanks, plus rocket-propelled grenades and rifles captured from the Yugoslav army.

The result: The well-publicized slaughter and rousting of hundreds of thousands of outgunned Bosnian Muslims by Bosnian Serbs.

It's time to level the field. In return for lifting the embargo, Bosnian Muslims must pledge not to use the arms to retaliate against Serb civilians.

Ending the arms embargo does entail risks. It could undercut Russian President Boris Yeltsin, whose opponents are sympathetic to the Serbs. And once the Muslims are armed, France and Britain will likely move their peacekeeping troops out of harm's way, threatening ground-based humanitarian efforts.

The fighting also will escalate unless the Serbs back down.

Yet the consequences of doing nothing are certain: Serbs will continue their relentless slaughter.

Grim alternatives, but the right choice is clear: The U.S. should push to give Bosnian Muslims the tools to fight their own battles.

▶ Increasing pressure on Serbs, 4A

More arms is no answer

OPPOSING VIEW **You don't put out a fire by throwing more gasoline on it. Work with peacemakers instead.**

It's easy to understand why the United States and the European Community have reached the limits of patience. For a year and a half, we've watched Muslims, Serbs and Croats kill each other, heard reports of mass rape and murder and been outraged that relief shipments are blocked. We've sat by helplessly as U.N. negotiations have faltered and have hoped sanctions would shake sense into the Serbs. We feel powerless because nothing has succeeded.

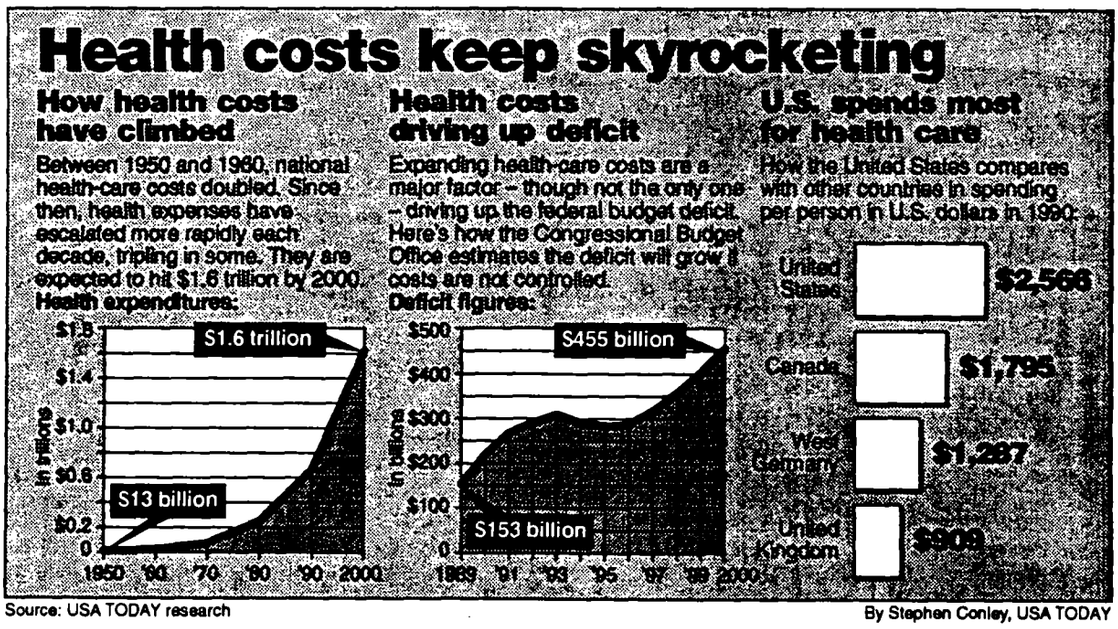
By Virginia Baron, a New York writer.

The world is waiting for us to do something, but must it be the provision of more force? President Clinton and Boris Yeltsin have just conferred on how the United States and Russia can cooperate, after years of pouring money and manpower into weapons that depleted national resources and now threaten everyone's safety again. Somalia is awash in old U.S. and Soviet weapons, endangering lives on all sides there. U.S. citizens and police are finally rejecting gun-lobby myths and demanding gun control because we're sick of violence. Why do we think more arms in Bosnia will end the killing?

