The original documents are located in Box 16, folder "Health (3)" of the James M. Cannon Files at the Gerald R. Ford Presidential Library.

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MEMORANDUM

THE WHITE HOUSE

WASHINGTON

2/18/76

MEMORANDUM TO: JAMES CANNON ✓
JAMES CAVANAUGH
DAVID LISSY
PAUL O'NEILL
JAMES LYNN

FROM: ROBERT GOLDWIN RG

You may be interested in the attached paper on hospital costs from Martin Feldstein of Harvard.

Attachment

Preliminary Draft

REGULATING HOSPITAL COSTS: AN ALTERNATIVE PROPOSAL

Martin Feldstein

Although national health insurance remains an important item on the political agenda, the serious and detailed discussion of health policy in Washington and in state capitals has turned to the control of hospital costs. Unfortunately, much of this discussion has focused on bringing hospital costs under some form of public utility regulation. Any such regulation is ill-suited to deal with the fundamental cause of hospital cost inflation and would be a source of serious inequities and inefficiencies. There is an alternative policy that deals directly with the cause of hospital cost inflation: control of the form of health insurance. Because the regulation of insurance is already an activity of the state governments, the plan described here would be an appropriate policy for a state government rather than the federal government.

The current paper has four sections. Section 1 discusses the nature and cause of hospital cost inflation. The second section shows why direct regulation would therefore not be an appropriate way to control hospital costs. Section 3 presents the insurance limit plan and discusses the way that it would affect hospital costs. The final section considers the potential acceptability of the insurance limit to consumers, hospitals and health insurance companies.

1. The Nature and Cause of Hospital Cost Inflation

The explosion of hospital costs has created an urgent need for new public policies. In 1950, the average cost per patient day in the nation's hospitals was only $16; by 1974, it was about $125, an increase of more than 650 percent! During the same period, the overall Consumer Price Index rose

only 114 percent. In just the 7 years from the introduction of Medicare and Medicaid in 1966 to middle of 1974, hospital costs increased 160 percent. Today hospital costs are continuing to rise at an annual rate of more than 15 percent.

The dramatic increase in hospital costs reflects a rapid change in the quality and style of hospital care. Other factors affecting hospital costs, including the greater than average rise in hospital wage rates, are responsible for relatively little of the overall cost increase. Unlike the other forms of price increase that are measured by the Consumer Price Index, the cost inflation of hospital care does not mean that consumers are paying much more for the same old product that they bought before but that they are buying a different and much more expensive product today. Today's care is more complex, more sophisticated and, hopefully, more effective.

The very great increase in hospital costs may not be justified by the resulting improvement in the effectiveness of care. The current high price of hospital care may instead entail a serious misallocation of resources and a failure of the health care system to reflect individual preferences. Moreover, high medical care costs are the primary source of inequity in our health systems, imposing financial hardship and a barrier to adequate medical care.

The major reason for the hospital cost inflation has been the very rapid growth in insurance. Extensive health insurance lowers the net price of care that the patient pays out-of-pocket at the time that he consumes services. There is now substantial evidence that hospital insurance makes patients and their doctors consume more services and more expensive services than they otherwise would.

Some simple but striking numbers will illustrate this point. In

1950, when average cost per day was $16, private insurance paid 37 percent of hospital bills. This means that on the average the net cost to a private patient was $10. In 1974, average cost per patient day jumped to about $125, but private insurance was paying 77 percent of the private hospital bill, leaving a net cost to the patient of $23.50. Although the net cost per patient day was up from $10 to $28.50, the general increase in all consumer prices meant that this $28.50 really only bought $13 worth of general goods and services in 1950 prices. Thus, in real terms the net cost to the patient hardly changed at all during the past 25 years. Consumer demand has therefore stimulated and supported the growth of more sophisticated and expensive care.

Looked at somewhat differently, with 77 percent of private hospital costs paid by insurance, an extra $10 of expensive care only costs the patient about $2 out-of-pocket. It is not surprising, therefore, that patients and their doctors continue to encourage the growing sophistication and expense of hospital care.

2. Direct Regulation of Hospital Costs

Direct regulation of hospital costs has been proposed as a way to stop the rapid rate of hospital cost inflation. At first it seems natural to apply the mechanism of public utility regulation to hospitals. However, a more detailed examination of this proposal shows that the problem of controlling hospital costs is fundamentally different from the issues now dealt with by public utility regulation. And, more important, the direct regulation of hospital costs would in the long-run make the nature and quality of hospital services completely unresponsive to the preferences of the patients and their physicians.

Consider first the experience of hospital cost regulation under the Economic Stabilization Program of 1971 to 1974. A special subcommittee of the Cost of Living Council continued to regulate hospital costs during the entire period of price controls. At first, controls were limited to hospital wages and to the prices charged for each specific type of hospital service (e.g. an x-ray, a particular laboratory test, etc.). Although this limited the increase in hospital costs, it did not get at the fundamental cause of hospital cost increase: the rapid increase in the quality or sophistication of services. During the final phase of the Economic Stabilization Program, the regulation of hospital costs was changed to a comprehensive limit on the overall increase in the cost per patient day (with minor adjustments for changes in occupancy rates, etc.). The American Hospital Association then filed suit against the Cost of Living Council, charging that such control of the quality of hospital care went beyond the stabilization program's legislative mandate. The issue became moot when the legislation expired in 1974.

The experience of the Economic Stabilization Program confirmed that the central issue in controlling hospital costs is to limit the quality of hospital care. The problem is thus fundamentally different from the usual subject of public utility regulation. In other fields public utility regulation is used to control the exercise of monopoly power, to set a fair rate of profit on invested capital, and to assume that minimum quality standards are maintained. In contrast to the typical public utility, most hospitals are nonprofit institutions that earn no profits. Minimum standards are already regulated through annual accreditation by a professional association.

Direct regulation of hospital costs is inappropriate because there is

no "technically correct" way to set the quality of hospital care. The appropriate quality of care is totally different in this respect from the appropriate rate of profit for a public utility. Controlling the quality of medical care is not a technical question that can be solved by bureaucrats, by the political process, or by an administrative tribunal. Nor can it be assigned to the process of physician peer review. Although peer review can try to assume the application of accepted standards of care, it cannot properly be used to establish what those standards should be. Deciding on the correct quality and style of medical care requires involving the individual family in the decision of how much they want to spend for medical care and how much they want to spend for other things. Although such direct involvement of households is not possible in determining the appropriate level of spending on such things as public safety or park facilities, it is possible for personal health services. The method that is developed for controlling hospital costs should assume that every individual consumer plays this crucial role in guiding the growth and form of hospital care.

Although imposing an arbitrary limit on the increase in hospital costs might be beneficial for a few years, it would in the long run make the quality of hospital care completely unresponsive to the preferences of the patients. How would a regulatory agency decide whether real hospital costs should rise at 4 percent per year, or 6 percent or 8 percent? After adjusting for the increase in wages and in the prices of things that hospitals buy, should costs and therefore quality be allowed to increase at 2 percent, or 4 percent or 6 percent? An arbitrary choice would eventually mean that the quality of hospital care will be very different from the level that patients and their physicians would choose.

And what would regulation do about differences among hospitals in the cost and quality of care? Would current differences be "frozen in" by limiting all hospitals to the same rate of cost increase? On what basis would a hospital be granted permission to add new services that increase its quality? Or would regulation seek to make all hospitals have the same level of quality and cost except for differences in the diagnostic mix of patients? These questions show two adverse effects of direct regulation. First, to the extent that current differences are maintained by limiting all hospitals to approximately the same rate of cost increase, direct regulation would be unfair to those who now live in the areas served by lower quality hospitals and who would prefer a more rapid increase in quality during the years ahead. And to the extent that all hospitals are required to have the same level of quality, direct regulation would force many lower and middle income families to pay for a more expensive style of care than they want while denying many other middle and upper income families the opportunity to purchase the higher quality of care that they would prefer. In short, direct regulation of hospital costs is not compatible with allowing a variety of institutions to develop in response to differences in patients' preferences.

3. Limiting the Inflationary Impact of Health Insurance

Because the explosion of hospital costs is caused by the growth of insurance, an appropriate way to limit undesirable increases in hospital costs is by restrictions on the insurance of hospital care. The current section outlines a specific proposal that would serve that purpose.

For the current discussion, the most important aspect of insurance is that it distorts the demand for health services. Because the patient

pays only a small fraction of the total cost at the time that he buys hospital care, he is encouraged to seek the most sophisticated services that are available. All hospitals are thus forced to compete for patients and doctors by imitating the range of facilities and staff of the most expensive teaching hospitals. Of course, the patients must pay for this expensive care through the higher insurance premiums that they pay directly or in the form of lower take-home pay. Unfortunately, the individual patient is helpless in limiting the rise in insurance premiums. Although a reduction in the demand for expensive care by all patients would permit lower premiums, no single individual can reduce his own premium in this way. Public regulation to restrict the insurance of hospital care could achieve for the individual consumers what they cannot achieve for themselves.

The original impetus for health insurance came from the hospitals themselves. They favored insurance as a method of prepayment that would eliminate the problem of collecting their hospital bills. As a result, the Blue Cross companies were established by the hospitals with the principle of paying hospital bills from the first day of care. This emphasis on "first dollar" coverage is completely contrary to the basic ideas of insurance as protection against large and unpredictable expenses. And yet, for a long time hospital insurance remained very "shallow," paying a large part of small hospital bills but failing to pay the very large bills that accumulated in a small number of cases. Even today, the insurance coverage is worst where it is needed most: for the payment of the very large "catastrophic" bills.

The time has come to restructure health insurance so that it

provides adequate protection without the unnecessary and undesirable distortion of the demand for hospital care. To do this, the state should restrict the type of health insurance that is sold, requiring every policy to have a substantial coinsurance rate.[1] The coinsurance rate should be set high enough to make patients and their physicans conscious of cost differences and thus sensitive to costs in their choices. To prevent imposing financial hardship or a barrier to needed care, the coinsurance rates should be scaled to income and an upper limit should be imposed on the family's required total out-of-pocket health care spending.

An example will illustrate how this plan of income related coinsurance rates might work in practice; it is important to bear in mind that the specific numbers are only illustrative and could be modified without losing the essential feature of the plan. Families with incomes of $13,000 or more would be required to have a coinsurance rate of at least 50 percent on the first $2,500 of annual health care spending and would be free to purchase any insurance it wants for spending in excess of $2,500. A family that buys complete insurance above $2,500 would face a maximum annual out-of-pocket spending of $1,250 or less than 10 percent of income.

Very few families, probably less than 10 percent, would actually reach the $2,500 maximum. This has two implications. First, for most families the actual out-of-pocket spending would be substantially less than 10 percent of income. Second, almost all families would be spending

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[1] The "coinsurance rate" is the fraction of each dollar of health care spending that the individual must pay out-of-pocket. (In contrast, a "deductible" is the amount that the patient must pay out-of-pocket before the insurance company shares any of the cost.)

at a level at which the coinsurance is effective. This is true even for families that experience an episode of hospital care; with a mean stay of 8 days and an average cost per day in 1974 of $125, the average hospital bill is $1,000.

The coinsurance rate would be scaled down for families with lower income. A simple rule might be a minimum allowable coinsurance rate of 4 percent for every $1,000 of income up to a maximum of 50 percent and applicable only to the first $2,500 of health care spending. This would limit each family's out-of-pocket spending to a maximum of 10 percent of income. Again, almost every family would actually spend less than this maximum and almost every family would be spending at a level at which the coinsurance is effective. The federal Medicaid and Medicare programs would continue as they are now for low income families and for the aged.

The effect of these higher coinsurance rates would make patients and their physicians much more sensitive to the real cost of providing hospital services. Physicians would not order tests or procedures without considering whether their benefit exceeded their higher cost to the patient. In choosing the hospital to which to send a patient, the physician would be more concerned about its general level of cost. The hospitals would respond to the increased cost-consciousness by limiting their rate of cost increase. In particular, community hospitals would discover that they could compete for patients and physicians best by providing care for the vast majority of cases at lower cost than the teaching hospitals instead of competing in quality and range of services with those institutions. In short, substantial coinsurance rates would create cost-consciousness among patients and physicians which in turn would induce

hospitals to limit the growth of the expensive services that patients would no longer wish to buy.

The substantial increases in coinsurance rates would of course lower the cost of insurance. For the great majority of families, the coinsurance rates described above would mean a substantial fall in premiums. Since most health insurance is bought by employers for groups of employees, these lower premiums would show up as higher wages. To assure that this happens without delay, the state might require that all year-to-year decreases in health insurance premiums be paid as additional wages unless some other form of compensation (e.g., greater disability insurance or retirement benefit) is agreed by formal collective bargaining.

4. Would Insurance Limits be Acceptable?

Until a few years ago, I would not have expected an insurance limit plan to be acceptable to consumers, hospitals and insurance companies. I believe that developments during the past few years have specifically changed underlying attitudes and would make a well-conceived and presented insurance limit plan quite appealing.

For consumers and employers, health insurance costs are now very substantial. Any proposal that lowers premium costs for everyone and simultaneously helps to contain the growth of hospital costs should be welcome. Perhaps most significant, the experience with no-fault auto insurance and the recent deductible increase show that the public can be educated to understand that they can benefit by restricting the available insurance.

Hospitals have generally favored comprehensive insurance as the simplest and safest method of collecting their bills. High coinsurance rates would complicate their financial activities, reduce demand for

expensive services, and force them to adapt to a new cost-conscious environment. But the alternative of direct regulation is likely to be even less appealing to them. The insurance limit plan should appeal to hospitals as the only way in which they can retain their independence.

The reaction of the insurance companies would depend in part on how the higher coinsurance rates affected their profits. The reduction in premium income need not entail a corresponding reduction in profits, but this is a complex issue that requires more attention than is appropriate here. More generally, the situation of the insurance companies and of Blue Cross is similar to that of the hospitals. A limit on coinsurance rates may not be desirable in itself but may be better than the alternative. If comprehensive direct regulation is introduced, there would soon be no role for private insurance or Blue Cross. Only by returning to the proper function of insurance, i.e, protection against relatively large and unpredictable expenditures, can the insurers contrive to play a major role in the financing of hospital care.

14

United States Senate

Washington, D. C., February 24, *19*76

Respectfully referred to

The Legislative Liaison
The White House
Washington, D. C.