What can we do? Support forces for reason and reconciliation in Bosnia, Croatia and Yugoslavia. Give them voice in our media. Increase radio coverage in the area and strengthen networks of resistance that already exist.

Expansion of the war will cripple the democratic process now struggling to operate. As in Somalia, the West deals only with the "warlords" and not with the democratic movement, the anti-war majority. There are Serbs who are defending their Muslim neighbors, communities resisting "ethnic cleansing." These are today's Solidarity workers, the dissidents pleading for our support. More weapons will only lengthen the war, deepen regional despair and postpone permanent solutions.

Don't expect health-care reform any time soon



Source: USA TODAY research

By Stephen Conley, USA TODAY

Changes needed?

We are going to have to see a lot more Americans in strict managed-care types of environments, HMOs, staff and group model HMOs. We're going to have to see a good chunk of the hospital beds in America close or be eliminated. We have a hospital industry that runs at somewhere between 65% and 70% capacity and makes a profit. There's no other industry in the Western world that could operate at 65% of capacity and still be in business. We are going to have to see a lot of specialists in America transform themselves into retirees or general practitioners. We have somewhere between 60%-70% of our medical professionals in specialities, 30%-40% in general practice. Every other country in the world, those percentages are reversed. So it is clear we have many more anesthesiologists, radiologists, surgeons, urologists, whatever than the least-cost mix of resources. You will see a lot more services being provided by nurse practitioners, by other kinds of technical-support staffs, and for all of this to occur to get the full benefits out of a system, it takes time. Besides fewer hospital beds, fewer specialists, a managed-competition system would also lead to a lot fewer insurance companies.

Where can we find some savings?

If you do managed competition, you have to ask: "Where are the savings going to come from?" A lot of people would like to think malpractice reform is going to save you big bucks or administrative reforms are going to save you a whole lot. But they really aren't.

These are things that'll save some money, but the real problem is not the level of health-care spending; it's the rate of growth. So what we have to do is think about ways of slowing down the rate of growth of health care.

It's nice to get the level down, too, but I'm saying that those various steps like administrative reform, malpractice reform, etc. that we all know can ratchet down the level really do nothing for the underlying rate of growth unless you think that these problems each year get more and more serious, and there's no empirical evidence to suggest that that's the case.

Can 'managed competition' work?

We have to understand that managed competition is something that doesn't exist anywhere in the world. Our feeling at the Congressional Budget Office is that such a system could be successful at reducing costs, but it's a very iffy proposition. It also is terribly important to realize it would take a good deal of time to reach this potential.

For managed competition to work, it's probably going to have to evolve. The system will work basically by having four components. The first is providing the consumer with financial incentives to buy the most cost-effective health care. . . . [But] having a motivation is not enough. You have to be an informed consumer, so another element is to provide consumers with information on quality, on outcomes, on other dimensions of the various health-care plans being offered. . . . You have to have a system whereby employees and others can periodically have an open-enrollment period and move from one plan to another. But that isn't all that is necessary. You have to have some way to protect the market from unfair competition. There is an immense amount of unfair competition that goes on where insurance companies are interested in insuring the healthy.

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Court declines appeal of Marine spy case

By Tony Mauro
USA TODAY

Clayton Lonetree, the first U.S. Marine ever court-martialed for spying, was thwarted by the Supreme Court on Monday in his effort to get his conviction overturned.

But his lawyer, Lee Calligaro, says Lonetree remains optimistic that he will be freed soon: "He is very confident that it will all work out in the final analysis."

Lonetree is serving a 25-year sentence at Fort Leavenworth, Kan., for having an illegal affair with a Russian woman and leaking classified information to the Soviet Union while serving as a guard at the U.S. Embassy in Moscow.

AP

LONETREE: Still has separate appeal pending

The court declined to hear Lonetree's appeal that his 1987 conviction was improper because illegally obtained confessions were used against him and because he never learned the identity of a secret witness who testified against him.

He still has a separate appeal pending in lower courts that seeks to overturn his conviction because of mistakes made by his first lawyer, William Kunstler.