MF
enl

Herman E. Talmadge

U. S. S.

Form No. 3

16—45102-3 GPO

Health

LEG: LAB & PUB WEL: HEALTH CARE DT:dm

February 19, 1976

Mr. Judson C. Moore
President
Judson C. Moore, Sr. Foundation
Box 21646
Emory University
Atlanta, Georgia 30322

Dear Mr. Moore:

This will acknowledge and thank you for your recent correspondence outlining your interest in and views on the possibility of conducting a White House Conference on Health in Atlanta.

Certainly, I would endorse such a proposal and have already contacted the White House in this regard. I hope that my expression of interest will be helpful.

It was good to hear from you and please let me know whenever I may serve you in any way.

With every good wish, I am

Sincerely,

Herman E. Talmadge

JUDSON C. MOORE, SR. FOUNDATION

Box 21646
Emory University
Atlanta, Georgia 30322

10 October 1975

Honorable Herman Talmadge
United States Senate
Washington, D.C.

Dear Senator Talmadge:

A few weeks ago, a Mr. John Wilson visited your office and left some information concerning my proposal for a Bicentennial Conference on Health. The information left at your office included a letter from me and a brief description of my ideas concerning the format and presentation for a possible health conference.

As a graduate student at Emory University currently involved in studies that I hope to apply towards a future PhD. in Biochemistry, and hoping to correlate this work with a medical degree, I am deeply aware of the great challenges our nation faces in the area of health. My personal interest in health have resulted in the involvement of the Judson C. Moore,Sr. Foundation, (a small family foundation named after my grandfather, a general practitioner) along similar lines of interest in health. Presently, I'm serving as President of this foundation.

When President Ford was in Atlanta last February for an Economic Conference, I had the opportunity to briefly speak with a Mr. Jeffrey Eves (Director of White House Conferences) about the possibility of White House sponsorship of a Conference on Health in Atlanta. The date of the conference could be Spring, 1976. I very briefly told Mr. Eves of the work of my family's foundations and related my feelings as to why a Conference on Health could be beneficial to the Public, Congress, and Health

Professionals. Mr. Eves requested that a report be sent to him outlining ideas regarding the format and presentation of the proposed conference. In a letter to Mr. Eves dated 15 February 1975, I indicated the report could probably be completed in a few weeks. I did not realize the enormity of the task! After working on plans for a conference proposal since March, the report is finally ready to be submitted.

As the nation is rapidly approaching the historic and important Bicentennial year, it is a particularly appropriate time for the citizens of this country to take stock of the health of our nation, its citizens, and its health system. The horizons will be unlimited in regards to the quality of health care our citizens can achieve if the Congressional and Administrative branches of government, the Public, and Health Professionals will work together to discuss and plan:

(1) how they may best define and resolve those crucial health problems requiring immediate attention, and

(2) how they may best contribute to health planning for the future.

The intelligence and resources exist in this country to admirably deal with the two issues above. A properly organized health conference could insure that the intelligence and resources are focused to assure the best possible results. The proposed Atlanta conference would stress coordinated discussion-planning among the Congressional and Administrative branches of government, the Public, and Health Professionals.

This type of coordinated discussion-planning can be very beneficial to all concerned. The proposed Atlanta conference would emphasize and promote the idea that Americans are all part of a great family. America is an economic family, a health family, and a social family. We must live by family priorities. This means sensible and reasonable approaches to immediate problems and coordinated planning in the fomulation of future policy.

JUDSON C. MOORE, SR. FOUNDATION

Knowing of your vital concerns about the health interests of our country's citizens and of the interests of the Domestic Council in assessing the feelings of the public on social issues, I am happy to send this report to you of my proposal for a Bicentennial Conference on Health to be held in Atlanta. This proposed conference would certainly be one important way of determining public feelings on the subject of health. Possibly, a series of these health conferences around the country based on the format proposed in the report, would be of help to the work of Congress in health areas. *

The following report is being sent to President Ford, Vice-President Rockefeller, Secretary Mathews, Mr. James Cannon, Mr. John Veneman, and Mr. Jeffrey Eves. I would appreciate you interest and support in this most vital proposal. If you feel further consideration of my proposal would be useful to the health interests of our country's citizens, I am sure a letter from you indicating this to each of the gentlemen would be most helpful. I submit this report with confidence and optimism, hoping that it may be helpful in assuring a bright outlook for the future health of our great nation.

With best wishes, I am

Sincerely yours,

Judson C. Moore

Judson C. Moore
President

JCM/nw
encl.

* With the general public concern regarding Federal spending, and the obvious need for a serious review in all areas of Federal spending, this conference could be significant in outlining rational assessments of the country's present health status and goals for the future in the light of sound economic policy regarding Federal spending.

ACTION

THE WHITE HOUSE

WASHINGTON

February 25, 1976

MEMORANDUM FOR THE PRESIDENT

FROM: JIM CANNON

SUBJECT: Message on Financial Assistance for Health Care

Attached for your signature are copies of the message for the House and the Senate on the Financial Assistance for Health Care Act.

It has been approved by HEW, OMB (O'Neill), Max Friedersdorf, and the Counsel's Office (Lazarus). Doug Smith has approved the text of the message for the Editorial Office.

RECOMMENDATION

I recommend that you sign both copies of the attached message.

Attachments

THE WHITE HOUSE
WASHINGTON

DATE

TO: Jim Cannon

FROM: SARAH MASSENGALE

Hartmann was told the couple will not qualify for Federal assistance unless they are divorced. This is not true. Federal assistance (medicare) is contingent upon the necessity for skilled nursing care rather

than merely custodial
care.

THE WHITE HOUSE

WASHINGTON

March 2, 1976

MEMORANDUM FOR: JIM CANNON

FROM: SARAH MASSENGALE SM
ALLEN MOORE AM

SUBJECT: ELDERLY COUPLE CONSIDERING DIVORCE TO RECEIVE ADDITIONAL MEDICAID BENEFITS

Hartmann Query: Does the case of the Flint family in Texas present an opportunity for the President to promote his Medicare Catastrophic Proposal.

Answer: No. This situation does not qualify for Medicare because the medical problem is not severe enough. The care Mrs. Flint requires is largely custodial, not medical, in nature.

Medicaid is a logical alternative. The difficulty is that Texas State Medicaid rules require the family's joint resources to be applied toward financing this care.

BACKGROUND

The Flints applied for Medicaid when Mrs. Flint first went into a nursing home. At the time, State officials told Mr. Flint that he would need to pay approximately $300 of his $500/month Social Security and pension income for the care. The State Medicaid program would pay the remainder. An apparent error by the nursing home in billing resulted in a retroactive bill to Mr. Flint of over $500. At that point, Mr. Flint learned that if he were divorced from Mrs. Flint, he would not have this State imposed liability for his wife's care, and all her bills would be paid for by Medicaid since she would be without income.

FEDERAL RESPONSE

This type of situation has been occurring with increasing regularity, but there are limits to what the Federal Government can do. States have the authority under Medicaid law to develop rules within fairly broad Federal guidelines. The result, under current regulations, is a lack of uniformity in the policies of the Medicaid and cash assistance programs with respect to the

responsibility of relatives to contribute toward the cost of supporting someone who is applying for public assistance.

Problems have arisen where SSI policies specify that the income and resources of a spouse or parent of an institutionalized individual are not counted in determining eligibility of the individual for SSI, while Medicaid regulations permit States to hold spouses and parents financially responsible for such individuals when they apply for Medicaid.

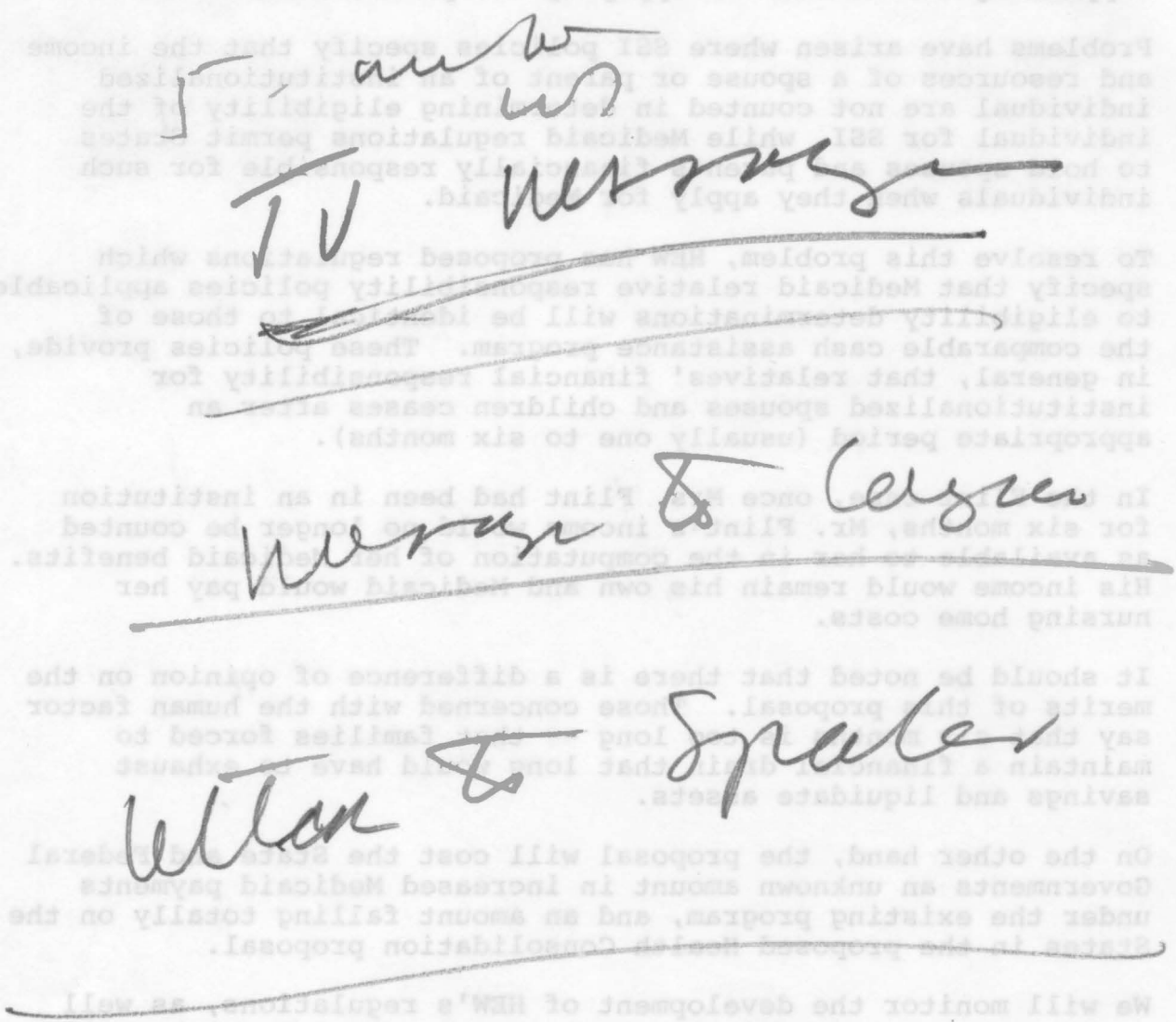
To resolve this problem, HEW has proposed regulations which specify that Medicaid relative responsibility policies applicable to eligibility determinations will be identical to those of the comparable cash assistance program. These policies provide, in general, that relatives' financial responsibility for institutionalized spouses and children ceases after an appropriate period (usually one to six months).

In the Flint case, once Mrs. Flint had been in an institution for six months, Mr. Flint's income would no longer be counted as available to her in the computation of her Medicaid benefits. His income would remain his own and Medicaid would pay her nursing home costs.

It should be noted that there is a difference of opinion on the merits of this proposal. Those concerned with the human factor say that six months is too long -- that families forced to maintain a financial drain that long would have to exhaust savings and liquidate assets.

On the other hand, the proposal will cost the State and Federal Governments an unknown amount in increased Medicaid payments under the existing program, and an amount falling totally on the States in the proposed Health Consolidation proposal.

We will monitor the development of HEW's regulations, as well as the progress of a similar legislative proposal which would reduce the time period to sixty or ninety days. We will report back with more detail when it is appropriate to do so.



THE WHITE HOUSE

WASHINGTON

March 2, 1976

MEMORANDUM FOR : STAFF SECRETARY

FROM : JIM CANNON

SUBJECT : Three Issues From Secretary Mathews

We received this at 5:00 p.m. on Tuesday, March 2 with a deadline of 9:00 a.m. Wednesday. All three of these subjects are particularly complex, and what we provide here does not deal in depth with any of the three problems.

1. Medicaid Reimbursement Fraud Investigations

The Secretary has created an Office of Chief of Investigations to conduct a concerted attack on the problem of Medicaid reimbursement fraud and abuse. A recent case which received national publicity revealed a widespread practice in Chicago area Medicaid clinics in which medical testing laboratories would give cash kick-backs to physicians on Medicaid billings. The states and the Federal government combined spend $14.7 billion in Medicaid reimbursements and the potential magnitude of abuse and fraud is significant. We strongly support HEW's investigative efforts and we should resist any pressures generated in opposition to this program.

2. Maximum Allowable Costs for the Reimbursement of Drugs under Medicare and Medicaid

Regulations to limit Federal reimbursement for the cost of drugs under the Medicare and Medicaid programs are due to go into affect on April 26th, 1976. These regulations originally published under Secretary Weinberger on July 31, 1975, were the result of 1 1/2 years of intensive study and review. While there is significant criticism of this program, it could save as much as $70 million. Therefore, despite this criticism this is a program

which we believe should be supported. There is certainly unnecessary waste in the high cost of prescription drugs under Medicare and Medicaid and these regulations may encourage physicians as well as the consumer to accept the use of equally effective generic drugs in the private health care sector and thereby save millions of additional dollars in unnecessary drug costs.

3. Busing Alternatives

In regard to the Secretary's letter on busing alternatives, I recommend that the President:

a. Should indicate his approval of the fact that Secretary Mathews has given the development of alternatives to busing the "highest priority" within the Department.

b. Should reiterate that a major focus of our efforts should be on identifying ways in which school districts can stay out of courts.

c. Should urge Mathews to press forward with his efforts and to keep the Domestic Council informed of his progress.

d. We sent a busing alternatives memorandum to the President. Up to now we have not learned of his decision as to which specific alternatives he wants explored further.