A military appeals panel found that Kunstler gave Lonetree "bizarre and untenable advice," but a military judge is studying whether reversing his conviction is warranted.

Also Monday, the court:

▶ Let stand the conviction of Louisiana federal judge Robert Collins for accepting a $100,000 bribe.

▶ Ruled in a Texas food-stamp dispute that the federal government may collect interest on some debts owed to it by states.

▶ Let stand a lawsuit claiming that Argentine military officers tortured Jose Siderman because he is Jewish. Argentina had claimed it is immune from such lawsuits in U.S. courts, but a lower court ruled that it may have waived that immunity.

Don't expect health-care reform any time soon

Hillary Rodham Clinton's task force is facing a deadline in early May to propose the outlines of a health-care-reform proposal. The proposal is expected to be based on a "managed competition" program, which would aim to guarantee coverage for everyone and control costs with competition among insurers. Congressional Budget Office Director **Robert Reischauer** discussed health-care reform with USA TODAY's **editorial board.** His remarks were edited from that interview.

USA TODAY

What is driving the high costs?

I'm a believer that what is happening is we are able to do things that we didn't dream of five or 10 years ago. We have basically no brakes on our system. People ration or determine what they purchase in our society in two different ways. One is individually. You have a budget constraint and you earn a certain amount and you have to decide. And those are personal decisions. Most of what happens in our society happens that way. You also have societal budget constraints. Defense: We decide we're going to spend $268 billion on defense and Congress votes on it, and that's the amount.

Health care is controlled by neither of these. The health-care system that we have has no constraints on it because nobody realizes how it's all being paid for. Most Americans don't think they are. And so there's sort of no reason for you to be concerned. Now why did cash wages grow so slowly over the past decade and a half? The answer is because medical fringe benefits went up so fast. . . .

The providers are basically a bunch of guys who have trained to provide the absolute best health care they can to a patient coming in. If Test A can improve the outcome by one iota, they're supposed to do it. Professionally, they believe that's the right thing to do. So you have the providers on the one hand trying to do everything that they know how to do, and the consumers are saying, "Do everything you can." So it's a combination of technology and this lack of a budget constraint anywhere.

How soon will we see changes?

We'll have a proposal [this year]. We'll have big debate, and this will come down to how strongly the president and the administration push for this. Even if they push quite hard, it's going to be something that, given the pace at which Congress moves, takes a number of years. . . . The problem is if you decided managed competition in October — a fantasy — it would probably take a year or two to write the regulations and implement decisions. It'll take another year or two to set up the health-care purchasing cooperatives and figure out how they're going to run. You'll probably be out with your first bids in four years or so. But in the meantime, you might have this other stuff (state experimentation) going along. It's too bad the state experimentation hadn't gone on starting in the early 1980s because then we'd have the benefit of that knowledge now. It takes years for them to get in place and then years to evaluate so you need reasonably five, six, seven years to come with any lessons. And you have to ask yourself, is it all going to be superseded by the [managed competition] proposal? . . . It's probable that if something (a managed competition plan) really did go through [Congress] or appear to be about to go through, it would contaminate the results of these experiments simply because the system would be reacting not only to the new New York state or Minnesota plan, but also to what is coming down the pike for federal legislation, and it would be positioning itself to be able to cope with that. And so it's not clear what you get out of this.

Will spending fall?

I find it very hard to believe that any kind of health-care reform in the short or intermediate run — meaning probably for the next decade — is going to lower federal spending on health care. I say this for three reasons. One is health-care reform is almost going to certainly involve more coverage of the uninsured. No. 2, health-care reform is almost certainly going to involve a leveling of the provider-reimbursement playing field. Right now, the big public programs of Medicare and Medicaid don't reimburse providers at the same rate that private health insurance does.

Finally, it's hard to think that we would define a standardized benefit package for the working-age population that was more generous than one defined for the elderly. Elderly have Medicare. It doesn't cover prescription drugs, doesn't cover long-term care, has no catastrophic limit to it. So you're going to have three things that'll drive up federal costs, and they might lead to willingness to accept new taxes.

Will it affect deficit?