Cannon FYI

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

OFFICE OF THE SECRETARY • ONE EAST WACKER DRIVE • CHICAGO 60601
AC 312 321-1146

March 8, 1976

Mr. James Cavanaugh
Assistant to the President
The White House
Washington, D. C. 20500

Dear Mr. Cavanaugh:

I had the opportunity to talk with the President on Friday, February 27th and renewed our friendship. As you perhaps know, he has addressed the members of our organization at our Annual Convention five or six times in the past several years.

The pharmacists of this country are disturbed with the regulation on Maximum Allowable Cost (MAC) and Estimated Acquisition Cost (EAC). I believe pharmacists throughout our country, the personnel in these drugstores and others in the drug industry would be happy to see the President intervene in our behalf and get this regulation postponed and give the pharmacists and others an opportunity to have an input, which would certainly provide the needs for all of the medicaid recipients and others that would benefit from this program. We do not want to see an increase in prices. We want to provide quality drugs and, at the same time, have a fee for our professional services that would be adequate for the pharmacist to continue to operate his business.

If the President were to act on this, I think he could expect support of not only the small drug store owner, but the large stores as well.

Sincerely,

Willard B. Simmons
Executive Secretary

WBSimmons:sum
Enclosure
P.S.: 15,000,000 people pass through these drugstores each day of the year!

THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

OFFICE OF THE SECRETARY • ONE EAST WACKER DRIVE • CHICAGO 60601
AC 312 321-1146

March 4, 1976

The Honorable Gerald R. Ford
President of The United States
The White House
Washington, D.C. 20500

Dear Mr. President:

It was a distinct honor and pleasure to have had the opportunity to visit with you for a few minutes last Friday. Kathy and I want to express our sincere thanks and gratitude for the opportunity to renew our friendship, pay our respects and to wish for you every success in the coming campaigns.

I appreciate, Mr. President, your expression of willingness to discuss with Health, Education & Welfare Secretary Mathews the feasibility of postponing the April 26 date for implementation of the MAC and EAC regulations so that pharmacists and others who will be affected by the regulations will have an opportunity to suggest modifications that would be more equitable to all concerned and help assure the continuity of pharmaceutical health care delivery to those who need it.

I look forward to receiving the pictures that were taken whereby we can publish them in the NARD Journal in the near future.

Sincerely,

Executive Secretary

WBSimmons:ldh

NEWS from the N.A.R.D.
THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS

CONTACT: Keith Kellum (312) 321-1146
or
Bill Arrott (312) 565-1200

PRESIDENT FORD TO WEIGH HEW
PRESCRIPTION PRICE PLAN

CHICAGO, Mar. 3--President Ford has agreed to investigate a plan recently proposed by the U.S. Department of Health Education and Welfare that would reduce government payments to pharmacists for Medicaid prescriptions, according to Willard B. Simmons, executive secretary of The National Association of Retail Druggists.

The President's decision stems from a recent meeting with Simmons, who informed the President that the delivery of pharmaceutical health care to needy Americans could be jeopardized if HEW implements its new prescription price reimbursement schedule as planned on April 26.

That schedule, called Estimated Acquisition Costs of Prescription Drug Products (EAC), is a wholesale price list of 300 widely prescribed drugs that HEW wants the states to use as a guide for reimbursing pharmacists for Medicaid prescriptions under the Maximum Allowable Cost (MAC) program.

A NARD study has shown that under EAC, community pharmacists all over the country would be reimbursed for Medicaid prescriptions in a number of instances for less than the actual cost of the drugs dispensed

Simmons said that the President expressed concern about possible inequities to community pharmacists and the resulting curtailment of services to Medicaid patients that might result from implementation of EAC.

"Mr. Ford indicated to me personally that he would talk to HEW Secretary Mathews about the feasibility of postponing implementation of EAC and MAC regulations," Simmons said.

# # # #

THE WHITE HOUSE

WASHINGTON

TELEPHONE MEMORANDUM

JAMES M. CANNON — March 15, 1976, 19

	TIME PLACED	DISC	NAME	ACTION
OUT	AM			
	3:47		George Humphreys called with Joe Boyd's number (212-488-4682)	
INC	PM			
OUT	AM			
	3:50		Willard Simmons, Director of the National Association of Retail Druggists called to speak with you about regulations on medicaid programs and druggists. He is a personal friend of the President and attended a meeting in the Oval Office 2 weeks ago. Mildred Leonard suggested to him that he speak with you.	
INC	PM			
OUT	AM			
INC	PM		312-321-1146	
OUT	AM			
INC	PM			
OUT	AM			
INC	PM		~~Mr. Cannon:~~ Mr. Simmons would be glad to come out to Washington	
OUT	AM			
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INC	PM			

U.S. GOVERNMENT PRINTING OFFICE:1970—O-375-347

March 15, 1976
6:10

Mr. Cannon:

Willard Simons, Director of the National Association of Retail Druggists, would be glad to come to Washington to meet with you. However, would like to talk to you on the phone tomorrow for 10 minutes to discuss his proposals. If you still would like to meet with him here, we can set something up for the week of March 22nd.

_____ yes, I will talk to him by phone 3/16.

_____ no, go ahead a set up meeting next week without phone call.

312-321-1146

INFORMATION

THE WHITE HOUSE

WASHINGTON

March 10, 1976

MEMORANDUM FOR: JIM CANNON

FROM: SPENCE JOHNSON

SUBJECT: Medical Malpractice Update

The availability and cost of medical malpractice insurance has been a visible national issue for the last 18 months. It has resulted from a dramatic increase in the number of medical malpractice suits as well as a substantial increase in the amount of the awards.

Factors contributing to the medical malpractice crisis include: increased technology and complexity of medicine, rising patient expectations, strained patient-provider relationships, increased willingness of the consumer to use the judicial system as an alternative for provider accountability, and the lengthy time-span between the adverse medical occurance and the settlement of a medical malpractice claim. Although the awareness of the causes and the affects of medical malpractice is the highest ever, effective solutions are not forthcoming.

Current trends show that the number of malpractice claims are increasing by about 10% per year, the number and size of awards continues to climb and only six casualty companies are writing policies in more than a single state as compared to twelve a year ago. Also, more doctors are practicing without medical malpractice insurance, especially in Alaska and California.

A fifty-state survey reported recently in Medical World News reveals continued deterioration in almost every state, even in some of those that passed comprehensive malpractice legislation during 1975. Last year over half the states passed some legislation dealing with medical malpractice. In fact, twenty-two states with an immediate crisis of availability of medical malpractice insurance authorized Joint Underwriters Associations (JUAs) or state pools of insurors to assure the availability of insurance.

Unfortunately the JUA concept has drawbacks. In some instances they do not have sufficient reserves which still express participating casualty companies' revenues if JUA reserves are not enough. Also premium rates continue to rise steadily and many physicians are discouraged, if not antagonistic, because they had expected some reduction in the rate of increase of premium.

Most state legislation which was enacted, however, did not deal with the matter of limiting contingency fees, although there is general agreement among experts that this needs to be done. This is true also of collateral benefits, structured payments as opposed to lump-sum payments, and loss prevention or risk control programs. As a result, legislative initiatives taken by the states have not effectively reduced the number of claims, the size of awards, or the increases in insurance premiums.

Perhaps the most dramatic case in point by which to illustrate this thesis is the Indiana law. Passed early in 1975, the Indiana law was considered the best model for comprehensive malpractice legislation. Four key elements were seen that would make the Indiana law effective in stabilizing premiums and creating a competitive environment for insurors; a relatively short statute of limitations, a limitation or cap, of $100,000 on physician-insuror liability, a state insurance fund for doctors who cannot get coverage elsewhere, and arbitration in the form of a mandatory, non-binding screening panel before a malpractice suit can go to court.

Despite this comprehensive approach, there has been no appreciable change in the number or amounts of malpractice suits in Indiana. Also, the cap on doctor's liability which held such great promise in reducing the judgements for medical malpractice claims was held unconstitutional by a lower state court. Many states are now awaiting settlement of the constitutional question of caps before proceeding with legislation in this area.

Another serious concern is the cost of defensive medicine, unnecessary testing as protection against malpractice suits, which has been estimated as high as $7 billion annually. In fact, medical malpractice is the fastest

growing item of dollar cost in the medical care system today. This alone is tremendous cause for concern in an industry that has led others in inflation and cost increases.

Because of the posture of the administration as well as affected groups, including the A.M.A., A.H.A., and A.B.A., that this is not a situation that requires federal intervention, there is effectively little that can be recommended. Though several bills were introduced in the Congress last year dealing with possible federal solutions, and hearings held in both the House and Senate, the concensus there also seems to be that federal intervention at this time is not warranted.

The Federation of American Hospitals, however, at their recent annual meeting did endorse, with some modifications, H.R. 6100, the "Medical Malpractice Claims Settlement Assistance Act" introduced by former-Congressman Hastings in April of 1975. This is the first group to indicate support for a federal approach.

I have attached a recent article from Medical World News which is a fairly comprehensive wrap-up of the current situation. More detailed background information on causes, state-by-state legislative efforts, and a review of proposed federal legislative alternatives can be provided if you so desire.

Malpractice Advisory

A year ago, the malpractice crisis was officially recognized nationwide. The St. Paul (Minn.) Fire and Marine Insurance Company was threatening to leave Maryland and Argonaut Insurance Company was getting ready to pull out of New York. Premiums were doubling and even tripling not only in states like California and Florida where the numbers of suits were multiplying and the dollar amounts of individual awards and settlements were topping $1 million, but also in states like Indiana and North Carolina where suits and high awards were relatively rare. In Michigan, two long-time carriers, Medical Protective and Shelby Mutual, were refusing to write new policies, although they still would insure old customers. It looked like a grim year ahead.

It was, and the outlook for 1976 is worse. St. Paul did, in fact, pull out of Maryland and Argonaut did withdraw from New York. Not only that, but St. Paul has in the past 12 months left 16 other states and Argonaut has pulled out or attempted to leave all states where it was the major carrier, including California, Florida, Idaho, Massachusetts, and Pennsylvania. (It may stay in Hawaii, where it makes a profit.)

MALPRACTICE: GRIM OUTLOOK FOR '76

No doctor can count any longer on finding policies at stable prices

Dr. Hedges at Juneau boat harbor

Several other major insurers, as of January 1975, such as Employers Insurance of Wausau and Lloyds of London, have either voluntarily dropped completely out of the malpractice insurance business or—like Signal Imperial of Los Angeles—have been forced out because of insolvency. About the only big companies writing new policies in more than a single state as 1976 got under way were St. Paul (only in the 33 states that will allow its controversial claims-made form), Medical Protective, Travelers, Hartford, and Aetna.

The list of states with problems either of availability or of exorbitant rates (anything under $10,000 for the highest risk categories is now viewed by many doctors as "cheap") has grown to include all but a handful—specifically Colorado, Georgia, Nebraska, and Oklahoma. Even in these states physicians are uneasy about their future.

Things have gotten so bad for Alaska's 270 physicians that about 30% of them are practicing without malpractice insurance. Doctors in Orange County in southern California are talking of going without insurance en masse if Travelers raises its premiums several hundred per cent this month, rates that would put orthopedists and neurosurgeons in the class paying $36,239. Other southern California doctors have threatened slowdowns if the situation doesn't improve.

Dr. Gary R. Hedges, a Juneau general surgeon who this year is president of the Alaska State Medical Association, says 13 of his city's 16 physicians—including himself—are practicing without professional liability insurance. The only new policies available, he says, are claims-made forms that, unlike St. Paul's, don't even guarantee "tail-end" policies for doctors who retire or switch plans.

"I'm not worse off without any insurance than I'd be with a policy like that," says Dr.

continued

MALPRACTICE LAWS IN THE 50 STATES AS OF YEAR'S END

(Entries printed in color denote proposed legislation for 1976)