We have a president who has committed himself to deficit reduction, and that's a big change. He has produced a deficit-reduction plan that is about three-quarters the size of the deficit-reduction plan adopted in 1990. It's going to lead to lower deficits in the intermediate term but is insufficient to solve the long-run problem. Even by his figure, by 1998, the deficit begins to rise. It begins to rise in large measure because of health-care costs. So, in a sense, we're waiting for the other shoe to drop. If the administration can do something about health-care costs, maybe we will have a prettier picture in the long run than the numbers now suggest. . . . But some kind of health-care reform is essential if we're ever in the long run — 15-25 years from now — going to get the budget problem under control, and it might involve a short-run increase in government expenditures to get us to that situation.

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From Boston Globe Page 18

New aid from West can cut both ways for Yeltsin

By Fred Kaplan
GLOBE STAFF

News Analysis

MOSCOW – Two questions emerge from the aid package President Boris Yeltsin brought home with him from Vancouver last night. First, how much and how quickly can it affect his popularity? Second, will it help him or hurt him?

One of the first things Yeltsin did last night, upon touching down in Siberia on his way back to Moscow, was to tell a crowd of well-wishers that this package of Western economic aid is different from the last package.

The last one, a $24 billion promise from the International Monetary Fund, was a lot of "advertising," Yeltsin said. This one is "concrete – we can control it starting in April and that's important."

The fact that Yeltsin had to apologize about aid before touting it as a virtue was a telling sign of a trend often overlooked in the West: Among a growing number of Russians, Western aid has taken on a taint not just of shame, which has always existed to some degree, but also of trickery.

Clinton devised the aid package to bolster Yeltsin's political fortunes at home. Yeltsin is now using his winnings as part of a campaign to gain support in an April 25 referendum that asks the Russian people whether they have confidence in their president.

However, Oleg Bogomolov, a well-known economist here with centrist political views, said yesterday, "I'm afraid that this massive Western moral support for Yeltsin can turn out to be counterproductive. Domestic support for Yeltsin's policies is not very large. So, for the West to provide such support – this makes us suspicious."

Already, Yeltsin's opponents are playing on this suspicion. Mikhail Astafyev, a leading hard-line deputy in the Russian congress, said yesterday that the summit was "just a propaganda campaign arranged by the West."

But Yuri Shchekoshchikin, a journalist for Literaturnaya Gazeta, said Yeltsin can overcome these doubts, at least among public opinion, if the money is seen to be invested in real projects.

Clinton seemed aware of this need in composing his aid package. Over 60 percent of the $1.6 billion will be distributed to the private sector, not through the central government, and in very specific projects: $58 million to repair oil pipelines, $50 million for a private-enterprise fund, $6 million for housing construction, and so forth.

Clinton also said in Vancouver that the $24 billion IMF program "was contingent on all kinds of things which never happened and could not reasonably have been expected to happen."

The $24 billion never materialized and, for that reason, has come to be an object of great resentment here – a symbol of the West's duplicity and Yeltsin's gullibility.

Earlier this month, Ruslan Khasbulatov, speaker of the Russian parliament and Yeltsin's main political foe, told the Congress of People's Deputies, to stormy applause, that Presidents Reagan and Bush "promised a lot . . . for . . . breaking up the Warsaw Pact, then for breaking up the Soviet Union, but the US Congress never gave a single penny."

Clinton seemed to address that point on Sunday when he said: "We're going to try to make sure that anything we say will be done – in fact will be done."

Last night's Russian TV newscast "Vesti," which tends to be pro-Yeltsin, echoed this theme, calling Clinton's package "realistic financial aid." Yesterday's Izvestia, which also supports Yeltsin's reforms, called it "realistic and effective."

Assuming Yeltsin can put a positive glow on Western aid, the question remains: Will the results be visible quickly enough to matter?

Even "Vesti" blew cautionary signals here, quoting US officials as saying it will take a few years for the Russian economy to turn around.

Yeltsin may have to hope that various social groups will feel grateful up front for benefits they may reap many months from now.

For example, the powerful oil and gas interests – which Prime Minister Viktor Chernomyrdin long represented – will certainly feel kindly toward the $2 billion worth of equipment repairs from the Export-Import Bank. But will they see it as help or just another inroad for a Western oil company trying to get a good deal out of exploiting Russian resources?