	Joint Underwriters Association	Self-insurance Plan	State Insurance Fund	Screening Committee or Arbitration (binding, unbinding)	Limit on Doctor's Liability (X 1,000)	MD-financed Catastrophic Fund	Tort Law Changes	Statute of Limitations (years after incident)	Limit on Lawyers' Fees (%)	Study Commission Established	Insurer Reports Claims to State Insurance Commissioner or Board of Medical Examiners	Major Insurance Carrier	Major Carrier's Rates for Orthopedists ($100,000/$300,000) (boldface denotes claims-made) 1/1/75	(1/1/76)	Legislature Meets	Comment
Alabama	★			★			★	2			★	Employers of Wausau	$1,692	($2,606)	5/4/76	Wausau withdrawing July 1977; ISO proposes rates up to $9,000.
Alaska	★		★	★		★	★	3	★[1]	★	★	Continental	$4,172	($4,172)	1/7/76	About 30% of doctors have no policies; individual premiums up to $40,000.
Arizona	★	★		★	★	★	★	2	N.J.[2]	★	★	Travelers	$3,621	($6,521)	1/13/76	Travelers withdrawing April 1976; Imperial in receivership; no other in sight.
Arkansas	★			★	500	★	★	2	N.J.			St. Paul	$1,686	($2,426)	1/12/76	Medical society hearing of more and larger malpractice suits.
California	★	★		★	★[3]		★	3	N.J.		★	Travelers	$7,200	($36,239)[4]	1/5/76	'Cataclysm' (due to price increases) expected in southern Calif. this month.
Colorado	★	★						2		★		Hartford	$3,122	($3,590)	1/7/76	Legislative thrust is strengthening board of medical examiners.
Connecticut					500		★	3	N.J.	★		Aetna	$5,258	($7,511)[5]	2/4/76	Doctors in droves joining medical society, which has state's only insurance plan.
Delaware	★			★			★	3	N.J.		★	Aetna	$6,297*	($11,010)[5]	1/13/76	All of state's seven hospitals may lose coverage at end of year.
Florida	★	★		★	100	★	★	4		★	★	Self-insurance plan	$8,243	($8,243)[6]	4/6/76	Argonaut withdraws Jan. 1; self-insurance plan has 2,500 applicants.
Georgia	★			★			★	3		★		St. Paul	$1,530	($1,760)	1/12/76	Situation is stable.
Hawaii	★	★		★			★	6	N.J.	★	★	Argonaut	$5,616	($6,884)	1/21/76	Argonaut wants to remain in Hawaii, only state it makes a profit in.
Idaho	★	★			150[7]		★[7]					St. Paul	$3,748	($2,054)[8]	1/12/76	State court ruled doctor's $150,000 liability limit unconstitutional.
Illinois	★	★		★[7]	500[7]		★	5	★	★		Hartford	$3,468	($5,084)	1/14/76	State court ruled liability limits and screening panels unconstitutional.
Indiana		★	★	★	100	★	★	2	15[9]	★	★	Medical Protective	$2,903	($3,289)	1/5/76	New law hasn't appreciably changed malpractice picture in Indiana.
Iowa	★			★	100	★	★	6	★[1]	★		Medical Protective	$1,935	($3,400)	1/12/76	Medical society wants to strengthen board of medical examiners.
Kansas	★			★	100	★	★	2	N.J.	★	★	Medical Protective	$1,810	($3,076)	1/13/76	Many individual physicians paying close to or in excess of $10,000.
Kentucky	★				100	★	★	5	N.J.		★	Medical Protective	$1,823	($3,304)	1/6/76	Governor's task force will propose comprehensive package of bills.
Louisiana			★	★	100	★	★	3	50		★	Hartford	$1,568	($5,241)	5/10/76	Society agreed Hartford correct when it cancelled policies of five doctors in 1975.
Maine	★			★	100	★	★			★	★	Hartford	$1,737	($4,754)	2/2/76	New doctors must pay up to twice ISO rates; JUA not activated yet.
Maryland	★	★		★			★	3	★		★	Self-insurance plan	$2,273	($5,038)	1/14/76	Self-insurance plan has sold 2,000 policies (there are 5,000 doctors).
Massachusetts	★	★		★	★		★	3	★	★		JUA	$2,657	($4,102)[10]	1/7/75	St. Paul withdrawing coverage from some 4,000 doctors; JUA new carrier.
Michigan		★	★	★			★	2½	N.J.[11]	★	★	Medical Protective	$5,551	($7,863)	1/14/76	ISO has filed new premium rates up to $34,883 for orthopedists.
Minnesota				★[11]			★				★	St. Paul	$2,196	($2,630)	1/26/76	Medical society wants to strengthen board of medical examiners.

Montana		★[12]						3		★		Aetna	$7,504	($13,287)[5]	1/3/77	Coverage is available although premiums considered high.
Nebraska		★[12]		★			★			★		St. Paul	$2,586	($3,010)	1/6/76	'As of today, there's no crisis,' according to state medical society.
Nevada	★			★	★		★	4	N.J.	★		JUA	$5,136[13]	($7,675)	1/17/77	As many as 25% of Nevada doctors practicing without insurance.
New Hampshire	★			★			★	2		★		Hartford	$486	($1,693)	1/5/77	'Prognosis' a lot better here than in neighboring states.
New Jersey			★	★	500		★	2	N.J.[11]	★		Chubb & Son	$6,325	($8,165)	1/13/76	Still a voluntary insurance market in New Jersey.
New Mexico	★	★		★	100	★	★	3	N.J.			Travelers	$3,315	($5,781)[14]	1/20/76	Travelers, withdrawing March 1, insures 90% of state's doctors (850).
New York	★	★	★	★[11]	★		★	2	N.J.	★		JUA–self-insurance plan	$14,329	($17,195)[4]	1/7/76	Self-insurance company expects to lower rates; already has 15,000 members.
North Carolina	★[7]	★		★	★	★	★	★				St. Paul	$871	($1,251)	1/12/77	Self-insurance plan has 400 of state's 4,700 doctors as members.
North Dakota		★[12]		★	500	★	★	2	15[16]			St. Paul	$1,819	($898)	1/4/77	Some problems insuring new doctors; companies selective.
Ohio	★			★			★	1	33⅓	★		Medical Protective	$5,148	($5,834)	1/1/76	Doctors disappointed tort reforms did not immediately lower premiums.
Oklahoma					150		★	4	N.J.			Ins. Co. of North America	$1,180	($1,594)	1/6/76	Only INA writing policies, but most doctors can buy insurance.
Oregon		★			★[17]	★	★	5	33⅓	★	★	CNA conglomerate	$3,016	($7,240)	1/10/77	Must renegotiate expiring contract with CNA by end of the year.
Pennsylvania	★			★		★	★	4[18]	N.J.	★	★	Medical Protective	$3,035	($5,957)	1/6/76	With $1-million 'umbrella' coverage, some doctors pay up to $18,000.
Rhode Island	★[11]									★		JUA	$1,209	($5,838)	1/6/76	JUA rates considered exorbitant by doctors, but no other policies available.
South Carolina	★			★	★		★	★		★		JUA	$1,010	($1,716)	1/13/76	St. Paul withdrawing; all doctors must buy policies from JUA.
South Dakota	★	★[12]		★			★	2		★	★	St. Paul	$6,428	($2,087)	1/6/76	Medical society fears exclusive JUA would be 'disaster' if imposed.
Tennessee	★	★		★			★	3	33⅓		★	JUA	$3,128	($12,509)	1/13/76	Shelby Mutual leaving; doctors must buy policies now from the JUA.
Texas	★			★	500		★	2	N.J.	★	★	Medical Protective	$4,065	($6,728)	1/11/77	Houston orthopedists buying basic policy from JUA, plus $1-million excess coverage, pays $26,900.
Utah	★				250		★	4		★		Aetna	$6,186	($10,603)[5]	1/12/76	For 1-year extension, Aetna requires medical society support of new laws.
Vermont				★			★	4	N.J.			Aetna	$4,430	($11,925)[5]	1/6/76	Aetna will pull out if new rates not approved; covers 450 MDs (50%).
Virginia	★	★	★	★	100	★	★	2	15[16]	★	★	St. Paul	$2,728	($3,432)	1/14/76	Availability not a problem, but doctors must pay double for $1 million.
Washington	★			★	300		★	2	N.J.		★	Aetna	$6,356	($10,847)[5]	1/12/76	Will try to get mandatory, binding arbitration next year.
West Virginia	★			★	100	★	★	2	N.J.	★	★	Aetna	$6,575	($10,583)[5]	1/14/76	Aetna only company writing new business in the state.
Wisconsin	★			★	200	★	★	3		★		Medical Protective	$2,433	($3,032)	1/20/76	'Over the hump but still an expensive proposition.' Orthopedists pay up to $11,000.
Wyoming	★	★		★	100	★	★	2	N.J.	★	★	Aetna	$1,899	($7,865)[5]	1/27/76	St. Paul pulled out in June but Aetna picked up most of 120 doctors.