The military will be glad to see the $6 million to build houses for its masses of retiring officers, but that only buys 450 houses. Will they see it as a good start or a laughable trifle?

Enterprise funds, educational seminars for bank managers, grass-roots doctor programs – few doubt such programs will help reform. But will they wend their way into the hearts and minds of the Russian people over the long haul?

Their effects in the short run – which, right now, may be what is most on Yeltsin's mind – nobody can predict.

X

deled on Canada's.

Magaziner, speaking via satellite, told the ence it would be politically difficult to sell such a plan, since it would entail a huge tax package to set the system up. "It's difficult to get from here to there," Magaziner said.

The Clinton administration favors keeping the current system under which most insurance is provided through employers, he said, but with modifications to include the uninsured and make insurance more affordable.

Magaziner also reiterated that the task force favors a "health security card" to guarantee coverage as people change jobs; a comprehensive basic benefits package; and free choice of providers, among other things. An Associated Press story reported yesterday that the "health security card" may use Social Security numbers to keep track of patients.

Clinton Aide Says Health Plan Precepts Are Set

By Christopher B. Daly
Special to The Washington Post

BOSTON, April 5—Using satellite technology, White House aide Ira Magaziner told a health care reform conference today that President Clinton's task force has reached agreement on the basic principles of a national health plan and is about to fill in the details.

Addressing a daylong conference organized by Sen. Edward M. Kennedy (D-Mass.), Magaziner also said the task force will probably miss its May 3 deadline by a week or two but that the administration plans to submit legislation by the end of May.

Magaziner said the task force plan will guarantee health care to all individuals, whatever their health, employment or economic status, from cradle to grave. It will allow a maximum of choice while cutting bureaucracy, reducing costs and improving quality, he said.

The conference was designed to allow Massachusetts health care providers to offer their ideas to representatives of the Clinton task force. Responding to questions via a two-way video hookup, Magaziner said the plan will provide new incentives—including higher pay—for doctors to enter primary care, such as family medicine or pediatrics, rather than medical specialties.

An issue of special concern in Boston is the fate of large teaching hospitals, which typically charge more for the same procedure than community hospitals because they are training new doctors.

The conference was held at New England Medical Center, a training facility of Tufts University Medical School. Among those attending were the chiefs of the teaching hospitals affiliated with Harvard, Boston University and others.

"I think we recognize the important role that is played by the teaching hospitals, and we're not going to want to see that role diminished," Magaziner said, promising continued federal support.

Kennedy, who organized the conference with the White House's blessing, said in an interview that he believes "the president is on the right track." He applauded Magaziner's "extraordinary outreach," saying he had never worked so closely with the executive branch.

Kennedy had arranged for a staff member to attend each of the specialized sessions during the conference, which drew an overflow crowd of more than 600 health specialists. Those same staff members serve on the White House task force, providing a link between the medical community, the senator and the president.

Kennedy aides acknowledged that the conference would have political benefits as well for the senator, who is up for reelection next year, by allowing him to connect with an important constituency. But they said the conference also reflected Kennedy's prominence in the 20-year debate over health care reform.

Governors Seek Right to 'Opt Out' of Federal Health Cost Controls

By Dana Priest and Ann Devroy
Washington Post Staff Writers

Representatives of the nation's governors yesterday asked the Clinton administration to allow states to implement health care reform measures that differ from the managed competition approach the president favors and to "opt out" of federally set short-term cost controls if they are "too onerous or unrealistic."

In a meeting with top staff members of the administration's health care task force, four governors said the federal government, not the states, should be responsible for enforcing any short-term cost controls, and that states should have the option of requesting that any controls be removed early, according to the governors' internal working documents, which they used in the briefing.

The papers do not define what is meant by "onerous or unrealistic" controls, but the options being considered by the administration's health care task force would require a large, new bureaucracy to implement and enforce private-sector controls, presumably at added cost to states.