[1]Court decides fees. [2]N.J. denotes so-called New Jersey rule, based on a sliding scale. In New Jersey, it is as follows: 40% on first $5,000, 33⅓% on next $45,000, 20% on next $50,000, 10% of anything over $100,000. [3]$250,000 limit on noneconomic damages (pain and suffering). [4]Provides $1 million/$3 million compared with same coverage by Argonaut on Jan. 1, 1975. [5]Aetna's package plan provides $1.25 million/$1.5 million coverage for orthopedists, plus several other features. [6]Provides $500,000 coverage per claim with no aggregate, compared with $100,000/$300,000 by Argonaut on Jan. 1, 1975. [7]Ruled unconstitutional by lower state court. [8]Provides $150,000/$300,000 compared with $100,000/$300,000 by Argonaut on Jan. 1, 1975. [9]On fees collected from catastrophic fund. [10]Rate hearings in late November may result in increased rates by Jan. 1, 1976. [11]Nonstatutory. [12]Five-state regional self-insurance plan proposed. Of these five states only North Dakota has passed law authorizing self-insurance. [13]Imperial's charge on Jan. 1, 1975 for $1 million/$1 million minimum policy it wrote for Nevada orthopedists before going into receivership. JUA rate is for $100,000/$300,000. [14]Provides $1 million/$1 million package compared with $1 million/$1.3 million by Travelers on Jan. 1, 1975. [15]State currently has six-year statute of limitations. [16]Of awards over $100,000. [17]Class 1 and 2: $100,000; Class 3 and 4: $300,000; Class 5 and 6: $500,000. [18] Limit on insurance company liability only.

THE WHITE HOUSE

WASHINGTON

March 24, 1976

MEETING WITH PRESIDENT'S COMMITTEE ON MENTAL RETARDATION
Thursday, March 25, 1976
12:15 p.m. (10 minutes)
The Cabinet Room

From: Jim Cannon

I. PURPOSE

To be briefed by PCMR on their report and recommendations on mental retardation.

II. BACKGROUND, PARTICIPANTS & PRESS PLAN

A. Background: You last met with PCMR in October 1974. You will recall that the Committee's functions are: to advise the President on the adequacy of the national effort to combat mental retardation; to coordinate activities of Federal, State, local and private organizations; and to inform the public and enlist their support.

At that meeting, you encouraged them to continue work on a major comprehensive report to examine the issues in the field of mental retardation and to get national guidelines for action in this field for the next quarter-century. The Committee has now completed this report, entitled, Mental Retardation: Century of Decision. The Committee's major recommendations, in the areas of full citizenship and legal rights, biomedical prevention, social prevention, humane services and public attitudes, are summarized at Tab A.

Secretary Mathews will open the meeting and introduce the group to you. Brief reports will then follow from several of the Committee members on their recommendations.

In addition to the report, the Committee continues to work toward achieving the national goals set in 1971: to reduce by 50 percent the incidence of mental retardation by the year 2000 and to return to the community 1/3 of the retarded in State institutions.

B. Participants: List attached at Tab B

C. Press Plan: Open Press Photo Opportunity

III. TALKING POINTS

1. Thank you, Secretary Mathews and all the other members of the President's Committee on Mental Retardation. I very much appreciate your coming here today on the first day of your Committee meeting to brief me on your findings and recommendations on activities in the field of mental retardation over the next 25 years.

2. You know that I continue to endorse our national goals to reduce by 50 percent the incidence of mental retardation by the year 2000 and to return to the community 1/3 of the retarded in State institutions.

3. And we will continue to do all we can to help our mentally retarded citizens become productive members of society. We'll work to improve housing and employment opportunities, to see that legal rights are recognized, and to encourage research.

4. But you and I both know, the Government can only do so much to help the mentally retarded live happy and productive lives. Most of the work has to come from the American people in their local communities. This Committee has done a great job in working with people all over the country. I'll be counting on you to continue your fine work for me.

The President's Committee on Mental Retardation has put in 18 months developing the most comprehensive report on the subject since that of the President's Panel in 1962. Major recommendations for the next 25 years deal with:

1. Full Citizenship and Legal Rights--Considerable progress has been made: e.g., a much larger percentage of children receiving their right to public education; many institutions, by court order or otherwise, offering treatment instead of warehousing. While much remaining work must be done by the States, the Federal Government can help in several ways, e.g.: LEAA can assist in improving handling of mentally retarded persons in the civil and criminal justice system; HUD can implement recent legislation on housing for the handicapped; all departments can actively enforce Rehabilitation Act amendments requiring affirmative action hiring of handicapped persons by government contractors. (Chapter 3, pp. 59-68)

2. Prevention (Biomedical)--The Committee sets a goal of reducing the incidence of mental retardation from biomedical causes by at least 50 percent by the year 2000. This can save billions in costs of care and in suffering. It can be achieved through application of present knowledge and advances through research. The report stresses a national education effort to protect the health of prospective mothers and inform them of optimal reproductive age (20-35). Maternal and child health care services must be available to all, especially those with low income and in rural areas. Continued research is needed on a wide spectrum of subjects, ranging from basic reproductive biology to specific problems of nutrition, drug hazards, and fetal development. (Chapter 4, pp. 71-78)

3. Prevention (Social)--In perhaps 85 to 90 percent of cases, mild retardation, not involving identifiable physical cause, is associated with environmental conditions--poverty, racial and ethnic discrimination, and family distress. To the extent that we can improve these conditions, we will reduce not only mental retardation but also crime, ill health, and other costly social ills. Based on successful experience in improving IQs of children in several locations, the report urges, among other things, assisting low-income parents in the early developmental training of their children in their own homes. It also calls for research on the best approaches to equitable, individualized education for all children. (Chapter 5, pp. 81-86)

4. Humane Services--The Committee stresses developmental services to lessen the dependence on supportive services, with protective services as a safeguard when other resources fail. The objective is maximum opportunity for every mentally retarded person to live in a community setting. The report suggests that community "brokers" be available to help retarded persons obtain services. Government should exercise greater quality control over services, and should plan manpower development required for effective service delivery. (Ch. 6, pp. 90-1

5. Public Attitudes--Public acceptance is crucial to retarded citizens in obtaining employment, housing, and recreation opportunities. We must use the education system and the techniques of mass communications to promote recognition of the worth of every human being, regardless of individual differences. (Chapter 8, pp. 107-113)

PARTICIPANTS

Secretary F. David Mathews, Chairman, PCMR
Mrs. Lorraine Beebe, Vice-Chairman, PCMR

Members

Elizabeth M. Boggs, Ph.D.
Geraldine M. Clark, Ph.D.
James D. Clements, M.D.
Henry V. Cobb, Ph.D.
Mrs. Robert A. Collier
Bill J. Doggett, M.Ed.
Arnold G. Gangnes, AIA
Michael R. Gardner
John P. Greene
Morley Hudson
Cecil B. Jacobson, M.D.
James N. Juliana
Lawrence A. Kane
Phillip U. Martinez, M.D.
Mrs. Cherrie Sevick
Beth Stephens, Ph.D.

Ex-Officio Members

John Read, Executive Assistant to W. J. Usery, Secretary of Labor
Mrs. Helen Holt, Assistant to the Secretary of Housing and Urban Development for Programs for the Elderly and Handicapped
Honorable Michael P. Balzano, Jr., Director of ACTION
Honorable Bert A. Gallegos, Director, Community Services Administration

Congressman Clair Burgener
Stanley Thomas, Assistant Secretary for Human Development, HEW
Fred J. Krause, Executive Director, PCMR
Raymond Nathan, Assistant Director, Communications, PCMR

Mr. Frank Menolascino, President, National Association for Retarded Citizens
Dr. Sue Warren, President, American Association on Mental Deficiency