States should also be given a chance to opt out of using price controls if they have alternative approaches that "meet the general goals of the national cost control strategy," the briefing papers state. "This may include states that have their own well-developed [doctor and hospital] rate-setting systems or those that may want to accelerate other forms of long-term cost containment.

Clinton, a former governor who is unlikely to forget his dealings with the federal Medicaid bureaucracy, has said he wants to give states maximum flexibility in implementing health reform. He has made no final decisions, however.

"The president has always stressed the need for state flexibility," said health care task force spokesman Bob Boorstin.

But administration officials say flexibility would be permitted only within the framework of certain federally established goals. For instance, while some states might choose to use a single-payer, Canadian-style approach, they would still be required to make a federally mandated standard package of benefits available to all state residents.

The meeting yesterday included governors Roy Romer (D) of Colorado, Carroll A. Campbell Jr. (R) of South Carolina, Howard Dean (D) of Vermont and George S. Mickelson (R) of South Dakota, all proponents of health care reform within the National Governors' Association.

The meeting followed the enactment in Florida of a major health reform bill that uses market competition and government regulation to guarantee access to care for all residents while aggressively controlling costs.

"What has happened in Florida is a very good sign because it demonstrates that states are committed to reform," said Boorstin.

But Florida is atypical. Most other states have not yet found politically acceptable ways to curb rising health costs and guarantee coverage for the uninsured. Financial rewards for states that meet health spending limits and quickly insure the uninsured is one of the options under consideration by the task force.

Citing the fact that managed competition has no proven track record—it does not exist in any significant form anywhere in the country—and implementing it may prove difficult for some states, the briefing paper says that "rather than develop a compromise that may not work, the federal government should allow for different, coherent proposals to develop in different states."

The governors also asked the administration to allow most Medicaid recipients to purchase health benefits through the proposed regional health insurance purchasing cooperatives where most other Americans would buy health coverage under the administration plan.

The cooperatives would bargain with health networks of doctors, hospitals and others to provide a standard package of benefits for an annual fixed fee.

...n highly structured residential care to group homes to living on their own with access to outpatient care.

The Massachusetts effort, however, has been bedeviled by budget cutbacks, inadequate community services, and the difficulty of coordinating care among many private agencies.

$14m apparently saved

From a purely economic perspective, Massachusetts' pilot effort in managed care appears to be successful. Out of a total budget of $200 million for mental health and substance abuse services projected for 1992, MHMA appears to have saved the state about $14 million, largely by moving substance abuse treatment out of hospitals and into less expensive detoxification centers in the community. And state officials project a savings of $22 million for 1993.

MHMA officials say they will be to able to achieve these savings without significantly reducing the level of care for Medicaid patients.

"I know there's been a lot of anxiety on the part of many providers, but as hospitalizations decrease, our premise is that outpatient services are expected to grow," said Elizabeth Patullo, executive director of MHMA. "We've been authorizing outpatient services since last July and I have yet to have anyone come to me with a case that's been denied."

However, many mental health professionals say the state has already wrung out most of the potential savings in cutting back on excessive hospital stays, and they do not see where additional cuts will come from – other than from an actual reduction of services to the poor.

"Our own experience thus far has been quite positive, but we're all sort of holding our breath waiting for the other shoe to drop," said Dr. Chris Gordon, medical director at Atlanticare West, a MHMA-approved mental health hospital in Lynn. "The pressures on MHMA to limit services are likely to increase this year."

Follow-up care criticized

Many mental health professionals say that some substance abusers and some chronically ill patients are already being stranded without follow-up care.

"Under the old system, the state was aware of the shortfall of residential beds" for recovering addicts, "and we didn't have to throw people back on the street or into shelters," said a substance abuse counselor in Boston who asked not to be identified out of fear MHMA will pull the agency's contract. "MHMA, however, is saying we are not going to pay for their care, and so these people leave and relapse into addiction."

Detox centers that refuse to discharge addicts after five days as required by MHMA (the old standard was 10 to 14 days) say they wind up absorbing the additional costs of treatment. Because clinics are still being paid by MHMA at the old rate of $110 a day per patient, they often spend more per patient than they receive because they are providing more intensive service.

Patullo acknowledges that the reimbursement rate for detoxification may be too low and says she plans to negotiate a higher rate with the detox clinics this spring. She says her company allows patients to spend extra time in detox or outpatient therapy whenever clinicians can make a case for it.

MHMA has not yet compiled the data that will show whether the short-term savings achieved by shorter and fewer hospital stays is cost-effective in the long term. But Alliance members say they have anecdotal evidence that the rate of rehospitalization is up for patients being treated in managed care. And if that's true, the short-term gains from the shorter lengths of stay could be offset by the increased number of times patients are hospitalized.

Mel Urban of Medfield fears that might be the case with his 25-year-old son, who he says was prematurely discharged from Fuller Memorial Hospital, which is affiliated with MHMA, after staying there 13 days because of a psychotic episode. Urban says hospital workers did not consult his family about a major change in medication and put the young man into a day treatment program he despises without exploring alternatives. As a result, Urban's son quickly stopped going for day treatment and is now moping around at home in bed, isolated and regressing.

"I don't think the system provided effective follow-up for him," Urban said. "I don't think MHMA is earning its keep."

From Boston Globe Page 21

Message mixed on health policies

Mass. group responds to Clinton task force

By Dolores Kong
GLOBE STAFF

Doubting the Legislature's ability to cap medical-care expenditures yet asking flexibility to shape health policy changes in Massachusetts, a group of legislators, business representatives and others sent a mixed message yesterday to President Clinton's Task Force on National Health Care Reform.

"One surprising conclusion was that there was no consensus that the state role should be a large one," said state Sen. Michael J. Barrett (D-Cambridge), in reporting the findings of a 35-member workshop to approximately 700 participants in a conference convened by Sen. Edward M. Kennedy. "There was a lack of confidence that the state Legislature could implement a budget or cap" to limit skyrocketing health costs, said Barrett, Senate chairman of the joint Health Care Committee.

The workshop as a whole also thought the state should have the right to add services, such as long-term care, not included in the basic benefits package proposed by the President's Task Force on National Health Care Reform. The workshop included former Gov. Michael S. Dukakis and former state Sen. Edward L. Burke.

"I hope there will be opportunity for states to have some flexibility," said Rep. Carmen Buell, House chairwoman of the joint Health Care Committee.

Only last week, Clinton's chief health adviser, Ira Magaziner, said the administration would give states freedom to take different paths in providing a national benefits package and meeting guidelines for care. For instance, if a state wanted to have a single-payer health coverage system, eliminating the bureaucracy of multiple insurance companies, it would be free to pursue that.

While Dukakis and many of the group's business representatives expressed doubt on the Legislature's ability to control costs, Buell and other legislators in the group said the state has been experimenting with ways to hold expenditures down.

"Granted, we haven't been real successful, but we've been trying," she said.

Barrett said he favors some sort of private-public partnership to control costs, which would "show more backbone than the Legislature has historically shown," when it comes to drawing the line on benefits.

The workshop looking at the state's role in overhauling the health care system was one of 16 working groups that hashed out recommendations for Kennedy to take back to Washington. The topics discussed paralleled those under study by the task force headed by Hillary Rodham Clinton; they included public health, primary care, AIDS and other chronic and terminal illnesses, cost control, and universal coverage and financing.

The participants – doctors, hospital administrators, consumer advocates and others – called upon the Clinton administration to be comprehensive in its changes. They recommended including everything from dental services to long-term care, from addressing minority health care to instituting insurance covering the homeless and unemployed. Those attending the conference, hosted by New England Medical Center, jammed into the main auditorium and two overflow rooms at the Tufts Medical School's Sackler Center.

While the wish list was long, many of the participants expressed a willingness to make sacrifices and a feeling that health care reform will become a reality sooner rather than later.

"The difference in today's conference is that people were beginning to put aside their ideologies and cliches and trying to find a common ground," said Kennedy in an interview. "That really is the basis for genuine compromise. That's what we need."

The discussions yesterday were too brief and general to yield any compromises, but if the disagreements in the working groups over such issues as how to control costs and provide universal coverage are any indication, the real debate over national health care reform has yet to begin.

For instance, some participants were reluctant to forgo what they think is the best approach to health care overhaul – a single-payer health insurance